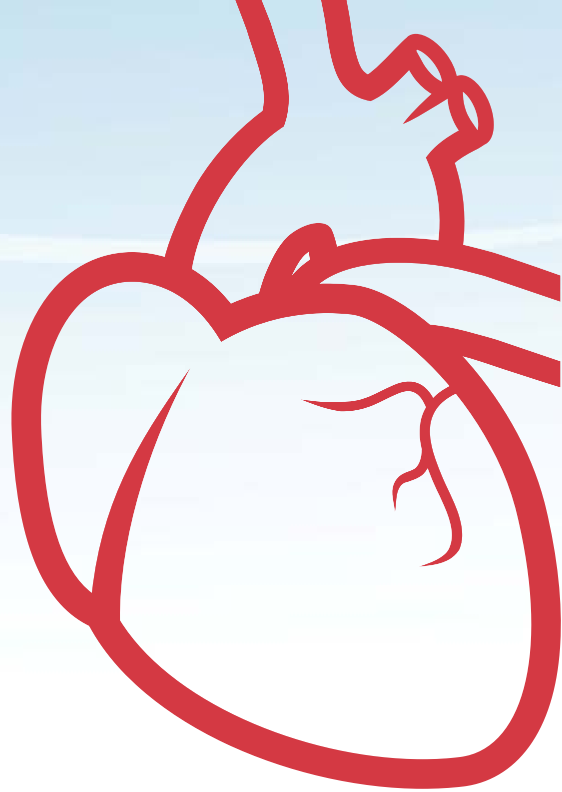

Heart Health Now!

The North Carolina Cooperative for AHRQ's EvidenceNOW

Advancing Heart Health in Primary Care

UNC
THE CECIL G. SHEPS CENTER
FOR HEALTH SERVICES RESEARCH

Community Care of North Carolina

Funded by the Agency for Healthcare Research and Quality (AHRQ) in the U.S. Department of Health & Human Services

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NC Population Data

- **Cardiovascular Death Rate 263 per 100K**

  -1/3 of all NC deaths (32nd in U.S.)

- **Annual cost: 4.6 billion dollars (inpatient alone)**

- **Risk Factors**

  - 65% obese / overweight
  - 54% lack physical activity
  - 40% high cholesterol
  - 32% HTN
  - 10% diabetic
  - 20% smoke

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Reduce CVD Risk

We can make an IMPACT!!!

- To Improve Patient Health
  - Control ***1 or 2 Measures:***

    Can reduce short-term event risk 25%

  - Control ***ALL Measures:***

    Can reduce lifetime CVD mortality risk 75%

Heart Health NOW

Advancing Heart Health in NC Primary Care

Why NOW?....

- **Getting Heart Health Better in NC**

- **THIS IS OUR TIME!!!!**
  - Fulfill the Promise of Primary Care That Policymakers Now Recognize
    - Prevent chronic disease ***period***, and…
    - Prevent chronic disease, systematically, from advancing to late complications

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Advancing Heart Health in NC Primary Care

- Major Goals

    1) Reduce cardiovascular risk (morbidity and mortality)

    2) The promise of primary care – PROVE VALUE

    3) Set up an effective system of dissemination and implementation that will help small practices thrive in a value-based care environment.

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- Who Can Participate?

1) 10 or fewer primary care providers at a single practice location (**N = 300**) with 750 to 900 thousand adult patients

2) Must have an EHR

3) Not getting practice support at the level prescribed by the project

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- **ARE WE READY?!!!!**
  - To Succeed - Primary Care Practices Must:
    - Build systems of care that quickly **stratify patients for risk**
    - Build systems of rapid engagement and reengagement to address these risks through

      1) enhanced medical treatment and

      2) lifestyle changes

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Reduce CVD Risk

- **Cardiovascular Disease Prevention & Management**
  - New clinical guideline recommendations
  - Evidence-based practices for CVD prevention, including:
    - CVD risk assessment – will define the 10 year risk profile for every practice patient on the likelihood of getting ab acute cardiac event, stroke, or cardiovascular death
    - Use of Aspirin – for patients who already have vascular disease and identification of those without disease who are likely to benefit
    - Blood Pressure & Cholesterol Management – including the new American College of Cardiology recommendations
    - Tobacco Cessation – treatment and counseling

