The Hypertension Project at Family Health Center of Worcester

MassAHEC Network — UMASS Medical School — A Commonwealth Medicine Academic & Community Partnership

Summer Service-Learning Assistantship Program

Family Health Center of Worcester

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Summer Assistantship Program
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Hypertension Fact Sheet

- Normal: 100-140mmHg/60-90mmHg
- Hypertension: >140/90 mmHg
- Malignant Hypertension: >180mmHg/120mmHg
- Uncontrolled Hypertension: average >140mmHg/90mmHg among those with hypertension (even with medication prescription)
- Risk factor for **hypertensive heart disease, coronary artery disease, stroke, aortic aneurysm, peripheral artery disease, and chronic kidney disease**
- First line of treatment should be lifestyle changes in diet and exercise
- DASH diet = Dietary Approaches to Stop Hypertension
- Second line of treatment is medication, when BP >160mmHg/100mmHg: **Thiazide diuretics, Beta blockers, ACE inhibitors, ARBs (angiotensin II receptor blockers), Calcium channel blockers, Renin Inhibitors**
- Signs/Symptoms: lightheadedness, headaches, vertigo, tinnitus, fainting, altered vision
- Basic Pathophysiology: Increased total peripheral resistance due to narrowing of small arteries/arterioles with normal cardiac output.

Background on HTN Project

-ADD FHW HTN PREVALENCE DATA HERE

-Hypertension Project at Family Health Center of Worcester: goal to better control hypertension in patients with uncontrolled hypertension using an integration of **clinic** and **community** aspects.

-Clinical Aspects:

- Education of patient on basic pathophysiology of hypertension
- Nurse Visit Standardization
- Loanable-at-home BP machines
- Chronic Disease Self-Management Programs (CDSMP)

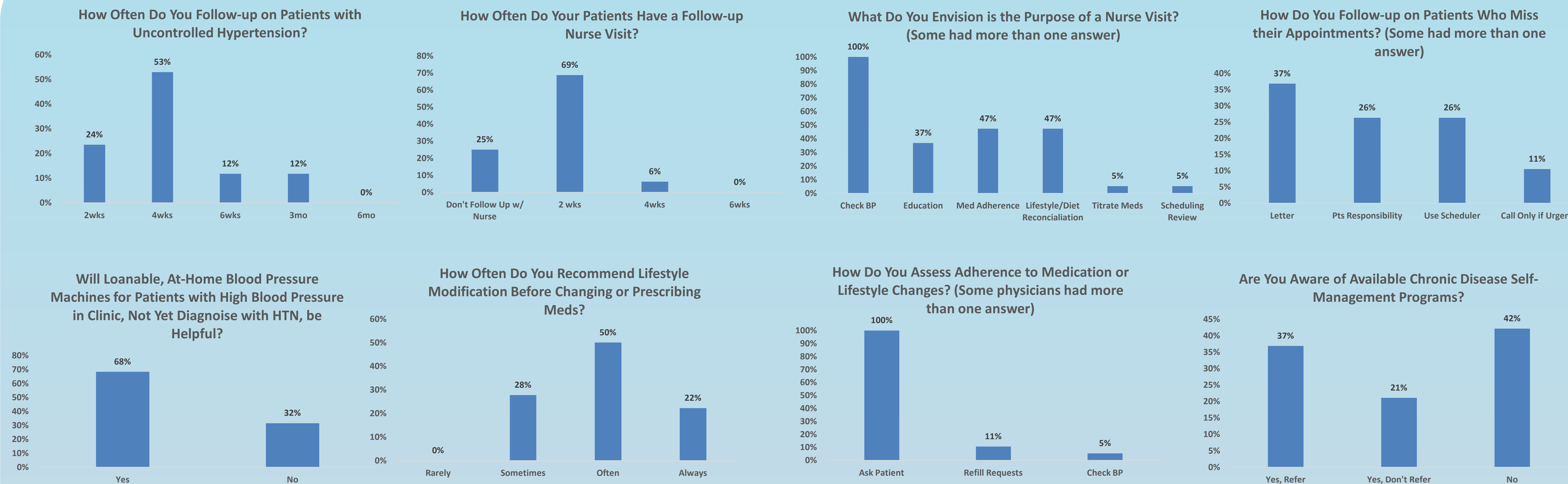
-Community Aspects:

- Education from community healthcare workers who have similar background to patient
- Partnerships with community resources:
  - Elderly Center
  - Mass Audubon
  - YMCA/YWCA
  - Mosiac for nutrition
  - CDSMP

Community Health Worker Role

-Motivational interviewing
-discussion of diet
-discussion of exercise
-home visits as needed

