



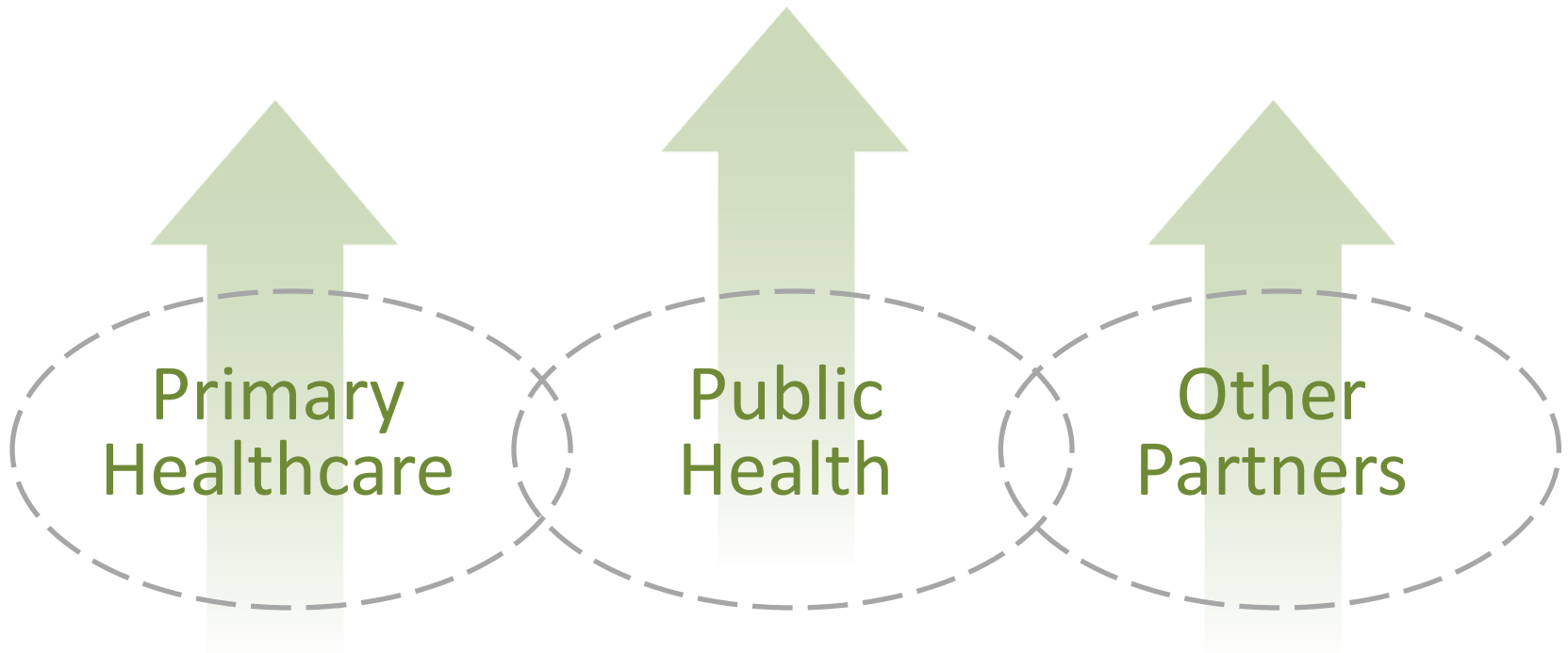
Digital Health Meeting

Agenda 5/1/17

TIME	ITEM	LEAD
11:00 – 11:15	Introductions	Rebecca Thompson, WCHF
11:15 – 11:45	ASTHO Million Hearts® Learning Collaborative Introduction of EPIC Link System Green County Project Learning	Rebecca Thompson, WCHF RoAnn Warden, Green County Public Health Patrick Loney, Monroe Clinic Amy Sweeney, Monroe Clinic Carrie Blum, Monroe Clinic
11:45 – 12:10	Edgewood MBA Student Presentation Observations and Opportunities Framework – Diagrams and Checklist	Shay Santos Shelly Coppernoll Kevin Dwyer
12:10 – 12:30	Reflections – Community Health Improvement Via Digital Health and Expanded Community- Clinical Linkage Systems	Rebecca Thompson, WCHF

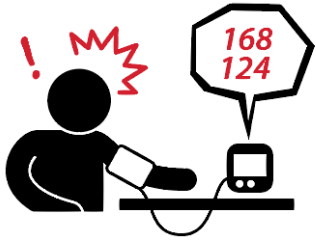


Elevation of Population Health Chronic Disease Improvement



Primary Healthcare + Public Health + Other Partners =
**Catalyzation of an Intersectoral Movement Towards
Population Health**

HEART HEALTH FACTS



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



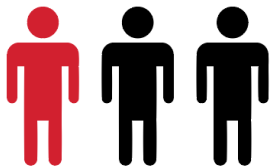
Coronary heart disease is the no. 1 killer of women age 25 and over in WI.



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



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



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



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



Healthy Hearts Wisconsin



- **Improving** Heart Disease Detection
- **Advancing** Treatment Strategies
- **Increasing** Public Awareness
- **Expanding** Education
- **Targeting** High-Risk Populations
- **Preventing** Recurrence
- **Controlling** Chronic Conditions
- **Committing** to Positive Change
- **Aligning** Patients, Practitioners & Organizations
- **Collaborating** with Partners for Better Health Outcomes for ALL



