

Heart to Heart Success Stories

... Achievements, Outcomes and Lessons Learned ...



**Wisconsin Blood Pressure
IMPROVEMENT CHALLENGE**



Wisconsin Blood Pressure IMPROVEMENT CHALLENGE

The Wisconsin Heart Disease and Stroke Alliance (HDSA), in partnership with the national Centers for Disease Control and Prevention (CDC) Million Hearts® Initiative (now Million Hearts® 2022), the Wisconsin Department of Health Services, and the Chronic Disease Prevention Program (CDPP), developed and implemented the Million Hearts® Wisconsin Blood Pressure Improvement CHALLENGE. The CDPP receives CDC State Public Health Actions grant funding to target approaches and interventions to prevent, control, and promote improvements in blood pressure control and management throughout Wisconsin. The Million Hearts® Wisconsin CHALLENGE was one of multiple efforts led by the CDPP and our partners to improve blood pressure outcomes as part of national efforts to prevent one million heart attacks and strokes. Cardiovascular disease is the leading cause of death and disability in Wisconsin (2016). Of 1.7 million adults living with hypertension statewide only 53 percent have their blood pressure under control and 47 percent are uncontrolled. (Yeon, S., et al. 2015, Hypertension Prevalence and Control Among Adults, NCHS Data Brief, No. 220) A shared vision for Wisconsin reduces heart attacks and strokes, saves lives, and reduces health care costs.

What is the CHALLENGE? The Million Hearts® Wisconsin Blood Pressure Improvement CHALLENGE was created to identify successful interventions by individuals or teams that have led to improved blood pressure control and management outcomes. The CHALLENGE aims to recognize clinical and community efforts, which are leading to lowered blood pressure, improved blood pressure control, and heart-healthy lifestyles. The success stories illustrate exemplary work and identify innovative and best practices for hypertension control. The Wisconsin Department of Health Services and our partners are committed to working collaboratively to improve cardiovascular outcomes. These stories are grouped by action category denoted by red page flags. Please join us in congratulating our *Heart to Heart Success Stories!*



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Making Those Daily Phone Calls...

EAU CLAIRE SAM'S CLUB PHARMACY



Setting: Retail/Community Pharmacy

Issue: Patients do not always take their medication properly or pick up their refills on time.

Intervention: Patients were called one week before their refills were due and asked if their blood pressure medicines could be refilled. If patients have more than one week of medicine remaining, they are gently counseled on their medications and asked to pick a date for their refill. Most patients will agree to getting their refills when given gentle and supportive counseling. If no one answered the call, a message was left for the patient asking them to call the pharmacy back and reminding them it was time for a prescription to be refilled.

Success: Most patients have been adherent with this phone call intervention. The pharmacy recently had a computer update and now pharmacy staff can more easily catch patients who are non-adherent and talk to them about why they are having difficulty taking their medications or in getting medications refilled.

Challenges: Some patients do not appreciate getting phone call reminders; although most welcome and appreciate receiving the calls. It takes a team approach to make patient calls.

Conclusion: Because pharmacy staff is proactive in calling patients before their refills are due, the pharmacy has experienced very few cases in Mirixa (individualized medication counseling technology) and Outcomes MTM (medication management therapy). This successful phone call intervention means less work and increased efficiency for the pharmacy team. This intervention lowers costs to insurers and health systems as patients do not need additional services such as Mirixa or Outcomes MTM when they receive proactive reminders to maintain adherence with their medications. The results are better patient health care and health outcomes.

Intervention Timeframe: 4 years

Total Impacted: 200 patients

Immediate Referral For a Patient with High Blood Pressure

WEST ALLIS HEALTH DEPARTMENT



Setting: Community-Based Clinic

Issue: In Wisconsin, an estimated 612,000 adults ≥ 18 years have uncontrolled hypertension. Challenges with insurance coverage and access to timely health care services remain a critical need.

Intervention: A 51-year-old man with a history of high blood pressure (BP) attended a walk-in screening. The man had not seen his primary care provider (PCP) recently and he was not taking any BP medications. The man stated he had attended another clinic where he learned his BP was extremely high (220/180) and he wanted to have it rechecked. The man reported he had an appointment with his PCP, but it was in two weeks. Although the client's face was red and he was sweating, he denied feeling ill and said his current condition was normal for him. The man's BP was very high (194/126). The public health nurse (PHN) suggested calling 911, but the client did not agree. The PHN instructed the client to go immediately to the urgent care clinic located across the street. Since the urgent care did not accept the client's insurance, he could not be seen. The staff asked to call an ambulance, but the client did not agree. The PHN instructed the client to go to the emergency room (ER) as soon as possible.

Success: The client called the PHN and said a friend had driven him to the ER, where he was given medications to lower his BP. He said he felt "a lot better" and he now understands the importance of taking his medications.

