HEALTHY HEARTS - AGGREGATION OF CLINICAL DATA

MARYLAND AND THE MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS

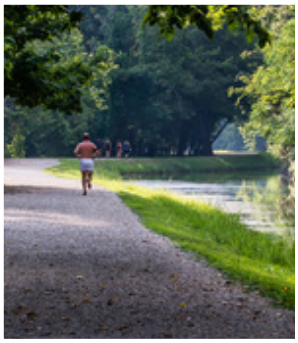
Million Hearts in Action

[Strategies for Achieving Million Hearts Goals]

In 2009, Maryland Department of Health and Mental Hygiene partnered with the Mid-Atlantic Association of Community Health Centers (MACHC) to provide technical assistance to federally qualified health centers (FQHCs) across the state to improve quality of care and health outcomes, specifically those related to the ABCS of heart health, among patients diagnosed with diabetes. Through this collective work, MACHC set new association-wide priorities to collect consistent quality data through targeted activities. The development of a statewide data warehouse at MACHC, which will be fully operational by early 2016, is critical to assessing FQHC population health and improve quality assurance at the clinic level.

[Fast Facts]

- Heart disease and stroke are the 1st and 3rd leading cause of death in Maryland, accounting for 1 out of every 3 deaths (30.4 percent).
- Every 33 minutes, one person in Maryland dies from a heart attack, stroke, or other cardiovascular disease-related event.
- The age-adjusted heart disease mortality rate for blacks is 1.3 times higher than for whites.
- Nearly 1.4 million adults in Maryland have hypertension, with non-Hispanic blacks reporting higher rates of hypertension (38%) than non-Hispanic whites (31.9%) or Hispanics (19.4%).



"This innovative project is an exciting opportunity that will allow Federally Qualified Health Centers to use data to drive policy and system changes in order to improve the health of Marylanders, particularly low income populations."

- Erica Smith, Manager, Evaluation and Data Team at Maryland Department of Health and Mental Hygiene

[What We Did]

Between 2010 and 2012, the Healthy Hearts program worked with MACHC to recruit four FQHCs to reach the medically underserved and uninsured Baltimore adults diagnosed with type 2 diabetes.

- Each FQHC adopted clinical practice guidelines, which include management goals of blood pressures.
- Interventions included: referrals to pharmacists, Maryland's tobacco Quitline, and other qualified professional for medication self-management education; blood pressure checks at every visit; and a presentation of patient data at monthly clinical staff meetings. Other tools were also used, such as intervention logs.

[What We Accomplished]

Between 2010 to 2012, the Healthy Hearts for Marylanders program reached more than 175,000 people at 34 clinics (4 FQHCs) across the state.

- Blood pressure control increased from a 17 percent at baseline in 2009 to 44 percent control within participating sites.
- The sites consistently exceeded Maryland and National 2011 HEDIS benchmarks for the Key performance Indicators; exceeded 2011 Maryland UDS benchmarks for HbA1c, BMI, blood pressure management, and smoking status; and made “remarkable” progress in assisting patients to stop smoking.
- The sites also identified additional opportunities for incorporating change within their care delivery system.

[What We Learned]

Reliable data at the state, regional, and local level and regular, ongoing monitoring are major keys to success. Accurate, real-time data allow sites to monitor outcomes, compare themselves to comparable sites, and adapt interventions if trends are moving in the wrong direction.

[What We Are Doing Now]

Beginning in 2013, MACHC, as the state’s federally designated primary care association, expanded the reach of the Healthy Hearts for Marylanders model to all the state’s 15 FQHCs. MACHC embarked on a data warehouse strategy under the aegis of the Community Care Informatics Center (CCIC) to drive aggregation, analytics, business intelligence and clinical transformation across its member health centers.

The data warehouse, is intended to aggregate data across all 125 clinic sites using multiple electronic health records and practice management systems. The data will guide program priorities; help identify strategies to better address the needs of the population; monitor costs; drive quality improvement efforts; and evaluate the effectiveness of interventions.

This will ensure data is being entered and reported in the same way in all Maryland FQHCs. Project organizers are working on streamlining the process, beginning data runs and coaching by early 2016. So far, 13 of the 15 FQHCs are fully on board and data tests are being conducted to identify potential challenges and address them prior to full implementation of the project. This is an innovative systematic approach to addressing chronic diseases in Maryland. The data warehouse, while not intended to be a surveillance system, could help in monitoring or aggregating the prevalence of conditions and control rates across FQHC populations in Maryland.

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