

virtual Roundtable

NACDD Fireside Chat and Virtual Roundtables Issue Brief

Team-based Approach to Controlling Hypertension



NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.



The National Association of Chronic Disease Directors (NACDD), in coordination with the Center for Disease Control's Division for Heart Disease and Stroke Prevention and Million Hearts®, is hosting a series of Fireside Chats in 2016. Fireside Chats provide a new, interactive format for state health departments to hear from content experts on a number of issues pertaining to cardiovascular health and 1305 priority areas. Through this series of Fireside Chats and follow up virtual roundtables, staff from state health departments will develop knowledge of identifying patients with undiagnosed hypertension, team-based approaches to controlling hypertension, supporting clinical decisions through this team-based approach, and new payment models that support components of team-based care.

On June 28, 2016, NACDD hosted the second Fireside Chat focused on team-based approaches to controlling hypertension. This event was a dynamic discussion among three distinguished speakers: Dr. Janet Wright, Executive Director, Million Hearts®;

Dr. Mehul Dalal, Chronic Disease Director, Connecticut Department of Public Health; and Dr. Bruce Gould, Medical Director of the Connecticut Community Health Centers Association Practice Transformation Network. The [recording](http://www.chronicdisease.org/default.asp?page=CVHWebinars) is available on NACDD's website at <http://www.chronicdisease.org/default.asp?page=CVHWebinars>. A [description of the event](#) and speaker bios are also available on NACDD's website.





Objectives from the Fireside Chat

Increase knowledge of state health department (SHD) staff on evidence-based team-based approaches to controlling hypertension (HTN), the SHD role in promoting team-based care to healthcare partners, and steps that a health system can use to integrate team-based care into clinical decision support systems in order to improve quality of care and enhance health outcomes.

Highlights from the Fireside Chat

Dr. Mehul Dalal

- Team-based care is one part of a larger healthcare transformation agenda
- Healthcare transformation is a crowded space and a dynamic process, there is a premium on adaptability
- Aligning federal/state/commercial demands on healthcare system is key
- Unlocking full potential of team-based care necessitates payer alignment (public/private and state/federal)
- Fee-for-service business model does not easily incent team-based care:
 - Billing provider is a revenue source, everyone else on the team is a cost
- Emerging business model under value-based payments
 - Greater emphasis on achieving outcomes, how does team-based care fit?
- Challenges:
 - Lack of consistent terms to refer to community health workers (navigators, coaches, outreach etc.)
 - Pharmacists typically do not have access to patient medical records – limiting primary care provider/ pharmacist link and full potential for medication therapy management (MTM)
- State health department role:
 - “Proof of concept” initiatives – demonstrate how team-based models work and that they can be effective
 - Identify and elevate appropriate expertise (community health workers and pharmacists)
 - Engage decision-makers in sustainability discussions or participate in existing forums
 - Discuss team-based care in context of population health improvement and health equity

For more information about Connecticut’s partnership with the University of Connecticut School of Pharmacy on a medication therapy management pilot as part of the Community Pharmacy Initiative: <http://newscribemedia.net/apps/NACDD/WWCDPC/display.php?id=524>

Highlights from the Fireside Chat

Dr. Bruce Gould

- Recommendations for team-based care
 - Define the Team: facility-based vs. community-based vs. global
- Challenges:
 - Different teams, speaking different languages
 - No way to communicate: dysfunctional electronic medical records (EMRs) are inaccessible to community
- Solutions:
 - Understand function, issues, and incentives in clinical care delivery
 - Identify handoffs, develop mechanisms for two-way communication, focus is always on the patient
 - EHR, Portals, texting, artificial intelligence and decision support in handhelds and EHRs
 - Safety Net without Walls: 2-1-1 as resource inventory with geo-mapping, gaps analysis, patient referral, monitoring and tracking system

