A Pharmacist Roundtable: Leveraging the Power of Treatment Intensification as a Team to Improve BP Control – June 7, 2022

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00:00:53.220 --> 00:01:07.440
Alison Smith: Welcome everyone to today's target BP webinar we are going to get started promptly to maximize this learning opportunity with their pharmacists Roundtable leveraging the power of treatment intensification as a team to improve blood pressure control.

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00:01:08.550 --> 00:01:16.860
Alison Smith: want to introduce myself on the next slide to say that I'm Alison Smith and I'll serve as your host and moderator today I'm a nurse and a public health professional.

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00:01:17.250 --> 00:01:25.320
Alison Smith: And the program director for targeted BP the national blood pressure initiative jointly, led by the American heart Association and the American Medical Association.

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00:01:25.770 --> 00:01:33.060
Alison Smith: For those of you who just finished submitting your data and at a station for the targeted VP recognition program, I want to thank you.

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00:01:33.750 --> 00:01:43.650
Alison Smith: We are just waiting through the submission analysis and are thrilled to see a record number of submissions and award achievements we're looking forward to formally announcing those awards.

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00:01:43.950 --> 00:01:54.690
Alison Smith: In September we're just so impressed and inspired by your work and your 10-year commitment to blood pressure, control and improving those control rates year over year.

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00:01:55.290 --> 00:02:07.920
Alison Smith: I want to cover a few housekeeping items on the next slide as we dive in here feel free to activate the live transcript feature and the clip for closed captioning and adjust the font size to suit your needs and preference.

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00:02:08.760 --> 00:02:18.510
Alison Smith: And on the next slide, I just wanted to highlight that we're going to be using both the Q amp and the chat features, to support your engagement and the interactivity of the program throughout so.

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00:02:18.780 --> 00:02:23.790
Alison Smith: If you have questions for the panelists at any time, please include those in the Q amp a.

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00:02:24.150 --> 00:02:33.060
Alison Smith: And if you see a question asked by someone else you can upload that question and it'll bump it to the top of the queue, and we'll address as many as those questions as we can.

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00:02:33.450 --> 00:02:42.840
Alison Smith: At the end of the hour, we've set aside about 15 minutes to dig into your questions also we can use the chat function to introduce yourself.

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00:02:43.500 --> 00:02:49.860
Alison Smith: We will also be dropping many resource links in the chat as the discussion unfolds.

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00:02:50.310 --> 00:03:01.170
Alison Smith: Following the program we will make the recording available, and we will also give you a complete list of those links for your future reference, so we can look forward to that and follow up.

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00:03:01.890 --> 00:03:04.620
Alison Smith: We will also look forward to your feedback and follow up.

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00:03:05.220 --> 00:03:17.790
Alison Smith: Just a few more reminders on the next slide, which is that we encourage you to visit target BP and the resources available on the website, there are many enduring CME.

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00:03:18.180 --> 00:03:25.410
Alison Smith: Opportunities and offerings that align with the map framework and also address some measure blood pressure.

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00:03:25.860 --> 00:03:34.320
Alison Smith: If you're not receiving our newsletter already, we encourage you to do so, and you can learn about upcoming events new resources policy developments.

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00:03:34.680 --> 00:03:45.570

Alison Smith: We are planning another event in the early fall our exact date tbd, but we'll be talking about self-measure blood pressure and the progress made in the last year in this emerging.

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00:03:46.050 --> 00:04:00.930
Alison Smith: Space So if you have a success story that you would like to share with you regarding self-measure blood pressure, please contact us and we may have the opportunity to highlight your health Center your healthcare organization in that program in the fall.

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00:04:02.160 --> 00:04:08.460
Alison Smith: Moving on, all of our programs really are centered on the map BP framework.

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00:04:08.910 --> 00:04:13.530
Alison Smith: This framework is an evidence-based quality improvement framework, as many of you know well.

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00:04:13.770 --> 00:04:21.840
Alison Smith: And it's based on the concepts of measuring act really acting rapidly and partnering with patients to systematically address the common challenges.

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00:04:22.140 --> 00:04:34.260
Alison Smith: diagnostic uncertainty therapeutic inertia and treatment nonadherence and today's event is going to focus on the act rapidly phase of the map framework delving deeper into the rule of treatment intensification.

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00:04:34.770 --> 00:04:45.840
Alison Smith: As a strategy to improve blood pressure control, we had recommended as a prerequisite, or a pre review the opportunity to listen to Dr Brent Egan’s recording program that's listed here.

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00:04:46.350 --> 00:05:00.900
Alison Smith: That we that we aired live last year but encourage you to revisit that if you haven't seen it a refresh your memory and that important presentation and also has the benefit of enduring see me and see.

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00:05:01.980 --> 00:05:05.070
Alison Smith: With that I want to dive into today's learning objectives.

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00:05:06.240 --> 00:05:18.570

Alison Smith: The really to outline the importance of treatment intensification and proven and blood pressure control to describe some of the common patient provider and health system challenges to improving treatment intensification.

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00:05:18.960 --> 00:05:28.020
Alison Smith: And ultimately, identify models of care tools and resources to systematically improve treatment intensification and medication adherence.

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00:05:28.830 --> 00:05:38.280
Alison Smith: With that I want to ask a quick poll question, and that is what is the single most powerful action that will improve a patient's blood pressure control.

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00:05:39.120 --> 00:05:45.720
Alison Smith: Your options are A. improving patient medication adherence B. shortening the time between office visits.

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00:05:46.260 --> 00:06:03.120
Alison Smith: C. intensifying treatment by adding a medication class or D or unsure so invite your responses here. I can see them rolling in we've got almost half of you responding by now just to get a few more responses in here before closing the poll.

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00:06:05.850 --> 00:06:08.670
Alison Smith: looks like we're leveling off.

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00:06:11.220 --> 00:06:19.770
Alison Smith: All right, if you want to share the results here, it looks like about half a little over half of you selected improving patient medication adherence.

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00:06:20.190 --> 00:06:34.350
Alison Smith: about a quarter chosen intensifying medication by adding a class and a little less than 13% shortening office time between visit so appreciate your feedback on that, so I think today's conversation will be a great.

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00:06:35.460 --> 00:06:43.620
Alison Smith: sort of dive into this topic so it's my pleasure now to introduce our Panel for our pharmacists Roundtable.

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00:06:44.610 --> 00:06:54.870

Alison Smith: I’m joined by three deeply accomplished pharmacist Dr Blyler is a clinical pharmacist and researcher at the Schmidt heart institute at Cedars Sinai medical Center in Los Angeles.

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00:06:55.230 --> 00:07:02.460
Alison Smith: Her research is focused on the prevention and treatment of cardiovascular disease and reducing health disparities through Community based practice.

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00:07:02.820 --> 00:07:12.180
Alison Smith: She served as one of the two full time clinical research pharmacists on the infamous barbershop trial, the NIH Nhi VI funded randomized trial that investigated.

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00:07:12.480 --> 00:07:21.630
Alison Smith: A novel Community based approach to treat hypertension and African American male patients and moment pharmacists barbers and physicians welcome Adair.

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00:07:22.080 --> 00:07:30.180
Alison Smith: Dr Eric MacLaughlin is a professor and Chair of the Department of pharmacy practice at Texas tech university health science Center.

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00:07:30.630 --> 00:07:37.440
Alison Smith: In the Jerry H Hodge school of pharmacy he's also a clinical professor in the department of family medicine internal medicine.

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00:07:37.740 --> 00:07:48.690
Alison Smith: At the Texas at Texas tech school of medicine and Dr MacLaughlin pies practices in a family medicine clinic providing team based comprehensive medication management services for patients.

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00:07:49.140 --> 00:08:01.320
Alison Smith: With hypertension and other chronic diseases as a pharmacist, he is a certified hypertension clinician and was a member of the guideline ready committee for the 2017 ag ACC hypertension guideline.

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00:08:02.130 --> 00:08:12.870
Alison Smith: And we are also joined by Dr Adams breasts currently an associate professor of population health science with tenure in the division of the health systems, innovation and research.

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00:08:13.350 --> 00:08:26.670

Alison Smith: And as an investigator at the VA Salt Lake City healthcare system as a formally trained to cardiovascular clinical pharmacist and population scientist Dr presses research in NIH funded.

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00:08:27.450 --> 00:08:36.540
Alison Smith: Research and his focus on prevention and treatment of cardiovascular disease are designed to optimize party basket or medication use and reduce health disparities.

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00:08:36.900 --> 00:08:46.890
Alison Smith: I want to thank each of you for being here on our pharmacist around table to share your perspectives, both through research, your research and your practice lenses.