Challenges: The client's insurance was not accepted at a local urgent care clinic. The client's PCP was unable to see him until his appointment in two weeks. The client had been without medications when he lacked insurance coverage.

Conclusion: This intervention was successful as a PHN at a walk-in BP screening identified a client who needed immediate medical care. The client followed through by going to the ER.

Intervention Timeframe: 4 days

Total Impacted: One client identified at a BP screening

She Didn't Know She Had a Problem Elevated Blood Pressure Found

HOPE EVANGELICAL FREE CHURCH



Setting: Community-Based Parish Nurse Program

Issue: In Wisconsin, there are an estimated 97,000 adults ≥ 18 years who are unaware they have elevated or high blood pressure (BP). BP screenings held in faith communities provided by parish nurses are valuable interventions for finding people unaware and undiagnosed with high BP.

Intervention: A woman with high BP was detected at a parish BP screening. The parish nurse suggested the woman see a provider to help reduce her BP. With support from the parish nurse, the woman's diet and exercise regimen were reviewed. She attended classes about cardiac care, which underscored the importance of managing stress. She also identified ways to manage stress and set goals for self-management of hypertension.

Success: The client has been seeing her provider on a regular basis and her BP has been controlled with lifestyle changes and taking medication as prescribed. The client has made great strides to reduce the stress in her life, which has helped her significantly.

Challenges: The client and her family were homeless at the time of the initial screening and follow-up screening. She was living with her cousin, which caused significant stress in her life. Since that time, her family found a small apartment of their own and moved out of her cousin's house. The client has support to help work through stressful situations, and she is improving her diet. Due to other physical problems it has been difficult to increase her physical activity.

Conclusion: The client is very thankful her elevated BP was detected. She is doing well and continues to consult her provider. The client continues to monitor her BP with clinical support and follow-up care provided by the parish nurse.

Intervention Timeframe: 13 months

Total Impacted: 1 client found with elevated BP out of a total of 75 people screened

Engaging Patients in Cardiac Care

AURORA WALKER'S POINT COMMUNITY CLINIC (AWPCC)



Setting: Community-Based Clinic

Issue: Community-based care can be challenging.

Intervention: AWPCC has used PDSA (plan–do–study–act) cycles to identify several effective strategies for managing hypertension (HTN) among the disparate populations it serves:

- Staff attend cultural sensitivity training and have excellent rapport with patients and their families.
- Patients have access to health coaches and nutritionists.
- Staff have regular blood pressure (BP) measurement training.
- BP is always taken last during intake. If BP is high, a second reading is taken five minutes later. If BP is still high, a patient is scheduled for a visit in two weeks. In some cases, portable monitors are given to patients to capture self-measurement.
- Some specialists volunteer at AWPCC; referrals are made if needed.
- Staff are trained in quality improvement practices and conduct frequent PDSA cycles to make changes.

Success: Among AWPCC patients with HTN, 89 percent have now achieved control.

Challenges: This population has considerable stress with limited resources, but family ties are strong. Patients understand that family members rely on them to have good health, so many are fully engaged. Engagement from the clinic is strong with lots of patient reminders and requirements to return to the clinic for prescription refills or if they have not been seen in six months. Health coaching empowers patients to make choices that work for them.

Conclusion: AWPCC has fully embraced the diverse community it serves. Building strong relationships with patients and families in a culturally sensitive manner and providing coaching that empowers and engages patients to focus on preventative approaches works wonders in this underserved setting. A strong focus on proper BP measurement technique and patient education support the high outcomes.

Intervention Timeframe: Unspecified (several years with PDSA cycles)

Total Impacted: All patients served by the clinic

Inter-Professional Education

Successful Teams and Case Studies in Cardiac Care

CONCORDIA UNIVERSITY WISCONSIN (CUW)



Setting: Academic

Issue: Inter-professional and team-based care is a reality in the health care marketplace. CUW has instituted Inter-Professional Education (IPE) as a cornerstone for all health and social care students. In two years, over 220 students have participated in IPE programming to build competency in the roles and responsibilities of varied health care professions. During programming, students discussed the values and ethics of person-centered care, increased teamwork, and strengthened inter-professional communication.

Activity: Students initially gathered in three large groups to engage with inter-professional teams of current practitioners and to learn advanced cardiac care from two care teams. Team one is a preventative cardiac care team of physicians (MDs), nurse practitioners, PharmDs, and exercise physiologists, as well as medical and pharmacy students. Students learn how teams function to coordinate care for high-risk patients, individualize care plans, and conceptualize and implement collaborative agreements between patients and care teams. Team two includes a PharmD, physician, nurse practitioner, social worker, physical therapist, and a nurse working with students in a medical intensive care unit. Team members highlight how they must work inter-professionally for more complex patient cases to reduce medical errors and improve outcomes. These patients have undergone complex procedures and require coordinated cardiac care.

