CAN WE DO BETTER?
NEW DATA EXAMINES METHODS TO OVERCOME CLINICAL INERTIA AND MORE EFFECTIVELY TREAT HIGH BLOOD PRESSURE

Data presented at ASH 2011 press briefing

NEW YORK, MAY 23, 2011, 9:00 AM EDT – Several studies to be presented at the American Society of Hypertension, Inc.’s 26th Annual Scientific Meeting and Exposition (ASH 2011) examine barriers to effective blood pressure management, including volume of patients, enforcement of evidence-based clinical guidelines, and the role of single dose combination treatment. The data, to be presented during a special press conference focused on “Achievements in Hypertension Control,” will be moderated by Henry R. Black, FASH, ASH Immediate Past President.

“As clinicians, we cannot become complacent about hypertension treatment. It’s not only about selecting the right treatment, but we also need to give careful consideration to the manner in which we administer it and how to best achieve adherence to what we recommend. We must continue to challenge ourselves and our practices to ensure that we are treating aggressively and appropriately to attain the best possible blood pressure goals and clinical outcomes for our patients,” says Dr. Black.

Studies to be highlighted in the press conference include:

Clinical Inertia in Hypertension: Identifying Barriers to Improve Quality
Despite improved treatments and improved education regarding the importance and benefits of effective blood pressure (BP) management, hypertension control rates remain suboptimal. A study to determine possible barriers to BP goal attainment conducted at Hattiesburg Clinic, a multi-specialty
medical group and a Consortium for Southeastern Hypertension Control (COSEHC) Cardiovascular Center of Excellence™, examined BP control rates and their relationship to clinical inertia, defined as a clinician’s failure to initiate appropriate therapeutic intensification.

Bryan Batson MD, Medical Director of the Hypertension Center at the Hattiesburg Clinic in Hattiesburg, MS, and clinic colleagues reviewed data from 1,824 patient clinic visits. The analysis found that no action was taken in 63 percent of cases when the patients’ BP was not at the recommended treatment goal. The number of patients seen by a provider was a statistically significant factor in determining clinical inertia. Inertia was exhibited 73 percent of the time in providers seeing more than 26 patients per day. There was also significantly greater inertia for patients with BP < 10 mm Hg above goal (71%), diabetic patients (70%) as compared to non-diabetics (57%), and non-Hispanic whites (66%) as compared to African Americans (52%).

“For hypertension control rates to improve nationwide, physicians should be cognizant of clinical inertia in their daily practice. Patient volume, ethnicity, diabetic status, and the magnitude of blood pressure elevation above goal have all been shown to heavily influence the degree to which action is taken and clinicians need to ensure they are making rational and informed choices at all times,” says Dr. Batson.

**How an Integrated Care Delivery System Increased Blood Pressure Control Rates**

Studies have been published on the effect of hypertension programs on BP control, but few have reported the efficacy of a large-scale, community-based hypertension program. In 2001, the Kaiser Permanente Northern California Hypertension Project was established and a hypertensive patient registry was created to identify at-risk patients. The project included the establishment of physician and medical center quality metrics to measure performance over time and the
Preventing and Treating Hypertension and Its Consequences

Development of an evidence-based clinical practice guideline that was disseminated, reviewed and updated every two years. Infrastructure was established, including the creation of non-physician clinic encounters for repeat BP measurements and promotion of fixed-dose combination medical therapy. Medical centers that improved and demonstrated superior performance were evaluated and the successful practices were disseminated to other medical centers.

Over an eight year period, the prevalence of controlled BP, defined as less than 140/90, increased between 2001 to 2009, from 44 percent to 80 percent after implementation of the hypertension program. During this period the number of individuals in the hypertension registry grew from 395,000 to 660,000, resulting in more than 350,000 additional people with controlled BP.

According to lead study author, Marc Jaffe, MD, Clinical Leader of the Kaiser Permanente Northern California Cardiovascular Risk Reduction Program, “We were encouraged by our results because they confirmed that we have many effective strategies at our disposal to make a significant improvement to patient care. We found that implementing these strategies through a systematic and comprehensive program in an integrated care delivery system did result in a significant increase in both blood pressure control rates and the number of individuals with controlled blood pressure.”