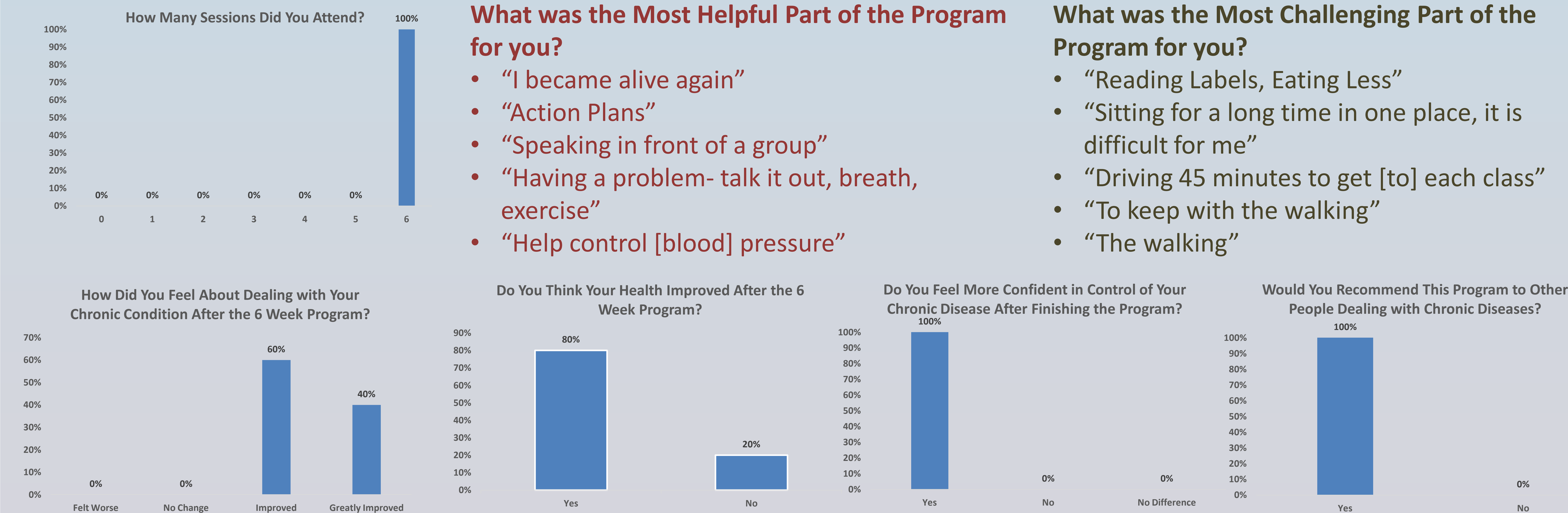
Physician Questionnaire (n=19)



Do You have any Comments on how to Improve the Care of Hypertensive Patients? (Select answers)

- Make Providers and Patients More Aware of Available Resources
- Identify the Patients and Invite to Chronic Disease Self-Management Programs without waiting for Provider Referral
- A Tracking System to Catch Patients Who Miss Appointments
- "I need to get in the habit of referring patients to the CD self-mgmt programs- they are a great resource"
- At Home Visits, More Nurse Visits

Patient Questionnaire for the "My Life, My Health" Workshop (n=5)



What was the Most Helpful Part of the Program for you?

- "I became alive again"
- "Action Plans"
- "Speaking in front of a group"
- "Having a problem- talk it out, breath, exercise"
- "Help control [blood] pressure"

What was the Most Challenging Part of the Program for you?

- "Reading Labels, Eating Less"
- "Sitting for a long time in one place, it is difficult for me"
- "Driving 45 minutes to get [to] each class"
- "To keep with the walking"
- "The walking"

Did You Notice Any Other Changes in your Daily Life After Doing the 6 Week Program?

- "I lost weight (10lbs), also walk five miles"
- "Better Mood"
- "I was more motivated and felt better about myself"
- "Better mood, handling situations differently, talking more"
- "Walked [more] and dealt [with] controlling pressure better"

Do You Have Any Further Comments or Feedback?

- "The size of the group was an asset. Smaller groups proves more participant from every member"
- "Continue the workshop to make people feel motivated and conquer their fears and live longer"

Standardization of Nurse Visit

Goal: standardization of nurse visit, with concrete goals for each visit as well as standardization of script and information to be covered by the nurse
-if uncontrolled: nurses visit every 1-2 weeks
-if controlled: nurse visit every 3-6 months

Nurse Visits Types (SEE HANDOUTS):

- Alcohol intake
- Smoking Cessation
- Physical activity assessment and education
- BMI/Weight, abdominal circumference and education
- DASH Diet education
- Stress Assessment and questionnaire, including behavioral therapist or mental health service referral if needed

Quality Improvement Work

HTN Registry:
-Review of registry consistently every 2-3 weeks with updates, status changes, BP and other readings.

Questionnaires:
-Provider Questionnaire on care of hypertensive patients
Patient Questionnaire on "My Health, My Life" Chronic Disease Self-Management Program

Future Work- Guidelines for Providers

- Education from clinical pharmacists
- What medications to use. What are bad combos
- When to do an EKG (before Beta or Ca blocker)
- Drug-drug interactions with psych meds
- Pharmaceutical review/education for nurses, MA, providers, NPs
- Nurse visit frequency