Students form small groups (eight to 10 students) to develop final IPE case work-ups with faculty facilitators. Preparation for the “Case of Mr. Jones” is done prior to the event, with the case inter-professionally discussed by students as care providers. Mr. Jones is a patient case with severe hypertension and presentation with “flu-like” symptoms. He has difficulty catching his breath when walking up stairs. Students work together to problem solve and ultimately develop a health and social care plan that includes hospital stay, discharge planning, and blood pressure monitoring with consideration of social and cultural issues for Mr. Jones and his family.

This complex case challenges advanced students and requires good teamwork and communication. These small groups of students meet and build rapport to engage fully as team members to deal with

“the real world of medical conditions”: heart failure, hypertension, medication adherence/management, and family dynamics involved with person-centered team-based care.

Success: This capstone event has proven successful on several levels. The emphasis on cardiac care and wellness speaks to all health care students. Establishing “real teams” in a collaborative environment is inspiring for students about to embark on clinical rotations and internships. Additionally, the case work-up is based on the complexities of severe hypertension and heart failure. An overarching goal is for students to experience how cardiac care teams perform daily and apply their skills, thinking, and inter-professionalism to a closely related case.

Students’ assessments and evaluations of the inter-professional events have been highly favorable over a three-year period. Students have responded positively to the synergy of large and small group activities. They have expressed satisfaction with the complex cardio-patient case utilizing their education, skills, and critical thinking while training.

Challenges: IPE symposia pose challenges in terms of logistics and faculty facilitator training and strives to continuously improve both large and small group presentations (e.g., adding opportunities for inclusion of varied health care professionals) to more fully engage students. Using a cardiac care-based case study remains part of the IPE capstone event due to the importance of managing patients with high blood pressure, hyperlipidemia, and related disorders. Our health and social care students complete IPE programming within a context of care in everyday practices and clinical experiences.

Conclusion: By embedding cardiac care and blood pressure control into our IPE programming, faculty feel strongly that our students will be better prepared for clinical work experiences. Students will apply inter-professional education into action and demonstrate how inter-professional teamwork can improve outcomes for patients with high blood pressure and/or other complex cardiovascular conditions. IPE has become fundamental to preparing students in mind, body, and spirit for health care vocations.

Intervention Timeframe: 3 years

Total Impacted: 700+ students (nursing, pharmacy, occupational therapy, physical therapy, social work, and physician assistant studies) and medical students (from the Medical College of Wisconsin)

Bi-Directional Referral and Blood Pressure Management

By a Public Health Nurse

GREEN COUNTY HEALTH DEPARTMENT



Setting: Community-Based Clinic

Issue: A middle-aged woman was seen during a Green County Health Department community blood pressure (BP) screening where she was found to have high BP. The woman explained to the public health nurse (PHN) that she had elevated BP readings and was prescribed medication. The PHN contacted Monroe Clinic and made a referral. A Monroe Clinic triage nurse contacted the patient and made a referral for the woman to see a primary care provider (PCP). The appointment was scheduled with the PCP office within two days. At the appointment, the patient's BP was found to be elevated, and it was discovered the patient had not been compliant in taking previously prescribed BP medications. The provider discussed the importance of diet, exercise, monitoring intake of sodium, and taking her medications to treat hypertension (HTN).

The patient attended a one-month follow-up appointment. Although she was taking her HTN medications as prescribed, her BP was found to be uncontrolled. The medication dosage was increased.

The provider and patient decided the woman would come to the public health clinic to have her BP monitored. The patient attended another one-month follow-up appointment. She was taking her medications as prescribed and was self-monitoring her BP at home daily; however, her BP readings were ranging between 114–135/70–85. The woman was monitoring her diet; although she was not involved in a routine exercise program. The PHN emphasized the importance of continuing to self-monitor her BP and the woman was instructed to call the PHN if she had readings greater than 140/90. The PHN reviewed the woman's diet and suggested some exercises.

Three months later, the woman returned for a follow-up appointment. She reported her BP was around 130–140/80–90. The patient was modifying her diet; however, she was still not in an exercise program. The PHN discussed other lifestyle changes that could be made.

The patient attended a six-week follow-up appointment. The patient continued to self-monitor her BP daily and reported it was lowered at

101–115/80. She reported participating in some activities and had lost eight pounds with reduced sodium intake. The patient continued to self-monitor her BP daily.

The patient attended another three-month follow-up at the public health clinic. She continued to self-monitor her BP daily. No other additional medications were started. The client was staying active and managing her stress.

