

Under Pressure: Black Men and the Battle of Hypertension

Summary of the NACDD and CDC Fireside Chat

Data show that Black men are disproportionately impacted by hypertension and cardiovascular disease (CVD). Despite this evidence, there is a lack of focused, multi-level, sustainable interventions tailored specifically for this population.¹

The National Institute on Minority Health and Health Disparities published a supplement in [Ethnicity & Disease](#) promoting the idea of implementing comprehensive multilevel interventions and strategies when addressing the social determinants of health and eliminating health disparities. For example, an initiative that seeks to reduce hypertension and cardiovascular disease morbidity and mortality in Black men would implement strategies across health systems and communities with providers, care teams, and patients.

From a public health perspective, the [Division for Heart Disease and Stroke Prevention](#) (DHDSP) at the Centers for Disease Control and Prevention (CDC) is working to identify, implement, and evaluate comprehensive, culturally appropriate, multilevel and sustainable interventions and strategies to address hypertension and disparities in Black men. To this end, objectives were identified for a Fireside Chat, [Black Men and the Battle of Hypertension](#).

To explore these issues, [Michael Sells](#), PhD, Senior Public Health Advisor, Division for Heart Disease and Stroke Prevention, posed a series of questions to [Keith C. Ferdinand](#), MD, FACC, FAHA, FNLA, FASH, the Gerald S. Berenson Endowed Chair in Preventive Cardiology and Professor of Medicine at Tulane University School of Medicine. The CDC DHDSP and the National Association of Chronic Disease Directors hosted the Fireside Chat in July 2019.



¹ Centers for Disease Control and Prevention. *A Closer Look at African American Men and High Blood Pressure Control: A Review of Psychosocial Factors and Systems-Level Interventions*. Atlanta: U.S. Department of Health and Human Services; 2010. https://www.cdc.gov/bloodpressure/docs/African_American_Executive_Summary.pdf

What is the current state of Black men's health, in general?

- Heart disease and stroke is the number one cause of death for all Americans, but it disproportionately affects Black men. Although life expectancy for all Americans has been gradually increasing, life expectancy for Black men is still at the bottom, and this is largely driven by cardiovascular disease.
- Data from the Behavioral Risk Factor Surveillance System (BRFSS) from 1993 - 2017 show that disparities by race, ethnicity, social class, and geography have been persistent.²
- It is difficult to know why this gap is so persistent. Genetics may be a factor, but it may also be due to whether a person adopts health-seeking behaviors, such as going to see the doctor or has access to insurance, or access to or specialists.
- The Reasons for Geographic and Racial Differences in Stroke ([REGARDS](#)) project has followed participants for more than a decade to understand why Southerners and Black Americans have higher rates of stroke and related diseases that affect brain health. The study found that the most important factor contributing to differences in hypertension incidence between Black and white participants was the "Southern dietary pattern," which has linkages to poverty, food insecurity, and food deserts in some Southern communities (e.g., high-fat and highly processed foods, high sodium, and low potassium foods). This accounted for 51.6% of the excess risk among Black men and 29.2% of the excess risk among Black women.

The following is a summary of Dr. Ferdinand's responses to questions posed during the fireside chat. Topic areas discussed included:

- The disproportionate impact of hypertension and cardiovascular disease among Black men.
- Increasing knowledge regarding clinical health systems and public health interventions related to hypertension among Black men.
- Issues concerning Black men and their overall health, including the social determinates of health and the social-cultural factors related to hypertension and cardiovascular disease in Black men.

What are the best practices, treatments, and approaches from the clinical health systems perspective surrounding Black men?

