



Heartwise

Using targeted home visits to improve blood pressure outcomes in primary care

MAY 2025

Issue

Primary care provides critical ongoing support to patients with cardiovascular needs, yet office-based primary care providers are limited in their ability to provide whole-person care addressing both medical and social needs. Research demonstrates that home-based blood pressure (BP) monitoring is more effective than office-based readings for the detection, diagnosis, and management of hypertension (high blood pressure), and whole-person care is crucial for effectively managing chronic disease and improving health outcomes.¹ Therefore, many patients with high cardiovascular conditions can benefit from direct care delivered in a home or other preferred settings, from providers who understand the social and environmental influences of their condition and who can communicate these insights, along with a shared care plan, back to office-based primary care and community providers.

Project goal

To strengthen primary care providers' (PCPs') and community partners' ability to deliver effective and equitable whole-person care with insights from home visits. By adding home-based medication reconciliation, care coordination, and patient-centered education to traditional, office-based primary care, we hope to reduce medication discrepancies and improve cardiovascular health for individuals with cardiovascular risk factors and polypharmacy (defined as 5 or more prescribed medications). We additionally aim to gain insight into the best strategies and workflows for communicating with providers and resolving medication discrepancies.

Background

This pilot builds on lessons learned from our [blood pressure pilot](#), which featured nurse and community health worker dyads providing home-based medication reconciliations and education to patients living with stage 2 or higher hypertension with other complex health and social needs. The dyads observed home

About Heartwise

Heartwise is the next step in the Camden Coalition's blood pressure pilot program, an intervention that addresses the need for equitable access to high-quality, culturally responsive care for people with heart conditions and other complex health and social needs by pairing nurses and community health workers to provide at-home medication reconciliations and education.

This next step in the program aims to address issues with medication discrepancies between care providers and patients with hypertension — a key contributing factor to worsened blood pressure; increased risk of hospitalization, and increased healthcare costs for patients and payers. This is accomplished by having the care teams, made up of nurse / community health worker dyads, submit individualized care plans to patients' local primary care and community providers, who collaborate with the dyad to help patients achieve their defined health and wellness goals.

Project partners

- North Gate II
- Fair Share Support Services
- Cooper Medical School at the Rowan University Family Medicine Residency Program



routines and tracked blood pressure for eight weeks before providing a comprehensive, complex needs-informed care plan to PCPs involved in the patient's hypertension care management.

We named the second phase of the blood pressure pilot "Heartwise," and used the lessons learned in the first phase to build a more formal partnership with a community partner and a primary care practice. We began by partnering with Fair Share Support Services (FSSS), the social services arm of Fair Share Housing Development and a sister non-profit of North Gate II, a low-income housing program for seniors, individuals with disabilities, and families and have recently expanded to partner with the Cooper University Health Care and Cooper Medical School of Rowan University's (CMSRU) Family Medicine Residency program (Cooper Residency Clinic). Similarly to the first pilot phase, the Camden Coalition's goal with the Heartwise pilot is to partner closely with community-based providers to facilitate the communication of patient information from the home-based medication reconciliation back to PCPs and other relevant clinical teams to help inform ongoing care. The Camden Coalition care team began receiving weekly North Gate II resident referrals to the Heartwise program in September 2024 and began accepting referrals from the Cooper Residency Clinic in March 2025.

Project design

Through the Heartwise pilot, PCPs and community partners serving Camden City's Medicaid beneficiaries partner with the Camden Coalition's community-based care management team — comprised of nurses and community health workers (CHWs) — assigning our team to conduct home visits for consenting patients with at least one cardiovascular risk factor. Eligible patients must also receive Medicaid benefits and show indications of polypharmacy, defined as five or more prescribed medications.

During home visits, our care team members observe medication routines and socio-environmental factors impacting patients' lives, conduct medication reconciliations, and foster authentic relationship-building through honest conversations about each patient's daily life and priorities. These insights are combined into a whole-person care plan that is shared back with the patient's PCP and community team, with the patient's consent.

