WISCONSIN DEPARTMENT of HEALTH SERVICES

Evidence-Based Strategies for Heart Health

Heart disease is the leading cause of death for men, women, and people of most racial and ethnic groups in the United States. The Centers for Disease Control and Prevention (CDC) promotes evidence-based strategies to support programs and activities designed to prevent and control heart disease and stroke.

The Wisconsin Department of Health Services Chronic Disease Prevention Program partners with communities, health systems, health care providers, insurers, and professional organizations to promote these six strategies to improve heart disease prevention and management.

	Outcomes		
Required Strategies	Short-term (1-2 years)	Intermediate (2-4 years)	Long-term (5+ years)
Track and Monitor Clinical Measures shown to improve healthcare quality and identify patients with hypertension	Increased reporting, monitoring, and tracking of clinical data for improved identification, management, and treatment of patients with high blood pressure and high blood cholesterol	Increased medication adherence among patients with high blood pressure and high blood cholesterol	
Implement Team-Based Care for patients with high blood pressure and high blood cholesterol	Increased use of and adherence to evidence-based guidelines and policies related to team-based care for patients with high blood pressure and high blood cholesterol	Increased engagement in self-management among patients with high blood pressure and high blood cholesterol	Increased control among adults with known high blood pressure and high blood cholesterol
Link Community Resources and Clinical Services that support systematic referrals, self-management, and lifestyle change for patients with high blood pressure and high blood cholesterol	Increased community clinical links that support systematic referrals, self-management, and lifestyle change for patients with high blood pressure and high blood cholesterol	Increased participation in evidence-based lifestyle interventions among patients with high blood pressure and high blood cholesterol	

SPOTLIGHT ON EQUITY

People of color are at particular risk for having and dying from cardiovascular disease (CVD). African Americans are two to three times more likely to die of heart disease compared with whites, and African Americans and other communities of color have higher rates of premature death resulting from CVD and higher CVD risk factors. Socioeconomic status, including education level, income level, and employment status, is also strongly associated with CVD risk. Linguistic and cultural differences contribute to poorer cardiovascular health in some marginalized groups. Care must be, acceptable, available, accommodating, affordable, and appropriate. Mental and behavioral health issues, particularly chronic stress and depression, also increase risk of poor heart health.

According to the American Heart Association (AHA), the most significant opportunities for reducing death and disability from CVD in the United States lie with addressing the social determinants of CVD outcomes. Interventions should include a combination of both population- and individual-level approaches to improve cardiovascular health and better support individuals at highest risk. Strategies must be adaptive and consider the needs of individuals of every age, race, gender, ability, and sexual orientation.

When reviewing the following strategies and designing interventions, it is important to apply a health equity lens.

Consider the following questions:

1) Who am I trying to serve with this strategy?
2) Will this intervention help me to identify and reach patients at highest risk?
3) How can I adapt this intervention to be culturally responsive and meet the needs of all patients?
4) If funding/staff capacity is limited, how can I prioritize our program to reach the patients who are at greatest risk?

Strategy 1: Promote the adoption and use of electronic health records and health information technology to improve provider outcomes and patient health outcomes related to identification of individuals with undiagnosed hypertension and management of adults with hypertension.

BACKGROUND

Many Wisconsin health systems use electronic health records (EHRs) and health information technology (HIT) to improve population health in some way, shape, or form. This strategy is interested in the use of EHRs and HIT to improve the identification and management of hypertension. For example, some patients with hypertension visit their provider regularly, and may even get their blood pressure checked and recorded, but remain undiagnosed. These populations are called "hiding in plain sight." Providers can use algorithms that search their EHR for "hiding in plain sight" patients, and create registries of them for follow-up. Health systems can also couple the use of HIT (e.g., the creation of patient registries for those with uncontrolled hypertension) with changing clinical practices (e.g., incorporating a standard pre-visit planning with the care team before each patient arrives) to improve hypertension management.

