POST-EMERGENCY DEPARTMENT DISCHARGE CLINIC TELEHEALTH PROGRAM FOR PATIENTS WITH UNCONTROLLED HYPERTENSION: A PILOT STUDY

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Poster #

Background

- Hypertension (HTN) affects 47% of US adults.
- Emergency Department (ED) may be the primary interaction many patients have with the healthcare system and main source of care for communities with limited access to primary care.
- Studies that tried to improve HTN at discharge from ED had limitations: small sample size, low retention rates, no control group, included only 1 racial group.
- At UAB, an ED-post discharge clinic (PDC) was established in 2022 to follow up patients with any ailment and with no designated primary care physician (PCP) within 3-7 days post discharge.

Project Aims

Aim 1: Determine the feasibility of delivering an integrated remote blood pressure monitoring (RBPM) and pharmacist led telehealth intervention for management of HTN among 12 ED-PDC patients with blood pressure (BP) ≥ 130/80 and ≤160/100 enrolled at the ED-PDC and randomized to the intervention.
Aim 2: Assess acceptability and adherence to a RBPM and pharmacist-led telehealth visits for BP management among 12 patients randomized to the intervention.

Study Design

Pilot hybrid implementation-effectiveness type 2 trial:

- 12 eligible patients will be randomized to RBPM and pharmacist led telehealth intervention
- 12 eligible patients will be randomized to usual care

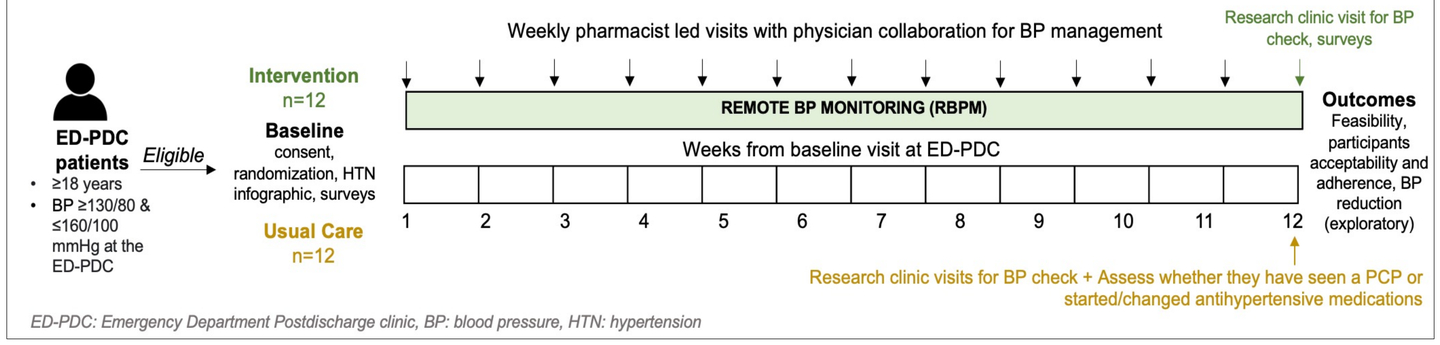
Eligibility Criteria:

- Patients seen at ED-PDC
- ≥ 18 years
- BP≥130/80 and ≤160/100mmHg
- English speakers
- Have smartphone with video capability
- No primary care provider

Interviews with community advisory board (CAB), healthcare workers, UAB stakeholders and patients.

Theoretical Framework

Figure 1. Study Overview



ED-PDC: Emergency Department Postdischarge clinic, BP: blood pressure, HTN: hypertension

Outcomes

Table 1. Study Outcomes

	Assessment
Recruitment	Assess weekly and monthly recruitment rate
Retention rates	% of participants attend week 12 study visit
Fidelity	Success in implementing the intervention as intended (e.g., train staff, deliver BP monitors)
Adherence to intervention	% of video visits attended, % who measure BP twice a day every day for 12 weeks
Acceptability of intervention	Qualitatively: subjective feedback from 1:1 interviews

Key Messages

- HTN is a public health problem
- ED serves as "primary care" for disadvantaged populations
- Interventions to improve BP control are not being implemented and are not reaching disadvantaged populations
- HTN management may be transformed by identifying patients at a care transition clinic following ED discharge
- Tethering a HTN management intervention to an exemplary care transition clinic, allows us to include a patient population that might have not been evaluated otherwise

Community Impact

Key Partners:

- UAB ED-PDC
- Community Advisory Board
- Pharmacists and other health care providers

Public Health & Societal Impact:

- Health care accessibility: Expand access to appropriate HTN care for **minoritized populations and persons lacking health insurance and regular primary care**.
- Health care delivery: Provide improved quality of care for patients with HTN, **particularly those with no established healthcare**.

References

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