CDC Town Hall Teleconference

Getting Blood Pressure Under Control
Q&A Transcript

September 11, 2012
2:00pm – 3:00pm EDT

Dr. Rich Schieber: This is Rich Schieber again. Thank you-all for those excellent presentations. These results are really exciting. I mean this is one of the most exciting set of presentations I've heard that is doable without breaking the back of a program in a long time.

So it's time for Q&A, and I'd like to remind everyone that you can get in the queue to ask a question by pressing star 1. You'll need to record your name when prompted, then you'll be announced into the conference by the operator when it's your turn to ask the question. And I really encourage each of you to take advantage of this opportunity. Let's have a brisk discussion to share our strategies, lessons learned, challenges, success stories, and it doesn't even have to be all success stories. But let's share what we know.

Operator, are there any questions at this point?

Coordinator: And at this time, I'm showing no questions. Again as a reminder, it's star 1. Make sure your phone is unmuted, record your name slowly and clearly for introduction, and it is star 2 to withdraw that request. Again, for a question or comment, press star 1 and record your name at this time. One moment while we wait for questions.

Dr. Rich Schieber: So Joy, let me start it out and ask you about the hypertension specialist, which is something new to me. Can you describe a bit about the training and certification that these folks have?

Joy Brooks: Absolutely, and Dr. Egan is also one of our trainers and partners in this initiative. The American Society of Hypertension is our partner in this training. We have been partnering as a division of heart disease and stroke prevention since 2005 on that initiative, and we actually sponsor those trainings throughout our state at least four per year that we sponsor, and there are also many additional trainings throughout the year wherein JNC 7 is taught, treatment to guidelines, of course, throughout our state, which is of utmost importance to us programmatically.

And the trainings actually provide those providers with the necessary materials and training necessary to prepare them for - sitting for the exam. Of course, additional study would be required prior to sitting for that exam. And we are very fortunate that that exam is now offered every year as opposed to every other year now.

And, of course, as a - as I illustrated, we now have 47 hypertension specialists in our state who have successfully earned that certification and who now serve as not only treating those patients who are most acute and hypertensive but serve as a referral base to many other physicians for those who are most difficult to treat.

And I would love for Dr. Egan to remark on the success of that program as well.

Dr. Brent Egan: Thanks Joy. Happy to say a few words. The original thought was that because South Carolina is a largely rural state that we needed the expertise distributed across the state and not just in the urban referral centers. So our objective from the beginning was to attempt to get about 1 specialist for every 20 primary care physicians and get a good geographic distribution.

If you actually look at the geographic distribution of hypertension specialists in South Carolina, it's different from almost every other state and that you'll see we have a number of specialists in rural areas. The other thing that's different about South Carolina is in most other states, the overwhelming majority of these hypertension specialists are already cardiologists, endocrinologists and nephrologists. In South Carolina, a majority of the hypertension specialists are primary care physicians who are also eligible to sit for the certification.

We ask the hypertension specialists to take a threefold role, and that is basically an extension of the academic mission to the community every day. That's excellence in patient care, education and health services research. When a practice has a hypertension specialist, not surprisingly, it was actually the intent is that practice generally does better overall. And these hypertension specialists serve as leader influential physicians, helping to improve the practice of other physicians around them.

So this has actually worked out quite well. We share the data with them, and they're able to help drive their own quality improvement programs locally. But again, the geographic distribution, the inclusion of many primary care physicians as designated hypertension specialists I think are a couple of the properties that allow them to be effective.

Coordinator: And I do have a couple questions from the phones if you're ready for those?

Dr. Rich Schieber: Yes, please.

Coordinator: And we do have a question or comment from Tina Love. Your line is open.

Tina Love: Hi, this is Tina Love from Medical Care Development in Maine, and I have a couple questions. One is I wondered how many of the OQUIN practices - you mentioned there's 216, but are any of them patient-center medical homes?

Rob Davis: This is Rob Davis. Joy, I'll take a shot at that if you'd like.

Joy Brooks: Sure.

Rob Davis: We have quite a few that are patient-centered medical homes. It's one of the things that we support in our practices. I could not tell you right off the top of my head the number. I could think right now of at least 20 or more certifications in medical home right now in practices that we have - in practice sites.

Dr. Brent Egan: Right, and many of those would be multi-site practices. So the actual number of practices, Rob, would probably be maybe triple that.

Rob Davis: It could easily be.

Dr. Brent Egan: Yes.

Rob Davis: So, the answer is yes, and the ones that are not are - many of them are working in that direction.

Tina Love: Okay, thank you. And I have one other question, and it has to do with the criteria on how you define adequately controlled blood pressure. And do you have a - you know, was it from the last visit that you look at the last blood pressure? Do you do trending on each patient? I'm just not sure how you quantify that.

Rob Davis: Well, you (unintelligible).

Dr. Brent Egan: Well, the NCQA standard is last blood pressure, and so we use the last visit, the blood pressure at the (unintelligible) visit to determine control rates.

Tina Love: Okay, thank you.

Coordinator: Thank you. Our next question or comment comes from (Susan Miller). Your line is open.