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00:08:47.550 --> 00:08:57.840
Alison Smith: Today we have a discussion outline that will share with you that we're going to start by reflecting on both gain the ground that we have actually lost and blood pressure control.

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00:08:58.290 --> 00:09:08.070
Alison Smith: Over recent years, and more significantly, during the pandemic and thinking strategically about the most impactful and quickest ways to regain that lost ground.

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00:09:08.730 --> 00:09:17.370
Alison Smith: And we're then going to shift our conversation into what are the barriers and solutions that exist to improve blood pressure control.

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00:09:17.820 --> 00:09:23.880
Alison Smith: Specifically, through treatment intensification and we're going to examine that through the lens of the patient.

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00:09:24.360 --> 00:09:31.320
Alison Smith: The provider on also the health systems and then Lastly, we want to dig into your questions around this topic.

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00:09:31.710 --> 00:09:45.330
Alison Smith: So, with that we'll sort of do away with the slides for a while and dig into our conversation with our team, I want to start with, Adam if you could help frame this bigger question overarching question.

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00:09:45.900 --> 00:09:56.550

Alison Smith: Given the ground that we have lost in blood pressure control, especially during the pandemic what are some of the impactful ways that we can improve blood pressure control quickly.

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00:09:57.600 --> 00:10:00.540
Adam Bress: Absolutely thanks Alison so much for the invitation.

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Adam Bress: So, I think the context for this today's discussion is the fact that hypertension or high blood pressure, remains the leading modifiable cause of heart disease in the US.

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00:10:12.690 --> 00:10:25.680
Adam Bress: and heart disease remains the number one cause of death in the US even over the past two years, during the coven 19 pandemic where so many Americans lost their lives to the pandemic.

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00:10:26.700 --> 00:10:44.850
Adam Bress: hypertension, is also a major contributor to health disparities it disproportionately impacts communities of color and especially those without health insurance or access to health care services, hypertension, is also highly prevalent it affects nearly 50% of the US adult population.

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00:10:45.900 --> 00:10:58.650
Adam Bress: However, the good news is that in the US, we do have widespread availability of safe, effective and inexpensive antihypertensive medications that lower blood pressure safely and effectively.

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00:10:59.100 --> 00:11:10.320
Adam Bress: And also reduce risk of heart disease, kidney disease and even cognitive alcoves safely and effectively However, despite this widespread availability.

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00:11:11.100 --> 00:11:25.380
Adam Bress: blood pressure control rates remain sub optimal or low at about 50% in the US overall and they've actually declined in the past seven years or so, and these declines are not simply due to the disruption of the coven 19 pandemic.

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00:11:26.520 --> 00:11:36.240
Adam Bress: These data suggests that that could that decline, and control rates began around 2014 and low control rates are.

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00:11:36.840 --> 00:11:46.200
Adam Bress: Even more pronounced among people of color in those without health insurance or access to health care services in terms of data we have.

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00:11:47.160 --> 00:11:55.620
Adam Bress: In communities of color black Americans have the highest prevalence of hypertension of any race, ethnic group in the US at about 45% when defined as.

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00:11:56.280 --> 00:12:08.760
Adam Bress: systolic diastolic 140 over 90 and although treatment rates are similar in black Americans to white Americans control rates are 30% lower among black Americans compared to white Americans.

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00:12:09.390 --> 00:12:18.960
Adam Bress: In contrast, Hispanic Americans have similar prevalence of hypertension, compared to whites but 20 to 30% lower rates of awareness, treatment and control.

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00:12:19.830 --> 00:12:27.060
Adam Bress: And that for Asian Americans treatment rates are similar to white Americans but awareness and control rates are lower compared to white Americans.

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00:12:28.440 --> 00:12:37.110
Adam Bress: Emerging data suggests that if we can focus on a few things in the clinic blood pressure control rates can be drastically approved.

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00:12:37.860 --> 00:12:47.550
Adam Bress: And of course, it's important to mention that continued focus on affordability and access to health care services is critical, from a population and policy standpoint.

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00:12:48.060 --> 00:12:57.450
Adam Bress: Yet in the clinic There are three things that we can focus on that are estimated to have an outsized impact will control first is high quality blood pressure measurement.

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00:12:58.290 --> 00:13:12.750
Adam Bress: The second is reduced therapeutic inertia which is defined as not intensifying and antihypertensive medication regimen despite the blood pressure being above a treatment goal, and the third is increased medication adherence.

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00:13:13.860 --> 00:13:22.350
Adam Bress: and any recent high quality simulation analysis read by led by Brandon bellows that Columbia University found that overcoming therapeutic inertia.

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00:13:22.890 --> 00:13:37.860
Adam Bress: Was the single intervention found to have the greatest impact on lowers control, in fact, their simulation estimated that if therapeutic inertia could get down to about 30% of the time, instead of the current estimations of 70 to 90% of the time.

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00:13:39.330 --> 00:13:46.440
Adam Bress: blood pressure control rates can be achieved at the 80% level, even with current adherence and follow up visit rates.

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00:13:48.090 --> 00:13:53.910
Adam Bress: Another analysis of a national database of electronic health record data that included 25 health systems.

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00:13:54.870 --> 00:14:04.290
Adam Bress: found in the United States found that blood pressure control rates were around 62% with 20% lower control rates among black Americans compared to white Americans.

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00:14:05.070 --> 00:14:09.870
Adam Bress: And one of the key findings in this analysis was that when blood pressure was not controlled.

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00:14:10.290 --> 00:14:29.850
Adam Bress: A new medication was only added 12% of the time, confirming these rates of therapeutic inertia in clinical practice between 80 and 90% and they also found that when the medications were actually intensified the result and blood pressure on average was about 15 points lower systolic.

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00:14:32.280 --> 00:14:41.820
Adam Bress: Another recent study that I think is relevant is an analysis, led by valley font tool, who analyze data from 11 safety net clinics in the San Francisco Bay area.

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00:14:42.990 --> 00:14:50.970
Adam Bress: And they found that among patients with hypertension in these clinics black patients had significantly higher rates of therapeutic inertia.

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00:14:51.810 --> 00:15:03.390
Adam Bress: had more clinic visits miss miss miss clinic visits than any other, race, ethnic group and their analysis and what their analysis very elegantly reveal was that treatment intensification.

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00:15:04.440 --> 00:15:15.330
Adam Bress: accounted for the greatest majority of the racial differences in blood pressure control it accounted for about 20% of the racial difference in the blood pressure control.

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00:15:15.960 --> 00:15:23.640
Adam Bress: These are, this is one of the first analysis to tease out kind of the mediating factors of ratio observe racial differences in control.

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00:15:25.410 --> 00:15:37.020
Adam Bress: And the authors concluded that these data support that interventions to provide more equitable provision of treatment intensification could reduce racial and ethnic disparities in BP control.

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00:15:41.850 --> 00:16:00.900
Alison Smith: Thank you, and that was a pretty sobering framing of the challenge and the opportunity man, I really appreciate you putting into focus the power of treatment intensification I think I'll quote one of our participants wow I really appreciated that to in the feedback in the chat.

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00:16:02.400 --> 00:16:05.070
Alison Smith: Other thoughts Derek do you have some thoughts on this.

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00:16:06.570 --> 00:16:10.350
Ciantel A Blyler: yeah, thanks for bringing me in great summary Adam you know, I think.

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00:16:11.820 --> 00:16:20.970
Ciantel A Blyler: I'm so glad that we're focused here today on treatment intensification, because I do think it is probably the most impactful thing that can happen with respect to improving control rates.

89
00:16:21.420 --> 00:16:29.820
Ciantel A Blyler: But I think it bears repeating, and I think Adam alluded to this as well you know, the first step, I think, before we even get there is getting patients back into care.

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00:16:30.390 --> 00:16:32.580

Ciantel A Blyler: I know, at least from my experience in my clinic.

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00:16:33.510 --> 00:16:39.450
Ciantel A Blyler: We did a great job of sort of leveraging Tele health during the pandemic we're all sort of forced to pivot and integrate that into our practice.

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00:16:39.720 --> 00:16:48.510
Ciantel A Blyler: And now we're having this like really tough time getting people to come back into the clinic and there were also patients who never really adopted Tele health in the first place, and so.

93
00:16:49.080 --> 00:16:57.600
Ciantel A Blyler: I think the first step is really, really re engaging them with the health care system, and then we can sort of tackle this issue of treatment intensification of visits.

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00:16:59.190 --> 00:17:04.890
Alison Smith: That certainly step one to make treatment intention intensification even possible.

