It Takes a Village

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I know what you’re thinking—“it takes a village” is a hackneyed phrase, and what is it doing in P&T?

Perhaps you missed a critically important report from the Institute of Medicine (IOM) last winter on an approach for preventing and controlling hypertension.1 It certainly appears that it does take a village to manage high blood pressure in the U.S.

As our readers probably know, nearly 73 million Americans (one in three adults) have hypertension. At the same time, this problem places huge economic demands on the health care system—estimated at $73.4 billion in direct and indirect costs in 2009 alone. Hypertension is relatively easy to prevent, simple to diagnose, and inexpensive to treat, especially if patients follow their medication regimens.

The Centers for Disease Control and Prevention (CDC), through its Division for Heart Disease and Stroke Prevention (DHDSP), provides national leadership to prevent, control, and reduce the impact of hypertension. To help in these efforts, the DHDSP developed a strategic plan that identified a number of key areas and goals for future work. To ensure that these future efforts were targeted effectively, the CDC asked the IOM to convene a special high-level national committee to identify priority areas and public health organizations to accelerate progress in reducing the burden of hypertension. As a result, the IOM issued its valuable report on hypertension.1 The report emphasizes seven important concepts, as follows:

First, as an overarching recommendation, the report indicates that DHDSP should give priority to strategies that can reach large numbers of people to improve the well-being of entire communities. It also says that “population-based policy interventions and interventions directed at system improvements are likely to be more practical and realistic in today’s resource-constrained environment.” As practitioners, we should collaborate with state and local public health officials on critical behavioral and lifestyle interventions that would target risk factors known to contribute to hypertension; this means eating a healthy diet, consuming less salt, and exercising more. All of us in the health professions have an obligation to educate the members of our society on these important behavioral changes.

Next, a national effort should be made to reduce sodium intake in the American diet. Approximately 90% of adults are consuming more sodium (about 3,400 mg/day) than recommended in the dietary guidelines—a limit of 2,300 mg/day for young, healthy adults and 1,500 mg/day for people older than 40 years of age, African-Americans, and patients with hypertension.2 Is your hospital cafeteria cutting down on the sodium content of its current offerings?

We should ensure an adequate potassium intake in the diet by encouraging the public to eat more fruits and vegetables.

We should be reducing risks among patients who already have hypertension. Many physicians are not providing treatment consistent with practice guidelines developed by the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC). This coalition of organizations and federal agencies issues guidelines when warranted by scientific advances. Is your medical staff generally adhering to the guidelines?

We should be collaborating with community health workers, who have often helped to enhance medication adherence among patients. These employees play important roles by linking diverse communities in the health care system. Is your institute reaching out to the community and educating its members, especially minority populations, about adhering to their medication regimens?

We should be working with employers, encouraging them to leverage their health care purchasing power to advocate for reduced deductibles and copayments for antihypertensive agents in their health insurance benefits packages. Such measures could eventually mean lower copayments, increased adherence, and a reduced societal burden associated with hypertension.

Finally, we should recognize that the federal government’s antihypertension program is dramatically underfunded in relation to disease prevention. We might contact our elected representatives and lobby them to improve funding for all prevention and wellness programs. This would definitely give us a bigger bang for the health care buck we’re spending.

From a P&T committee’s perspective, we blithely continue to approve dozens of new agents to control blood pressure, and based on population-health studies, the evidence is overwhelming that if we undertake the seven-point plan, we’ll have a much greater impact on hypertension in our community. As the IOM suggests, focusing attention on these high-priority areas may eventually bring about significant improvements in public health, including a lower prevalence of hypertension, better quality of care, fewer health disparities, and, ultimately, reduced mortality and morbidity resulting from heart disease and stroke. All I can say is, “Amen!”

As always, I’m interested in your views. My e-mail address is david.nash@jefferson.edu. Please also visit my blog at http://nashhealthpolicy.blogspot.com.

REFERENCES
