RHIP Cardiovascular Disease Prevention Workgroup
PacificSource—Boardroom (4th Floor)
2965 NE Conners Avenue, Bend

Agenda: June 28, 2016 from 4:00pm-5:00pm

Call-In Number: 866-740-1260
7-Digit Access Code: 3063523

1. **4:00-4:05** **Introductions—All**
2. **4:05-4:40** **Blood Pressure Standardization Project—Cyndi Painter-Press, Mosaic Medical**
3. **4:40-4:55** **Patient Education—Divya Sharma & Karen Steinbock**
4. **4:55-5:00** **Action Items—All**
   - **Next steps**

Next Meeting: July 26 from 4-5pm (Location TBD)

Cardiovascular Disease - Clinical (9)	Organization
Mark Backus	Cascade Internal Medicine Specialists
Mary Deeter	La Pine Community Health Center
David Huntly	Epidemiologist - Community Member
Alison Little	PacificSource
Leslie Neugebauer	PacificSource
Summer Phinney	Bend Memorial Clinic
Robert Ross	St. Charles Health System/St. Charles Medical Group
Divya Sharma	Central Oregon IPA & Mosaic Medical
Karen Steinbock	Central Oregon IPA

EvidenceNOW
Advancing Heart Health in Primary Care

Northwest Cooperative

EvidenceNOW: Advancing Heart Health in Primary Care is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to transform health care delivery by building a critical infrastructure to help smaller primary care practices improve the heart health of their patients by applying the latest medical research and tools. EvidenceNOW establishes seven regional cooperatives composed of public and private health partnerships that will provide a variety of quality improvement services typically not available to small primary care practices. The goal of this initiative is to ensure that primary care practices have the evidence they need to help their patients adopt the **ABCS** of cardiovascular disease prevention: **A**spirin in high-risk individuals, **B**lood pressure control, **C**holesterol management, and **S**moking cessation. The initiative also includes an independent national evaluation designed to determine if and how quality improvement support can accelerate the dissemination and implementation of new evidence in primary care.

Cooperative Name:
Healthy Hearts Northwest: Improving Practice Together

Principal Investigator:
Michael L. Parchman, M.D., M.P.H., Group Health Cooperative

Cooperative Partners:
MacColl Center for Health Care Innovation and the Center for Community Health Evaluation, both at Group Health Cooperative

Qualis Health

Oregon Rural Practice-based Research Network (ORPRN) at Oregon Health & Science University

University of Washington School of Medicine

Geographic Area:
Washington, Oregon, Idaho

Project Period:
2015-2018

Region and Population

The Pacific Northwest has a mix of highly agricultural and sparsely populated counties with a growing Hispanic population and large and growing urban centers. Heart health indicators vary considerably across the region. They are worse in small rural counties where primary care has fewer internal quality improvement (QI) resources than in more populated urban areas. For example, heart attack deaths in some small rural counties are almost twice as high as in larger metropolitan counties. In addition, mortality rates from stroke are higher in the region than in the United States as a whole.

Specific Aims

1. Identify, recruit, and conduct baseline assessments in 320 small- to medium-sized primary care practices across Washington, Oregon, and Idaho during the project's first year.
2. Provide comprehensive practice support to build quality improvement capacity within these practices.
3. Disseminate and support the adoption of patient-centered outcomes research (PCOR) findings relevant to aspirin use, blood pressure and cholesterol control, and smoking cessation (ABCS) quality measures.
4. Conduct a rigorous evaluation of strategies that enhance the effectiveness of external practice support to improve QI capacity, implement patient-centered outcomes research findings, and improve ABCS measures.
5. Assess the sustainability of changes made in QI capacity and ABCS improvements and develop a model of scale-up and spread for improving QI capacity in primary care practices.

Reach

- Goal for Number of Primary Care Practices Recruited: 250-320
- Goal for Number of Primary Care Professionals Reached: 750-960
- Goal for Population Reached: 1.13-1.44 million

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Comment from Principal Investigator

Michael Parchman, M.D., M.P.H.

"Our goal is to build a sustainable infrastructure for ongoing improvements in the delivery of primary care in the Pacific Northwest that contributes to the Triple Aim, improves the experiences of those who provide care within the practice, and prepares primary care providers for value-based care reimbursement models. We will make a substantial contribution to the field of implementation science by advancing understanding of how to effectively provide external practice support to build QI capacity and improve cardiovascular risk factors for a substantial number of people served by small- to medium-sized primary care practices."