Million Hearts[®] 2022 Goals

Phase 2 of National Campaign

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

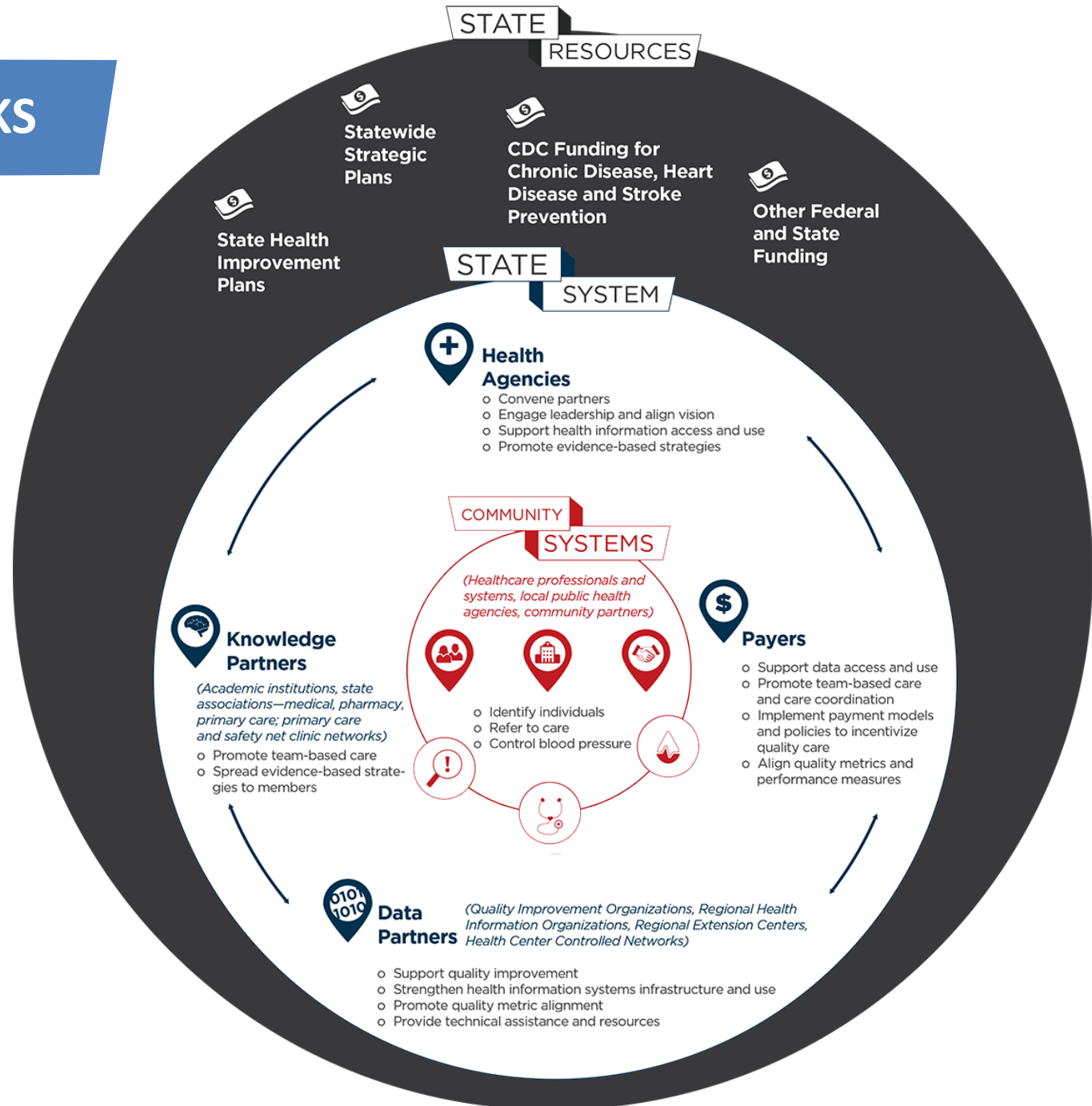
Wisconsin Healthy Hearts

ASTHO 1 of 6 Initiatives – Chronic Disease Prevention & Control Unit Connection

1. **Coverdell Stroke** – 1 of 9 States – Stroke Prevention Project with 40 Hospitals and EMS – 5 Year Grant
2. **CDC 1305** – Million Hearts[®] WI Campaign And Various Healthy Heart Initiatives – 5 Year Grant
3. **WISEWOMAN** – Connecting Women Eligible For the Breast Cancer and Control Program to Blood Pressure Screening and Risk Reduction Counseling
4. **Healthy Hearts in the Heartland** – Metastar Primary Care Heart Research Project
5. **SmartCare** – Wisconsin/Florida Project – Heart Health Appropriate Use
6. **ASTHO** – Million Hearts[®] Learning Collaborative – 5 State Project



HOW IT WORKS





CROSS-SECTOR CONNECTIONS TO IMPROVE OUTCOMES

Using a **framework of rapid-cycle quality improvement**, states are implementing activities for data-driven action, standardizing clinical practice, community-clinical linkages, and financing and policy to turn the gears and generate systems change and improved health outcomes.

Evidence-based programs provide examples of successful strategies to turn each gear.





Wisconsin State ASTHO Team

Million Hearts[®] Learning Collaborative



GREEN COUNTRY WISCONSIN

there's an art to it.



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



Wisconsin
Community
Health Fund
*Growing & Focusing Resources
For Healthy Communities*