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00:17:06.270 --> 00:17:09.480
Alison Smith: really appreciate that point Eric anything you wanted to add here.

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00:17:12.570 --> 00:17:19.440
Eric MacLaughlin: Not a lot extra I think they're you know there's a lot to unpack there, I think, several of those points could probably be an hour seminar on its own.

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00:17:20.400 --> 00:17:27.540
Eric MacLaughlin: You know, to it there's point we were having a discussion I think offline and another meeting out even just regional differences with some of the healthcare systems were.

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00:17:27.990 --> 00:17:41.730
Eric MacLaughlin: You know, certain areas of the country are still remote and having those challenges we you know I'm in Amarillo Texas, we pretty much all gone back and so to mostly non-Tele health, but we have different challenges we've got a much more rural.

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00:17:42.900 --> 00:17:49.080
Eric MacLaughlin: Population here in West Texas, and so we have our own sets of of challenges from that standpoint.

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00:17:49.590 --> 00:18:01.470
Eric MacLaughlin: It to Adams point on the treatment intensification and I don't want to steal anyone's thunder but, but I think you know spot on that treatment intensification is probably with medications number one thing we can do, and it just.

101
00:18:02.130 --> 00:18:11.880
Eric MacLaughlin: drives home I've seen a patient last week where pressure really wasn't well controlled on a single agent, not on multiple agents just adding another agent that was synergistic.

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00:18:12.420 --> 00:18:18.180
Eric MacLaughlin: You know drop the systolic blood pressure 15 points and all of a sudden he's at goal wasn't hypertensive but actually.

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00:18:18.720 --> 00:18:26.850
Eric MacLaughlin: was able to get them at target goal just by simply adding another drug in particularly using a fixed those combinations so again I don't want to steal.

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00:18:27.450 --> 00:18:44.790
Eric MacLaughlin: Adams thunder or there's thunder at all, but I think that the point to drive home obviously it's Multifactorial but treatment intensification with drug therapy is really important, and obviously lots of potential reasons why we're not doing that, and we got to do better.

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00:18:45.630 --> 00:18:56.220
Alison Smith: I think I appreciate that plan, and I think I don't think anyone here is dismissing the importance of lifestyle modification at all during this conversation today it's just that.

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00:18:56.760 --> 00:19:06.810
Alison Smith: That that takes time it takes time to achieve those gains that are possible through lifestyle modification and through treatment intensification we reduce.

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00:19:07.080 --> 00:19:15.540
Alison Smith: Risk more rapidly, and then we can work in partnership with patients over the long haul on lifestyle modification, so I think it's just an important footnote here.

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00:19:16.020 --> 00:19:25.380
Alison Smith: And I appreciate that someone already raised the question in the chat So what are the best ways I feel like I've been set up to combat clinical inertia, so thank you for that.

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00:19:26.340 --> 00:19:34.920
Alison Smith: For our participants so as we think about their number of barriers that interfere are created for treatment intensification.

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00:19:35.670 --> 00:19:46.440
Alison Smith: Both from a patient perspective, a provider perspective and the broader health system, and so we were going to sort of unpack each of those we want to start with patients first and think about.

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00:19:46.860 --> 00:20:02.670
Alison Smith: What are the barriers that patients face, and what are some of the solutions that we see working to help address in our society we're going to start with a dare who's going to TEE this up for us and then we'll dive into each of these barriers sequentially.

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00:20:03.870 --> 00:20:17.130
Ciantel A Blyler: Okay, great yeah, so I think when we think about patient level barriers to achieving really any health outcome, whether that be blood pressure control or meeting let's say like one see target for example.

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00:20:17.790 --> 00:20:32.970
Ciantel A Blyler: What often comes to mind is patient adherence which was interesting to have that sort of initial lead in question, you know, most people that's immediately where we go to as clinicians it's the patients, and you know patient adherence is in and of itself a Multifactorial problem.

114
00:20:34.140 --> 00:20:46.980
Ciantel A Blyler: So, you know and the issues that arise with patient medication adherence also provide sort of barriers to treatment intensification so I'll kind of go through what I think are the big key factors here so in 2011.

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00:20:47.220 --> 00:20:52.830
Ciantel A Blyler: The American college of preventative medicine documented basically five key factors that affect patient medication adherence.

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00:20:53.910 --> 00:20:57.600
Ciantel A Blyler: And there are patient level barriers and at least four of these domains so.

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00:20:58.260 --> 00:21:14.550

Ciantel A Blyler: The first domain is socio economic factors which I think most of us, especially as pharmacists are pretty familiar with these includes or lack of insurance medication costs low health literacy and to a certain extent cultural beliefs about disease and treatment.

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00:21:15.750 --> 00:21:18.330
Ciantel A Blyler: So, a lot of these sort of fall into that patient domain.

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00:21:19.140 --> 00:21:25.650
Ciantel A Blyler: The second domain being healthcare system related factors are sort of skip over this, because I know we're going to discuss that in latter parts of our discussion today.

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00:21:26.220 --> 00:21:34.140
Ciantel A Blyler: The third domain is medical condition or concomitant illness related factors, so these could include things like depression.

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00:21:34.830 --> 00:21:48.540
Ciantel A Blyler: developmental disability or sort of any other chronic condition that can take precedence or contribute to you know take precedence during medical visit or contribute to treat overall treatment burden.

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00:21:49.740 --> 00:21:56.280
Ciantel A Blyler: Then there are therapy related factors again as pharmacists we're very sort of in tuned with these.

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00:21:56.880 --> 00:22:03.540
Ciantel A Blyler: So, this does exist at the patient level, and I think you know there's this idea of either actual or perceived side effects.

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00:22:04.350 --> 00:22:19.050
Ciantel A Blyler: I'll give the example of when I was working in the barbershop study our treatment algorithm that we used completely avoided the use of hard to fourth buys it, which is probably one of the most, if not being most commonly prescribed antihypertensive.

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00:22:20.160 --> 00:22:29.370
Ciantel A Blyler: And that wasn't because an initial discussion with participants, a lot of the men indicated that they had heard from a relative or friend that diuretics or.

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00:22:29.760 --> 00:22:40.710

Ciantel A Blyler: hide record size and, in particular, caused erectile dysfunction now I whenever I tell people that it always causes an upward there are people who will say absolutely not it's not a side effect of that medication.

127
00:22:41.040 --> 00:22:54.120
Ciantel A Blyler: Other people are sort of willing to believe it, but whether actual or perceived it plays an enormous role on whether or not a patient is going to take a medication, and so this again creates barriers to intensifying treatment or adhering to treatment.

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00:22:55.920 --> 00:23:09.360
Ciantel A Blyler: The final domain is patient related factors; these include motivation understanding the need for treatment and having sort of a lack of support network or family to help encourage adherence to treatment.

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00:23:10.590 --> 00:23:16.110
Ciantel A Blyler: So pretty comprehensive in terms of you know, outlining some of the domains that affect.

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00:23:17.280 --> 00:23:18.660
Ciantel A Blyler: Adherence and also.

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00:23:20.010 --> 00:23:25.410
Ciantel A Blyler: intensification and adherence to that that regimen with respect to solutions.

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00:23:26.820 --> 00:23:36.150
Ciantel A Blyler: there's a nice statement I think we're going to drop in the chat that AJ medication adherence scientific statement provide some really nice services think solutions to how we can overcome some of these barriers.

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00:23:37.620 --> 00:23:46.680
Ciantel A Blyler: To address socio economic factors, you know, Adam alluded to this we've got excellent generic low cost-effective medications and that's really what we should be.

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00:23:47.250 --> 00:23:55.740
Ciantel A Blyler: prescribing for people sort of regardless of insurance status so medications like em loaded pain, which really should be first line or you know pennies per tablet.

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00:23:57.180 --> 00:24:04.500

Ciantel A Blyler: Another way that we can address access to care is leveraging the team, including people like pharmacists, nurses practitioners.

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00:24:05.970 --> 00:24:17.910
Ciantel A Blyler: Other you know patient advocates to help extend care to everybody and to address insurance gaps and eligibility to address the issues of concomitant illness.

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00:24:18.690 --> 00:24:23.490
Ciantel A Blyler: We have to ensure other illnesses are being addressed so things like depression should be addressed and treated.

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00:24:23.910 --> 00:24:36.120
Ciantel A Blyler: And I think you know it's probably worth mentioning that you know referrals especially care for hypertension is you know, should be on providers minds if it's something that they can't always be laser focused on during that.

