COLLABORATING EFFORTS TO IMPROVE HYPERTENSION IN AMERICAN INDIAN/ ALASKA NATIVE PATIENTS AT SNAHC

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OBJECTIVES

- The learner will be able to apply the process of PHN/CHW program management including admission criteria, referrals, intake and home visit structure.
- The learner will be able to identify patient barriers to care using tools, relationship building and workbook activities.
- The learner will be able to improve PHN, CHW and health care provider communications at their clinic site and create a health home for patients.

FORMATION OF PHN/CHW HOME VISITATION PROGRAM

- Data collected from UDS Reports, GPRA reports, Diabetes talking Circle Surveys and SNAHC staff surveys to identify high risk patients
- Admission criteria determined/policy and procedure created
- PHN case management implemented during clinic visits, telephone calls and home visits
- PHN and CHW collaborate to provide program sustainability

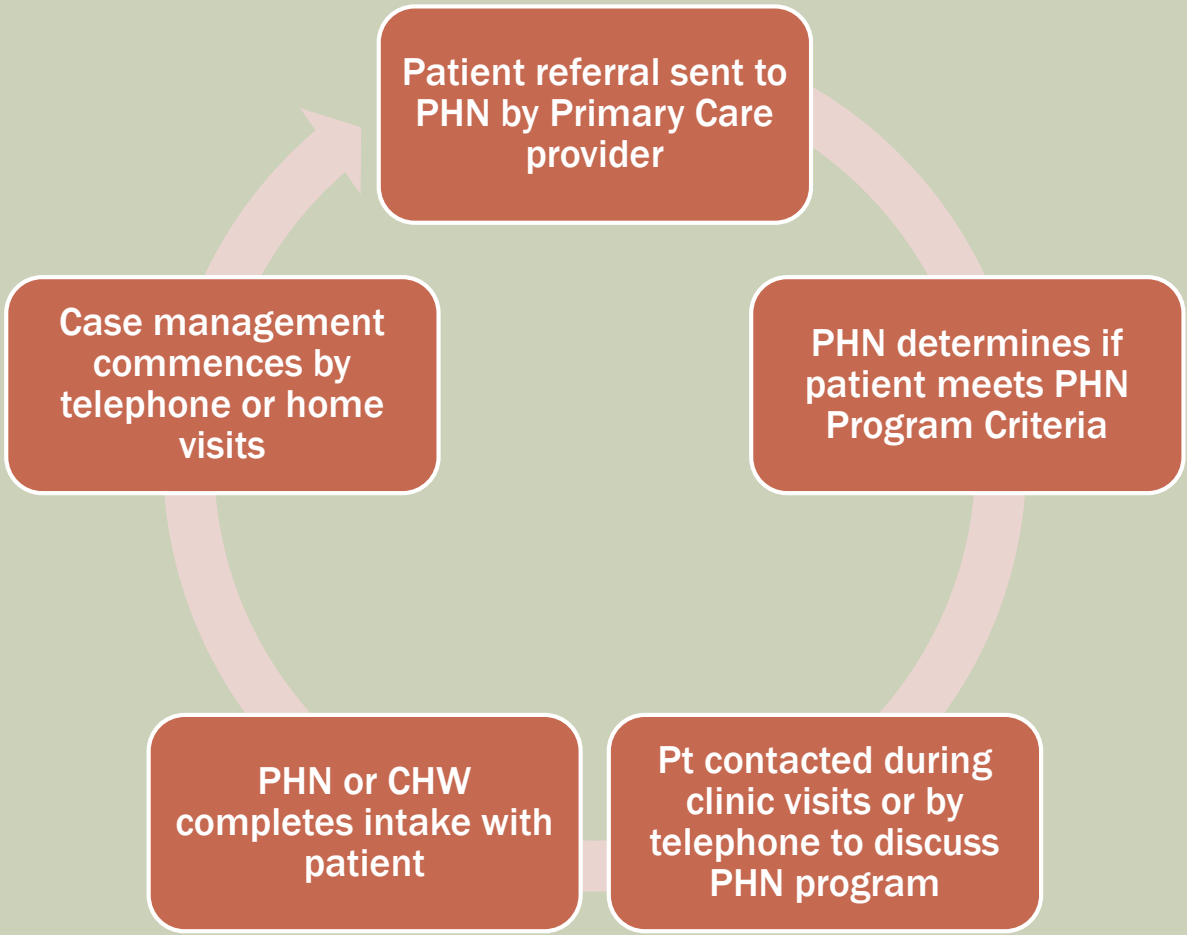
PHN CASE MANAGEMENT ADMISSION CRITERIA

- Must be registered as a patient at SNAHC
- AI/AN
- Have a diagnosis of hypertension with multiple cardiovascular disease risk factors
- Referred by Primary Care Provider

PHN PROGRAM INTAKE

- Care agreement reviewed and signed by patient.
- Case management needs assessment completed.
- Short and long term goals established using a high blood pressure and diabetes plan.

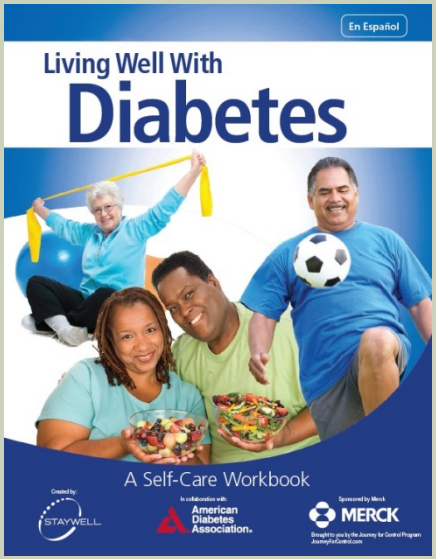
PHN AND CHW WORKFLOW

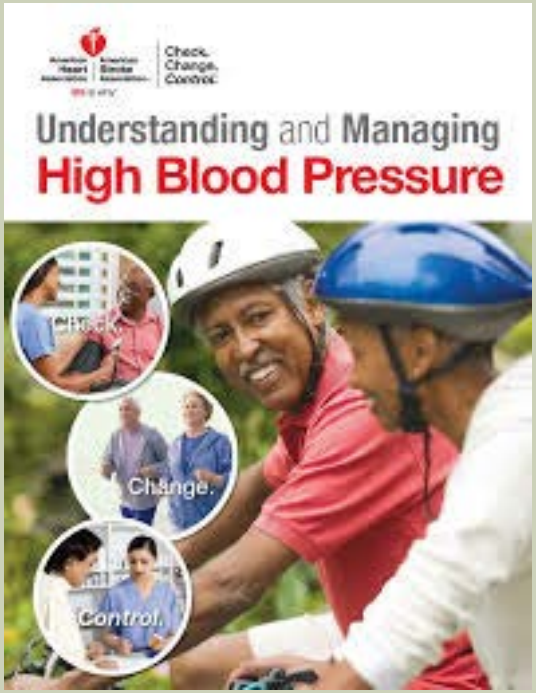


IDENTIFYING AND DECREASING PATIENT BARRIERS TO CARE

- Tools
  - IHS Food Insecurity Tool
  - Budgeting
- Worksheets and Workbooks
  - American Association of Diabetes Educators Self-care Behaviors worksheets
  - American Heart Association Workbook
  - American Diabetes Association Workbook
- Relationship Building

