

Team-Based Care to Improve Blood Pressure Control: Implementation Resource Webpage

AREB 2022 Coffee Break Presentation

Ami Bhatt, MPH

Nicole Therrien, PharmD, MPH

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Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease and Stroke Prevention



MODERATOR

Hello and welcome to today's Coffee Break presented by the Applied Research and Evaluation Branch in the Division for Heart Disease and Stroke Prevention at the Centers for Disease Control and Prevention. My name is Allison White, and I am a ORISE Fellow and I will be acting as today's moderator. Our presenters are Ami Bhatt, a contracted health scientist, and Dr. Nicole Therrien, a pharmacist. We all work with the Applied Research and Evaluation Branch on the Applied Research and Translation team.

Before we begin...

- All phones have been placed in SILENT mode.
- Any issues or questions?
 - Use Q & A box on your screen
 - Email AREBheartinfo@cdc.gov



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MODERATOR

Before we begin, there are some housekeeping items. If you are having issues with audio or seeing the presentation, please message us using the chat box or send us an email at AREBheartinfo@cdc.gov. Please hold your questions until we reach the end of the presentation. Since this is a training series on applied research and evaluation, we hope you will complete the poll at the end of the presentation and provide us with your feedback.

Disclaimer

The information presented here is for training purposes and reflects the views of the presenters. It does not necessarily represent the official position of the Centers for Disease Control and Prevention.

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MODERATOR

As a disclaimer, the information presented here is for training purposes and reflects the views of the presenters. It does not necessarily represent the official position of the Centers for Disease Control and Prevention. So, without further delay. Let's get started. Ami and Nicole, the floor is yours.

Background
The Community Preventive Services Task Force Findings
Implementation Webpage
Core Interventions & Strategies to Support Team Based Care
Implementation Tools & Resources

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Thank you, Allison. In today's presentation, we will start with some background to get on the same page before we dive into the updated findings from the Community Preventive Services Task Force for Team Based Care to improve blood pressure control; then we will introduce an implementation webpage to support the task force findings; we will highlight core strategies to support team-based care and finish by sharing select implementation resources and tools.



BACKGROUND

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Let's start by highlighting background information about high blood pressure and team-based care.

The Surgeon General's Call to Action to Control Hypertension

Key Messages

- Hypertension control is possible.
- Hypertension is common; control is not; together we can change that.
- Progress has stalled and disparities persist.
- We know what works to control hypertension; we must tailor, replicate and scale those interventions.

*"Intervention is needed now because progress on reducing cardiovascular disease deaths... has stalled.... Fortunately, changes in health care systems, such as protocol-driven and **team-based care**, have been shown to improve hypertension control across many different populations groups."*

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Many of you may already have some awareness of the Surgeon General's Call to Action to Control Hypertension, released in October 2020. The Call to Action summarizes data on hypertension control for all populations, identifies the top 10 strategies for achieving control, and provides recommendations for improving control.

As you know, hypertension, also called high blood pressure, is very common. Unfortunately, hypertension *control* is not. Although significant gains have been achieved, our nation's progress in hypertension control has stalled.

- Nearly 1 in 2 adults in the US have hypertension, yet only about 1 in 4 have it under control to < 130/80 mm Hg, which equates to over 82 million US adults with uncontrolled hypertension.
- If left uncontrolled, then hypertension can increase a person's risk **of** heart disease, stroke, heart failure, kidney disease, pregnancy complications, and cognitive decline later in life.

We know that there are certain groups that are affected more than others by hypertension. It is important that we acknowledge these differences and work to

