Health Impact Statement

Support the Engagement of Non-physician Team Members in Hypertension and Cholesterol Management in Clinical Settings

Problem

In America, cardiovascular disease is a highly prevalent chronic condition that affects millions of individuals. Cardiovascular disease is the leading cause of death in the United States and accounts for approximately one in three deaths.[1,2] In Rhode Island (RI), more than half of the adult population (55.8%) has at least one chronic disease, including cardiovascular disease, and more than 1 in 4 adults have multiple chronic diseases.[3]

Despite the increasing health threat cardiovascular disease presents to thousands of Rhode Islanders, control of key cardiovascular disease risk factors remains poor. According to the Centers for Disease Control and Prevention (CDC), two major risk factors for cardiovascular disease are hypertension and high cholesterol.[4] In 2017, approximately 1 in 3 Rhode Islanders reported ever being diagnosed with hypertension (33.1%), with the prevalence significantly higher among those below 400% of the federal poverty level (37.7%).[5] The data also reported that 1 in 3 RI adults responded ever being diagnosed with high cholesterol (30.8%). However, 15.4% of the adult population had not had their cholesterol tested for more than 5 years, with the rate of unknown cholesterol status significantly higher among Hispanics (22.8%) when compared to non-Hispanic White (13.4%) and Black (15.5%) residents.[5]

CDC recommends team-based care as an effective strategy to prevent and/or manage complications from heart disease and stroke.[6] The implementation of team-based care aims to enhance patient care and has been successful in a variety of settings including, but not limited to, Federally Qualified Health Centers, patient-centered medical homes, and pharmacies.[7] The advantages of team-based care are vast and include expanded access of care, increased patient education and self-management support, improved care coordination, and enhanced quality improvement.[8]

Intervention

The Rhode Island Diabetes, Heart Disease, and Stroke Program's (RIDHDS) response efforts focused on one main outcome: to increase use of and adherence to evidence-based guidelines and policies related to team-based care for patients with high blood pressure and/or high blood cholesterol. RIDHDS focused on partnering with and supporting team-based care in RI's Federally Qualified Health Centers and free clinics since the patient populations of these practices are disproportionately people of color and people with low income. In addition, these practices are primarily based in health equity zones. Nearly all health equity zones have very high rates of families living below 400% FPL. As a result, RIDHDS anticipated that targeting resources in those areas was the most effective and equitable way of addressing hypertension and cholesterol management. Through funding provided by CDC, RIDHDS implemented the following strategies and activities to support the engagement of non-physician team members in patient care:

- Contract with healthcare organizations that are part of Care+Community+Equity (CCE) initiative to conduct team-based care quality improvement projects and assessment of existing workflows and policies;
- Support CCE sites with their technical assistance needs and practice facilitation, with help from a partnership with Care Transformation Collaborative of RI (CTC-RI);
- Convene CCE sites for Best Practice Sharing meetings;
- Use data on team-based care to foster best practice sharing and inform decision making for workplan and scope of work activities;
- Partner with the RI Health Center Association for Best Practice Sharing meeting co-chair on support and assistance in identifying speakers for various topics;
- Participate in the state's Pharmacy Workgroup and work toward integrating pharmacists into primary care teams; Support group in finalizing and implementing activities from the workgroup action plan; Support the creation and use of collaborative practice agreements (CPAs);
- Collaborate with CTC-RI to offer Pharmacy Learning Collaboratives to implement a pharmacy-related quality improvement initiative;
- Partner with Community Health Worker Association of RI (CHWARI) to develop and implement a communications plan for the promotion of community health worker (CHW) trainings, including the Cardiovascular Disease/Diabetes specialty training

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Health Impact

In five years, RIDHDS and its partners have put tremendous effort into engaging non-physician team members in hypertension and cholesterol management. This work has been successful in implementing team-based care. CCE practices participated in and developed team-based care quality improvement projects each year for the management of hypertension and high cholesterol. CCE practices identified a variety of non-physician team members that participated in the projects, including nurse care managers, registered nurses, CHWs, pharmacists, behavioral health clinicians, dental health professionals, and dietitians. A few examples of the projects undertaken by the practices are below:

- **A pharmacist worked on an aspirin program to prevent stroke and heart attack** in patients and identified hypertension and high cholesterol patients that may benefit from the 340B Pharmacy Program.
- **Health center staff identified and outreached to patients with hypertension, high cholesterol, or both to develop care plan goals** and receive additional support in making positive changes to improve their overall health.
- **Registered nurses and other healthcare professionals collaborated to increase the number of 90 day or more prescriptions written for patients with chronic conditions**, with the aim of increasing medication adherence.
- **A practice established monthly meetings with clinical and quality improvement staff to discuss meeting quality measures**, increasing engagement, and increasing the number of patients on a statin therapy.

In 2018, it was reported that 16,300 patients received care in CCE practices that were implementing new or enhanced team-based approaches or policies to address blood pressure and cholesterol control. In 2021, it was confirmed that a majority of the CCE practices (5 of 7) are Patient-Centered Medical Home (PCMH) NCQA accredited and participated in team-based care per NCQA standards. Therefore, the number of patients who were being treated in CCE practices using team-based care increased to 53,808. In the final year, there were 63,285 patients who had their conditions managed by CCE practices implementing team-based care. The increases may be attributed to PCMH status, increased patient panel sizes in recovery from the COVID-19 pandemic, restored data reporting capacity in healthcare sites, or any combination of these factors.

Through the work of RI's Pharmacy Workgroup, the number of pharmacists participating in care teams through CPAs increased from 3 to 36 from 2018 to 2022. To support the integration of pharmacists, RIDHDS collaborated with CTC-RI to provide primary care teams opportunities to participate in pharmacy quality improvement initiatives to improve the safe, effective, and efficient use of medications. During the first learning collaborative, practices participated in an initiative to reduce preventable hospitalizations and emergency department usage through team-based care. Participants discussed CPAs relevant to their quality improvement initiatives and shared CPA samples and templates. Additionally, through conversations with the RIDOH Board of Pharmacy and the internal review committee, the CPA approval process was changed to simplify the application process. During the second learning collaborative, participating practices developed workflows for the nurse care manager(s) and pharmacist(s), established standardized pathways between team members, and operationalized the teams.

In addition to pharmacist integration, RIDHDS partnered with CHWARI to promote the engagement of CHWs in the care team via a communications plan for CHW trainings, including the Cardiovascular Disease/Diabetes specialty training.
The specialty training and subsequent certification provides CHWs with knowledge and skills in the management and prevention of cardiovascular disease and is intended to better equip CHWs to operate as members of the care team.

The COVID-19 pandemic was a barrier to the engagement of non-physician team members in hypertension and high cholesterol management. The pandemic limited in-person visits, and the use of telehealth resulted in a disconnect in team-based care. Partners expressed that it was difficult for practices to coordinate having several team members participate and help patients in one virtual visit. Additionally, the lack of reimbursement for the direct services of non-physician team members and allied health professionals posed a challenge.

Moving forward, RIDHDS and its partners will continue to implement team-based care and support the integration of non-physician team members in the prevention and management of hypertension and high cholesterol.

References

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