 **Monroe
Clinic**

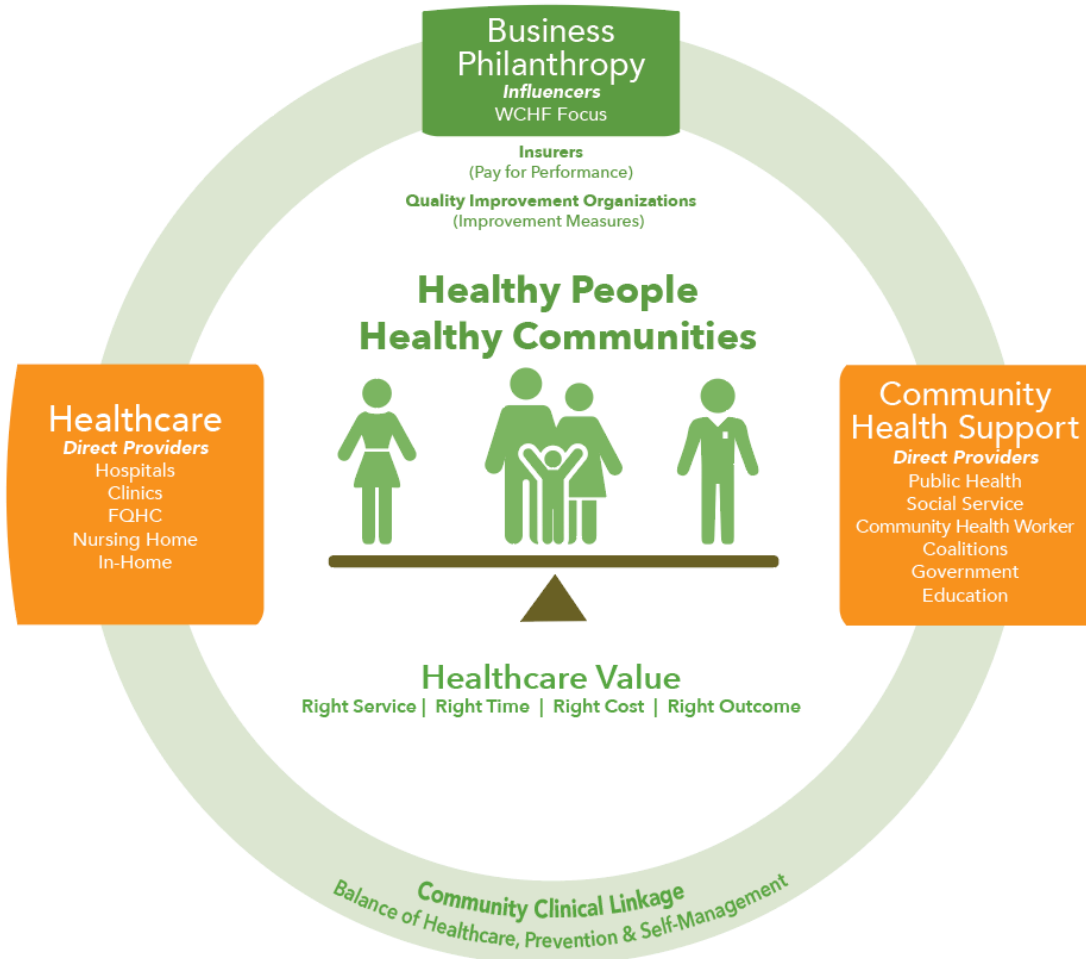
 **Monroe
Clinic**
PARISH NURSE

SWCAP
Southwestern Wisconsin Community Action Program, Inc.