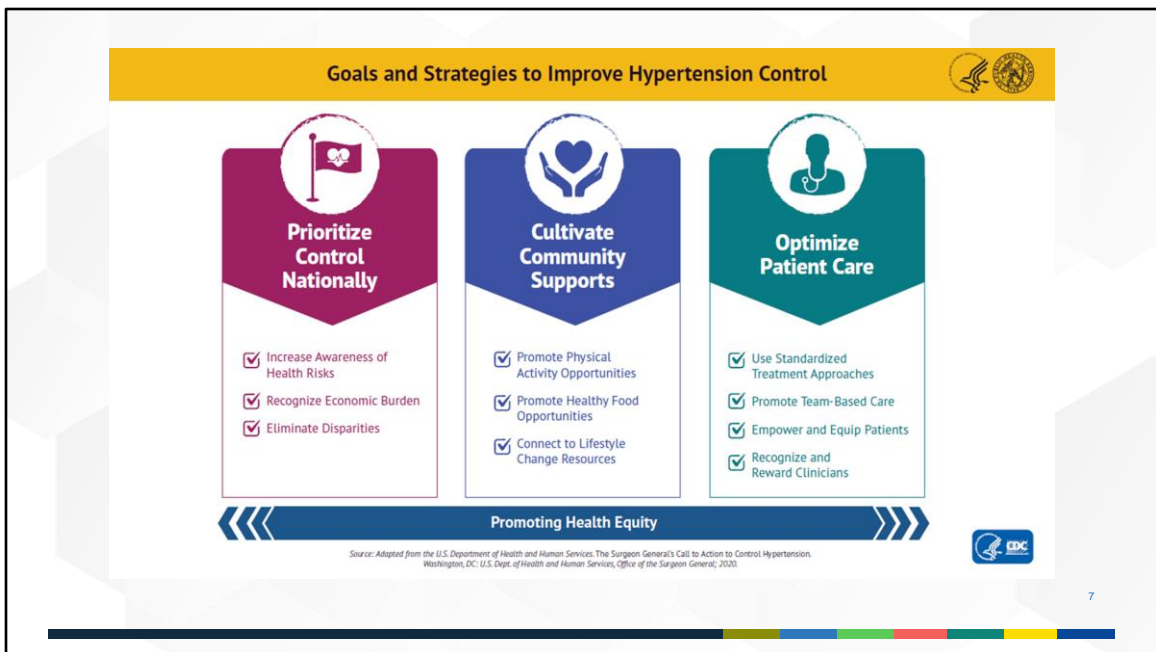
address the factors that impact hypertension risk and hypertension control among these groups.

- Black or African American **adults** have a higher hypertension prevalence than any other race or ethnic groups.
- They also develop hypertension at younger ages and have more severe outcomes than white adults.

The Surgeon General's *Call to Action* identifies some of the factors that negatively affect hypertension control in people who are at increased risk, including inequalities in the distribution of social, economic, and environmental conditions needed for health, as well as racial discrimination, racism, and external stressors that have been shown to increase the risk of hypertension.

Despite these challenges, hypertension control is still possible. We know what works to control hypertension, and we need to tailor, replicate, and take these strategies to scale.

Link: [The Surgeon General's Call to Action to Control Hypertension \(cdc.gov\)](https://www.cdc.gov/nchs/data/press/releases/2017/s071017_hypertension.htm)



At the core of the Call to Action there are 3 goals and 10 associated strategies to accelerate progress meeting these goals.

These include:

- 1). Goal 1: Ensuring that hypertension control is a national priority; (or Prioritize Control Nationally)
- 2). Goal 2: Ensuring that the places where people live, learn, work, and play support hypertension control; (or Cultivate Community Supports)
- 3). Goal 3: Optimizing patient care for hypertension control.

One of the four strategies outlined to support this goal is promoting the use of health care teams to manage hypertension, which is our topic today.

Hypertension control is influenced by multiple factors, yet improvements in hypertension control can support broad health improvements – including the promotion of health equity.

What is team-based care?

- Team-based care (TBC) is a strategy implemented at the health system level. It aims to enhance patient care by having health professionals work collaboratively with the patient and their primary care provider.
- Health professionals in TBC can include:
 - Nurses
 - Pharmacists
 - Community health workers
 - Many others

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Many of you may be familiar with team-based care, or TBC. For those who are less familiar, TBC is a strategy implemented at the health system level to enhance patient care by having health professionals work collaboratively with the patient and their primary care provider.

The team includes the patient and the patient's primary care provider, both of whom work in coordination with other health professionals, who may include nurses, pharmacists, community health workers, physician assistants, dietitians, medical assistants, pharmacy technicians, occupational therapists, social workers, community paramedics, consulting clinicians, and other health professionals.



