

CME CREDIT EDUCATIONAL OBJECTIVE: Readers will think about strategies to improve hypertension control in African American patients

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Overcoming barriers to hypertension control in African Americans

ABSTRACT

Barriers to blood pressure control exist at the patient, physician, and system levels. We review the current evidence for interventions that target patient- and physician-related barriers, such as patient education, home blood pressure monitoring, and computerized decision-support systems for physicians, and we emphasize the need for more studies that address the effectiveness of these interventions in African American patients.

KEY POINTS

Rates of cardiovascular disease and related death are disparately high in African Americans.

Ways to improve how physicians manage blood pressure in this patient population may include chart audit with feedback, a computerized clinical decision-support system, and keeping up-to-date with treatment guidelines. However, more data are needed to determine the effectiveness of these interventions.

A novel method of health education is the use of narrative communication—ie, storytelling. Culturally appropriate storytelling may allow patients to identify with a story as it relates to their own lives.

A team-based approach to blood pressure control that involves nurses, pharmacists, and physician assistants should be emphasized, even though studies that have shown positive results did not focus specifically on African Americans.

HIGH BLOOD PRESSURE takes a devastating toll on African Americans. Better control can go a long way to closing the “mortality gap” between African Americans and white Americans. But which strategies are best to address this complex problem?

In this report, we review the evidence on practice-based approaches to improving blood pressure control, from new styles of patient education to home blood pressure monitoring, focusing on studies in African Americans (TABLE 1).¹⁻¹¹

BETTER CONTROL IS NEEDED

Better control of hypertension is certainly needed. In the United States, African Americans have disparately high rates of cardiovascular disease and death from cardiovascular disease.¹² (In this review, “African American” refers to non-Hispanic blacks, and “whites” refers to non-Hispanic whites.) According to the National Health and Nutrition Examination Survey (NHANES), from 1988 to 2008 the overall age-adjusted prevalence of hypertension in African Americans was 40%, vs 30% in whites.¹³ Partly because of this, African Americans have worse hypertension-related outcomes, including higher rates of fatal stroke, heart disease, end-stage kidney disease, and death compared with whites.¹⁴⁻¹⁸ Thus, hypertension is the single most common contributor to the mortality gap between African Americans and white Americans.¹⁹

Fortunately, clinical research has shown that better control of blood pressure produces cardiovascular benefits in African Americans.²⁰ To date, however, the primary care

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treatment of hypertension in African Americans is suboptimal due to patient-related factors, to physician practice factors, and also to barriers in the health care system (TABLE 2).^{21–23}

■ PATIENT-RELATED BARRIERS

Patient-related barriers^{24–40} include:

- Poor knowledge about hypertension and its consequences^{31,32}
- Poor adherence to drug therapy (a major factor,^{24–26} as African Americans have poorer adherence rates than whites,^{27–29} which may explain some of the racial disparity in blood pressure control³⁰)
- False health beliefs^{34–37}
- Inability to change one’s lifestyle
- Side effects of antihypertensive drugs³²
- Unrealistic expectations of treatment (eg, a cure³³)
- Demographic factors (eg, socioeconomic status, educational level, age, sex).^{24,38–40}

Perhaps the most salient and easily modifiable of these factors are patients’ reluctance to modify their lifestyle and their misconceptions about the causes, treatment, and prevention of hypertension. Patients whose beliefs are discordant with traditional biomedical concepts of hypertension have poorer blood pressure control than those whose beliefs are concordant.⁴¹ This may be more relevant to African Americans, since they are known to have cultural health beliefs that differ from those of Western culture (eg, that hypertension is a curable rather than a chronic illness, and that hypertension is a disease of nerves that often affects the blood and clogs the arteries).⁴²

■ PHYSICIAN-RELATED BARRIERS

Barriers to effective blood pressure control at the physician level^{43–48} include:

- Nonadherence to treatment guidelines⁴⁴
- Failure to intensify the regimen if goals are not met⁴⁵
- Failure to emphasize therapeutic lifestyle changes.^{43,46–48}

When primary care physicians do not follow evidence-based guidelines, the reason may be that they are not aware of them or that

they do not understand them. In a national survey of 1,029 physicians that was designed to explore how well physicians know the indications for specific antihypertensive drugs and how closely their opinions and practice agreed with national guidelines, only 37.3% correctly answered all of the knowledge-related questions.⁴⁹

Other reasons for nonadherence are that physicians may disagree with the guidelines, may not be able to follow the guidelines, may not believe that following them will achieve the desired effect, or may have no motivation to change their practice.⁵⁰

Whatever the reason, Hyman et al⁵¹ reported that as many as 30% of physicians did not recommend treatment for patients with diastolic blood pressures of 90 to 100 mm Hg, and a higher proportion did not treat patients with systolic blood pressures of 140 to 160 mm Hg.

