Wisconsin Nurses Association  
Background: Concepts and Recommendations to Practical Action

BACKGROUND

Problem/Issue

Heart disease is the leading cause of death in Wisconsin and the United States (Wisconsin Department of Health Services, 2016). Hypertension is a major contributor to heart disease. Untreated and uncontrolled hypertension leads to stroke, heart failure, kidney disease, and myocardial infarction. Identifying and defining populations with hypertension can lead to appropriate treatment and control. Treatment and control of hypertension improves outcomes and reduces costs to the health care system and to the economy.

One of every three adults in Wisconsin has hypertension or approximately 1.3 million Wisconsin adults. Less than half of adults with hypertension are adequately in control (46%). Among those with uncontrolled hypertension, many adults (40%) are unaware they have it, and another 45% of adults with uncontrolled hypertension are seeking treatment, but it is still not in control. Nearly 90% of U.S. adults with uncontrolled hypertension have a usual source of health care and insurance, representing a missed opportunity for hypertension control (Centers for Disease Control and Prevention [CDC], 2012).

On November 13, 2017, revised national hypertension guidelines were issued by the American College of Cardiology and the American Heart Association, among others. The 2017 guideline is an update of the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7), published in 2003. The 2017 guideline is a comprehensive guideline incorporating new information from studies regarding blood pressure related risk of cardiovascular disease, ambulatory blood pressure monitoring, home blood pressure monitoring, blood pressure thresholds to initiate antihypertensive drug treatment, blood pressure goals of treatment, strategies to improve hypertension treatment and control, and various other important issues (see https://targetbp.org/guidelines17/). The Wisconsin Nurses Association (WNA) documents provided in this release are consistent with the new national guidelines.

Approach

Starting in 2014 and continuing to the present, WNA has worked with the Wisconsin Department of Health Service’s Division of Public Health, Chronic Disease Prevention Program (CDPP) under funding opportunity No. CDC-RFA-DP-1305 for chronic disease prevention from the CDC, U.S. Department of Health and Human Services. This statewide grant focuses on chronic disease prevention, with an emphasis on the prevention and control of hypertension, diabetes, and obesity. WNA’s efforts specifically focus on:

- Hypertension prevention, detection, treatment, and control.
- Improving systems of chronic disease prevention, including community linkages.
- Advancing a Wisconsin-centric model of patient-centered team-based care.
The three priority target populations were identified by the CDC and Wisconsin Division of Public Health’s CDPP:

- Patients with undiagnosed hypertension, those hiding in plain sight (40%);
- Patients whose hypertension is not controlled (54%); and
- Patients whose hypertension is controlled (46%).

**INTRODUCTION**

WNA is pleased to provide two foundational concepts for clinical and community settings to use to improve prevention, detection, and management of hypertension:

1) **Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model**
2) **Interprofessional Clinical Hypertension Expert Panel Recommendations**

These two concepts were designed to address hypertension, but can be applied to other conditions and even preventive initiatives.

The concepts also represent a *call to practical action* by health systems (herein known as parent organizations) and interprofessional patient health care teams, as well as state and local health departments, institutions of higher education, professional organizations/societies, and others. We strive for systemwide collaboration and partnerships between health systems and communities to accelerate improvements in the prevention, detection, and management of hypertension throughout Wisconsin.

**CONCEPTS**

**Concept 1: Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model (WNA, 2016)**

Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model builds upon the existing and emerging work of many partners in Wisconsin and the nation to foster health care transformation that advances patient-centered team-based care and to move toward value-based care, improved patient health and safety, and improved health of the population. WNA, in collaboration with a community of partners and reviewers, developed the model. The model relies on the dynamic interplay of an engaged patient, three core elements, three influencing factors, and durable linkages and connections to communities.

**Engaged Patient:**
- Empowered by the team and parent organization to be active, informed, and engaged
- The central focus of the model
- Aspires to achieve *care by me* and not just *care to me* (Okun et al., 2014)

**Core Elements:**
- The parent organization
- The interprofessional health care team
- A diverse workforce

**Influencing Factors:**
- Core principles and shared values
- Hallmarks of Wisconsin Practice
• Triple (quadruple) Aim of Health Care™

**Community Linkages and Connections:**

• Mutual investment in durable linkages and connections between health systems and communities is critical. Patients (caregivers, family, and support systems) live, grow, work, learn, and play in communities. Investing in durable connections by health systems contributes to healthy people in healthy communities.