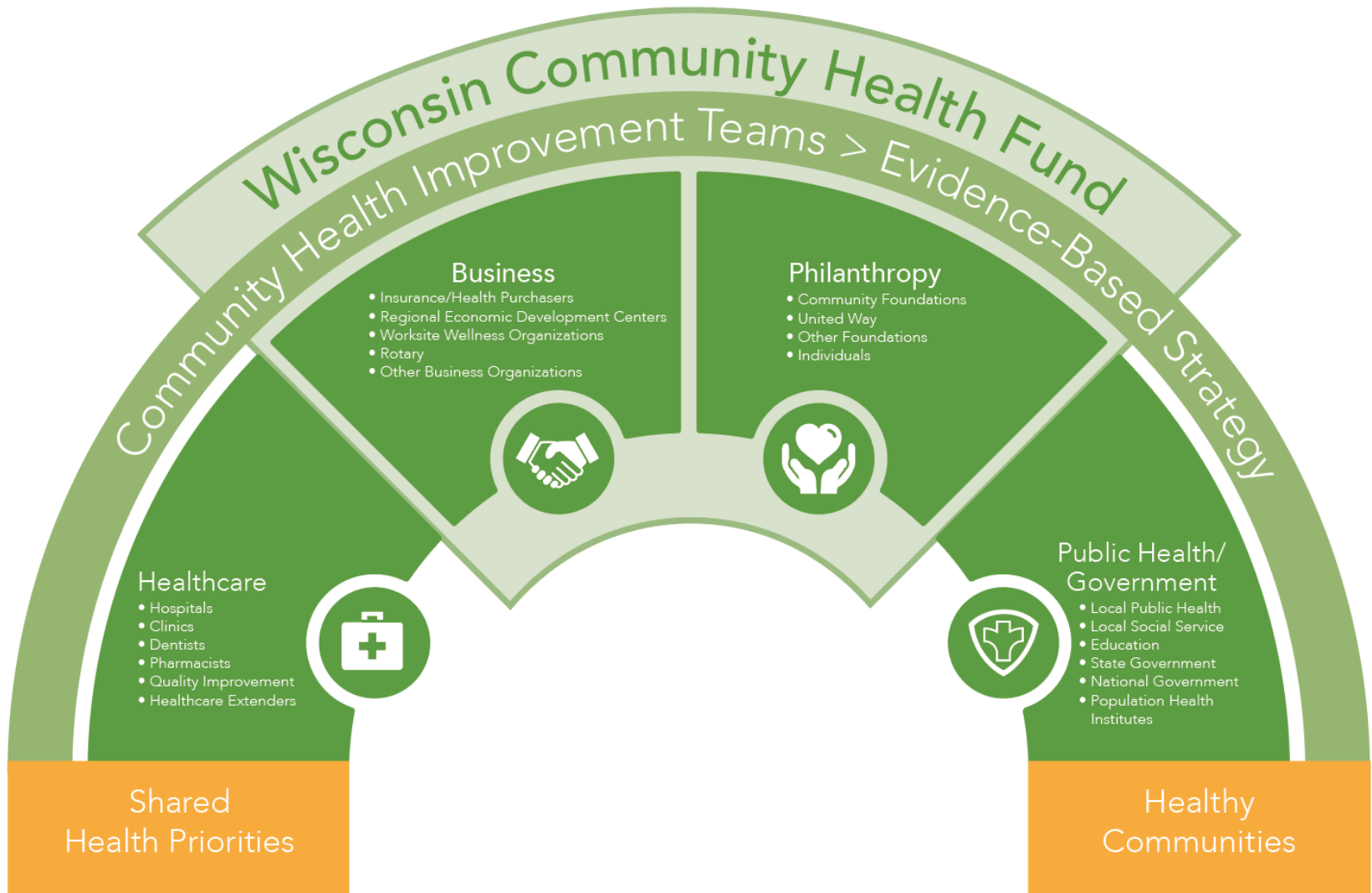


WCHF Community Health Value Exchange

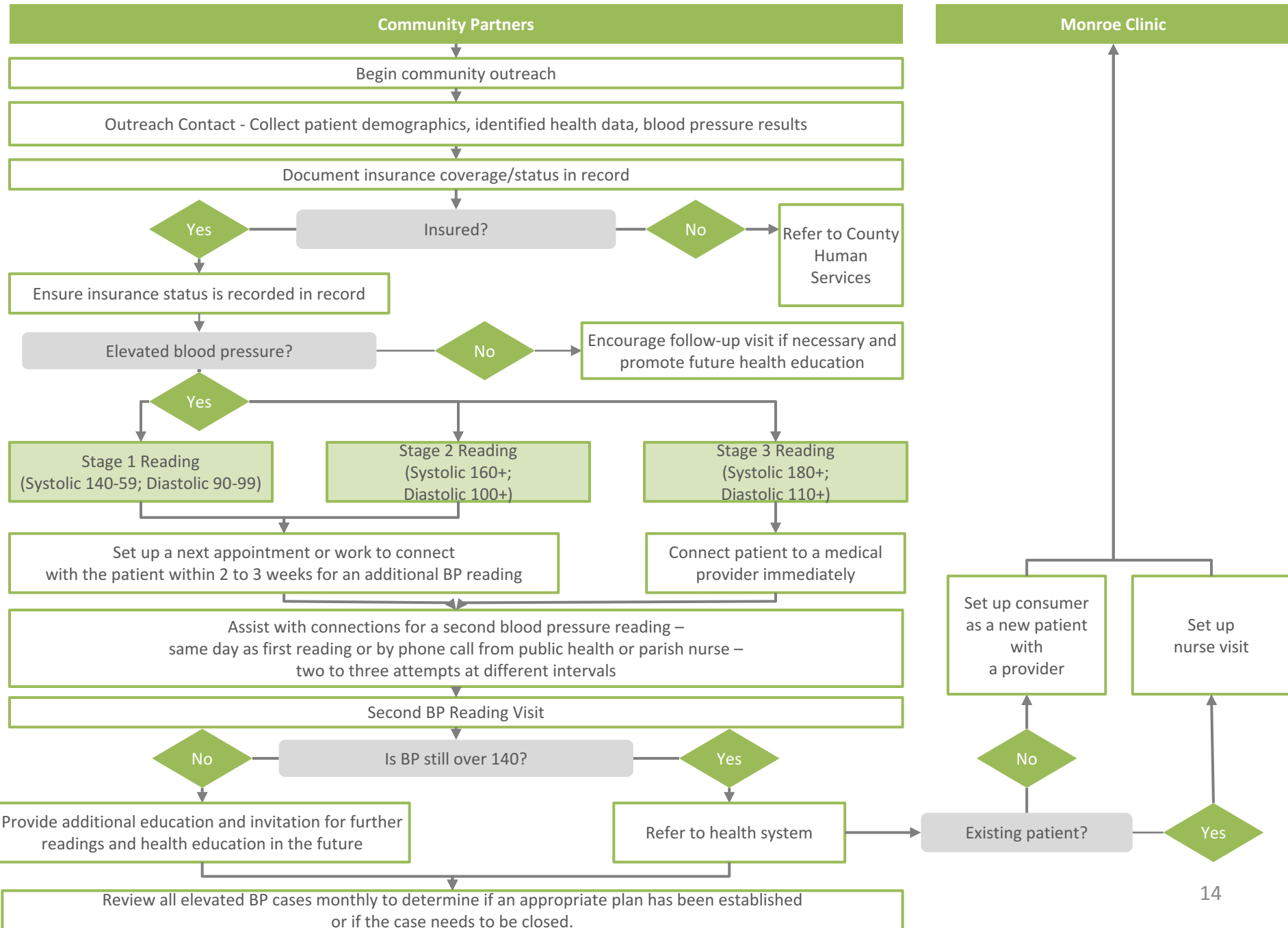




WCHF Resource Bridge – Project Coordinator



Green County Hypertension Community Care Protocol Flow Chart [Updated 6.3.16]





Health Department 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

Wal-Mart Parking Lot Event



Digital Announcements

Heart Health Education Events & Social Media Ads

— FREE HEALTH CLASS —
**HEART HEALTH:
KNOW YOUR NUMBERS**

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

StarGuardian
FOUNDATION

Wisconsin
Community
Health Fund
Wisconsin's Community Improvement
for Healthy Communities

WiFACTS

25+

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

**SUBSCRIBE & ENGAGE TODAY
FOR HEALTHIER TOMORROW!**

**Wisconsin
Community
Health Fund**
Wisconsin's Community Improvement
for Healthy Communities



Heart Health Month



NGSD Go Red Day!



Rural Health Day

Family Practice Residents | Hypertension Medical Education

Youth-Centered
Information



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.



Media Efforts

Education Spread and Partner Recognition



POST MESSENGER RECORDER

109 5th Ave., New Glarus, WI
(608) 527-5252

Serving the communities of
Belleville, Monticello, and New Glarus



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Green County Healthy Hearts

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February 16, 2017 | Vol.133, No. 7



Photo courtesy of Rebecca Thompson

New Glarus School Nurse Kayla Zimmerman, New Glarus High School Principal Jeff Eichelkraut and Rebecca Thompson, Director of the Wisconsin Community Health Fund. Zimmerman coordinated the event for the district.

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.

MOST POPULAR:

COMMENTS
VIEWED

1. Vietnam War Hero Passes Awa...
2. PATRICIA N. MOEN
3. New Glarus Wild Game Feed
4. Music Fest is Changing its...
5. Chenoweth and Gerner Compet...


Post Messenger Recorder PMR New Glarus Monticello Belleville News Publishing

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.



Green County Healthy Community Coalition

Community Resource Expansion Opportunities

- Connected to the local CHNA/CHIP Plans
- Green County Hypertension Community Care Agreement – support from 20+ multi-sector partners
- Creation of a website for community health care protocols

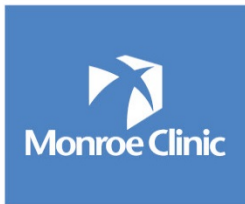


© 2014 County Health Rankings and Roadmaps

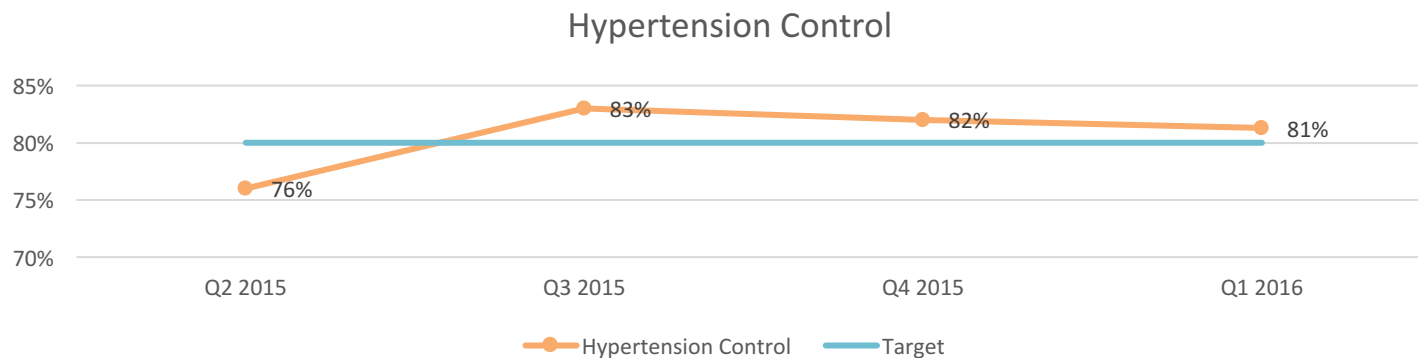


Community Partner Learning

- 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
- Public Health functioning in Chief Health Strategist Role – guiding other partners to be leaders in health
- Public health accreditation – improvement activities important component of strategic management system
- Motivational interviewing training and practice = very helpful
- Communication between community and hospital partners = challenging when not coordinated



