Community Led Approaches to Strengthening Heart Health in Brown County, Wisconsin

Learn how partners are engaging communities affected by cardiovascular disease to improve heart health and create lasting transformational change.

In 2020, cardiovascular disease (CVD) was the leading cause of death in Wisconsin. More than 12,000 Wisconsinites died, resulting in a profound impact on their families. Stroke was the fifth leading cause of death, claiming more than 1,900 lives.[1,2] Disparities in CVD deaths continue, with approximately six out of 10 fatalities occurring among male Wisconsin residents. About one in 10 of these CVD deaths were residents who identify as Black.[2] These trends have persisted since 2013.

To reduce the impacts of CVD, the Wisconsin Department of Health Services (DHS) Chronic Disease Prevention Program (CDPP) received The National Cardiovascular Health Program (23-0004) funding. This five-year cooperative agreement from the CDC (Centers for Disease Control and Prevention) began in 2023. The program goal is to prevent and manage CVD by improving blood pressure and cholesterol control rates, especially for those experiencing poor health outcomes.

Success Story Contributors

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Work under this cooperative agreement focuses on:

- Tracking and monitoring clinical, social services, and support needs measures that are demonstrated to improve health and wellness, health care quality, while identifying patients at the highest risk of CVD with a focus on hypertension and high cholesterol.
- Improving patient outcomes by implementing team-based care to prevent and reduce CVD risk with a focus on hypertension and high cholesterol prevention, detection, control, and management by reducing barriers to care.
- Linking community resources and clinical services that support bidirectional referrals, self-management, and lifestyle change to address factors that may put certain individuals at increased risk of cardiovascular disease with a focus on hypertension and high cholesterol.

In reviewing data for high blood pressure, high cholesterol, and socioeconomic status, five statewide groups were identified:

- Adults 24 to 54 years old
- Adult males
- People who identify as Black
- Medicaid recipients
- People with social determinants of health (SDoH) barriers

Barriers include limited access to primary care, higher poverty rates, and higher unemployment rates.

CDPP also investigated priority populations by county and census tract using the CDC Social Vulnerability Index (SVI) and Population Level Analysis and Community Estimates (PLACES) data. Through this analysis, Brown County was identified as one of 12 priority counties.

Trusted community partners

The cooperative agreement requires the establishment or participation in a cross-sectoral learning collaborative consisting of at least 51% members of the priority population. During the application process, DHS identified potential partners in high-need counties well-positioned for this community-clinical work. Wello, a community-based organization in Brown County, was selected to co-lead. Wello strives "to co-create community conditions that drive high levels of health and well-being for all." They believe co-creation encourages better momentum, support, and purpose.

"Heart disease is the silent threat in our community, but awareness and action are the keys to breaking the cycle. Taking care of your heart is taking care of your legacy."

- Charles Caston, community partner navigator of We All Rise: African American Resource Center

Through their long-standing community-centered efforts, Wello involved people in the community to understand why CVD disparities persist despite availability of evidence-based prevention and mitigation strategies. They identified three organizations with long-standing relationships and a history of working on relevant projects to assist leading local efforts while representing and serving the identified populations.

The leadership team includes:

- Casa ALBA Melanie, a Hispanic and Latinx resource center.
- COMSA, an immigrant and refugee resource center.
- We All Rise African American Resource Center.

These organizations have a rich history of working together developing and delivering programs ranging from healthy, organic food

access, vaccine promotion, and technical assistance on grant evaluation.

The significant community connections and trust built by each serves as a solid foundation for the project. They emphasize a comprehensive approach to fostering community conditions that promote high levels of well-being. By addressing both upstream factors and clinical components, they implement sustainable and holistic strategies to drive this work forward.

Addressing mistrust to create change

Building or rebuilding trust, a key element to transformational change, takes time. Due to historical and ongoing trauma, community-based partners lacked trust with institutions–especially health care. Wello's executive director, Natalie Bomstad, stated this project came during, "a window of opportunity to do something transformational." The COVID-19 pandemic exposed systemic challenges members of our communities face. The city of Green Bay within Brown County officially recognized these challenges as a public health crisis. As a result, this presented an opportunity to convene a group of diverse partners to mobilize to increase health care and resource access to improve health outcomes.

