

Summary of the Meeting of
The National High Blood Pressure Coordinating Committee

April 29, 1977

Bethesda, Maryland

Introduction

Dr. Levy opened the meeting by noting that provisional mortality data for 1976 show that the decline in morbidity and mortality flattened for heart attack but continued for stroke. The total drop in stroke death rate since 1970 is now a little over 22%. He stated that the figures are quite impressive and suggested that the Program has played a role in making possible such a decline.

Dr. Levy reported that the February meeting of state and regional officials jointly sponsored by NHLBI and the Bureau of Community Health Services to discuss the 314(d) Revenue Sharing funds was very successful. It offered an opportunity to inform participants about the Program and the Coordinating Committee's goals, and to introduce them to our new initiatives.

Dr. Levy then remarked that the Joint National Committee Report had been published and was an instant "best seller." He stated that the report and its contents were well represented in our testimony before both Appropriations Committees.

Dr. Levy mentioned that the Weinstein and Stason book "Hypertension: A Policy Perspective" (Harvard University Press) was followed up by articles and an editorial in the New England Journal of Medicine. NHLBI comments and evaluation regarding the assets and debits of this publication have been distributed to the Committee.

Agenda Item 1: Issues in Blood Pressure Measurement

Mr. Ward recalled that a need had been identified last September to investigate existing, new, or modified training materials on blood pressure measurement. A paper, "A Review of Techniques and Training Programs for the Measurement of Blood Pressure," was distributed to all attendees and Dr. Ware was called upon to present this paper.

Dr. Ware cited the various reviewers of the original document—including Drs. Dustan and Krishan, as well as external individuals, internal Institute groups, and the NHBPEP staff members. Dr. Ware indicated the need for some training models in blood pressure measurement, and for a greater sensitivity to the factors involved in the precision of measurements. He also stated that as a result of Dr. Dustan's participation in the initial review of the document, the document reflects coordination with the new AHA committee to establish criteria for blood pressure.

Members of the Committee were asked to review the document and comment in writing within the next month. A third revision will be prepared for review prior to the next meeting.

In closing, Mr. Ward explained that the distribution of the final document would depend on the recommendations of the Coordinating Committee.

Agenda Item 2: Report on NBME Audit Project

Mr. Robert Gold introduced the audit project being conducted by the National Board of Medical Examiners. The NBME medical audit technique is being used to link continuing education of physicians to the objective evaluation of the quality of care they render. In 1975, the Program was successful in getting the National PSRO Council to endorse its basic guidelines for screening, evaluation, and therapy and to encourage the entire PSRO program to begin studies to audit hypertension and to begin using these guidelines. While not mandatory, for PSROs, it was the first time that information from the NIH data base had been systematically disseminated throughout the PSRO program and was seen as a model for getting objective information into quality-of-care assessments.

Information about recommended guidelines was not enough. Such information was readily available, and since it reflected a consensus, it could provide the basis for uniform and consistent criteria for care at the time the health services research community and the quality assurance community began to look to ambulatory care for quality assessment. Consequently, in 1975, the NBME hypertension medical audit study was initiated to develop model hypertension and medical audit criteria, as well as self-instructional materials that could be used by various organizations to systematically review records to assess the extent to which they conformed with the NHBPEP guidelines.

A report on the first phase of this project—development and field testing of ambulatory care audit materials for hospital clinics—was presented by Dr. Vivian Erviti and Dr. Bryce Templeton of NBME (Director and Co-Director, respectively). A summary of this report is available from Drs. Erviti and Templeton at NBME.

Mr. Ward noted that the Bureau of Community Health Services Quality Improvement Division is interested in using these audit materials, when developed, in their 1800 service sites.

Agenda Item 3: Report on National Conference

3.1 The April 1977 Conference

Dr. Moser, Chairman of the 1977 National Conference, reported that he thought the conference was a resounding success. He commended Dr. Krishan, as Chairman of the Abstract Review Committee, on an excellent job in selecting high caliber abstracts.