TRIAGE

Individuals eligible for Heartwise are determined by our triage team via referrals from North Gate II, an affordable housing and

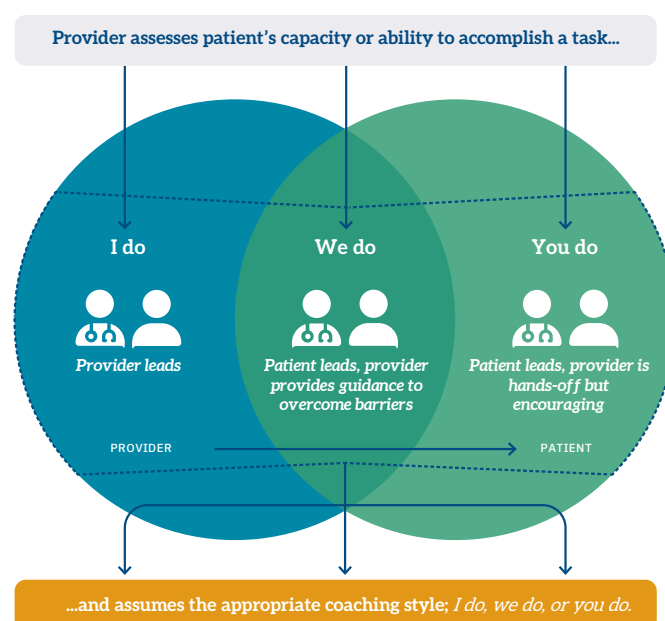
supportive services agency in North Camden, and the Cooper Residency Clinic. Other candidates identified through the **Camden Coalition Health Information Exchange** (HIE) are triaged for program eligibility. All triaged patients are assigned to our care team through our care management platform TrackVia. Patients referred through North Gate II are connected to our care teams through a warm hand-off from their case workers.

INTAKE AND CARE PLANNING

Once patients consent to participate in the Heartwise intervention, the Camden Coalition care team completes an in-person, home-based intake assessment to better understand the participant's goals. Once goals are established, the care team uses our **COACH framework** to help the participant achieve independent and confident chronic health management and systems navigation by moving through the three coaching styles for each task.

The care teams additionally conduct an initial assessment during the intake process to measure participants' self-reported levels of medication and treatment adherence. Nurses from the care team dyads complete a medication reconciliation with participants within their first month of engagement.

Following enrollment and onboarding, participants receive at least one at-home visit per week for the first month. After one month, the care team designs a care plan, performing a complete acuity assessment to determine the frequency of visits necessary going forward to address the participant's level of complex care needs.





INTERVENTION AND PARTNER ENGAGEMENT

The care team builds **authentic healing relationships** with participants through home visits. As they learn about participants' goals and needs, they also provide connections to community resources, assistance with enrolling in benefits and other supports, home blood pressure monitors and instruction on use, disease-specific diet and lifestyle guidance, and medication management education and strategies. If needed, they also provide connection to other Camden Coalition programs including **Housing First** and **Medical-Legal Partnership**.

Participants are continually empowered to better their treatment adherence and self-management through medication management education during home visits. The team conducts a second medication and treatment adherence assessment 60 days after enrollment.

Partners receive weekly status updates on referrals who have been enrolled, graduated, deemed ineligible, lost to follow-up, or are difficult to engage. Care teams meet with teams from each partner once monthly to provide updates to care plans.

OUTCOMES

We assess graduated Heartwise participants for three key outcomes:

1. Improved medication self-management, as per the rate of self-reported medication adherence.
2. Reduction in medication barriers, discrepancies, and preventable adverse medication events, based on the rate of participants who received an in-home medical reconciliation, the rate of medication discrepancies identified, and the rate of discrepancies resolved.
3. Successful completion of patient-identified goals, based on the rate of priority patient goals that were met.

With our provider partners, we plan to assess our communication pathways between community-based care teams and outpatient PCPs and determine how they can be replicated and/or improved.

We will additionally seek to pursue policy solutions that will improve access to care for our patients, including reducing barriers to getting blood pressure cuffs through insurance and seeking billable opportunities to sustain Heartwise.

The Heartwise program is planned to run from July 2024 – July 2026.

Next steps

We are currently focused on further establishing and scaling our Heartwise referral network through a clinical partnership with the Cooper Medical School at Rowan University Family Medicine Residency Program. We plan to pilot a formal communication pathway with the expanded Heartwise referral network to more efficiently share details from in-home medication reconciliations and foster collaborative strategies to address medication barriers and discrepancies. We are also working to establish partnerships with local pharmacists to better inform medication recommendations identified from reconciliations. Our hope is the care team can also address medication barriers with PCPs to resolve discrepancies and/or optimize regimens for patients going forward.

Contact us

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Citations

1. Shimbo D, Artinian NT, Basile JN, et al. Self-Measured Blood Pressure Monitoring at Home: A joint policy statement from the American Heart Association and American Medical Association. *Circulation*. 2020;142(4). doi:10.1161/cir.0000000000000803