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00:24:36.600 --> 00:24:47.730
Ciantel A Blyler: Medical visits think it's great to sort of ensure that at least one provider is sort of laser focused on blood pressure and is, you know always looking at the numbers and willing to intensify treatment at each visit.

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00:24:48.810 --> 00:25:02.970
Ciantel A Blyler: completely understand that you know primary care providers have all of it to deal with, and you know if someone comes in, with a broken leg, you know the blood pressures and not of interest at that visit, or a rash or whatever it costs, whatever it may be.

141
00:25:04.590 --> 00:25:08.100
Ciantel A Blyler: And then, finally, to address sort of the therapy and patient related factors.

142
00:25:09.030 --> 00:25:22.230
Ciantel A Blyler: You know I think again as pharmacists we're very comfortable with the idea of providing sort of baseline education on the benefits and risks of treatment, but that doesn't happen in every setting, particularly if a pharmacist is not involved.

143
00:25:23.280 --> 00:25:32.970
Ciantel A Blyler: And you know I think we have to let our patients know the risks of remaining on treatment or not, or not intensifying treatment and make clear what our goals are of treatment.

144
00:25:33.600 --> 00:25:42.960
Ciantel A Blyler: Again, in my barbershop work, you know, the vast majority of the men participated in our trial had excellent insurance coverage they had physicians that they could go see.

145
00:25:43.590 --> 00:25:51.930
Ciantel A Blyler: But they often communicated to me that when they saw the doctor the doctor just wrote a script and said, take this and go home they didn't know what their goals where they didn't know.

146
00:25:53.130 --> 00:25:59.250
Ciantel A Blyler: Why the medication was being prescribed they didn't know how it worked, and it was just sort of the simple act of sitting down and explaining.

147
00:26:00.030 --> 00:26:11.610
Ciantel A Blyler: This is why this medication was given to you that completely changed their outlook on whether or not they were going to take the medication, you know, again, many of them came to me with full bottles saying you know I got this, but I never took it.

148
00:26:12.840 --> 00:26:24.480
Ciantel A Blyler: And again, this is kind of an ongoing conversational work, you know continuing at each touch base to reeducate on the importance of adherence that and the potential need for uptight ration to achieve our goals.

149
00:26:25.920 --> 00:26:37.230
Ciantel A Blyler: You know I think in my practice it's very common for patients to sort of balk at the idea of adding drugs, especially once you started that one drug you've convinced them you've got to start one.

150
00:26:38.670 --> 00:26:47.880
Ciantel A Blyler: adding a second or third there's a lot of resistance, you know they would prefer to Max out doses of single pills, but again if you're.

151
00:26:48.360 --> 00:26:55.140
Ciantel A Blyler: taking the time to sit down and educate them and explain that you know with higher doses there that might equate to.

152
00:26:55.440 --> 00:27:08.610
Ciantel A Blyler: More side effects, whereas low doses of two medications could be equally, if not more efficacious you know the sort of a shift

happens and patients are more open to the idea of multiple medications at lower doses.

153
00:27:09.660 --> 00:27:15.000
Ciantel A Blyler: You know, in the barbershop work we used a very nice infographic I think we pulled from the sprint work.

154
00:27:15.660 --> 00:27:19.740
Ciantel A Blyler: That showed, you know look that the difference in sprint between getting the intensive.

155
00:27:20.100 --> 00:27:33.960
Ciantel A Blyler: blood pressure treatment goal and the higher goal was a difference between taking two and three medications and the difference between two and three medications could result in a 25% lower risk of stroke, and you know that's impactful for patients, when they can see.

156
00:27:35.370 --> 00:27:41.850
Ciantel A Blyler: An infographic like that sort of again shifts the mindset and they're more willing to accept in treatment intensification.

157
00:27:42.720 --> 00:27:47.490
Ciantel A Blyler: So again, as I said, this is just sort of you have sort of an ongoing discussion with patients.

158
00:27:48.000 --> 00:27:54.420
Ciantel A Blyler: Which brings me to my last point, and this is part of the map BP framework, which is that we should be partnering with patients.

159
00:27:55.140 --> 00:28:01.170
Ciantel A Blyler: Any change that we make to treatment should be a shared decision between the patient and the provider.

160
00:28:02.010 --> 00:28:10.500
Ciantel A Blyler: We should be taking the time to get to know our patients know how they generally feel about medications understand what challenges they face with respect to adherence.

161
00:28:10.860 --> 00:28:20.550
Ciantel A Blyler: And also learn what side effects are acceptable to them, because what might be acceptable to me won’t be acceptable to somebody else you know I.

162

00:28:21.180 --> 00:28:28.710
Ciantel A Blyler: don't wear sandals if I have puffy ankles for me and load up, I don't mind, but a foot model would mind that you know, we should be.

163
00:28:29.310 --> 00:28:38.880
Ciantel A Blyler: knowing what you know, is acceptable to them, and only then can we really offer what is an appropriate treatment regimen because we all know, the best regimen is the one the patient will take.

164
00:28:40.410 --> 00:28:47.580
Ciantel A Blyler: I learned this sort of the hard way I'll share this one anecdote again from barbershop you know I've been doing it for several months and.

165
00:28:47.940 --> 00:28:51.900
Ciantel A Blyler: I saw a patient in a barbershop checked his blood pressure, it was above goal.

166
00:28:52.140 --> 00:29:01.020
Ciantel A Blyler: And you know, the next step in our algorithm was to actually add a diabetic, as I said, we avoided doing it at first line we started with an arm and a calcium channel Blocker but.

167
00:29:01.320 --> 00:29:12.240
Ciantel A Blyler: third step was to add a diuretic and you know I knew a lot about this guy I knew that he likes to work on his antique trucks, and he had 25 children that's not an exaggeration, I knew he had 25 children I knew.

168
00:29:12.540 --> 00:29:22.980
Ciantel A Blyler: The sort of personal details about him but I've never asked him what he did for work, it just I never really took that that in depth of the social history, but when I told them I'm going to add this diuretic.

169
00:29:23.370 --> 00:29:35.340
Ciantel A Blyler: And this is the potential side effects, he said, a Derek I'm a truck driver, I cannot take a water pill, I will be in the restroom all the time, and it will affect my ability to carry out my job, and I was.

170
00:29:35.850 --> 00:29:44.370
Ciantel A Blyler: sort of mortified that I didn't know that about him, and that I had just sort of decided unilaterally like this is the next

step, this is what our algorithm says, and this is what you're going to take.

171
00:29:45.000 --> 00:29:52.080
Ciantel A Blyler: And so, from then on, I kind of learned take a whole social history get to know the patient get to know what side effects of that you know.

172
00:29:52.350 --> 00:30:05.190
Ciantel A Blyler: acceptable to them, you know to me running to the restroom every hour gives me a break from my computer but to someone who is in a truck and in you know time is of the essence that's just not a realistic medication to add to the regimen so.

173
00:30:06.390 --> 00:30:07.620
Ciantel A Blyler: And I said that was my last point, but.

174
00:30:07.650 --> 00:30:16.890
Ciantel A Blyler: My actual last point that we actually should also be thinking about designing new care delivery models that address these sorts of common barriers.

175
00:30:18.240 --> 00:30:27.330
Ciantel A Blyler: To medication adherence and and design care models that inherently promote adherence and patient engagement barbershop being one example.

176
00:30:28.710 --> 00:30:32.280
Ciantel A Blyler: And with that I'll sort of open it up to the team to see if there's other comments.

177
00:30:33.720 --> 00:30:41.430
Alison Smith: Thanks so much they're really appreciate you walking through some of the major factors, the miss the financial considerations.

178
00:30:41.910 --> 00:30:49.530
Alison Smith: And really touching on the importance of partnering with patients, there is a whole separate webinar about motivational interviewing that's.

179
00:30:50.040 --> 00:31:00.120
Alison Smith: available if anyone is interested in turning back to that, but to eric's point we could spend another hour on each of these points anything pressing that Adam you like to join in here.

180
00:31:01.800 --> 00:31:24.120
Adam Bress: No, I don't think I have too much useful add a dare that was comprehensive and very informative I think the one thing that gives me hope is staying tuned on some of the emerging data on how to reduce clinical uncertainty at the point of care whether it's around adherence how much.

181
00:31:25.830 --> 00:31:34.080
Adam Bress: Of the regimens that patient actually taking the clinical uncertainty around that question, I think, is a big factor I hear from clinicians around whether to intensify or not.

182
00:31:35.370 --> 00:31:42.990
Adam Bress: And that adherence pieces obviously and very challenging in terms of how do we actually measure adherence because we know self-report can be challenging and unreliable.