Partners began by thoroughly exploring the issues to ensure that no steps are overlooked during this five-year initiative. During the first year, partners undertook significant efforts to strengthen relationships, formed a common understanding of what heart health means, and worked to identify the breakdown between evidence-based practices and persisting health disparities.

The leadership team undertook a literature review and fishbone diagram exercise. This was to ensure a commitment of fairness was at the core of their work. The exercises also confirmed alignment with their organizational missions. This grounding meant returning to the beginning to understand the structural and systemic issues that created and reinforce poor health outcomes. The literature review[CH1] helped participants better understand the scope of heart disease within their communities, past interventions, and provide information that could help educate staff, patients, and clients of each organization. It also emphasized the need for more tailored approaches that acknowledge the systemic issues contributing to poor health outcomes. For instance, studies like those from Williams & Mohammed (2013) have shown that experiencing bias acts as a chronic stressor, exacerbating cardiovascular risks. Co-leads have expressed interest in doing more in-depth, culturally specific reviews with the collaborative members to continue efforts for all to better understand and care for their clients and patients.

This project came during "a window of opportunity to do something transformational."

The community leads shared that their communities were impacted by multiple adverse heart events and related deaths since the project's beginning. These events surfaced common barriers their communities faced to achieving optimal heart health, especially access to care. Casa ALBA Melanie, COMSA, and We All Rise completed a quality improvement process using fishbone diagrams to establish the root causes of the issues their communities face when accessing healthcare and preventing CVD.

Common themes relating to the social determinants of health were identified as:

- Mistrust.[CH1]
- Lack of community member representation.
- Need for increased awareness and sensitivity to patients in the health care setting.
- Cost of care.
- Inadequate health education.
- Language barriers.

Co-leads and collaborative members are passionate about CVD prevention, which can be accomplished by addressing these issues, while understanding each community faces distinct challenges that may require customized approaches. Charles Caston, community partner navigator of We All Rise: African American Resource Center noted, "Our ancestors overcame countless challenges—let's honor them by prioritizing our health. A healthy heart means a stronger future for our families and communities."

Expanding community-specific care

Following the initial work to understand and address root causes, the local leadership team has identified several future opportunities to implement to improve heart health in their communities. Casa ALBA Melanie intends to expand their health risk assessments outside of Green Bay, reaching more of Brown County. The assessments measure height, weight, body mass index, blood pressure, cholesterol panel, blood sugar, and vision while providing education and counseling in Spanish on all these topics. Patients are linked with primary care providers for follow-up. To expand these assessments, Casa ALBA Melanie plans to partner with other agencies such as NEW Community Clinic, a federally qualified health center, and Brown County United Way, who are able to deliver services and resources to the communities in need, helping to reduce transportation barriers.

COMSA also plans to partner with NEW Community Clinic by having their mobile health unit go to places of worship to provide screening and care in safe spaces. COMSA is also organizing two events for the community. The first provides attendees training to use automated external defibrillators (AED) and cardiopulmonary resuscitation (CPR). The other focuses on educating individuals on mental health

and wellness and social connectedness. Both events provide education on how to be heart healthy with a connection to important resources.

A CHWs' inherent connections to their communities, local resources, and health care systems within the area provide an opportunity for a multisolving approach.

We All Rise identified hosting peer support groups with a health education series focused on heart health. They invited facilitators of color, like Dr. Raul Mendoza-Ayala, to speak to the community about heart health. They also conducted health screenings and referrals to NEW Community Clinic, while ensuring people were aware of the safety net and social needs services that We All Rise provides as opportunities to help prevent CVD for their clients. As Caston observes, "Hypertension and stress are battles many of us face daily, but through education, support, and lifestyle changes, we can rewrite the story of Black health."

The engagement and integration of community health workers (CHW) into the learning collaborative and care teams plays a significant role in program success. Because they serve as a conduit for patient-centered care and education, CHWs help to bridge the community-clinical gap and help to address barriers for communities accessing healthcare. A CHWs' inherent connections to their communities, local resources, and health care systems within the area provide an opportunity for a multisolving approach.