- The provider-patient relationship is one of the most important interactions we have to help us lead healthier, longer lives.
- Factors in the clinical setting, such as time constraints, impact the primary care provider's ability to spend time with patients. And, while electronic health records (EHR) have been valuable for documentation and collection of data, they have not necessarily positively

² Cunningham TJ, Croft JB, Liu Y, Lu H, Eke PI, Giles WH. Vital Signs: Racial Disparities in Age-Specific Mortality Among Blacks or African Americans — United States, 1999–2015. MMWR Morb Mortal Wkly Rep 2017;66:444–456. DOI: <http://dx.doi.org/10.15585/mmwr.mm6617e1External>

contributed to the provider-patient relationship.

- Talking with patients one-on-one and providing literacy and culturally appropriate education is helpful. Providing copies of lab results and explaining test results helps to empower patients by understanding why it is important to control hypertension by changing a person's lifestyle and taking medication as prescribed.

Is there a way to utilize tools within the EHR, such as clinical quality measures, to better identify who we may be missing?

- Using EHR data to monitor clinical quality measures will often help illuminate disparities within the practice that providers may not be aware of.
- Applying evidence-based medicine equally across the patient population eliminates the need to make special adjustments for any specific population.

"I teach my students to treat everyone with the same degree of evidence-based medicine, and the quality measures should follow."
- Dr. Ferdinand

What are some of the psychosocial or cultural factors providers must consider to keep people from falling through the cracks?

- In one word - trust. The community needs to trust that when they seek care they are going to an environment where they are wanted and where the clinical providers really care about them. I think that overlies much of the interaction we see that leads to poor adherence and worse outcomes.
- If the person does not believe in the clinician or does not trust the environment, he or she will not adhere to recommendations. Even those who live close to thought leaders in cardiovascular health are not guaranteed good outcomes - it is how that medicine is applied in populations that matters.
- Black men need to be educated about their condition so that they seek healthcare; and so that they want to have the appropriate diagnostic workup and to receive evidence-based medicine. So that they want to feel better and live longer.
- I usually don't talk about death. I put disability rather than mortality on the front. If you talk about stroke and disability, the inability to have sexual relationship, the inability to speak, or the possibility of going on dialysis, they get that.
- The mortality message can be effective with older men who want to be present for their grandchildren. The Association of Black Cardiologists has a saying "Children should know their grandparents."

What would you tell a practitioner that they need to be more cognizant of?

- Sit down and talk one-to-one with your patients. They have done analyses that show the patients do not want more time, they want good quality time.
- Then, apply evidence-based medicine as best you can to every patient.

What do you think of when one mentions the term “team-based care”?

- Team-based care makes sense. With only 15 minutes for the usual visit, it is difficult to change the patient’s perceptions. The patient has to be educated about his condition so that he seeks healthcare, and some of that education can fall to other members of the team.
- There may be extra steps required during the visit, such as checking if a patient has insurance, what medications are in their formulary, and if they can afford the co-pays. Engaging a patient navigator, if available, to assist with this can be helpful.
- Patients also can be scheduled for a nurse visit for a blood pressure evaluation, which can eliminate barriers, such as taking time away from work or having to pay an additional co-pay for an office visit.

What types of miseducation do people come into their provider with?

- Sexual dysfunction is one. Some of the older medicines (e.g., diuretics, methyldopa, beta blockers, reserpine) did cause erectile dysfunction. The newer medicines, especially when combining medicines at low to moderate doses in combination therapy, have almost no side effects at all. Patients need to understand that we now have alternatives.

“We often don’t talk about stress because it is hard to measure, but clearly there are now indications that people who are always in a state of hypervigilance are impacted by stress.”
- Dr. Ferdinand

Is there an age discrepancy when looking at Black men and the onset of hypertension?

- Yes - the rates of hypertension are not only higher, but it also starts earlier, it is more uncontrolled, and there are more complications of hypertension in Black men. This is not necessarily due to genetics. The [Bogalusa Heart Study](#) by Gerald Berenson showed that in Black children, cardiovascular risk

factors start to manifest starting in preteen/early teenage years. This is probably due to several factors, such as the Southern diet, physical inactivity, and stress.

