Million Hearts State Learning Collaborative
State Snapshot

WISCONSIN

State Health Agency: Wisconsin Department of Health Services
State Health Official: Karen McKeown, RN, MSN

For this project, the Wisconsin Department of Health Services led a team of state and local partners including local health departments, community-based organizations, faith communities, health systems and clinics, quality improvement organizations and others to establish bi-directional referral systems between community blood pressure screening, clinical healthcare, and community resources. These systems were tested in three pilot sites (Milwaukee, West Allis, and Green County). The project deployed health extenders, such as community health workers, parish nurses, and public health nurses, and focused on accurate blood pressure measurement, motivational interviewing training, and lifestyle change through physical activity. These health extenders screened, provided outreach, referred at-risk hypertensive individuals to clinical care, and offered community resources including self-management supports. Health system partners queried data through electronic medical record (EMR)/health information technology (HIT) and applied algorithms to identify patients with undiagnosed hypertension and low medication adherence. These partners developed plans, protocols and follow-up strategies/approaches to engage at-risk patients ("hiding in plain sight") for improved hypertension outcomes.

Current Reach: *18,776 adult residents in three priority target populations with hypertension (Green County adults [18-84], African American/Black adults [18-84] in two zip codes, and Hispanic/Latinos of reproductive age in West Allis).*

Potential Reach: *34,707 total adults [18-84] with hypertension within the three target population sites (Green County, two City of Milwaukee zip codes, and the City of West Allis).*

Last edited: 2/12/2018

This publication was supported by the Division for Heart Disease and Stroke Prevention of the Centers for Disease Control and Prevention (CDC) under cooperative agreement: 5U38OT000161.

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TRANSFORMING SYSTEMS SAVING LIVES

AIM STATEMENT

In Wisconsin, the project will improve blood pressure control through a team-based approach by increasing identification, diagnosis, and referral of people at greatest risk for hypertension. By June 2017, the project will:

- Increase HTN control (measured by NQF 0018) among currently diagnosed in target populations by 10%
- Increase those who have access to data systems in each partnership to identify individuals with previously unidentified HTN (defined as two elevated BP readings in the previous year with no diagnosis) to 100%
- Increase newly-diagnosed individuals with HTN by 10%
- Increase individuals engaged in their treatment plan by 60%
- Increase referrals within integrated public health-community partner-clinical networks by 10%.

BURDEN OF HYPERTENSION

Approximately 1.3 million adults in Wisconsin have hypertension and less than half of them are in control. Of those adults with hypertension in Wisconsin, approximately 32.3% are unaware they even have hypertension, compared to the national rate of 31.4% (BRFSS 2013).

KEY PARTNERS

State

- Wisconsin Department of Health Services
- Pharmacy Society of Wisconsin
- Wisconsin Collaborative for Healthcare Equity
- Wisconsin Community Health Fund

Local/Regional

- City of Milwaukee Health Department
- Green County Health Department
- West Allis Health Department
- Las Animas-Huerfano Counties District Health Department
- YMCA of Metro Milwaukee
- Southwestern WI Community Action Program
- Milwaukee Men's Health Referral Network
- West Allis Latino Health Fair Vendors

Community/Clinical

- Children's Hospital of Wisconsin
- Froeftert Hospital and Medical College of Wisconsin
- Sixteenth Street Community Health Clinic
- Monroe Clinic and Hospital
- St. Ann Center
- Hayat Pharmacy

Other

- WEA Trust Insurance Corporation
- MetaStar
- Health Care Extenders
- Medical College of Wisconsin
- Marquette University
- Alverno College

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TARGET POPULATIONS

The project focused on target populations in three pilot sites (City of Milwaukee, City of West Allis, and Green County). Partners at the Milwaukee site were focused on African Americans living in two zip codes within the city. Partners at the West Allis site targeted the total Hispanic/Latino population and included women of childbearing age who were pregnant and postpartum. At the Green County site, partners targeted residents living in a rural county.

EVIDENCE-BASE/BEST PRACTICES USED

- Health Care Extenders: Community health workers, promotoras, public and parish nurses
- AHA's Check. Change. Control (CCC) program and CCC Tracker Online, a tool for self-management of BP
- Motivational Interviewing
- "Hiding in Plain Sight" algorithms- the Geisinger Health System and the Palo Alto Medical Foundation approaches and CDC HTN toolkit
- Million Hearts Hypertension Prevalence Estimator Tool

