



## ASTHO Heart Disease and Stroke Prevention Learning Collaborative *Spotlight on National Partners*

### How South Carolina Addresses Health Disparities in Hypertension

Written by the National Association of Chronic Disease Directors

Jacqlyn Atkins and Tiffany Mack of the South Carolina Department of Health and Environmental Control (DHEC) find that many health practitioners struggle with cultural competency and how to view their work with patients through a health equity lens. Atkins, a health systems coordinator at the health department, and Mack, a program administrator within DHEC's division of diabetes, heart disease, obesity, and school health, are both members of the National Association of Chronic Disease Directors (NACDD). During a recent fireside chat on [addressing health disparities in hypertension control](#), they discussed the role of the state health department in identifying and controlling hypertension.

Atkins and Mack were joined by Brent Egan, senior medical director of the Care Coordination Institute and current president of the International Society on Hypertension in Blacks. Hosted by the NACDD cardiovascular health initiative, in coordination with CDC's Division for Heart Disease and Stroke Prevention and Million Hearts, the fireside chat was a live, interactive panel discussion moderated by Janet Wright, executive director of Million Hearts.

Themes emerging from the discussion included: the vital role of data in identifying areas or populations with high rates of hypertension, the importance of partnerships both within and outside of state agencies, and the need for a deliberate intention to reduce disparities when forming new partnerships.

Panelists shared the following advice:

- Make addressing health disparities a first thought—not an afterthought, as health equity so often can be.
- Don't be discouraged. It may take time to get the process together. DHEC and its partners took steps to prepare and provide data to clinical practices.
- Use data to identify the levers for improvement.

South Carolina prioritizes eliminating health disparities in its work, using cultural competency training as the model for spreading the message. DHEC created a presentation specifically for clinical practices and tied cultural competence to patient-centered medical home (PCMH) standards. For those practices



providing a PCMH, demonstrating cultural competence helps them meet these standards and serves an additional benefit for participating in the department's training. DHEC also recommends comprehensive, self-paced cultural competency trainings offered by the National Office of Minority Health through its [Think Cultural Health](#) resource portal.

Mack describes DHEC's work with clinical practices in the region: "It's important to approach them about changing the conversation," she says. "Emphasize that the health department is not there to add to their workload, but to complement the work they are already doing." DHEC calls its program SC PHASE: Prevention and Health Across Systems and Environment, an acronym that resonates with partners better than the program's funding number designation—1305 or 1422.

To identify practices serving priority populations, the DHEC chronic disease epidemiology team used Medicaid data defined by zipcode for 15 counties. This method pinpointed certain practices for recruitment and resulted in participation by some practices, but not all. Regardless of their participation in quality improvement activities, all identified practices receive information and follow-up from DHEC. Local health district staff conduct clinic trainings and academic detailing through sub-contracts with DHEC. Mack provides guidance on academic detailing and recruiting practices. Working with the South Carolina Office of Rural Health, DHEC's chronic disease program is creating a change packet that any medical practice can use to engage disparate populations.

Once practices are engaged, DHEC and the designated "physician champion," Dr. Egan, focus on team-based care and undiagnosed hypertension, help practices modify their electronic health records, and provide real-time information using registries, flagging, and protocols. Gathering qualitative information from practices such as who is on the team, what protocols they use, and how often they meet, is essential. Egan's group, the Care Coordination Institute, gives individual physicians a dashboard report on their patient's hypertension control and PCMH practices receive a "daily huddle" report to use in planning care for the patients they'll see that day. The training and reports provide a sustainable foundation that supports the work, even in the face of evolving clinical guidelines.

Egan values the 15-year partnership with DHEC and is pleased to see how the [M.A.P. framework](#), developed by the American Medical Association, is being applied to address hypertension control in the Center for Family Medicine, part of South Carolina's Greenville Health System. As Egan points out, "every practice believes it delivers better-than-average care, but they all want to find ways to do better."

NACDD's [cardiovascular health initiative](#) shares resources and program information to help states improve identification and control of hypertension through "Off the Cuff," a weekly health system update for members.

**Learn more about the National Association of Chronic Disease Directors:**

[www.chronicdisease.org](http://www.chronicdisease.org)