COMMUNITY PREVENTIVE SERVICES TASK FORCE (CPSTF) FINDINGS

As we move to discuss the recently updated findings from the Community Preventive Services Task Force, referred to as the CPSTF, I will start with a quick overview of the CPSTF.

[Heart Disease & Stroke Prevention: Team-Based Care | The Community Guide](#)

CPSTF and The Community Guide

- “The CPSTF is an independent, nonfederal panel of public health and prevention experts whose members represent a broad range of research, practice, and policy expertise in community preventive services, public health, health promotion, and disease prevention.”
- The Community Guide is a collection of evidence-based findings of the CPSTF based on systematic reviews of effectiveness and economic evidence.



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The CPSTF is an independent, nonfederal panel of public health and prevention experts whose members represent a broad range of research, practice, and policy expertise in community preventive services, public health, health promotion, and disease prevention. The CPSTF provides evidence-based findings and recommendations about community preventive services, programs, and other interventions aimed at improving population health.

The Guide to Community Preventive Services, also referred to as The Community Guide, is a collection of evidence-based findings of the CPSTF based on systematic reviews of effectiveness and economic evidence. It is a resource to help select interventions to improve health and prevent disease in states, communities, community organizations, businesses, healthcare organizations, or schools.

CPSTF Findings: TBC Improves Blood Pressure Control and is Cost-Effective

- The CPSTF recommends team-based care to improve blood pressure control.
- Update to 2012 CPSTF recommendation on this topic.
- “A systematic review of evidence from 54 studies shows team-based care **increases the proportion of patients with controlled blood pressure** and reduces systolic (SBP) and diastolic (DBP) blood pressure.”
- “A separate review of economic evidence from 27 studies indicates **team-based care is also cost-effective.**”



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In December of 2021, the CPSTF released an updated recommendation for TBC to improve blood pressure control, based on strong evidence of effectiveness in improving the proportion of patients with controlled blood pressure and in reducing systolic (SBP) and diastolic blood pressure (DBP).

Findings provide strong evidence of effectiveness for TBC organized primarily with nurses and pharmacists working in collaboration with primary care providers, patients, and other professionals.

Evidence also demonstrates meaningful improvements in blood pressure control for Black or African American and Hispanic or Latino patients. When implemented by health care providers serving racial and ethnic minority patients, interventions are likely to advance health equity.








IMPLEMENTATION WEBPAGE

Team members on the Applied Research and Translation team within the Division for Heart Disease and Stroke Prevention collaborated with the folks in the Community Guide Office and the CPSTF to **create an implementation to support this updated CPSTF finding.**

This implementation webpage is the third in a series that support CPSTF findings on topics related to heart disease and stroke prevention. Each implementation webpage is available on DHDSP's website and provides helpful links to The Community Guide's website and the CPSTF findings, as well as additional resources that may support those working to implement the findings.

TBC Implementation Resources Webpage

-  Developed via collaboration between ART team, Community Guide Office, and CPSTF.
-  Incorporates recommendations from WHO, AMA, and the Surgeon General.
-  Highlights and organizes the strategies that support TBC interventions.
-  Uses the “Identify-Assess-Act” Framework to highlight implementation resources.
-  Works with partners to design and format the webpage.

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The link to the implementation webpage for TBC to improve blood pressure control will be shared in the chat box at the conclusion of the presentation. This webpage highlights resources, actionable steps, and implementation guidance for the adoption of TBC to improve hypertension control and improve cardiovascular health.

This resource webpage provides state and local health department leaders with information, tools, and resources to integrate this strategy into programs in their communities. The purpose of the implementation resource webpage is to inform audiences about the key factors and considerations involved when implementing this intervention into health systems.

I will now hand off the presentation to my colleague, Ami, to discuss key information featured on the webpage.



CORE INTERVENTIONS & STRATEGIES

Let's start to explore the interventions and strategies highlighted in the review findings and implementation webpage.

Interventions



Facilitate **communication and coordination** of care support among team members.



Enhance the use of **evidence-based guidelines** by team members.



Establish **regular, structured follow-up** mechanisms to monitor patients' progress and schedule additional visits as needed.



Actively **engage patients** in their own care.