Intervention: The PHN provided BP education including self-monitoring of BP and supported the patient in taking her HTN medications and making lifestyle changes.

Success: The patient's BP readings improved; the patient lost weight, became more active, and was successful in self-monitoring her BP daily and taking her medications as prescribed.

Conclusion: Public health interventions were important for continued BP self-monitoring with the patient.

Intervention Timeframe: 9 months

Total Impacted: 1 patient example in a program that has screened 131 people to date

Improving Patient Communication Through Pharmacy Driven Questionnaires

FITCHBURG HOMETOWN PHARMACY



Setting: Community Pharmacy

Issue: Poor patient-provider communication can result in sub-therapeutic outcomes for patients with chronic disease states including hypertension (HTN). Pharmacists are well equipped to enhance medication adherence by identifying patient-specific barriers and finding ways to overcome them. Fitchburg Hometown Pharmacy has many unique services including medication box fills accompanied by free personal delivery. This convenience offers easy access to medications similar to mail order pharmacies; however, it also offers ample opportunity to improve patient-pharmacist communication, identify patient questions and concerns, and contribute to better patient outcomes.

Intervention: This ongoing project has enrolled 40 medication box patients and includes three components. First, medication pill boxes are hand-delivered to a patient's door weekly or biweekly. Second, delivery staff administer a two-minute, three-question paper survey to assess adherence, efficacy, and safety of the patient's medication therapy, including those medications for HTN. These questions are rotated with similar questions every week to avoid repetition. Third, a monthly phone call addresses any new patient questions and follows up on medication issues identified earlier. The call focuses on chronic disease management, including therapeutic goals and home blood pressure (BP) monitoring. During this phone call, patients are also offered an in-person comprehensive medication review and assessment.

Success: Out of the first 21 patients enrolled and called, 15 agreed to a comprehensive medication review and assessment as part of medication therapy management services to learn more about their medications and troubleshoot any issues they may have experienced with their medication management. All 14 patients with HTN or diabetes did not know their BP or blood glucose goals. Twelve out of 14 patients did not monitor their BP regularly at home, but four were willing to purchase a home BP monitoring cuff to use on their own.

Challenges: A big barrier to the medication box enrollment and the three components with patients is time. Some pharmacists

do not have enough time in their normal everyday activities to complete these crucial “patient check-ups.” However, these types of interventions can really impact patient health. By empowering patients to take an active role in their health care and take ownership of their medications and BP monitoring, hospitalizations can be prevented and health outcomes improved.

Conclusion: Preliminary findings are promising, suggesting that the intervention may help recruit patients interested in receiving comprehensive medication review and assessment services. The intervention also identifies patient confusion about therapeutic goals as well as the lack of home monitoring, which pharmacists can then address. Although repetitive, the weekly questionnaires give patients an opportunity to think about their medications and to discuss any concerns.

Intervention Timeframe: 46 months

Total Impacted: 40 patients



By empowering patients to take an active role in their health care and take ownership of their medications and blood pressure monitoring, we can prevent hospitalizations and improve health outcomes.

Wisconsin WISEWOMAN Program

Supports Self-Management of High Blood Pressure

AURORA WALKER'S POINT COMMUNITY CLINIC (AWPCC)



Setting: Community-Based Clinic

Issue: Women identified with elevated blood pressure (BP), diabetes, and lipid levels with cardiovascular risk factors can greatly benefit from the Wisconsin WISEWOMAN program if they meet program requirements. Since 2009, the WISEWOMAN program has provided ongoing clinical services incorporating evidence-based approaches such as team-based care and behavioral support interventions including motivational interviewing to strengthen clinical engagement with clients to self-monitor their BP, health coaching, evidence-based lifestyle programs, and referrals to community resources. (Note: WISEWOMAN is an acronym for Well-Integrated Screening and Evaluation for Women Across the Nation.)

Activity/Intervention: Two clients came to the clinic: one client was found to have BP of 134/90 and the other woman had BP of 124/98 and was currently on medication for her hypertension (HTN). Both women were enrolled in the WISEWOMAN program, which offered them clinical follow-up, medication check-ins, and health coaching to support and manage their high BP. Initially, AWPCC staff provided the clients with the Well Woman WISEWOMAN initial screening that includes clinical follow-up and medication check-in. Program clients receive clinical support to make therapeutic lifestyle changes with health coaching during three coaching sessions. In these sessions, staff support clients to improve their diets with healthy eating, increase their physical activity levels, and assist clients to set SMART (specific, measurable, attainable, realistic, and timely) goals.

Each client came in for two more successive annual screenings. One client's BP at her next visit was 110/80. This same client returned for two more successive annual screenings and has maintained her BP in an average range.

Both clients were provided program guidebooks on healthy eating and physical activity. Program tools for education included a portion plate, measuring cups, a listing of community health resources, and BP re-checks.

