Complete Transcript of Modalities to Achieve Hypertension Control in Clinical Practice: A Call to Action!

[00:00:03] Welcome to SMA's Women's and Children's Health podcast, a publication of the Southern Medical Association. This podcast explores all aspects of care of the female patient across her lifespan. It will also explore the special and unique care of children and adolescents.

[00:00:24] Welcome back to the Southern Medical Association's Women's and Children's Health Podcast. I'm Lee Boughton and today we're with Dr. Donald DiPette again. He is one of the faculty members for our 2019 Focus on Women's Health Conference in Kiawah, South Carolina and we're discussing one of his lectures which is entitled "Modalities to Achieve Hypertension Control in Clinical Practice: A Call to Action."

[00:00:] Dr. DiPette why do you need to investigate and/or develop new modalities to lower blood pressure and achieve increased hypertension control?

[00:01:06] Lee, again, it's going to be very similar to the previous podcasts that we also have available for the upcoming summer Kiawah meeting. And it's because our control rates for hypertension regionally and nationally are still far below where we should be - given the fact that we have safe and effective pharmacological and hypertensive medications. We know quite a bit about the pathophysiology of hypertension and we also know that lifestyle modification lowers blood pressure and improves patient health. But despite all of this knowledge and all of this previous education over the last - I would say three to four decades - control rates are still well into the 50 to 60 percent, whereas they should be achieving 95 or even possibly 100 percent control rates given our resources and our knowledge about the disease state. So, this is why I think, if you will, we've been doing the same thing over and over again probably at least for the last 10 years maybe even the last 20 years and our control rates have not significantly increased.

[00:02:16] Faced with that dilemma, I do think it behooves us to spend some time - and we're going to be giving a curricular time at the meeting - to discuss issues such as this to try to talk about some new modalities, try something different, because clearly what we're doing now - has done a great deal if you will - but we're stuck. We're stuck at the 50 to 60 percent range and we could be doing far better, and we should be doing far better than that. There's a lot of morbidity/mortality to prevent in treating the patient with hypertension and there must be new discussions and new modalities and perhaps even new approaches to a disease that we know quite well and we're very familiar with.

[00:03:06] But in general what are some of these new ways to increase the control of hypertension?

[00:03:12] Well that's the good question and that's the big question. Actually some of these new modalities and discussions are taking place globally - outside of the United States. Sadly, as opposed, to inside the United States. I mentioned that the prevalence of hypertension globally is increasing. The control rates of hypertension globally are even more dismal than in high income countries like the United States, Canada, and Western Europe. Control rates are as low as 14 percent, possibly even, at the best, 30 percent globally. But interestingly, even in these low- and middle-income countries, globally there's robust discussions going on. On how to achieve rapid augmentation or increases in hypertension control rates because the goal as everyone is centered on is to prevent

cardiovascular disease, and hypertension is the leading risk factor for cardiovascular disease. In addition to diabetes, etc.
[00:04:17] So, some of the modalities that are being discussed and actually have been already implemented are the following - perhaps we should have a standardized formulary. In other words, instead of going into a candy store and having two hundred different candies to pick - perhaps we should have fewer. And, of course, I'm alluding to pharmacologic therapy for hypertension. One modality might be to have just a smaller number of safe and effective antihypertensive agents. Perhaps, a primary agent and a secondary agent within each of the major classes that are available for the active clinician to treat the hypertensive individual. That might help because it might decrease the complexity of treating that hypertensive individual instead of choosing from two hundred pharmacologic agents. Perhaps, it would be wiser to choose from products ten - or fifteen - hypertensive agents across the major classes.

[00:05:19] The second thing is how are you going to use these anti-hypertensive medications once you develop this formulary - once you develop the ones you're going to select from? And we are finding that some simple intervention has made a dramatic difference in improving control rates. Again, this is external to the United States - but some places inside the United States as well such as Kaiser Permanente in Northern California - and that is the use of a very simple standardized treatment algorithm. A pharmacological algorithm, if you will, where it's regimented. It's simple. It has four to perhaps six steps and the team that's seeing that hypertensive patient has access to the algorithm, that's bought into the algorithm, and uses the algorithm. We are going to discuss this at length during the upcoming Women's Health Symposium.