Each resource center employs or works with CHWs. In light of their unique roles, the team discussed hosting regular meetings for the CHWs participating in this project to directly interact with one another. Due to variations in CHW employment structures, there are differing scopes of work and unique limitations associated. Wello's director of strategic partnerships, Beth Heller, believes that these meetings will foster a space where CHWs can communicate authentically and "…de-centralize power and decision making and prioritization for those roles."

In addition to working with the community-based workforce, Prevea Health has been a highly engaged clinical partner. Prevea's quality team excelled in helping partners understand the data. They demonstrated the differences between data sets, what data may be used from electronic health records, and how to effectively use the information obtained. Analysis of the SDoH data, in combination with clinical data, will serve as a useful tool to benchmarking success of this project and provide guidance for quality improvement. Prevea Health also pledged to engage a champion provider and care team focused on improving the health of the priority population through team-based care interventions.

Community partnerships

Engaging multi-sector partners is imperative for driving transformational change. The organizations and the individuals contribute their unique perspectives to project objectives, making networking and building connections crucial to the success of this collaborative. Considering the importance of community voice, leaders continue to engage trusted collaborators to contribute to the efforts of improving cardiovascular health in Brown County. The effort is very intentional,

involving people to work on different strategies enabling project progress in conjunction with benefits to them and their organization. Collaborative in-person meetings help foster teamwork and build new fruitful connections. The efforts connect community-based organizations, insurers, pharmacies, federally qualified health centers, hospitals, and more. Connecting different sectors provides greater access to resources and services that may have been previously unavailable. It also highlights and strengthens the interconnectedness of each organization's work and respective projects.

Partners expressed enjoyment working within this multi-sector learning collaborative structure. They believe it is an innovative way to create impact with these funds across the state. They observe that it's made them view health and well-being in a different way. Partners appreciate CDPP's help whether fostering connections, offering resources, or helping with new evaluation and reporting structures.

Needs-based initiatives

By focusing on enhancing heart health, the group has broken this concern into manageable components based on need. The collaborative adopted strategies to ensure that all efforts to achieve the overarching grant objectives are aligned with the needs of the priority population. By addressing community need such as distrust in systems, creating an understanding of the importance of this work, and specific challenges each organization and their patients and or clients face, we are ultimately moving toward the goal of improving heart health.

Successes

We All Rise described successes of this project to date as "Awareness:getting people comfortable in safe spaces to talk about heart health; accessibility: increased ability to get screenings with no insurance needed; community connections: bridging community resource gaps and establishing safe spaces to improve the confidence of individuals navigating the health system."

The project also successfully established positive working relationships within the collaborative, specifically between the CDPP team and Brown County Leadership Team. Beth Heller shared, "This is so important because groups in our community have been approached to participate in institutionally-centered initiatives rather than community objectives. This may seem like semantics, but by starting from the very beginning, taking time to frame and acknowledge the problem from the community perspective and centering community leadership in how we are addressing the issue of heart disease we have created important groundwork because people

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Success was further demonstrated by attendance and response to both the initial October 2023 leadership team meeting and a June 2024 whole-collaborative meeting. Individuals saw a safe space to authentically engage and contribute to this work. This work has also provided further opportunity to strengthen relationships between the community and Prevea Health as well as center community leadership while working with Prevea on collecting, analyzing, and acting upon SDoH data. The collaborative looks forward to continuing to expand and create new partnerships in years two through five of this initiative.

Partners observe that this project has made them view health and well-being in a different way.

This project operates alongside other initiatives, both those funded by the CDC and those that are not. Wello's systems approach means they weave funds from federal, state, and local sources, also known as braiding, to maximize impact. For example, money from the Advancing a Healthier Wisconsin Endowment grant funds the CHW position working on this effort at We All Rise. The Juneteenth event focused on heart health in the Black community organized by We All Rise was funded in part by a CDC RISE grant.

Wello is also supporting the implementation of new referral tracking systems into the practice management software used by the leadership team. This enhancement supports better tracking the range of referral types. This multisolving approach advances health equity in a multitude of spaces, while improving overall wellbeing.

While data collected to date has been qualitative, Wello's current Community Health and Well-Being survey data helped partners understand how the populations being served view their well-being.

This information provides insights about potential program improvements. In the coming years quantitative data or metrics will be gathered more rigorously through the development of tools designed to track referrals and measure impact effectively.