- We know when you do ZIP code analyses in neighborhoods with high levels of violence and less access to healthy foods available (food deserts) – there is more cardiovascular disease.
- The older Joint National Commission (JNC) Guidelines recommended teaching Black Americans how to relax using rhythmic breathing and meditation as these had a beneficial effect on hypertension. These recommendations are not in the [current guidelines](#) because it is hard to measure and to determine who is benefiting, but I continue to believe stress is a real factor.

From your perspective both as a provider and public health practitioner, how can public health improve and help to contribute to this work?

- Clearly public health is an important component, as is the doctor-patient relationship. Community awareness of disease, knowing risk factors, seeking appropriate care, and modifying lifestyle are necessary to address these disparities.
- For example, looking at the [Los Angeles Barbershop Study](#) lead by Dr. Ron Victor, people went to the barbershop because it was a comfortable and welcoming place where they

wanted to be. Pharmacists were able to offer point-of-care services, such as lab tests and to provide evidence-based medicine and prescribe medication at the barbershop. In the study, they were able to lower blood pressure very robustly in a large cohort of Black men. However, it was very costly and involved a lot of moving parts, and clinical practices don't always have that level of support.

Can you talk about the work you did with REACH in the barbershops and how that was different from what you just described?

- In the past, programs that did screening and education to raise awareness found that levels of awareness were fairly high. What the Los Angeles Barbershop Study did that was different was to include point-of-care services that included lab, such as electrolytes and glomerular filtration rate (GFR), and prescribing evidence-based medicine in a setting where clients were already going.

What additional social and environmental determinants should be considered to address these disparities?

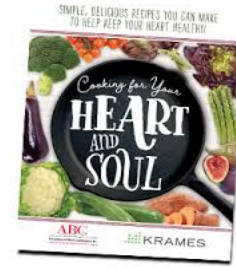
- One of the reasons disparities are so persistent is because they are so complex. In addition to the things we have discussed, such as improving the environment where clinical care is delivered using team-based care including nurse practitioners, pharmacists and others, we must look at the social environment in which people live.
- Finding affordable housing in city settings is challenge. Even people with a job may not have insurance or they may not be able to afford the co-pays for visits, medications, etc. Somehow, we need to address universal healthcare and access to insurance but also make sure plans are adequate so that patients can get the care they need. For example, I saw a patient yesterday with diabetes and very high blood sugar. Although the patient was aware of his diabetes and knew how to take his medicine, he was unable to afford the doctor visits, so could not follow up.
- There was a recent report in [JAMA](#)³ looking at counties that did not expand Medicaid that found higher degrees of mortality than in counties that did expand Medicaid. This now provides data that demonstrates that not having insurance leads to worse outcomes.

How do we impact behavioral and lifestyle changes given the environment that many are living in?

- Looking at diet and environment: sodium has impact on hypertension and Black people tend to be more salt sensitive. We need to help patients understand the need to modify their diets to remove processed foods that are high in sodium and saturated fat.

³ Khatana SAM, Bhatla A, Nathan AS, et al. Association of Medicaid Expansion with Cardiovascular Mortality. *JAMA Cardiol.* 2019;4(7):671–679. doi:10.1001/jamacardio.2019.1651

- The [Association of Black Cardiologists](#) has produced a [cookbook](#) focused on a plant-based diet to help people prepare tasty meals that are culturally appropriate to the Black community.



From your experience, what can public health practitioners do from a community perspective to help Black men?

- Back to the issue of trust, the Black community has to perceive that what we are doing as beneficial.
- As well, any grant that is given should integrate with the community rather than just bringing something to the community and saying, “here it is.”
- Don’t just rely on reports from grantees, because people may not be doing all they say they are doing, and that may contribute to why these disparities are so persistent.

What are some ways that community-clinical linkages can be used to address hypertension and CVD in Black men?