■ BARRIERS IN HEALTH CARE SYSTEMS

Although health care systems present barriers to optimal blood pressure control,^{20,27,31,52} there is evidence that most cases of uncontrolled hypertension occur in patients with good access to care.^{32,53,54} For example, an NHANES study⁵³ suggested that most patients with uncontrolled hypertension had in fact seen a physician on average at least three times in the previous year. And this may be more pervasive in African Americans: one survey found hypertension was uncontrolled in 75% of hypertensive African American patients despite free access to care, free medications, and regular follow-up visits.⁴¹

Thus, the most significant barriers to blood pressure control appear to be patient-related and physician-related.

■ INTERVENTIONS AIMED AT PATIENTS

The most common approaches to improving blood pressure control at the patient level, regardless of race, are patient education,^{55–61} home blood pressure monitoring,^{62–67} and behavioral counseling to address misconceptions about hypertension,⁶⁸ to improve adherence to drug therapy,^{69–73} and to encourage lifestyle modifications.^{74–78}

Not all physicians recommend lifestyle modifications to their patients with hypertension

TABLE 1

Practice-based studies of hypertension control in African Americans

AUTHORS (YEAR)	INTERVENTIONS AND CONTROL	% AFRICAN AMERICAN	IMPROVEMENT IN BLOOD PRESSURE
Houston et al ³ (2011)	Three DVDs that contained patient stories Usual care ^a	100	11.21 mm Hg systolic (<i>P</i> = .012) 6.43 mm Hg diastolic (<i>P</i> = .012)
Bosworth et al ⁴ (2009)	Behavioral intervention Home monitoring intervention Home monitoring and behavioral intervention Usual care	49	3.9 mm Hg systolic (<i>P</i> = .010) 2.2 mm Hg diastolic (<i>P</i> = .009) ^b
Svetkey et al ⁹ (2009)	Physician intervention Patient intervention Physician and patient intervention combined Usual care	37	9.7 mm Hg systolic (<i>P</i> = .0072) 5.4 mm Hg diastolic (<i>P</i> < .05) ^c
Hicks et al ⁶ (2008)	Computerized decision support Usual care	33	No
Ogedegbe et al ² (2008)	Motivational interviewing counseling Usual care	100	No ^d
Carter et al ¹⁰ (2009)	Clinical pharmacist intervention Usual care	26	20.7 mm Hg systolic (<i>P</i> < .05) 9.7 mm Hg diastolic
Hunt et al ¹¹ (2008)	Pharmacy practitioners intervention Usual care	Not reported	6 mm Hg systolic (<i>P</i> = .007) 3 mm Hg diastolic (<i>P</i> = .003)
Artinian et al ⁵ (2007)	Usual care plus home monitoring Usual care	100	7.5 mm Hg systolic (<i>P</i> = .04) ^e
Roumie et al ⁸ (2006)	Provider education Provider education and alert Provider education, alert, and patient education	Not reported	16 mm Hg systolic (<i>P</i> = .012) ^f
Levine et al ¹ (2003)	More intensive vs less intensive	100	No ^g
Montgomery et al ⁷ (2000)	Computer-based clinical decision support system plus cardiovascular risk chart Cardiovascular risk chart alone Usual care ^h	Not reported	4.6 mm Hg systolic (<i>P</i> = .02) ⁱ

^aDVD interventions were delivered at baseline, 3 months, and 6 months.

^bStatistical significance was seen with the combination of home monitoring and behavioral intervention.

^cIn the combined physician and patient intervention group and also in the patient intervention group alone. The largest impact was with the combined patient-physician intervention, which is reported above.

^dMotivational interviewing counseling led to maintenance of drug adherence over time; there was a nonsignificant trend toward a net reduction in systolic pressure in favor of motivational counseling.

^eFollow-up reported at 12 months. The significance was seen only in systolic blood pressure.

^fThe significance was seen in the patients whose providers were randomized to patient education group.