STRATEGY OVERVIEW: Since 2013, DHS has partnered with the Wisconsin Primary Health Care Association (WPHCA), the Wisconsin Collaborative for Health Care Quality (WCHQ), and the Chronic Disease Quality Improvement Project (CDQIP) to increase the potential use of HIT for hypertension identification and management among providers and insurers across Wisconsin. Many WCHQ member health systems report blood pressure control rates for patient populations with diagnosed hypertension, and some community health centers represented by WPHCA are utilizing Azara DRVS (a population health management platform) to produce hypertension registries and explore control rates within their clinics. The Chronic Disease Quality Improvement Project is a consortium built around the shared reporting and use of chronic disease quality of care measures, including blood pressure control among health plan members with diagnosed hypertension. This strategy aims to increase awareness, familiarity, and use of these existing HIT/EHR resources within local public health and health care provider circles to improve identification and management of patients with hypertension.

KEY RESOURCES

- Wisconsin Collaborative for Healthcare Quality, Performance Reports
- Wisconsin Chronic Disease Quality Improvement Project: HEDIS® 2018 Summary Data
- Explore Federally-Qualified Health Centers' data on the Health Resources & Services Administration website
- Set Your Heart on Health: a toolkit for local health departments and communities
- CDC: Million Hearts: Undiagnosed Hypertension Partner Toolkit, Undiagnosed Hypertension, Hypertension Prevalence Estimator Tool
- Million Hearts: Leveraging Health Information Technology (HIT), Quality Improvement (QI), and Primary Care Teams to Identify Hypertensive Patients Hiding in Plain Sight (HIPS)
- Million Hearts® Action Guides: Series for Clinicians, Public Health Practitioners, and Employers
- Office of National Coordinator for Health Information Technology (ONC)

Strategy 2: Promote the adoption of evidence-based quality measurement at the provider level (e.g., dashboard measures to monitor health disparities and implement activities to eliminate health care disparities).

BACKGROUND

There are health and health care disparities in cardiovascular health outcomes across the nation and Wisconsin. One way to address these disparities is to improve the quality of health care provided to populations who are affected disproportionately by high blood pressure and high blood cholesterol due to socioeconomic or other characteristics, including inadequate access to care, poor quality of care, or low income.

Health care systems can use standardized Clinical Quality Measures (CQMs) to help identify these priority or sub-populations. Standardized CQMs are tools to measure and track the quality of health care services provided by professionals and hospitals within the health care system. The measures use data associated with providers' ability to deliver high-quality care and relate to long term goals for quality health care. Patient care measurement includes: adherence to clinical guidelines and processes, safety measures, use of resources, care coordination, patient engagement, health outcomes, and population and public health. Using standardized CQMs allow health care systems to continuously monitor health care disparities and have a concerted, tailored effort to reduce and eliminate the identified disparities.

STRATEGY OVERVIEW: In collaboration with statewide partners and communities, this strategy aims to improve hypertension, cholesterol, and heart health outcomes by advancing the adoption of evidence-based quality measurement at the provider level, promoting best practices, and establishing stronger community-clinical relationships.

KEY RESOURCES

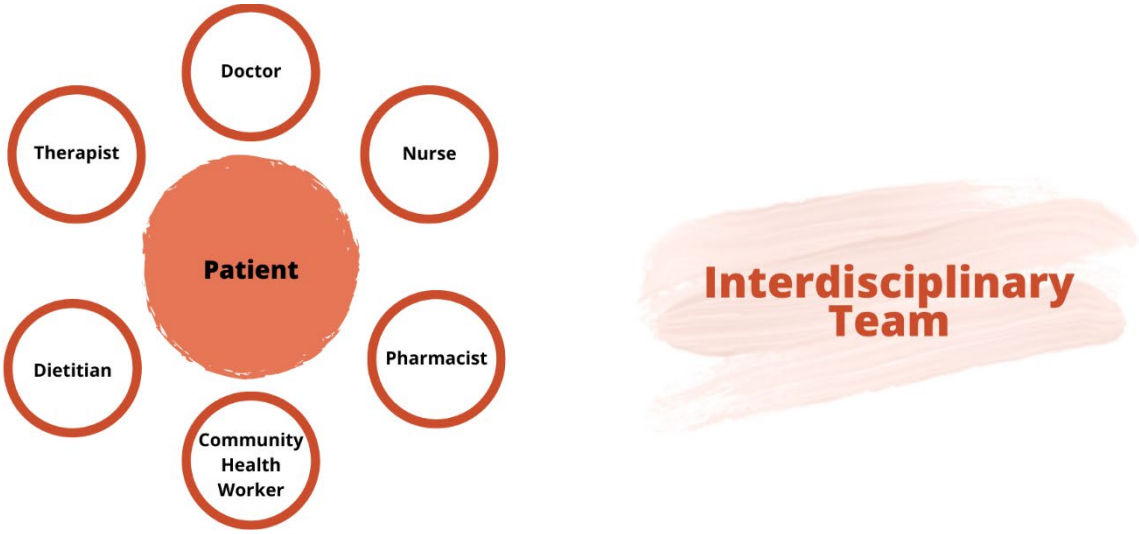
- The National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Implementation and Action Toolkit: a standardized social determinants of health screening instrument for use in a primary care setting
- CDC: Million Hearts: Caring For Underserved Populations
- *Set Your Heart on Health*: a toolkit for local health departments and communities
- Wisconsin Collaborative for Healthcare Quality's 2019 Wisconsin Health Disparities Report
- American Academy of Family Physicians: The EveryONEProject

