



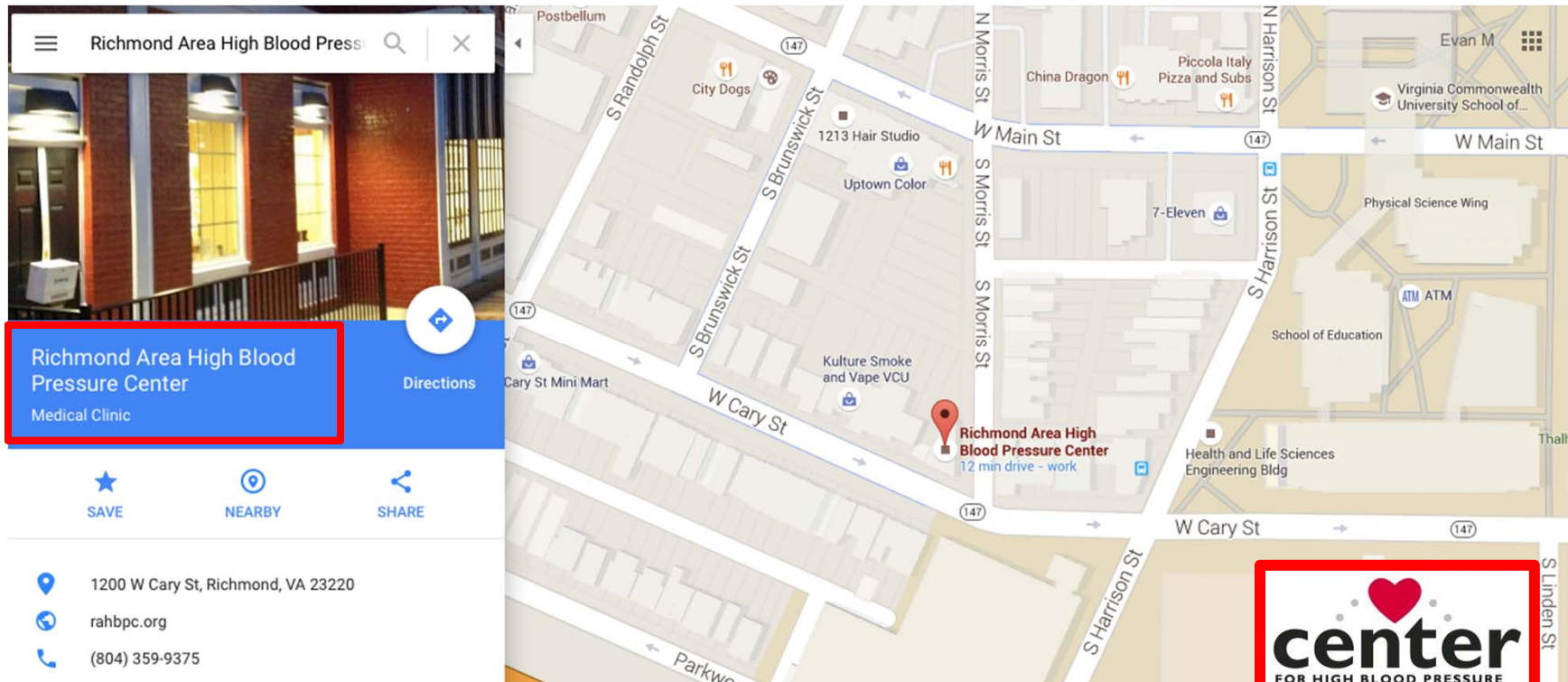
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the center
FOR HEALTHY HEARTS