TOOLS AND WORKBOOKS



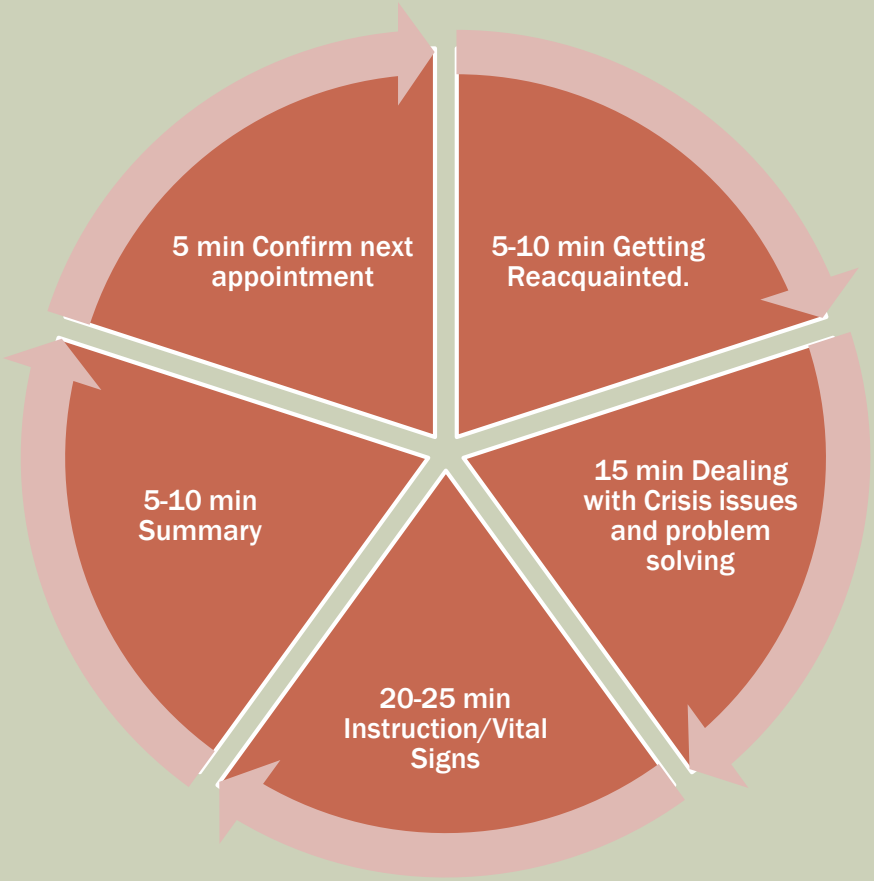


IMPROVING COMMUNICATION

- Prepare a list of questions prior to provider appointments.
- Accompany clients during appointments.
- Attend morning huddle in Medical Department.
- Review provider instructions during home visits.

HOME VISIT

THE HOME VISITING "HOUR" COMMUNITY HEALTH WORKER AND PHN GUIDELINE TO HOME VISITS



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GROWTH OF PHN PROGRAM WITH CHW IN 2016

	Jan.	Feb.	March	April	May	June	July	August	Sept.	Oct.	Nov	Dec
Total # Patients Encounters	23	49	69	61	58	75	90	97	77	115	77	103
Total # Primary Care Visits	23	12	10	8	10	8	19	18	5	16	15	14
Total # PHN Office Visits						4	2	2	3	4	2	8
Total # Warm Handoffs	23	12	10	8	10	8	19	18	5	16	15	14
Total # Home Visits by PHN	-	6	13	12	8	12	5	11	17	21	8	19
Total # Home Visits by CHW							3	1	7	8	6	8
Total # No shows Home Visits						2	1	1	1	0	0	0
Total # of Phone Calls	9	30	36	33	30	41	54	46	32	52	37	45
Total # of participants in Talking Circle/Support Group	-	-	-	-	-	-	14 “Healthier Living” class	14 “Healthier Living” class				
Total # of home blood pressure monitors distributed through PHN grant funding								4	1	2	1	2

BLOOD PRESSURE OUTCOMES

	Initial BP	BP after participating in program
Patient #1	190/89	136/78
Patient #2	160/90	127/83
Patient #3	162/105	136/82