^gBoth groups had a significant decrease in mean systolic and diastolic pressures and a significant increase in the percentage of individuals with controlled high blood pressure. No difference between the levels of intervention.

^hThis represent the primary follow-up. Although primary follow-ups were done at 6 and 12 months, only data at 12 months were reported.

ⁱStatistical significance was seen only with the risk-chart group only. The significance was seen only in systolic blood pressure.

Patient education

Patient education can improve blood pressure control.^{58,79–82} Its aims are to increase patients’ understanding of the disease⁸³ and to encourage them to be more active in their own care.^{80,84,85}

Patient education has a moderate effect on blood pressure control. The average proportion of patients whose hypertension was under control in community-based trials of various interventions ranged from 60% to 70%, compared with 38% to 46% with usual care.^{56,80,81}

However, these strategies largely did not address misconceptions patients have about hypertension. This issue is especially critical in African Americans, who may have different perceptions of hypertension and different expectations for care⁴¹: beliefs that hypertension is “curable,” not chronic, and that medication is needed only for hypertension-related symptoms may translate to poorer rates of medication adherence.

Levine et al¹ evaluated the efficacy of home visits by trained community health advisory board workers in a neighborhood in Baltimore, MD, with a high prevalence of hypertension. Participants were randomized to receive either one visit or five visits during the 40-month study period. Both groups had a statistically significant reduction in blood pressure, and in both groups the proportion of patients with adequate blood pressure control increased significantly. The results support the use of a practice- and community-based partnership to improve blood pressure control in African American patients.

Ogedegbe et al² randomized 190 hypertensive African American patients to receive usual care or quarterly counseling sessions that used motivational interviewing focused on medication adherence. The counseled patients stayed adherent to their medications, whereas adherence declined significantly in those receiving usual care. This effect was associated with a modest, nonsignificant trend toward a net reduction in systolic blood pressure with motivational interviewing.

A novel method of health education is the use of narrative communication—ie, storytelling. It has a good amount of evidence to support it, as culturally appropriate storytelling may allow patients to identify with a story as

TABLE 2

Barriers to blood pressure control

Patient-related barriers

- Poor adherence to drug therapy
- Lack of knowledge about hypertension
- Inability to engage in lifestyle changes
- Health beliefs
- Medication side effects

Physician-related barriers

- Nonadherence to treatment guidelines
- Failure to emphasize lifestyle modifications
- Clinical inertia: failure to titrate antihypertensive regimen

Barriers in health care systems

- Lack of access to care
- High cost of medications
- Absence of clinical decision support systems
- High copayments

it relates to their own lives.^{86–89} Examples of educational storytelling include:

- A woman with hypertension discussing what it means to have high blood pressure, and the benefits of controlling it, such as living long enough to see her grandchildren grow up
- A man discussing the importance of involving family and friends to help control blood pressure, and how dietary modifications can be made to ensure that salt alternatives are used when the family does the cooking.

Storytelling should be done in a culturally appropriate context. For example, storytellers should have the same background as the patient (ie, similar socioeconomic status and ethnic background): patients are more likely to be influenced if they identify with the storyteller and imagine themselves in a similar situation.

Houston et al³ randomized 299 hypertensive African Americans to view either three DVDs that featured patients with hypertension or three “attention-control DVDs” on topics not related to hypertension. The intervention group’s DVDs focused on storytelling and “learning more.” In the storytelling section, patients told personal stories about what it meant to have hypertension and gave advice on how to best interact with health care

The most significant barriers to blood pressure control appear to be patient-related and physician-related

providers and methods to improve medication adherence. A “learning more” section focused on what high blood pressure is, addressed therapeutic lifestyle changes, and encouraged patients to communicate with their health care providers. The patients who viewed the patient narratives had significantly lower blood pressure at 3 months than those assigned to usual care. Although blood pressure subsequently increased in both groups, the benefits of the intervention still existed at the end of follow-up.

Important to note about two of the above three studies¹³ is that the interventions were done by people other than physicians, thus emphasizing the importance of a team approach to blood pressure control.

Behavioral counseling

The effectiveness of lifestyle modifications such as diet, weight loss, and physical activity in preventing and treating hypertension is well established.⁷⁴⁻⁷⁸ For example:

- In the Dietary Approaches to Stop Hypertension (DASH) trial,⁷⁶ a healthy diet lowered blood pressure about as much as single drugs do, particularly in African Americans.
- The Trial of Nonpharmacologic Interventions in the Elderly (TONE)⁷⁴ showed that exercise can lower blood pressure in obese hypertensive patients.
- The PREMIER trial (Lifestyle Interventions for Blood Pressure Control)⁷⁵ showed that a single brief counseling session could produce substantial decreases in blood pressure in patients with stage 1 hypertension or high-normal blood pressure.