183
00:31:45.540 --> 00:31:54.060
Adam Bress: The second is around clinic clinical uncertainty around the measurement I think we're making much more progress there in terms of automated office blood pressure and home monitoring.

184
00:31:54.780 --> 00:32:03.480
Adam Bress: and hopefully we can reduce the clinical uncertainty in the measurement and perhaps focus more on how can we get a reduced clinical uncertainty in the inherent piece.

185
00:32:03.900 --> 00:32:13.860
Adam Bress: And then, lastly, I just want to emphasize the point, the point, Dr bottom made around the patient acceptance piece and providing empathy to them regarding.

186
00:32:14.940 --> 00:32:22.950
Adam Bress: Taking a chronic medication for something for a disease that may be a symptomatic and perhaps cause some news and side effects and.

187
00:32:25.620 --> 00:32:26.520
Adam Bress: appreciate appreciating now.

188
00:32:28.080 --> 00:32:35.250
Ciantel A Blyler: yeah I really like that point Adam it's not something I had thought about talking about, but I think.

189
00:32:36.600 --> 00:32:42.000

Ciantel A Blyler: You know, again my experience, if you sort of create an open.

190
00:32:42.900 --> 00:32:56.910
Ciantel A Blyler: sort of open the lines of communication with patients that they'll tell you, if they're not taking a medication, you know, as I said, from day one, there were many patients who came and said look, this is what my doctor is giving me I'm just not taking it and I'd say why and they'd be like.

191
00:32:58.110 --> 00:33:00.780
Ciantel A Blyler: I don't know what it is, I don't know why it was given to me.

192
00:33:01.470 --> 00:33:16.290
Ciantel A Blyler: And I think a lot of this has to do and I'd say, well, did you tell your doctor this and they're like No, of course, not I don't want to upset my doctor and I think a lot of this is sort of rooted in the power dynamic like patient provider power dynamic.

193
00:33:17.520 --> 00:33:27.420
Ciantel A Blyler: And so, I think if we cultivate sort of like an environment where patients feel comfortable sharing what their concerns are what their challenges are.

194
00:33:27.660 --> 00:33:34.500
Ciantel A Blyler: And also, just being honest with us about whether or not they're taking their medications, then we can sort of change this dynamic of like.

195
00:33:34.740 --> 00:33:45.780
Ciantel A Blyler: Patients hiding or lying or saying of course I take a Doc and then creating this sort of clinical certainty about you know what should we do should I give them more medication or am I just giving them another thing to add to the medicine cabinet.

196
00:33:46.650 --> 00:33:57.450
Ciantel A Blyler: I think it's sort of so important to be open, one of the things I often do as a again as a provider myself, as I say to people I literally have to take one medication a day and I miss it.

197
00:33:58.710 --> 00:34:04.920
Ciantel A Blyler: pretty much routinely like once every other week I am not perfect, and I take one medication and many of my patients take.

198

00:34:05.430 --> 00:34:15.780
Ciantel A Blyler: 510 15 medications, and so I can only imagine how difficult that is, and I think oftentimes leading with that allows for them to not be perfect and allows for them to say to us like.

199
00:34:16.290 --> 00:34:29.790
Ciantel A Blyler: Okay yeah I do miss at least once or twice a week and, and then we can have this room discussion of like okay well how do we improve that together, you know, do we need to simplify things do we need combination pills what you know what do we need to do to make it easier for you.

200
00:34:30.630 --> 00:34:39.480
Alison Smith: yeah appreciate y'all highlighting some of the importance of creating a you know, an open and therapeutic relationship leveraging the team and figuring out who.

201
00:34:39.720 --> 00:34:46.050
Alison Smith: Has the time and rapport to create that relationship with a patient and manage expectations that.

202
00:34:46.410 --> 00:35:01.530
Alison Smith: The average patient with retention takes two or more medications to reach the goal and so sort of setting that expectation and keeping our eye focused on the importance of that goal and reducing risk is certainly important, I wish we could I wish we had five hours.

203
00:35:01.560 --> 00:35:15.660
Alison Smith: Honestly, I know we're going to move on to our next question and I'm going to turn to Eric T this one up and thinking about the barriers and solutions from a provider perspective and talk us through some of those highlights.

204
00:35:16.920 --> 00:35:22.410
Eric MacLaughlin: yeah thanks and there's been some great stuff in the in the chat box and I'd love to respond to all of it it's.

205
00:35:24.090 --> 00:35:32.190
Eric MacLaughlin: Really good and provocative information, maybe we'll have a little bit at a time to hit some of these other questions but um you know to.

206
00:35:33.060 --> 00:35:42.240
Eric MacLaughlin: Your point Alison about thinking about what other barriers, you know from a from a provider perspective, Adam sort of alluded to this a little bit either earlier talking about some of the.

207
00:35:43.260 --> 00:35:53.400
Eric MacLaughlin: Concerns or uncertainty folks might have regarding Okay, is this really high blood pressure, well you're just stressed you just came in or out it's close enough I'm not really worried.

208
00:35:54.180 --> 00:36:07.800
Eric MacLaughlin: My I don't think that's a really true measurement or you know patients tell you about my blood pressure is fine at home, I you know I check it all the time, and you know it's Okay, there you know I get that quite a bit and again I'm in a family medicine clinic.

209
00:36:09.300 --> 00:36:15.630
Eric MacLaughlin: work with family medicine academic clinic with faculty and residents and.

210
00:36:16.080 --> 00:36:25.110
Eric MacLaughlin: And I usually get the console but we get this uncertainty issue quite a bit, and again I think this leads to some of that therapeutic inertia, we were talking about.

211
00:36:25.800 --> 00:36:32.730
Eric MacLaughlin: One of the biggest things, I think that we can do, though, in addition to yes definitely adding intensifying drug therapy when it's indicated.

212
00:36:32.970 --> 00:36:38.880
Eric MacLaughlin: Thinking about you know fixed those combinations versus single agents getting it to what a dare was bringing up earlier about.

213
00:36:39.270 --> 00:36:49.500
Eric MacLaughlin: You know, taking a Multifactorial approach and finding out okay what's the reason here oftentimes I feel like Sherlock Holmes, is it a drug, is it a disease to do they have.

214
00:36:50.370 --> 00:37:01.350
Eric MacLaughlin: I mean I've done referrals for home health care because someone has significant memory issues or you know again very, very Multifactorial, but I do think one of the things that is changing.

215
00:37:03.150 --> 00:37:04.860
Eric MacLaughlin: Over the last couple years that I've seen.

216
00:37:06.150 --> 00:37:12.600

Eric MacLaughlin: is particularly with regards of home blood pressure, monitoring and I thought I did see a comment in the chat box earlier about.

217
00:37:13.650 --> 00:37:24.570
Eric MacLaughlin: One of our attendees I think so doing a lot of SF EP or self-measure home blood pressure, monitoring and I think there's more and more data that's coming out that shows that.

218
00:37:25.170 --> 00:37:33.420
Eric MacLaughlin: Indeed, doing self-measured home blood pressure monitoring is a fantastic way to not only diagnose hypertension.

219
00:37:34.110 --> 00:37:47.250
Eric MacLaughlin: but also to monitor response to therapy make adjustments based on those high blood pressure readings and more and more data coming out that shows hey this is, this is a really pretty decent tool back.

220
00:37:47.730 --> 00:37:56.430
Eric MacLaughlin: And there was a paper that Dr Beverly green and colleagues published this year, looking at the diagnostic.

221
00:37:57.930 --> 00:38:10.680
Eric MacLaughlin: accuracy basically of looking at clinic blood pressure measurements home blood pressure measurements and kiosk home BP measurements, and this was up in Washington state, but they did a randomized.

222
00:38:11.730 --> 00:38:24.750
Eric MacLaughlin: trial, where they looked at clinic blood pressures they looked at basically usual care, and they also had a group where they gave validated home blood pressure, monitors that had Bluetooth capability.

223
00:38:25.560 --> 00:38:34.740
Eric MacLaughlin: That would transmit that data, and then they also looked at kiosks chaos blue blood pressure measurements and then these kiosks were actually validated.

224
00:38:35.550 --> 00:38:41.400
Eric MacLaughlin: You know the methods by which they did them or a little bit different with each obviously usual cares usual care what the kiosks they did.

225
00:38:42.000 --> 00:38:47.760

Eric MacLaughlin: triple get blood pressure measurements on three days and with the home blood pressure monitoring group.

226
00:38:48.510 --> 00:38:56.670
Eric MacLaughlin: They did duplicate blood pressures twice a day for five days, so you know taken to blood pressures in the morning and to at night and then an average in those readings.

