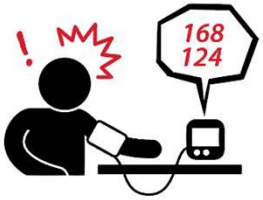
Heart Health Equity
Learning Series

Rebecca R. Thompson, CPA, CFRE, MPH
Wisconsin Community Health Empowerment Fund, Inc.
(608) 228-5044
rebeccat.wchf@gmail.com | wchef.org

Wisconsin Community Health Empowerment Fund
Growing & Focusing Resources Enabling Healthy Communities

WISCONSIN
HEART HEALTH FACTS

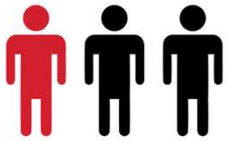


Approximately 1.3 million adults in WI have hypertension and less than half of them are in control.

Coronary heart disease is the no. 1 killer of women age 45 and over in WI.

Of those who are uncontrolled, 40% are unaware that they even have hypertension.

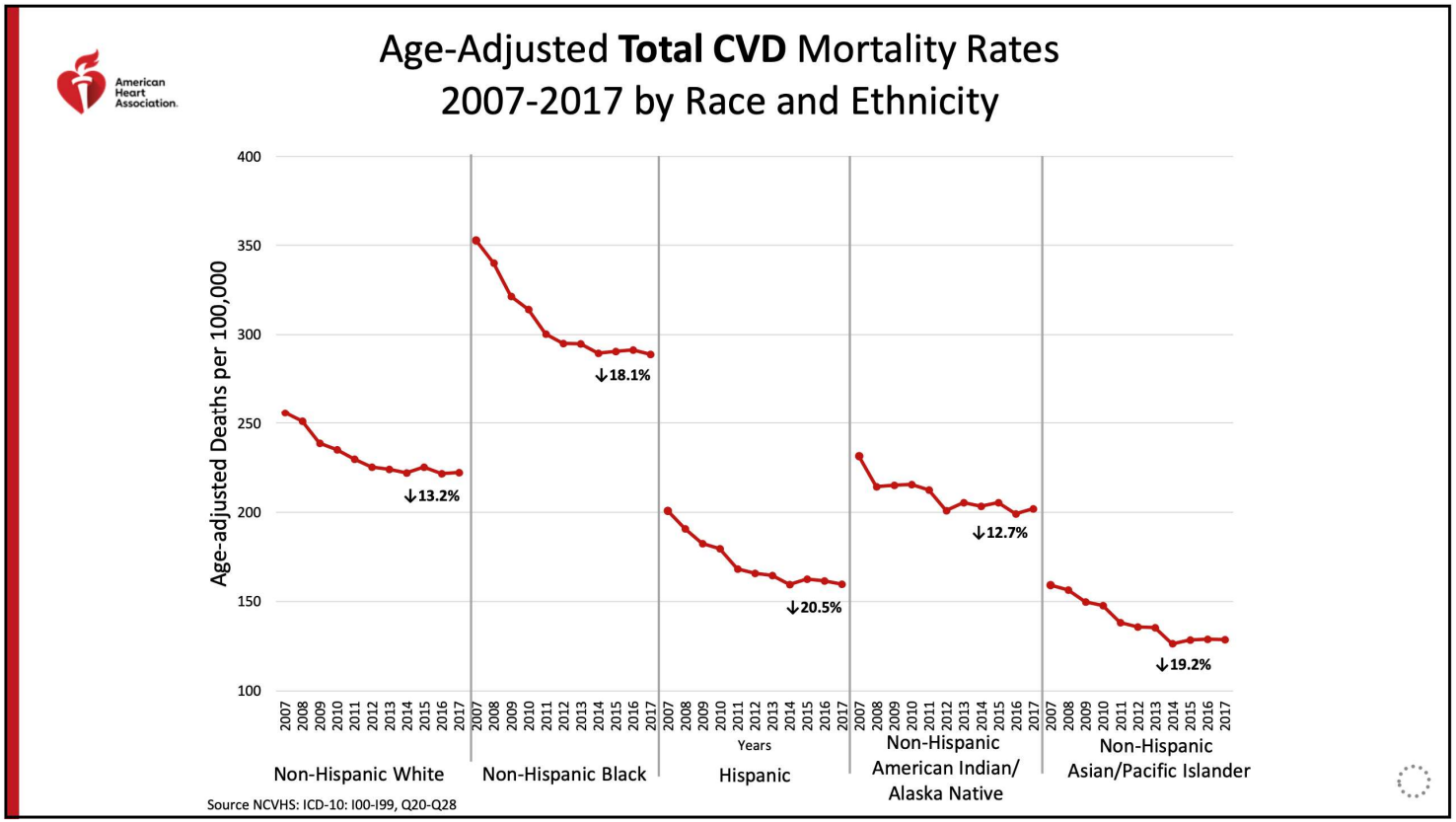
CVD is the leading cause of death and disability in Wisconsin.



1 out of every 3 adults in WI dies from a heart attack or a stroke.

If over 45 years of age, 36% of men and 47% of women will die within 5 years after their first heart attack.