Susan Miller: Yes, thank you very much. It was a very interesting presentation. My question is, are you linking your results with meaningful use or how are you?

Rob Davis: Joy, would you like for me to take that one?

Joy Brooks: You sure can.

Rob Davis: Okay, this is Rob. The answer is we provide for our providers. We give them reports that show how they stack up against NCQA certifications. We also can provide them reports that can help with meaningful use. Most of the meaningful use data comes out of the electronic health records directly. In our case what we do is we have a business associates agreement that Joy mentioned earlier that allows us to go into the electronic health records, pull out datasets, and then we can take that data - this data (unintelligible) for them and give them information based on that.

So we can give them more detail reports than they're able usually to get in their EMR with the limited IT support they have onsite.

Susan Miller: Okay, and so you-all are doing this in a proactive manner like on a quarterly basis not waiting till the end of the year?

Rob Davis: Actually what we do is we have a variety. We give people a paper report. Physicians each get a paper report once a quarter so that's the minimum update we have. Many of our providers are providing us downloads of data every week. We have some that are moving, and one already, that is giving us a daily download. So as frequently as they give us a - as we receive as a data update, we update their reports online. So if they give us an update tonight, they have a new report tomorrow.

Susan Miller: Okay, that's perfect. Thank you.

Rob Davis: Thank you.

Coordinator: Thank you, and again as a reminder if you have a question or a comment, it is star 1. Make sure your phone is unmuted and record your name slowly and clearly for introduction, and it is star 2 to withdraw that request. Again for further questions or comments, press star 1 and record your name at this time. One moment while we wait for questions.

Dr. Christopher Tashjian: Yes just - if people can hear me. I was going to make one comment. As we went in the paper world to looking at our data twice a year to looking at it monthly on all of our diabetics and our ischemic vascular disease and hypertensive patients, and that's made a huge difference. And that data is available pretty much on a regular basis, but we actually go over it with the care coordinators monthly. And for us that's been huge.

Coordinator: And we do have a question or comment, if you're ready for that at this time? We have a question or comment from Tara Truhill. Your line is open.

Tara Truhill: Hi, I've - I want to ask about how you have specifically worked with pharmacists and what that interface was like? How difficult was it to get pharmacists involved in medication adherence and those kinds of things?

Dr. Christopher Tashjian: Who's the question for?

Tara Truhill: For anyone who feels like they would like to respond?

Dr. Christopher Tashjian: This is Dr. Tashjian in Wisconsin. We actually use our EMR to go over adherence, because the EMR tells us exactly when we last prescribed the medicine, and we know when they come - when it comes due. So we can use that to say, "You're either refilling it too soon," or "You're - you know, you should have refilled it a long time ago."

Now we can query from the pharmacies through our EHR as to when they - you know, when they actually get it filled, but we find just using the data that our EMR gets - gives us really does work well for adherence.

Tara Truhill: Thank you.

Rob Davis: One thing - this is Rob with OQUIN. In our case we actually have a pharmacist that works with us, and he helps us with providing continuing medical education, if you will, for our practices. And then what we're able to do by collecting information is we can show them exactly what their prescription patterns look like, and we can show them how they compare to the network as a total.

We don't have a good way today of knowing what prescriptions are actually filled so that we could test the hairs from that direction. That's something

we'd love to do, but we don't have a good way of doing that now. So right now we rely mostly on what prescriptions are written and whether they're refilled.

Coordinator: And does that complete your question or comment?

Tara Truhill: Yes, thank you.

Coordinator: You're welcome. Our next question or comment is from Elizabeth Cohen. Your line is open.

Elizabeth Cohen: Thank you. Thank you very much for an excellent presentation. It's much appreciated. I work in New York City. I'm from Columbia University, and I work in New York City with health disparities in urban health. And I'm wondering if we could comment a little bit on the health disparities that are seen in blacks and African-Americans and low-income populations and if you could help me get started in really addressing this with those populations?

Dr. Brent Egan: Yes, this is Brent from OQUIN in South Carolina. We've made an effort to as much as we can bring in practices, FQHCs, rural practices that serve a lot of the minority individuals. We continue to see disparities in hypertension control. They have narrowed somewhat.

I think that one of the challenges we have is that African-Americans, I'm sure as you know, develop hypertension earlier and more severe, so even when the treatment rates are equal, the control tends not to be quite as good. I think if we looked at delta from the original baseline, I think the all-in blood pressure is about as much. And then the other part of that is when people develop their hypertension younger, especially men, it's hard to get them and retain them in the healthcare system. So we continue to have disparities.

One of the things we have observed since the disparity is greater in men than women is that men seen at VA hospitals between white and blacks, the disparity for men is about half at the VA sites what it is at the civilian sites. Using our electronic data that we have, it looks like a couple of factors probably are contributing. One, at the VA sites, African-American men are seen more often than white men for their hypertension, where the reverse is true at the civilian sites. The black men are seen less often.