KEY PROJECT SUCCESSES

Data

- Sixteenth Street Community Health Center developed and used an algorithm listed by CDC to identify patients with undiagnosed hypertension (HTN) in need of treatment. The Federally Qualified Health Center (FQHC) built upon this initial data query, identifying 84 undiagnosed patients, from a population of 2,513, with at least two elevated blood pressure (BP) readings above 140/90 and no diagnosis of HTN in the electronic medical record (EMR). Follow-up protocols and workflows were put in place for patients with HTN and diabetes with prompts in the EMR to guide care.
- Wisconsin Collaborative for Healthcare Quality (WCHQ), a consortium of health systems/clinics, represents 65% of the largest systems in Wisconsin. WCHQ used the Geisinger and Palo Alto approaches to identify patients with undiagnosed HTN in the EMR. WCHQ used these approaches for two measurement periods (period 1: January to December 2015; Period 2: September 2015 to June 2016). Both approaches showed improvement over time. In period 2, the Geisinger approach resulted in 158,776 undiagnosed hypertensive patients, or 20.51% of the 773,993 patients included (period 1: 21.20%). The Palo Alto approach resulted in 162,714 patients with undiagnosed HTN, or

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20.92% of the 777,931 patients included (period 1: 21.71%). Froedtert Hospital also utilized the approaches shared by WCHQ to analyze over 248,800 patients. According to Geisinger criteria, 20.5% of patients were identified with undiagnosed HTN (14,923 of 72,881 patients). The Palo Alto approach identified 21.2% of patients (15,601 of 73,559 patients).

- The Milwaukee site implemented the American Heart Association (AHA) Check. Change. Control. Program in both years. In year two, participants recorded their BP, showing a reduction after just eight weeks. In February 2017, the baseline average BP was 135/88. By May 2017, the baseline average BP had decreased to 130/85.
- Monroe Clinic in Green County used the Million Hearts Prevalence Estimator Tool to identify 37,673 patients with HTN. Actual prevalence is larger than predicted by the tool, meaning Monroe Clinic is doing a better than expected job of identifying patients with HTN. This is above the 75th percentile for identifying hypertension in Wisconsin.
- The Monroe Clinic's review of BPs indicated that 25% of the sample of BP measurements contained systolic readings of exactly 140/80. The clinic began a HTN initiative to improve BP control and BP measurement accuracy. Clinic staff received BP measurement accuracy training with follow-up methods to use for patients with HTN. To date, Monroe Clinic reports 84% of patients with HTN have their BP under control compared to 77% in the previous year. That increase corresponds to an additional 500 people with their BP under control.

Standardizing Practices

- Community Health Workers and Milwaukee Health Department Men's Program staff incorporated Motivational Interviewing (MI) techniques successfully into their work.
- The City of West Allis Health Department developed and tested protocols for screening and referral that are customized to the Hispanic/Latino community. As a result, BP checks were imbedded into the WIC and postpartum outreach programs.
- The Green County Health Department revised its Adult BP Screening policy. The Department further developed protocols for BP screening, referral, and follow-up. A community-clinical referral form was also designed for participants to take to providers.
- Monroe Clinic plans to use registries to do more outreach to patients with HTN. A triage nurse was put in place to connect with the Medical Home program and timely follow up care was arranged for seven of eight patients.
- MI training was offered by MetaStar for sites and community partners. Agency CHWs/*promotoras* integrated MI approaches into their client interactions.

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Community-Clinical Linkages

- The Green County Health Department was linked to the Monroe Clinic via EPIC's Care Link. Individuals with high BP readings can now be referred to providers at Monroe Clinic for health care services as needed. The St. Ann Center and Hayat Pharmacy also became active partners.
- The City of West Allis Health Department and the Sixteenth Street Community Health Center continued to improve communication, collaboration, and referral linkages. As paid health extenders with developed skills and protocols, the *promotoras* worked in the Latino community to provide screenings, referrals, and education. Sixteenth Street Community Health Center has also improved self-manage plans to include pill box assistant, a check-out system for BP cuffs, and a "Chronic Care" section to provide integrated healthcare services.

PROJECT SCALABILITY AND SPREAD

- St. Ann Center, the Milwaukee Health Department Men's program, Hayat Pharmacy, and Children's Hospital of Wisconsin worked with AHA's CCC program at the Northside YMCA. St. Ann Center and the Milwaukee Health Department Men's Program plan to continue bi-directional referrals for those screened with HTN.
- AHA has secured funding through the Greater Milwaukee Foundation to offer SMBP monitors through a new partner, Health View, to participants during the next year of CCC.
- The Wisconsin Department of Health and the Wisconsin Collaborative for Healthcare Quality are is working to implement their measure for identifying undiagnosed hypertension across more health systems in the state.
- The joint leadership of WCHF and the Green County Health Department helped to facilitate and strengthen the Green County Healthy Community Coalition. The coalition is developing a community-based heart health and hypertension resource website.
- The Sixteenth Street Community Health Center, West Allis Health Department, Green County Health Department, and WEA Trust widely disseminated the protocols they developed to seventeen FQHCs, additional health departments, and other insurance providers. More presentations and webinars are planned to further communicate the team's findings.

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