Heart Disease:
Addressing Hypertension in Homeless Populations

Health Care for the Homeless, Manchester, New Hampshire

BACKGROUND

How can health care providers across the country prevent a million heart attacks? That was the challenge issued by the Centers for Disease Control and Prevention (CDC) with the Million Hearts® Campaign.

The City of Manchester's Health Care for the Homeless (HCH) Program, based at Catholic Medical Center, is a primary care clinic for people experiencing homelessness. HCH Manchester accepted and rose to the Million Hearts® Campaign challenge. Working with the Community Health Access Network they pursued a hypertension focused quality improvement project which was funded by the New Hampshire Division of Public Health Services through a Cooperative Agreement with the Centers for Disease Control and Prevention.

CHALLENGE

Hypertension is a leading cause of heart attacks, so the team at HCH looked to improve the way they measure blood pressure and help patients with hypertension to bring it under control. In January 2016, 57% of patients had controlled blood pressure (a reading below 140/90*). HCH made it their goal to increase control rates to 62% within 6 months.

SOLUTION

The nurses at HCH started by taking a look at how they measure blood pressure and what barriers their patients face in maintaining a healthy level. "We educated the RNs and they observed each other to make sure there's consistency and accuracy in the blood pressure readings," says Tracy Tinker, MSN, RN, CNL, CDE, a nurse care coordinator at HCH.

The biggest changes came in patient education and communication. "Some factors, like access to healthy foods, were out of our control," says Tinker, "but we saw that there were many common themes we could tackle."

> *"To see someone who has so many barriers and reasons why they can't manage their disease, yet they're actually doing it, is amazing."*

Providers and RNs realized that patients generally had low health literacy. Now, they reinforce the importance of taking medications and the risks of stopping and restarting. "Hearing the same message multiple times from providers in various roles has proven very helpful," she notes. HCH schedules patients with high blood pressure readings for more frequent follow up appointments. The HCH outreach team also meets patients outside the facility to remind them of their appointments, the importance of taking medications, and to return to the clinic before their prescriptions run out.

Health Care for the Homeless, is located in the same building as New Horizons for New

Hampshire, an adult homeless shelter, soup kitchen and food pantry. This allows the team to build relationships with patients and manage chronic conditions, contributing to the success of the Million Hearts® focused quality improvement project.

RESULTS

The many challenges HCH was able to address allowed them to improve hypertension control rates beyond their initial goal of 62%. Within the 6 month project period, control soared from 57% to 70%, an increase of 13 percentage points.

NEXT STEPS

Health Care for the Homeless continues to work to improve hypertension control and identify new ways to address patient barriers. Plans for next steps are as follows:

- HCH nurse coordinators, health educators and the Street Outreach Team will continue to explore heart- healthy food choices with homeless patients who have limited access to food and face food insecurity daily.
- HCH nurse coordinators will discuss heart healthy menu choices and preparation with chef staff at local soup kitchens.
- HCH nurse coordinators, health educators and behavioral health providers will continue to screen, address, and intervene for co-occurring substance use and tobacco use disorders in patients with hypertension.
- HCH will begin to implement a new effort to promote patient self-monitoring of blood pressure (SMBP). Certain homeless patients with hypertension will receive a device along with nurse education. Patients will be followed up with during regularly scheduled visits to assess improvement of blood pressure, adherence to care plan and progress toward achievement of self-management goals.

CONTACT INFORMATION

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*Hypertension guidelines have changed since the start of this project. Hypertension is now considered 130/90 or above.