Success: One client said, "The main thing I have done to control

my BP is walking for exercise; changing my diet by consuming less tortillas, coffee, and soda; and eating more vegetables.” She used BP self-monitoring regularly and stated, “One helpful thing is I have a BP machine and I check my BP at home so I have a way of knowing what my BP is. If it is high, I go outside to walk for 20 to 30 minutes. I check my BP every other day, and I keep the monitor at my bedside. The monitor is in a visible place, ready and waiting, and it helps me remember to check my BP. Health coaching was helpful, as was having the annual WISEWOMAN visit. My recommendation for others who have high BP is to do some type of exercise to help control their BP.

The other client reported the following:

“The main thing that has helped me control my BP is that I became very good at taking my medication at the correct time every day. If I realize I missed a dose, I take it right away. I take two pills—one in the morning and one in the evening. I remember to take my pills because I have made it part of my daily routine. When I get up and go to take a drink first thing in the morning, I know it is time to take my pill with it. At nighttime, before bed, I always know that I need to take my pill before I lie down in bed.”

“I try to eat a well-balanced diet. I don’t eat red meat; I try to eat more chicken and fish. I haven’t done much exercise.”

“I don’t check my BP outside of the clinic. I bought a home monitor, but I gifted it to my mom. I haven’t purchased a new one.”

“The annual WISEWOMAN visit helps me as well. I have my BP and cholesterol checked. I also have two other regular visits per year at the clinic separate from the WISEWOMAN program, and those are helpful, too.”

“If I were to give advice to someone who has a new diagnosis of high BP, I would say that the most important thing is to take your medication as prescribed and accept that it is a long-term medication. Even if you are feeling okay, you still need to take your medication every day.”

“Health coaching has had an influence on helping me control my BP. When I chat with my coach, she gives me advice and tips that I wouldn’t have come up with on my own, which is helpful.”

CONTINUED...

Wisconsin WISEWOMAN Program

Supports Self-Management of High Blood Pressure

AURORA WALKER'S POINT COMMUNITY CLINIC (AWPCC)



Challenges: The first client stated she had “no time” to exercise because her “work schedule was always changing.” Walking was the most realistic way for the client to keep physically active and address her challenges.

The second client stated barriers to incorporating healthy lifestyle changes were that she loves to eat, she lacks support for making healthy changes, she usually has to rush to eat, and there is always soda in her house.

Conclusion: The Wisconsin WISEWOMAN program staff at AWPCC supported both clients. The first client became able to self-manage her high BP and through health coaching assistance, made lifestyle changes by becoming more physically active and eating a healthier diet. This client became more educated about the importance of monitoring her BP, taking medications as prescribed, and making lifestyle changes.

The WISEWOMAN services offered at AWPCC supported and engaged the second client to also self-manage her high BP. Through education, the client gained an understanding about the importance of taking her medications as prescribed and the necessity of medication adherence in reducing hypertension and in controlling BP.

Intervention Timeframe: 3 years

Total Impacted: Two client examples from a program that has served 1,453 women to date

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My recommendation for others who have high blood pressure is to do some type of exercise to help control their blood pressure.

“

Health coaching has had an influence on helping me control my blood pressure. When I chat with my coach, she gives me advice and tips that I wouldn't have come up with on my own, which is helpful.

Blood Pressure Case Management By a Public Health Nurse

WEST ALLIS HEALTH DEPARTMENT



Setting: Community-Based Clinic

Issue: An elderly woman from India came to the West Allis Health Department to have her blood pressure (BP) checked. She was very anxious and scared due to recently being diagnosed with high BP, and she stated she had very little knowledge regarding hypertension (HTN). She explained to the public health nurse (PHN) that her husband had a severe stroke about a year ago, and she had been his main caretaker. She felt isolated and overwhelmed with the situation. Her son, who lives in the U.S., came to India to visit and encouraged her to see a medical provider who found she had high BP, put her on medication, and told her she must find a way to manage her stress. The woman's son decided he would stay in India to care for his father, and she would go to her son's home in the U.S. to live with his wife and daughter for a couple months. Her provider in India thought this would be a good idea as long as she could find someone to monitor her BP while she was in the U.S.

At the woman's first visit, her BP was 140/70; she was very anxious, and there were some communication barriers. It was decided that the woman would come to the clinic to have her BP monitored once a week at first and then every two weeks. The PHN educated the client about the risks of untreated HTN, her medications, and other lifestyle changes she could make to help control her BP. The PHN also recommended the client go to an exercise class at a senior center to help with her isolation issues. As the weeks went on, the client's BP was monitored; she was offered support and further education by the PHN. The client was going to the West Allis Senior Center two times a week for an exercise class, and she enjoyed being with people her own age.