Challenges

Staff capacity remains a main challenge for all the partners. Delegation of tasks across a strong team has been key to navigating capacity concerns. The leadership team structure also supports success. Wello serves as the backbone organization supporting administrative and planning components. This enables We All Rise, Casa ALBA Melanie, and COMSA to focus on direct service to priority populations. CDPP provides resources to build capacity for all agencies to complete this work.

Sustainability

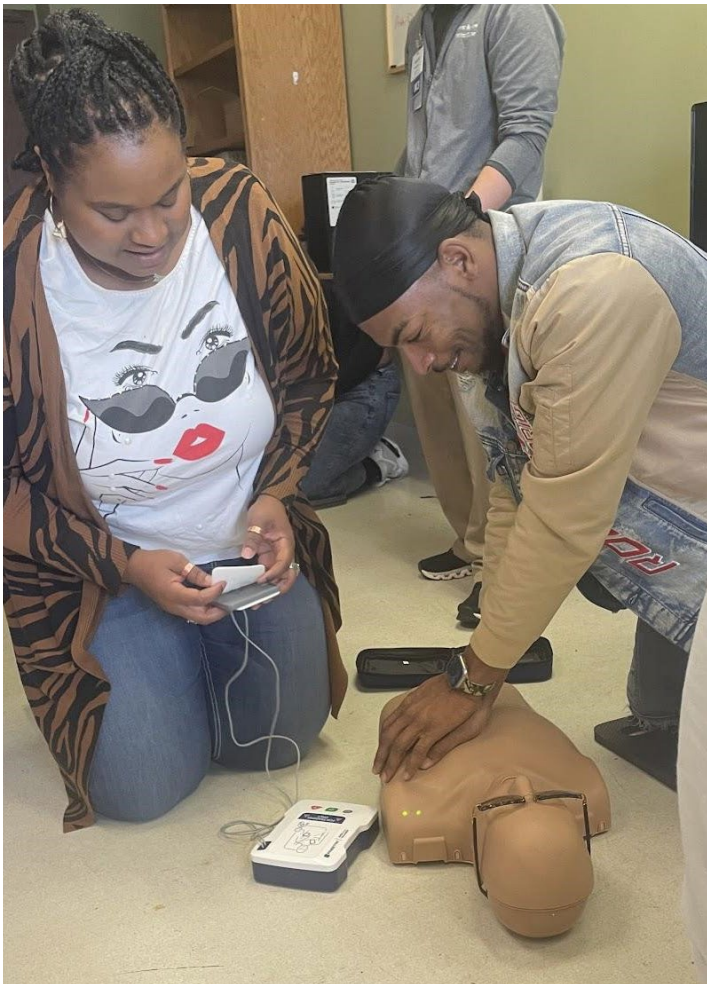
The first year of this project established a foundation of trust centered in community leadership. The remaining four years of this project will provide time and space to foster transformational change.

For other collaboratives looking to replicate the success of the Brown County Heart Health Collaborative, members recommend:

- Following a step-by-step approach for the analysis of the issues at hand.

- Centering community voice.
- Taking time to establish trust.
- Building connections with a wide range of collaborators.
- Remaining open-minded (not assuming there is only one right way to do things).

Continuing to embrace these shared values over the next four years will be crucial for the continued success of the Brown County Heart Health Learning Collaborative. The collaborative overall hopes to see improved blood pressure and cholesterol control as well as fewer deaths due to heart disease complications, especially within communities significantly impacted. Additionally, they hope to see people of color more regularly accessing preventative care as damaged relationships are reconciled.



These goals may be accomplished by improving the connection between community and clinic, where initiatives are developed based on community need considering both upstream and downstream factors. Acknowledging community-clinical linkages will not always be the answer, various innovative community-based initiatives will also be implemented to achieve the collaborative's goals. "It takes a village," and the Brown County Heart Health Collaborative has formed one of their own committed to improving the health of their community.

Citations

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3. Williams, D. R., & Mohammed, S. A. (2013). Racism and Health I: Pathways and Scientific Evidence. The American behavioral scientist, 57(8), 10.1177/0002764213487340. https://doi.org/10.1177/0002764213487340