Notable Project Features

- Project will have significant participation by rural practices.
- Regional design allows the Cooperative to understand how specific State factors affect health care delivery.
- Design will study rapid scale-up and spread of practice support to build QI capacity.

Approach and Methods

Practice Recruitment and Enrollment

Primary recruitment targets are practices that need significant help in building their QI capacity, but have an Office of the National Coordinator 2014 certified electronic health record that can assist with their QI efforts. Target practices will be small (<10 practitioners) and independently owned and operated. Smaller practices affiliated with larger organizations also will be recruited if the larger organizations have limited experience with providing support for primary care QI. The Cooperative will recruit by:

- Reaching out to practices with which the Cooperative already has strong relationships.
- Leveraging relationships within social networks of already-recruited practices and reaching out to members of the Cooperative's State-level organizational partners.

Support Strategy

Each participating practice will receive 15 months of support in two key areas:

- *Health Information Technology Support and Use of Data for Physician Quality Reporting System (PQRS) Reporting and Quality Improvement.* The Cooperative will help the practices improve PQRS reporting of ABCS measures by creating a tailored Action Plan to guide the support. The practices will be divided into three tiers, depending on how experienced they are in PQRS reporting and how much information technology support they need. Health information technology staff will support practices through ongoing phone and secure Internet communication.
- *External Practice Quality Improvement Support.* This support will enhance the practices' capacity to use new PCOR findings to change their care practices and improve ABCS measures. This content will be disseminated to the practices using academic detailing (i.e., educational outreach through self-paced learning modules and phone calls). To build their QI capacity to adopt and implement PCOR heart health findings, practices will be assessed using PCMH Change Concepts and then receive tailored external support through (1) practice facilitation (i.e., a kick-off meeting, face-to-face visits, regular phone calls); (2) shared learning opportunities (i.e., Regional Improvement Collaboratives led by the practice facilitators with monthly phone calls and Webinars); and (3) affinity groups to conduct "deep dives" on improvement work across the smaller regional groups of practices.

Evaluation

Practices will be divided into small regions of 20 practices each. Each small region will be assigned to one of 16 practice facilitators. Each region of practices also will be randomized to one or more strategies hypothesized to enhance the effectiveness of the external practice support for more rapid adoption of PCOR heart health findings and improvement of QI capacity. This design efficiently uses participating practices and enables estimation of interactions between strategies.

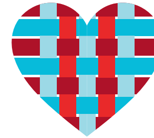
Strategies for Disseminating Study Findings and Lessons Learned:

The Cooperative will disseminate findings through an external website, social media, presentations, manuscripts and outreach to key opinion leaders and potential early adopters.

Last updated date: May 13, 2015

Oregon Rural Practice-based Research Network

Project Overview



HEALTHY HEARTS NORTHWEST

Improving practice together

There is a need for building critical infrastructure to help smaller, primary care practices throughout the Pacific Northwest use the latest evidence to improve heart health. Heart health indicators vary considerably across the region. They are worse in small rural counties where primary care has fewer internal quality improvement (QI) resources than in more populated urban areas. For example, heart attack deaths in some small rural counties are almost twice as high as in larger metropolitan counties. In addition, mortality rates from stroke are higher in the region than in the United States as a whole.

Achieving better heart health outcomes for patients is an ongoing priority for the Oregon community. As our healthcare environment continues to evolve rapidly, smaller practices face challenges around the ability to effectively use data and improve quality. This is increasingly important for reimbursement eligibility. Many smaller practices lack the internal resources for optimizing health information technology (HIT) and building QI capacity.

Healthy Hearts Northwest: Improving Practice Together (H2N) is part of EvidenceNOW, the AHRQ grant initiative to transform health care delivery. With partners Qualis Health, and the MacColl Center for Health Care Innovation (recipient of the AHRQ funding for this initiative and H2N PI office), the Oregon Rural Practice-based Research Network (ORPRN) at the Oregon Health & Science University (OHSU) will select 130 small- and medium-sized primary care practices throughout Oregon to participate in H2N. ORPRN seeks to help these practice build their quality improvement (QI) capabilities and infrastructure, and to transform practices into learning organizations that engage in sustained, continuous, systematic QI. The practices will learn practical strategies that can strengthen their organizations and restore the joy to primary care. The initial focus of H2N will be implementing Patient-Centered Outcomes Research (PCOR) to improve heart health, as described within the Million Hearts campaign related to **ABCS**: **A**spirin, **B**lood pressure, **C**holesterol and **S**moking cessation.