227
00:38:57.510 --> 00:39:05.490
Eric MacLaughlin: And what they found when they compare that to our gold standard, which is a 24-hour ambulatory blood pressure measurement.

228
00:39:06.030 --> 00:39:14.130
Eric MacLaughlin: was a basically there was no real statistic no statistical difference at all between the home blood pressure, monitor group and the ambulatory BP group.

229
00:39:15.000 --> 00:39:21.360
Eric MacLaughlin: The primary outcome was systolic blood pressure change and the difference there was only negative point one.

230
00:39:22.080 --> 00:39:30.780
Eric MacLaughlin: negative point one millimeters of mercury difference, in other words the home blood pressure with basically systolic wise almost essential these same.

231
00:39:31.410 --> 00:39:44.220
Eric MacLaughlin: mean except one 10th of a millimeter mercury off, which is really not clinically significant but interestingly that clinic blood pressure measurements were almost five millimeters mercury actually lower than ambulatory BP monitoring.

232
00:39:45.900 --> 00:39:50.430
Eric MacLaughlin: And the kiosk was almost 10 million millimeters of mercury higher.

233
00:39:51.300 --> 00:40:03.660
Eric MacLaughlin: So I think data from this study, again I think it's an important study back in the 2017 guidelines, you know home blood pressure monitoring or I think what the guideline says, out of office measurements.

234
00:40:04.470 --> 00:40:15.330

Eric MacLaughlin: were recommended certainly for diagnosis and confirmation of high blood pressure and particularly to you need, though, is really to diagnose white coat and mass hypertension.

235
00:40:15.840 --> 00:40:23.340
Eric MacLaughlin: which I think are significant issue we still see about 30% of patients have white code and, ironically, about 30% have my test hypertension.

236
00:40:23.970 --> 00:40:28.200
Eric MacLaughlin: So just to recall, you know white coat hypertension is basically where your blood pressure.

237
00:40:28.710 --> 00:40:35.790
Eric MacLaughlin: In the clinic setting are higher than at home or out of office clinic settings and mass hypertension is basically the opposite of that.

238
00:40:36.240 --> 00:40:42.570
Eric MacLaughlin: Where maybe the clinic measurements look good but actually when you're out of the clinical setting they're actually higher.

239
00:40:42.960 --> 00:40:54.420
Eric MacLaughlin: And that does portents significantly increased risk of cardiovascular events basically just like it would almost with sustain hypertension, so what we've been doing in our clinic is doing a lot more.

240
00:40:55.530 --> 00:41:03.900
Eric MacLaughlin: routine use of self-measure blood pressure recordings, we have patients bring in their monitor if they don't have a validated device that's on the.

241
00:41:04.650 --> 00:41:12.120
Eric MacLaughlin: validate EP or website so it's great tool where I'll send patients that they don't have a home blood pressure, monitor certainly can go there and.

242
00:41:13.740 --> 00:41:28.260
Eric MacLaughlin: find a device that is validated but we're having patients bring in their monitor and target BP has a great tool to assess the accuracy of a patient's blood pressure, monitor, where you're taking a series of readings.

243
00:41:29.490 --> 00:41:32.640

Eric MacLaughlin: With the patients monitor you check it with your clinic.

244
00:41:33.750 --> 00:41:43.560
Eric MacLaughlin: validated monitor hopefully it's automated isometric device, not the manual anaerobic one you have hanging on the wall, we still have those we never use them.

245
00:41:44.070 --> 00:41:54.210
Eric MacLaughlin: We do use automated validated devices, but there's a whole series procedure that you do and we actually incorporated that procedure into our EHR.

246
00:41:54.630 --> 00:42:10.500
Eric MacLaughlin: And routinely if we have a new patient with high blood pressure, again, providing that education, doing the Sherlock Holmes and figuring out okay why aren't you controlled, is it a medication adherence issue is it social economic issues, is it hey I'm a truck driver and I gotta take that.

247
00:42:12.060 --> 00:42:19.650
Eric MacLaughlin: Again lots of lots of different reasons, but you know, making sure we have, I think, accurate readings is really, really, really important.

248
00:42:20.520 --> 00:42:31.620
Eric MacLaughlin: You know, with statistics and studies there the adage that garbage in garbage out if you do a study and you don't want data you're using it that it's accurate can't hang your hat on it then it's really not very good so.

249
00:42:32.190 --> 00:42:42.270
Eric MacLaughlin: Again, using a validated, monitor and importantly teaching the patient and making sure they using it correctly and our clinic staff, making sure they're doing blood pressures correctly, I still see.

250
00:42:42.990 --> 00:42:49.500
Eric MacLaughlin: You know, inappropriate or incorrect technique, even in our clinic I hate to say so, unfortunately.

251
00:42:49.830 --> 00:42:58.620
Eric MacLaughlin: I think that's that that's oftentimes the case so again making sure we're getting accurate readings, with proper technique patient education staff education.

252
00:42:58.980 --> 00:43:08.430
Eric MacLaughlin: And again, making sure that those monitors are accurate, I think are important caveats or factors when it comes to therapeutic inertia and getting folks to go.

253
00:43:09.900 --> 00:43:15.660
Alison Smith: Thank you Eric, I really appreciate you reflecting on the importance of measurement accuracy, the.

254
00:43:16.140 --> 00:43:27.210
Alison Smith: Power of self-measure blood pressure if it's related back to the team and used in diagnostic and treatment decision shared decision making, so it's a really very important point.

255
00:43:27.870 --> 00:43:41.130
Alison Smith: I'm going to move us on because we are we've got so many so many great comments to still cover and a few questions to address so I'm going to actually turn back to Adam for our last discussion question to think about.

256
00:43:41.790 --> 00:43:53.130
Alison Smith: What are the system level barriers and solutions as it relates to treatment intensification and then, if you'll have other comments, we can sort of filter those in and defend our remaining section, so I'll turn back to you, Adam.

257
00:43:53.820 --> 00:43:59.340
Adam Bress: Absolutely, there was Thank you Eric for that there was a point that Eric made that I want to emphasize that I think.

258
00:44:00.630 --> 00:44:11.370
Adam Bress: foreshadows this next section on systems of care, which is the critical importance of the art of clinical pharmacy or the art of medicine that really does.

259
00:44:12.030 --> 00:44:21.990
Adam Bress: The hard work of creating the time and space to truly manage the patient and the agent related variables, to achieve the optimal pharmaceutical result and.

260
00:44:24.270 --> 00:44:26.310
Adam Bress: Treatment protocols get us there.

261
00:44:27.480 --> 00:44:32.610

Adam Bress: Most of the time, but not all the time, and I think Adair and Eric both.

262
00:44:33.780 --> 00:44:39.930
Adam Bress: told stories that we all know of around the challenges of creating that space where patients feel.

263
00:44:40.410 --> 00:44:55.200
Adam Bress: Safe or are able to share what's truly going on for them, whether it's an adherence issue a side effect issue a belief about efficacy or effectiveness issue, and I think that transitions nicely to team-based care where these models.

264
00:44:56.700 --> 00:44:58.380
Adam Bress: empower highly trained.

265
00:44:59.400 --> 00:45:09.150
Adam Bress: clinicians such as pharmacists are nurses to create that space and time to do the Sherlock Holmes works work that Eric mentioned.

266
00:45:10.410 --> 00:45:16.200
Adam Bress: So, the context of this next section is that some health systems are doing much better than others in terms of control.

267
00:45:18.420 --> 00:45:21.630
Adam Bress: And there's a multi-faceted complicated.

268
00:45:22.890 --> 00:45:37.560
Adam Bress: reason for why that's the case and separately, there is a pretty large body of evidence now showing what works from a system level to achieve better control.

269
00:45:39.510 --> 00:46:00.390
Adam Bress: Systems such as Kaiser and VA achieve control rates in the 80 ish percent range at 90% range and they do this because they do well, a few things the first is they invest in team-based care with nonnon-physician providers that are empowered to intensify regimens and monitor therapy.

270
00:46:01.500 --> 00:46:13.950
Adam Bress: And they also have data infrastructure to allow for patient registries and utilization of standardized treatment protocols that help empower providers to provide high quality care.

271

00:46:14.970 --> 00:46:19.950
Adam Bress: To all patients, and they also leverage these systems to have good patient follow up.

272
00:46:20.520 --> 00:46:29.490
Adam Bress: And there, I think, better position to integrate some of the technologies that Eric mentioned around home monitoring, which is an emerging technology that.