Evaluation of a Treatment Algorithm Using Combination Therapy for the Management of Patients with Hypertension and Hypercholesterolemia (STITCH2)

Evidence-based medicine has shown that hypertension control rates can be improved with the use of simplified treatment algorithms. With this knowledge, researchers in Ontario evaluated whether a simplified yet comprehensive treatment algorithm featuring initial use of single pill
combinations (SPCs) would improve management of patients with both hypertension and dyslipidemia.

The researchers studied 35 primary care practices randomized to either guidelines-based care or to a simplified algorithm for the management of patients with hypertension and dyslipidemia (STITCH2 care). Physicians randomized to the STITCH2 algorithm were trained to use an SPC combining an ACE inhibitor/angiotensin II blocker with diuretic, followed by an SPC combining a calcium channel blocker (CCB) with statin, followed by other adjunctive therapy as required. Physicians randomized to the guidelines-based care were instructed in current Canadian guidelines.

Practices enrolled up to 50 patients with a history of both hypertension and dyslipidemia and at least one condition above target. The impact of treatment was assessed at the practice level with the control rate for both BP and LDL at 6 month follow-up as the primary endpoint.

At baseline, mean(± SD) BP was 144/85±16/11 mm Hg and LDL was 117±43 mg/dl. Elevated BP and LDL were present in 88% and 68% of patients, respectively. The primary endpoint was 31.3±24% with STITCH2 care, vs. 28.1±15% with guidelines-care (p>0.1). However, similar to findings in STITCH, STITCH2 care resulted in greater reduction in systolic BP (STITCH2-care: 16.2±9 mm Hg, Guidelines-care: 10.1±7 mm Hg, p=0.04). LDL reduction was only marginally greater in STITCH2 practices (STITCH2: 17.4±7.8 mg/dl, Guidelines: 13.6±9.7 mg/dl, p>0.1). The STITCH2 care algorithm resulted in greater use of any SPC compared to guidelines care (73.8% vs. 26.5%; p<0.01) and greater use of the SPC of CCB/statin (31.2% vs. 5.4%; p<0.01).

“These data confirm the value of simple algorithms emphasizing the use of single pill combinations for managing hypertension, likely because of the added convenience of reducing
“pill burden,” explains lead study author G.K. Dresser, MD, PhD, FRCPC, Associate Professor of Medicine, Robarts Research Institute, University of Western Ontario. “However, it is important to note that a single comprehensive algorithm targeting both hypertension and dyslipidemia did not perform better than guidelines-based care in the management of patients with multiple risk factors.”

The Impact of Initial Treatment of Hypertension on Control in the First Year: Comparison of Initial Monotherapy, Free-dose Combination and Fixed-dose Combinations

A wealth of data have shown that initial therapy with single-pill combinations (SPC) achieve more rapid BP control than initial monotherapy (MONO) with sequential add-on. Additional studies have reported better adherence to SPC than to the same medications administered as free-dose combinations (FREE).

To better understand the relative efficacy of these different treatment approaches, researchers evaluated the effectiveness of initial therapy with MONO, FREE, or SPC to achieve BP control in previously untreated patients with hypertension.

A total of 107,870 patients from practices in the southeast United States were included in the analysis. In univariable hazard regressions, initial SPC (HR 1.27, 95% CI [1.23–1.30]) was more likely to produce BP than FREE (1.03 [1.01–1.05]) which was more likely to produce control than MONO. In multivariable regression adjusting for age, sex, initial BP, site of care, diabetes and chronic kidney disease, SPC and FREE remained predictive of BP control. The inclusion of race/ethnicity did not significantly alter the respective hazard ratios.
“We are hopeful that these findings, which suggest that initial single pill combinations is clinically effective for achieving more rapid BP control, will add to existing evidence and help us fine-tune treatment algorithms to achieve blood pressure goals within the first year of treatment and ideally within the first 3 – 6 months. Single-pill combination may achieve more rapid BP by reducing the number of pills and copayments leading to better patient adherence as well as ease of titration that reduces clinical inertia,” says lead study author Brent Egan, Professor of Medicine and Pharmacology, Medical University of South Carolina.

About the American Society of Hypertension
The American Society of Hypertension, Inc. (ASH) is the largest U.S. professional organization of scientific investigators and healthcare professionals committed to eliminating hypertension and its consequences. ASH is dedicated to promoting strategies to prevent hypertension and to improving the care of patients with hypertension and associated disorders. The Society serves as a scientific forum that bridges current hypertension research with effective clinical treatment strategies for patients. For more information, please visit www.ash-us.org.

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