More than 700 attended, with diverse disciplines represented: about one-fifth were physicians, one-fifth were nurses, and the rest were persons from state and federal governments and health agencies, and students; about 4% were drug company representatives. It was also financially a success; the small surplus will be used next year to defray the costs of mailing, printings, and other expenses associated with the next conference.

In view of the success of the conference, Dr. Moser stated that he strongly feels there is a need for such a meeting and recommended that they be continued even beyond next year, for which we are already committed.

Dr. Moser reported that facilities for the 1978 meeting are now being investigated.

3.2 Additional Comments by Committee Members

After expressing agreement that it was a very fine meeting overall, Mr. Gorman expressed disappointment in the media coverage. Dr. Levy concurred, but stated that there will be a cover story in the May 30 issue of the Medical World News.

Mr. Bochner stated that he felt it was superior to the previous two, in that it offered a more open, informative type of meeting and free information exchange among individuals involved in hypertension. He further suggested that the accomplishments of the first three National Conferences be evaluated now to help determine how they should be structured in the future.

Dr. Panagis thought the conference had achieved his concept of the main objective of this type of meeting: to get more physicians, nurses, and community and public health workers together. He was most pleased with the direction this conference had taken and cautioned that the achieved balance not be lost by going too far into the medical and clinical aspects of the problem and forgetting those who are involved with these kinds of programs.

Dr. Moser gave his assurance that the conference planners were very much aware of this and had taken great care in the review of abstracts to achieve a balance.

Dr. Panagis remarked on the excellence of the papers presented in the two workshops that he moderated, particularly the one on cost of health care. He feels that this is an area that should continue to be highlighted by the Planning Committee.

Dr. Moser commented that the Planning Committee hopes to include next year several "how to" sessions for nurses, nurse practitioners, and paramedics in which they can trade lessons learned in specific cases.

3.3 1978 Conference and Abstract Chairmen

Dr. Krishan was nominated as Chairman of next year's meeting and Dr. Norman Kaplan as Chairman of the Abstract Review Committee. These recommendations were accepted by the Committee.

3.4 Composition of Planning Committee

Mr. Ward opened a discussion of the composition of the Planning Committee. Should the group be more representative of professional categories, or should it continue to include people who are familiar with its intent and purpose, and with the details of conference management and operations?

Dr. Moser suggested that it should involve professional as well as other groups, but certainly not political pressure groups. He cited the membership of the Planning Committee for this year's meeting, and felt that it was fairly diverse and broadly representative of different professional groups and that it should be kept that way.

After considerable discussion, it was the consensus of the Committee that this philosophy be adhered to. It was further suggested by Dr. Levy, that the Planning Committee's recommendations be presented at the October 7 meeting of the Coordinating Committee so that the total program activities could be reviewed and endorsed before the next conference.

Dr. Krishan stated that his tentative plans are to organize the Abstract Review Committee by the end of June for a meeting in early July, so that the fall meeting would be suitable.

Mr. Ward noted some suggestions that the national meetings might on some occasion have reason to include international aspects. The notion is timely, since a suggestion was to be made later in the meeting (see Item 8) to move next year's HBP Month from May to April to coincide with "International HBP Month." Since April is traditionally the month for our national meetings, he proposed that consideration be given to some international flavor in the next one. The idea was generally acceptable to the group.

Agenda Item 4: Prevalence Data

Dr. Levy noted that the prevalence data presented in his testimony this year before the Appropriations Committee caused confusion as to why the number of hypertensives had increased four million over last year—from 23 million to 27 million—and that the Congressional Record now shows the difference between 23 and 27 million. He further noted that by employing the definition of hypertension used by most practitioners, there are 50 million or more people with high blood pressure. He stated that this is clearly a confusing issue and one suitable for discussion. He then called upon Dr. Dustan to lead this discussion.