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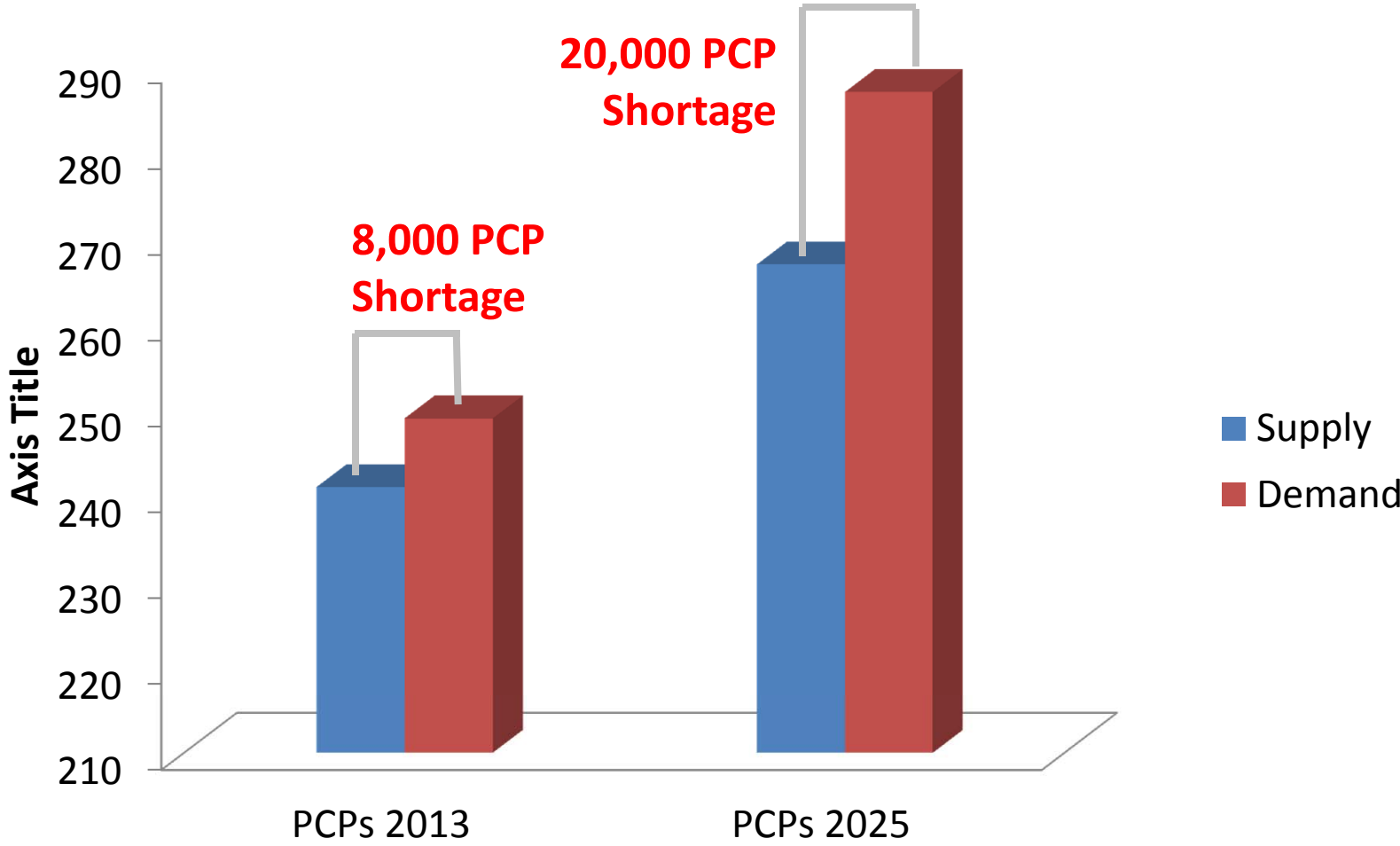
Center for High Blood Pressure



- 1983 – Established to address hypertension in the urban African American population
- 2008 – Mission revised to include diabetes and chronic disease



Primary Care Provider (PCP) Shortage 2013-2025



AAMC Updated Report. The Complexities of Physician Supply and Demand: Projections Through 2025. March 2015

