Yes We Can Improve Outcomes
Parish and Public Health Nurses Address Hypertension
From a Population and Community Perspective
Our Speakers Have No Relevant Financial Interest. Thank You!
Key Components of Million Hearts®

Keeping Us Healthy
Changing the environment

Excelling in the ABCS
Optimizing care

Focus on the ABCS
Health information technology
Innovations in care delivery

Health Disparities
# Million Hearts® 2022 Goals

## Keeping People Healthy
- Reduce Sodium Intake
- Decrease Tobacco Use
- Mitigate Particulate Exposure
- Increase Physical Activity

## Optimizing Care
- Aspirin When Appropriate
- Blood Pressure Control
- Cholesterol Management
- Smoking Cessation

## Improving Outcomes for Priority Populations
- Blacks/African-Americans
- 45-64 year olds
- People who have had a heart attack or stroke
- People with behavioral health issues
- Others
Approximately 1.3 million adults in WI have hypertension and less than half of them are in control.

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

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

Coronary heart disease is the no. 1 killer of women age 25 and over in WI.

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

If over 45 years of age, 36% of men and 47% of women will die within 5 years after their first heart attack.
What is Million Hearts® Wisconsin?

Million Hearts® Wisconsin
Statewide public/private stakeholder collaboration

- Health Systems
- Public Health
- Academic Partners
- Professional Associations
- Community Organizations
- Employer groups
- Industry Partners
- Payers
- Foundations
- Million Hearts® Wisconsin – BP measurement

- Million Hearts® Pledge
- Videos
- Resources
- Toolkits
- Grand Rounds
- Webinars
- MH WI CHALLENGE
- Patient Engagement
- Team Up. Pressure Down.

- MH WI BP Improvement Challenge “Stories”
- Atrium Clearinghouse-Clinical Cardio Vascular Tools and Resources
- Coordinated clinical and community prevention
- Share best practices and videos
- Promote ASTHO Million Hearts® project
- Million Hearts® Wisconsin – BP measurement
ASTHO Million Hearts® Learning Collaborative

State Project Objectives

- Creating and standardizing protocols
- Leveraging data systems
- Using team based care models
- Decreasing hypertension
Wisconsin State ASTHO Team
Million Hearts® Learning Collaborative
Green County – 1 of 3 Wisconsin Teams – Rural Example – Test Rapid Heart Health Improvement Strategies
Green County – Bridges to Health
Public Health, Community Clinic, Monroe Clinic Parish Nurse, Monroe Clinic
WCHF Community Health
Value Exchange

Healthy People
Healthy Communities

Business Philanthropy
Influencers
WCHF Focus

Insurers
(Pay for Performance)
Quality Improvement Organizations
(Improvement Measures)

Healthy People
Healthy Communities

Healthcare Value
Right Service | Right Time | Right Cost | Right Outcome

Community Health Support
Direct Providers
Public Health
Social Service
Community Health Worker
Coalitions
Government
Education

Community Clinical Linkage
Balance of Healthcare, Prevention & Self-Management
**Green County Hypertension Community Care Protocol Flow Chart [Updated 6.3.16]**

**Community Partners**

Begin community outreach

Outreach Contact - Collect patient demographics, identified health data, blood pressure results

Document insurance coverage/status in record

Ensure insurance status is recorded in record

Elevated blood pressure?

Yes

Stage 1 Reading (Systolic 140-59; Diastolic 90-99)

Stage 2 Reading (Systolic 160+; Diastolic 100+)

Stage 3 Reading (Systolic 180+; Diastolic 110+)

Set up a next appointment or work to connect with the patient within 2 to 3 weeks for an additional BP reading

Connect patient to a medical provider immediately

Second BP Reading Visit

Is BP still over 140?

No

Provide additional education and invitation for further readings and health education in the future

Yes

Refer to health system

**Monroe Clinic**

Set up consumer as a new patient with a provider

Set up nurse visit

Existing patient?