At the VA actually the same number of prescriptions are written for the black and white hypertensives, and the civilian settings, the black hypertensives are actually receiving more prescriptions. What we think is going on is that the VA since there's assistance in getting the medications, they're received, whereas at the non-VA sites and given that the un-insurance rate is significantly higher in the African-Americans, we think a lot of those prescriptions aren't being filled.

Consistent with that, when the VA increases medication, blood pressure falls about 5 millimeters systolic for every change. At the civilian sites, it's only falling 2-1/2 to 3 millimeters with each medication change. So we think that's probably part ability to receive medications. It also may be the VA patients are likely to take the meds. But somewhat against that, is that blood pressure control for white men is the same at VA and civilian sites whereas for black men, blood pressure control is significantly better at VA than civilian sites.

So we think at the end of it, a lot of it - a lot of the disparity probably at least 50% comes down to access to care and medications. So I think if we can improve access to care and medications we can eliminate about 50% of the disparity, and that's what our data suggests. Hopefully that answers at least part of your question.

Elizabeth Cohen: Yes, that's fantastic. Thank you.

Dr. Brent Egan: Let me just add one more thing, because we do emphasize lifestyle. One of the things we've created is DASH for Good Health Southern Style. We had great difficulty getting any of our patients to adhere to a DASH eating plan. So we had an African-American nutritionist who's also pastor of her own church, create DASH for Good Health Southern Style, which basically takes the premise of DASH and puts it more into some of the southern recipes that people really enjoy.

So we had a twofold purpose with creating DASH for Good Health Southern Style. First of all, it had to taste good, and secondly, it couldn't cost more, because most of our patients and actually a lot of our providers are under the assumption that healthy food doesn't taste good and it costs more. And we just figured that would be a nonstarter since there's not many people that will pay more money for food that they don't want to eat.

So we've actually had quite a bit of success if we get people to try the DASH for Good Health Southern Style. We think that's another part of some of the success in narrowing disparities.

Rob Davis: That cookbook, by the way, is available on our Web site for free.

Joy Brooks: Yes, it's on both of our linkages on my first page for OQUIN's site and (HGSP) site. You can find them there.

Dr. Rich Schieber: Thank you. This is Rich again. I'd like to ask Chris Tashjian a question. Considering going to scale, one of the steps would be for a rural clinic to infuse other rural clinics with this idea and getting them to follow suit. I don't

want to so much get to the rural to big city barriers, because I'm not sure we would have time. But you're welcome to if you want. But even to get other rural clinics engaged, what do you think we would need to do?

Dr. Christopher Tashjian: Well, I think there's a couple of things you need to do, and for us, the most important thing was making that actual decision that we are going to put the patient at the center. And then the second thing was - is that this is a team sport.

It's really interesting, because we measure things by the bucket. So hypertension is just one part of the bucket, you know. We don't consider our patient under control unless they're on aspirin, their blood pressure is controlled, their lipids are controlled, and they don't smoke. So for us to get a positive tick in our minds, we need all four of those.

And what we found was is when we had three really highly motivated providers, the best we could do was about 45%, which was still probably twice as good as the national average. But when our providers let it go, and this is my message to all the providers, is when we let it go and we empowered our staff to take ownership and to be part of the team, we went up to 57%, which is like best in class for the whole - for the Minnesota, Wisconsin area.

And so that's the message I would have for them is if you make this a team sport and you bring your staff into it, two things happen. You have less responsibility on your shoulders. You get better numbers, and your staff is more engaged, and they're happier too.

Dr. Rich Schieber: How long did that process take for you, would you say, until it was fully engaged in your office?

Dr. Christopher Tashjian: It took probably a full year.

Dr. Rich Schieber: That's not very long.

Dr. Christopher Tashjian: Well, and again, that's the beauty of being in a small rural office, and I think we truly have a huge advantage in that A, we know our staff and we know our patients. And so I think in the bigger - you know, we have one of our clinics in River Falls has 16 providers, and they have more trouble with it, because again, it's easier to get 2 or 3 providers engaging their staff to all roll in the same direction than it is to get 15 providers.

And so my response to the rural docs and the onesies, twosies up to five, you know, we should be leading the way. We can do this. You know, and I'll be honest with you, if we can do it, anybody can, because we're not using huge resources. We don't have departments or anything else. We have just us.

Dr. Rich Schieber: Fantastic. It's time to close, but before we do, I'd like to invite you to take a moment and look at the next-to-last slide in the PowerPoint slide deck, which is Slide 38. Both of today's state presentations are featured in Public Health Practice Stories from the Field. This is a series that highlights how a broad range of public health practices are being implemented in the field.

Also you can find links directly to these stories on the Vital Signs Town Hall Conference Web site or you can visit the link at the bottom of the slide to see all the current Public Health Practice Stories from the Field.

Lastly, please let us know how we can improve these teleconferences to be more beneficial to you. Please email your suggestions, and we really want

them, to ostltsfeedback@cdc.gov. That's O-S-T-L-T-S, O-S-T-L-T-S feedback - one word - @cdc.gov.

Thank you to each of our presenters and to all who participated in the call. Have a great afternoon. Bye-bye.

Coordinator: That concludes today's conference call. Thank you for your participation. You may disconnect at this time.