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The CPSTF findings describe four interventions that were commonly incorporated into TBC programs to facilitate successful implementation.

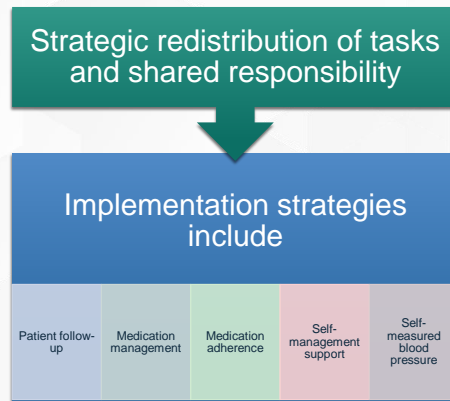
TBC programs can:

- Facilitate communication and coordination of care support among team members.
 - This can allow patients engaged in TBC to receive consistent messaging across team members. Team members can support improved patient care and distribute team member workload, which may work to mitigate clinician burnout.
- Enhance the use of evidence-based guidelines by team members.
 - **Guideline-directed treatment can improve management of high BP, and applying standardized, evidence-based treatment protocols supports consistency in care across**

diverse patient groups.

- Establish regular, structured follow-up mechanisms to monitor patients' progress and schedule additional visits as needed.
 - Structured and timely follow-up improves adherence to hypertension self-management plans for patients, increases frequency of patient contact, and thereby may help overcome clinical inertia which refers to a lack of intensification of treatment, including medication or lifestyle modification recommendations, in patients whose blood pressure is considered uncontrolled.
- Actively engage patients in their own care.
 - Individuals that are empowered and equipped to engage in their own hypertension care are more likely to know their BP numbers, take medications as prescribed, and engage in healthy lifestyle changes.

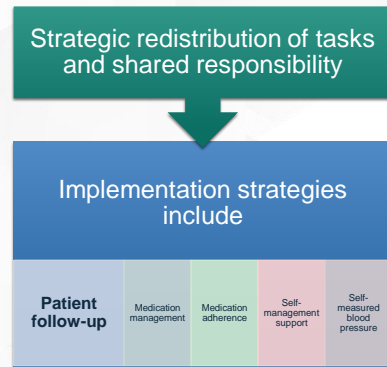
Team-Based Care: Strategies



When implementing TBC, team members strategically redistribute and share responsibilities to support the care plan developed by the patient and their primary care provider. Strategies used when implementing TBC to improve blood pressure control include the following: Patient Follow Up, Medication Management, Medication Adherence, Self Management Support, and Self-Measured Blood Pressure (SMBP).

TBC Strategies: Patient Follow Up

- Team members support patients after their visits with their PCP.
- This could include:
 - Use of a patient self-management plan.
 - Leveraging technology to communicate with patients and to improve adherence to their self-management plans.
 - Confirm appointments and treatment plans.



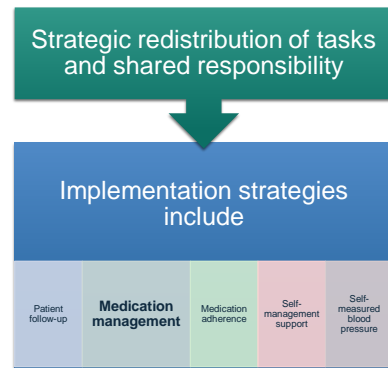
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Patient Follow-Up

Team members can support patients after their visits with their primary care provider (PCP). This could include designing or facilitating use of a patient self-management plan, using technology to regularly communicate with patients and to improve adherence to their self-management plans, and regularly confirming appointments and treatment plans.

TBC Strategies: Medication Management

- To achieve BP control, adjusting the doses of medications may be necessary. Team members can support this by:
 - Making recommendations to the PCP or independently managing medications.
 - Pharmacists may engage in medication management by using:
 - Pharmacists' Patient Care Process.
 - Collaborative Practice Agreements to implement collaborative drug therapy management (CDTM).



