Reducing Hypertension Among African-Americans
Learning Collaborative

Keith C. Ferdinand, MD, FACC, FAHA, FASPC, FNLA

Moderated by Ayanna V. Buckner, MD, MPH, FACPM
• Please stay in listen-only mode.

• The slides will be posted on the ACPM website.

• If you have any questions please type them in the chat box and we will address them during the Q/A session.

• During the Q/A session, you may also ask a question by using the ‘Raise Hand’ feature

• ACPM will email the participants a brief feedback survey after the webinar
Our Impact

• ACPM is a national medical specialty society that represents physicians who work at the unique intersection of clinical care and population health.

• ACPM members have both an MD (or DO) and MPH and are trained to care for both individuals and populations.
Where PM Doctors work

- University, 19%
- Other, 14%
- Federal Govt, 13%
- Military, 10%
- Self Employed, 9%
- Local Govt, 7%
- State Govt, 6%
- Industry/Business, 6%
- Health Plan/System, 4%
- Hospital, 4%
- Assoc./Foundation/NGO, 3%
PM’s Agenda: Design Upstream Interventions
Reducing Hypertension Among African-Americans
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DISCLOSURES

Speaker’s Bureau
None

Consultant
Amgen, Sanofi, Boehringer Ingelheim, Novartis, Quantum Genomics

Stocks
None

Patents
None
OBJECTIVES

• Summarize the most important lessons learned in the treatment of hypertension in the African American community

• Discuss what bold, upstream actions to reduce the burden of hypertension among African-Americans can empower us to create blue zones here in the United States

• Highlight what changes to the current standards of care are needed to reduce the burden of hypertension among African-Americans and empower us to create blue zones here in the United States
What are the most important lessons that guide your work to address the high prevalence of hypertension and poor control rates in the African American community?
“Of all the forms of inequality, injustice in health care is the most inhumane.”

- Martin Luther King, Jr.
Civil rights legislation in the 1960s.
Documenting Disparities

“Nothing captures the nature of health inequities as clearly as the persistent life expectancy gap between whites and blacks”

Alan R. Weil, Editor-in-Chief, Health Affairs August 2016, vol. 35 no. 8, 1347
Heart Attack at 49—America’s Biggest Killer Makes a Deadly Comeback

Doris Washington, center, and her daughters Stephanie, 20, and Sydnie, 13, the family of Oscar Washington Jr., who died of a heart attack at 49

The evidence shows...

- High blood pressure is a continuous, direct, linear risk for ASCVD and stroke.
- Controlling HTN is essential.
- **Primary care** is critical to improve outcomes. Moreover, team-based care is necessary for tighter control.
- Lifestyle and evidence-based pharmacotherapy with multiple antihypertension drugs is shown to decrease CVD morbidity and mortality.
The evidence shows…

• Suboptimal risk control is the most important factor responsible for disparate outcomes vs. genetics.
• Major SES factors potentially are manageable with knowledge (education) and focused resources.
• Access to care is the low hanging fruit for reducing health disparities.

So, why are we missing this opportunity?
My Second Chance to Live Heart Healthy: Mr. C.A.'s story.

http://millionhearts.hhs.gov
Million Hearts 2016 article placed in over 2,300 US news publications and reached over 29 million

http://www.houmatimes.com/online
What are some examples of the bold, upstream ideas and/or programs that can help reduce hypertension among African-American women and men?
Strategic Imperatives for Improving hypertension control among African Americans

• Implement guideline-based protocol
• Problem-solve in medication adherence
• Advance practice of self-measured blood pressure monitoring
• Increase access to and participation in community-based activity programs
Pharmacist-delivered care for hypertension in barbershops led to dramatic reductions in blood pressure in black men, according to study results presented at the American College of Cardiology’s 67th Annual Scientific Session.

The cluster-randomized trial, which was simultaneously published in the New England Journal of Medicine, enrolled 319 black men with a blood pressure of ≥140 mm Hg at 52 barbershops in Los Angeles County. Men in the intervention group received monthly monitoring and medication management from specially trained
Positive components of the LABP intervention

Physician-Pharmacist Collaboration
Collaborative agreement between physicians and doctoral-level pharmacists with specialized certification as hypertension clinicians prescribed drugs, measured BP, encouraged lifestyle, and monitored electrolytes.

Effective Antihypertensive Drug Regimen
Two-drug therapy protocol including amlodipine and long-acting angiotensin-receptor blocker (ARB) or angiotensin-converting-enzyme (ACE) inhibitor with long-acting thiazide-type diuretic, indapamide as a third medication.