Over the course of 15 months, ORPRN will:

1. Provide a Practice Enhancement Research Coordinator (PERC) to support improving ABCS heart health measures, including how to use EHRs for QI purposes. The PERC will visit the practice regularly, with monthly calls in between visits, and will be accessible by phone.
2. Assist with producing reports of ABCS clinical quality measures.
3. Provide benchmark reports on ABCS clinical quality performance measures to the practice on each measure, with benchmarks at a regional, state, and national level.
4. Provide high-value information about how to participate in value-based reimbursement programs, such as PQRS and meaningful use.
5. Provide survey results back to the practice that indicate opportunities for improving QI infrastructure.
6. Conduct webinars every other month to assist practices with meeting H2N improvement milestones.
7. Convene phone-based office hours to discuss different topics and share lessons learned.
8. Support participation in this study as meeting ABFM and ABIM MOC Part IV requirements.
9. (For those selected) Identify and coordinate a site visit to an exemplar practice.
10. (For those selected) Provide training in the use of evidence-based cardiovascular risk reduction calculation and care planning.
11. Keep the practice informed about the overall study. We want to help participating practices as much as we can, so we may adjust specific aspects as the study progresses.

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The practice agrees to improve ABCS performance measures and will:

1. Schedule a two-hour, in-person “Welcome visit” with a PERC.
2. Complete surveys at 3 time points: upon project enrollment, at the end of the 15 months of practice support, and 6 months after completing 15 months of practice support:
   a. A practice or clinic-level survey completed by a practice manager or leader.
   b. A survey completed by all clinicians and staff who work in the practice.
3. Designate a “Healthy Hearts Champion”, usually a physician or non-physician (nurse practitioner or physician assistant) clinician and a point of contact for the H2N project team.
4. Convene a Healthy Hearts Improvement Team of at least three individuals comprising the Healthy Hearts Champion and a representative from the front and back office.
5. Provide protected time for the Healthy Hearts Improvement Team to meet internally weekly to develop and work on improvement milestones and conduct small cycle tests of change to improve ABCS heart health measures.
6. In addition to the internal Improvement Team meeting, at least two members of the Improvement Team will:
   a. Participate in face-to-face visits or a monthly phone call with the PERC.
   b. Attend a Healthy Hearts Webinar with all practices across the 3 states for one hour every other month.
   c. Participate in phone-based office hours.
7. Collect and provide the study team with aggregate practice-level data (unique to each practice location) on clinical quality measures related to aspirin use, blood pressure control, cholesterol control, and smoking cessation (ABCS) quarterly from enrollment until April 30, 2018.
8. (For those selected) At least two individuals from the practice will conduct a one-day site visit to an exemplar clinic within the first 12 months after enrollment.
9. (For those selected) Clinicians, nurses, and medical assistants will participate in training on the effective use of a cardiovascular risk calculator.
10. Agree to be (publically) recognized as a participant in this project.

Please contact ORPRN’s H2N project manager, Caitlin Dickinson, at summerca@ohsu.edu or 503-494-9106. More information about H2N is available http://www.ohsu.edu/xd/outreach/oregon-rural-practice-based-research-network/.

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Quality Measures Crosswalk – Million Hearts and Other Incentive Programs

BLUE = Required GREEN = Optional

Million Hearts Domain	Million Hearts Clinical Quality Measure	CMS Physician Quality Reporting System (PQRS)	CPC 2015 eCQMs	CMS EHR Incentive Program (MU)	PCPCH	CCO Incentive eCQMs	UDS	ACO Medicare Shared Savings Program (SSP)
Aspirin When Appropriate **NQF: #0068**	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic** Percentage of patients aged 18 years and older who were discharged for AMI/CABG/PCI **OR** diagnosed with IVD **AND** documented use of aspirin or other antithrombotic	**Yes**	No	**Yes**	No	No	**Yes**	**Yes**
Blood Pressure Control **NQF: #0018**	**Hypertension (HTN): Controlling High Blood Pressure** Percentage of patients aged 18 through 85 years who had a diagnosis of HTN **AND** whose blood pressure was adequately controlled (<140/90) during the most recent visit in the measurement year	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Cholesterol Management **NQF: n/a**	**Cholesterol— Statin Therapy for the Prevention and Treatment of Cardiovascular Disease** Patients who are at high risk of cardiovascular events who were prescribed or are on a statin. **High Risk definition categories** 1. Patients >= 21 years of age who were previously diagnosed	No	No	No	No	No	No	No
Smoking Cessation **NQF: #0028**	**Preventive Care and Screening: Tobacco Use** Percentage of patients aged 18 years and older who had two visits or one preventive care visit within 24 months who were screened about tobacco use one or more times **AND** who received cessation counseling intervention if identified as a tobacco user	**Yes**	**Yes**	**Yes**	**Yes**	**Yes** - as of 2016	**Yes**	**Yes**

