The important gap community health workers and care managers can fill in high blood pressure care

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People who experience sustained hunger because of food insecurity

aren't thinking about checking their numbers, taking medication or getting to a doctor's appointment, she said. They're focused on where they're going to find their next meal. "Not only do they not have any food, but it's constantly on their minds. And that can result in depression, which is a whole other can of worms that needs urgent attention."

It's also where Stacye Cooper comes in. A Baltimore registered nurse and care manager at Evergreen Nephrology, her job is to identify the barriers preventing people with high blood pressure and other health issues from meeting their health goals—and find ways to overcome them.

Hunger often isn't the only obstacle.

"You find out from the patient where they are in their disease process, whether they need health literacy, medication management, what their goals are," she said.

"Then we can come up with attainable goals and solutions that work for the patient. For example, the goal may be for them to make sure they are compliant with health care appointments, but they don't have transportation. If they can't get there, it's a problem."

Stacye helps solve those problems by providing patients with rideshares, connecting them to food pantries and other resources, such as patient assistance programs to pay for medications.

Two years ago, while working at a different clinic, she was part of a study that analyzed the effectiveness of using care managers and community health workers to address the needs of people from socially and economically marginalized groups who have uncontrolled high blood pressure. The findings were published in the American Heart Association journal *Circulation*.

High blood pressure, also called hypertension, is a major risk factor for cardiovascular disease—one of the largest contributors to racial, geographic and socioeconomic disparities in life expectancy.

Prior research has consistently found disparities in hypertension rates and other cardiovascular risk factors, as well as in access to quality care, for Black and Hispanic people, people with lower incomes and those living in rural areas.

Dr. Lisa Cooper, the new study's co-lead author and director of the Johns Hopkins Center for Health Equity in Baltimore, said she wanted to explore whether care managers alone or with additional support from community health workers and remote consultation from specialists could help mitigate some of these disparities.

In the RICH LIFE study, short for Reducing Inequities in Care for Hypertension: Lifestyle Improvement for Everyone, Cooper and her colleagues studied 1,820 adults with uncontrolled high blood pressure and at least one other risk factor who were being treated at 30 community-based primary care practices across Maryland and Pennsylvania.

Participants were randomly divided into two groups: an enhanced standard of care group and a collaborative care group in which care managers assessed and addressed each participant's barriers to care. The care managers had access to a network of specialists and community health workers. About 59% of the participants were women and 57% were Black, with an average age of 60.

Health care professionals in both groups were given extra training and updated devices for measuring blood pressure.

Both groups made equal progress in reducing blood pressure. Systolic

blood pressure—the top number in a reading—dropped about 14 points on average, and diastolic—the bottom number—dropped about 6 points. But the group working with care managers reported greater satisfaction with the care they received.

"We found that when patients had a care manager alone or with a community health worker, they felt that the care they got was more responsive to their needs," said Cooper, who also is a professor of medicine at Johns Hopkins University. "So, in terms of patient experience, the collaborative care program was a little better. But in terms of blood pressure control, both groups did very well."

That wasn't what Cooper expected to find.

"I expected to see a more dramatic effect by the collaborative care program," she said.

"In this country, we know that people with low income and, as a group, Black, Hispanic and people in rural areas, have less access and poorer quality of care for hypertension and associated conditions like diabetes and high cholesterol and depression," Cooper said.

"We also know they have exposure to more negative social determinants of health, things that make it harder for people to engage in healthy behaviors."

Because of a historical lack of investment, they may live in a neighborhood without safe walking paths or access to healthy foods. "They are more likely to be exposed to stress from higher levels of poverty and discrimination," said Cooper, who had hoped that providing a care manager and community health worker to help people overcome those barriers would lead to more dramatic improvements in blood pressure than simply following standard care.

But care managers and community health workers did appear to provide an advantage for participants living in rural areas and those with pre-existing heart disease. Compared to people receiving enhanced standard of care, people in these two groups made greater progress in lowering blood pressure.

People in rural areas may have seen more dramatic improvement in blood pressure control than their urban peers because their access to care was lower to begin with, said Dr. Jordana Cohen, an associate professor of medicine and epidemiology at the University of Pennsylvania's Perelman School of Medicine in Philadelphia. Cohen was not involved in the new study.

"Rural areas are low-hanging fruit," she said. "There are so few resources. As a group, people who live there are much more ripe for this type of intervention because they have the least access to health care professionals and specialists."

Cooper agreed. "Having a specific nurse and community health worker assigned to them is what made the difference."

Likewise, people with heart disease may have had more room for improvement because they "tend to be sicker," Cooper said. "They take more medications and have more doctor appointments."

It might be more challenging to make progress for some people, especially those with low incomes, Cohen said. "If someone is working two jobs and doesn't have time to travel to a health care appointment, that's not something you can overcome with a care manager."

But care managers and community health workers did play an important role in linking people to needed resources, Cooper said. And that's an important first step in looking for ways to improve care for people

whose health suffers from a multitude of negative social determinants of health.

"It's really important to focus on these groups," she said. "If the broader issues are not addressed, then they won't be able to benefit from what we know works when it comes to lowering blood pressure."

More information: Lisa A. Cooper et al, Equitable Care for Hypertension: Blood Pressure and Patient-Reported Outcomes of the RICH LIFE Cluster Randomized Trial, *Circulation* (2024). DOI: 10.1161/CIRCULATIONAHA.124.069622