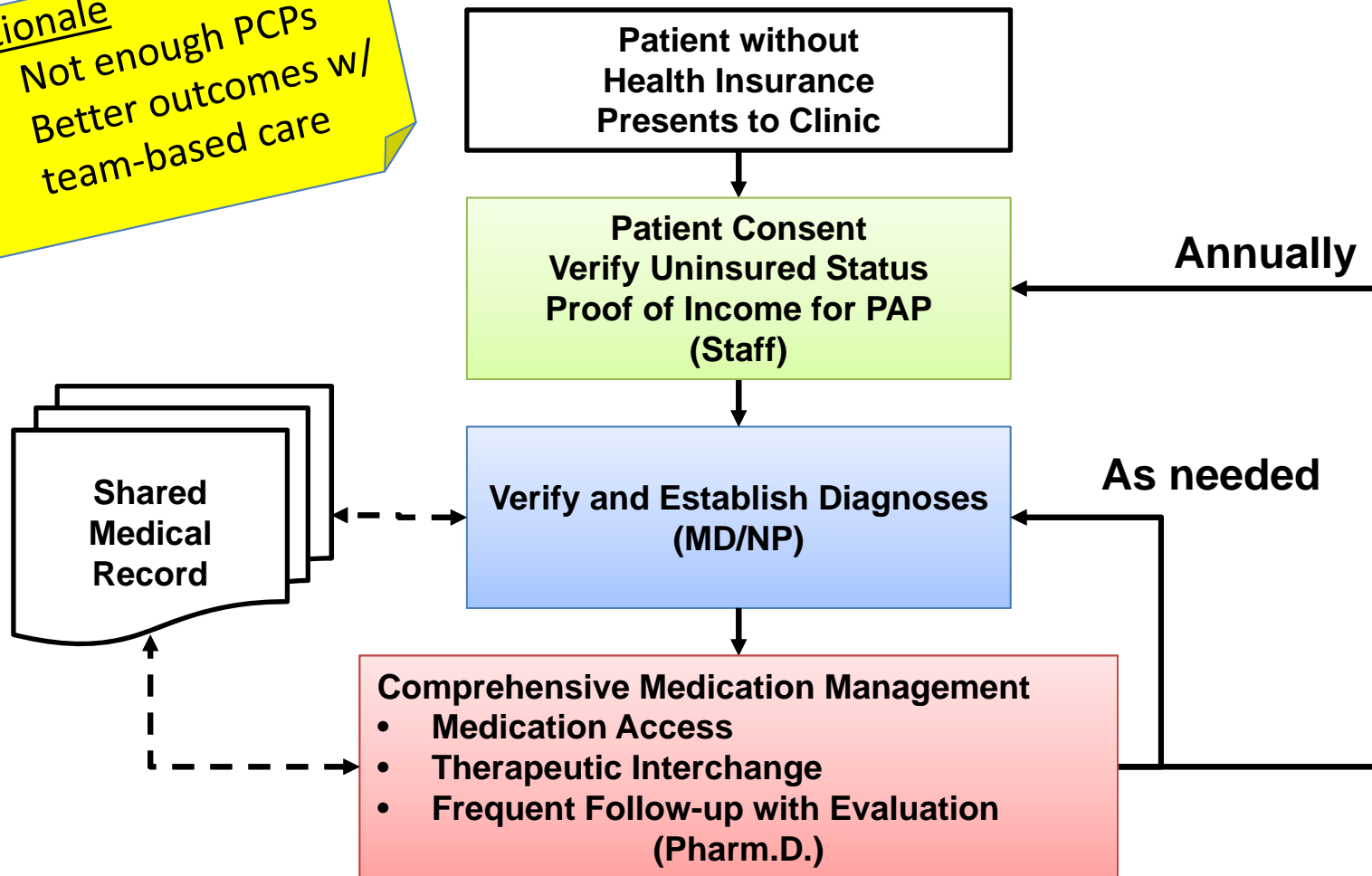


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Center Patient Care Model

Rationale
1. Not enough PCPs
2. Better outcomes w/
team-based care

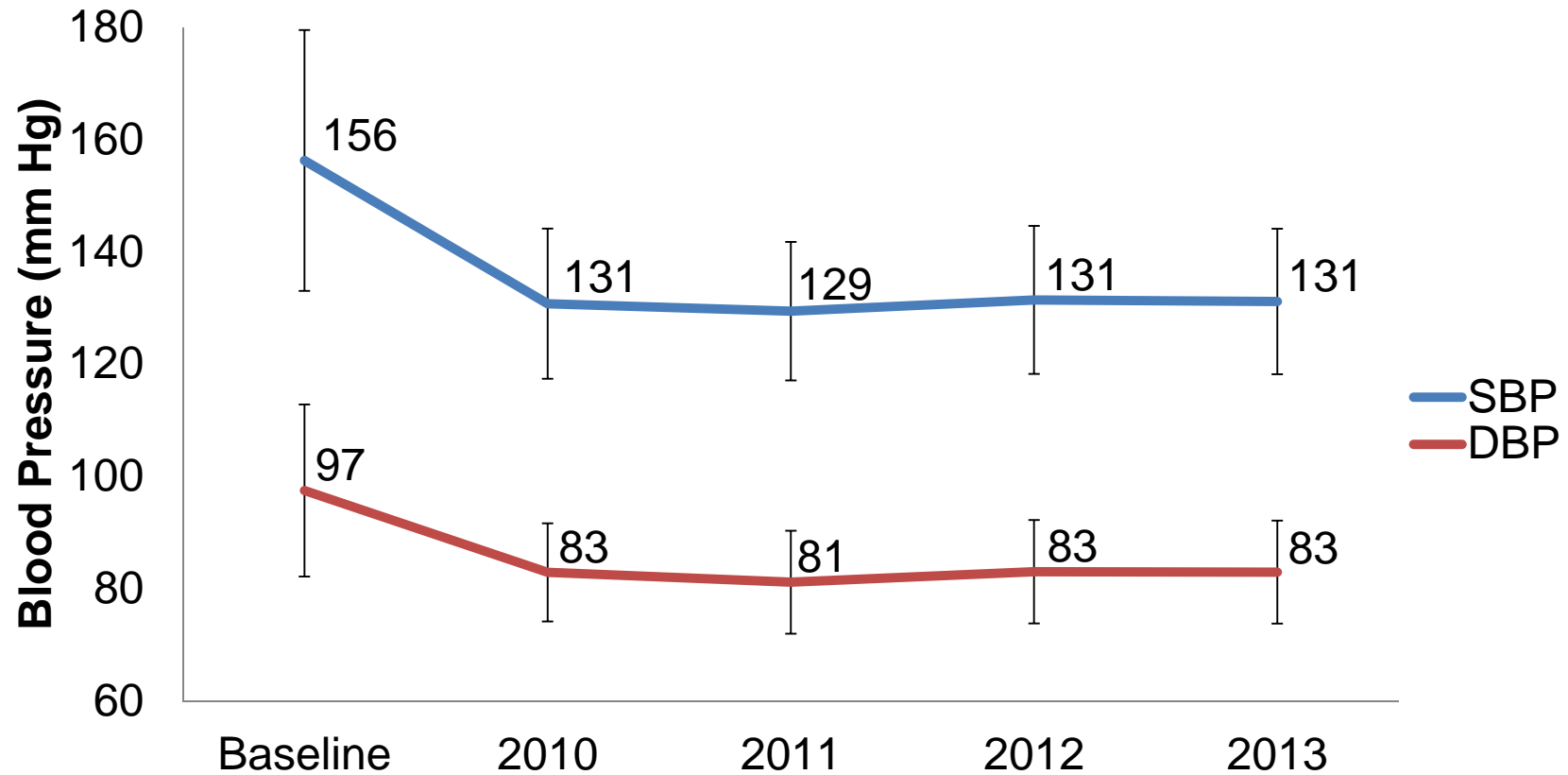


Center Patient Characteristics

Characteristics (n=172)*	n (%)
*Patients with ≥ 2 pharmacist visits during 2009	
Age mean \pm SD, years	51.3 \pm 9.9 (32-81)
Gender	
Female	106 (61.63)
Male	66 (38.37)
Ethnicity	
African American	131 (76.16)
White	31 (18.02)
Asian	4 (2.33)
Hispanic	3 (1.74)
Other	3 (1.74)
Past Medical History	
Hypertension	172 (100.00)
Hyperlipidemia	56 (32.56)
Diabetes	32 (18.60)
CVA/TIA	7 (4.07)
Coronary Artery Disease	6 (3.49)
Smoker	67 (38.9)
Body Mass Index (BMI) mean, kg/m ²	33.5 \pm 8.2

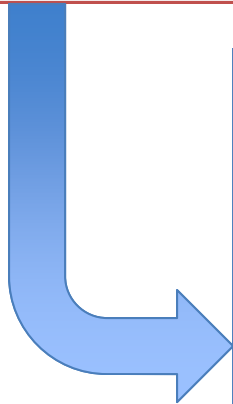


Mean Blood Pressure Baseline through 2013 (n=172)



Comparison of Center BP Control Rates with National Benchmarks

Comparison of BP Control Rates with National Averages				
	Center for High Blood Pressure	General Population	Non-Hispanic blacks	Uninsured Population
% of patients with BP <140/90	68.2%	54.1%	47.1%	29.8%
<p>¹ Heart Disease and Stroke Statistics – 2015 Update. Circulation. 2015;131:e29-e322</p> <p>² Haves and Have-Nots: Gaps Widen in Control of BP Among Insured and Uninsured. Medscape. Available at: http://www.medscape.com/viewarticle/825367. Accessed May 20, 2014.</p>				