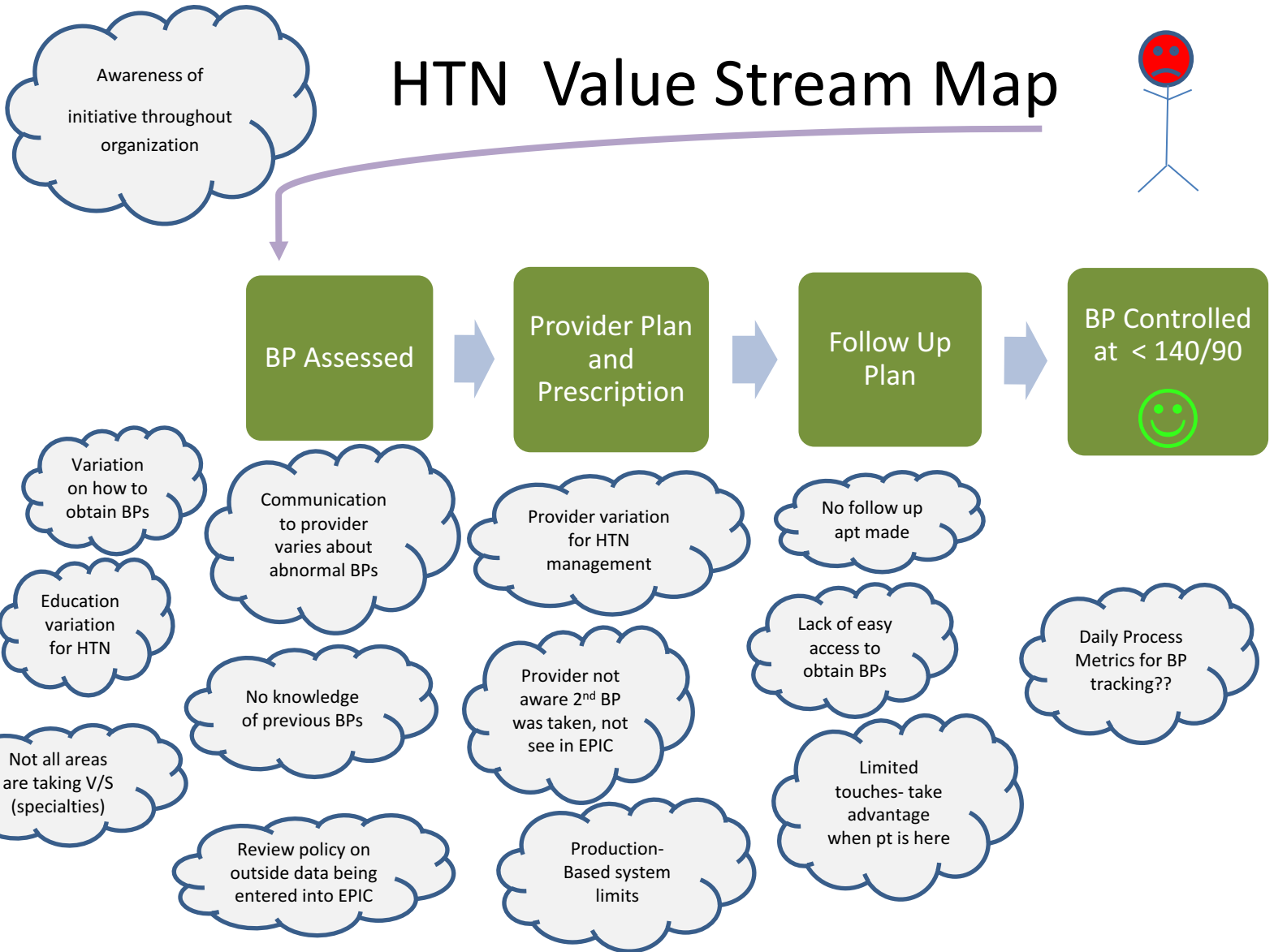
Hypertension Control – Clinical and Data System Interventions



- Elevation of hypertension to Health System Annual Quality Improvement Agenda
- Current results in top 75th percentile of state and national performance benchmarks, but always room for improvement!
- Million Hearts Prevalence Indicator Tool – Identified hospital system was on track for detecting hypertension



