NACDD

Issue Brief

Addressing Health Disparities in Hypertension Control

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NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

Controlling blood pressure is a major step toward preventing heart disease and stroke. The National Association of Chronic Disease Directors' (NACDD) Cardiovascular Health initiative shares resources and program information to help states improve identification and control of hypertension. In coordination with the Centers for Disease Control and Prevention's Division for Heart Disease and Stroke Prevention, NACDD hosts fireside chats and other learning opportunities with a focus on hypertension, including its the third fireside chat and follow up virtual roundtables that focused on Addressing Health Disparities in Hypertension Control.

The fireside chat, conducted on Feb. 7, 2017, was moderated by Dr. Janet Wright, executive director of Million Hearts® and featured Jacqlyn Atkins and Tiffany Mack of the South Carolina Department of Health and Environmental Control (DHEC). They were joined by featured speaker and longtime DHEC partner, Dr. Brent Egan, senior medical director of the Care Coordination Institute (CCI) and current president for the International Society on Hypertension in Blacks.

DHEC has made health disparities a priority in its work to improve the lives of South Carolinians and works with many partners as part of its 1305 and 1422 CDC cooperative agreements. During the fireside chat, presentations focused on the role of the state

partners to identify and control hypertension rates, using cultural competence education as the mode for spreading the message and practice improvement. Atkins and Mack shared how DHEC has partnered with physician champions like Dr. Egan and with the Office of Health Equity and the Office of Rural Health. They call their program SC PHASE: Prevention and Health Across Systems and Environment, which has resonated with partners.

Several themes emerged from the discussions including the role of data in identifying areas or populations with high rates of hypertension; the need for a deliberate intention to address health disparities and achieve health equity when providing technical assistance; and the importance of working with partners who share your mission.

Using Data to Identify Areas or Populations with High Rates of Hypertension

To identify practices serving priority populations, the DHEC chronic disease epidemiology team used both BRFSS and Medicaid data defined by zip code for 15 contiguous counties out of 46 counties. To identify the target counties, chronic disease epidemiologists used mortality, prevalence, inpatient hospitalization, and emergency department data by race for various chronic diseases and conditions that included diabetes, hypertension, heart disease, stroke and obesity. The chronic disease epi team obtained this data through a request submitted to Medicaid. This request for data is also used for specific CDC performance measures for diabetes and hypertension medication adherence.

South Carolina is divided into four regions, and each region has a core community team and designated SC PHASE staff in addition to their core community team. SC PHASE team leads and clinical coordinators, who work at the local level, recruit clinical practices in the identified counties to engage in practice improvement using readiness assessment and signed contract agreements to make practice improvement more likely to occur. This method pinpointed certain counties for recruitment and resulted in participation by practices in SC PHASE.

Deliberate Intention to Address Health Equity When Providing Technical Assistance

Through their work, DHEC staff observed that many practitioners struggled with cultural competency and how to understand patients through a health equity lens. DHEC provides technical assistance to practices, helping them to create and implement policies and protocols with a deliberate focus on identifying patients with undiagnosed hypertension among priority populations. South Carolina has approached this effort with an educational perspective and has taken on cultural competency training as their mode of spreading the message.

Atkins, the former director of DHEC's South Carolina Office of Health Equity, emphasized innovative tools such as the creation of the Cultural Competency Presentation for local health departments to use. This presentation also outlines additional resources available. DHEC also uses the National Office of Minority Health's comprehensive, self-paced, cultural competency trainings offered through the Think Cultural Health resource portal. Mack pointed out that when working with practices, it is important to approach them about "changing the conversation," and to assure them that the health department does not intend to add to their work load but to "complement the work you are already doing." Part of that approach is helping the clinics to better understand their patients, their environment and culture, and possible approaches to real-life challenges, such as medication adherence.