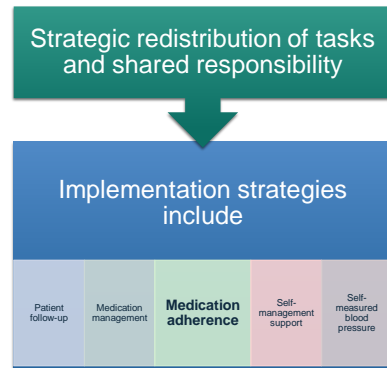
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Medication Management

Achieving blood pressure control often requires adjusting the doses of medications to find the right fit for the patient. Qualified team members may support this process by making recommendations to the PCP or independently managing medications. Pharmacists may engage in medication management by using the Pharmacists' Patient Care Process and Collaborative Practice Agreements to implement collaborative drug therapy management (CDTM)

TBC Strategies: Medication Adherence

- Team members can support patients to improve adherence to medications or to their self-management plans by:
 - Identifying barriers.
 - Using education and coaching to address barriers.
 - Leveraging recommendations such as CPSTF tailored pharmacy-based interventions to improve medication adherence.



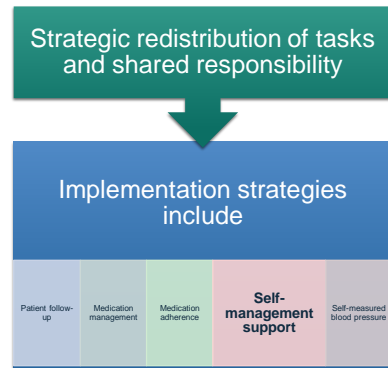
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Medication Adherence Support

Patients may face barriers to taking their medications as prescribed or following their self-management plan. Team members can help patients improve adherence to medications by identifying and working to address these barriers with education and coaching. CPSTF recommends tailored pharmacy-based interventions to improve medication adherence.

TBC Strategies: Self-management support

- Team members can support and empower patients to take an active role in their BP management by:
 - Recommending lifestyle changes, including adopting a healthy diet, increasing physical exercise, maintaining a healthy weight, and not smoking.
- Use strategies like:
 - Health behavior counseling.
 - Coaching.
 - Education.



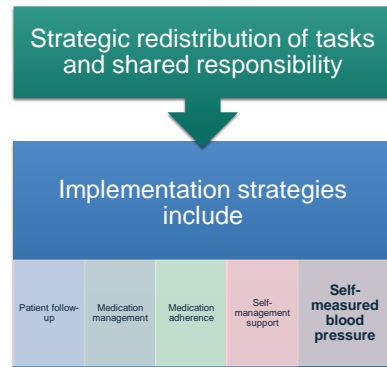
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Self-Management Support

Lifestyle changes, including adopting a healthy diet, increasing physical exercise, maintaining a healthy weight, and not smoking, can be difficult to achieve and maintain. Team members can support and empower the patient to take an active role in their high blood pressure control. Strategies include health behavior counseling, coaching, and education.

TBC Strategies: Self-Measured Blood Pressure (SMBP)

- CPSTF recommends SMBP interventions and SMBP interventions when combined with additional support to improve BP control.
- Team members can use these resources to:
 - Recommend regular use of at-home personal BP monitoring devices to assess and record blood pressure.
 - Work collaboratively with other team members and the patient to educate, train, and support patients' regular use of SMBP devices.



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Self-Measured Blood Pressure (SMBP)

Patients may benefit from regular use of personal blood pressure monitoring devices to assess and record blood pressure, typically at home. CPSTF recommends SMBP interventions and SMBP interventions when combined with additional support to improve blood pressure control outcomes. Team members can collaborate to educate, train, and support patients' regular use of SMBP devices.



IMPLEMENTATION TOOLS & RESOURCES

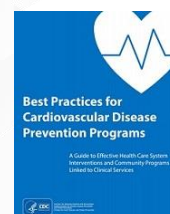
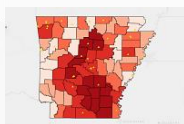
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Now, I'll go over some of the implementation tools and resources shared on the webpage.

Implementation Resources and Tools

Identify	Identify patient populations or communities that face a disproportionate rate of hypertension.
Assess	Assess facilitators and barriers to implementing TBC interventions.
Act	Act to implement TBC interventions with strategies that complement the CPSTF recommendation.



