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SOUTH DAKOTA HEALTHCARE

SUCCESS STORY

Hypertension Management Program Implemented at Medicine Shoppe

Challenge

Cardiovascular disease is the number one cause of death in South Dakota, a chronic illness usually associated with elevated or uncontrolled blood pressure (hypertension). Healthcare systems are continually searching for new and innovative ways to treat their patients in a manner most beneficial and effective for them. This often times requires looking to healthcare providers and team members based in the community, who are typically more accessible to the patient.

Solution

The Community Pharmacy Enhanced Services Network of South Dakota (CPESN SD) partnered with the Heart Disease and Stroke Prevention Program (HDSPP) to offer an eight-month community-based hypertension management program through six community-based pharmacies.

Results

CPESN SD's stores (community-based pharmacies) have been quick to implement this program. Community-based pharmacists are often looking for ways to play a larger role in the healthcare team and this provides an excellent opportunity to ensure consistent education, awareness and follow-up related to hypertension and healthy lifestyle choices.

Timeline

HDSPP first partnered with CPESN SD in July 2019. At that time, CPESN SD developed and implemented a new protocol to identify patients with uncontrolled hypertension and developed a new non-physician enhanced team-based hypertension management program for the pharmacy setting. Participating pharmacies received education on the program objectives and requirements and participant recruitment and enrollment began in November/ December 2019. The program closed patient enrollment at the end of February 2020 to allow for alignment with the project period.

Key Components

Each participant enrolled in the HDSPP/CPESN SD hypertension management program received one-on-one education and lifestyle counseling, including an ongoing series of services designed to teach and counsel participants on how to make healthy lifestyle choices, such as exercise, diet, and tobacco cessation. An automated blood pressure cuff was supplied so participants could regularly check their blood pressure at home as part of the program. Upon enrollment, each participant worked with their hypertension management coach to establish a baseline blood pressure, develop a care plan and course of treatment, establish blood pressure goals, receive blood pressure goal counseling and lifestyle and behavioral modification recommendations, and reconcile all medications. Participants also received a written summary of the initial education session. In addition to their initial education session, participants received training on home blood pressure readings and ways to document, weekly care calls from a pharmacy care team member with pharmacist intervention if required, monthly meetings to discuss medication compliance, treatment progress, and update goals, and electronic documentation and health record exchange with the appropriate healthcare team members. Each participant completes eight months of hypertension management services as part of this program.

Evidence-Based Interventions

HDSPP partnered with the CPESN SD to implement two evidence-based interventions: Support engagement of non-physician team members in hypertension management and Facilitate use of self-measured blood pressure monitoring with clinical support among adults with hypertension.

Successes

A patient presented to the Medicine Shoppe for an initial consult to determine eligibility for the pharmacy's newly launched Hypertension Management Program (HMP). Multiple in-store readings showed her blood pressure at 168/104, well above a safe or healthy blood pressure range. Based on conversation with the patient, the pharmacist determined she has uncontrolled hypertension. She was enrolled in the HMP. Over the next 90 minutes, the pharmacist counseled her on the risks of uncontrolled hypertension (including stroke), proper blood pressure goals, management, and lifestyle modifications. The pharmacist encouraged the patient to contact her physician or urgent care clinic immediately based on her elevated blood pressure. That afternoon, she was seen by a physician who, in clinic, quickly gave her a blood pressure lowering agent for her safety. The physician also prescribed an additional regularly scheduled blood pressure reducing agent for maintenance therapy. Several days later, during the weekly care call (part of the HMP) the patient voiced how she was so grateful for the advice and for the opportunity to be involved in the HMP.

A patient presented to the Medicine Shoppe with a prescription for a brand new blood pressure medication and a new hypertension diagnosis. During counseling, the pharmacist asked if the patient received any counseling from their physician. The patient said "no" other than to go to the pharmacy and pick up his prescription. The pharmacist asked about any follow-up appointment for his condition, he said "I guess my yearly exam". The patient was enrolled in the Medicine Shoppe's HMP with an initial blood pressure of 152/90. The patient received 90 minutes of one-on-one pharmacist counseling about his newly diagnosed condition (hypertension), risks, lifestyle management, and proper blood pressure monitoring technique. The patient also received a brand new blood pressure monitor to take home. Over the next 6 weeks the pharmacy care team called the patient weekly, for hypertension monitoring, adherence check ins, and blood pressure readings. At the 6-week point, the patient's average blood pressure was 145/85, still above goal. The pharmacist contacted the participant's physician with his blood pressure readings. Three days after the pharmacist intervention, the physician met with the patient for an appointment. The physician felt his blood pressure was still above goal so the physician opted to increase the dosage for his blood pressure medication. The pharmacy called the patient for their weekly call and the patient mentioned the physician's wishes, but the pharmacy had not received an updated script and the patient did not have his new dose of medication. The pharmacist contacted the physician for the updated script. The pharmacy obtained the script, filled it, and linked it with the patient's medication synchronization. The pharmacist followed up with the patient over the next six weeks and the patient's blood pressure stabilized at goal. The pharmacy continued following up with the patient over the next several months to ensure the blood pressure remained at goal. This patient was sent home from the clinic with a new diagnosis for a condition that affects every organ system in the body and a prescription to treat it. The patient received virtually no counseling on his condition, no information about his medication or how to monitor his blood pressure, and no plan for follow-up. The community pharmacy intervention and partnership with DOH allowed the community pharmacy to be directly involved with the patient. This program has no doubt made a major impact for this patient and will continue to for others.

One of the participants at the Medicine Shoppe in Rapid City is an 85-year-old woman who enrolled three months ago with dangerously high blood pressure. Through the monitoring program and the pharmacy's contact with her physician, she has reached her blood pressure goal. On 03/27/2020, the patient was supposed to have a routine follow up appointment for monitoring her blood pressure but because she was doing so well through her enrollment in the Medicine Shoppe's program, her provider's nurse told her she would be able to extend the amount of time between her routine blood pressure monitoring visits. Due to her success in the pharmacy-led program, this individual was able to avoid a clinic visit, which could have potentially exposed her to COVID-19, Medicare dollars were saved as this appointment was avoided, and her provider was able to have additional time to focus on other facility and patient needs during this time of healthcare crisis.

Next Steps/Other Info.

CPESN SD will receive funding again in fiscal year 2021 as part of the HDSPP 1815 Year 3 cooperative agreement with Centers for Disease Control and Prevention. During Year 3, CPESN SD will enroll an additional 60 participants in their hypertension management program and will develop and implement a provider referral system to assist with participant recruitment.

> *"As readily accessible medication therapy experts, community pharmacy care teams are in the unique position to provide medications in addition to serving a critical role in the health care team by providing patient training, lifestyle recommendations, and monitoring for hypertension and other disease states."*
>
> **– Josh Ohrtman**
> *Medicine Shoppe*

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