Improved HTN control

Trusted Site of Blood Pressure Intervention
Black-owned barbershops with clientele comprised primarily of self-identified regular patrons. Resources to promote cohort retention (95%) and offset costs of drug and transportation.

Ferdinand, K. Circulation. 2018;138

A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines
**BP Goal for Patients With Hypertension**

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<th>COR</th>
<th>LOE</th>
<th>Recommendations for BP Goal for Patients With Hypertension</th>
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<tr>
<td>I</td>
<td>SBP: B-R&lt;sup&gt;SR&lt;/sup&gt; DBP: C-EO</td>
<td>For adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher a BP target of less than 130/80 mm Hg is recommended.</td>
</tr>
<tr>
<td>IIb</td>
<td>SBP: B-NR DBP: C-EO</td>
<td>For adults with confirmed hypertension, without additional markers of increased CVD risk, a BP target of less than 130/80 mm Hg may be reasonable.</td>
</tr>
</tbody>
</table>

SR indicates systematic review.
AHRQ found strong evidence that SMBP plus additional support was more effective than usual care in lowering blood pressure among patients with hypertension.
Feedback loop between patients and health care providers supporting SMBP

Self-measured blood pressure readings
- Lifestyle habits (e.g., smoking, diet, exercise)
- Medication side effects and adherence barriers
- Insights into variables affecting control of blood pressure

Patient

Provider

Adjustments to medication type and dose to achieve goal blood pressure
- Suggestions to achieve lifestyle changes
- Actions to sustain or improve adherence
- Advice about community resources to assist in controlling blood pressure
Reimbursement for SMBP

New CPT Codes to Cover Self-Measured Blood Pressure (SMBP)

Self-measured blood pressure (SMBP) is the regular measurement of blood pressure (BP) by a patient outside the clinical setting, usually at home.

Benefit to patients and providers

- SMBP helps providers diagnose and manage hypertension more effectively using an average of up to seven days of BP readings that are more representative of a patient’s daily mean BP compared to clinic readings.
- SMBP helps engage patients in self-management of high BP.
99474-: Self-measured blood pressure:
  - Using a device validated for clinical accuracy
  - Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (min. of 12 readings)
  - Collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional*
  - With report of average systolic and diastolic BP and subsequent communication of a treatment plan to the patient
Social Determinants of Risk and Outcomes for Cardiovascular Disease

A Scientific Statement From the American Heart Association

Edward P. Havranek, MD, FAHA, Chair; Mahasin S. Mujahid, PhD, MS, Co-Chair; Donald A. Barr, MD, PhD; Irene V. Blair, PhD; Meryl S. Cohen, MD, FAHA; Salvador Cruz-Flores, MD, FAHA;

George Davey-Smith, MA(Oxon), MD, BChir(Cantab), MSc(Lond);
Cheryl R. Dennison-Himmelfarb, RN, PhD, FAHA; Michael S. Lauer, MD, FAHA;
Debra W. Lockwood; Milagros Rosal, PhD; Clyde W. Yancy, MD, FAHA; on behalf of the American Heart Association Council on Quality of Care and Outcomes Research, Council on Epidemiology and Prevention, Council on Cardiovascular and Stroke Nursing, Council on Lifestyle and Cardiometabolic Health, and Stroke Council

Circulation. 2015;132:00-00. DOI: 10.1161
Potential Sources of Disparities in Care

Patient-Level
- Patient preferences
- Treatment refusal
- Care seeking behaviors and attitudes
- Clinical appropriateness of care

Health Care Systems-Level
- Lack of interpretation and translation services
- Time pressures on physicians
- Geographic availability of health care institutions
- Changes in the financing and delivery of health care services

Provider-Level
- Bias
- Clinical uncertainty
- Beliefs/stereotypes about the behavior or health of minority patients

Factors Reported to Affect Adherence

Social and economic dimension
- Limited English proficiency
- Low health literacy
- Lack of family or social support network
- Unstable living conditions/homelessness
- Burdensome schedule
- Limited access to health care facilities
- Lack of health care insurance
- Inability/difficulty accessing pharmacy
- Medication cost
- Cultural and lay beliefs about illness and treatment

Ferdinand, K. et al. JACC VOL. 69, NO. 4, 2017
Reducing Hypertension Among African-Americans

www.acpm.org/initiatives/hypertension/
Thank You!