Strategy 3: Support engagement of non-physician team members in hypertension and cholesterol management in clinical settings.

BACKGROUND

This strategy focuses on improving the way the clinical care team functions to manage hypertension and cholesterol, more specifically, by increasing the presence of clinical providers who are not physicians, such as nurses, pharmacists, community health workers, and dietitians, on clinical care teams to manage these conditions. This type of service delivery has been coined, "team-based care." There is strong evidence that multidisciplinary care teams achieve better management of chronic conditions, and many organizations are beginning to take notice.

Some national agencies, like the Institute of Medicine, released definitions of team-based care, which argue that these models of care are most effective when they are patient-centered, meaning the whole care team considers, understands, and respects the patient's current and emerging needs. Engaging the patient and providing culturally competent care can work to reduce health disparities.



STRATEGY OVERVIEW: This strategy aims to increase the number of health systems in Wisconsin that have documented practices, policies, or systems with enhanced elements of team-based care to manage hypertension and cholesterol.

KEY RESOURCES

- *The Community Guide,* Community Preventive Services Task Force's Team-Based Care to Improve BP Control
- Wisconsin Nurses Association (WNA) Overview of Patient-Centered Team-Based Care (PCTBC)
- Million Hearts® Action Guides

Strategy 4: Promote the adoption of Medication Therapy Management (MTM) services between pharmacists and physicians to manage high blood pressure and lifestyle modification.

BACKGROUND

Medication Therapy Management (MTM) Services are a covered Wisconsin Medicaid service where certified pharmacists provide Comprehensive Medication Review and Assessment (CMR/A), which includes reviewing prescribed medications, adherence, self-management, and control for hypertension, diabetes, and other chronic conditions. MTM services are an important strategy to improve hypertension, CVD, and diabetes outcomes. MTM services show effectiveness in improving hypertension and medication adherence outcomes, and reduce costs.

The Wisconsin Pharmacy Quality Collaborative (WPQC) is a network of accredited pharmacies with certified pharmacists who provide MTM services using quality-based best practices and team-based care. MTM systematically provides proven interventions that increase patient self-efficacy and commitment to self-management of health problems. MTM includes directly engaging patients in their care by assessing patient progress using goal-setting and problem-solving support.

Community-clinical linkages play a critical role in promoting adoption of MTM services and improving hypertension identification, management, and control among patients. The Wisconsin Chronic Disease Prevention Program promotes a multi-disciplinary team-based, patient-centered approach that includes public health as a partner in strengthening community-clinical linkages for blood pressure control. Public Health departments may identify and recommend patients with uncontrolled hypertension and medication non-adherence to WPQ-accredited pharmacies providing MTM. MTM services are a proven method to improve medication adherence and improve

hypertension, CVD, and diabetes outcomes.

