

# FOR PATIENT CENTERED PRIMARY CARE...

## *Partner with Your Patients*

*This series shares case studies on how primary care practices are engaging patients in improving the practice.*

The **Hypertension Equity Workgroup** was created in August 2015, commissioned by the San Francisco Department of Public Health Black/African American Health Initiative (BAAHI). This group has taken patient engagement to the next level, tackling a pressing health issue and its associated health disparities in their healthcare system.

### What was the issue?

A citywide community health assessment revealed that Black/African American (B/AA) residents in San Francisco have higher premature mortality rates in every disease category as compared to other ethnicities. BAAHI was formed to address these health disparities. The Hypertension Equity Workgroup was tasked with the overarching goal of improving B/AA blood pressure control for patients diagnosed with hypertension in an effort to reduce the disparity gap with the overall population.

### How did they engage their patients?

Knowing that addressing health disparities requires change within the community, this workgroup incorporated patients from its inception. Patients are not just “advisors,” but active workgroup participants who partake in monthly meetings to review data and design strategies. For instance, patients from the workgroup present twice during the year to all medical directors and leadership within the network at Monthly Management Meetings. There are 10 patient representatives who actively participate in the workgroup, with priority placed on representing the seven sites with the highest population of B/AA patients.

### PRACTICE PROFILE

**Name:** Hypertension Equity Workgroup, San Francisco Health Network, San Francisco, CA

**Number of Primary Care Clinics:** 14 PC, 7 Equity (sites with highest proportion of B/AA patients)

**Patients in Care:** Currently serves over 120,000 individuals

**Patient Demographics:** 13% Medicare, 54% Medicaid, 18% Other Public Insurance, 15% Uninsured

**Level of Engagement:** Organizational Design

**Notable Highlight:** Patients as workgroup members to address health disparities

### What was the result?

The network held focus groups with non-workgroup patients about hypertension to better gauge how the B/AA community perceives and understands high BP. Patients

wanted clinic staff to recognize that there are many non-clinical barriers making it difficult to keep BP under control, such as access to food and chronic stress. This feedback informed the mission statement, which was collectively created by the entire group:

*“Health equity means everyone has a fair opportunity to be healthier – opportunities that work for patients who are sicker, have fewer resources, and face significant barriers. For our Black/African American patients living with hypertension, controlling blood pressure is complicated by trauma, inadequate housing and jobs, and the societal effects of racism. In order to address this health inequity, we are utilizing data, problem solving, and developing resources together to support our patients to live healthier lives.”*

This mission statement is threaded throughout the work that has resulted from this group: Home BP Monitoring Toolkit: Patient workgroup members stressed the importance of having advice and tips specifically for the B/AA community. The home BP monitoring toolkit is multifaceted and incorporates elements for both patients and clinic staff. For patients, it includes a BP cuff and culturally relevant patient education materials. For clinic staff, it contains strategies on how to coach patients to effectively use home BP monitoring cuffs. Food Pharmacy: Patients frequently identified lack of access to nutritious food as a key obstacle to effective hypertension management. This aligned with the Food Pharmacy Project, a collaboration between clinics and the San Francisco and Marin Food Bank to provide healthy food to patients. Workgroup members and patients conducted food pharmacy site visits to identify what foods and recipes they enjoyed and what could be improved. Their suggestions informed the creation of materials and a volunteer training. The food pharmacies are scheduled to launch at all equity sites in late 2018.

## What advice do they have for others?

“Building relationships with the patients is so core to patient engagement,” shares Helen Gambrah, Health Equity Intern. This relationship has been important in creating the space for patients to share their expertise, and more importantly, have others hear their feedback and suggestions. This is particularly crucial for the topic of health disparities, where patient partners illuminate upstream determinants of health such as racism and nutritional access. “When patients give feedback, we take it seriously and act on it. It’s manifested in the work that we do.”

### How can I learn more? Visit:

[San Francisco Health Network website](#)

UCSF Center for Excellence in Primary Care [Patient Engagement page](#)

[Institute for Patient and Family Centered Care](#)

**Thanks for the case study to:** Helen Gambrah, Health Equity Intern; Sarah Cox, Population Health Project Manager & Analyst; LaKisha Garduno, Interim Associate Medical Director, Potrero Hill Health Center; Ellen Chen, Primary Care Director of Population Health & Quality