Million Hearts Learning Collaborative
State Snapshot

Project Reach

Current Reach: Community Outreach: 28,950 adults living in three zip code target area.

Potential Reach: 566,000 adults in CT who have been told they have hypertension.

CONNECTICUT

State Health Agency: State of Connecticut Department of Public Health
State Health Official: Raul Pino, MD, MPH

Led by the State of Connecticut Department of Public Health, state and local partners tested approaches in Bridgeport and Stratford neighborhoods to reach at-risk individuals with uncontrolled high blood pressure and connect them to clinical and self-management support. The University of Connecticut, School of Pharmacy (UConn) coordinated the partnerships among Housatonic Community College, Optimus Health Care, a Bridgeport-based Federally Qualified Health Center (FQHC) and Bridgeport Pharmacy to identify people in the community with uncontrolled high blood pressure and engage them in care. UConn also developed collaborative practice agreement protocols to be used between pharmacists and physicians in team-based hypertension treatment management. CHW student interns from Housatonic Community College were trained by Optimus in blood pressure measurement and referral protocols to engage in community outreach activities and meet members of the community "where they were". Optimus Health Care accepted clinical referrals directly from the CHWs in the field. In addition, the Optimus clinical pharmacist identified and, in collaboration with an Optimus CHW, worked to engage clinic patients with uncontrolled hypertension to participate in comprehensive medication therapy management (MTM) through collaborative practice agreements with Optimus providers. The pharmacist at Bridgeport Pharmacy which serves the same community as Optimus also provided MTM to at-risk clients identified through claims data analysis. University of Connecticut Pharmacy students worked with the pharmacist to identify patients and initiate MTM. He also entered into a collaborative practice agreement with providers at Optimus, establishing a unique community pharmacist-FQHC provider relationship. Connecticut's work also involved collaboration with Bridgeport Hospital and St. Vincent's Medical Center to integrate and coordinate care efforts through the Cardiovascular-Diabetes Task Force community Know Your Numbers screening activities. Another aspect of this year's effort was a return on investment (ROI) analysis conducted by Optimus on the value of the CHW outreach and referral activities. It is anticipated that this will help inform decisions regarding the sustainability of the CHW role.

Aim Statement

By August 31, 2017, the Bridgeport-Stratford community-clinical collaboration will establish effective, expandable protocols across clinical settings, community resources including CHW student interns, community pharmacy and pharmacy students and public health systems to identify at-risk individuals within the community with uncontrolled high blood pressure or hypertension and engage them in clinical and/or self-management support to achieve blood pressure control and promoting health equity in Connecticut.

Burden of Hypertension

Approximately 31.3 percent of adults in Connecticut have ever been told by a doctor, nurse, or other health professional that they have high blood pressure, compared to the national rate of 31.4 percent. Cardiovascular disease is the leading cause of death in Connecticut, killing more than 18,000 residents in 2013. African American adults in Connecticut have significantly higher rates of high blood pressure (37.7%) than white (26.8%) and Hispanic adults (30.5%). African Americans in Connecticut also experience significantly higher death rates from heart disease and stroke than the Connecticut population overall (BRFSS 2013).

Target Populations

Partners targeted individuals at risk of adverse hypertension outcomes, with a focus on improving health equity. While outreach efforts focused on Black and African American residents of Bridgeport and Stratford, any interested members of the community who presented for blood pressure screening or were identified via clinical records with uncontrolled high blood pressure were served. Both of the selected communities have large racial and ethnic minority populations, and poverty rates (18.8%) that are higher than the state average (10.2%) (American Community Survey, 2009-2013).

