Million Hearts State Learning Collaborative
State Snapshot

TEXAS

State Health Agency: Texas Department of State Health Services
State Health Official: John Hellerstedt, MD

Led by the Texas Department of State Health Services (DSHS), state and local partners worked with three local health departments (LHDs) in North and East Texas to implement health systems strategies and foster community-clinical linkages to improve blood pressure control. The LHDs engaged community health workers (CHWs) to promote linkages between health systems and community resources for adults with hypertension. Additionally, LHDs engaged payers and non-physician team members to connect clinical and community resources. LHDs exchanged health information through utilizing bi-directional referral systems between community and clinical services. Local and state health information partners served as resources to the LHDs implementing these activities. LHDs supported blood pressure self-management by measuring and reporting patients' blood pressure readings at home with the support of CHWs and clinical staff. Lending libraries were established in an effort to encourage self-monitoring of blood pressure. Standardized referral processes between community resources and health systems were also developed and implemented during this project. Other project partners such as the Texas Pharmacy Association explored using data systems, including pharmacy data and hospital discharge data, to assist in efforts to improve blood pressure control.

Current Reach: *In 3 LHDs, a total of 260 patients with hypertension were identified as diagnosed and uncontrolled through screening. Of these patients, 110 were referred to services.*

Potential Reach: *In addition to continuing work with the 3 LHDs with a total population of 400,000, Texas plans to expand the project to three neighboring counties to potentially reach another 363,528 people.*

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TRANSFORMING SYSTEMS SAVING LIVES

AIM STATEMENT

By June 30, 2017, the Texas team will work with stakeholders to:

- Increase hypertension control in diagnosed populations.
- Reduce undiagnosed hypertension among high-risk targeted populations.
- Design a system that effectively connects and integrates public health, healthcare providers, hospitals, and state and community partners.

BURDEN OF HYPERTENSION

Nearly one out of three Texans have hypertension. The prevalence of hypertension is not evenly distributed throughout the state or the population; African-Americans have the highest rate of hypertension (41.2%), while 23.8% of Hispanics and 32.3% of White residents have hypertension. Public Health Regions (PHRs) 2, 4, and 5 have among the highest hypertension rates in the state (35.1%, 32.4% and 36.8%, respectively) (Texas Behavioral Risk Factor Surveillance System (BRFSS), 2015).

TARGET POPULATIONS

Partners targeted residents of PHRs 2, 4, and 5, which have higher hypertension prevalence rates and higher mortality rates from heart disease and stroke than the rest of the state. These PHRs are located in North and East Texas, an area which faces limited healthcare access, minimal health resources, and limited culturally appropriate strategies to support diverse communities, particularly Hispanic and African American residents. The total population for Jasper, Newton, Smith, and Wichita counties is approximately 400,000.

KEY PARTNERS

State

- Texas Department of State Health Services
- United Healthcare Community Plan of Texas
- Superior Health Plan
- Texas Pharmacy Association
- TMF Health Quality Institute

Local/Regional

- Jasper-Newton County Public Health District
- North East Texas Public Health District (NET Health)
- Wichita Falls-Wichita County Public Health District
- University of Texas Health Science Center at Tyler
- North Texas Regional Extension Center
- American Heart Association, Southwest Affiliate

Community/Clinical

- Texas Area Health Education Center East

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EVIDENCE-BASE/BEST PRACTICES USED

- Self-measured blood pressure monitoring
- Utilizing team-based care in hypertension control
- Utilizing health information technology to support clinical decision tools for hypertension control
- Diabetes self-management education
- Diabetes Prevention Program
- Dietary Approaches to Stop Hypertension (DASH) Diet

KEY PROJECT SUCCESSES

In the targeted areas, a total of 260 patients were identified through screening as diagnosed and uncontrolled. Of those patients, a total of 110 were referred to services. Some notable project successes include the development of a bi-directional referral system between Northeast Texas Public Health District and University of Texas Health Science Center (UTHSC) at Tyler-Tyler Clinic as well as the development of linkages between local health departments (LHDs) and United Healthcare (UHC). UHC worked to share member demographic information with community partners in order to connect them with community resources for achieving blood pressure control. In addition to these activities, LHDs have implemented self-measured blood pressure monitoring projects tied to clinical support, established lending libraries, and have adopted policies and procedures for project implementation. New partnerships have been established with the Texas Pharmacy Association and local pharmacies in North and East Texas using a cloud-based system which allows doctors to refer patients with uncontrolled high blood pressure to a community-based pharmacist network.

Other project successes include: collaboration with local emergency rooms; establishment of a 340B pharmacy in a local hospital; creation of a referral system between the emergency room and LHD; and utilization of the DSHS Community Diabetes Education Programs to identify clients that are at-risk for high blood pressure or hypertension.

PROJECT SCALABILITY AND SPREAD

- Continue to provide support to the three funded LHDs/communities to implement activities and enhance community-clinical linkages.
- Leverage existing state-level partners to expand reach and enhance infrastructure.

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- Develop a self-measured blood pressure monitoring model for replication and sustainability at both the community and regional levels.
- Expand hypertension project and implementation of a lending library to a large health system in Northeast Texas. The site will be required to present their success to other health systems statewide to showcase the project.
- Implement blood pressure monitor lending libraries at local libraries, food banks, housing projects and faith-based groups with existing sites.
- Integrate blood pressure management education and navigation services into existing classes, such as diabetes self-management and Diabetes Prevention Programs provided by CHWs.
- Continue implementation of the bi-directional referral system.
- Support the engagement of pharmacists as health care extenders used for hypertension control statewide.

Texas identified three other counties to work with in the future. These counties are Gregg County, Potter County and Randall County. If these communities are engaged, the project could potentially reach an additional 363,528 people.

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