STRATEGY OVERVIEW: This strategy aims to improve heart health and controlled hypertension outcomes through increased use and promotion of MTM services. Increased partnership and collaboration with Pharmacy Society of Wisconsin/WPQC (community pharmacists) and health systems will help provide patients with education and support to improve understanding of and enhance skills for medication adherence and self-management of high blood pressure. Partnership and collaboration with Medicaid and other insurers that can reimburse for MTM services (CMR/As) will help sustain these improvements.

KEY RESOURCES

- PSW's Wisconsin Pharmacy Quality Collaborative
- Million Hearts Action Guides, including Medication Adherence: ActionSteps for Public Health Practitioners
- The Community Guide Economic Evidence Supports Pharmacy-Based Interventions for Cardiovascular Disease Prevention

Strategy 5: Develop a statewide infrastructure to promote sustainability for CHWs to promote management of hypertension and high blood cholesterol.

BACKGROUND

Community Health Workers (CHW) are frontline public health workers who are trusted members of the community with an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison between health care services, social services and the community. In this role, CHWs facilitate access to services and improve quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through activities like outreach, community education, informal counseling, social support, and advocacy.

The Pathways Community HUB (HUB) is a community-based care coordination model that engages community health workers. The model's primary strategy is to identify those at greatest risk, and address social determinants as well as barriers to service and care at the individual level. Factors affecting an individual's health are translated into 'Pathways', and centrally tracked until completion to avoid duplication of services.

Wisconsin currently has two HUBs: UniteMKE (now UniteWI) in Milwaukee, and Great Rivers in La Crosse County. To ensure their financial stability long-term, these HUBs braid public and private funding. They contract with community care agencies, community-based organizations, and federally qualified health centers. Efforts are underway to support the expansion of the HUB model across Wisconsin.

STRATEGY OVERVIEW: This strategy aims to increase the number CHWs trained and the counties in which they provide cardiovascular prevention and management care coordination, as well as stabilize CHW reimbursement mechanisms.

KEY RESOURCES

- Agency for Healthcare Research and Quality's Pathways Community HUB Manual
- American Public Health Association's CHW Position Paper (2014)
- CDC's Million Hearts: CHWs and Million Hearts
- Pathways Community HUB Institute
- The Community Guide Cardiovascular Disease: Interventions Engaging Community Health Workers
- Wisconsin CHW Network

Strategy 6: Facilitate use of self-measured blood pressure (SMBP) monitoring with clinical support among adults with hypertension.

BACKGROUND

Self-measured blood pressure is the regular measurement of blood pressure at home, or places beyond clinic walls. This strategy specifically emphasizes clinical support tied to self-measured blood pressure. "Clinical support" for self-measured blood pressure for adults with hypertension could mean that: clinic staff instruct patients with hypertension on how to properly measure their own blood pressure, the clinic has a blood pressure cuff loaner program, self-measured blood pressure measurement results are recorded on a paper or electronic log and shared between the patient and clinic staff, or all of the above.

In Wisconsin, local health departments, community pharmacies, and community-based organizations have facilitated clinical support of self-measured blood pressure over the last few years. Some examples include: starting blood pressure cuff lending programs with libraries, referring mothers identified for suspected hypertension during a WIC clinic to a primary care doctor, and offering free blood pressure readings at health fairs and referring those identified with suspected hypertension to clinics and community resources.

STRATEGY OVERVIEW: This strategy aims to see an increase in the number of clinics that have policies and practices that encourage self-measured blood pressure with clinical support for patients with hypertension. Studies show that self-measured blood pressure with clinical support is more effective at controlling hypertension and should improve blood pressure control among individuals with hypertension in the long term.

KEY RESOURCES

- Target: BP™ (American Medical Association and American Heart Association): helps health care organizations and care teams improve blood pressure control rates through an evidence-based quality improvement program and recognizes organizations for their commitment
- MetaStar e-learning modules: Patient Self-Measurement of Blood Pressure and Taking an Accurate Blood Pressure Reading-Outpatient Adults
- Million Hearts Action Guide: SMBP Monitoring Action Steps for Public Health and Series for Clinicians, Public Health Practitioners, and Employers: Hypertension Control: Change Package for Clinicians

For more information:

Chronic Disease Prevention Program

https://www.dhs.wisconsin.gov/disease/chronic-disease.htm

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