National CVD Mortality Rates By Race and Ethnicity



Million Hearts® 2027 Priorities

Building Healthy Communities

- Decrease Tobacco Use
- Decrease Physical Inactivity
- Decrease Particle Pollution Exposure

Optimizing Care

- Improve Appropriate Aspirin or Anticoagulant Use
- Improve Blood Pressure Control
- Improve Cholesterol Management
- Improve Smoking Cessation
- Increase Use of Cardiac Rehabilitation

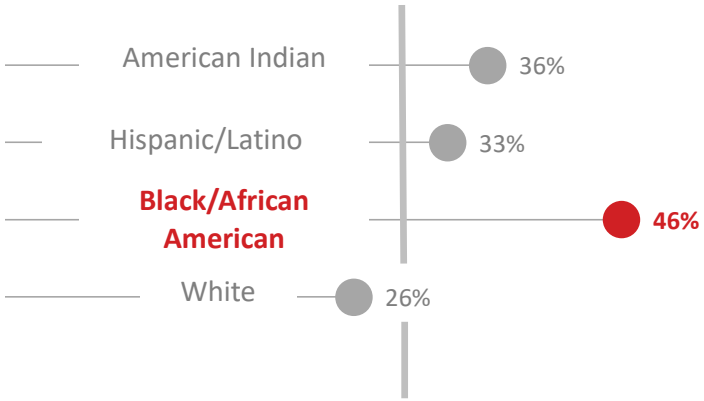
Focusing On Health Equity

- Pregnant and Postpartum Women with Hypertension
- People from Racial/Ethnic Minority Groups
- People with Behavioral Health Issues Who Use Tobacco
- People with Lower Incomes
- People Who Live in Rural Areas or Other 'Access Deserts'

What Does This Mean for WI?

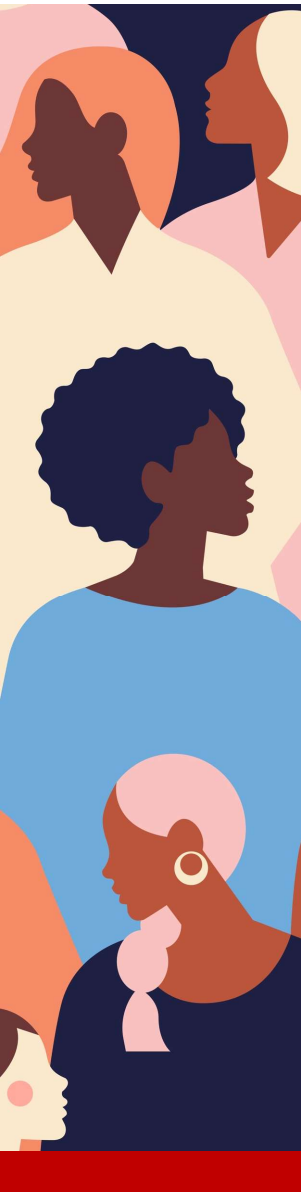
PRIORITY POPULATIONS

Blacks/African Americans have higher hypertension rates than other racial/ethnic populations.[1]



Total Cardiovascular Disease Hospitalization Rate per 1,000 Medicare Beneficiaries, 65+ (2013-2015)[2]

	WI	US
All Races/Ethnicities	107.1	122.8
Black	165.1	163.9
White	105.1	120.4
Hispanic	109.0	110.4



WISCONSIN HEALTHY HEARTS SURVEY 2020

SURVEY PARTICIPANTS: 79 | **PARTICIPANT ELIGIBILITY:** Heart Disease or a Heart Disease Caregiver

71% age 30 – 61

90% women

55% African American

13% non-English speaking

INSURANCE

77% had access to some type of insurance

4% reported not having health care coverage

HEALTH CHALLENGES

41% reported managing obesity

40% reported having diabetes or pre-diabetes

26% reported struggles with an unhealthy diet

26% reported physical inactivity

Heart Health Education

Desired Virtual Content

5 to 10 minute videos, infographics, QR codes, monthly In-person gatherings – NO PAPER!

Heart Health Plan

67% reported having a Heart Health Plan with a medical provider

33% did not = Opportunity to enhance education and medical provider relationship

Heart Health Education

TODAY

78% Medical Appointment
26% Online
4% Community (e.g., grocery stores, churches)

TOMORROW

33% More Online
75% Medical Appointment
14% People/Community
19% Faith-based Groups

Heart Health Supports

Self-Measured Blood Pressure

- **Education** – 19% would like to use a BP Cuff at home but do not have access to one – desire education from a medical provider
- **Access** – 61% purchase online; 39% medical provider; 39% pharmacy

Community Health Workers

- 63% would welcome support from a CHW
- 37% reported some hesitancy due to needs met by medical provider or concerns for privacy
- CHW Confusion – What are CHWs? Opportunity for awareness campaign

Pharmacy

- Participants interested in receiving more heart health support from a pharmacy – concern for available time or how to connect to this service

Other Opportunities

- More time with medical providers for heart health education
- Growth in a diverse workforce, especially in rural areas, for populations of color
- Increase in the prescribing of heart health supports that do NOT involve medication
- Increase in heart health information for young people and parents

Survey Creators: Wisconsin Chronic Disease Prevention Program, Wisconsin Women's Council, EQT By Design, Wisconsin Community Health Empowerment Fund

Impact of Pandemic on **Heart Disease**

Morbidity and Mortality Weekly Report (MMRW)

MMRW, June 15

Hospitalizations were 6 Times Higher – Death 12 times higher with chronic underlying condition including heart disease

MMRW, June 22

Effects on Use of Emergency Department – Heart attack visits declined by 23%

MMRW, September 11

Delay or Avoidance of Medical Care – Estimated 41% U.S. residents delaying medical care

Source: https://www.cdc.gov/mmwr/index.html

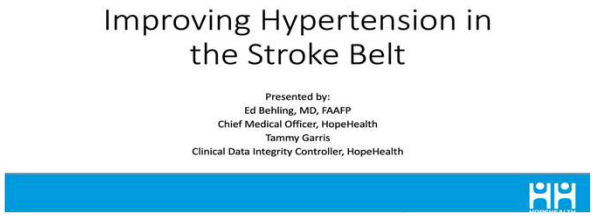
Heart Health Equity Learning Series

Session 1: “Heart Failure in Black Americans: Differences and Disparities.” **Dr. Alanna Morris, MD, MSc, FHFSA, FACC, FAHA**, Emory University.

Session 2: “Hypertension in the Time of Telemedicine: Self-Measured Blood Pressure Monitoring.” **Sonia Ayala, MA, LCSW,** Esperanza Health.

