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

Integrating Community-Clinical Linkages into Local Health Departments' Community Health Improvement Plans to Prevent and Control Hypertension
Written by the National Association of County and City Health Officials

According to CDC, one in three adults is hypertensive and only half of those with high blood pressure have their condition under control. Furthermore, another one in three adults is pre-hypertensive, meaning their blood pressure is higher than normal but not yet in the high blood pressure range. Hypertension is also an issue of health equity: African Americans develop high blood pressure more often, and at an earlier age, than whites and Hispanics. The effects of hypertension are grim. Hypertension can cause heart attacks, strokes, chronic heart failure and kidney disease. In 2013, more than 360,000 deaths included hypertension as a contributory cause.

Local health departments (LHDs) are on the front lines of reducing the burden of hypertension and other chronic diseases in their communities. Most LHDs provide community health education and marketing campaigns and some also provide primary care services. These are key elements in a comprehensive approach to hypertension reduction. However, LHDs fill the even more critical role of aligning a community's systems and resources—hospitals, healthcare clinics, employer wellness programs, transportation systems, schools, recreational centers, and other nonprofit and for-profit direct service providers—to reduce and prevent hypertension.

The National Association of County and City Health Officials (NACCHO) represents nearly 3,000 LHDs that advance evidence-based interventions to reduce health disparities and protect and improve the health of all people in their communities. One of NACCHO's key roles is helping LHDs determine how to implement new public health recommendations—for instance, a directive to implement interventions that lower the disproportionately high rates of hypertension and heart disease among African American populations. NACCHO provides technical assistance, aggregates best practices, and connects LHD leaders and staff to facilitate peer learning.

The Community Health Assessment and Improvement Plan
If you are pre-hypertensive, chances are your doctor will tell you to exercise more and eat less salt. However, such advice fails to consider the broader context in which people live. People who live under

the poverty line have limited access to healthy food, medical care, and safe neighborhoods in which to exercise. In order to achieve health equity and reduce hypertension, LHDs must address social determinants of health: the conditions in which people live, work, learn, and play.

LHDs serve as chief health strategists within the communities they serve. From this position, LHDs convene stakeholders to review data and identify their community's specific needs, identify existing resources, and develop systems that will align resources to improve their population's social

determinants of health. This process, which entails conducting a community health assessment (CHA) and developing a community health improvement plan (CHIP), is typically conducted every three years to identify and assess community health needs and prioritize interventions. A variety of tools and processes may be used to conduct a CHA/CHIP, including employing NACCHO's Mobilizing for Action Through Planning and Partnerships (MAPP); the essential ingredients are community engagement and collaborative participation.

To begin the CHA process, LHDs convene a diverse group of community stakeholders, including government officials, neighborhood representatives, small and large business owners, community service staff, and members of the faith community. Once convened, the LHD-facilitated stakeholder group works together to review nationally and locally collected public health data, using findings from surveys such as the CDC's Behavioral Risk Factor Surveillance System, to provide a guiding overview of health behaviors, chronic disease conditions and preventive services at the county level. Data reviews allow the stakeholder group to identify health needs and health disparities within their own communities.

After identifying public health needs, the stakeholders collaborate to identify health assets and determine how resources could be aligned to improve population health. For example, they consider whether their communities have a sufficient number of health clinics for the uninsured, adequate public transportation options, ample job opportunities and safe housing.

Finally, the stakeholder group works together to develop a three-year community health improvement plan that contains evidence-based or informed interventions that leverage their community's resources in new and innovative ways to meet the community's health needs.

Applying CHA and CHIP Processes to Prevent and Control Hypertension
LHDs can use the CHA/CHIP process to develop community-clinical linkages to help promote and control hypertension at the local level. One of the primary approaches to addressing hypertension-related health disparities is the development of community-clinical linkages.

Community-clinical linkages are broadly defined as social determinants of health-based systems designed to leverage community resources from various sectors to connect target populations with resources to improve health. One example of a community-clinical linkage would be a farmer's market located in a historically black neighborhood that partners with a local hospital to provide "prescription"

coupons for fruits and vegetables to hypertensive and pre-hypertensive patients. Representatives of these community and clinical resources may already be represented in the LHD-facilitated stakeholder group, can be invited into the LHD-facilitated stakeholder group or can choose to partner externally with the LHD-facilitated stakeholder group.

LHDs and other stakeholders can use the CHA/CHIP approach to design and deploy community-clinical linkages to reduce the rate of hypertension by using the following strategies:

1. **Deliver culturally competent, sensitive healthcare and health education.** To be effective, healthcare and health education must be provided in a cultural and religious context appropriate for each patient. To achieve this, a LHD-facilitated stakeholder group could work with healthcare providers and health educators to provide and integrate trainings, materials and systems to ensure the delivery of health services tailored to meet the target populations' needs.

2. **Increase the accessibility of healthcare.** Communities disproportionately affected by hypertension must be able to access healthcare to identify hypertension and manage medications effectively. To support this, the LHD-facilitated stakeholder group can meet with members of these communities to identify barriers to healthcare access, such as transportation, insurance or knowledge of services. The stakeholder group can then partner with decisionmakers to align community resources to meet the community's specific needs. For instance, if a target population identifies a lack of transportation services connecting their neighborhood with the nearest local federally qualified health center, the stakeholder group can work with the county public transportation office to develop new bus routes to address this need.

3. **Develop referral systems between community programs and clinical providers.** Referral systems are a high-impact strategy for identifying and controlling hypertension. For example, a YMCA may partner with a local clinic to provide reduced-rate memberships for persons diagnosed with hypertension. Likewise, an LHD may implement a hypertension screening system that refers hypertensive patients directly to clinical services. To support systematic development of these referral systems, the LHD-facilitated stakeholder group can convene community resource representatives, share examples and guide development of cross-partner systems that maximize the effect of each partners' ability to improve community health outcomes.

In conclusion, each community's needs and resources are different. By working with a LHD through the CHA/CHIP process, a community can ensure evidence-informed, community-clinical linkages are strategically aligned to meet the specific needs of their population, effectively reducing hypertension and improving the public's health.

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www.naccho.org/programs