BlueCross BlueShield of Texas

Eight Steps Toward Health Equity in Hypertension

Great disparities exist between groups in the U.S. around the incidence, prevalence and sequelae of hypertension. You may have seen evidence of this in your own practice.

While the problem may seem large, you can make a difference in closing the health equity gap right in your office by following these eight steps:

1. Educate Yourself
2. Gather Key Disparities Data for Your Patients
3. Assess Your Office Culture
4. Reach Out to Your Patients
5. Use Evidence-based Interventions
6. Ask About Social Determinants of Health
7. Utilize Community Resources
8. Speak Up

The Healthcare Effectiveness Data and Information Set (HEDIS®) quality measure for adults 18 to 85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled based on the following criteria:

- Adults 18-59 years of age whose blood pressure was <140/90 mm Hg.
- Adults 60-85 years of age, with a diagnosis of diabetes, whose blood pressure was <140/90 mm Hg.
- Adults 60-85 years of age, without a diagnosis of diabetes, whose blood pressure was <150/90 mm Hg.

1. Educate Yourself

Cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural and linguistic needs of patients.[1] Addressing ethnic minority patients' perceptions of hypertension and its treatment through the use of cultural appropriate hypertension education increases adherence to medication and lifestyle recommendations.[2]

With an emphasis on learning about a culturally and linguistically appropriate clinical encounter, the U.S. Department of Health and Human Services offers free resources to learn more about applying the National CLAS Standards in daily work.

2. Gather Key Disparities Data for Your Patients

Race or ethnicity, sex, age, disability, socioeconomic status and geographic location all contribute to an individual's ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of your office's patient population.

By using resources like those listed below, you may determine key disparities of your patients.

- Mapping America: Every City, Every Block
- US Census Bureau: American Fact Finder
- Kaiser's Dual Eligible Beneficiaries (by race/ethnic)

3. Assess Your Office Culture

- Make sure all patients feel welcome in your office by having your staff follow a cultural competency checklist.
- Visit the National CLAS Standards and the Communication Guide on the U.S. Department of Health and Human Services Office of Minority Health website for suggestions and training on culturally appropriate signage at the right reading level.
- Have culturally diverse reading material in the office.
- Make cultural competence an item at your monthly staff meetings.
- Make some hours and walk-in policies helpful to people with limited resources.

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4. Reach Out to Your Patients

Proactive outreach is effective in closing care gaps. The registry function in the electronic medical record can be used to find patients whose last recorded blood pressure (BP) was over 139/89. Consider inviting them back for an appointment or a recheck with a nurse.

Another way to consider making contact with your patients who have hypertension is to offer free drop-in BP checks. Make sure to schedule follow-up visit before a patient leaves the office for every two to four weeks until the BP is controlled.

5. Use Evidence-based Interventions

The American Heart Association's (AHA) BP Improvement Program outlines a practical, evidence-based approach to improving BP control for your patients by focusing equally on three critical areas:

- MEASURE blood pressure accurately, every time
- ACT rapidly to address high blood pressure readings
- PARTNER with patients, families, and communities to promote self-management and monitor progress

The AHA also promotes self-measurement of BP with valuable tips and tools you can use.

6. Ask About Social Determinants of Health (SDoH)

Examples of SDoH include transportation limitations, access to healthy foods, ability to afford medication, safe and affordable housing, public safety and physical barriers, especially for people with disabilities.
Providers may assess each patient's SDoH by using a list like the one on HealthyPeople.gov.

7. Utilize Community Resources

Many organizations host chronic disease self-management education classes. Check the Texas Department of State Health Services Cardiovascular Disease and Stroke Partnership and its resources or the Texas A&M Center for Population and Aging Chronic Disease Self-Management Program for workshops and programs.

8. Speak Up

Don't think your power to affect change stops at the office door. Voice your support for improvements in SDoH.

[1]Betancourt, J. R., Green, A. R., & Carrillo, J. E. 2002. Cultural competence in health care: Emerging frameworks and practical approaches. New York: The Commonwealth Fund

[2]National Institute of Health, Development and evaluation of a culturally appropriate hypertension education (CAHE) training program for health care providers, June 8, 207. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5464541/