As the client's return date to India approached, she again started to get anxious about monitoring her own BP. The PHN decided to give the client a home BP monitoring device she could take back to India. After using the monitor together a few times, the client was able to demonstrate to the PHN that she was able to correctly use the device. The client was very grateful to receive the monitor. The client stated she was feeling much more confident in being able to control her BP because she had learned many ways to help manage her stress and

health. At her last visit, the client's BP was 128/62, which was greatly reduced, and the client was pleased with the outcome.

Intervention: The PHN provided BP education, including BP self-monitoring, support, and client case management all in a culturally sensitive manner.

Success: The client's BP readings improved. Anxiety and stress were reduced with increased activity and socialization. The client was successfully instructed on BP self-monitoring.

Challenges: Language and cultural barriers

Conclusion: Successful public health intervention. The client returned to India with increased knowledge regarding her health and strategies for lowering her BP.

Intervention Timeframe: 9 weeks

Total Impacted: 1 client



The client stated she was feeling much more confident in being able to control her BP because she had learned many ways to help manage her stress and health. At her last visit, the client's BP was 128/62, which was greatly reduced, and the client was pleased with the outcome.

Bravehearts: A Corporate Wellness Toolkit

EDGEWOOD COLLEGE SCHOOL OF BUSINESS MBA PROGRAM
AND THE UW CREDIT UNION



Setting: Corporate Workplace

Issue: Hypertension control and healthy lifestyle promotion within a corporate setting

Intervention: Million Hearts® inspired an eight-week online corporate wellness program offered to all UW Credit Union employees during the summer of 2016.

- Module 1: Understanding the Risks of High Blood Pressure (BP)
- Module 2: Heart Healthy Eating Habits and the Rainbow Challenge
- Module 3: Controlling High BP/Supporting Loved Ones
- Module 4: Stress Reduction and Proper Exercise

Prize incentives such as food gift cards, cookbooks, personal BP monitors, water bottles, and four-hour blocks of earned vacation were given to members who completed the program.

Challenges: There were initial concerns surrounding the program's summer launch date. (The pilot effort was offered in the summer as staff and an intern were available for program support.) While employee vacations impacted participation, 20 percent corporate involvement for the wellness activity was close to the national average of 22 percent involvement. If the program were offered at a different time of the year, participation levels might have differed.

Success: Twenty percent of the workforce (103 participants) completed the Bravehearts program.

Conclusion: Modules were developed and are easily replicated and shared with other entities. There is an effort to expand the Bravehearts program throughout Wisconsin.

Intervention Timeframe: 8 weeks

Total Impacted: 103 participants

PACTeam Hypertension Reduction

VETERANS ADMINISTRATION (VA) WEST CLINIC



Setting: Clinic/Community-Based Program

Issue: Team-based, clinical support for patient hypertension (HTN) in their home communities is key to reducing HTN.

Intervention: A registered nurse (RN) leads the PACTeam (Patient Aligned Care Team) HTN management program at the VA West Clinic in Madison, Wisconsin. This program started as a dual project with a lead pharmacist; however, as the pharmacist's administrative commitments grew, the RN was assigned as team lead. The team collaborated in person during chart reviews and delegated the following actions:

- Provided medication therapy management services by the PharmD.
- Provided face-to-face visits by the primary care provider.
- Performed phone visits by the nurse case managers to discuss diet/lifestyle modification and non-pharmacological interventions.
- Tracked home blood pressure (BP) trends and forwarded the assessments to the primary care provider or the PharmD if additional follow-up care management was needed.
- Confirmed home BP trends at or below the patient's individual goal by the licensed practical nurse.

The RN worked very closely with the medical assistants to ensure scheduling of these services went smoothly.

Success:

- Ten percent reduction in patients with HTN.
- Panel size growth by 25 percent.
- Thirty-eight of 76 patients with HTN had reduced BPs that tend to be at or better than their individual goal (50 percent reduction) during the initial phase.

Intervention Timeframe: 46 months

Total Impacted: 200 patients

Pharmacists and Blood Pressure Control: A Win for Patients, A Win for Health Care

GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN



Setting: Clinically-Based Pharmacy

Issue: Barriers prevent patients from taking their hypertension (HTN) medications properly and can lead to high rates of uncontrolled HTN, increased health care costs, and can contribute to rising mortality due to nonadherence by patients. Protocols requiring provider approvals create barriers delaying patient access to the HTN program and services.

Intervention:

Group Health Cooperative set three systemwide goals:

1. Improve patient health and quality of life by providing superb care and impeccable service.
2. Reduce overall health care costs by controlling blood pressure (BP) and reducing cardiac events.
3. To reach National Committee for Quality Assurance/Healthcare Effectiveness Data and Information Set standards and lower BP for all our patients.