The Interprofessional Clinical Hypertension Expert Panel Recommendations focus on two of the core elements: parent organizations and patient-centered health care teams.

**Concept 2: Interprofessional Clinical Hypertension Expert Panel Recommendations**

In September 2016 and again in May 2017, WNA convened a diverse clinical expert panel representing five distinct health care provider groups with extensive experience in providing frontline care (physicians, advanced practice registered nurses, pharmacists, physician assistants, and registered nurses). Their work was supported by key collaborating organizations, including Wisconsin Department of Health Services-Division of Public Health, Wisconsin Collaborative for Healthcare Quality, MetaStar Inc., Wisconsin Primary Health Care Association, University of Wisconsin-Madison School of Nursing, University of Wisconsin School of Medicine and Public Health, and the Wisconsin Academy of Family Physicians. Additional collaboration was sought from experts from the Medical College of Wisconsin / Milwaukee Veterans Administration Hospital and Marshfield Clinic (Attachment 1).

As experienced frontline clinicians, the panel possesses expert understanding of both health care systems and patient care. These clinicians work together as interprofessional teams that include certified medical assistants, licensed practical nurses, and other health care team members. The expert panel was charged to develop recommendations to improve systems of care for the prevention, detection, and management of hypertension, focusing on the three priority target populations described earlier.

The panel was unanimous in its belief that patient-centered teams cannot move toward value-based care and achieve quality metric payment without the leadership and dynamic engagement of parent organizations and interprofessional patient health care teams.

**RECOMMENDATIONS* [“Refer to the Recommendations section for the complete set of recommendations”]**

**Interprofessional Clinical Hypertension Expert Panel Recommendations - Highlights:**

• Establish a culture of patient-centered team-based care for hypertension prevention, detection, and control.

• Allow all team members to practice to their top of license or top of education for non-licensed team members.

• Establish a systemwide principle: All health providers are involved in the prevention, diagnosis, and treatment of hypertension.

• Improve information technology and the electronic health record dashboard to support efficiencies in care delivery and patient safety.

• Establish systemwide goals to manage hypertension using state and national quality metrics.
- Establish hypertension management teams to champion excellence in the prevention and control of hypertension for patients who are undiagnosed and patients who have uncontrolled hypertension.
- Improve communication within and among team members.
- Collaborate with the parent organization and information technology services to develop registries, dashboards, and other system improvements that work for teams.
- Acknowledge and disseminate team successes shown to improve efficiencies and effectiveness of operations and patient care.
- Provide leadership to create durable linkages between health systems and communities to improve hypertension outcomes that benefit the health of Wisconsin’s population through effective partnerships.

**CALL TO PRACTICAL ACTION**

The foundational concepts have been developed and are ready for practical action.

- **Adopt the Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model**
- **Utilize the Interprofessional Clinical Hypertension Expert Panel Recommendations**
- **Apply Concepts Beyond Hypertension to Other Chronic Conditions**

These recommendations have the potential to be applied beyond the condition of hypertension to diabetes and other chronic conditions. The electronic health record is the central tool to target population groups within health systems regardless of condition/disease. Team care management can then develop structured systems to improve management and subsequent outcomes of chronic medical conditions. Successful improvement in health system performance and population health outcomes calls for explicit collaboration and shared leadership between parent organizations and interprofessional health care teams. Systems-oriented shared leadership can move us beyond treatment and cure to creating health for patients, populations, and communities.

- **Develop and Sustain Durable Community Linkages**

The recommendations stress the importance of leadership from Wisconsin’s health systems to mutually develop and sustain durable linkages with communities and the community organizations that serve those communities. Patients simply do not live in clinics and hospitals; as such, it is critical that the resources of health systems and communities work together. Durable linkages can improve patient access to preventive and chronic care services; enhance health care delivery, public health, and community-based activities to promote healthy behaviors; engage patients to get help to change unhealthy behaviors; and support clinicians to get help for services they cannot provide themselves (Agency for Healthcare Research and Quality, 2016).
Next Steps
On November 9, 2017, WNA will begin statewide dissemination of these recommendations. Our intent is to stimulate dialogue, clarification, and improvement of the recommendations using patient-centered team-based care approaches. We believe this will accelerate implementation and improvement within Wisconsin health systems and our public health system to benefit the people of Wisconsin and the communities where we live, grow, work, learn, and play.

Acknowledgement and Recognition
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References


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