HTN Value Stream Map





Health System Learning

- 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

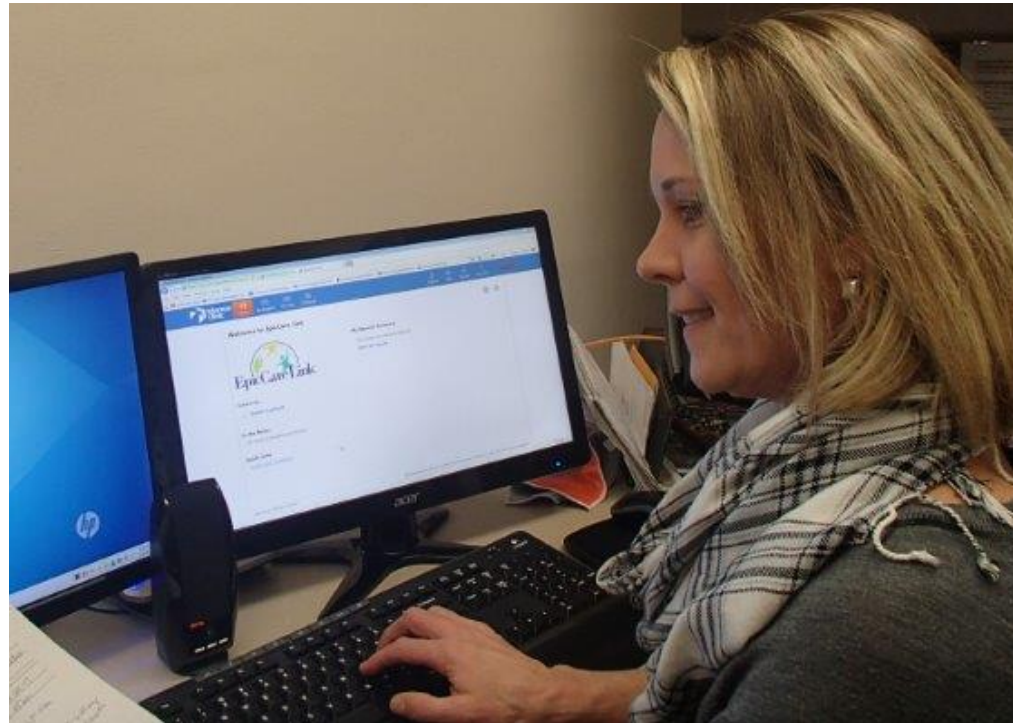




History Made!

First Public Health Department with access to EPIC

(Electronic Community-
Clinical Linkage System)



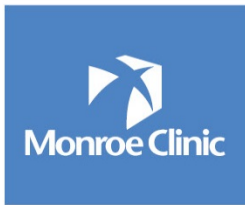
Monroe Clinic EpicCare Link

What is EpicCare Link?

EpicCare Link is web-based application for connecting organizations to community users. It provides community users secure access to select patient information in Monroe Clinic's Epic data repository.

Who are our Customers?

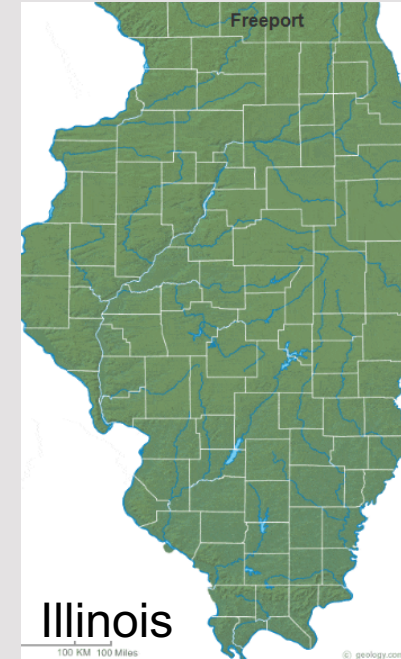
On April 5th, 2016 we provided Link access to 3 local Nursing Homes, External Auditors, External Billers, Green County Birth to Three Department, and to a Chiropractor's Office.



How many users have access?

As of 4/25/17 there are 118 users in Monroe Clinic's EpicCare Link. Those users expand into 3 states.

EpicCare Link Access Sites

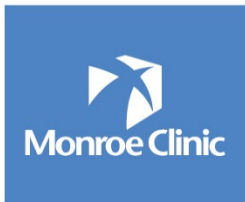


What can EpicCare Link provide?

- Access to Provider Notes
- Lab Results
- Imaging Results
- Patient Demographics
- Medication List
- Procedure Reports
- Allergies
- Patient History
- Problem List
- Access Management
- Release of Information
- Messaging between outside organization and Monroe Clinic through In Basket

Our Future

Monroe Clinic continues to expand to other local nursing homes and county health departments to provide continued health care. We strive to keep caregivers, providers and partners informed of our patients health.