Session 3: "Improving Hypertension Control in the Stroke Belt." **Dr. Behling**, Medical Director and **Tammie Garris**, Quality Improvement Director for Hope Health Centers of Florene, South Carolina.

View the entire learning series here:
https://www.dhs.wisconsin.gov/heart-disease/alliance.htm



Produce Prescription Programs

Produce prescription for hypertension (PRxHTN) program

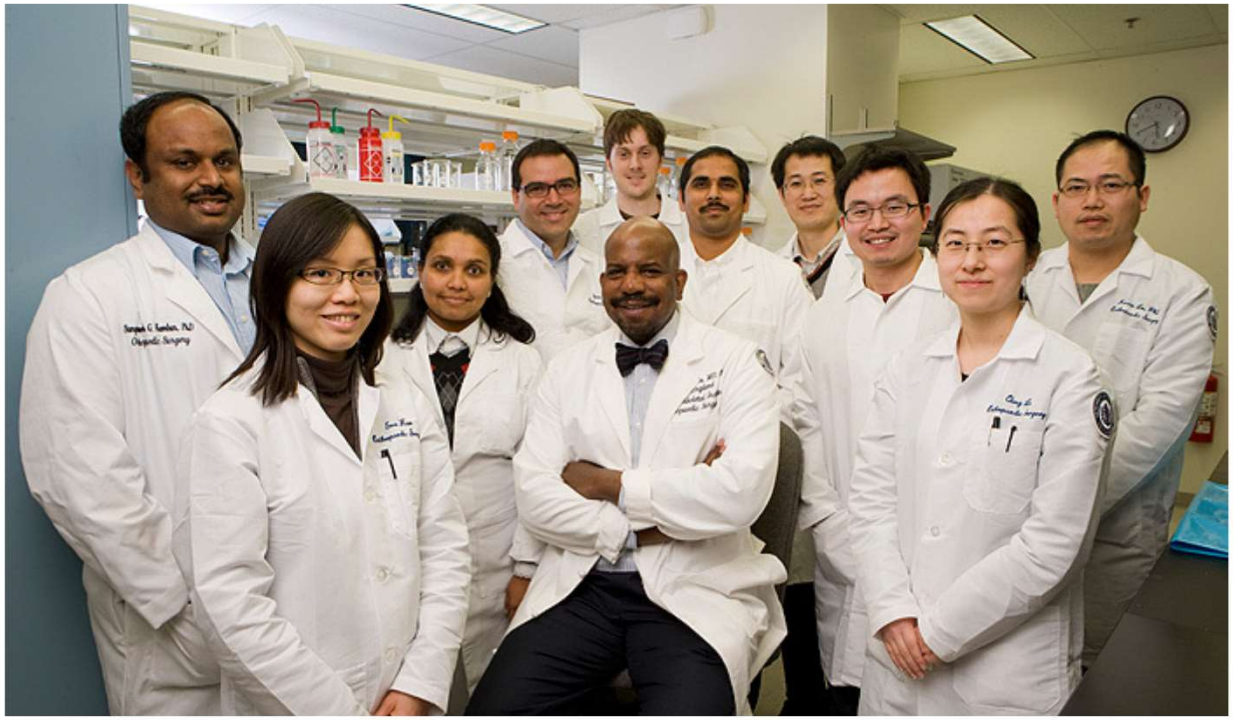
- 3 monthly, nonphysician provider visits for HTN adults screening positive for food insecurity
- Including BP measurement, nutrition counseling, and four $10 farmers market produce vouchers
- Dietary measures were collected at visits 1 and 3.
- Voucher use was tracked via farmers market redemption logs.

Behavior	No.	Intake	Postprogram	*P* Value
Health care team "always" talks about overall diet, %[a]	122	41.0	64.8	<.001[b]
Health care team "always" talks about increasing fruit and vegetable consumption, %[a]	121	38.0	75.2	<.001[b]
Daily servings of fruit, mean (standard deviation)[c]	125	1.6 (1.3)	2.4 (1.2)	<.001[d]
Daily servings of vegetables, mean (standard deviation)[c]	126	1.7 (1.1)	2.5 (1.3)	<.001[d]
No. days ate fast food in past week, mean (standard deviation)	129	1.3 (1.4)	0.7 (1.0)	<.001[d]