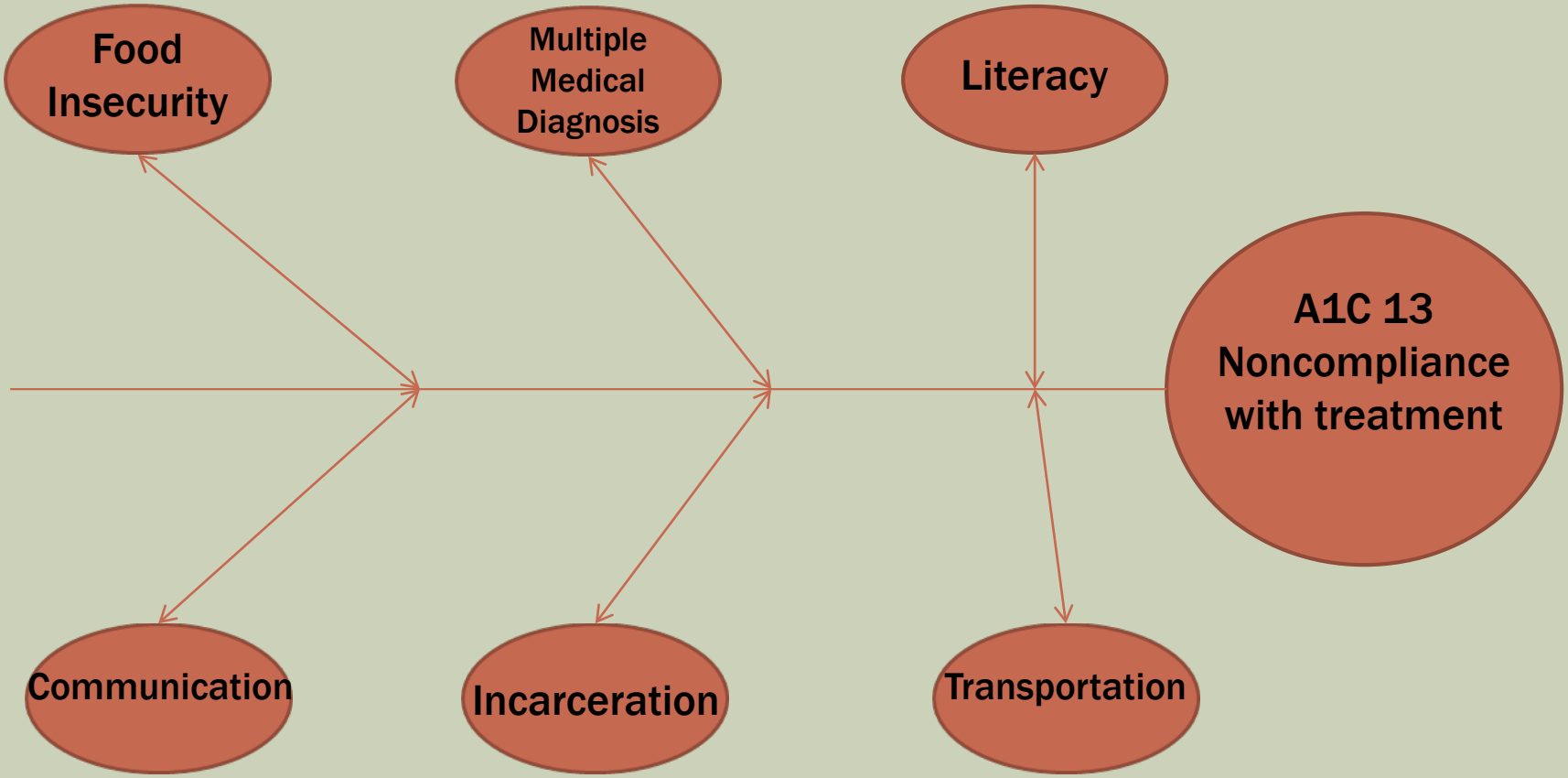
CASE STUDY

Patient background

- Age: 50+ male patient
- Medical History of:
  - HTN
  - DM 2
  - Chronic viral Hep C (treated prior)
  - Severe Mental Health DX
  - Hyperlipidemia
  - Obesity
  - Noncompliance with therapy.

- Intervention Strategy: First home visit on 6/30/2016. Public Health Nurse visits on Tuesdays. Community Health Worker visits Thursdays.

CASE STUDY


Food Insecurity
Multiple Medical Diagnosis
Literacy
A1C 13 Noncompliance with treatment
Communication
Incarceration
Transportation

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