Panel 1
Moderator: Dr. Tim Bartholow, WEA Trust

Panel 1: Overview

Screening and Identification of Undiagnosed and Uncontrolled Hypertension

Panelists representing payers, providers, community, and advocacy/statewide organizations will share practical strategies and practices currently be implemented in Wisconsin to improve HTN and CVD outcomes.

Goal: Prompt action and generate ideas on how you and your organization can implement or apply the shared strategies/practices and set the stage for the afternoon workgroups.

Panelist

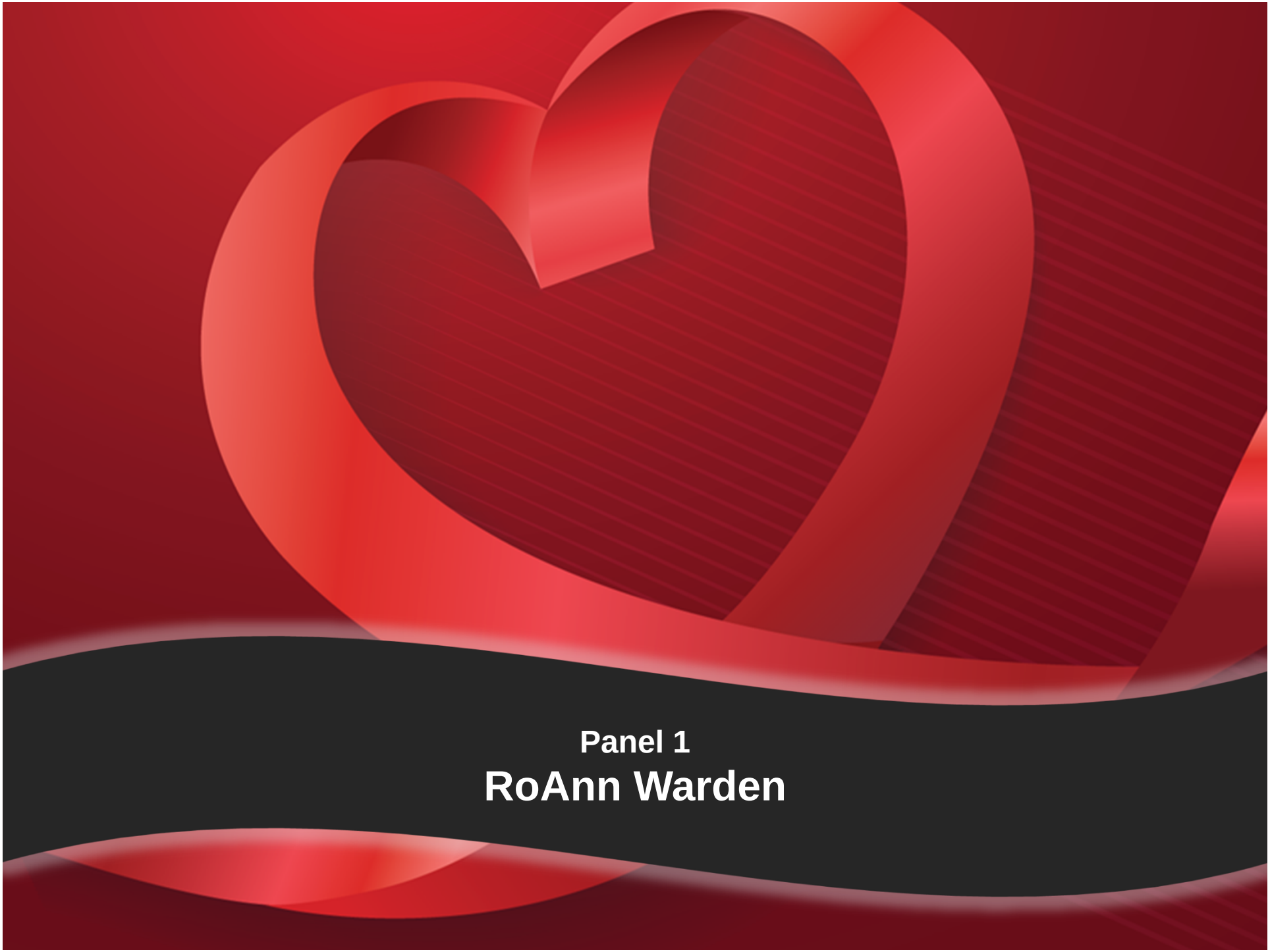
RoAnn Warden
Green County Public Health

Holly Nannis
Sixteenth Street Community Health Center

Gabrielle Rude
Wisconsin Collaborative for Healthcare Quality

Dr. Susan Schneider and Maria Gulan
Aspirus

Kari Trapskin
Pharmacy Society of Wisconsin



Panel 1

RoAnn Warden

Who do you represent?

- Name of organization: Green County Public Health Department
- Identify type: Community
- Located/Number of Locations: Southwestern WI on WI and Il border. Public Health office is located in the county seat - City of Monroe.
- Reach/Service Area: Green County (predominately rural, small towns, pop.37,000)

How do you screen for or identify undiagnosed and uncontrolled hypertension?