EMORY UNIVERSITY SCHOOL OF MEDICINE

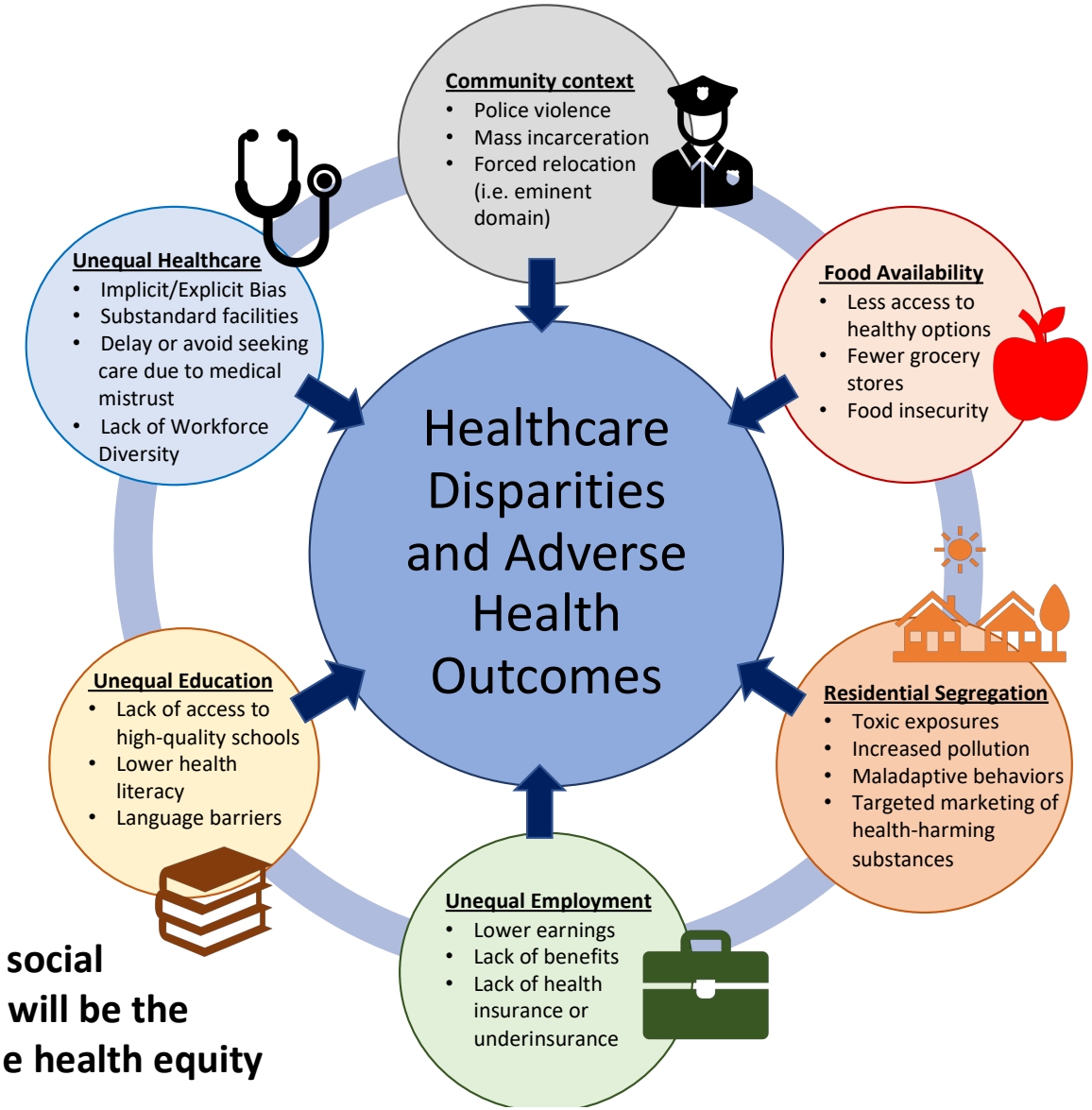
Department of Medicine

Trapl Prev Chron Dis 2018



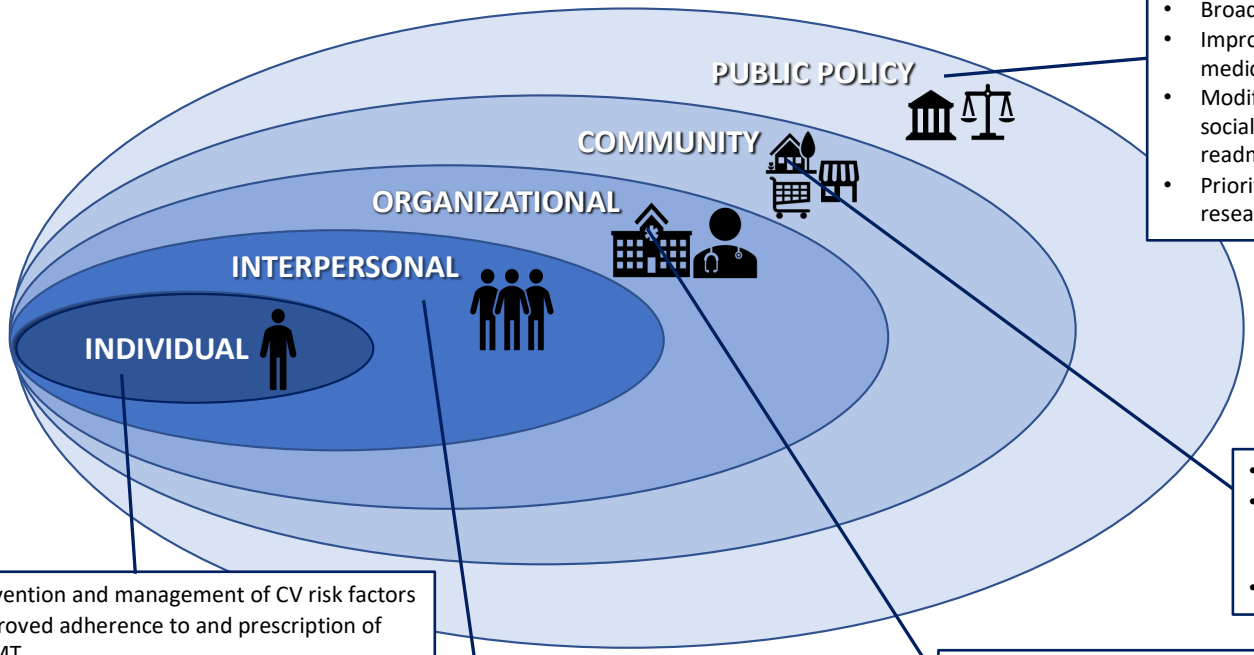
What does your Care (or Research) Team Look Like?

- Who's on It?
- Does it reflect your "wisdom" as a leader?
- Does it reflect the patient population you wish to reach?
- Does it reflect the society in which we live?



Achieving equity in the social determinants of health will be the only way to achieve true health equity

Targets for improving racial HF disparities using the framework of the social-ecological model



- Broaden insurance coverage
- Improve financial access to novel medical therapies with better efficacy
- Modification of the HRRP to incorporate social determinants of risk for hospital readmissions
- Prioritize funding for health disparities research

- Improve access to healthy foods
- Improve access to cardiac rehabilitation and facilities to increase physical activity
- Increase greenspace

- Prevention and management of CV risk factors
- Improved adherence to and prescription of GDMT
- Appropriate use of precision medicine
- Improved participation in research and clinical trials
- Patient-centered education to facilitate shared-decision making with providers about medication costs, device therapies, etc.