Examples: Million Hearts, Pharmacist Medical Therapy Management



Virtual Roundtables

Subsequent to this Fireside Chat, NACDD, with support from and in coordination with the Association of State and Territorial Health Officials (ASTHO), held follow-up virtual roundtables. During these roundtables, state health departments could ask questions about what was presented during the fireside chat and share their experience in supporting team-based care (TBC). Participants discussed the role of state health departments in providing technical assistance to healthcare partners on the role of team-based care; how they leveraged I305 and Million Hearts to develop partnerships; the role of community health workers to support self-management programs and engage hard-to-reach populations; how they are leveraging other statewide initiatives such as the [State Innovation Model \(SIM\)](#) initiative to support policy change for team-based care; and successes and challenges in identifying patients who will benefit from a team-based approach.

Alaska Depends on Community Health Aides Given Remote Geography

The Alaska Division of Public Health (DPH) has developed a learning community on hypertension control with the AK Primary Care Association (APCA), which represents 212 community health centers. Funding through I305 has helped the DPH elevate their relationship with the APCA. They are currently working with six pilot sites and are adding six more sites this year. Alaska has recently started a state-run community health worker certification program and operates a Community Health Aide Program, which provides grants for third-parties to train community health aides as Community Health Practitioners.

For more information about CHW training and certification standards, visit

<http://www.astho.org/public-policy/public-health-law/scope-of-practice/chw-certification-standards/>

Iowa Develops Pharmacist-Provider Teams

The Iowa Department of Public Health contracted with the University of Iowa, College of Pharmacy to recruit and train pharmacist/medical provider teams. Dr. Bill Doucette and his team have developed resource materials, facilitated team meetings and trainings, and monitor the work of the teams. As part of their contract, each team attends a one-hour, face-to-face training with Dr. Doucette focused on steps and principles on working together, as well as develops a plan for their collaborative work. The project focuses on practices with external pharmacies and is supported through I305. They have trained about 35-40 teams over the years and continue to work with about five new practices each year. Dr. Doucette also developed a positive deviant study on lessons learned from this project, looking at the characteristics of a successful team, examining factors such as team members retiring or compatibility issues and looking at whether they have established collaborative practice agreements.

To receive a copy of the curriculum developed by the University of Iowa and any additional special reports, please contact Terry Meek, Iowa Department of Public Health, terry.meek@idph.iowa.gov.

NACDD's What's Working Database: <http://www.newscribemedial.net/apps/NACDD/WWCDPC/admin/dompdf/SuccessStories.php?id=463>

ASTHO Case Study:

<http://www.astho.org/Programs/Prevention/Chronic-Disease/Million-Hearts/Case-Study-IA/>

Final Report to the Iowa Department of Public Health:

<http://www.astho.org/Programs/Prevention/Chronic-Disease/Million-Hearts/Iowa/Final-Report/>



Nebraska Enhances Health Information Technology and Team-Based Care for Improved

The Nebraska Chronic Disease Prevention and Control Program has assisted over 50 clinics statewide through a menu of services that support the improvement of health information technology, team-based care, self-measured blood pressure monitoring (SMBP), and increasing the detection of undiagnosed hypertension. Educational opportunities include online forums, webinars, sharing of tools and resources, and an ongoing series of peer-to-peer learning collaboratives. These collaborative learning sessions are designed to showcase practices who have conducted a quality improvement project or have implemented new policies, protocols, data collection/reporting methods, and other improvements so other clinics can learn about the successes and avoidable pitfalls. Complete and comprehensive documentation helps clinics move toward improved coding and billing and can assist them in utilizing additional fee for service codes, such as the Chronic Care Management (CCM) Services code for Medicare beneficiaries. The CCM code covers non-face-to-face care coordination services for Medicare beneficiaries with multiple chronic conditions by a physician or other qualified health care professional such as a pharmacist, nurse midwife, clinical nurse specialist, nurse practitioner, or physician assistant.