For the past two years, the clinical pharmacy department has helped patients with HTN and/or statin use via a collaborative practice agreement with providers on an opt-in basis.

Pharmacists have been able to

- Initiate and monitor medication therapy.
- Provide education to patients regarding the purpose of their medications.
- Provide education to patients regarding non-pharmacologic treatments for HTN, hypercholesterolemia, and/or cardiovascular disease.
- Provide BP readings in clinics on a walk-in basis to patients with HTN.

Success: There was a percentage increase of patients with both pre- and post-intervention BP values documented:

- Pre-Registered Pharmacist Intervention: 69 percent
- Post-Registered Pharmacist Intervention: 81 percent

Statin Use:

- Increase in statin utilization: 18 percent
- Decrease in cost per day of therapy: 43 percent

Challenges: One of the barriers experienced during this program was waiting for providers to approve patients for the Clinical Pharmacist Hypertension Program. Recently senior medical leaders have signed a new collaborative practice agreement, which has essentially removed that barrier.

Summary: There is more work to be done and this new collaborative practice agreement expands the patient population on which the clinical pharmacists will intervene. In addition to patients with HTN, patients with diabetes or chronic kidney disease have been added to the pool of patients that pharmacists may manage. Time and time again, pharmacists have proven they are essential to a team-based care approach, which benefits patients in becoming medication adherent and controlling their BP leading toward improved health and lifestyle change. Improved HTN outcomes result in better patient care and reduced health care costs—a win for everyone.

Intervention Timeframe: 2 years

Total Impacted: 200 patients



Time and time again, pharmacists have proven they are essential to a team-based care approach, which benefits patients in becoming medication adherent and controlling their BP leading toward improved health and lifestyle change. Improved HTN outcomes result in better patient care and reduced health care costs—a win for everyone.

A “Techie” Way to Finding Those “Hiding in Plain Sight”

WISCONSIN PRIMARY HEALTH CARE ASSOCIATION (WPHCA)



Setting: Community-Based Clinics

Issue: WPHCA’s efforts toward improving chronic disease in Wisconsin is wide-ranging, but focuses on supporting the work of Wisconsin’s Federally Qualified Health Centers (FQHCs) in their efforts to improve the health of their patients. WPHCA realizes that capturing, organizing, and analyzing data is essential for chronic disease management. However, the capacity to work with data in a small and large scale can be challenging at times given the difficulties of pulling data from clinical systems, analyzing data, and making it actionable. This is especially difficult when attempting innovative ways to solve long-term problems. WPHCA understands the difficulties in managing data within FQHCs and wanted to help make the processes more streamlined, adaptable, and accurate.

Activity/Strategy: WPHCA identified Data Reporting and Visualization System (DRVS), a data analytics and population management reporting tool developed by Azara Healthcare, LLC, to be the opportunity to increase the capacity of FQHCs to have readily accessible patient and population data, particularly information about patients with uncontrolled diabetes and patients with potentially undiagnosed hypertension (HTN). The DRVS tool interfaces with an FQHC’s electronic health record to pull relevant data and display it in a meaningful and actionable way that is accessible by care team members. With accurate, real-time data, FQHCs are better equipped to manage the health of their patient populations and to report on the successes and challenges of their programs, such as the self-management of chronic diseases. WPHCA has been working with FQHCs on a continuous basis to analyze readiness for this data reporting tool and timeframes for implementation.

Success: WPHCA has assisted three FQHCs with implementing the Azara DRVS data reporting tool and more FQHCs are planning on implementing DRVS in the near future. It has taken extensive time and effort to manage the process, from the selection of DRVS to the point of implementation. WPHCA is excited to start utilizing this reporting tool to its full capacity and supporting care team members in their efforts to improve outcomes. A current example is being able to create real-time registries of patients who are potentially undiagnosed

with HTN. By reducing the burden of data mining, FQHCs are able to invest more time and effort into improving patient outcomes, which includes increasing the number of patients with controlled HTN. WPHCA is working with several FQHCs to create these registries and to build appropriate quality improvement interventions to target those on the registry. Over time, these FQHCs, in partnership with WPHCA, will make a big difference in the lives of patients with chronic diseases.

Challenges: Barriers to implementing Azara DRVS include data access issues, technical and financial difficulties, and the constraints in overall capacity of FQHCs. As discussions continue, FQHCs receive assistance from WPHCA, and additional funding opportunities become available, WPHCA is optimistic that more FQHCs will be able to implement DRVS. Fortunately, FQHCs are overcoming a majority of these barriers and moving forward in the adoption of this new data reporting tool.