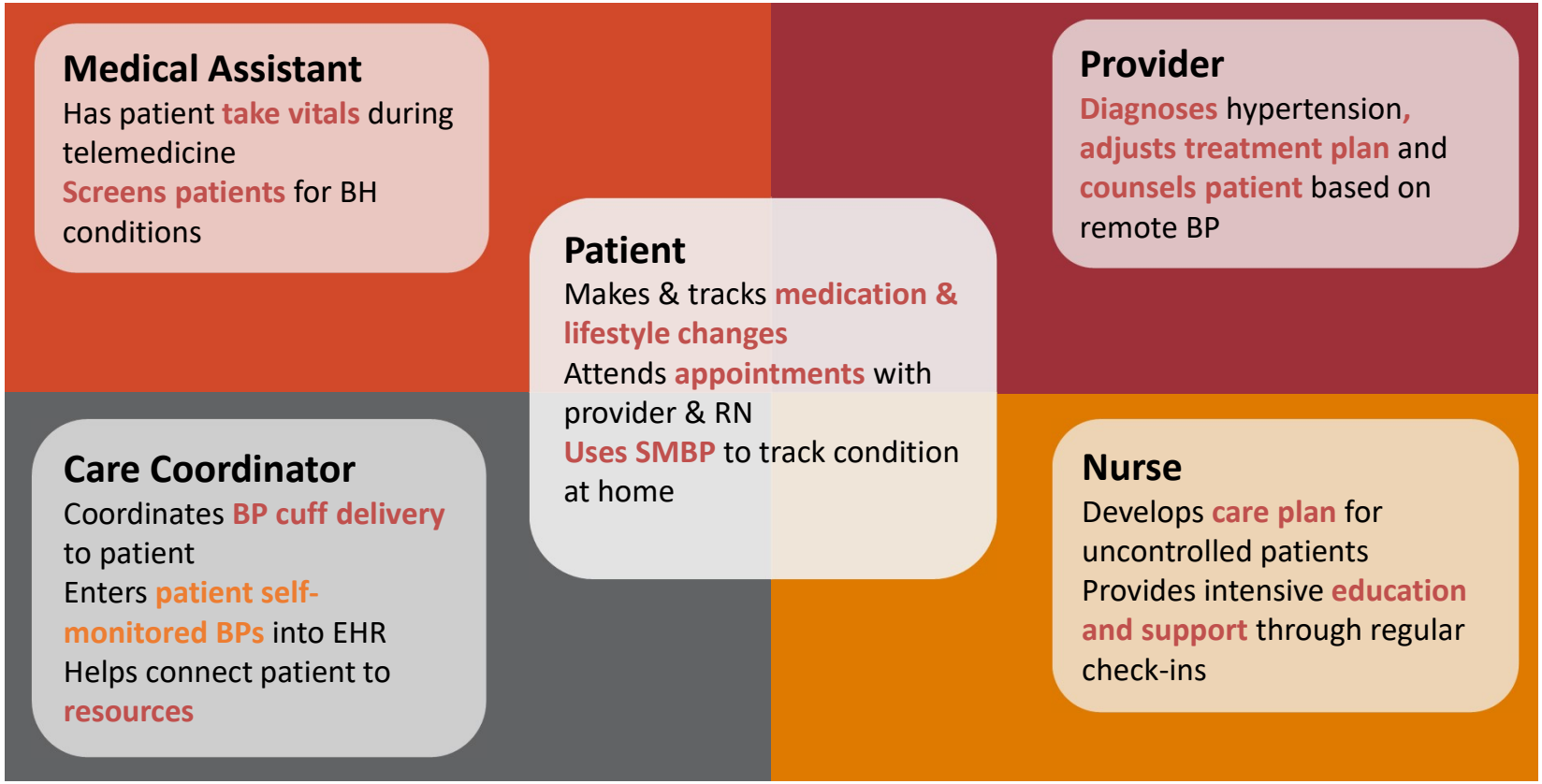
- Appropriate family-based counseling to identify presence or rare genetic variants (DCM, HCM, aTTR)
- Improved social support for advanced HF therapies

- Mandatory implicit bias training for clinicians
- Improved use of precision medicine (i.e. genetic screening, etc)
- Use eEMR to facilitate automated cardiology consultation and medication prescription for patients with high risk clinical features

EMORY UNIVERSITY SCHOOL OF MEDICINE
Department of Medicine

Nayak, Hicks and Morris. Circ HF 2020

Esperanza – Patient Team and Text Messaging Outreach Campaign



ESPERANZA health centers

HopeHealth – Heart Health Patient Supports

Remote Patient Monitoring

- Devices distributed to high-risk patients

Patient Education

- **Heart Wise Class** – Patients and their families with cardiovascular disease
- Well Power Weight Management – Physician performed health risk assessment, labs, and education sessions with nutritionists and health coach

Medication Assistance

- Drug assistance programs

HopeHealth – Heart Health Provider Support

Hypertension Control Dashboard

- Metrics displayed by provider, patient population, number of medications

Provider Education

- Physiology of hypertension and rationale for treatment decisions

Antihypertensive Treatment Rubric

- Recommendations from Clinical Pharmacists based on disease state

Medication Assistance

- Drug assistance programs

Conclusions

- Black Americans have the highest risk for heart disease
- Communities matter and access to Social Determinants of Health matter – equity cannot be achieved without it
- At the highest policy level, Wisconsin should continue efforts to expand its Medicaid programs and access to health care
- Who is on the care team matters! Does the care team mirror the population you are trying to serve?
- Community Health Workers, Care Coordinators and Medical Assistants all have vital roles in connecting patients to needed community supports
- There are expanded opportunities for education through SMBP, telephone monitoring apps, text messaging campaigns and group learning classes
- Pharmacists - emerging heart health leaders