CCM Fact Sheet:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

Nevada Uses Community Health Workers to Support Self Management

The Nevada Division of Public and Behavioral Health's Heart Disease and Stroke Prevention Program worked with a Federally Qualified Health Center to pilot a self-management blood pressure program. Additional funds from I305 were sub-granted to facilitate hiring one full-time CHW to participate in the pilot. The CHW met with patients to review how to use a blood pressure cuff appropriately, provide informational material regarding the importance of maintaining blood pressure control, and reviewed daily blood pressure recording logs. Nevada is currently expanding this program to additional sites and has received cuffs donated by the American Heart Association. They are discussing coverage with the Nevada SIM team and have also talked with the Health Plan of Nevada about adding it as a worksite wellness initiative and covering it for state employees.

For more information:

<http://nevadawellness.org/wp-content/uploads/2016/02/SMBP-success-story.pdf>

Utah Supports Several Pilots Related to SMBP Tied with Clinical Support, Pharmacists and CHWs

In 2015 the Utah Department of Health started a second round of their pilot project to address hypertension. They awarded a subcontract to the Midtown Community Health Center to implement a HTN treatment protocol including a blood pressure self monitoring program. Midtown worked on a variety of areas, including home blood pressure monitors that were compatible with their patient portal; integrating a referral system and tracking outcomes into their electronic health record; and formally adopting the Million Hearts HTN Treatment Protocol. Utah is also looking at expanding the role of pharmacists and CHWs with a focus on reimbursement. Utah has had conversations with Medicaid and individual Medicaid ACOs about coverage for team-based care. They have a subcommittee looking at the return on investment (ROI) for CHWs addressing hypertension and diabetes. This community-linkage team includes partners from the Academy of Family Physicians and Medicaid, and they plan to share this information with the legislature.

They are also looking at the role of pharmacists and have worked with Moose Pharmacy in North Carolina to establish a community pharmacy enhanced services network. If you are interested in working with North Carolina to develop a Community Pharmacy Enhanced Services Network (they have CMMI funds to support states), contact ashley@moosepharmacy.com



Vermont's Care Coordinators Support Services at Home Program

In July 2011, the Support and Services at Home (SASH) program was launched to connect Vermont residents with community-based services and promotes coordination of health care. Local SASH coordinators use panel management activities to increase use of team-based care to manage and increase control of HTN. CHWs meet with SASH participants in their home and at housing community centers to monitor blood pressure, connect them to medical homes and educate them about blood pressure management. It is anticipated that these activities will be expanded and take place in additional locations in year four of I305.

Slides for SASH coordinators on HTN measurement: <http://www.astho.org/Programs/Prevention/Chronic-Disease/Million-Hearts/Million-Hearts-Tools-for-Change/SASH-Training-Slides-for-Self-Management-of-Hypertension-and-Pre-Hypertension-%28Vermont%29--slide-deck/>

ASTHO Case Study: <http://www.astho.org/Programs/Prevention/Healthy-Aging/SASH-Issue-Brief>

Evaluation of SASH: <https://aspe.hhs.gov/basic-report/support-and-services-home-sash-evaluation-second-annual-report>

Wisconsin Develops a Toolkit for Pharmacists on Medication Therapy Management and Works with Several Partners to Support Statewide

Since 2012, the Wisconsin Department of Health Services, Division of Public Health, Chronic Disease Prevention Program (CDPP) partnered with the Wisconsin Pharmacy Quality Collaborative (WPQC)/Pharmacy Society of Wisconsin (PSW). Through a CMS grant the WPQC/ PSW worked with the Wisconsin Medicaid program and five health plans to implement and provide Level I and Level II Medication Therapy Management (MTM) services. As a part of this work, the WPQC/PSW developed many materials including a Medication Adherence toolkit, adherence materials, Hypertension and Hyperlipidemia toolkit, on-demand training modules addressing self-management for blood pressure and accuracy in blood pressure measurement, and MTM training curriculum. To date, WPQC/PSW has certified 725 pharmacists, 167 pharmacy technicians, and 171 pharmacy students on clinical best practices for implementation of Level I and Level II MTM services.

