



# HEALTHY HEARTS NORTHWEST

## IMPROVING PRACTICE TOGETHER

Steven Brantley, MPH<sup>1</sup>; Cullen Conway, MPH<sup>1</sup>; Beth Sommers, MPH<sup>1</sup>; Caitlin Dickinson, MPH<sup>1</sup>; Lyle J. Fagnan, MD<sup>1,2</sup>  
<sup>1</sup>Oregon Rural Practice-based Research Network, OHSU, <sup>2</sup>Department of Family Medicine, OHSU

EvidenceNOW  
Advancing Heart Health in Primary Care

### Project Description

Cardiovascular disease is the leading cause of death for both men and women in the United States, accounting for 1 in every 4 deaths.<sup>1</sup> Coronary heart disease costs the US approximately \$108.9 billion each year.<sup>1</sup> Healthy Hearts Northwest (H2N) is part of a three-year national initiative called EvidenceNOW, funded by the Agency for Healthcare Research & Quality, aimed at improving cardiovascular health across the United States. Designed for small- to medium-sized primary care practices, H2N is an opportunity to build Quality Improvement (QI) infrastructure while working towards better heart health outcomes for patients. Each practice works with a Practice Facilitator to tailor the program for their specific needs, and receives 15 months of structured support. Facilitators help practices identify areas for improvement, and introduce practices to new ideas, tools, and methods while guiding them to integrate a comprehensive QI structure into the existing framework of their medical practice.

### Project Support

High Leverage Changes — Key Driver Diagram				Elements of QI Support	Content
Outcomes	Change Concepts	High Leverage Changes	Key Activities/Steps	Health IT assessment & support	<ul style="list-style-type: none"> <li>Assistance and support in the development and validation of practice-level and panel-level CQM reports</li> <li>Optimization of clinical decision support</li> <li>Delivery of benchmarking reports from national, regional, and local comparisons</li> </ul>
Improved outcomes in ABCS measures	Organized Evidence-based Care	Embed clinical evidence on ABCS into daily work to guide care for patients	<ul style="list-style-type: none"> <li>Review the evidence supporting the ABCS for primary and secondary prevention of cardiovascular risk</li> <li>Review treatment guidelines for ABCS measures</li> <li>Educate staff on clinical guidelines</li> <li>Select patient ed materials for primary and secondary prevention</li> </ul>	Practice facilitation	<ul style="list-style-type: none"> <li>Regular technical assistance on QI methodology, tools, and strategies</li> <li>≥8 on-site practice visits over 15 months, monthly phone calls, and ad hoc practice facilitation availability for needed support</li> </ul>
	Quality Improvement Strategy	Utilize reliable, robust data to understand and improve ABCS measures	<ul style="list-style-type: none"> <li>Develop process to pull data from EMR</li> <li>Review data for accuracy and build confidence in data</li> <li>Develop process to support accurate data entry/collection</li> <li>Use data to identify gaps between the evidence-based guidelines and current care for all patients on panel</li> <li>Create population-based reports and visual data dashboards</li> </ul>		
	Continuous Team-based Healing Relationships	Establish a regular QI process involving cross-functional teams	<ul style="list-style-type: none"> <li>Set aside regular meeting time for cross-functional QI team</li> <li>Select a QI methodology (PDSA, MFI) to structure improvement efforts</li> <li>Train team members on QI methodology</li> <li>Practice good meeting skills</li> <li>Regularly review data on ABCS outcome and process measures to understand areas for improvement</li> <li>Invite patient(s) to participate on the QI team</li> </ul>		
	Patient-centered Interactions	Identify at-risk patients for prevention outreach	<ul style="list-style-type: none"> <li>Understand current patient panel relative to ABCS</li> <li>Select actionable improvement goals based on ABCS data</li> <li>Recall patients overdue for care/outreach related to ABCS testing, education, counseling</li> </ul>		
	Care Coordination	Deepen patient self-management support for action planning around ABCS	<ul style="list-style-type: none"> <li>Use workflow mapping to examine current processes and explore other approaches</li> <li>Introduce preventive screenings and educational materials for ABCS measures into workflow</li> <li>Develop/enable point of care reminders based on ABCS guidelines</li> <li>Scrub charts daily to flag patients needing support on ABCS</li> </ul>		
Increased QI capacity at sites		Define roles and responsibilities (tasks) across the care team to identify and manage ABCS population	<ul style="list-style-type: none"> <li>Understand current patient panel relative to ABCS</li> <li>Select actionable improvement goals based on ABCS data</li> <li>Recall patients overdue for care/outreach related to ABCS testing, education, counseling</li> </ul>	Training on cardiovascular risk calculators & collaborative learning through site visits	<ul style="list-style-type: none"> <li>Clinically focused learning opportunities for care teams to address common issues in CVD population management</li> <li>Collaborative learning by visiting peers' clinics</li> </ul>
		Deepen patient self-management support for action planning around ABCS	<ul style="list-style-type: none"> <li>Train staff in motivational interviewing</li> <li>Develop shared care plans with patients, emphasizing goal setting led by patient values</li> <li>Follow up with patient progress toward care plan goals</li> </ul>		
		Develop robust linkage to smoking cessation, CDSMP, and other evidence-based community resources	<ul style="list-style-type: none"> <li>Create list of community resources and keep in a location accessible to all staff members</li> <li>Outreach to community resources to build referral pathway</li> <li>Provide list of resources to patients</li> <li>Proactively refer patients to community resources and assist in establishing patient with the resource</li> </ul>	Shared learning through webinars & office hours	<ul style="list-style-type: none"> <li>Interactive webinars</li> <li>Office hours opportunities with clinical experts</li> <li>Shared tools and resources between participating sites</li> </ul>

### Project Goals

- Better outcomes for patients**  
H2N is an opportunity to improve the health of your patients and community by focusing on heart disease, the leading cause of death in the US.
- Better outcomes for practices and providers**  
H2N is designed to break the cycle of limited bandwidth by addressing practices' capacity for improvement. Improved knowledge, streamlined workflows, and better data access are a few ways H2N will help primary care practices deliver better care to patients.
- Better outcomes for primary care**  
The small primary care practice is at the center of our Nation's healthcare system, and it is where most people receive care. H2N is helping to equip more doctors with the latest clinical evidence and the tools needed to apply it to their practice.

### Practice Quotes

- "This is an excellent opportunity to improve health outcomes for our county." (Clinician)
- "In the past we provided data that wasn't particularly useful or actionable. It didn't have a lot of meaning for the providers. We are hoping to change that through this project." (Practice Manager)
- "This project gives us a jumpstart, and re-boosts our energy." (Practice Manager)
- "Providers are generally going to know the recommendations, but we want to break it down so everyone on the team knows what they are looking for, what they are doing, and why." (Clinician)
- "What a blessing to get to do this work that will shape [our] knowledge and capacity." (Practice Manager)
- "For every adult that walks in here, we, as a team, need to be thinking about the ABCS measures" ... "It's not the driver that ultimately wins the race, it's the pit crew." (Clinician)
- "QI has not taken root or been sustainable with us providers in the past because we do not trust our data." (Clinician)

### Practice Participation

There are 94 Oregon practices enrolled in H2N across seven regions, each represented by an H2N practice facilitator.

**Practice Demographics**

- 35 practices in urban and 59 in rural areas
- 58 system-based practices and 36 independent practices
- 63 PCPCH-certified practices
- 43% of practices designated as a medically underserved area
- 5 providers per practice on average
- 924 average patient panel size for full-time providers