Conclusion: WPHCA collaborates with FQHCs in its efforts to improve patient outcomes. Azara DRVS is a data reporting tool that, when fully implemented in FQHCs, will not only provide easier access to data, but will make it actionable. The data will be put into the hands of staff who can make a difference in the lives of patients through the management of chronic disease and targeting patients with undiagnosed HTN and uncontrolled diabetes.

Year Started: 2014

Current Status: Implementation

Intervention Timeframe: 2 years

Total Impacted: 18 Wisconsin FQHCs; 300,000 patients

Monroe Clinic Hypertension Initiative

MONROE CLINIC



Setting: Community-Based Clinic

Issue: The hypertension initiative at Monroe Clinic began in early 2016 with the goal of improving blood pressure (BP) control for patients diagnosed with hypertension (HTN). BP control in this population is defined as a BP less than 140/90. Currently, Monroe Clinic serves more than 7,000 patients with an active HTN diagnosis. Of those, only 77 percent experienced BP control prior to this initiative. Top performing organizations in Wisconsin report 80 percent of their patients with HTN experience BP control.

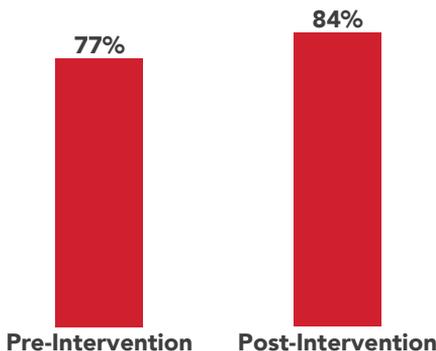
Intervention: As part of this initiative, the group worked closely with clinic staff to ensure nurses and medical assistants correctly executed BP measurement. This included discussion of when and how to best measure patient BP during a clinic visit. Additionally, the group has educated staff on appropriate follow-up methods for patients identified as hypertensive.

Success: To date, Monroe Clinic reports 84 percent of patients identified with HTN are experiencing BP control.

Intervention Timeframe: 1 year

Total Impacted: 500 patients

Due in part to this intervention, an additional seven percent of people with HTN at Monroe Clinic have their BP in control. That is an extra 500 people compared to the start of the intervention.



Preventing Medication Errors Implementing a Checklist

COMMUNITY PHARMACY



Setting: Community Pharmacy

Issue: A community pharmacy experienced a failure in its barcode system, which led to a documented medication error. Due to the system's inability to scan certain products, the wrong type of medication was dispensed to a patient with high blood pressure.

Intervention: A checklist was implemented into the pharmacy workflow. This step required the pharmacist or pharmacy technician to complete a visual inspection of the product being dispensed to ensure the correct product is given to the patient.

Success: The pharmacy team reported increased awareness when dispensing medication.

Challenges: The biggest challenge is maintaining accountability for completing the checklist, especially when the pharmacy is busy. During peak hours, the checklist may be perceived as a hassle rather than a safety tool.

Conclusion: An intervention to prevent medication errors was successfully implemented into a pharmacy workflow. The pharmacy team used a visual inspection checklist to ensure the correct product is dispensed when the barcode system is unable to scan products.

Intervention Timeframe: Less than one year

Total Impacted: In process

HYPERTENSION CONTROL RESOURCES AND TOOLKITS

STATE RESOURCES

BP Connect Health

A specialty staff protocol to improve follow-up after high blood pressures

www.hipxchange.org/BPConnectHealth

MyHEART: Information and Resources for Young Adults With Hypertension

University of Wisconsin School of Medicine and Public Health

www.hipxchange.org/MyHEART

Toolkit for Improving Hypertension Care & Outcomes

Wisconsin Collaborative for Healthcare Quality (WCHQ)

www.hipxchange.org/HypertensionCare

NATIONAL RESOURCES

American Heart Association (AHA)

www.heart.org/HEARTORG/Conditions/HighBloodPressure/High-Blood-Pressure-or-Hypertension_UCM_002020_SubHomePage.jsp

American Medical Association (AMA)

www.stepsforward.org/modules/hypertension-blood-pressure-control

Association of State and Territorial Health Officials (ASTHO)

www.astho.org

Improving the Screening, Prevention, and Management of Hypertension: An Implementation Tool for Clinic Practice Teams

Washington State Department of Health

www.healthit.gov/sites/default/files/13_bptoolkit_e13l.pdf

Measure Up, Pressure Down Provider Toolkit to Improve Hypertension Control

American Medical Group Foundation

www.measureuppressuredown.com/hcprof/find/provtoolkit_find.asp

Million Hearts® Action Guides

<https://millionhearts.hhs.gov/tools-protocols/action-guides.html>

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**Wisconsin Blood Pressure
IMPROVEMENT CHALLENGE**



**WISCONSIN DEPARTMENT
of HEALTH SERVICES**

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