REACHing to a Healthier Anishinaabe

2012

Fostering Linkages in Clinical Systems & Community Services

Hannahville Indian Community

ACCESS TO HIGH QUALITY CLINICAL AND COMMUNITY PREVENTIVE SERVICES

Summary

In 2008, less than 10% of Hannahville Indian Community's diabetic patients were receiving comprehensive care for their condition. Data also showed that there was room for improvement in the assessment and documentation of weight and smoking status of clinic patients. Through the Inter-Tribal Council of Michigan (ITCM) REACH grant program, Hannahville worked to improve the care provided to clinic patients and create sustainable change in the tribal health system by pursuing program accreditation for diabetes self-management and implementing policies and procedures for screening and treatment. By 2012, the proportion of diabetic patients receiving comprehensive care had doubled, and key risk factors for diabetes complications, such as tobacco use and obesity had improved substantially as well. Today, Hannahville is exceeding performance standards for many measures of quality patient care.

FAST FACTS

22%

Adults in ITCM REACH tribal communities have ever been diagnosed with diabetes.

68%

Adults in ITCM REACH tribal communities are overweight or obese.

SUCCESS STORY

Challenge

Hannahville Indian Community is home to about 400 tribal members known as the *Potawatomi* ("Keeper of the Fire"). The Hannahville reservation consists of less than 10 square miles of relatively rural land in the south central region of Michigan's Upper Peninsula. According to local data, less than 10% of Hannahville's diabetic patients were receiving comprehensive care for their condition, which includes checking A1c, blood pressure, and cholesterol; undergoing a foot exam and retinal evaluation; and having controlled blood pressure. Data also showed that there was room for improvement in the assessment and documentation of weight and smoking status of all active clinic patients.

Solution

Healthcare providers can serve a unique role in ensuring that patients experience the most effective combination of clinical services and community preventive services, particularly in Tribal communities which often consist of centralized locations for a collection of key services and resources, and are visited regularly by many tribal community members. Hannahville healthcare providers and behavioral health staff collaborated to develop a system connecting individuals to resources according to their own specific needs and to better support patients' health. The Hannahville Tribal Health Center began following procedures in preparation for applying for clinical accreditation to ensure that all patients were asked if they currently use commercial tobacco or were regularly exposed to secondhand smoke, weighed to determine whether their Body Mass Index (BMI) put them at risk for other conditions or complications, and screened for cholesterol level, blood pressure, nutrition, and level of physical activity. When results indicate that the patient could benefit from clinic or community resources, they are appropriately referred using the clinic's electronic health record system. For instance, if the healthcare provider learns as a result of these assessments that a patient's diabetes is not adequately under control, that patient may be referred to a registered dietician, support group, fitness coaching, or self-management education classes.

Results

All of these actions result in a comprehensive system of community health that supports people in their efforts to live well. Since implementing policies and procedures for screening and referral, more diabetics are getting the comprehensive care that they need. Other indicators of clinical outcomes and patient health have improved in multiple areas as well, including BMI risk assessment, blood pressure control, diabetes comprehensive care, and tobacco use assessment.

The percent of diabetic patients that have received all components of comprehensive care for diabetes has nearly doubled since implementing systemic changes. Similarly, the percentage of patients with a previous hypertension diagnosis who currently have controlled blood pressure increased nearly 10%; the proportion of patients screened for tobacco use and exposure doubled; and the percentage of patients with measured and documented BMI increased by more than 30%.

These figures suggest an overall positive change in the community toward a more robust health system that improves the health and wellbeing of patients and residents.

Future Directions

The Hannahville Health Center will continue monitoring quality care indicators associated with diabetes program accreditation and comprehensive screening and referral in order to provide patients with the most appropriate and effective care possible. Ongoing programming, such as chronic disease self-management classes and worksite wellness initiatives, will serve as a resource to which providers can refer patients as needed and help to reinforce education of community members about the health benefits of healthy eating, physical activity, stress reduction, and seeking regular medical care and following through with recommendations and referrals form their healthcare providers.

FOR MORE INFORMATION

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