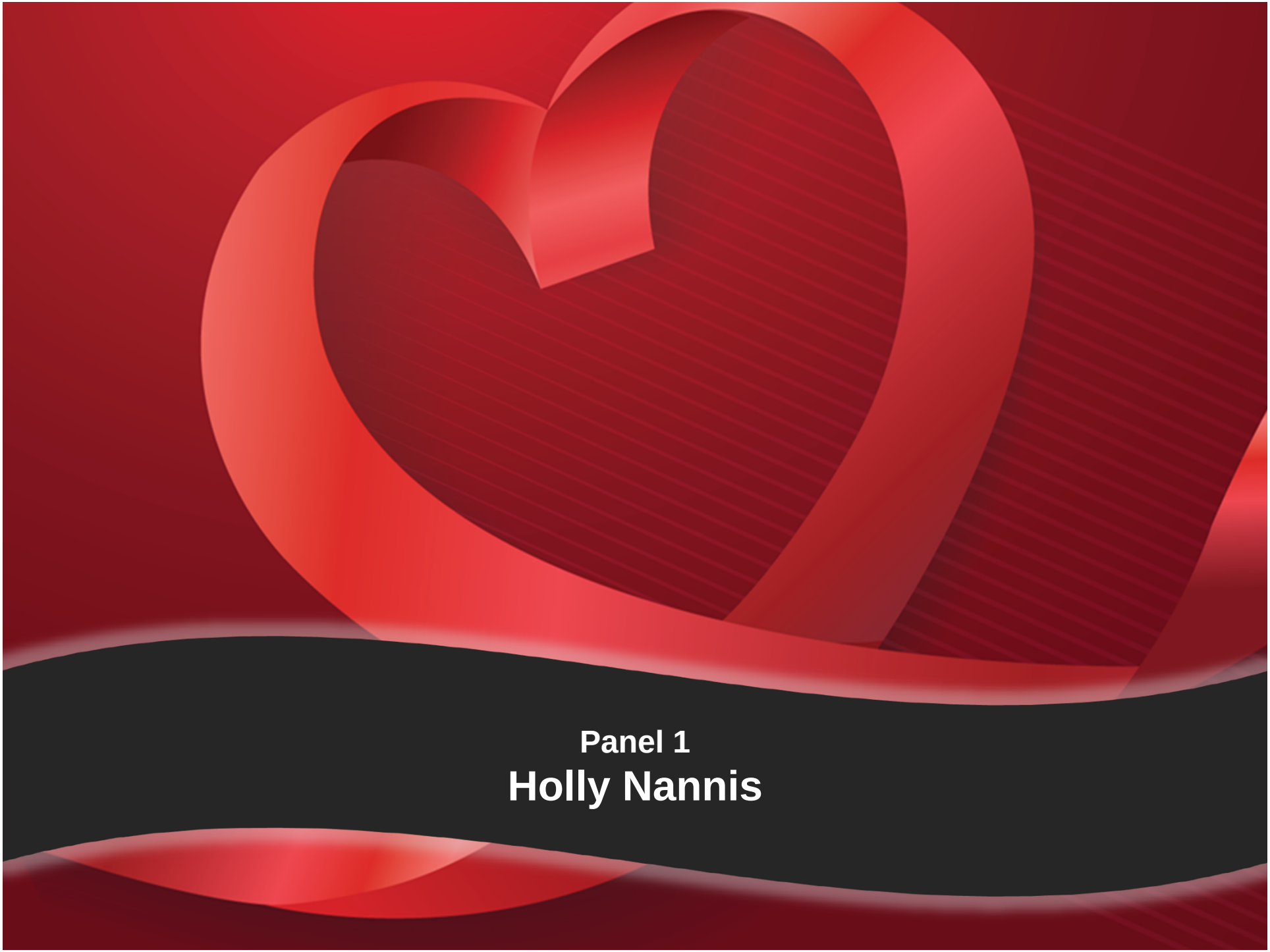
- **What is your organization doing**?
  - Public Health Nurses conduct blood pressures screenings, education, and recommend lifestyle modifications during all adult immunization visits. Offer blood pressure screening to anyone requesting a bp check/re-check.
  - Promote use of Green County HTN Community Care Protocol to other Bp screeners as a guide.
  - Serve as a resource for blood pressure measurement trainings.
- **What is the impact**?
  - Elevated importance of blood pressure screenings and having controlled bp's within our own department and community.
  - Identifying people with high blood pressure or uncontrolled Bp and referring them for treatment and rechecks. These are people that may not have been identified with HTN.
  - Increased staff competence /elevated importance of identification of HTN with Bp measurement accuracy, education and counseling (MI technique).
- **Who plays a role in the work**: Public health, community, health systems and GC Healthy Community Coalition.
- **How is this work being sustained**? Adopted Bp screenings as standard operating protocol. This has added an extra 5-8 minutes to our immunization visits.

