Racial and Ethnic Approaches to Community Health (REACH) Project

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Background

Heart disease and stroke are the leading causes of death in the U.S.

Many of the risk factors for heart attack & stroke are preventable and manageable with appropriate medical care, including identification and management of high blood pressure, high cholesterol, diabetes, obesity and smoking.
The risk factors are more prevalent among African Americans & Latinos, leading to health inequities for cardiovascular disease.
Alignment with Population Health Division Strategic Plan

**Headline Indicator: Percent of Blacks/African Americans with heart disease**

![Graph showing Black/African American and SF Ischemic Heart Disease Rate, per 100,000 population](image)

- Work with the community and partners to tailor a campaign to increase awareness about heart disease prevention and empower Black residents to take control of their heart health.

- Use quality improvement activities to standardize the delivery of care for patients with high blood pressure.
Risk of Death (NHS Atlas of Risk – Asap Science)
Purpose of the REACH Project

- To address health inequities among AA’s and Latinos through a community-based approach
- To reduce cardiovascular disease
- To improve social connectedness
- To improve quality of life
Why we applied for the REACH grant

- To address the racial and health disparities in SF, which aligns with the Black/African American Health Initiative within SFDPH

- To align with the Community Health Improvement Plan (CHIP) – focus areas: Healthy Eating & Physical Activity; Access to Quality Healthcare & Services and Safe and Healthy Living Environments
Why we applied for the REACH grant

- To expand upon the Quality Improvement African American (AA) Hypertension Project with Southeast Health Center & the Bayview YMCA
- To implement the Healthy Hearts SF: Million Hearts Initiative Plus Campaign
Began planning in June 2013 – started March 2014

Goal was to reduce blood pressure among a subset of AAs patients with hypertension at SEHC by Dec 2014

Set up systems with SEHC and at the Bayview YMCA for providing exercise prescriptions to AA hypertension patients to attend the Y.
Physical Activity
Nutritional cooking class
Success story – Group walk
Success Story

She was so motivated from the walk, that now she attends Water Aerobic classes on a regular basis.
Preliminary Results

- 27 Weeks – March 7 thru September 5, 2014
- 176 Referrals from SEHC to the Y
  - 38 Intakes were conducted at the Y
  - 22% of patients went to the Y
- 341 classes attended at the Y by SEHC patients
- Blood pressure – TBD

Many additional positive outcomes:
- Decreased Depression
  - Increased socialization
  - Decreased Isolation
- Reduced Weight – healthy eating
- Increased Self Esteem
- Taken Off Medications
- Healthy Risk Taking
- Exercising outside of Y programs
Outcomes of the REACH grant

- Increase daily consumption of fruits & vegetables, and healthy beverages
- Reduce exposure to second-hand smoke
- Improve social cohesion
- Increase community-based resources related to better control of cardiovascular health
Strategies

IDENTIFY – identify and ensure the quality of community prevention resources for patients referred from their primary care medical homes

IMPROVE - access to community prevention resources and the flow of patients between community agencies and the primary care medical homes

LINK - community prevention resources to patient primary care medical homes
Activities of the REACH grant

- Engage patients to find out where they might want to seek services
- Hire a Program Coordinator and two REACH Coordinators to engage with the clinic –based teams and the community prevention resource agencies and 211.org
- Partner with 211.org to enhance database of community prevention resources
- Utilize Health Information Technology to track patients engagement and clinical outcomes – assist in evaluation and dissemination
- Grant provides just under $800k to conduct the activities and meet the outcomes from 9-30-14 thru 9-29-17
Community engagement

- The project has received support from various community organizations.

- Convene an Request for Application process for community agencies to conduct culturally appropriate activities in and by the community that impact the heart health of AA’s and Latinos in SF.
Community engagement

Engage with patient’s in a community-based participatory approach throughout the length of the project

Partner with SFHIP throughout the length of the project
Partnership with SFHIP

- SFHIP leadership provided letters of involvement for the REACH grant
- The goals of REACH aligns with the SFHIP focus areas

Level of Involvement desired from SFHIP includes:
- Serve as REACH advisory committee
- Promote and guide the RFA process
- Serve on interview panels
- Review documents as needed
Inter-departmental Partnerships

- Ambulatory Care Branch
- Applied Research, Community Health Epidemiology, and Surveillance Branch
- Community Health Equity & Promotion Branch
- Environmental Health Branch
- Maternal & Child Health Branch
- Office of Equity & Quality Improvement
- San Francisco Health Network
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