Dr. Dustan summarized the discussion at the last meeting, noting that the basic problem arises because many physicians, if not most, use the cutoff level of 140/90 in defining high blood pressure and perhaps part of the answer to the attendant problems stemming from the use of this set of figures can be found in the JNC Report. She quoted from this report (page 4, "Blood Pressure Confirmation") and, in summary, felt that our understanding of the total problem requires definitive guidelines for handling each of the various ranges of elevated blood pressure, and that it was necessary to emphasize to Congress that we do not as yet have information that will determine the efficacy of treatment at all blood pressure levels.

Dr. Levy added that considerable effort was required recently in clarifying our position with the Office of Technology Assessment (OTA). Most medical students are taught that the definition of hypertension is >140/90. Our recommended cutoff of 160/95 has not been clearly understood, and OTA vigorously attacked our program on the ground that since the majority of patients were in the range of 140/90 and 160/95, we were unnecessarily recommending therapy for these people. Dr. Levy noted that medical audits indicate that those who have gotten our message are, in fact, aggressively treating people with 140/90 and higher, regardless of our specific guidelines. He then asked for discussion as to whether we should clarify this issue in any way.

There was considerable discussion regarding the problems and issues of the definitions of the various categories of hypertensives and how we should attempt to standardize them in some way to achieve consistency. It was suggested that perhaps the question should be addressed to the academicians, because that is where the initial concepts are developed.

Dr. Dustan stated that we need some statement defining these items; one that we can all use. It was decided that with the help of some members of the Coordinating Committee, the NHBPEP staff would prepare an initial draft of this statement which will focus on clarification of what is meant by the different levels, with specific discussion of variables for each. This will be prepared and presented for review at the July meeting.

Agenda Item 5: Recall Practice Issues

In the absence of Dr. Hunt, Dr. Krishan led this discussion. He stated that although personally he was not inclined to establish recall as a standard, he had conferred with several other people having interests in sociology, health care delivery, and the law, as well as with Dr. Hunt. Thus, his remarks represented a certain consensus as well as the viewpoint of the National Kidney Foundation.

He presented the following four reasons for approaching this issue with caution:

1. We do not have adequate scientific information about the nature of the recalcitrant behavior. Non-compliance occurs in all demographic classes and there is no unifying explanation concerning

the many factors of compliance; it remains to be proven whether patient reminders as opposed to patient education is the best method to ensure compliance.

2. Quantitatively, the magnitude of effort would be enormous. Data from three community programs in Minnesota, with which he has been involved, indicate that compliance has been excellent (95%), but that 15% of these regularly failed to keep their appointments and that it takes an average of three reminders to get them to return. If one were to extrapolate this level of hard-core recalcitrants to the total volume of visits for hypertension, the magnitude of a national effort could be immense.
3. The question of medical ethics also enters the picture. Although AMA's code of ethics admonishes physicians not to neglect their patients, it indicates that the distinction between solicitation and active recall procedures is best left to local bodies, applying local ideas within local settings. Thus, any effort by this Committee to promote a uniform recall system should recognize normative behavior of physicians within regions, groups, or practices: they can do anything they want to, and recall should not be endorsed as a public policy.
4. The medical/legal concerns should be considered from two points of view: (1) If the medical profession establishes a new standard of practice for hypertension, in due time our courts would hold that similar recall measures should apply to other patients when in need of continued care. (2) If such standards are established as public policy, it is possible that the law would require a physician to make a reasonable effort to locate the patient and encourage return. This would entail a notation on the patient's record and it is questionable that physicians will be able to cope with the magnitude of the problem when it spills over into other medical disorders.

Dr. Krishan then stated that his negative viewpoint was presented not so much as a final position, but as a start for further discussion.

In the discussion that followed, it was agreed that while some sort of recall practice is clearly useful, probably most practitioners already have their own method of recall. Thus, while the concept does have merit, the consensus was that it would not be feasible as a national policy, and an alternative view was expressed that perhaps some kind of recommendation could be made that could be recognized as a standard of medical care to be used throughout the country.

Dr. Moser reiterated his view that the recall system may be well received by many patients and is a very good practice, but feels that the National Program has stressed this many times in a different way, and that patient and physician

education will lead to better response by both parties. He felt that it should not be set as a dictum, but rather as a measure to be considered in the local context.