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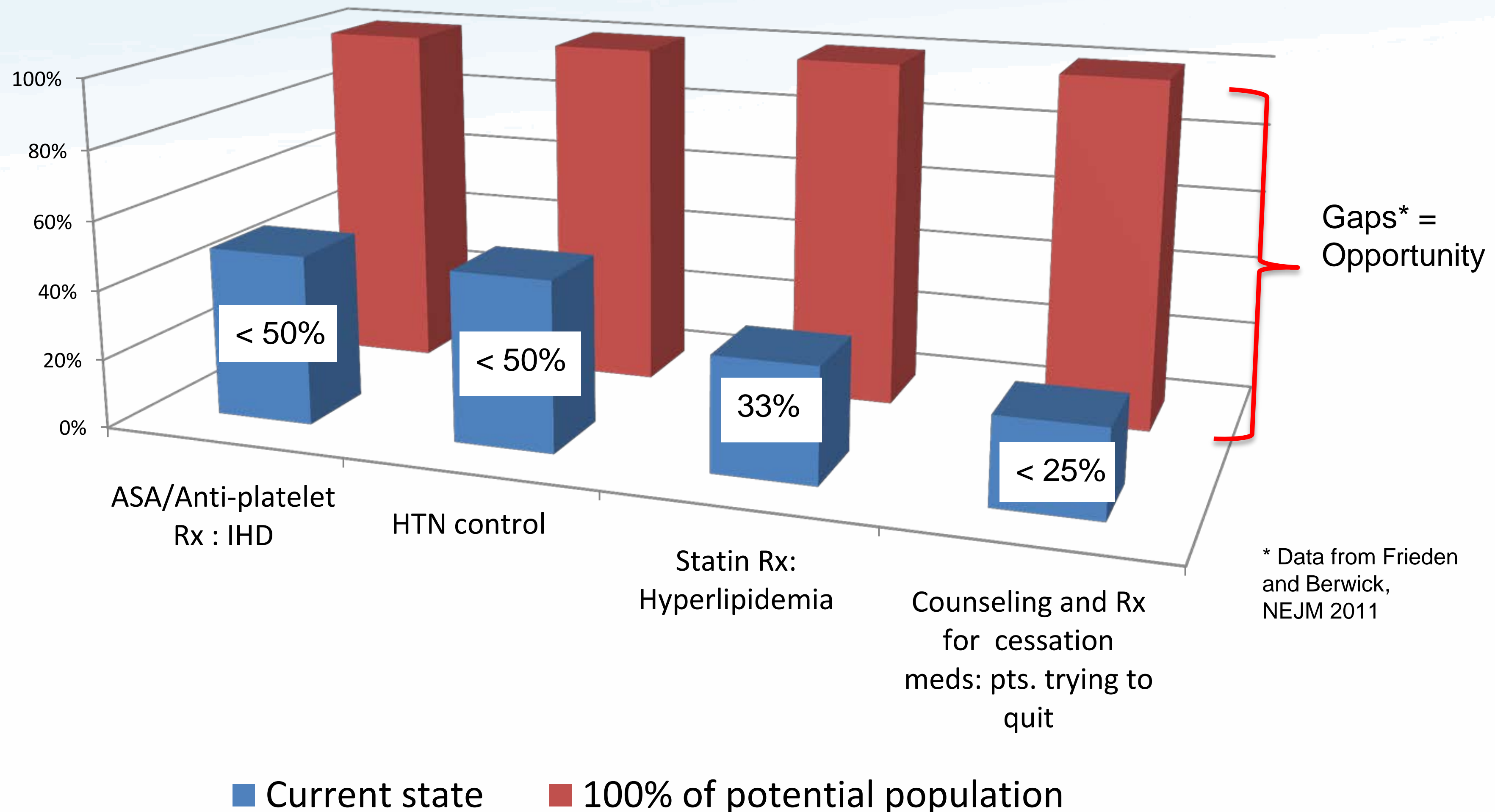
Reduce CVD Risk

- **Hypertension Management**
  - How will the SPRINT study affect the next measure definition?
  - Are the JNC-8 targets dead?