Amy Sweeney- Application Specialist

amy.sweeney@monroeclinik.org

Carrie Blum- Chief Information Officer

carrie.blum@monroeclinik.org

Edgewood MBA Student Presentation



Project Scope & Approach

Seek Input from
Key
Stakeholders

Review
Hypertension
Program

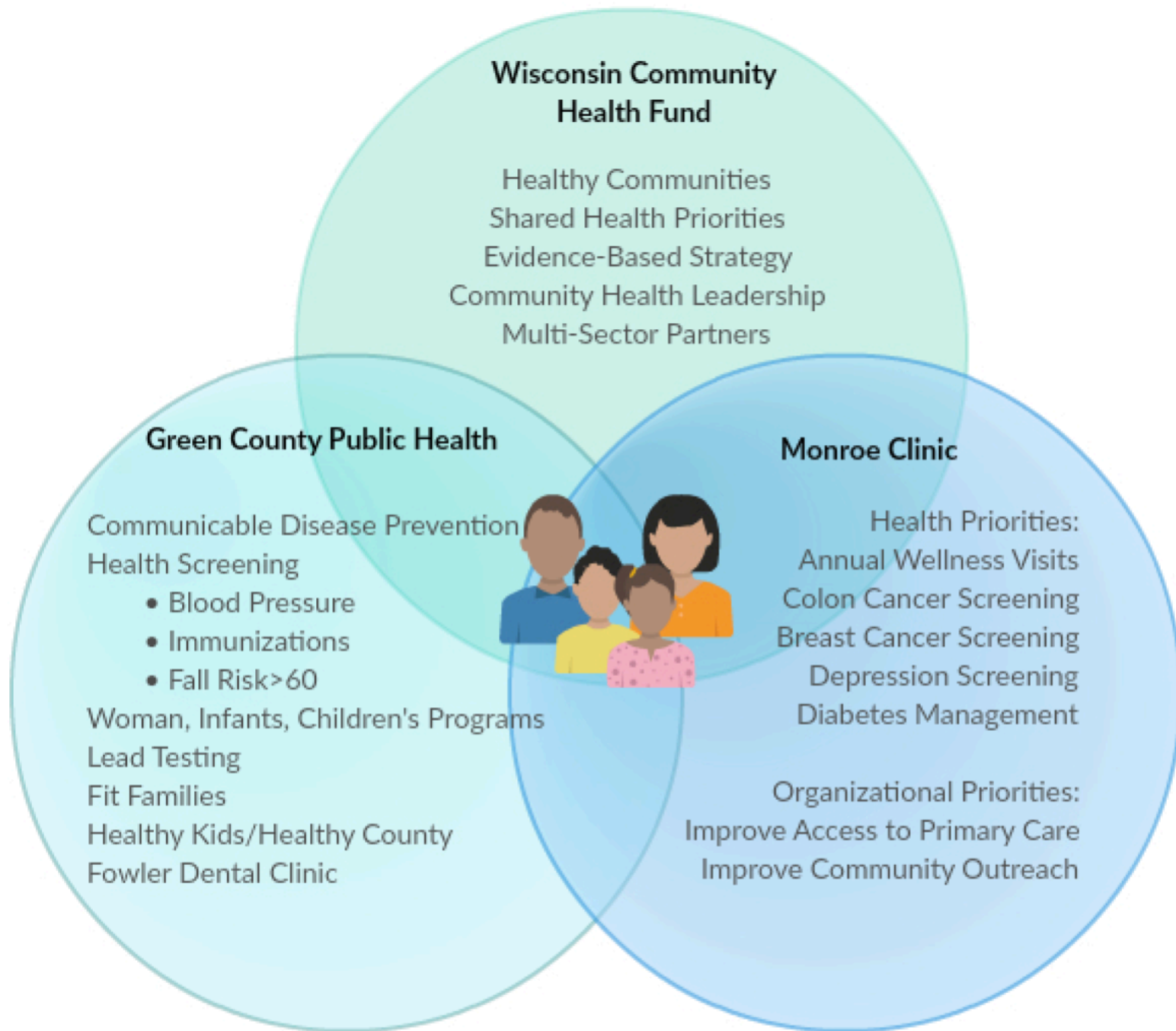
Develop
Framework
for Selection

Identify
Future
Health
Initiatives

Link
Strategic
Initiatives

PDSA

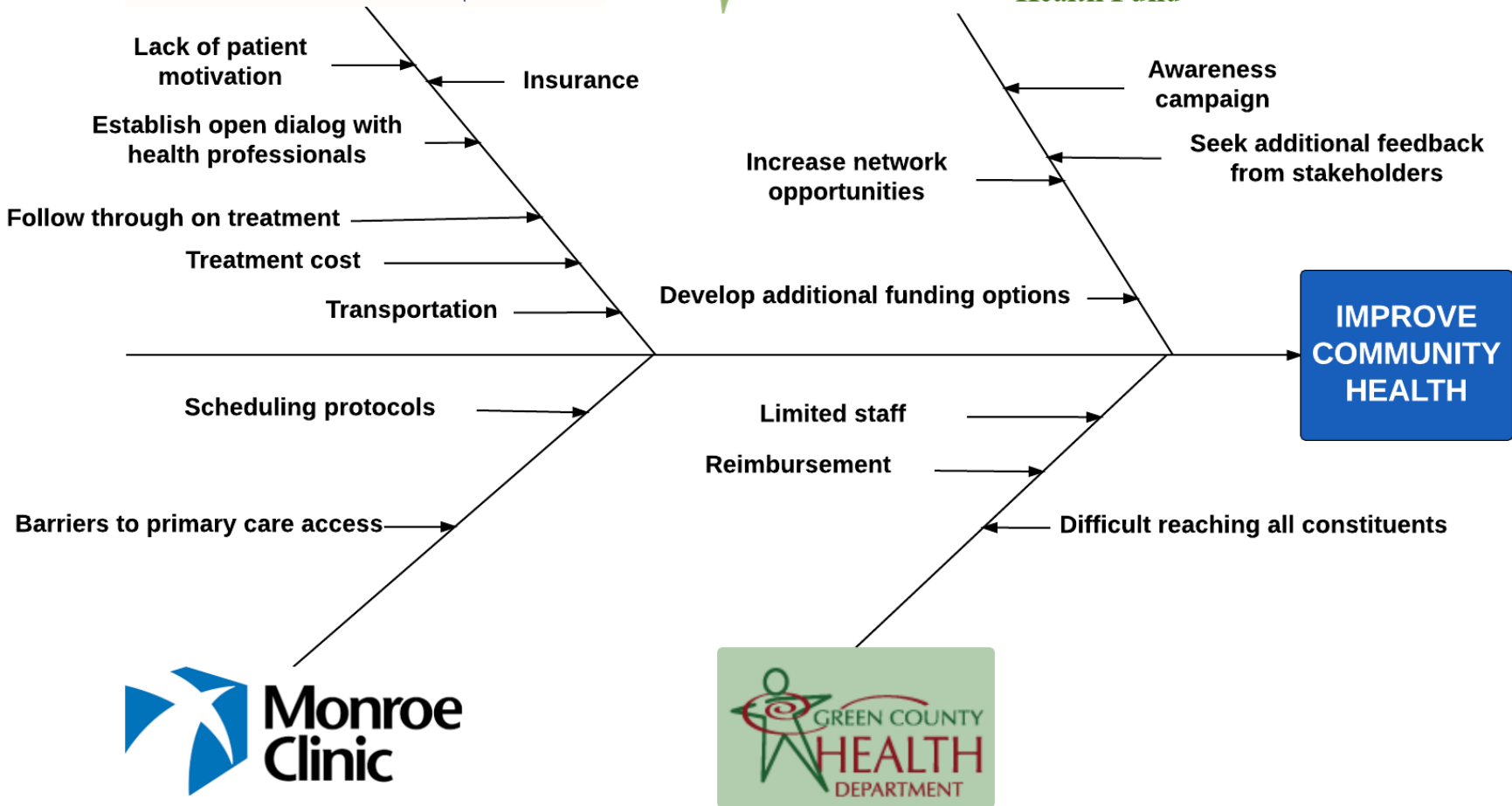
Framework



Community Members



Wisconsin Community Health Fund



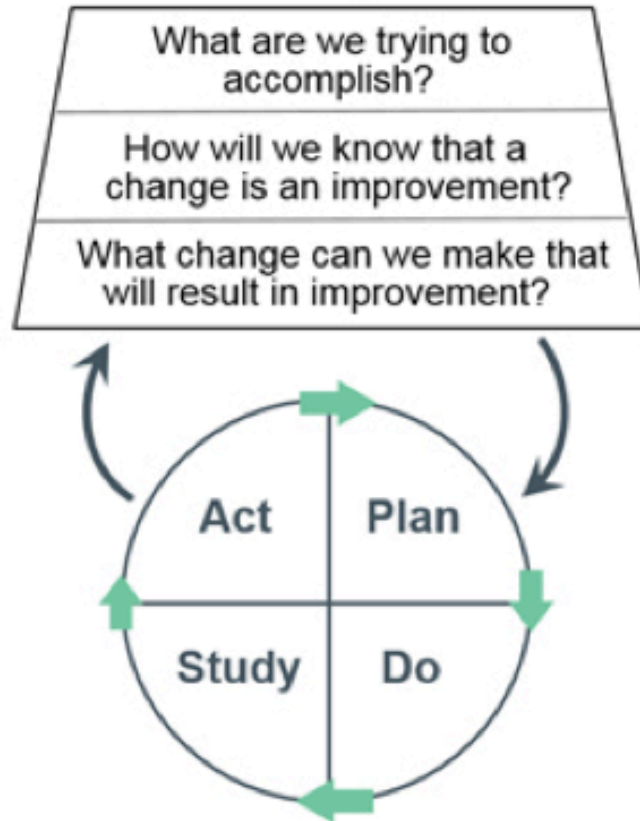
Review Hypertension Program

- **Process Variation**
 - Equipment
 - People
 - Communication
 - Venue
- **Barriers to Follow-up Care**
 - Access to Primary Care
 - Communication
 - Insurance
 - Variation in Treatment Plans
- **Key Learning and Successes**
 - Critical to have Right Stakeholders
 - LEAN approach - “What problem are we trying to solve?” and small tests of change
 - Incorporate into Current Initiatives for Sustainability
 - Elevated Blood Pressure is not a “low-income, uninsured issue”

Community Health Project Selection Framework

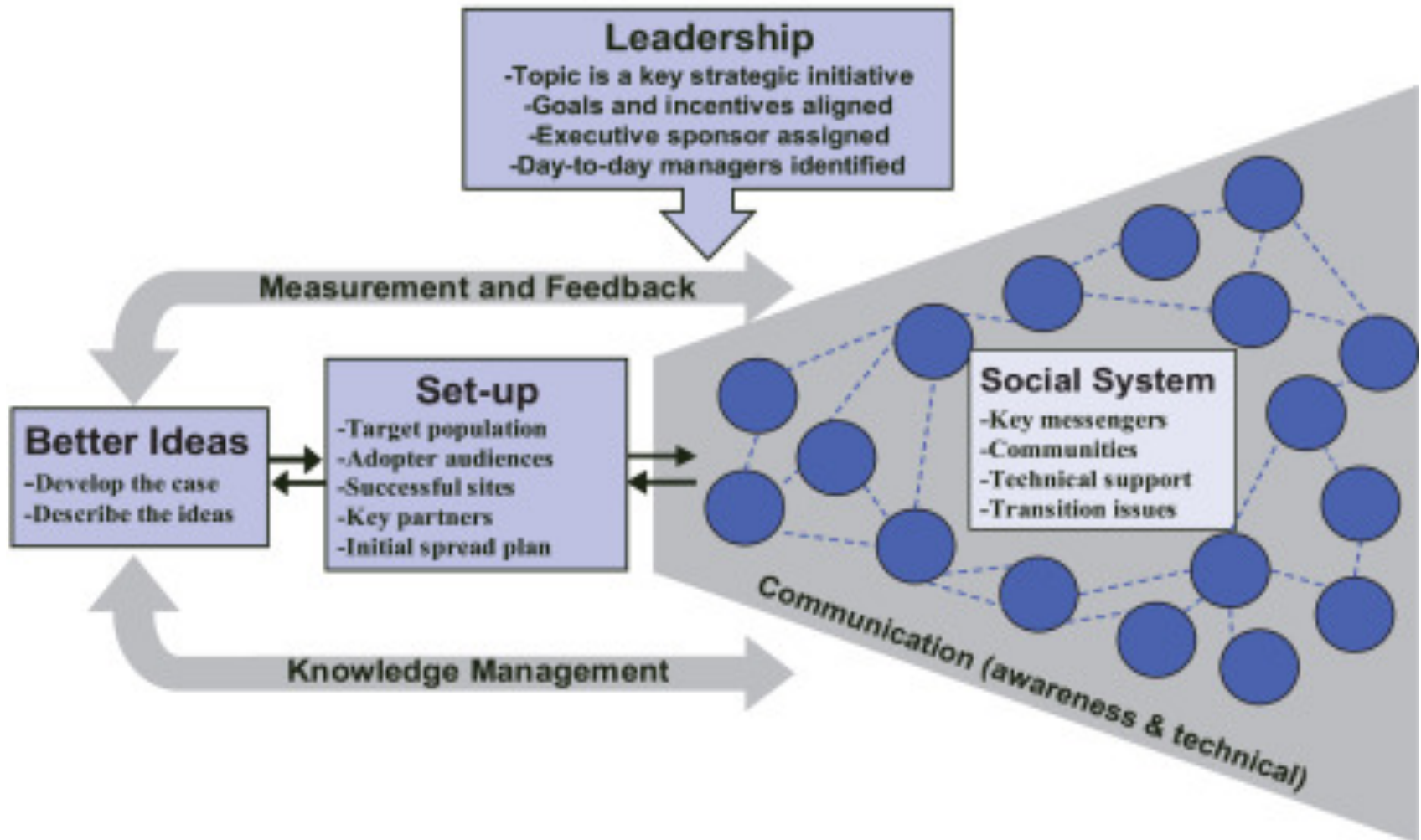
Priority	
	<input type="checkbox"/> Relates to CHNA/CHIP Priorities