No

Yes

Refer to County Human Services

Encourage follow-up visit if necessary and promote future health education

Assist with connections for a second blood pressure reading – same day as first reading or by phone call from public health or parish nurse – two to three attempts at different intervals

Review all elevated BP cases monthly to determine if an appropriate plan has been established or if the case needs to be closed.
Green County Health Department

Our Mission Statement: To be a reliable resource that educates, serves, and leads the people of Green County to optimal health and well-being.

STAFF

SERVICES

• Communicable Disease
• Immunizations
• Chronic Disease Screenings
• Maternal Child Health
• WIC/PNCC/SafeKids/HV
• Emergency Preparedness
• CHIP / CHA
• Personal Care Services
Community Blood Pressure Screenings

- Personal Care Agencies (Staff)
- Dementia Summit (Family Caregivers)
- Health & Human Service Employees
- Senior Fun Fest (Seniors)
- YMCA (Younger Adults)
- Walk In’s
- Churches
- Schools
- Community Clinic
- Wal-Mart Parking Lot Event
Lessons Learned
From Public Health and Community Clinic

• Renewed value and importance of BP screening in public health
• Public health involvement critical in the development of community care protocols
• Clear need for annual BP measurement training and equipment calibration
• BP screenings = opportunity for enhanced healthy lifestyle education and connection to other community health supports
• Income and insurance status did not impact screening results or level of interest
• Resources are needed to address the barriers to obtaining health care
• Motivational interviewing training and practice = very helpful
• Communication between community and hospital partners = challenging when not coordinated
Public Health Leading Community Health Protocols

Transition to Chief Health Strategist

Community Chief Health Strategist (NACCHO)

• Address the growing gap between the expansion of healthcare services and the achievement of health among individuals and communities

• Underscore the need for new and sustained leadership at the community level

• Bring community stakeholders together to prioritize the needs of the community

• Share their experience in providing essential services and leadership, engage communities to identify and support policy solutions, and collect, analyze, and share data

• Leverage resources to build integrated systems to achieve health equity
Domain 3: Inform and educate about public health issues and functions
  Provide information to coalition, community partners, clinics about proper BP measurement-staff training, LHD role
  Embedded into more of our programs and increasing community outreach

Domain 4: Engage with the community to identify and address health problems
  Staff re-prioritization on BP screening
  Community Partnerships-Coalition
  Blood pressure screenings and education at the community level - finding the “hidden in plain sight”

Domain 7: Promote strategies to improve access to care
  Partner with Monroe Clinic for bi-directional referrals and other medical providers-
  Establishing additional formal/informal partnership-
  Pharmacies and Dental Offices.
Parish Nursing/Faith Community Nursing

• Professional Practice of Nursing with Scope and Standards defined by the American Nurses Association and Health Ministries Association
• Must be a Registered Nurse with a current active license in the state(s) of practice.
• Focus of practice is whole person health: mind, body and spirit.
• 30 year Anniversary 2016: International Parish Nurse Resource Center
• Certification is now available through ANA
Education Curriculum Development

• Development of education program for practice was essential — Basic Education for Parish Nursing

• Rosemarie Matheus: Marquette University

• Ann Solari Twadell: IPNRC – Loyola

Current Curriculum

• The Foundations of Faith Community Nursing curriculum is an intensive course built to equip those wishing to either become a faith community nurse in their faith community or to strengthen the ministry in which they are already involved

• https://westberginstitution.org/foundations-of-faith-community-nursing/
Parish Nursing
Monroe Clinic

• Began in 1997 – Celebrating 20 years
• Unpaid Model vs. Paid Model
• Parish Nurses/FCN’s have worked in own congregation as well as whole community
• Multiple roles including Health Advocate and Health Educator
• Currently 16 FCN’s or RN’s interested in Health Ministry – partnering with Monroe Clinic Parish Nurse Coordinator
Project Connection with Parish Nurses