Key Partners

State

- State of Connecticut Department of Public Health
- University of Connecticut, School of Pharmacy

Local/Regional

- City of Bridgeport Department of Health & Social Services
- Town of Stratford Department of Health
- Community Health Center Association of Connecticut

Community/Clinical

- Optimus Health
- Bridgeport Pharmacy
- Bridgeport Hospital
- St. Vincent's Medical Center
- Bridgeport Primary Care Action Group/ Cardiovascular-Diabetes Task Force

Evidence-base/Best-Practices Used

- Community health workers
- Medication therapy management

Key Project Successes

Community Clinical Linkages:

CHW student interns from Housatonic Community College in Bridgeport offered BP screenings at local venues (grocery stores, barber shops, food pantries, churches) meeting the community members "where they are". The interns were trained in referral protocols and had access to the appointment scheduler at Optimus Health Care to make immediate referrals as needed. Pharmacy students from the University of Connecticut worked with the MTM-certified pharmacist at Bridgeport Pharmacy to identify clients through claims data analysis who may have medication adherence concerns. These students conducted outreach and initial screening.

Success Story: The positive health impact of team-based clinical care through community-clinical linkage is illustrated in the recent story of one Optimus Health patient. This 38 year old woman had a history of hypertension, and was screened with a diastolic pressure of 125 mmHg. After evaluation in the ED, she returned to the clinic for follow up care. The patient expressed misunderstanding her medication and treatment regimen. The Optimus CHW used the clinic's standardized screening for patients' social determinants of health and identified a number of issues that the patient was struggling with and that interfered with her ability to adhere to treatment. Through the interventions of the CHW, the patient has been helped to address her multiple concerns and is back on track with managing her hypertension. She will also be engaging with the clinical pharmacist for additional MTM supports to improve her blood pressure.

Health System Interventions:

Medication Therapy Management: Collaborative Practice Agreements between the Optimus physicians and the Optimus consulting pharmacist and the Bridgeport Pharmacy were established. These agreements allowed the pharmacists to provide medication therapy management using established hypertension protocol to patients identified with uncontrolled hypertension through clinic EHRs or pharmacy client records. The collaborative practice agreement established between the FQHC and the community-based pharmacist was unique and provided evidence to support expanding this model to improve access to care.

Optimus Health Care conducted a return on investment (ROI) study on the value of CHW outreach which produced a 2:1 return. Discussions with Optimus administration are anticipated to identify plans for using the data for outreach decisions and for sharing with other health centers.

Success Story: In Year One of the ASTHO Million Hearts Learning Collaborative, the Optimus clinical pharmacist and an Optimus physician at one site utilized their collaborative practice to develop improved hypertension care interventions. Since this innovation, the percent of patients whose hypertension is controlled (BP under 140/90 - NQF 0018) has improved from 62% to 69%, and 7 point improvement in one year.

Project Scalability and Spread

Potential scalability and spread include maintaining and enhancing the relationship with Housatonic Community College CHW program for ongoing participation of CHW student interns for community based hypertension outreach. In addition, continued support of the referral access for the interns to Optimus Health and to Bridgeport Pharmacy would further support this approach in Bridgeport. To expand into other communities, this collaborative model could be developed among community health centers, local pharmacies with MTM certified pharmacists and local community college with a CHW training program.

Another avenue for scalability and spread is to explore supporting the MTM component of the ASTHO efforts by replicating the model being successfully implemented through the CT WISEWOMAN project whereby pharmacists are providing MTM services to uninsured women with hypertension. Expanding partnership with the WISEWOMAN efforts could enhance CT's efforts to improve patients' treatment adherence and their clinical outcomes.
Connecticut DPH leadership anticipates using lessons and materials gained from the ASTHO experience as a foundation for scalability and spread in statewide hypertension control:

- Refine the CHW outreach and referral protocols to become ready-to-use tool kits to add a degree of consistency in community-based hypertension initiatives in high risk communities.

- Encourage local health departments and other health organizations to use the tool kits within their own communities to identify people with hypertension, connect them to clinical and self-management supports including comprehensive MTM.

- In the context of ongoing health reform initiatives such as the State Innovation Model, promote comprehensive MTM and collaborative practice agreements between physicians and community pharmacists as an evidence based approach to improve access to care and enhance patients' self-management of hypertension.

- Continue to explore how MTM can be a reimbursable service.