Good&HEALTHY
SOUTH DAKOTA HEALTHCARE

# SUCCESS STORY

## *Hypertension Management Program Implemented at Shane's Pharmacy*

## 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 pharmacy in February 2020 to pick up a new blood pressure medication. She had heard about the blood pressure program from a family member and was interested in participating. Two weeks into follow-up on the hypertension program the patient developed peripheral edema from her blood pressure medication. The pharmacist contacted her provider and the medication was switched to clonidine. The pharmacist followed up with the patient weekly and her dose was adjusted to reach her goal blood pressure of <130/80 mmHg. During weekly follow up calls, the pharmacist encouraged the patient to implement lifestyle changes such as the DASH diet and exercise. The patient slowing began exercising and increased her activity level as tolerated. About one month later, her blood pressure readings were low and she began experiencing some light-headedness periodically. The pharmacist educated the patient to reduce her clonidine dosage and report back with her blood pressure readings in a week. Her blood pressure readings improved with the reduced dose.

In May 2020, the patient expressed concerns that she may still have some edema present. The pharmacist contacted her provider to assess any lab abnormalities suggesting fluid overload at her last visit. Her lab information was unremarkable so the pharmacist discussed with her provider that it might be best to change her medication to Chlorthalidone to eliminate any potential side effects from clonidine. The new prescription was obtained and the pharmacist continued to follow up weekly with the patient. Her blood pressure readings were soon within goal on the new medication and the patient's swelling of feet improved.

## 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.

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