- Blood Pressure Competency Training with MC Cardiology Staff and Green County Public Health
- Motivational Interviewing Education
- Webinars and Phone conferences
- Conducted 5 BP screenings at congregations in Monroe, 1 in Dec 2015 and 4 in Jan & Feb, 2016 – total screenings = 67; 4 Clients referred, 2 refused
- BP screening done in Brodhead in April 2016 with Wellness Expo, 7 screened, 0 referred
- Also conducted screenings in Albany in beginning of June – total number 6 with a total number screened at 81
Challenges

• Number of available Faith Community Nurses to do the screenings – Sunday is often the day they are at their own congregations

• Congregational & Community Environment Lack of privacy

• Health Literacy — Limited time & space for education

• “BP Shopper”
Moving Forward

- Continue to identify screening opportunities throughout the county

- Continued follow up as needed using EPIC reporting EPIC accessibility by PNC

- Further identification of community and state partners for example Wisconsin Women's Health Foundation Grapevine Program

- Annual BP education training and competency

- Annual equipment recalibration for accuracy through Monroe Clinic
Hypertension Control – Why Important for a Health System

• Based on this project, the local health system selected hypertension control as one of its top 10 quality priorities for measurement

• Current results in top 75th percentile of State organizations and in the top tier of national goals, but always strives for improvement!

• Prevalence Indicator Tool – Identified hospital system was on track for detecting hypertension
HTN Value Stream Map

Awareness of initiative throughout organization

BP Assessed
- Communication to provider varies about abnormal BPs
- Provider variation for HTN management
- Provider not aware 2nd BP was taken, not see in EPIC
- Production-Based system limits
- Limited touches- take advantage when pt is here
- Daily Process Metrics for BP tracking??
- No follow up apt made
- Lack of easy access to obtain BPs
- Not all areas are taking V/S (specialties)
- Review policy on outside data being entered into EPIC
- No knowledge of previous BPs
- Education variation for HTN
- Variation on how to obtain BPs

Provider Plan and Prescription
- No follow up apt made
- Limited touches- take advantage when pt is here
- Production-Based system limits
- No knowledge of previous BPs
- Education variation for HTN
- Variation on how to obtain BPs

Follow Up Plan
- No follow up apt made
- Limited touches- take advantage when pt is here
- Production-Based system limits
- No knowledge of previous BPs
- Education variation for HTN
- Variation on how to obtain BPs

BP Controlled at < 140/90

No
knowledge of previous BPs

Awareness of initiative throughout organization

BP
- Assessed
- Plan
and Prescription
- Follow Up Plan
- BP Controlled at < 140/90
Execution Strategy – Thundercloud Prioritization

• Data analysis revealed there was a lot of rounding in measurement (i.e. BPs at exactly 140/80...)

• Initial focus on basics - making sure equipment is calibrated and staff are competent in measuring BP – RN developed Hypertension Education Competency Program – led by a physician champion

• Central Triage RN - identified as contact point for community-clinical linkage – provided follow up and personal connection to medical care and necessary financial support

• All Vitals Program – implementation of BP measurement throughout all specialty care (was not consistent in the past)

• Hiding in Plain Sight – exploring utilization of electronic health record system for undiagnosed hypertension

• Continued promotion of heart health education throughout the hospital system
History Made!

First Public Health Department with access to EPIC
(Electronic Community-Clinical Linkage System – opportunities for expanded electronic data systems within pharmacies)
Green County Healthy Community Coalition
Population Health Improvement Opportunities

• Creation of a website for community health care protocols
• Green County Hypertension Community Care Agreement – drawing a variety of multi-sector partners
• Coalition = link to the area’s Community Health Improvement Plan
FREE HEALTH CLASS