[00:06:16] In addition, perhaps we should be trying to change how we administer the medications. When I was taught, of course, pharmacology of hypertension - it would start with one drug. See what happens. Increase the dose. If it's still not at goal, add a second drug and so on and so on. That takes a lot of time. There is a lot of steps to that process. And perhaps we could do better. And one possibility in terms of doing better is to use perhaps two medications at once, once the hypertension has been diagnosed in the individual patient. You would use lower doses so there would be two drugs in combination. Either as two single pills given together or even better as a fixed-dose combination because now you're giving two medications in one.

[00:07:06] The other intervention is that, even in small practices, we should have a registry. We should know who our hypertensive individuals are in our practice. And once we know who they are we should know their blood pressure and then we should be able to determine these steps - the treatment steps, if you will - and then who is at goal and who is not at goal. So, we can see how we're doing. Then with that data we could promptly give feedback to the practicing clinicians within that practice, or that health system, if you will. Or even that region, if you will. Because we know that if you give feedback, people are going to change They're going to increase their intervention. They're going to become much more assertive, if you will. And we have seen that in some of these low-to-middle income countries and organizations within the United States like Kaiser Permanente, that following this simple algorithm, including starting two antihypertensive medications at once (either as two single pills or as a fixed-dose combination) has dramatically led to increased hypertension control rates.

[00:08:17] How can the busy clinician incorporate these newer modalities into their individual patient care?

[00:08:23] Actually what's really interesting is these modalities, albeit new, are simple. And they're not changing any of the way that we have been treating hypertension. In other words, there's not new medication that we're using. We're using the medications that we presently have. We are just changing *how* we use the medications. We are changing how we standardize the treatment of hypertension. Again, as I mentioned, standardize the medications we're going to choose from. Make them draw from a smaller pool, if you will. But still have complete expansive treatment and therapeutic agents available.

[00:09:03] And then, of course, standardize and simplify the algorithm. Make it a must, not a should. And then provide feedback back to those clinicians. This can be done in a one-person practice. if you will. And it can be done in a practice like Kaiser Permanente that has six thousand clinical providers. And we've demonstrated that it is - actually it *is*, rather I know nothing is easy in life, but I would say that it's not hard. It just takes dedication and it takes an open mind to think about these newer modalities. Because after all, there are significant barriers to hypertension control. There's a reason why we are only treating, we are only controlling, 50 percent of our hypertensive population of the United States. Again, a high-income country. And those barriers are easy to define.

[00:09:57] There are patient barriers, there's healthcare provider barriers, and there's health system barriers. And we have to take a holistic approach to these barriers and try to - try to attack, if you will - and intervene on as many of the barriers as possible.

[00:10:13] So, for instance, a patient barrier is poor adherence to treatment. We know that there's a vast - there's a good number- of hypertensive individuals that don't adhere to the treatment that we prescribe. There's also a healthcare barrier, such as clinical or therapeutic inertia. And that's the failure to increase the medication or added medication when it's clinically indicated. And we also know that our active and busy practicing clinicians sometimes don't adhere to treatment guidelines, even when it's appropriate. And finally, we have health system barriers. Among many, one of them is health systems tend to - I don't know why, but it's been my experience and my colleagues experience elsewhere, health systems tend to make things complex. And they tend to make things, including medical regiments like even treating the hypertensive individual, complex. And I know that we can address these barriers with the modalities that we're going to discuss and not only is it just theoretic anymore. We actually have documented evidence and outcomes from low-to-middle income countries outside the United States - such as Cuba, Colombia, Barbados, and Chile, if you will. And then within the United States such as the Kaiser Permanente experience in Northern California. All of these different modalities will be discussed and I'm really, really, looking forward to an active and robust discussion because some of these are new. And even though they're not new in terms of what we're using - the methodology, if you will, it's going to really rub against some teachings that some of us that are a little bit older have been taught - even when we were in medical school. But again, open minds are positive, and we should always address new data. A new drug becomes available, would we talk about that new medication - of course. So, we should do the exact same thing when we're talking about new treatment modalities. There should be no difference. We should just be, we should be as excited at new treatment modalities as well as when a new therapeutic modality comes forward.

[00:12:29] If you're interested in seeing, Dr. DiPette and learning more - please visit our Website – sma.org/whpodcast. The meeting is held at Kiawah Golf Resort, in beautiful Kiawah, South Carolina on July 15th through 18th. If you want to learn more and you cannot attend the meeting live, we have you covered. Focus on Women's Health is also available as a webcast.