What is a primary challenge that is holding back the work?

Competing health priorities in public health and limited funding for public health activities. Funding is typically in Silos.

What one action could others do to help support or join this work?

Pay public health/community providers for prevention activities. A referral, education and counseling provided that led a person to be seen by health care provider for treatment of uncontrolled or undiagnosed HTN.



Panel 1

Holly Nannis

Sixteenth Street
COMMUNITY HEALTH CENTERS

- Sixteenth Street Community Health Centers
- Federally Qualified Health Center
- 4 locations offering medical, behavioral health, health education and social services. Satellite clinics in the United Community Center and St Anthony Schools. 80% Latino, 70% live in poverty
- Serve nearly 40,000 patient's on the south side of Milwaukee and in Waukesha
- WIC location serving 6,400 participants

Sixteenth Street
COMMUNITY HEALTH CENTERS

- Electronic Health Record reports, community screenings, lobby table education with BP checks, walk overs, chart reviews and BP checks during diabetes self-management education.
- More data leads to early diagnosis, improved diabetes AND hypertension control.
- Awareness, education and self-management is key !
- Educators and families develop plan, provide tools, support for success.
- Integrated BP protocol and self reports into education documentation, appt codes, electronic BP cuff lending, linkage to medication assistance, pill boxes, walk in checks, physical activity and healthy eating programs. Community involvement essential.

What is a primary challenge that is holding back the work?

Stress…..families we serve have challenges related poverty and immigration. Capacity of health center to help families overcome those challenges.

What one action could others do to help support or join this work?

Make blood pressure a priority for early education on healthy lifestyles. Small adjustments early will lead to enhanced quality of life and delay other chronic conditions.

Panel 1

Gabrielle Rude, PhD

Director of Practice Transformation
Wisconsin Collaborative for Healthcare Quality

Who do you represent?

- Wisconsin Collaborative for Healthcare Quality
- A multi-stakeholder, voluntary consortium of Wisconsin organizations
  - Members: health systems, medical groups, clinics, and hospitals
  - Stakeholders: purchasers, policy and advocacy organizations, government agencies, research institutions and foundations.
- Membership includes approximately 65% of Primary Care Providers in Wisconsin

Diabetes QI Steering Team

2018 Team Participants

- WCHQ Members
  - *Access Community Healthcare Community
  - Aspirus
  - Marshfield
  - Medical College of Wisconsin
  - Mercy Health System
  - *ProHealth
  - Sauk Prairie Healthcare
  - ThedaCare
  - UW Health
- WCHQ Partners
  - DHS
  - MetaStar
  - *RWHC
  - UW HIP

Hypertension QI Steering Team

2018 Team Priorities

1. Medication Adherence
2. RN nurse visit workflow/protocol for elevated BP
3. Follow up BP workflow from specialists
4. Train staff and/or providers to use a standardized method for taking blood pressure with annual competency testing (**Strategy 1 in the toolkit**)
5. Home self-monitoring BPs
6. Use a standardized protocol for treating hypertension **(Strategy 2 in the toolkit)**
7. Provide ongoing, collaborative **patient education** and/or self-management and lifestyle change to patients with hypertension **(Strategy 3 in the toolkit)**
8. Standard process for BP equipment maintenance and calibration