Gaps = Opportunity
There is room to improve

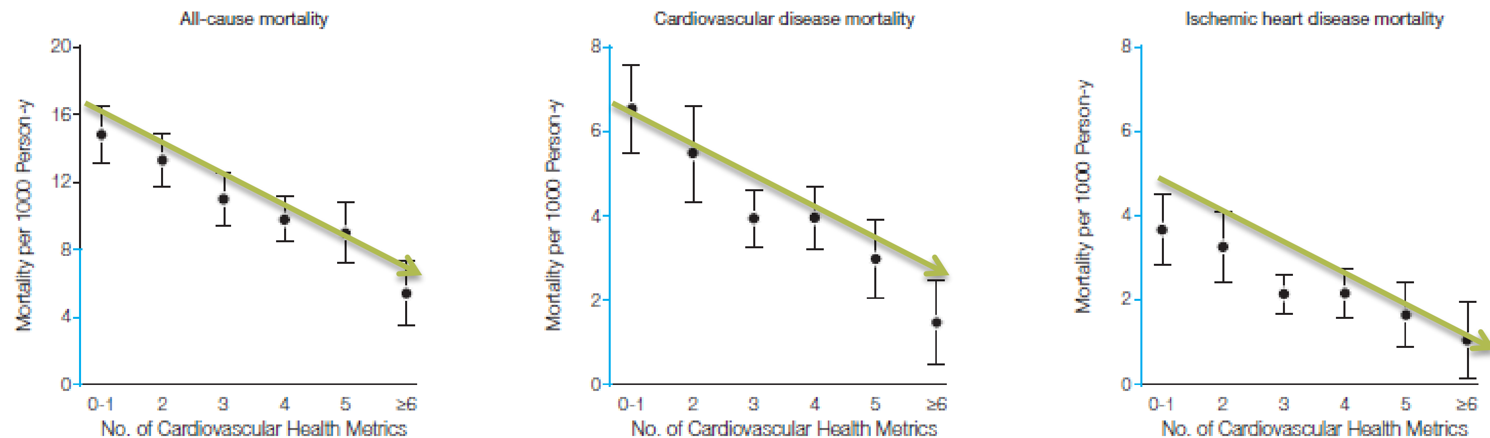


Risk factors are graded, thus risk reduction on several fronts can improve outcomes

From Yang, JAMA 2012

Healthy metrics = 1) not smoking 2) being active 3) normal BP 4) normal blood glucose 5) normal cholesterol 6) normal weight 7) healthy diet

Graded Response: Higher # of healthy factors → Lower mortality



All Cause Mortality | CVD Mortality | IHD Mortality

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Practice Transformation

- **The Interventions:**
  - Evidence Synthesis
  - Sophisticated Informatics: up to date dashboards with risk stratification and flexibility to update measures (CCNC Informatics Center)
  - On Site Practice Facilitation – Ratio of 15 practices to 1 facilitator

    - A local workforce (9 AHEC Regions)
  - Webinars / Learning Collaboratives

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Practice Transformation

- High-Leverage Changes
  - Implement Electronic Database – clinical information systems
  - Population “Drill Downs” and systems of engagement**
  - Workflow redesign – **not all on the provider** / team roles
  - Rapid cycle QI
  - Use Template for Planned Care – delivery system design
  - Use Protocols – decision support
  - Adopt Self-management Support Strategies

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Practice Transformation

- **Benefits to Primary Care Practices**
  - Prepare practices to transition to value-based care
  - Help practices learn to use informatics / analytics to maximize best practices and good outcomes
    - Access to HHN Dashboard and other IC tools
    - Work through connectivity and reporting issues so that practices will be successful in future initiatives
  - Help practices learn to do population health management

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Practice Transformation

- **Benefits to Primary Care Practices**
  - 4 to 10 hours of practice facilitation per month (practice bandwidth the limiting factor)
  - Sophisticated dashboards and analytics (and workflows and use cases)
  - Physician expert consultation on clinical directions and building systems (One on One, learning collaboratives, webinars)

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Practice Transformation

- **Benefits to Primary Care Practices**
  - Intense Intervention for 12 months
  - Maintenance Phase – lighter touch
  - Dashboard / population management tools available throughout

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Practice Transformation

- **What Do Practice Facilitators Do?**
  - Help analyze workflows
  - Help the practice think through tasks to maximize efficiency and outcomes
  - Help apply QI techniques – use data to perform small tests of change and take successful “mini-tests” to scale

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Practice Transformation

- **What Do Practice Facilitators Do?**
  - Introduce the practice to informatics approaches that identify patients at greatest risk whether they're in the office or not.
  - Help practices design care to engage and reengage at risk patients to modify this risk quickly
  - Help work on important issues that either weigh on or simply excite the practice

Heart Health NOW
Practice Transformation

- DOES PRACTICE FACILITATION WORK IN REDUCING CARDIOVASCUALR RISK?

