Extending TN-HHN Efforts with CDC Funding

The Tennessee Heart Health Network is extending its efforts with Centers for Disease Prevention and Control (CDC) support. CDC support will enable us to increase our focus on geographic areas in Tennessee with highest levels of hypertension and adverse social determinants of health that underly poor cardiovascular health.

We remain deeply committed to continuing to work with our 62 core participating practices. “We are going to do our best in our work going forward to support and provide educational content, Learning Collaboratives, and other tools and opportunities over the next several years to continue to support your efforts to improve care,” TN-TNN Principal Investigator Jim Bailey said in an October 4 Learning Collaborative. A recording of the presentation is available online. To summarize:

Ongoing Practice and Health System Support will include:

- Health Coaches and Community Health Worker (CHW) Training - Free training for two employees at each practice and half price for training of additional staff
- Pharmacist-Physician Collaboration - We will continue to assist practices in training and deploying more ambulatory pharmacists into primary care practices
- Online Learning Collaboratives - Learning Collaboratives will continue to be open to all current TN-HHN members and partner organizations and will feature subjects and speakers of interest to our members
- TN-POPnet Services - Many of our health systems and practices have just established their data feeds to the TN-POPnet. We will continue maintaining data feeds and rolling out the following interventions to interested member practices:
  - Quality improvement (QI) feedback reports
  - Motivational Heart Health Messages
  - Identification, outreach, and referral of high-risk patients for diabetes self-management education (DSME), diabetes prevention program (DPP), and hypertension treatment services
  - Remote patient monitoring (RPM) services in collaboration with Compwell

—Contact Annie Ninan, FNP, MBA (anninan@uthc.edu) for more information or to sign up for TN-POPnet services—

New CDC Support for Highest Need Tennessee Neighborhoods will include:

- Intensive Support for Highest Need Census Tracts - Special learning collaboratives and resources will support practices and patients in Tennessee’s 40 census tracts with highest prevalence of hypertension (adult hypertension prevalence of 53% or more)
Learning Collaboratives and Toolkits

Primary care practice support will focus on best practices for identifying and addressing social determinants of health (SDOH) — things like transportation and food insecurity that greatly impact cardiovascular outcomes — and how primary care can "close the loop" on social service needs.

- Geographic Information System (GIS) Tools to assist practices and patients in getting social services to address SDOH close to home
- Toward that end community health workers will play a larger role, with TN-TNN providing online training for CHW and Health Coaches
- Extending Care into the Community by increasing:
  - Community—clinical links to address social services and support needs
  - Use of CHWs and health coaches, and
  - Use of self-monitoring of blood pressure (SMBP) with clinical support

An Update on Heart Health Messages

TN-HHN leadership specifically confirms its commitment to supporting the ongoing rollout of Heart Health Messages (HHM) over the coming year. Implementation of HHM has been especially slow because of difficulties establishing data feeds and other technical issues.

"Delivering motivational heart health messages to your highest risk patients has proven much more difficult logistically than we thought it was going to be," said Jim Bailey, MD, Principal Investigator of the TN Heart Health Network. Even so, TN-HHN has pledged to deliver the HHM intervention to the practices that signed up for this intervention at or below cost, even if it is as late as the second half of 2024.

HHM works by sending personalized and tailored text messages to a participating clinic's highest risk patients. TN-HHN uses practice electronic health record data in the TN-POPnet to identify eligible patients, send them invitations to participate, provide the practice a list of patients who sign up, and send out the motivational messages. (All done securely. More details in the Toolkits section of the TN-HHN website.) "Tailored motivational text messages like these have been proven to move patients' behaviors around healthy eating, physical activity, and taking medications correctly," Dr. Bailey notes.

We have learned that invitations to patients alone are not enough to generate robust signups. We are now working with participating practices to advertise the HHM program and encourage patient enrollment through posters with QR codes, clinic letters to patients, flyers, and encouragement from clinic staff is needed as well. Currently, HHM is being rolled out at Christ Community Health Services and Regional One Health and other practices will soon follow.

View our library of Clinical Voice and Patient Voice video stories.

Don't Miss Out! Join Us for Our Free Online Learning Collaboratives

The TN Heart Health Network Learning Collaborative series has become one of TN-HHN's most popular offerings. Twice a month at noon, experts and colleagues from our participating practices and health systems give presentations on Teams. Attendees are encouraged to share their own experiences and ask questions.

If you are not already receiving regular reminders of upcoming Learning Collaboratives, please contact Jennifer Ride at jride@qsource.org or 901-275-3863. Presentations for the current month and the upcoming month are also listed in this monthly newsletter. Some of our favorite Learning Collaboratives are available on the TN-HHN Network Webinars page.

Please let us know if you have a topic you would like to see addressed in a future Learning Collaborative.
### October

10/18/2023  Lessons Learned from Voices of the Patient  
Susan Butterworth and Gladys Hunt  
Members of the Tennessee Heart Health Patient and Family Advisory Councils (PFAC) will provide patient-centric insights into how improvements can be made in the delivery of heart health care.

10/26/2023  Strategic Coaching: Guiding Participants through Disease Management/Prevention & Wellness Programs  
Pat Stout and Joanne Collins  
Joanne Collins, a certified health and wellness coach, strategically coaches clients and guides participants through disease management/prevention and wellness programs. She will speak about the provider experience.

### November

11/09/2023  Mental Health First Aid  
Susan Butterworth and Kathy Lovett  
Learn how to identify early signs and symptoms of mental health issues for both employees and patients. Plus, tips will be provided on how to begin a conversation and provide referrals/resources to assist these individuals.

11/15/2023  Managing your Diabetic Patients During the Holidays  
In this session you will hear creative ways practices assist their patients in managing chronic diseases during the holiday season. Please come willing to share any tips you have found successful in your practices.

Note: Learning Collaboratives email invitations will come from Alicia Collins at Qsource.
The Tennessee Heart Health Network is the signature initiative of the Tennessee Population Health Consortium.

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