Hypertension QI Steering Team

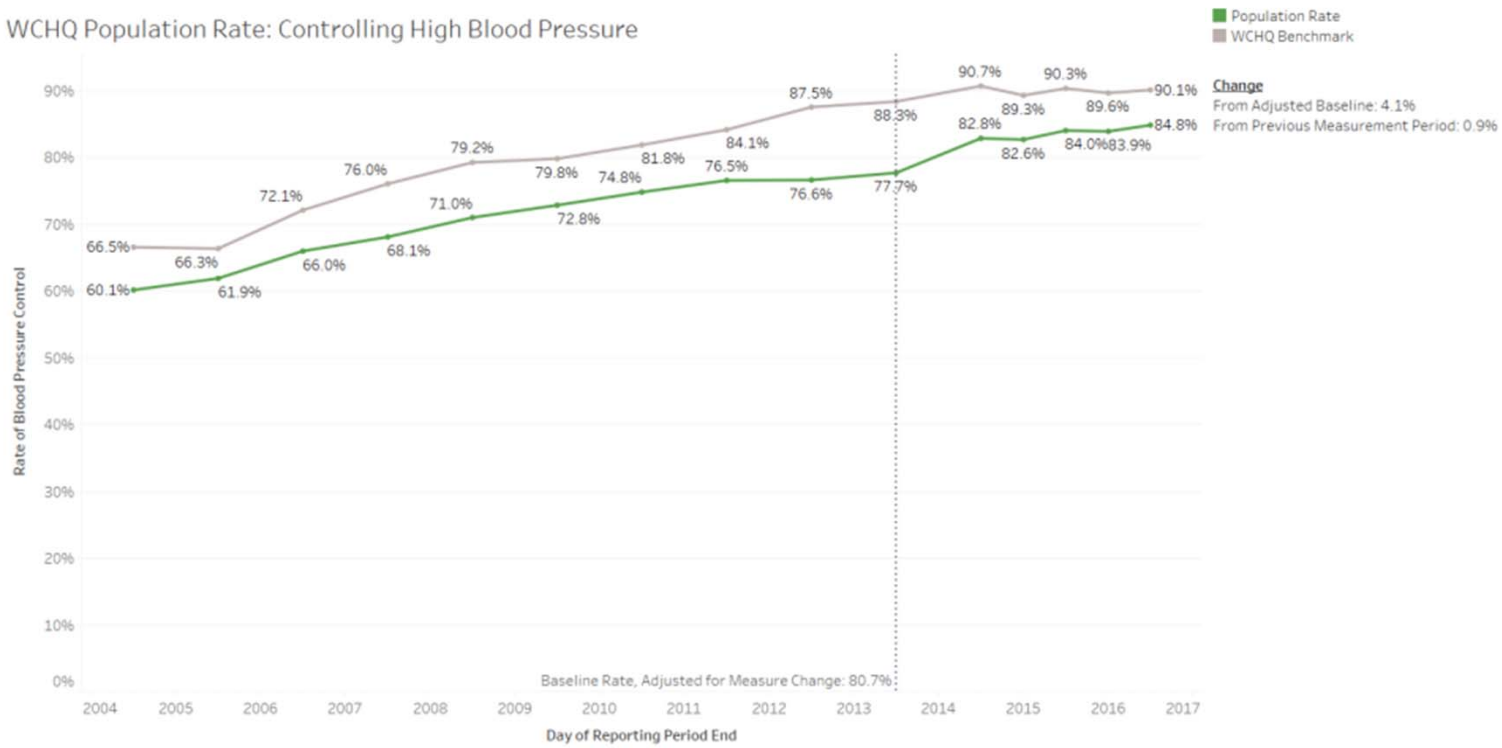
2018 Team Priorities

'Undiagnosed Hypertension Hiding In Plain Sight'

1. Measure intent - internal team use for population identification and improvement strategies
2. Next Steps
   - Update measure description & specification
   - Completes cross-mapping for antihypertensive medications.
   - Run the measure.

Hypertension QI Steering Team - Data

WCHQ Population Rate: Controlling High BP



What is a primary challenge that is holding back the work?

- Coordination across health systems and partners to find the patients hiding in plain sight
- Get the entire state working together!

What one action could others do to help support or join this work?

- All WCHQ members should be a part of our steering team.
- Partner organizations should consider joining ad hoc- what do you want to share?

Panel 1

Maria Gulan, RN, VP of Ambulatory Service and Patient Experience

Susan Schneider, MD, CMO

Aspirus

Aspirus Health System

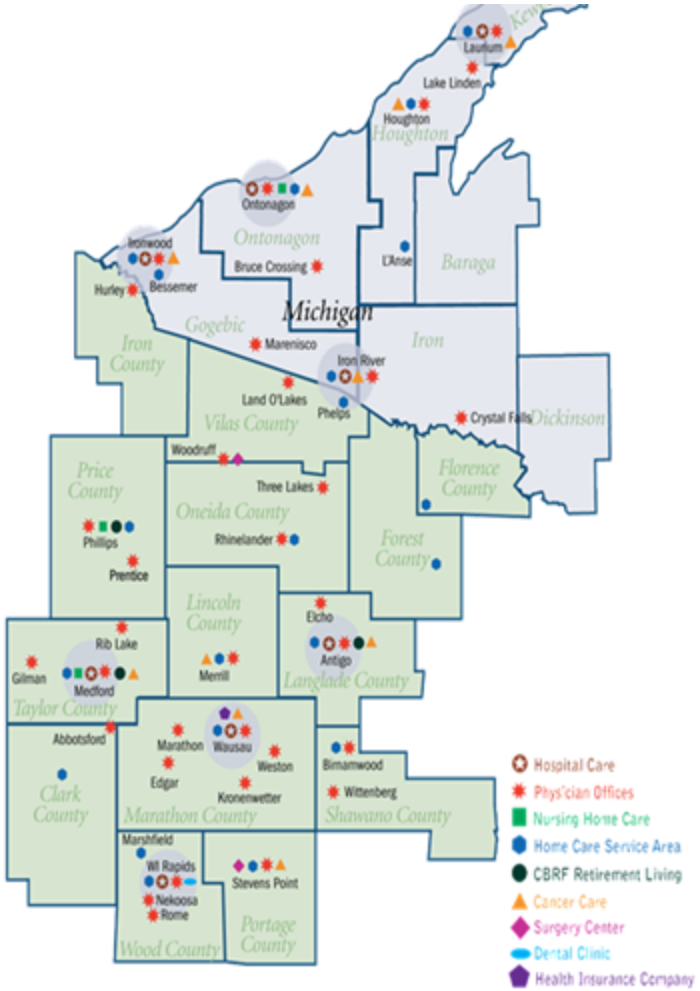
Non-profit, community-directed health care system serving North Central Wisconsin and the Upper Peninsula of Michigan

More than 7,000 employees

Integrated Health System

- 14 Wisconsin counties
- 7 Upper Michigan counties
- 8 hospitals
- 50 clinics
- Home health and hospice care
- Pharmacies
- Critical care and helicopter transport
- High-quality affiliated physicians
- Member of AboutHealth ACO
- Aspirus Arise Health Plan

Aspirus Network (contracting entity organized as a PHO) integrated network provider that regionally aligns more than 450 Aspirus employed and affiliated independent physicians and 300+ Advanced Practice Providers.