United Way of Wisconsin 211 Information and Referral - SDOH Connection Support

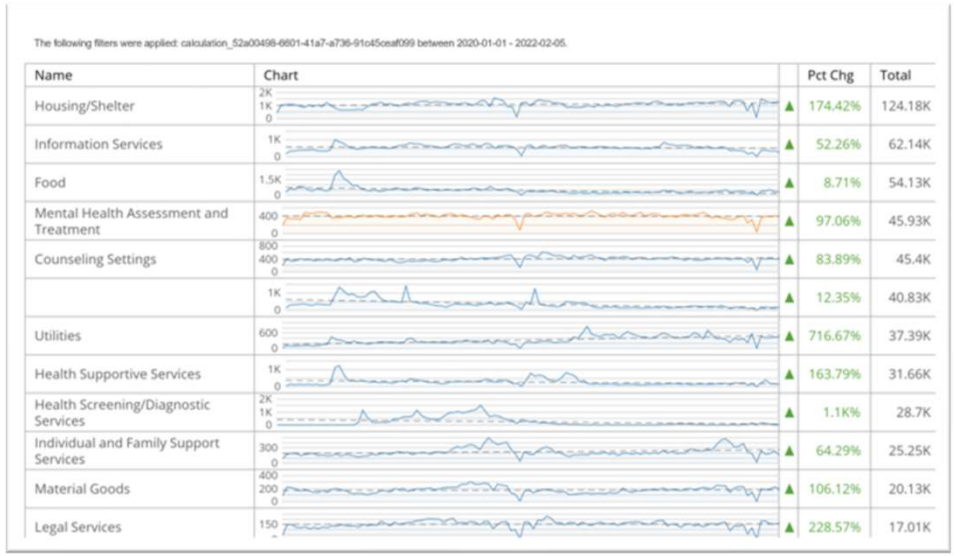
NO COST — Friends and Family

$ — Public Information Websites

$$ — 211 24-Hour Contact Centers

$$$ — Specialized I&R (some powered by 211)

$$$$$ — Navigators/Care Coordinators

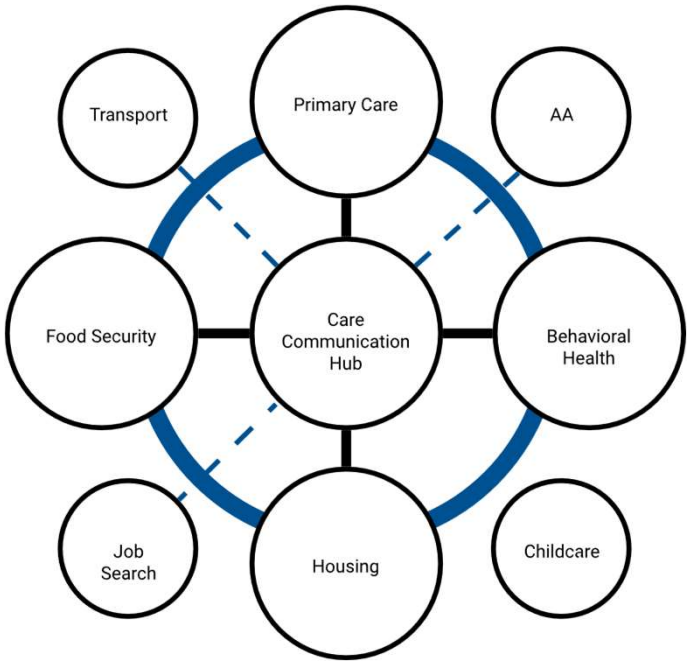


The following filters were applied: calculation_52a00498-6601-41a7-a736-91c45ceaf099 between 2020-01-01 - 2022-02-05.

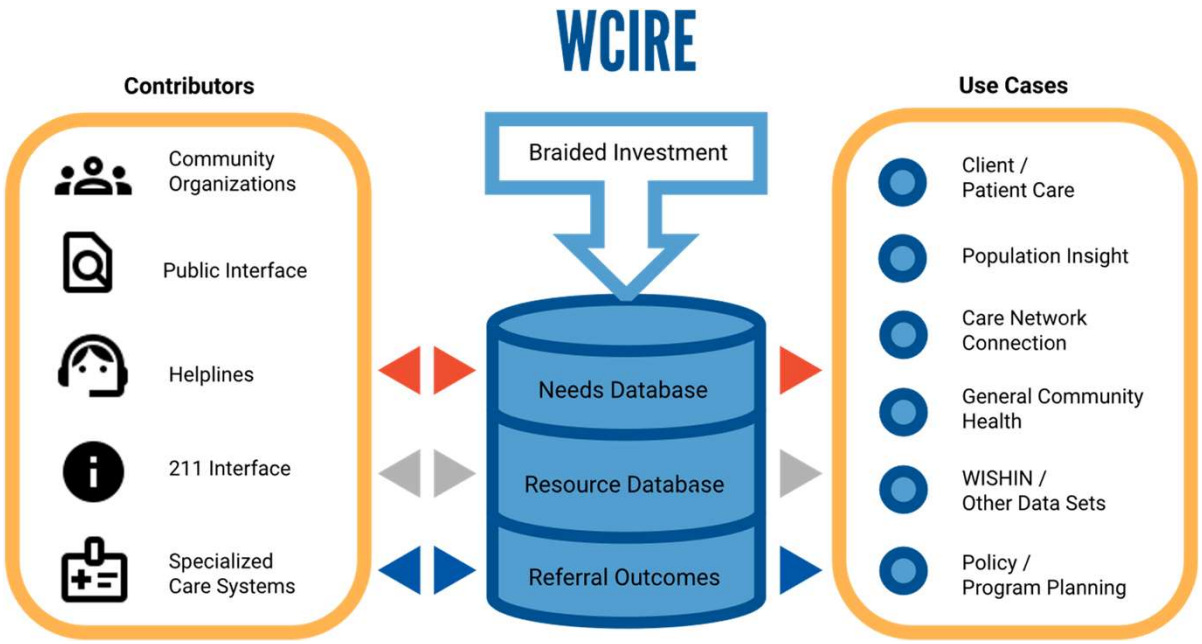
Name	Chart	Pct Chg	Total
Housing/Shelter	2K 1K 0	▲ 174.42%	124.18K
Information Services	1K 0	▲ 52.26%	62.14K
Food	1.5K 0	▲ 8.71%	54.13K
Mental Health Assessment and Treatment	400 0	▲ 97.06%	45.93K
Counseling Settings	800 400 0	▲ 83.89%	45.4K
	1K 0	▲ 12.35%	40.83K
Utilities	600 0	▲ 716.67%	37.39K
Health Supportive Services	1K 0	▲ 163.79%	31.66K
Health Screening/Diagnostic Services	2K 1K 0	▲ 1.1K%	28.7K
Individual and Family Support Services	300 0	▲ 64.29%	25.25K
Material Goods	400 200 0	▲ 106.12%	20.13K
Legal Services	150	▲ 228.57%	17.01K