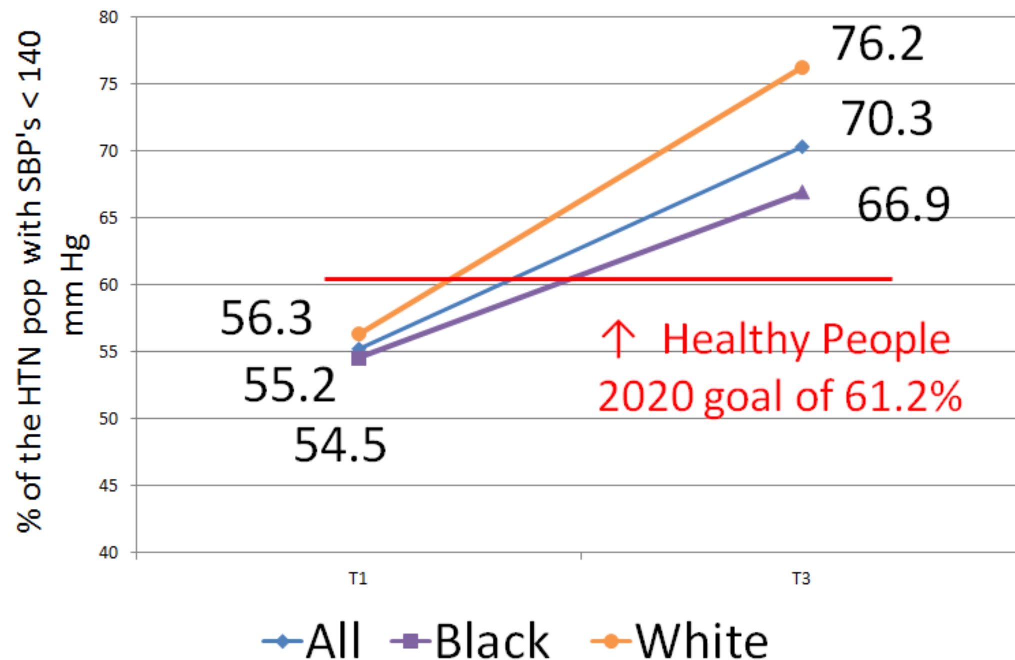
Cases:
Experiences from NC primary care practices:

2 different examples, both focused on BP control….

- 19 practices worked with NC AHEC practice coaches to enhance their care delivery to improve BP control
  - 14,502 patients with HTN
- 6 practices in eastern, NC worked together to improve HTN control in a QI project
  - ~ 5,000 pts with HTN

Cases

- Example 1: 19 practice group:
  - 11 practices were able to increase their control % by AT LEAST 5% !
- Example 2: patient group



Welcome accesscarenam

CCNC SERVICES

CATEGORIES: Heart Health Now **ORGANIZATIONS:** Wake County **REPORTING PERIOD:** 04/01/2014 - 03/31/2015

Heart Health Now ▾ | Wake County ▾ | 04/01/2014 - 03/31/2015 ▾

Export

Other Demographic Data

Other HHN Measures

Patient Name	DOB	Gender	Age	ASCVD Pooled 10 Year Risk Score	Smoking Status	LDL	HDL	Total Chol	SBP	Aspirin for Prim. Prev. of CVD	Controlling High Blood Pressure	Risk Based Statin Therapy	Tobacco Use Screening	Tobacco Cessation
		F	49Y 2M			true	false	false		false	true	true	false	false
		F	48Y 10M			true	false	false		false	true	true	false	false
		F	60Y 3M					e		false	true	true	false	false
		M	61Y 11M					e		false	true	true	false	false
		M	57Y 10M					e		false	false	false	false	false
		M	77Y 10M					e		false	false	false	false	false
		F	73Y 3M					e		true	false	false	false	false
		M	64Y 1M			true	false	false		true	false	false	false	false
						true	false	false		false	false	false	false	false
						true	false	false		false	true	true	false	false
						true	false	false		true	false	false	false	false
						true	false	false		true	false	false	false	false
						true	false	false		true	false	false	false	false
		F	23Y 4M			true	false	false		false	true	true	false	false

Risk Score Filter:
7.5 – 9.9%
10%
Null

Notes:
- Default sort by patient name
- Can sort by column

trend

Heart Health NOW

Advancing Heart Health in NC Primary Care

- **FAQ:**
  - Can ACOs participate? **YES**
  - Can practices work on other workflows or measures with practice facilitators? **YES, as long as they keep working on cardiovascular risk**

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Conclusions

- Cardiovascular disease remains the #1 killer in NC
- Small practices, especially in rural areas, have very little support to identify high risk patients and intervene in a systematic way
- Heart Health Now! uses the best of UNC, AHEC, & CCNC to provide **support** to help **practices** prevent these catastrophic events among patients, neighbors, and friends.
- Aims to prove that small PCPs can produce great results with the right systems of dissemination and **support**