This approach was accepted by the committee.

Agenda Item 6: Pediatric Task Force and Task Force on Heart Disease in Children

Dr. Blumenthal stated that the Report of the Task Force had been published in the May issue of Pediatrics, the journal of the American Academy of Pediatrics. He then presented several slides summarizing this report, adding that the charge to the Task Force was to address primarily practicing physicians caring for children and to identify the state of the art regarding:

- proper techniques for obtaining blood pressure in children;
- the data base on blood pressure distribution in childhood;
- predictors of future development of primary hypertension if they could be identified; and
- drug therapy for children with hypertension.

Dr. Blumenthal mentioned that the findings and data in the report were based on present conditions and information available to the Task Force. Since much data have been gathered in the interim, the Task Force realizes that alterations will have to be made in time. In closing, Dr. Blumenthal stated that in view of the voluminous amount of data being incorporated, he strongly feels a new committee should be appointed in a year or two.

In a brief status report on The Task Force on Heart Disease in Children, Dr. Blumenthal noted that this group of individuals, appointed by Dr. Levy, consists of pediatric cardiologists, cardiovascular surgeons, epidemiologists, psychiatrists, a biostatistician, and a population geneticist. This group has been divided into four general working groups to address the following research issues, around which the final report will be developed:

- (a) acute rheumatic fever and rheumatic heart disease;
- (b) congenital heart disease;
- (c) the exciting new field of childhood dysrhythmias and the exploration and review of the development of the conduction system and how it applies to the disease in adults; and
- (d) the exploration of the problem of identifying the precursors of heart disease in the adult as they occur in children.

Agenda Item 7: 1977 HBP Month

Mr. Ward briefly reported on the activities of 1977 HBP Month. No substantive changes have been made in the overall plans for the Month since it was discussed at the last meeting. In line with the change in thrust of the overall Program, the theme of "Staying on Treatment" has been emphasized to all groups involved and much work had been done to stress this theme in all materials produced by the staff, as well as those produced by regional and local community groups. The new Advertising Council's materials have been produced and will be sent out. (These films were shown later in the meeting.) The evaluation process for the Month will be continued and Mr. Ward solicited cooperation from all in getting requested information back to us.

Agenda Item 8: 1978 HBP Month

Mr. Ward presented a recommendation that, for next year at least, we consider changing HBP Month from May to April inasmuch as the International Society and Federation of Cardiology is sponsoring an "International High Blood Pressure Month" and the World Health Organization (WHO) has agreed to participate in that event. One planning meeting for this effort had already been held in Geneva. Since the U.S. was not officially represented at that meeting, it is hoped that we can send someone to another workshop scheduled for the end of this year (no specific date). He noted that the theme adopted for this effort is "Down With High Blood Pressure," which we can readily support with relevant materials we have already developed.

Mr. Ward added that this organization is very interested in our JNC Report and is planning to distribute our recommendations internationally along with another document produced by the European Society of Cardiology ("Preventing Coronary Disease as a Guide to the Practicing Physician"). He agreed to send the Committee a copy of this latter document when it is received, and suggested that we could compare the viewpoints of the American and European approaches to hypertension.

In summary, Mr. Ward presented the two issues to be agreed upon at this point as:

- (a) Do we want to change our Month date to April next year?
- (b) Is this group willing to accept the Institute's Program staff to serve in a liaison role with the international groups in this effort?

In support of these two issues, Dr. Levy stated that in his discussion with the head of the World Health Organization's Cardiovascular Disease Section, it was revealed that this activity is being planned with the active support of the WHO. Dr. Levy felt that perhaps the United States would be out of line if we did not agree to take part. He also stressed that unless this effort was a resounding success, it probably would not be repeated.

Dr. Levy asked for comments on the two issues as presented by Mr. Ward. Since no opposing comments were offered, both were deemed to have been answered unanimously in the affirmative.

