Michelle, an African American Kaiser Permanente patient in Southern California, was disheartened when her doctor informed her that she had high blood pressure. Eager to reduce her blood pressure, she and her doctor worked together to develop a diet and exercise regimen. Throughout her journey, Michelle was grateful for the reinforcement from her doctor: “Even in my visits when I started the weight loss, she was very encouraging. That makes you want to lose a little more and do the best you can. I think that I started doing some of these things so by the time I came back she would notice a difference.” Michelle has successfully reduced her blood pressure, lost over 20 pounds, and built a sustainable, healthy lifestyle.

**Policy Context**

Disparities in health care and outcomes have persisted for many years, but recent attention by health care organizations and the United States government has increased responsiveness to the issue. In 2011, the Department of Health and Human Services (HHS) released its “Action Plan to Reduce Racial and Ethnic Health Disparities,” which is one of the largest federal initiatives to reduce disparities to date. One of the five key goals of the plan is to transform health care by increasing access to care and reducing disparities in the quality of care. In particular, the HHS seeks to expand access to primary care and ramp up efforts to combat cardiovascular disease.

**The Challenge**

Over 40 percent of African Americans have high blood pressure, a rate that is one of the highest in the world. Racial disparities between African Americans and whites are striking: in addition to having a higher prevalence of high blood pressure, African Americans are more likely to develop hypertension at a younger age and are at higher risk of strokes, heart failure, end-stage renal disease and deaths from heart disease. In addition to genetic, environmental, social, and lifestyle factors, researchers believe that disparities in health care quality are driving these differences. Although health care disparities have lessened slightly, they remain widespread in the United States. A 2013 report found that African Americans receive worse care than whites for about 40 percent of quality measures, such as hypertension and dehydration admissions, and worse access to care for 33 percent of measures, such as insurance coverage and wait times.

**Kaiser Permanente Solution**

In the early 2000’s Kaiser Permanente began to collect data on patients’ race and ethnicity. We compared our information to the quality measures in the Healthcare Effectiveness Data and Information Set (HEDIS) and identified where health disparities existed within our organization. While all our members ranked well above the national average for hypertension control, we discovered that African Americans had lower rates of hypertension control than whites. After thoroughly examining the drivers and possible interventions, we made reducing disparities in hypertension control a program-wide initiative in 2011. Our goal is to exceed
the 90th percentile within the HEDIS measures for all members, and to close any disparity gaps that remain, no matter how small.

The National Equitable Health Care Outcomes (ECHO) team developed a toolkit based on best practices in hypertension management. Our Southern California region was the first to implement this toolkit in 2012, and developed a series of initiatives to improve blood pressure control among African Americans. These initiatives include:

• Expanding access to care by offering group medical appointments, telephonic visits and financial assistance for medications.
• Improving trust and communication between providers and patients through culturally tailored communication guides. The “Four Habits Practice Tool” emphasizes building rapport with the patient, eliciting the patient’s perspective, demonstrating empathy, education, and assessing knowledge of his/her care plan.
• Supporting patients in making healthy behavior changes. New patients receive an interactive salt questionnaire to assess sodium intake. All patients can receive information on DASH (Dietary Approaches to Stop Hypertension), an eating plan that outlines meals low in sodium and high in nutrients.
• Practicing evidence-based medicine. Evidence-based clinical practice guidelines are utilized to determine medication and treatment plans for African American patients. Treatment Intensification (TI) is used to tailor medication therapy for patients with high blood pressure.
• Leveraging health information technology – such as patient registries – to support population health management and to measure outcomes of clinical interventions.

Outcomes

Between 2011 and 2013, control of high blood pressure increased from 79.8 percent to 82.5 percent among African Americans. In the Southern California region, the rate of hypertension control among African Americans increased from 83.2 percent to 85.4 percent. The gap between African Americans and whites in hypertension control fell from 4.8 percent down to 3.6 percent. For both groups, Kaiser Permanente exceeded the HEDIS national 90th percentile for control of high blood pressure.

At our Gardena, California medical offices, an estimated 27 strokes and/or heart attacks were prevented due to hypertension control efforts, leading to a savings of $629,000.

Practical Implications and Transferability

Dr. Ronald Copeland, senior vice president, national diversity and inclusion strategy and policy, and chief diversity and inclusion officer for Kaiser Permanente, outlines several keys to success in combating health disparities. These include: increasing awareness of the issue, gaining buy-in from leaders, integrating disparities work into quality improvement projects, developing a sound intervention design plan, engaging communities, and spreading successful practices across the organization. These strategies are currently being applied at Kaiser Permanente so that care disparities can be reduced in not only hypertension care but also other areas.

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