Unfortunately, these results have been hard to translate into primary care practice, especially for African American patients. Several studies have evaluated the impact of lifestyle interventions on blood pressure control in primary care practices with a large population of African American patients.

Bosworth et al,⁴ in a study of a practice in which almost half the patients were African American, randomized patients to receive usual care, nurse-administered tailored behavioral telephone counseling, home blood pressure monitoring, or home monitoring plus tailored behavioral telephone counseling.

The combination of home monitoring and tailored behavioral telephone counseling led to a statistically significant improvement at 24 months compared with baseline.

Home blood pressure monitoring

The effectiveness of self-monitoring in improving blood pressure control is also well documented.^{62,63,65-67,90-95}

Pickering et al⁶² studied patients with poorly controlled hypertension in a managed-care setting and found a reduction of 7 mm Hg systolic and 5 mm Hg diastolic pressure after 3 to 6 months of home monitoring compared with usual care.

Mengden et al,⁹⁴ in a similar study, found average blood pressure reductions at 6 months of 19.3/11.9 mm Hg in the home-monitoring group vs 10.6/8.8 mm Hg in the usual-care group.

The effect of home blood pressure monitoring may be greater in African Americans.

Rogers et al⁹³ found it to be more effective at lowering blood pressure than usual care in a group of 121 patients with poorly controlled hypertension followed in primary care practices, and these reductions were twice as large in African American patients than in white patients.⁹³

Bondmass,⁹² in a study of 33 African American patients with poorly controlled hypertension, reported a 53% control rate within 4 weeks of home monitoring. All patients in the study had uncontrolled blood pressure at baseline (> 140/90 mm Hg).

Artinian et al⁵ evaluated the effect of nurse-managed telemonitoring on blood pressure control vs enhanced usual care. All participants were African American. The monitored group had a significantly greater reduction in systolic pressure at 12 months compared with those who received enhanced usual care.

PHYSICIAN-LEVEL INTERVENTIONS

Most interventions to improve how physicians manage patients with hypertension are designed to improve adherence to treatment guidelines. In most cases, these interventions are based on continuous quality improvement and disease management concepts such as

Given the consequences of uncontrolled hypertension in African Americans, patient education is extremely important

physician education and academic detailing, reminders, feedback on performance measures, and risk-assessment tools.^{96,97}

Physician education

Interest is increasing in physician educational interventions for blood pressure control.^{24,98}

Inui et al,⁹⁹ in an early study in a primary care practice, found that patients of physicians who received tutorials on hypertension management were more compliant with their drug regimens and had better blood pressure control than patients of physicians in the control group.

Jennett et al,¹⁰⁰ in a similar randomized clinical trial, found that physicians who participated in an education activity were more adherent to treatment guidelines at 6 and 12 months compared with those who did not participate.

Maue et al¹⁰¹ showed that rates of blood pressure control improved from 41% to 52% after a 6-month educational intervention for physicians in a managed-care setting.

Tu et al¹⁰² reviewed 12 studies in which seven different physician educational interventions were used either alone or in combination and concluded that physician education improves compliance with guidelines for managing hypertension.

Unfortunately, these studies did not report outcomes separately for African American and white patients.

Hicks et al⁶ found that disease management approaches that target physicians whose patients with hypertension are mostly African American did not yield clinically relevant improvement in these patients, and that minority patients were significantly less likely to have their blood pressure controlled at the end of the study compared with their non-Hispanic white counterparts.

Feedback to providers

Several studies have shown that, given reminders and feedback systems, physicians will change their practice.^{103–106}

Mashru and Lant¹⁰⁴ combined chart audits and physician education in primary care practices and found they improved physician performance measures such as accuracy of diagnosis, number of patients who received

cardiovascular risk assessment, and number of patients whose treatment was based on clinical laboratory assessments.

Feedback takes many forms but consists mostly of computerized information¹⁰⁷ or peer-to-peer academic detailing with opinion leaders.^{108–110}

Dickinson et al,¹⁰⁶ for instance, showed that computer-generated listings of patients' blood pressures combined with a physician education program on clinical management of hypertension led to increased knowledge and better follow-up on their patients.