Agenda Item 9: Ad Council Material (Preview)

Jacqe Admire gave a brief report on activities relating to our efforts with the public media. She explained that the total media program includes TV, radio, mass print, magazines, professional journals, public appearances, and involvement with other organizations that produce similar materials. The PSAs will be sent to approximately 700 TV stations, more than 1,000 radio stations, and the major newspaper syndicates. In addition, this campaign includes transit cards, outside posters, and other similar materials.

Ms. Admire added that although this year's emphasis is on maintenance of treatment, our prior emphasis on awareness has not been neglected.

Ms. Admire briefly described the TV announcements to be viewed, before showing them:

- our last year's Ad Council spot (time bomb) with added emphasis on treatment;
- two American Heart Association spots and one from the American Osteopathic Association which shows the change in emphasis, not only on our part, but on theirs (appreciation was expressed for their cooperation in furthering our campaign goals); and
- two spots prepared by the Ad Council for the Program.

Mr. Ward stated that he thought this was the first time the American public would be exposed to a simultaneous message from many sources that is in concert, yet which enables each producer to retain their individual identities.

Dr. Levy expressed his concern about the print campaign, since we may be faced with some criticism about overemphasizing drug therapy. Ms. Admire explained that drug therapy is the only therapy the Institute can support at this time. Mr. Ward added that we are trying to identify some effective alternative therapies (e.g., weight control) that we can build into the hypertension message.

Annie Collins noted that the basic idea of relating loved ones to treatment was conceived by the Committee on Hypertension in Minority Populations.

Agenda Item 10: Information Sharing

- RFP for Demonstrations in Work Setting (G. Ward)

Twenty-seven proposals were received that are of good quality and offer some very good demonstration programs. The contract awards will be made in August and a full report will be presented at the Coordinating Committee's meeting in October.

- Work Setting Working Group (G. Ward)

An ongoing ad hoc working group has been established consisting of representatives from labor, management, and occupational health, and specialists in hypertension, health education, community action, etc. Robert Johnson, Director of the National Center for Health Education, has agreed to chair the group, and its first meeting is scheduled for May 18.

- Native American Workshop (A. Collins)

Over 100 Native Americans attended this workshop which was held on April 20-22 in Arlington, Virginia. From this meeting, 13 recommendations were forthcoming relating to the needs of this population in the area of hypertension. This meeting is the first in a series designed to offer ethnic groups an opportunity to state their high blood pressure problems.

- National Kidney Foundation and Dairy Queen Campaign in Minnesota (G. Ward)

No final report was submitted; however, it was considered successful based on the number of people screened and followed up, and the number of volunteers participating.

- American Heart Association (H. Dustan)

Although the final decision has not yet been made, it is believed that the AHA will support a new hypertension journal which will report on clinical and laboratory investigations.

AHA is supporting this year's HBP Month by preparation of a TV spot and letters sent to TV stations urging them to use the spot.

- Task Force on Hypertension (H. Dustan)

This task force is now well underway in identifying the state of knowledge, research needs, areas to be investigated, public health issues to be pursued, etc. A final report consisting of the first two summary books is expected by December. Other specialty reports will follow.

- Hypertension Day at AHA Annual Meeting (H. Bochner)

The New York State Affiliate of AHA is devoting a full day (November 2) to hypertension during their annual meeting in Rochester. This will be a training session for local chapters in setting up community programs.

- American Nurses' Association (E. Giblin)

The ANA is actively supporting HBP Month with publicity being sent to all state and local affiliates regarding materials that are available, the American Journal of Nursing will feature an editorial and articles on hypertension, and a local TV station will show the film on maintenance which was developed by Merck, Sharp and Dohme.

Four joint conferences of ANA and AHA members are planned to investigate the implementation of cardiovascular nursing standards and quality assurance in patient care.

- Milwaukee/State of Wisconsin Activities (C. Panagis)

For HBP Month, a mass public seminar is planned to be held in Milwaukee.