The CDPP continues to work with the WPQC/PSW to identify health plan partners and their pharmacies to participate in the initiative. Based on lessons learned, the CDPP and WPQC/PSW will continue to identify opportunities to spread learning to the ~3,000 pharmacists statewide to promote the value of MTM services, including comprehensive medication reviews, and are collaborating with community pharmacists on self-management of blood pressure and medication adherence.

PSW Materials: www.pswi.org

NACDD What's Working Database: <http://www.newscribemedial.net/apps/NACDD/WWCDPC/display.php?id=287>

Million Hearts Wisconsin Blood Pressure Improvement CHALLENGE:
<https://www.dhs.wisconsin.gov/heart-disease/million-hearts.htm> or www.WIBPIC.org

Healthy Hearts in the Heartland and MetaStar:
<http://www.healthyheartsintheheartland.org/>

Wisconsin Collaborative for Healthcare Quality (WCHQ) offers three improvement toolkits presenting evidence-based strategies and resources: Blood sugar (A1c) control for patients with diabetes, Blood pressure control for patients with hypertension, and Screening for colorectal cancer at:
www.hipxchange.org



Washington, Colorado Pass Legislation that Supports Reimbursement for Pharmacists

On May 11, 2015, Washington became the first state in the country to require that pharmacists are included in health insurance provider networks. The Department of Health is working with their pharmacy association to discuss implementation, as the bill goes into effect on Jan. 1, 2017.

<http://www.pharmacytimes.com/news/big-win-for-pharmacist-provider-status-in-washington-state#sthash.lD2hVihK.dpuf>

<http://lawfilesexternal.wa.gov/biennium/2015-16/Pdf/Bill%20Reports/House/5557-S.E%20HBR%20HCW%2015.pdf>

Colorado passed a bill in June 2016 on statewide protocols for pharmacists. This will allow pharmacists across the state to be reimbursed for healthcare services otherwise provided by a physician or advanced practice nurse; calls on insurance plans to include pharmacists in their network of providers; and expands collaborative practice agreements.

<http://copharm.org/2016/06/colorado-law-expands-opportunities-pharmacists/>
[http://www.leg.state.co.us/clics/clics2016a/csl.nsf/fsbillcont2/BD2B352DBD8BBD8787257F24006436C2/\\$FILE/135_enr.pdf](http://www.leg.state.co.us/clics/clics2016a/csl.nsf/fsbillcont2/BD2B352DBD8BBD8787257F24006436C2/$FILE/135_enr.pdf)

Additional Resources

Additional information can be found at <http://www.nacdd1305.org/healthsystems/>

The Task Force on Community Preventive Services released recommendations for team-based care (TBC) for improving blood pressure control on the basis of strong evidence of effectiveness. <http://www.thecommunityguide.org/cvd/teambasedcare.html>

A Program Guide for Public Health - Partnering with Pharmacists in the Prevention and Control of Chronic Diseases provides definitions, in depth description of the role of pharmacists, pharmacist scope of practice policies and strategies for partnering with local pharmacists in your state. The guide also provides examples of evidence-based programs such as the Asheville Project and the Diabetes 10-City Challenge. http://www.cdc.gov/dhdsp/programs/spha/docs/pharmacist_guide.pdf.

CDC's Team Up. Pressure Down is a nationwide program in partnership with the Million Hearts® initiative, to lower blood pressure and prevent hypertension through pharmacist-patient engagement. http://millionhearts.hhs.gov/docs/tupd/tupd_materials_overview.pdf

If you require this document in an alternative format, such as large print or a colored background, please contact Miriam Patanian at patanian@chronicdisease.org or 678.373.1487.

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