

FIELD NOTES



Problem

African Americans have higher rates of high blood pressure than any other racial or ethnic group in the United States.¹ In 2013, 44% of African Americans living in California² and 50% of African Americans living in San Francisco had been diagnosed with high blood pressure.³

Program

The Hypertension Health Equity Project began in 2015 as a quality improvement and equity initiative of the San Francisco Health Network's Primary Care group, a branch of the San Francisco Department of Public Health. The goals of the Hypertension Health Equity Project are to advance health equity, provide high-quality care, and improve blood pressure control for African American patients with high blood pressure in the San Francisco Health Network.

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Overview

In 2015, the San Francisco Health Network, a branch of the San Francisco Department of Public Health (SFPDH) adopted six pillars of quality to improve patient care. One of the pillars is equity, or the elimination of disparities. The network chose high blood pressure (hypertension) as the core quality metric for equity because of identified racial disparities in blood pressure control among patients in the network's 12 primary care clinics. The Hypertension Health Equity Project monitors this metric and develops strategies to reduce the care delivery gap for African Americans with high blood pressure in the clinics. The project convenes a Health Equity Workgroup to review clinic-specific data and identify effective interventions to address the root causes of disparities in blood pressure control. The workgroup consists of primary care clinic staff and patient advisors, SFPDH leadership and staff, and community partners.

Using a quality improvement (QI) framework, the Hypertension Health Equity Project developed several strategies for engaging patients with high blood pressure, especially African Americans. The project created tailored health education materials, a home blood pressure monitoring tool kit, and a medication algorithm designed to identify effective treatments for African American patients with high blood pressure. The project also developed and piloted patient identification and outreach activities, chronic care visits with registered nurses, and a clinic-based food pharmacy. The table below lists core components of the Hypertension Health Equity Project as described by leadership, staff, and partners.

Core Components	Program Description
Vision Messaging	The Hypertension Health Equity Project fosters a culture of equity. One of the ways they do this is by increasing data sharing across clinics. The project uses electronic health record (EHR) data and a health equity data dashboard to compare high blood pressure control rates for African Americans to overall control rates for each clinic. QI leaders at each clinic are asked to track and share data openly, encourage a culture of discussion, and be aware of how interventions to improve high blood pressure control may affect health disparities.
Medication Algorithm	The project collaborated with the University of California San Francisco to create a tailored medication algorithm based on studies showing that some antihypertensive therapies work better than others for African Americans. This algorithm helps clinic staff identify alternative therapies for patients who do not respond to initial treatments.
Tailored Patient Education Materials	The project created a patient brochure on how to prevent heart disease, including lifestyle changes that patients can make to manage high blood pressure. Patient advisors helped tailor the materials for African Americans. The brochure is included in the EHR system so clinicians can use it with patients.
Home Blood Pressure Monitoring Tool Kit	The tool kit shows clinic staff how to coach patients to monitor their blood pressure at home and take actions to lower their blood pressure. It includes resources that clinicians can give to patients, such as blood pressure logs and tailored patient education materials. Registered nurses use the tool kit during chronic care visits.
Patient Identification and Outreach	The project uses its EHR system to identify patients with uncontrolled high blood pressure, especially African Americans, and create a patient registry. Clinic staff then contact patients to invite them to participate in registered nurse chronic care visits and the clinic-based food pharmacy.
Registered Nurse Chronic Care Visits	The project offers chronic care visits with registered nurses to expand access to care for patients with high blood pressure and improve continuity of care. The visits are being pilot tested in five primary care clinics, and the project plans to expand them to all 12 clinics.



“Everyone on our team pushes beyond the scope of only treating hypertension as a clinical issue. We are redefining traditional roles. Patient advisors help create treatment options, non-clinical professionals provide care and support beyond the exam room, and collectively, we are all responsible for addressing and reducing socioeconomic barriers to care.”

—Hypertension Health Equity Project
Team Member

Food Pharmacy

At the clinic-based food pharmacy, patients can use prescriptions from health care providers to select healthy foods from a food pantry. The food pharmacy also offers cooking demonstrations, consultations with nutritionists, and lifestyle change coaching with pharmacists. Grant funding and donations from local food banks support the food pharmacy.

Intended Participants

African Americans who use the San Francisco Health Network’s primary care clinics are the intended participants in the Hypertension Health Equity Project. Of the 11,000 African American patients in the network, this health equity intervention is intended to meet the health and social needs of the approximately 4,000 African American patients with high blood pressure.

Goals & Expected Outcomes

The project seeks to improve the quality of care and reduce health disparities for African American patients with high blood pressure. For fiscal year 2016–2017, the goal was a 20% relative improvement in blood pressure control for African Americans from each clinic’s baseline performance in 2015. As of May 2017, two clinics had met this goal.

Progress Toward Implementation

Since 2015, the Hypertension Health Equity Project has made progress toward implementing strategies to improve blood pressure control among African American patients in the San Francisco Health Network. As of May 2017, the project has encouraged a culture of equity by sharing data across its 12 clinics. It has also developed a medication algorithm, tailored education materials, and a home blood pressure monitoring tool kit. A food pharmacy was pilot tested in one clinic and chronic care visits with registered nurses in five clinics. Seventy-five percent of patients who participated in the food pharmacy pilot test said it gave them more access to healthy food, and 50% said they were now eating healthier foods. Progress measures for the chronic care visits are not available; however, the two clinics that met their blood pressure control goals were among the five that participated in the pilot test.

Addressing Health Disparities

The Hypertension Health Equity Project began in 2015 after health officials noted that the gap between high blood pressure control rates for African Americans and the total population increased, despite improvement in blood pressure control overall. To address this gap, the project’s Health Equity Workgroup identified the root causes of disparities, with input from patient advisors who lived in the communities, and initiated the following activities to reduce these disparities:

- ❖ **Chronic Care Visits with Registered Nurses:** African Americans often face barriers to accessing health care and receive poorer quality care than whites.⁴ The project offers chronic care visits with registered nurses to provide better access to care for patients. At these visits, nurses use high blood pressure education and self-management materials tailored to the unique needs of African American patients. The project developed these materials with input from patient advisors who serve on the Health Equity Workgroup.
- ❖ **Clinic-Based Food Pharmacy:** African Americans have higher than average rates of food insecurity,⁵ which means they may not have access to healthy, low-sodium foods that can help lower blood pressure. In partnership with local food banks, the project offers a food pharmacy in its clinic to promote consumption of healthy foods, increase nutrition knowledge, and increase access to healthy food. Food pharmacies provide culturally appropriate food and recipes, and offer opportunities for patients and their families to learn about and incorporate healthier food into their diet.
- ❖ **Health Equity-Focused Hypertension Data Monitoring:** Data sharing promotes an information-driven approach to reducing disparities and improving the quality of care that clinics provide to patients.⁶ The project collects, tracks, and shares with clinic staff the blood pressure control rate for African American patients and sets goals for improving in blood pressure control.

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3. UCLA Center for Health Policy Research. [California Health Interview Survey website](#). Accessed October 19, 2017.
4. Agency for Healthcare Research and Quality. [2016 National Healthcare Quality and Disparities Report website](#). Accessed January 12, 2018.
5. US Department of Agriculture. [Household Food Security in the United States in 2016](#). Washington, DC: US Department of Agriculture; 2017.
6. Kilbourne AM, Switzer G, Hyman K, Crowley-Matoka M, Fine MJ. Advancing health disparities research within the health care system: a conceptual framework. *Am J Public Health*. 2006;96(12):2113–2121.