ASTHO Brief
Exploring critical issues in state and territorial public health.
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# Systems Change Approaches for Engaging Families in Hypertension Control

Heart disease is the leading cause of death and strokes are the leading cause of serious long-term disability in the United States. Hypertension (high blood pressure) is a major risk factor for heart disease and stroke. One in three people in the United States has hypertension and approximately half are unaware of their diagnosis. To support jurisdictions in the United States, U.S. territories, and freely associated states in reducing the burden of heart disease and stroke on the public's health, ASTHO and CDC's Division for Heart Disease and Stroke Prevention developed a process to support systems change to improve health outcomes and reduce hypertension.

This brief explores how state and territorial health agencies (S/THAs) can engage people who provide social support for individuals and families with hypertension. Lessons in this brief are taken from the ASTHO/CDC Heart Disease and Stroke Prevention Learning Collaborative, in which 31 S/THAs participated from 2013-2018 to test, implement, and scale up approaches to address hypertension. ASTHO and CDC worked with a subset of S/THAs in the learning collaborative to evaluate Plan, Do, Study, Act (PDSA) cycles that engage families in hypertension control, including through CDC's WISEWOMAN program. The pilot programs included clients and their family members in order to increase blood pressure awareness and management through screenings, enhance health system partnerships using electronic medical records (EMRs) to coordinate familial services, provide health resources (e.g., self-management classes, cooking workshops, group visits at hypertension clinics), as well as promote lifelong heart-healthy behavioral changes.

**Implement Various Engagement Models**

Blood pressure management requires a multi-pronged approach, including changes in diet, physical activity levels, medication use, and social support. Health departments in this learning collaborative tested ways to adapt their systems to meet community needs, often necessitating a multi-sectoral approach. Programs referred and improved connections to primary care providers, health education courses, weight management programs, and other resources that support health holistically.

- ***Spotlight:*** Alabama's Mobile County Health Department identified 5,000 people in the department's EMR system with elevated blood pressure readings. Urgent care staff and newly hired community health workers used the EMR system to make referrals to primary care providers and a community health education course.

**Leverage Cross-sectoral Partnerships**

Referrals and connections between clinical, public health, and community resources through evidence-based public health strategies require engaging related specialists. ACA allows public health and healthcare providers to expand access to services and programs. While insurance expands access, hospital systems are important partners for health promotion activities not covered by insurance.

- ***Spotlight:*** The South Carolina Department of Health and Environmental Control collaborated with HopeHealth to expand health education and integrate each client's self-measured blood

pressure (SMBP) monitoring plan into their EMR. The patient's SMBP plan is reviewed at each visit to a HopeHealth provider or service to continually improve his or her blood pressure. HopeHealth is expanding their hypertension management health education course to address all aspects of hypertension and other chronic illnesses.

**Identify Individuals and Families Living with Hypertension**

Maintaining client records is an essential part of clinical care. Community health workers and other public health staff in clinical settings can utilize EMR systems for identifying clients with elevated blood pressure, with or without a hypertension diagnosis in their record. Clients who are identified as having uncontrolled hypertension can then be connected to resources and programs to support their lifestyle changes and treatment recommendations.

- ***Spotlight:*** The Utah Department of Health partnered with several clinics to encourage referrals into their tailored familial support programs in two counties. Clients were identified through the Utah BeWISE Program and were asked to invite a support person to be screened for high blood pressure during their follow-up call. Anyone screened with high blood pressure was also invited to participate in health coaching services.

**Expand Successful Strategies**

While each learning collaborative team developed systems-level changes tailored to their own jurisdiction and health system, many processes proved successful across teams. Key strategies included:

- ***Regular stakeholder meetings.*** Stakeholder meetings are an integral part of building shared values and maintaining progress towards aim statements developed by the group. Along with standing meetings with ASTHO and CDC, S/THA program teams met often to discuss lessons learned, successes, and updates.
- ***Establish communication channels across systems.*** Sustaining processes and procedures requires a change not only in what clients are offered, but how providers care for clients by integrating streamlined referrals, cross-sectoral communication, and team-based solutions into the standard operations.
- ***Data sharing for referrals.*** Quality data sharing is essential to coordinate services and referrals for individuals with high blood pressure and their families who enter the healthcare system (i.e., through urgent care, a primary care provider, or a pharmacy). Clinical providers can connect patients to community services and track their use through bi-directional referrals.

**Summary**

S/THAs can use systems-level strategies to drive changes in familial support of blood pressure management. These strategies include holding regular stakeholder meetings across public health and clinical teams, establishing communication channels between stakeholders, and utilizing data sharing for referrals from clinical to community services. Key steps include: (1) establishing a method to identify and support individuals and families with hypertension, (2) adopting protocols for engaging families in care and educational courses, and (3) using ASTHO's Tools for Change to identify examples and best practices.

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