RHIP Workgroup Updates: May

Behavioral Health: Identification & Awareness

- This group meets the fourth Tuesday of every month from 9-10am and currently has 20 members.
- In May, the group agreed to provide technical assistance for the Mental Health Prevention & Promotion grant for Central Oregon. This grant will work to normalize the public's perception of accessing resources for depression, anxiety, suicidal ideation, and substance use. The group also reviewed the minimum standards required to be able to bill for behavioral health integration in primary care. In June, the group will develop the elements of workflow necessary to screen and properly code for SBIRT/CRAFFT within clinics.

Behavioral Health: Substance Use and Chronic Pain

- This group meets the third Wednesday of every month from 4-5pm and currently has 19 members.
- During the May meeting, the group discussed the differences between at Behavioral Health Consultant with addictions experience and the Peer Support Specialist or Recovery Mentor roles. The group reviewed the SUD resource list for providers. This document will be finalized and placed on the COHC website for reference, with updates provided every six months. In June, the group plans to develop a treatment algorithm to support primary care toward better addressing substance use. This group will also develop strategies to address the second and third health indicators in their section.

Cardiovascular Disease—Clinical

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 9 members.
- During the May meeting the group decided that their year one focus will be on blood pressure standardization along with patient education around proper blood pressure checks. In June, the group will discuss standardization in greater detail and plans to invite other clinics to the table for the discussion (i.e., High Lakes Health Care, BMC, Weeks Family Medicine, La Pine Community Health Center, Dr. Burkett, among others).

Diabetes—Clinical

- This group meets the second Thursday of every month from 9-10am and currently has 12 members.
- This group will meet for the first time on June 9 to focus solely on the clinical goal of improving control of type 2 diabetes.

Cardiovascular Disease & Diabetes—Prevention

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 25 members.
- In May both prevention groups met separately to prepare to combine their efforts moving forward. Both CVD & Diabetes believe that their prevention efforts align very well and the strategies and organizations that need to be at the table are the same in order to meet the prevention goals for these two areas. Diabetes is still developing a resource document that will eventually be shared with providers and throughout the community. Cardiovascular Disease discussed ideas of how to increase physical activity throughout Central Oregon.

RHIP Workgroup Updates: May

Oral Health

- This group meets the third Tuesday of every month from 11-12pm and currently has 19 members.
- The Oral Health workgroup has begun to 'assign' potential projects/actions to their work plan. They continue to scrub their Spectrum document to better refine the services, and projects currently in use in the Tri-county area. Advantage Dental presented on a Public Service Announcement that had been previously sunset. The group may be interested in dusting it off and revitalizing. In June, the group will receive training/education relative to the 'One Key Question' initiative. Mosaic will provide an overview of their model for the new Dental Hygienist they have hired.

Reproductive Health/Maternal Child Health

- This group meets the second Tuesday of every month from 4-5pm and currently has 22 members.
- In May a presentation was given around AFIX (immunization program). A favorable report was given relative to capturing (coding) the 1st trimester visits outside of the global pregnancy benefit. Discussion continues on the Perinatal Care Continuum project, the group felt a bit more finessing of the proposal was necessary. Next month, the group will review data surrounding Adverse Childhood Experiences (ACEs).

Social Determinants of Health

- This group meets the third Friday of every month from 10-11am and currently has 27 members in kindergarten readiness and 26 members in housing.

Education & Health

- The group collectively identified strategic strategies that would increase School Readiness (as identified by the 5 Dimensions of Readiness) discussed in last months meeting. Current, in use, strategies were shared out with the rest of the team. The June meeting will have an in-depth presentation on our Region's Kindergarten Readiness data. The goal is to collectively prioritize a strategy or strategies the team wants to include in their work plan.

Housing

- In May, the workgroup discussed ways they could add value with out duplicating the work of other agencies and groups like the Homeless Leadership Coalition (HCL). The workgroup determined that they could focus their efforts on advocacy, policy, and resource development. The workgroup additionally decided to form a small task force to review the updated 10 Year Plan to End Homelessness (High Desert Home) strategies to identify specific activities they could take on.