

ENHANCED PRACTICE TRANSFORMATION

Improving blood pressure control

Opsam Health Hypertension equity for Black patients

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EPT Final Learning Community, 2026



Opsam Health

Who we are and who we serve



Caring for the Community Since 1973

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1	Practice type Federally Qualified Health Center serving San Diego County
2	Patients served 15,727 patients served in FY2026 84.09% covered by Medi-Cal/Medicaid, 1,060 uninsured
3	Our EPT population of focus Black patients with hypertension Baseline data showed a BP control disparity
4	What this storyboard is about Four coordinated changes to improve BP control and reduce the disparity

Before the intervention

The June baseline showed a persistent control gap

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Only 58.76% of Black patients with hypertension met the BP control measure.

Where we were

Prior to EPT, Opsam examined health quality measures at the overall population level rather than stratifying the results by race. Therefore, we implemented workflows and QI projects in a non-race stratified focus.

Race-stratified data obtained showed the disparity among our black patients (significant equity gap was discovered -- 65% ave BP control rate among non-blacks vs 58% among black patients), but the visit response was not yet a single, reliable workflow that specially focuses on this population.

Education, social needs screening, medication simplification, and rapid follow-up needed clearer connections to ensure these processes are geared in a culturally sensitive manner to improve this measure among this population of patients

58.76%

BP control among Black patients with hypertension
June baseline before QI implementation

What the team learned

Staff and patient interviews identified four change targets

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We paired interviews with a cause-and-effect diagram to move from assumptions to targeted changes.

Evidence reviewed

6 Staff members, all medical assistants were interviewed. Interview insights highlighted the need for culturally competent, evidence-based hypertension care for Black patients. Responses, such as “they are usually overweight” or “they commonly don’t follow provider instructions” showed potential implicit biases that may affect BP care.

3 patients were interviewed. The key challenges identified are healthcare mistrust among Black patients, which can reduce treatment adherence and follow-up, and socioeconomic barriers that limit access to healthy food, supportive resources, diagnostics, medications, and sustainable lifestyle change.

Using the results from staff interviews, patient interviews, cause-and-effect diagram, and BP control data race stratification were done to identify change ideas to improve this measure among this population.

Four change targets

1 Communication

Culturally responsive education and plain-language teach-back

2 Social needs

PRAPARE for every patient in the focus cohort

3 Treatment burden

Single-pill combinations when clinically appropriate

4 Follow-up delay

Return visit in fewer than four weeks

Four coordinated changes

The workflow links education, social needs, treatment, and follow-up

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Every uncontrolled visit now triggers a consistent clinical and support response.

Prepare the team

Staff and clinicians receive regular training in culturally responsive care via Opsam's Compliatric LMS

A plain-language teach-back handouts covering hypertension, home BP monitoring, and practical nutrition that is specifically geared towards this population were distributed.

Providers received training regarding latest guideline on BP control, including medication decision pathway and access to combination pill preference list within the electronic medical record.

Workflow regarding early follow-up appointments for patients with uncontrolled BP, medication adjustments or new medications were reinforced

1 Training

Culturally responsive care and plain-language teach-back

2 Screening

PRAPARE for every Black patient with hypertension

3 Treatment

Single-pill combination when clinically appropriate

4 Follow-up

Appointment in fewer than four weeks if BP is uncontrolled

Act during the visit

Complete PRAPARE for every Black patient with hypertension. When clinically appropriate, prescribe a single-pill combination for uncontrolled or stage 2 hypertension. Schedule follow-up in fewer than four weeks when BP not at target or medication changes or dose adjustments occur.

