Hypertension kills more people in the US than any other health condition. Effective and low-cost therapies are widely available, and their appropriate long-term use significantly lowers the risk of stroke, myocardial infarction, kidney failure, and death. Yet fewer than half of all US adults have their hypertension controlled, and these rates have declined in recent years. Hypertension is common in Black people in the US, as is hypertension-related morbidity and mortality, exacerbated largely by adverse social and structural determinants of health. Thus, addressing hypertension control in this population is a critical issue for improving population health and health equity.

The landmark Los Angeles Barbershop Blood Pressure Study (LABBPS) achieved hypertension control in Black men by delivering pharmacist care at barbershops serving primarily Black customers. In this cluster randomized trial, barbers screened their customers for hypertension, and those with uncontrolled hypertension were encouraged to follow up either with a pharmacist who met them in the barbershop and prescribed treatment under a collaborative practice agreement with their primary care clinician (intervention) or directly with their primary care clinician (control). At 6 months, participants receiving the pharmacist-led intervention were taking a greater number of blood pressure medications, including longer-acting medications, and achieved large reductions in systolic blood pressure (21.6 mm Hg compared with control) that were sustained through 1 year. We found this intervention to be cost-effective and estimate that such a program has the potential to reach 1 in 3 Black men with hypertension and avert 40% of major adverse cardiovascular events in program participants. However, reproducing the trial’s impressive blood pressure reduction in real-world settings will require creative solutions for key implementation challenges.

**Innovation in Financing**

In a health system in which reimbursement is increasingly tied to value, the failure to incorporate health equity into traditional quantitative assessments of value is a major barrier to scaling up community-based interventions. Financial models that value—and pay for—health equity are necessary to support novel community-based prevention strategies.

How much should payers be willing to pay per patient for this program? Prevention programs are often unfairly expected to pay for themselves in the long run. To be cost neutral, barbershop-based hypertension control programs would have to cost $237 per person annually (excluding medication costs). But cost neutrality is an economic standard seldom applied to new therapies, which are assumed to be cost-effective at $100 000 or less for each incremental quality-adjusted life-year (QALY) they generate. If this conventional cost-effectiveness threshold were applied to barbershop-based hypertension control programs, they would be cost-effective at $1498 per person per year.

But if achieving health equity is of value to society, public and private payers should be willing to pay an additional amount for interventions that reduce health inequities. So, if they are willing to pay $100 000 per QALY gained for a new pill that lowers blood pressure, spending $150 000 or $200 000 per QALY could be justified for a strategically designed, evidence-based intervention that improves health outcomes in a systematically marginalized population with a disproportionate burden of uncontrolled hypertension and its complications. At these higher cost-effectiveness...
thresholds, barbershop-based hypertension programs would be cost-effective at an annual cost of $2128 to $2758 per year.

Innovation in Health Care Delivery

After a community-based intervention's efficacy is demonstrated in a clinical trial, its implementation in the real world requires adaptation to local resources and regulatory environment. The LABBPS can be thought of as a community-clinic linkage model of a multi-intervention bundle. Each element—pharmacist-led hypertension management delivered in partnership with a trusted community leader (barber) at a convenient community and communal venue (the barbershop)—contributes to sustained blood pressure reduction and also generates potential costs. National scale-up will require adaptations of 1 or more of these components to fit the relevant context in various community-based settings. For instance, in settings in which each payer is responsible for a small proportion of eligible patients, multiple payers or accountable health systems may contract with a single program on a per-capita fee basis, possibly with additional financial incentives for patient retention and hypertension control. This third party would then enroll barbershops and employ pharmacists, helping keep down costs for individual payers. Alternatively, in settings in which travel times between barbershops are expected to be substantial, relying on pharmacists at community pharmacies may lower costs, as would the use of telemedicine encounters for follow-up.

Implementation will also need to be responsive to the regulatory environment. In the LABPPS, collaborative practice agreements with physician practices allowed pharmacists to titrate antihypertensive medications, as permitted in California. Some states require more direct physician oversight, which may increase the logistical burden and cost at these locations.

Because these adaptations may alter the effectiveness of the intervention, scale-up efforts should be accompanied with a careful evaluation of effectiveness. However, once a functional workflow is established, the therapeutic relationship between the pharmacist and the patient may be extended to other prevention programs (such as management of diabetes or COVID-19 vaccinations) at relatively low marginal cost for each additional intervention. Nationwide implementation of community-based prevention programs such as the pharmacist-led hypertension control program will require innovation in health care financing and implementation. In a value-based payment environment, society must value health equity and be willing to pay for it. Scale-up will also require careful adaptation to local settings and continued evaluation of effectiveness. Nevertheless, effective community-based prevention programs with appropriate financing and implementation can reach populations left behind with traditional approaches to health care.

ARTICLE INFORMATION

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