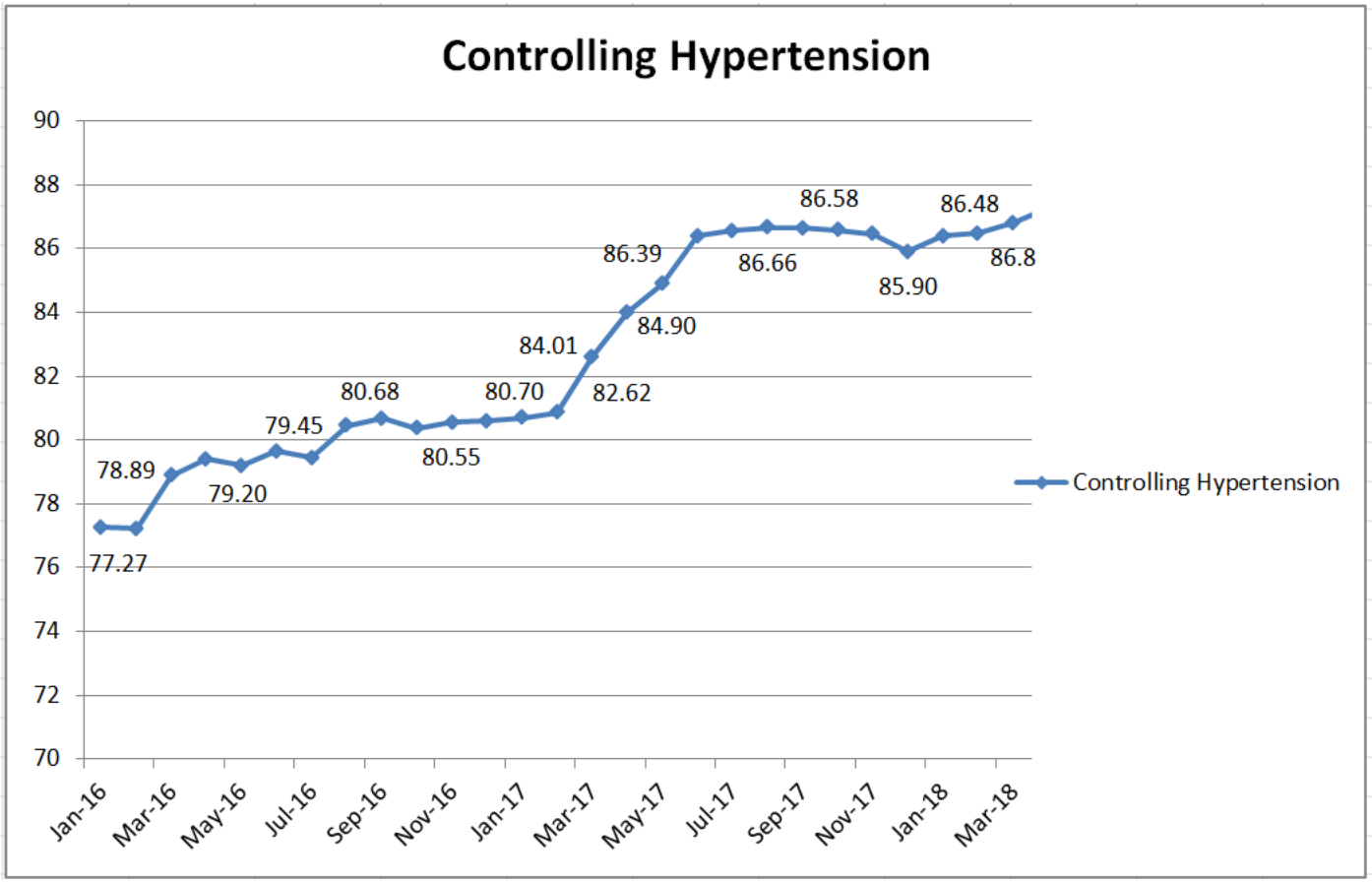


Strategies for Engagement…

Provide Tools, Training, Resources and Motivation

- ✓ Focus on Patient
- ✓ Prioritized Optimal Care for the System
- ✓ **Educate**
- ✓ Set Reasonable, Achievable, Stretch Goals
- ✓ Promote Culture of Team Based Care
- ✓ Standardize Clinical Workflows
- ✓ **Educate**
- ✓ Align metrics within the system
- ✓ Leverage Technology – HTN Registry
- ✓ Distribute Refined Data Analytics (Patient Level Detail)
- ✓ **Educate**
- ✓ Implement Visual Management/Transparency of Performance
- ✓ Incentivize, Reward for Performance
- ✓ Celebrate Successes Along the Way

Impact of Engagement



What is a primary challenge that is holding back the work?