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State and local health departments and public health practitioners play an important role in promoting and supporting evidence-based strategies for this health system–level intervention.

With the Identify-Assess-Act framework, state and local health departments can use specific tools and resources to accomplish their respective implementation goals and address challenges that arise along the way. The following list includes implementation resources and tools to use during each stage of the framework. For more information, please use the links included on the

webpage.

Identify patient populations/communities disproportionately affected by hypertension.

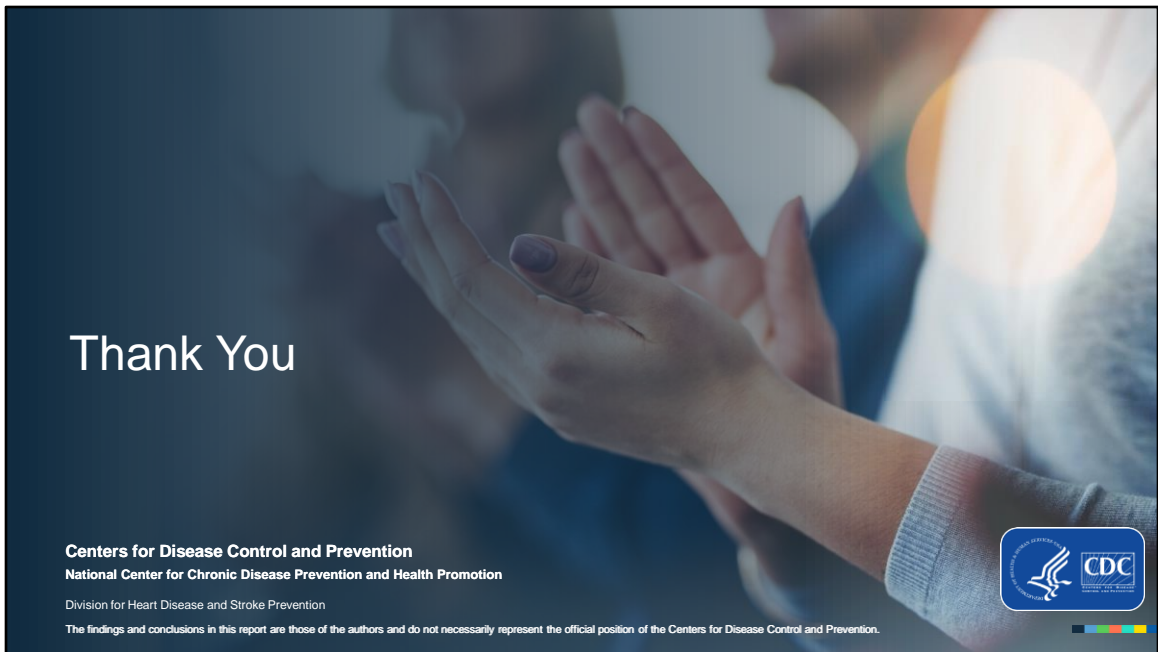
- CDC's Interactive Atlas of Heart Disease and Stroke
- GIS Index Map

Assess facilitators and barriers to implementation.

- CDC Health Systems Scorecard
- Community Health Worker Toolkit
- Creating Community-Clinical Linkages Between Community Pharmacists and Physicians: A Pharmacy Guide

Act to implement interventions and strategies.

- Integrating Community Health Workers on Clinical Care Teams and in the Community
- Collaborative Practice Agreements Guide
- Hypertension Management Program Toolkit



MODERATOR

This concludes today's Coffee Break presentation. At this time, we will take questions from the audience. Please enter your question into the Q/A feature at the bottom of your screen. As we wait for questions from the audience, I'll ask our presenters a question to help start the discussion.

Question: When implementing team-based care, is there an "ideal" or recommended team composition?

Answer: There is no "ideal" composition of team members, the members included on teams should reflect the needs of the community they are serving.

Links to share:

CPSTF Finding: [Team-based Care Improves Blood Pressure Control and is Cost-effective | The Community Guide](#)

Implementation Webpage: [Team-Based Care to Improve Blood Pressure Control | cdc.gov](#)