Mean Number of Visits between 2010 and 2013		
	Patients with Stage 2 Hypertension (n=81)	All Other Patients (n=91)
PharmD (Range)	7.48 (1-20)	6.89 (0-19)
Physician (Range)	1.15 (0-5)	1.03 (0-3)



Secrets of Center Success

- Optimization of distinct interprofessional roles
 - Diagnoses established by **physicians**
 - Medication management by **pharmacists**
 - Urgent care by **nurse practitioners**
 - Case management by **nurses**
 - Education and coaching by **student lay health workers**
 - Nutrition education by **dietitians**
- Access to a common medical record
- Frequent follow-up with evaluation
- Collaborative practice agreement with sufficient scope of practice to implement medication changes at the time of the visit
- Specialized services – focus on chronic disease challenges
 - Certified Diabetes Educators
 - Cardiology, Nephrology
 - Clinical pharmacy specialists



Secrets

1. High touch – right provider skill mix
2. High intensity – right visit frequency



Everybody has problems...

Center

- Lack of funding diversification
- Inconsistent annual cash flow

ED

- Uninsured patients access ED for non-urgent issues
- No formalized referral mechanism

PCMH

- Long wait time until first appointment
- Inadequate resources to rapidly meet patient needs

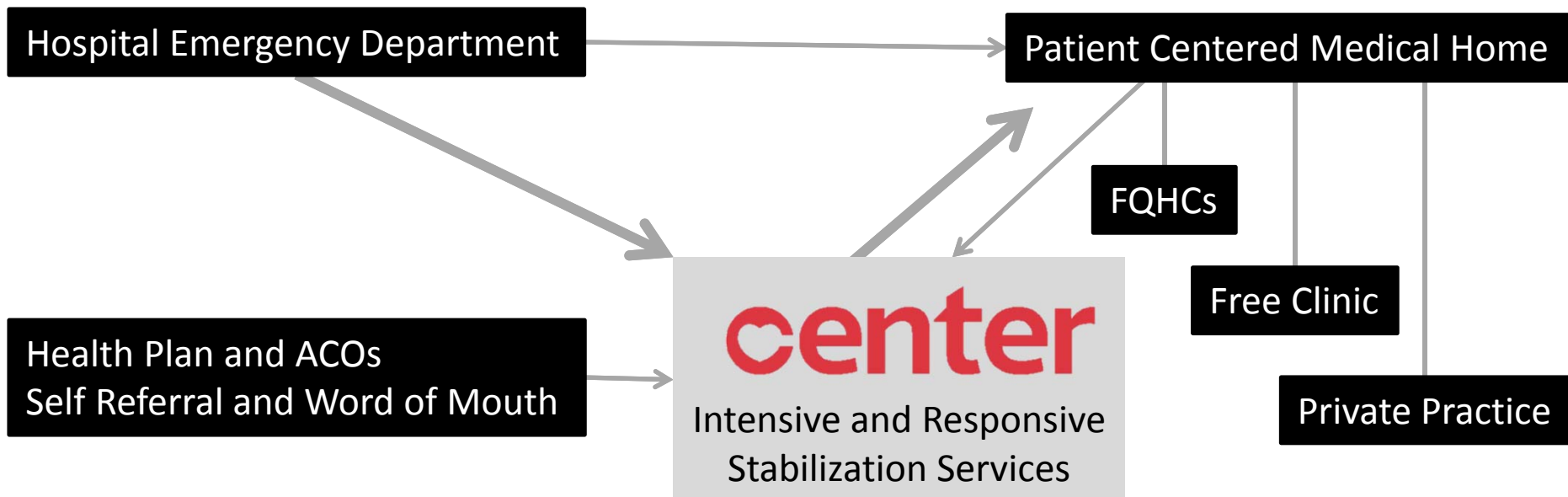
Patients

- Combination of medical and social issues
- Poor health literacy impedes navigation



Center for Health Hearts

a specialty medical home and free clinic for uninsured patients with chronic disease



Our Services

Appointments within 72 hours
Medication Management and Access
Pharmacy, Cardiology, and Nephrology Specialists

Patients We Serve



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Conclusions

- The shortage of primary care providers may pass 20,000 by year 2025.
- An asynchronous team-based care module improved hypertension control in an uninsured, primarily African-American, urban population.
- Successful chronic disease management of this challenging population suggests that more widespread adoption of similar collaborative care models should be considered across all payers.

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