- Documentation challenges and metric fatigue

What one action could others do to help support or join this work?

- Align metric specifications (MACRA, HEDIS, Payor, WCHQ, etc…)

Panel 1

Kari Trapskin, PharmD

Who do you represent?

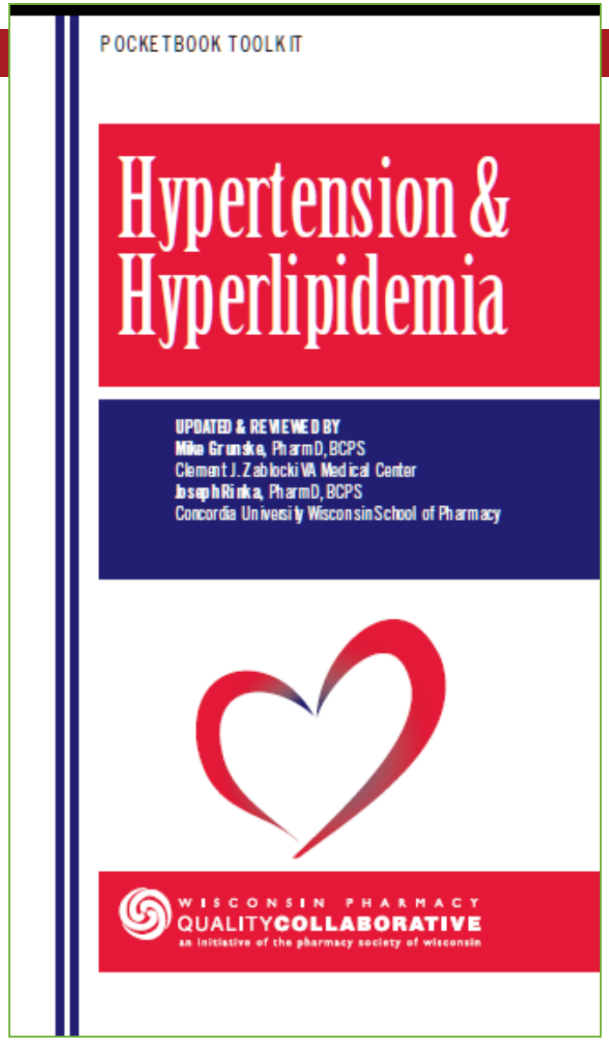
- Pharmacy Society of Wisconsin (PSW)
- Professional association
  - ~4000 members (pharmacists, pharmacy technicians)
  - Statewide reach
- Wisconsin Pharmacy Quality Collaborative (WPQC)
  - >250 accredited pharmacies
  - >500 certified pharmacists

How do you screen for or identify undiagnosed and uncontrolled hypertension?

- WPQC pilot focused on pharmacist-provided Comprehensive Medication Review (CMR) Services by pharmacists
- WEA Trust
  - Push list based on analytics
    - Patients with HTN dx, HTN medication claims, low adherence, WPQC pharmacies
  - Marketing
- 6 Community Pharmacies (Kenosha, Sauk Counties)
- PSW: training, support, connection to DPH
- Sustainability
  - Part of larger WPQC program
  - Value-based payment proof of concept

PSW Hypertension Toolkit

- General concepts, guidelines, clinical pearls, and self-measurement of blood pressure information



PSW/WPQC Adherence Toolkit

- Domains based on social determinants of health
  - Barriers/Solutions

POCKETBOOK TOOLKIT

Adherence

UPDATED & REVIEWED BY:
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Sara M. Koth, PharmD – UW Health
Erin K. McCreary, PharmD – UW Health
Kate Schaafsma, PharmD – Froedtert Hospital
Julia D. Schrader, PharmD Candidate 2017
Kari L. Trapskin, PharmD – Pharmacy Society of Wisconsin
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Beth A. Martin, PhD, MS, RPh – University of Wisconsin School of Pharmacy

WISCONSIN PHARMACY QUALITY COLLABORATIVE
an initiative of the pharmacy society of wisconsin

Hypertension service

- **Visit One**: Comprehensive Medication Review (CMR) focused on adherence to HTN medications along with a focus on self-measurement of blood pressure.
  - Pre visit Health Survey via iPad
    - Health survey includes health belief survey

Hypertension service

- **Visit Two:** (approximately 2-4 weeks later): Targeted follow-up CMR focused on adherence to HTN medications and self-measurement of blood pressure progress.
  - Pre visit Health Survey via iPad
    - Health survey includes health belief survey

How to measure your blood pressure at home

Follow these steps for an accurate blood pressure reading

1 PREPARE

Avoid caffeine, cigarettes and other stimulants 30 minutes before you measure your blood pressure.