Our Collective Challenge: Definitions

Care Networks



Community Information Exchange



Top Needs By Category

Top Requests by Category - 2021

Housing

63,673

Health Care / COVID 19

58,010

Mental Health / Substance Use

52,676

Information Services

31,475

Utility Assistance

22,928

Food / Meals

16,256

Individual, Family, and Community Supports

14,106

Legal, Consumer, and Public Safety

12,330

Wisconsin Lifeline
Family Services of Northeast WI

Family Services

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

iCarol

2-1-1 Wisconsin

STATEWIDE

2-1-1 Great Rivers 2-1-1 Get Connected. Get Help.

aunt bertha

GUNDERSEN HEALTH SYSTEM®

United Way of Door County

2-1-1 Wisconsin

Door County Partnership for Children

Epic

United Way Fox Cities

ThedaCare

United Way of Dane County

Epic

SSMHealth

UWHealth

Group Health Cooperative of South Central Wisconsin

IMPACT connect

IMPACT Connect is a collaborative partnership of agencies combining efforts to make social services assessable and navigable to the people who need them. IC is led by IMPACT – the regional provider of 211 services and the go-to source for social service referrals in SE WI. NowPow provides the technology platform.

IMPACT
Changing Lives. For Good.

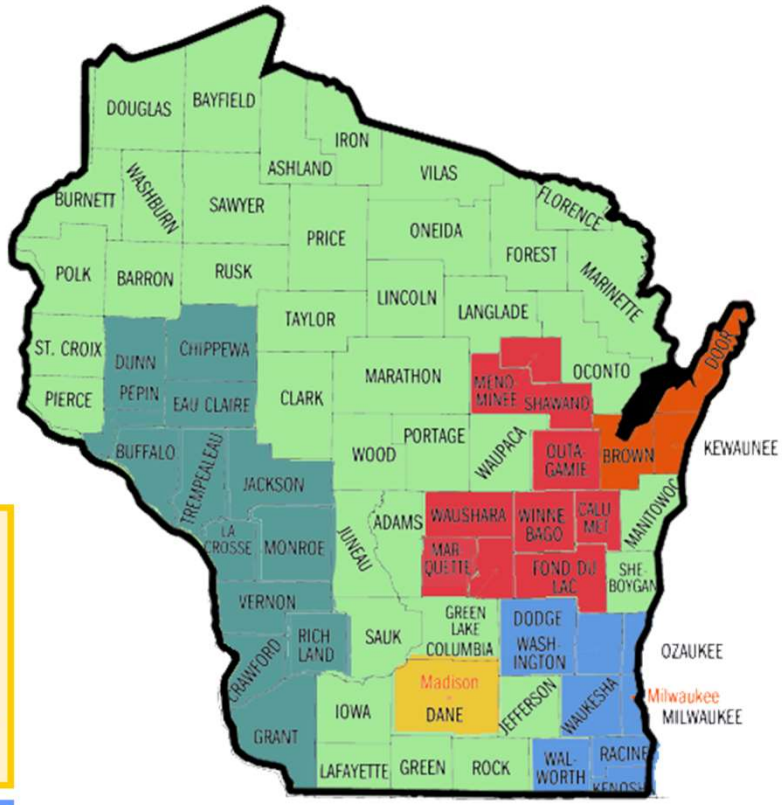
NOW POW

Children's Wisconsin

Aurora Health Care

MILWAUKEE HEALTH CARE PARTNERSHIP

Froedtert & Medical College of Wisconsin



211 WI INTEGRATIONS & PROJECTS

WCHQ Disparities Improvement Initiatives

School of Medicine and Public Health, University of Wisconsin-Madison | Marshfield Clinic Research Institute | Medical College of Wisconsin | Wisconsin Health Information Organization – Better Information. Better Decisions. | Wisconsin Collaborative for Healthcare Quality

Objective

- Understand where health disparities exist and build capacity to reduce disparities and advance health equity through statewide partnerships

Goals

- Identify populations with the greatest disparities in access to care, healthcare use, and health outcomes.
- Address known healthcare gaps, encompass best practices for addressing disparities, and evaluate impact.
- Facilitate health system, academic, and community partnerships to develop interventions targeting disparities that lack evidence-based interventions

Disparities Improvement Team

The WCHQ Disparities Improvement Team brings health system members and stakeholders together throughout Wisconsin to decrease the gaps in both health care access and health outcomes.