- Health Navigators can help people figure out how to get access to insurance.
- We can empower people by educating them about disease risk and associated morbidity so that they can be ambassadors for themselves and ask questions related to their care.
- The DASH diet and the Mediterranean diet can address the dietary piece.

As a clinician, how do you recommend educating your peers on the importance of community programs to help manage hypertension?

- We need to make sure the Guidelines are being implemented by educating providers about how to apply the guidelines in practice.
- Provide patient handouts with easy-to-read, large font, culturally appropriate information about high blood pressure and diet.
- Public health provides funding to address hypertension; it is important to follow up to make sure they are implementing programs.

Can you speak to the importance of being culturally sensitive and culturally appropriate?

- It is not always possible to have a provider from the same background, but any provider can spend time talking with a patient about lifestyle changes, getting sense of the patient’s literacy level, and having available appropriate literature to compel a patient to change his lifestyle.
- In the smoking literature, we know that one of the best predictors of smoking cessation is that a doctor intervenes.

Can you give us insight on specific approaches that will reach Black men?

- The barbershop approach is difficult to reproduce because of cost. But we should enlist barbershops, sororities, and non-traditional sources of care to not just do screening, but to do outreach, education, and to help people understand the need to seek appropriate care in the clinical setting. As well, having a linkage to clinics and providers who can provide care.
- Because screening is not reimbursable, providing grants that can outreach to high-risk communities using quality measures to show that they are doing what they say they are doing can be helpful.

“Self-measured blood pressure (SMBP) with a validated machine and educational support about technique can be a qualitative leap in detecting the burden of hypertension.”

- Dr. Ferdinand

What strategies can we implement to bring Black men into direct care?

- Barbershops are the best.
- Also, faith-based initiatives have been shown to be beneficial but more so for Black women.

Have you found success by providing incentives to participate in care?

- There have been studies in which they have provided free medications and adherence is still poor. As well, there have been studies giving incentives to visit the doctor, and the outcome is still poor.
- Emphasizing the importance of healthy behaviors is more impactful than financial incentives.

How do you deal with cultural perceptions in the community?

- Educate patients that treating hypertension is one of the best things you can do for death and disability, and we now have modern medicines that do not have the same side effects as many of the older medications.
- Introduce the concept of risk and decreasing risk, and once you have a strong relationship, they will want to engage in health-seeking behaviors.

What is the responsibility of the provider?

- Back to the issue of trust: the provider needs to make sure they are treating the patient with respect, and public health interventions need to have built in demonstrations of success – they need to know that we are moving the ball.
- Eventually, we will all have to look ourselves in the eye and ask what do we need to do in order to do better because what we are doing right now is not working.

Is there anything else you would like to leave us with?

- What we know, based on trials, is that in people who are diagnosed with high blood pressure who are not treated after two years, 50% will have a heart attack, stroke or die.
- We must educate patients that the data have shown that high blood pressure is an increased risk for death and disability.
- The role of public health is important because it impacts people's lives, so we must be dedicated to the work. We are expected to positively impact patient's lives so we have to try as best we can to deliver that.
- Finally, treating hypertension is the most powerful risk factor to reduce the gaps in [morbidity and mortality](#). The grants that you provide that help people to control hypertension are doing more to impact death and disability than anything else.

Resources

CDC A Closer Look at African American Men and High Blood Pressure Control
http://www.cdc.gov/bloodpressure/aa_sourcebook.htm

CDC Vital Signs™ May 2017
African American Health. Creating Equal Opportunities for Health
<https://www.cdc.gov/vitalsigns/aahealth/index.html>

CDC Science-in-Brief. Population Care Management and Team-Based Approach to Reduce Racial Disparities among African Americans with Hypertension
https://www.cdc.gov/dhdsp/pubs/docs/sib_march2016.pdf

CDC Million Hearts®
Hypertension Control Change Package, Second Edition.
<https://millionhearts.hhs.gov/tools-protocols/action-guides/htn-change-package/index.html>