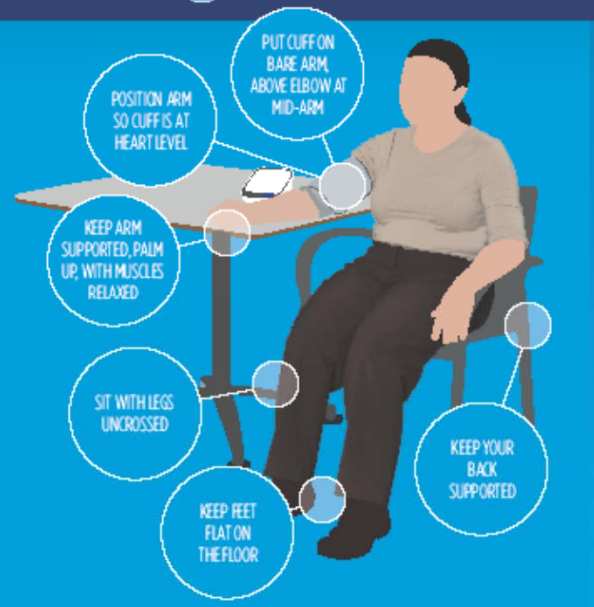
Wait at least 30 minutes after a meal.

If you're on blood pressure medication, measure your BP **before** you take your medication.

Empty your bladder beforehand.

Find a quiet space where you can sit comfortably without distraction.

2 POSITION



3 MEASURE

Rest for five minutes while in position before starting.

Take two or three measurements, one minute apart.

Keep your body relaxed and in position during measurements.

Sit quietly with no distractions during measurements—avoid conversations, TV, phones and other devices.

Record your measurements when finished.

TARGET:BP

MEDICATION ACTION PLAN

RESOURCES TO HELP WITH MY MEDICATION PLAN

- ❒ Bus Pass
- ❒ Call 2-1-1
- ❒ Contact local senior center or ADRC
- ❒ Align medication refill dates
- ❒ Delivery or mail-out services
- ❒ Community cab/ shuttle info: _____
- ❒ Family members/ friends who could help pick up prescriptions: _____

- ❒ Goal to improve health (i.e. blood pressure goal): _____
- ❒ Home testing plan: _____
- ❒ OTC products/ strategies to manage side effects
- ❒ Helpful tools or smart phone apps: _____

- ❒ Medication information, instructions, and visual aids that fit my needs
- ❒ Large font size
- ❒ Translation

Pharmacy phone #: _____

- ❒ Single dosage form
- ❒ Different shapes or colors of prescription bottles
- ❒ Phone alarm
- ❒ Family members or friends to help remind me to take my medications
- ❒ Helpful websites and apps
  - MyMedSchedule.com
  - NexDose.com
  - Epill.com
  - Forgettingthepill.com
  - Thedidit.com
  - Mango Health App
  - MediSafe App

- ❒ Change Medication
- ❒ Tablet splitting
- ❒ Combination product
- ❒ Manufacturer coupons
- ❒ Savings cards
- ❒ Free or low cost clinics
- ❒ ForwardHealth WI (Medicaid) (1-800-362-3002)
- ❒ Federally Qualified Health Centers (FQHC)
- ❒ Community Support
  - www.211wisconsin.org
  - Dial 2-1-1 on phone
  - Local United Way
- ❒ Prescription discount and assistance websites
  - pparx.org
  - needymeds.org

Patient resources based on barriers and solutions identified

MY MEDICATION PLAN

In the next _____ (one week; 2 weeks; month) I will:

Start date for my plan: _____

Things that could get in the way of my plan:	Ways I will prepare for these problems:
1.	1.
2.	2.
3.	3.

My pharmacist _____ (name) will:

- ❒ Contact my doctor about: _____
- ❒ Other: _____

Plan to FOLLOW UP with my pharmacist:

_____ (pharmacist name) will check in with me on _____ (date) via (phone call, visit) to discuss today's plan.

What is a primary challenge that is holding back the work?

Data sharing/contracts
Short time line

What one action could others do to help support or join this work?

Team-based care: Consider partnerships with community pharmacies (or pharmacies within health system) (referrals, transitions of care, SMBP follow up, collaborative agreements)

Panel 2
Moderator: Gina Dennik-Champion, WNA

Panel 2: Overview

Patient Centered Team-Based Care

Panelists representing payers, providers, community, and advocacy/statewide organizations will share practical strategies and practices currently be implemented in Wisconsin to improve HTN and CVD outcomes.

Goal: Prompt action and generate ideas on how you and your organization can implement or apply the shared strategies/practices and set the stage for the afternoon workgroups.

Patient-Centered Team-Based Care

Panelist

Dr. Chris Tashjian
Vibrant Health Care

Tina Bettin
ThedaCare

Bria Grant
UniteMKE

Geeta Wadhwani
United Healthcare

Panel 2

Chris Tashjian, MD, FAAFP

Who do you represent?