	<input type="checkbox"/> Common Links (Priorities, Interests, Mandates, etc.) between Partners
	<input type="checkbox"/> Impact on Community Health
	<input type="checkbox"/> Required Resources are Available <ul style="list-style-type: none"> <input type="checkbox"/> Human Capital (right people w/right skills) <input type="checkbox"/> Technology & Equipment <input type="checkbox"/> Facilities <input type="checkbox"/> Funding (short-term & long-term)
	<input type="checkbox"/> Clearly Defined Goals & Objectives
	<input type="checkbox"/> Identifiable Value for Each Stakeholder
	<input type="checkbox"/> Key Performance Metrics based on Data

PDSA Model for Improvement



*From the institute for healthcare improvement and the Health Resources and Services Administration

Framework for Spread





Reflections

Community Health Improvement via Digital Health
And Expanded Community-Clinical Linkage Systems





WISCONSIN COMMUNITY HEALTH FUND

Leading a New Legacy & Promise
For Healthy Communities

Thank You

Rebecca R. Thompson, CPA, CFRE, MPH
Executive Director
Wisconsin Community Health Fund, Inc.

Professor Raj Kamal

Students: Shay Santos, Shelly Coppernoll, Kevin Dwyer, Alex Arnold
Edgewood MBA Program

Carrie Blum, CIO
Patrick Loney, VP
Amy Sweeney, Application Specialist
Monroe Clinic