HEART HEALTH: KNOW YOUR NUMBERS

MON, APR 10 | 5:30PM
FOUNDER'S HALL, MONROE CLINIC

Heart Disease is the No. 1 Killer of Women Age 25 & Over in Wisconsin

SUBSCRIBE & ENGAGE TODAY
"1 HEALTHIER TOMORROW!"
NGSD Go Red Day!
Heart Facts for Kids

- The heart is about the size of your fist, and you won’t believe all of the cool things this important organ can do!
- The heart has four chambers and is found not on your left side but actually in the middle of your chest between your lungs.
- The heart weighs between 7 and 15 ounces, which is about the same as a bottle of Heinz Ketchup!
- The average adult heart beats 72 times a minute, 100,000 times a day and 3,600,000 times a year.
- You have felt your own heart beating and it actually works like electricity. As your heart contracts, or tightens up, it makes all of the chambers smaller and pushes blood back into the blood vessels. When your heart relaxes again, the chambers get bigger and the blood comes back to your heart.
- All of your blood vessels, arteries, veins and capillaries, things that carry blood, if stretched out would go around the world twice!
- To keep your heart healthy you need to exercise at least 30 minutes most days of the week.
- Why the heart is associated with love? Greeks believed the heart was the seat of the spirit; the Chinese associated it with the center of happiness and the Egyptians thought the emotions an intellect arose from the heart. Plato confirmed that reasoning comes from the brain but that love comes from the heart.

Disease of the heart is one of our state’s and country’s top reasons for death. Take care of your body and heart — eat healthy food and exercise — and help to share more love with others!

For more information about healthy hearts visit:

www.heart.org
https://millionhearts.hhs.gov/
Green County Healthy Hearts

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In the month of February and beyond, residents of Green County can take advantage of exploring opportunities for healthy hearts. Chances are high that you, or someone in your family, will be affected by Cardiovascular Diseases (CVD). Cardiovascular diseases, including heart disease and stroke, unfortunately kill nearly 1 in 3 people in Wisconsin and represent the leading cause of death in women age 25 or older.

So, what can we do to prevent death and heart disease? The good news is that 80% of cardiovascular diseases are preventable with education and action. Education means understanding the numbers that effect heart health, which are: Total Cholesterol, HDL (good) Cholesterol, Blood Pressure, Blood Sugar, and Body Mass Index (BMI). Clinics, hospitals, pharmacies and self-monitoring tools are available to help you understand your numbers and risks for heart health challenges.

Listed below are some guiding principles and tools for support from the American Heart Association and Centers for Disease Control:

**Eat smart** - know what is on your plate - eating healthy does not have to mean dieting or giving up all of the foods you love. Learn how to ditch the junk, give your body the nutrient-dense fuel it needs, and love every minute of it!

**Add color** - to your diet - all the colors of the rainbow - all the time - life is why - color is how!

**Move more** - a good goal is 150 minutes a week, but if you don’t want to sweat the numbers, simply move more! Find forms of exercise you like and stick with, and build more opportunities to be active into your routine.
Project Reflections

Broad Mix of Community and Hospital Partners – important for community health protocol development and sustainability

Keep It Simple – start with a small change – “Bigger is not Better”

Public Health as a Chief Health Strategist – demonstrates role of public health in improving systems for community care – leading alignment

Expanded Community Health Capacity – the addition of new partners to community health improvement expanded the community’s capacity for further Community Health Improvement Plan work – relationships brought to a new level – strengthened respect and trust

Protocol Integration into Daily Activities – following many of the pilot project efforts, the BP screenings were implemented into more routine work thus creating a strategy and environment for sustained improvement change

National Million Hearts Campaign – assisted with setting a community goal and tying the community goal to a larger purpose – campaign slogans and materials helped to add clarity and clout to the project

Further Expansion of Electronic Community-Clinical Linkage Systems – Highly Recommended – many opportunities for improved care, partnerships and communication with the implementation of electronic community – clinical linkage systems
Discussion and Questions
Leading a New Legacy & Promise
For Healthy Communities

Thank You

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