In addition, the cultural competency training helps practices meet other objectives, including meeting patient-centered medical home standards and receiving continuing medical education credits. Each medical practice does have to provide proof of completing the self-guided trainings. This deliberate approach has been successful for DHEC and its partnerships.

Working with Partners that Share Your Mission

DHEC has developed many partnerships to support this work. These include relationships within the state health department between the Division of Diabetes, Heart Disease, Obesity and School Health, the Office of Health Equity, and with other agencies such as the South Carolina Office on Rural Health (SCORH). SCORH has provided coordinators and quality improvement coaches that work directly with practices in several regions around the state. With SCORH, DHEC is creating a change packet that practices can use to engage disparate populations.

Through a partnership that goes back more than 15 years, DHEC is working with partners like Dr. Egan at the Care Coordination Institute (CCI) to look at policies and programs focused on team-based care and undiagnosed hypertension, helping practices modify their electronic health records and provide real-time information through registries, flagging, and protocol development. CCI provides monthly and quarterly disparities reports, along with dashboard measure reports, that compare individual providers to the practice as a whole on selected measures. CCI helps practices apply the American Medical Association's MAP framework (Measure Accurately, Act Rapidly and Partner with patients, families, and communities). A daily "huddle" report displays information on the patients clinicians will see that day to help practices adjust their work flow to best serve their patients' needs. CCI also works with the practices to obtain more qualitative information such as who is working on the team, what protocols they use, and how often they meet. CCI is developing a guide for the practices that will provide a sustainable foundation that supports the work even in the face of evolving clinical guidelines.

Dr. Egan values the 15-year DHEC partnership and is proud of the work applying the MAP framework to obtain "Kaiser-like numbers" for hypertension control in the Center for Family Medicine. In this population of minority and under-insured patients, the hypertension control rate jumped from 61 percent to 88 percent within just six months. As Dr. Egan pointed out, "every practice believes they deliver better than average care," but "they want to find ways to do better." In 16 practice sites across four counties, the average control rate increased from 65 percent to 75 percent in six months for patients seen at least twice.

All 16 contracted medical practice sites have or will participate in the cultural competency trainings. By linking training to practice requirements such as patient-centered medical home standards and providing CME credit, DHEC encourages participation and adds value. Medical practices are maintaining their hypertension control improvement and 17 new sites are implementing hypertension control strategies in 2017 based on lessons learned from the initial practice improvement work. DHEC and CCI combined action builds a sustainable foundation to support best practice in hypertension control in the face of ever-evolving clinical guidelines.

Conclusion

This fireside chat allowed audience members from states with large and small populations to hear about the experience of a rural state like South Carolina and to apply lessons learned in their own state. During the NACDD virtual roundtables, several rural states noted that given their isolated communities, the state health department role is crucial, especially in working with the local health departments. Partners such as quality improvement organizations, physician champions, departments of health equity and agencies that represent specific populations or geographic areas can help heart disease and stroke prevention programs to improve the identification and control of hypertension. As seen through this example, state health departments play an integral role in promoting the message of health equity and providing useful tools and resources to support this work.

Additional Resources

Additional information can be found at:

Cultural Competency presentation (c.ymcdn.com/sites/chronicdisease.site-ym.com/resource/resmgr/cvh/cvh_health_disparities_slides/SC_PHASE_Cultural_Competenc.pptx)

Cultural Competency Resource Guide from the National Partnership for Action to End Health Disparities (docs.google.com/viewer?a=v&pid=sites&srcid=bnBhLXJoZWMub3JnfHJlZ2lvbjR8Z3g6NTQzYjM1M2U2ZWJhMzAz)

Fireside Chat: Addressing Health Disparities in Hypertension Control (vimeo.com/203190138)

M.A.P. Framework (targetbp.org/m-a-p-introduction/)

Think Cultural Health (thinkculturalhealth.hhs.gov/)

If you require this document in an alternative format, such as large print or a colored background, please contact Miriam Patanian at patanian@chronicdisease.org or 678.373.1487.

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