Again, however, these studies did not distinguish between African American and white patients, which makes it difficult to judge whether or not these approaches work differently for physicians with a large proportion of African American patients.

Computerized decision-support systems

Computerized decision-support systems have proliferated in primary care practices.¹¹¹

McAlister et al¹⁰³ found that general practitioners randomized to manage hypertension with the assistance of a computer obtained better outcomes than with usual care.

Montgomery and Fahey,¹⁰⁷ in a systematic review, found improved blood pressure control in two of the three trials that compared computer-generated feedback reports and reminders to usual care. Specifically, 51% of patients whose physicians received reminders either had controlled blood pressure or were at least receiving treatment vs 33% in the control group at 12 months. This difference was even higher at 24 months.

Montgomery et al⁷ later randomized primary care practices to use a computer-based decision-support system and a cardiovascular risk chart, the risk chart alone, or to continue as usual. Results indicated no reduction in cardiovascular risk in the computer-system or the chart-only group, whereas patients in the chart-only group had a significant reduction in systolic pressure and were prescribed more cardiovascular drugs. This study indicates that use of a computerized decision-support system is not superior to chart review and audit feedback alone.

Evidence that computerized decision systems improve blood pressure control in Afri-

The effectiveness of lifestyle changes in preventing and treating hypertension is well established

can Americans is scant. However, when one looks at the evidence from studies of African Americans, the outcomes do not seem to differ between African American and white patients.

Hicks et al⁶ examined the effectiveness of computerized decision support in improving hypertension care in a racially diverse population. Physicians were randomized to receive computerized decision support or to provide usual care without computerized support. Both groups improved significantly in prescribing appropriate drugs but not in overall blood pressure control. Furthermore, the study showed no reduction in racial disparities of care and blood pressure control.

A potential explanation for the lack of improvement in blood pressure was that the intervention dealt with making sure the appropriate drugs were prescribed rather than making sure physicians also appropriately intensified antihypertensive management when necessary.

■ INTERVENTIONS TARGETING PATIENTS AND PHYSICIANS

Several studies have targeted both patient and physician-level barriers to blood pressure control in practice-based settings.

Roumie et al⁸ randomized physicians to one of three intervention groups:

- “Provider education” consisting of an e-mail message with a Web-based link to the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-7)
- Provider education plus a computer alert with information about their patient’s blood pressure
- Provider education, a computer alert, and patient education (ie, patients received a letter encouraging adherence to drug therapy, changing their lifestyle, and talking with their doctor about their blood pressure).

Patients whose providers were randomized to the third group had better blood pressure control. The report did not differentiate African American vs white patients. The data, however, did show the effectiveness of adding

patient education to provider education to improve blood pressure control.

Bosworth et al,¹¹² in a study in which 40% of patients were African American, randomized patients to usual care or to bimonthly nurse-delivered behavioral telephone counseling. They also randomized providers either to receive computer-generated decision support designed to improve adherence to guidelines or to receive no support.

There were no significant differences in rates of blood pressure control in the intervention groups compared with a control group. Although differences in blood pressure control between groups were not significant, patients randomized to behavioral intervention had significantly better blood pressure control at the 24-month follow-up than at baseline.

Svetkey et al⁹ evaluated the effects of physician intervention, patient intervention, and physician intervention plus patient intervention compared with control on systolic blood pressure at 6 months. They found that an intensive behavioral lifestyle intervention led to a significant reduction in systolic pressure at 6 months. By itself, the physician intervention did not have a meaningful effect, but patients in the combined physician-and-patient-intervention group experienced the greatest reduction (9.7 ± 12.7 mm Hg).

It takes a team

Physicians should not be the only focus in helping patients achieve blood pressure control. Although physician and patient factors need to be addressed to improve blood pressure control in African Americans, emphasis should also be placed on interdisciplinary, team-based care utilizing health care providers such as nurses, physician assistants, and pharmacists. Team-based care has been shown to have the greatest impact of all the strategies for improving blood pressure control.¹¹³ There is a good amount of evidence involving interventions with a focus on health care providers other than physicians, although the data lack a sufficient focus on African Americans.