The state of Wisconsin had decided to utilize 314(d) funds to establish a network for statewide coordination. Coordination will be through a central office and six regional offices (part of the State Department of Health) and will involve 112 local public health agencies. This concept has been well received by public health and state and local medical societies.

Agenda Item 11: Recommendations on Membership

Mr. Ward posed three questions for discussion:

1. Criteria for participation on the Coordinating Committee
2. The mechanism for processing requests for participation or to solicit participation
3. Consideration of several specific groups who have requested or are being considered for participation

With respect to the first item, he offered the following as a way to articulate the philosophy expressed among the members of the Committee from time to time:

That the organization have a clear relation to hypertension control, such that its policies and viewpoints as an independent organization would have significant impact on hypertension control.

With respect to the second question, he noted that responsibilities had been assigned to two members of the Committee, but the demands of time had precluded them from carrying out this role.

Dr. Levy suggested that it might not be appropriate for us to deny anyone the right to come to the meetings or join in the discussions. He suggested that we might have two kinds of membership; one group who would contribute regularly to the activities of the Committee, and another group who would be invited in who might be interested in high blood pressure but could not be really thought of as having a major effect on the Program. He defined a participating member as one who came to meetings and participated actively in the high blood pressure program as distinct from the other type of membership which would be more in the nature of a liaison representative. The dilemma the Committee faces is that while it is hard to deny anybody some sort of membership, to grant everyone membership means that we would have a sizeable and diverse set of members. He asked for suggestions from the group and particularly whether anyone had any difficulty with the notion of two kinds of membership.

In the absence of any discussion of this distinction, Dr. Levy accepted the consensus of the group that that guideline would be acceptable. After a lengthy discussion of the terms "ex officio," "non-voting," "liaison," and other terms to describe the two types of membership, it was tentatively decided to use the terms "voting" and "liaison" memberships to make a distinction.

As to the makeup of a membership committee, Mr. Ward suggested that at each meeting we designate three sitting members who would have that responsibility until the next meeting of the Committee. This would share the load and not put any single organization into a controlling position.

Dr. Dustan asked if there was a list of questions or criteria that this group could propose for specific membership applicants, and after discussion, Mr. Ward offered to have the High Blood Pressure Education Program staff produce a first-cut for review.

In accordance with Mr. Ward's suggestion, Dr. Panagis, Dr. Weinstein, and Dr. Todd were designated as the Membership Committee until the next meeting, and criteria guidelines were requested within about three weeks or less for review.

Mr. Ward then presented the list of eight groups who have either been specifically recommended by the Committee or have specifically requested consideration. A group of four members of the Committee have discussed these candidates and Mr. Ward presented the consensus recommendation of that group of four with respect to each. He noted that since the discussion had proceeded without the distinction between voting and liaison membership, that the "yeses" could be construed as equivalent to voting memberships and the "nos" as liaison memberships. The following list and recommendations were presented:

- American Red Cross - Yes
- American Pharmaceutical Assn. - Yes
- American College of Physicians - split 2/2
- American Assn. of Family Practitioners - split 2/2
- American College of Chest Physicians - No
- American Optometric Assn. - No
- American Dental Assn. - No
- American Podiatry Assn. - No

In response to a question, Mr. Ward indicated that the podiatrists see primarily an elderly population which has a high prevalence of hypertension. They can act as detectors and they can act as educators and compliance reinforcers. As further background, Mr. Ward noted that the American Red Cross, the APhA, and the Optometrists had all been waiting a significant time (over six months). Dr. Dustan felt that the Committee should vote now on those who had been waiting, but suggested that the criteria to be developed be applied for the more recent candidates.

After discussion of the roles of the American Red Cross, the American Pharmaceutical Association, and the American College of Physicians, a motion was made and seconded that these three be accepted as voting members. The motion was unanimously passed. The remaining candidates will be considered at the next Coordinating Committee meeting.

That being the last item of business before the Committee, the next meeting was confirmed for July 11, 1977, and the fall meeting was set for October 7, 1977.

The meeting was adjourned at 3:00 p.m.