Monthly BP control improved

Black patients with hypertension, June through September

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58.76%

June baseline

76.00%

September

+17.24

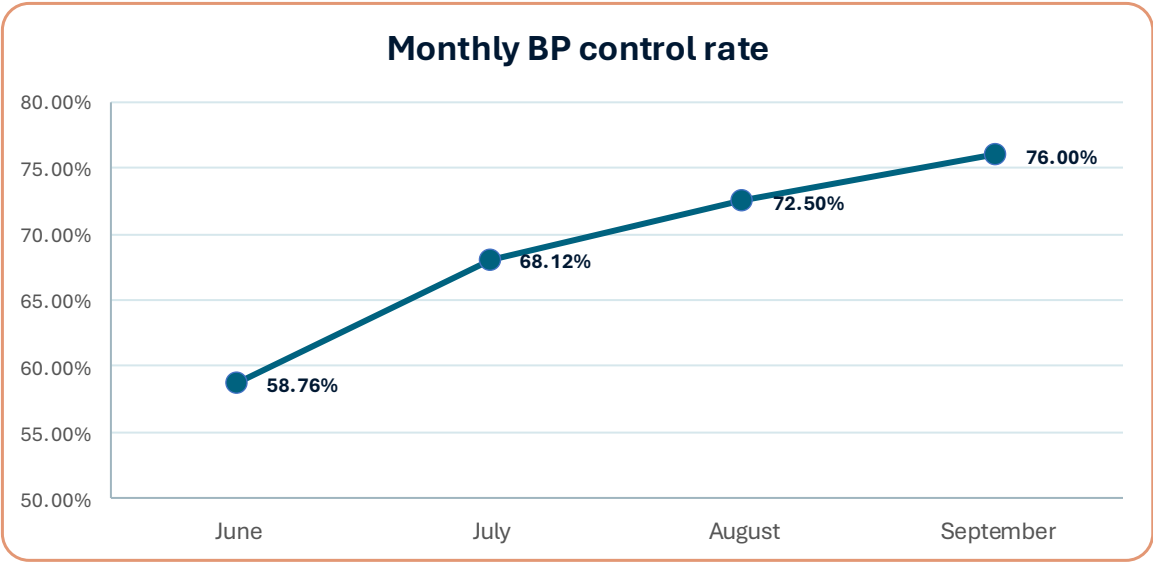
percentage-point gain

The measure

Blood pressure control measure defined as % of black patients seen ages 18-85 years who has a diagnosis of HTN and who BP was adequately controlled (<140/90) obtained in the most recent visit within the measurement period.

The challenges

As with any other QI projects (PDSA) that we perform, there are the initiators and then there will be the laggards. Presenting data improvement is a powerful way to change the laggards, and true enough with the seen improvement just by the first month and continued increase and sustained results, staff have embraced the process and is more inspired to promote care from an equitable lens, with change in behavior towards caring for racially diverse population.



How the workflow changes a visit

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The case:

A Black adult with uncontrolled hypertension takes several daily medicines and is unsure how to monitor blood pressure at home. They leave their appointments with questions and has no clearly scheduled follow-ups.

What happens during the visit

The team completes PRAPARE screen for all patients to identify barriers that may affect their care. Appropriate referral to a case management team follows if there is any identified gap, such as homeless, food insecurity or lack of transportation. The provider was encouraged to prescribe a single-pill combination when clinically appropriate to reduce the amount of pills to be taken and promote adherence. Use of a plain language teach back method was done. . Before the patient leaves, the next appointment is set for fewer than four weeks and our dedicated outbound call center tasked with calling patients who have been lost to follow-up reaches out and reschedules patients, if needed.

1 Understand and screen

Teach-back, home BP monitoring, nutrition, and PRAPARE

2 Simplify treatment

Single-pill combination when clinically appropriate

3 Recheck promptly

Follow-up appointment in fewer than four weeks

A repeatable equity-focused workflow

The capability Opsam Health has now

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We can now respond consistently when a Black patient with hypertension has uncontrolled blood pressure.

- 1 Identify the cohort with race-stratified data
- 2 Complete PRAPARE at the visit
- 3 Use clear education and intensify treatment appropriately
- 4 Book follow-up in fewer than four weeks

What happens reliably

The workflow connects patient understanding, social needs, medication choice, and follow-up timing during the same episode of care.



Who this reaches

Black patients with hypertension, especially those with uncontrolled or stage 2 blood pressure and barriers that may affect adherence.

Monthly visibility

The team can view race-stratified BP control as a trend, not a single snapshot.

Keeping the improvement in place

The workflow becomes part of routine care

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The intervention used training and changes to existing clinical and support workflows.

What it took

Staff and clinician training regarding cultural sensitivity and reducing implicit biases in patient care

Plain-language teach-back content applicable to the black population

PRAPARE integrated into visits using ecw structured data collection

Provider and scheduling workflow changes to ensure early follow-up and monitoring for those with uncontrolled BP

Recommended sustainability plan

Keep the four actions as standard work. Assign role-based ownership, include refresher training, and review race-stratified BP control monthly.

TRAINING

start-up need

<4 WEEKS

follow-up standard

MONTHLY

equity review

How it continues

A durable process keeps education, screening, treatment intensification, and timely follow-up inside routine care after the grant ends.

What we would share with peers

Lessons from the initial QI cycle

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1

What would we do differently?

Opsam could have involved Black patients earlier in designing the intervention, provided home BP monitors and community health worker outreach, and tracked patient counts and process measures from the start to identify which strategies had the greatest impact.

2

Where would we build next?

Opsam can develop a Power BI-driven dashboard that pulls data directly from eClinicalWorks (eCW) in real time to monitor BP control by race, track interventions, identify care gaps, and guide timely outreach

3

What others can reuse

The four-part workflow: culturally responsive teach-back, PRAPARE screening, single-pill combinations when clinically appropriate, and follow-up in fewer than four weeks. Pair it with a monthly race-stratified run chart.

Your 90-Second Preview

Opsam Health is a Federally Qualified Health Center serving San Diego County, and our EPT work focused on a clear disparity: only 58.76% of Black patients with hypertension met the BP control measure at our June baseline when compared to non-blacks who averaged at 65% control rate. Staff and patient interviews, supported by cause-and-effect analysis, led us to combine culturally responsive teach-back, PRAPARE screening, single-pill combination therapy when clinically appropriate, and follow-up in fewer than four weeks. By September, the control rate reached 76.00% after improving every month, and our storyboard shows how another practice can connect race-stratified data to a repeatable response during each visit.

THANK YOU

Questions?

Opsam Health

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