- Vibrant Health Family Clinics
- Family Physician, Million Hearts Champion
- River Falls, Ellsworth, and Spring Valley Wisconsin
- Reach/Service Area: Western Wisconsin
  - AKA The “West Coast” … of Wisconsin

How do you use patient centered team-based care to improve outcomes?

- What is your organization doing?
  - Team based care. Everyone is accountable and EVERY visit is a hypertension visit
- What practices or strategies are you implementing?
  - Monthly review of all patients not at goal…as a TEAM
- What is the impact? Measurably better care.
  - Control rates in the high 80's to low 90's percentile
- Who plays a role in the work
  - Scheduling, Providers, Nursing, Lab, X-Ray
- How is this work being sustained?
  - Part of our culture, Monthly reviews, transparent reporting of the data

What is a primary challenge that is holding back the work?

We need to see the patients in order to diagnose and treat. High deductible plans are incenting patients not to come.

What one action could others do to help support or join this work?

Simple communication via magnet or pad of paper to remind providers to address hypertension at every visit if BP > 140/90

Panel 2

Tina Bettin DNP, MSN, RN, FNP-BC, APNP

Who do you represent?

- ThedaCare
- Health System; non-profit
- Located/# of locations-Northeast Wisconsin; 7 hospitals; 31 clinics
- Reach/Service Area: 9 counties; serves over 200,000 pts annually & employs 6700 health care professionals; level II trauma center, comprehensive cancer treatment, stroke & cardiac programs; CHAT; Mayo Clinic Care Network

How do you use patient centered team-based care to improve outcomes?

- Presently undergoing primary care re-design. Monitor boards in clinics. Community based paramedics & expansion of this program; starting outpatient care management team; best practice alerts; annual quality goals; Outpatient departments monitoring & forwarding BPs to providers
- Overall success 85% as an organization--stable
- All members of team including hospital (PSR to provider/CEO) to partners like the paramedics (not employed by system)
- Performance skills every 2 yrs for front line care staff; Free BP checks (at all clinics) with dedicated staff for at the larger clinics; standard work with BP rechecks at visit

What is a primary challenge that is holding back the work?

Patient compliance and buy in as well as persistent rotating insurance plans and the lack of insurance plans

What one action could others do to help support or join this work?

Providing patients with accurate at home blood pressure cuffs.


Panel 2
Bria Grant

Who do you represent?

- Name of organization

  UniteMKE

- Identify type: Health plan, payer, community, advocacy and other

  Community Public Health Convener

- Located/Number of Locations:

  2474 N 37th Milwaukee, WI 53210

- Reach/Service Area:

  Milwaukee County

How do you use patient centered team-based care to improve outcomes?

- What is your organization doing?
  - Enhanced Community Care Coordination
- What practices or strategies are you implementing?
  - Value-Based Coordinated Care
- What is the impact?
  - Greater ROI
  - Tracked Outcomes
  - Sustainable employment for Community Health Workers
- Who plays a role in the work (e.g., health plans, health systems, community, advocacy and other)?
  - Everyone, but most importantly the Community Health Worker
- How is this work being sustained?
  - Various grant initiatives
  - Health Plan Agreements

What is a primary challenge that is holding back the work?

One's value for the various professional role's of the care team.

What one action could others do to help support or join this work?

Encourage community based organizations to join UniteMKE as we work to standardize community care coordination, strengthen the our (payer, provider, community and patient) communication to reduce disparities.

Panel 2

Geeta Wadhwani

Who do you represent?

- UnitedHealthcare Community & State
- Identify type: Health plan
- 66 Wisconsin Counties (including 6 new counties in 2018)
- Serving approximately 168,000 Medicaid Members across the State

How do you screen for or identify undiagnosed and uncontrolled hypertension?

- What is your organization doing? What practices or strategies are you implementing?
  - **ASTHO Pilot Partnership**:
    - Using ICD10 codes to identify those who have been diagnosed with hypertension at targeted Milwaukee clinics; Coordinating with clinics to identify eligible patients. Overall we can identify populations with HTN by geographic (locally and regionally) and health system or clinic level
    - Difficult to identify those who are HTN undiagnosed utilizing claims data
  - **Replicate and Share an Ellsworth Clinic Practice:**
    - Create a BP Magnet reminding clinics/systems to recheck blood pressures when they are >140/90
    - Shared with Health systems, clinics, FQHCs & WPHCA across the state
    - Also shared with some patients who are participating in the ASTHO pilot

How do you screen for or identify undiagnosed and uncontrolled hypertension?

- What is the impact?
  - **ASTHO**:
    - Information sharing
    - Development of relationships across multiple organizations to support identification, referral, documentation practices
    - Coordination of efforts to identify and connect individuals to clinical and social services
  - **Replication of Best Practice: (examples below from some partnering clinics):**
    - Established a staff quality team
    - CBP rate from 63.1% (early 2016) – 84.3% in early 2017
    - Revised protocols to incorporate Magnet in process
    - HTN rates 61% - 68.2% controlled (in a CY)
- Who plays a role in the work: Health Plan, Clinics, Community Partners, Public Health