273
00:46:30.360 --> 00:46:39.630
Adam Bress: As Eric mentioned is giving us, we believe, as accurate of measurements, as the gold standard the 24-hour ambulatory blood pressure monitoring.

274
00:46:41.940 --> 00:46:43.980
Adam Bress: In terms of randomized evidence.

275
00:46:45.180 --> 00:46:46.740
Adam Bress: The evidence is very clear.

276
00:46:47.970 --> 00:46:49.320
Adam Bress: The Karen mills paper in.

277
00:46:51.390 --> 00:46:56.910
Adam Bress: shows clearly that the implement implementation strategy that's most effective at lowering BP.

278
00:46:57.900 --> 00:47:11.160
Adam Bress: Is a multi-level team-based care approach with a not with a non-physician provider, that is actively measuring blood pressure, high quality fashion tie trading medications and taking ownership of follow.

279
00:47:12.720 --> 00:47:24.750
Adam Bress: And this approach is starting to be replicated in diverse populations, we heard from a dare regarding the barbershop which intervention included many of these aspects.

280
00:47:26.220 --> 00:47:31.920
Adam Bress: So, there's good prior knowledge that these principles will apply to.

281
00:47:33.090 --> 00:47:40.380
Adam Bress: A range of populations in terms of cultural beliefs, race, ethnicity socio economic status access.

282
00:47:43.770 --> 00:47:55.350
Adam Bress: There are many challenges in in in lamenting team-based care cost is one that comes to mind the healthcare systems, usually have to.

283
00:47:56.760 --> 00:48:12.000
Adam Bress: have an upfront investment in that provider, and this can be challenging, given the current reimbursement environment which is very complicated and very state to state and I'll let Eric or dare speak more to that because I think they have more expertise there.

284
00:48:14.760 --> 00:48:19.680
Adam Bress: and moving forward with solutions, I think we look to institutions that.

285
00:48:21.660 --> 00:48:27.270
Adam Bress: have done this well, especially if their patient population or case mix matches your own.

286
00:48:28.530 --> 00:48:36.780
Adam Bress: And then remember the principles remember the randomized evidence non-physician providers empowered to tie treatments and follow up.

287
00:48:38.190 --> 00:48:45.480
Adam Bress: Providing them the time and space to see patients in a way that works for them and they patients, I think, are the principles that we should tailor.

288
00:48:47.100 --> 00:48:49.500
Adam Bress: To meet the unique needs of the population you're treating.

289
00:48:52.020 --> 00:49:04.890
Alison Smith: And thank you for outlining that I'm going to turn to each of you just one last time for any responses on this particular topic or any sort of takeaway thoughts that that you each have.

290
00:49:05.550 --> 00:49:19.350
Alison Smith: I really appreciate you highlighting the importance of clinical leadership and team-based care and the you know growing evidence behind that those strategies to meet your patient population, where they are.

291
00:49:20.610 --> 00:49:21.420

Alison Smith: A Derek do you have.

292
00:49:22.500 --> 00:49:26.460
Alison Smith: Some remarks or concluding thoughts at this stage.

293
00:49:28.710 --> 00:49:31.770
Ciantel A Blyler: not too much to add, I want to make sure we have enough time for questions.

294
00:49:33.120 --> 00:49:42.450
Ciantel A Blyler: To go back to eric's part about MAP BP I just think that that is playing sort of an outsized role in our lot of our practices, right now, you know, again, as I.

295
00:49:42.690 --> 00:49:54.060
Ciantel A Blyler: mentioned the beginning of the talk, you were having a lot of challenges, especially here in Los Angeles getting people to come back into the clinic they become so accustomed to this Tele health setup and so now we're really having to.

296
00:49:55.590 --> 00:50:01.740
Ciantel A Blyler: count on SVP and make sure that people know how to measure accurately report those readings, so that we can make informed decisions about treatment.

297
00:50:03.420 --> 00:50:06.780
Ciantel A Blyler: And yeah, I guess I'll leave it at that there's not too much more that I wanted to add.

298
00:50:08.160 --> 00:50:08.430
yeah.

299
00:50:09.570 --> 00:50:12.930
Eric MacLaughlin: I don't have much either I mean it's obviously it's a huge topic, I think.

300
00:50:13.530 --> 00:50:23.970
Eric MacLaughlin: Adam capping that off and talking about some of the other implementation strategies, the some of the benefits that in the Kaiser system, the VA system has an and particularly the team-based care, I think that article.

301
00:50:24.780 --> 00:50:38.400

Eric MacLaughlin: That he cited and mentioned earlier, is fantastic and there's very strong data in the guideline at the class one a recommendation for team-based care very, very strong data because, again, I think it takes a village there's a lot of factors involved.

302
00:50:39.870 --> 00:50:48.990
Eric MacLaughlin: From patient education, it really does take a village, and I think the more eyes are looking at it and it frankly takes a lot of time and.

303
00:50:49.500 --> 00:51:04.590
Eric MacLaughlin: You know, ultimately, I think we do need some healthcare system reform, particularly with regards to payment models and those types of things, I think that would probably help out quite a bit as well, so I'll kind of leave that dangling there at the end.

304
00:51:05.700 --> 00:51:06.630
Adam Bress: And nothing else and.

305
00:51:06.960 --> 00:51:17.310
Adam Bress: Definitely, so one thing I wanted to mention in my opening that I forgot was, I mentioned the cost as a barrier, but I forgot to mention the the cost effectiveness data.

306
00:51:19.110 --> 00:51:27.000
Adam Bress: There are numerous cost effectiveness reports out there, looking at team-based care from different angles, including another paper.

307
00:51:27.480 --> 00:51:35.100
Adam Bress: Led by I believe Kelsey Brian and Brandon bellows that that there was a part of looking at the cost effectiveness specifically of the Barbara intervention.

308
00:51:35.670 --> 00:51:47.280
Adam Bress: And the upshot from all these reports is that it's, it is high value across a range of scenarios regarding the F t of the pharmacist or the delta SVP of cheap.

309
00:51:47.670 --> 00:51:59.820
Adam Bress: So, across all those different scenarios it's still highly cost effective, so those data are also important when we're trying to make the case to health system managers population health managers around.

310

00:52:01.170 --> 00:52:04.620
Adam Bress: The kind of cash outlay for setting up some of these programs.

311
00:52:05.610 --> 00:52:06.570
Alison Smith: And we certainly.

312
00:52:07.680 --> 00:52:26.160
Alison Smith: You know, we know that, to the point made earlier that the medications needed to control, you know we know how to control blood pressure, we have no or low-cost medications to do so, the tools to diagnose the condition are much cheaper than any other conditions in terms of the.

313
00:52:27.180 --> 00:52:36.180
Alison Smith: equipment required to diagnose, so it is certainly it's more than a winnable battle, I will say also that the American the AJ and the AMA are working together.

314
00:52:36.690 --> 00:52:44.490
Alison Smith: Both to try to achieve Medicare coverage of self-measure blood pressure devices and then we're also working at the state level together.

315
00:52:44.760 --> 00:52:52.170
Alison Smith: To maximize the coverage and reimbursement to support the services and devices and are having some we.

316
00:52:52.620 --> 00:53:02.370
Alison Smith: are celebrating a win in Maryland this year and working on several other states so to try to improve and I address the access issue that you will meet as a point.

317
00:53:02.970 --> 00:53:14.100
Alison Smith: I see one question that I have two questions in the chat one is if you're if you have at your fingertips, the graphic that you mentioned related to the barbershop.

318
00:53:16.020 --> 00:53:25.800
Alison Smith: we're certainly invite you to drop in the chatter we can add it to the follow up email, the one specific question that that came up really had to do with I think the challenge of helping.

319
00:53:26.250 --> 00:53:35.760

Alison Smith: inform patients about the risks associated with and side effects associated with their medications that sometimes can be deterrence to adherence.

320
00:53:36.150 --> 00:53:53.070
Alison Smith: Maybe creating more concerns but I'm curious in your clinical experience, if you all have recommended either tools or strategies that you recommend to try to address some of those challenges Eric, I'll start with you on that, if you have some thoughts on that.

321
00:53:53.550 --> 00:53:58.050
Eric MacLaughlin: Sure, yeah I know exactly what you're talking anytime when it goes to pick up a prescription.

322
00:53:58.590 --> 00:54:04.560
Eric MacLaughlin: You see a list of side effects like why in the world would I ever take this medicine, so it know it's awful so.

323
00:54:05.250 --> 00:54:16.440
Eric MacLaughlin: In health literacy, of course, is that is an issue um I think this comes a point I think we're education its multiple touch points are really critical someone the prescription is written.