Activities

- **CEO Summit**: Leaders from WCHQ member organizations met in December 2021 to set priorities for reducing disparities. The rural health systems selected Colorectal Cancer Screening as the priority measure. The urban health systems selected Hypertension Control and Diabetes A1c Control as the priority measures.
- **Improvement Team**: The Disparities Improvement Team launched in January 2022.
- **Publish Reports**: Develop additional reports that cover statewide disparities results and disparities among subpopulations in Wisconsin. The June 2022 report will explore the impact of the COVID-19 pandemic on the disparities, focused on the priority measures identified by WCHQ member organizations.

Heart Health & Equity Highlights

Pharmacists as Leaders

- Serving >1,500 Hypertension Patients
- Pilot for African American Patients

UW Health ACO

- Tracking & Sharing more race & ethnicity outcomes

Re-measurement & Follow-up Protocols

- >40 Clinics!
- Getting the Job Done
- Expand this Practice

Quartz Insurance Partnership

- Providing Blood Pressure Cuffs

Developed a Workflow

- Adopted by MCW
- Identifying high blood pressure in **specialty care**
- Making **Primary Care Referrals**

Quit Connect

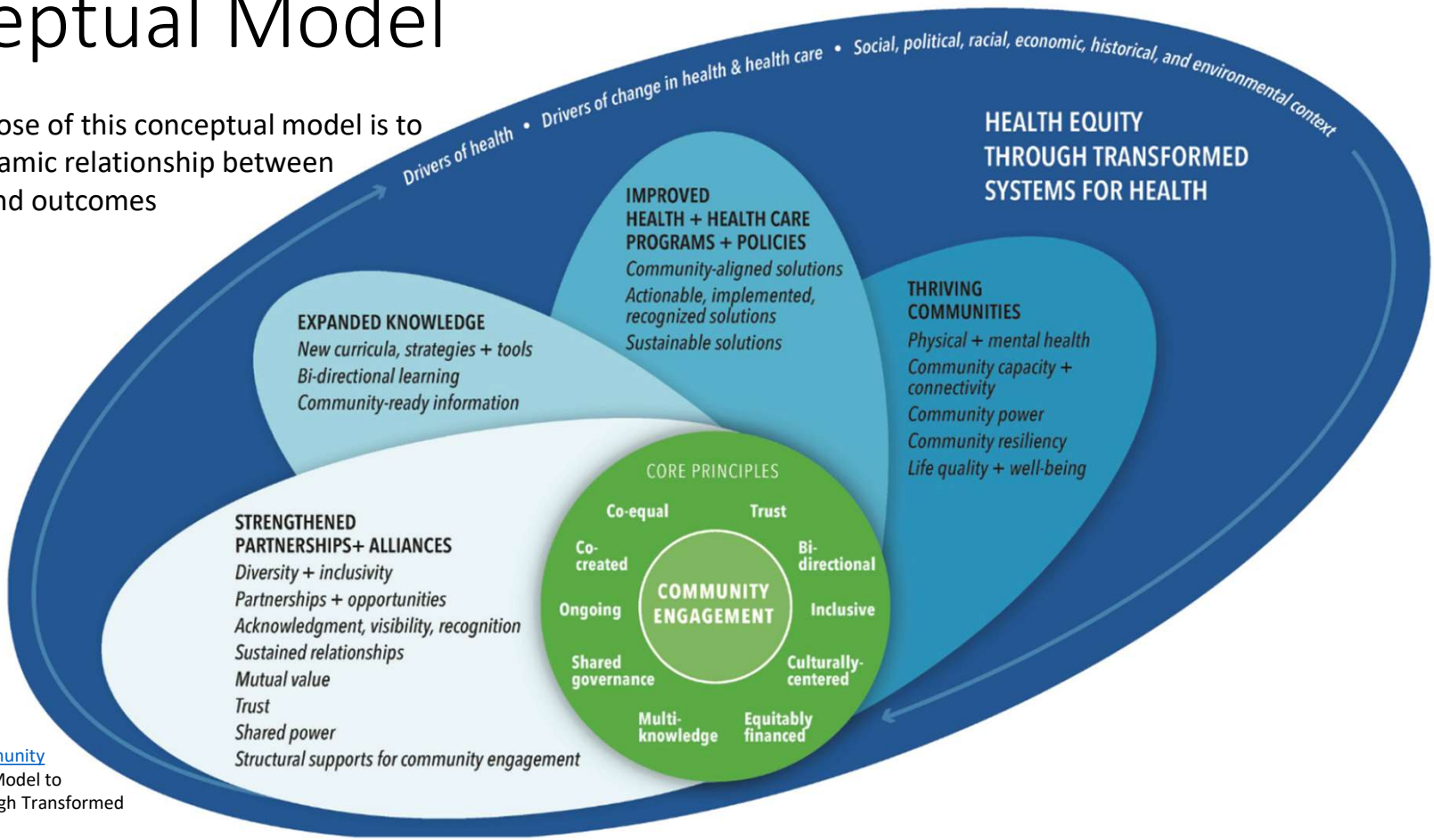
- Success with Tobacco Cessation Hotline
- Shared Beyond WI
- CDC Million Hearts Tobacco Change Package

American Heart Association Health Equity Initiatives

- AHA's 2024 Impact Goal is all around health equity and we've underscored a series of specific commitments to help address health disparities
- AHA is a key partner in the National Hypertension Control Initiative which is aiming to help 350 Community Health Centers across the US (6 in Wisconsin) improve lower rates in hypertension control
- Our EmpoweredToServe Business Accelerator offers an opportunity to obtain start-up funding for companies/non-profits that are seeking to address health disparities. Visit the AHA's wider EmpoweredToServe efforts.
- AHA is coordinating with others to champion efforts around the state to help seek public funding for Produce Incentive/Double Dollars efforts
- The AHA's Sr. Rural Health Director role builds off of the 2020 Presidential Advisory on Rural Health and represents a growing acknowledgment of the disparities that rural communities face

Assessing Community Engagement (ACE) Conceptual Model

The main purpose of this conceptual model is to reflect the dynamic relationship between engagement and outcomes



"Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health"