ACPM

AMERICAN COLLEGE OF PREVENTIVE MEDICINE

Advancing Hypertension Care

Hypertension, a strong predictor for cardiovascular complications such as heart attack, stroke, and heart failure, is a critical public health issue. In response to this challenge, ACPM funds projects across five diverse clinical settings to develop practice models that advance the standard of preventive care for hypertension in African American Men.

Grady Health Systems

Tougher Than Blood Pressure Peer Education Program

Project Description:

Grady initiated the Tougher than Blood Pressure Peer Education Program recruiting African-American men as ambassadors and guides for men at risk for hypertension. The Grady team created a training and orientation program, and sets expectations for the Peer Educators to work with Grady patients as well as contacts made by each Peer Educator in his own community. This program is located in four of Grady's clinics: Primary Care Center, Asa Yancey, East Point, and Camp Creek Neighborhood Health Centers.

In a companion activity, Grady's Population Health team is creating a patient registry for Hypertension, designed to identify African American men in their patient population with controlled or uncontrolled hypertension, the last blood pressure measurement, and the date of the next visit. This information is used to provided targeted outreach to patients by both peer educators and clinicians to bring the patients closer to clinic resources.

Patients receive information on self-measured blood pressure monitoring (SMBP), healthy cooking and eating, and lifestyle change. Patients with uncontrolled hypertension are referred to see a nurse every 2 weeks and for 3-month follow-ups after their hypertension is under control. Patients can also be referred to Grady's internal programs such as their Healthy Living Class, Smoking Cessation Class, and meetings with a pharmacist to review their medications. Additionally, Grady is partnering with the YMCA Atlanta Blood Pressure Self-Monitoring program, which provides education material in their clinics.

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Social Determinant of Health (SDoH) Addressed:
Grady has chosen to address the Social Determinant of food insecurity. The team uses a screening tool to identify patients who could benefit from Grady's Food As Medicine program, which provides nutrition counseling, food pharmacy servies, and connections to community resources to address this need.

Organization:

Grady Health Systems' Ambulatory Services Division consists of 22 Hospital-based Specialty services, 5 Neighborhood Primary Care Centers, a Faculty-based Primary Care Center (PCC), an Infectious Disease Program Center, and a Multi-Specialty Outpatient Center. The Ambulatory Services Division has long experience in diabetes screening, testing, and referral programs and is seeking to leverage these skills and experiences to develop and implement hypertension reduction initiatives.

The Neighborhood Health Centers and Primary Care Centers serve HRSA-designated Medically Underserved Areas and Primary Care Health Professional Shortage Areas. This vulnerable population suffers a disproportionate burden of disease from chronic illnesses such as diabetes and hypertension, as well as the diseases prevalent in vulnerable populations, such as HIV/AIDS, substance abuse, and tuberculosis.

Data collected from the PCC suggests that the majority of the patients are poor (nearly 90% of those surveyed report family incomes less than $20,000), chronically ill (2/3 with 4+ chronic diseases), have low literacy levels (57% reading below an 8th grade level) and demonstrate low patient activation (60% lack knowledge and confidence to take action in self-management of health).

In 2019, the patient population was 90% African American, 5% Hispanic, 5% White and others.

Materials, Technology, Resources and Partnerships:

- An algorithm to define patients to be included in the registry.
- Peer Educator training program.
- Culturally appropriate patient outreach materials.

Payor Mix:

- Medicaid 14%
- Medicare 25%
- Uninsured 48%