Carter et al,¹⁰ in a randomized controlled trial in which 26.3% of the patients were African American, found that an intervention consisting of clinical pharmacists giving physicians drug therapy recommendations based on

Physician feedback consists mainly of computerized information and peer-to-peer academic detailing with opinion leaders

national guidelines resulted in a significantly lower blood pressure compared with a control group: the mean reduction was 20.7/9.7 mm Hg in the intervention group vs 6.8/4.5 mm Hg in the control group.

Carter et al¹⁴ performed a meta-analysis of 37 studies and found that two strategies led to a significant reduction in blood pressure: a pharmacist-led intervention with treatment recommendations to physicians resulted in a systolic pressure reduction of 9.30 mm Hg; and nurse-led interventions resulted in a systolic pressure reduction of 4.80 mm Hg. Again, many of the studies cited in this meta-analysis lacked a focus on African Americans.

Hunt et al¹¹ conducted a randomized controlled trial in which pharmacists actively participated in the management of blood pressure. They were involved with every aspect of care, including reviewing medications and adverse drug reactions, assessing lifestyle behaviors and barriers to adherence, making dosing adjustments, and adding medications. Patients randomized to the intervention group achieved significantly lower systolic and diastolic pressures (137/75 vs 143/78 mm Hg in the control group). However, information about race was not included.

The above studies are just a few out of a large body of evidence demonstrating the value of team-based care to improve blood pressure control. It has yet to be determined whether these models can improve blood pressure control specifically in African Americans, since so many of these trials lacked a focus on this group. Promising is an ongoing randomized prospective trial by Carter et al¹⁵ evaluating a model of collaboration between physicians and pharmacists, with a focus on patients in under-represented minorities.

■ **SO WHAT WORKS?**

Although there is a growing body of literature on interventions to try to reduce disparities in hypertension and blood pressure control between African Americans and whites, only a few randomized controlled trials have focused on African Americans, and several have not reported their results.¹¹⁶ So the question remains: How should we interpret the available data, which are aggregated across racial

groups, and put it into practice when caring for hypertensive African American patients?

Patient education. In trying to overcome patient-related barriers, emphasis should be on patient education, in particular addressing misconceptions about hypertension and promoting adherence to antihypertensive therapy. This is evident from the narrative storytelling intervention by Houston et al.³ Although this is the first study of its kind, this strategy may be something to consider if future studies replicate these findings. Culturally appropriate storytelling may allow patients to identify with the stories as they relate to their own personal lives. It can be an effective way to address patient education and change behaviors.

Self-monitoring with a home blood pressure monitor has also proven effective in the management of hypertension in African Americans. Indeed, the few studies that reported findings in African Americans showed impressive reductions in blood pressure. The benefits of home monitoring are well documented, and the effect on physician-related barriers such as clinical inertia are also quite impressive.¹¹⁷ However, most of these studies did not assess the long-term impact or cost-effectiveness of home monitoring on blood pressure control.

Behavioral counseling. Although we have good evidence of the effectiveness of behavioral counseling, whether this is sustained long-term has been less studied in African Americans. Thus, while interventions that targeted African Americans have reported impressive reductions in blood pressure, the effect tends to be greatest during the first few months of implementation, with the benefits disappearing over time.

Physician-related interventions. With regard to physician-level interventions, research has focused on physician education, utilizing alerts and computerized clinical decision-support systems. Evidence is scant on whether the use of computerized systems results in improved hypertension care in African Americans. However, a closer look at the data from studies that report outcomes in African American and white patients shows that the results do not seem to differ between these groups. Still, there is insufficient information about the im-

Studies confirming the value of a team approach to blood pressure control have not focused specifically on African Americans

pact on hypertensive African Americans.⁶

Strategies that address both patient- and physician-related barriers can improve overall blood pressure control; however, there is a lack of data comparing outcomes in hypertensive African Americans with those of whites, making it difficult to know if this would be an effective strategy in African American patients alone.

More studies needed that focus on African Americans

Developing interventions to improve blood pressure control in African Americans should be an ongoing priority for research if we intend

to address racial disparities in cardiovascular disease. Although it is reassuring that there is a growing body of evidence and research with this focus,¹¹⁸⁻¹²¹ more research is needed to determine effective strategies that address barriers related to physician practice and to the health care system overall as they relate to blood pressure control in African Americans. More importantly, these strategies should also emphasize a team-based approach that includes nurses, pharmacists, and physician assistants. Developing targeted interventions for hypertensive African Americans will help reduce disparities in the rates of cardiovascular illness and death in this patient population. ■

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