324
00:54:17.400 --> 00:54:24.870
Eric MacLaughlin: Whether it be a physician a PA nurse, we have, I have a club are prescribing agreement here in Texas with our family medicine docs.

325
00:54:25.350 --> 00:54:35.970
Eric MacLaughlin: When we send a prescription, I sent one to the pharmacy Okay, this is what it is, these are, these are the benefits and these are the risks, and this is the likelihood of the risk, and these are the most common side effects.

326
00:54:37.320 --> 00:54:43.590
Eric MacLaughlin: I usually try to have the caveat that you know information that you're going to get from the pharmacy is going to list everything under the sun.

327
00:54:44.160 --> 00:54:48.780
Eric MacLaughlin: A lot of times the incidence rates are some of those side effects are no different than placebo.

328
00:54:49.170 --> 00:54:57.210

Eric MacLaughlin: So, what I try to really focus on is the most common side effects and how to mitigate and manage those side effects should they happen and then again hopefully if they're getting.

329
00:54:57.660 --> 00:55:08.640
Eric MacLaughlin: That new prescription, there is a legal requirement to counsel patients, when you pick up a prescription and so, at least the offer to be made now whether patients take that up or not.

330
00:55:09.510 --> 00:55:14.640
Eric MacLaughlin: But what I like to do you know we own and operate a pharmacy or sometimes I go down and fill in.

331
00:55:15.120 --> 00:55:23.880
Eric MacLaughlin: For them, if needed, and I'll counsel patients on again similar issues, this is what the medication is used as how to use it, these are the most common side effects you like the see.

332
00:55:24.390 --> 00:55:40.470
Eric MacLaughlin: If you are to see any most patients tolerated just fine so again, I think, providing that patient counseling and education is is probably the main avenue, I would say to kind of address some of those issues that you're going to see some of that patient literature, a handout.

333
00:55:41.070 --> 00:55:46.830
Alison Smith: Good patient education, how to transcend a larger package insert that's really.

334
00:55:47.220 --> 00:55:55.920
Alison Smith: intimidating, so thank you, I have one question that came up in the Q amp a that I just want to pose quickly before we have to wrap up here and I do wish we had three more hours.

335
00:55:56.700 --> 00:56:17.640
Alison Smith: Which is thinking about your each of your experiences in how systems and the opportunity to leverage the talents of pharmacists, as part of the care team are there other strategies or experiences to improve that trust and the integration into the team that anybody wants to share briefly.

336
00:56:21.180 --> 00:56:35.880
Eric MacLaughlin: Adam what briefly I you know I we've had a team-based protocol, for I think close to 20 years and I've been working with down a message for a long time, and a lot of it's honestly it's relationship development and sometimes it takes time.

337
00:56:36.960 --> 00:56:49.620
Eric MacLaughlin: The financial models, I think there was a comment about pharmacies being recognizes providers by Medicare yeah that's absolutely one of the barriers there, I think we have found some creative ways around it, where we'll have our attending physician.

338
00:56:50.790 --> 00:56:59.640
Eric MacLaughlin: pop their head and say hi quickly I'll give them a quick rundown on what's going on and we do billing instead of two levels under the attending physician, and they sign our note.

339
00:56:59.970 --> 00:57:11.730
Eric MacLaughlin: review our insider nope but you know it's obviously not particularly efficient, but you know I think if we can get some of these other models in place and I think.

340
00:57:12.270 --> 00:57:24.270
Eric MacLaughlin: In other managed care settings the VA and even some private insurances and these some really interesting on statewide initiatives that are being done with independent assurances and other independent groups and some other states.

341
00:57:24.630 --> 00:57:31.710
Eric MacLaughlin: kind of this demonstration projects are really showing the benefit and to Adams point earlier that that return on investment.

342
00:57:32.430 --> 00:57:35.670
Eric MacLaughlin: is really showing from a you know from local economic standpoint or.

343
00:57:36.000 --> 00:57:50.190
Eric MacLaughlin: economic standpoint in general that hey, this is a worthwhile intervention, you should pay for the services because guess what you're saving a lot of money down the road with decreased morbidity and mortality hospitalizations and those types of things so um you know we do.

344
00:57:51.540 --> 00:57:52.110
Eric MacLaughlin: That sorry.

345
00:57:52.530 --> 00:57:58.620
Alison Smith: No, no, thank you for that I just Derek just you Adam is there anything else you'd like to add, before we wrap up.

346
00:57:58.680 --> 00:58:09.330
Adam Bress: No, I thought that was great I think giving empathy here is important it's I think we're all it's frustrating, you know and exhausting because we want progress.

347
00:58:10.650 --> 00:58:23.370
Adam Bress: In this, and we want to contribute in the faith of not very high-quality evidence kind of supporting what the ask is both from an effectiveness and from a cost effectiveness perspective and I.

348
00:58:24.930 --> 00:58:38.640
Adam Bress: I think, in my experience in the 10 years I've been doing this, I agree with Eric completely it's a lot of relationships and what I found for me is identifying the passionate minority first.

349
00:58:40.320 --> 00:58:46.470
Adam Bress: The people that are on board and working with them, hopefully, some of them are physician leaders at your health system.

350
00:58:47.520 --> 00:59:00.990
Adam Bress: and managing up making it easy for them to do the thing you're asking them to do by providing them the justification or the business plans or whatever, and have it invite them to just say hey can you put this forward.

351
00:59:01.680 --> 00:59:08.160
Alison Smith: Thanks, early adapters and champions are certainly pivotal anything else you want to add a day before we wrap up.

352
00:59:08.430 --> 00:59:09.780
Ciantel A Blyler: No Okay, I know we're short on time.

353
00:59:10.980 --> 00:59:17.880
Alison Smith: I cannot thank each of you enough, I think this is going to need to be a weekly series now we'll continue this conversation I hope in the future.

354
00:59:18.150 --> 00:59:26.640
Alison Smith: I want to thank all of our participants for joining us today, we do have one quick question that we want to ask you again before we wrap up.

355
00:59:27.420 --> 00:59:38.730

Alison Smith: And really, we're wanting to ask you the same question again what is that single most important and powerful action that will improve a patient's blood pressure control.

356
00:59:39.420 --> 00:59:46.140
Alison Smith: And I will ask my colleagues to launch that Pole, is it improving patient medication adherence is.

357
00:59:46.530 --> 01:00:00.420
Alison Smith: shortening the time between visits, is it intensifying treatment by advocate adding a medication cost or are you unsure I appreciate your feedback here, I see a shift and the responses already.

358
01:00:02.640 --> 01:00:04.890
Alison Smith: And I'm going to.

359
01:00:06.000 --> 01:00:08.280
Alison Smith: just give it two or three more seconds.

360
01:00:09.420 --> 01:00:15.480
Alison Smith: All right, if you could share the results and then we'll wrap up today, thank you very much.

361
01:00:16.200 --> 01:00:22.470
Alison Smith: It looks like we have a big shift where 73% of you are identifying what was highlighted in.

362
01:00:22.980 --> 01:00:28.410
Alison Smith: The bellows article and many other publications, the power of treatment intensification to reduce risk.

363
01:00:28.770 --> 01:00:36.930
Alison Smith: rapidly, while we then work on some long-term longer-term lifestyle change, so thank you all for participating in that that poll.

364
01:00:37.320 --> 01:00:47.010
Alison Smith: And the next slide I just want to highlight one resource which is relatively new I think in the last year for targeted up it's really a compilation of all of the map resources, the.

365
01:00:47.640 --> 01:01:00.600
Alison Smith: The Quick Start guides for measuring accurately acting rapidly partner with patients and using self-measure blood pressure,

actually throughout each of those phases, for the diagnosis of hypertension that intensification of treatment to reach goal.

366
01:01:01.050 --> 01:01:06.720
Alison Smith: As well as a long-term strategy for encouraging medication adherence and lifestyle modification so.

367
01:01:07.320 --> 01:01:12.540
Alison Smith: they're combined for ease of use, with some a little bit of additional context.

368
01:01:12.870 --> 01:01:23.490
Alison Smith: With that I want to thank you all again for joining us and encourage you to respond to the survey that will pop up as soon as we exit the program here your feedback means a great deal to us.

369
01:01:23.790 --> 01:01:32.580
Alison Smith: And it really helps us plan our future programs, but that, thank you for what you do every day and caring for patients with hypertension, thank you very much.

370
01:01:34.350 --> 01:01:35.250
Ciantel A Blyler: Thank you, thank you.

371
01:01:36.240 --> 01:01:36.540
Eric MacLaughlin: Thank you.