UIHI
Urban Indian Health Institute
A Division of the Seattle Indian Health Board

Cardiovascular Disease Best Practices

Patients diagnosed with chronic diseases can face limitations in daily living, suffer from lower quality of life, and die earlier than those without chronic diseases.[1] Chronic diseases also have major impacts on healthcare utilization and expenditures.[2] Best practices are intended to improve the quality of care and health outcomes. The principles presented in this resource guide were developed based on findings from a survey of Urban Indian Health Organizations and an extensive literature review of cardiovascular disease (CVD) practices in American Indian and Alaska Native (AI/AN) communities.[3,4] Examples and tips for how healthcare organizations and providers can apply these principles to both community-based and clinical CVD interventions are highlighted.

Overview of CVD Best Practices

- **Cultural relevance:** Programs, approaches and materials should be appropriate and applicable to the patient's cultural heritage, personal experiences, and community.[3,4] Establishing trusting relationships and being knowledgeable about the AI/AN community can strengthen the relationship between the patient and increase the likelihood that patients will implement their providers recommendations.[3-6] Integrating traditional dance into exercise programs or traditional foods into nutrition planning can be culturally appropriate additions to CVD programs.

- **Multi-faceted interventions:** Two-thirds of people over the age of 65 have more than one chronic condition.[7] Many chronic conditions, such as CVD and diabetes, have similar risk factors. These chronic conditions also share similar management behaviors that can improve multiple health outcomes. Interventions that address multiple factors, such as diet and exercise, produce better outcomes than single component interventions. Addressing multiple risk factors maximizes the use of resources and is a holistic approach to disease management.[3,4]

- **Support:** By definition, a chronic disease such as CVD is long lasting and rarely cured completely. Caregivers, family and friends play a critical role in assisting and encouraging persons with a chronic disease in making daily choices that can improve their health-related behaviors and clinical outcomes.[8] Peer mentors and group activities can model healthy behavior and provide positive social persuasion.[3,4] Patients need ongoing support that reinforces behavior change outside the clinic setting; social relationships can provide that support in daily life.[3,4]

- **Coordination of care:** Patients with chronic conditions generally require services from different providers to support their disease management. It is crucial for all types of providers to have a clear understanding of their role as well as communication with the entire care team to improve patient outcomes.[3,4] Meetings where case managers, clinicans, community program coordinators and other key providers can discuss specific cases is one way to collaborate on patient care. Coordination of care maximizes resources without duplicating efforts.[3,4]

- **Access:** Transportation services, extended hours in the evening or on weekends, and a variety of providers being available on-site increase a patient's ability to engage in interventions.[3,4] Additional programs such as mobile medical services can expand the reach of programs to individuals who would otherwise have not have access to care.[4]

- **Diverse approaches:** There are many effective ways to deliver interventions: phone, face-to-face, one-on-one, groups and interactive technologies are examples of different ways to engage patients. Providing activities in a variety of formats and settings can help reach a wider range of patients and increase retention and motivation of participants.[3, 4]

- **Personalized goal setting:** Coupled with group activities, individualized goals enable providers and patients to customize management plans to the patient's needs and specific situation.[3,4] Individualized goals also encourage accountability towards behavior change.[3,4] Work with patients to develop specific plans for achieving realistic short-term goals (for example, losing a pound a week) to build self-management skills.

- **Active follow-up**: Ongoing follow-up with feedback and reminders, such as monthly check-ins on progress towards goals or phone calls before appointments, help sustain behaviors over time and builds a patient's self-confidence by documenting, reinforcing and celebrating small successes.[3,4] Sustaining contact between providers and patients also builds trusting relationships.

The information and best practices presented here provide a foundation for improving the delivery of health care for patients with CVD.

Citations and Resources

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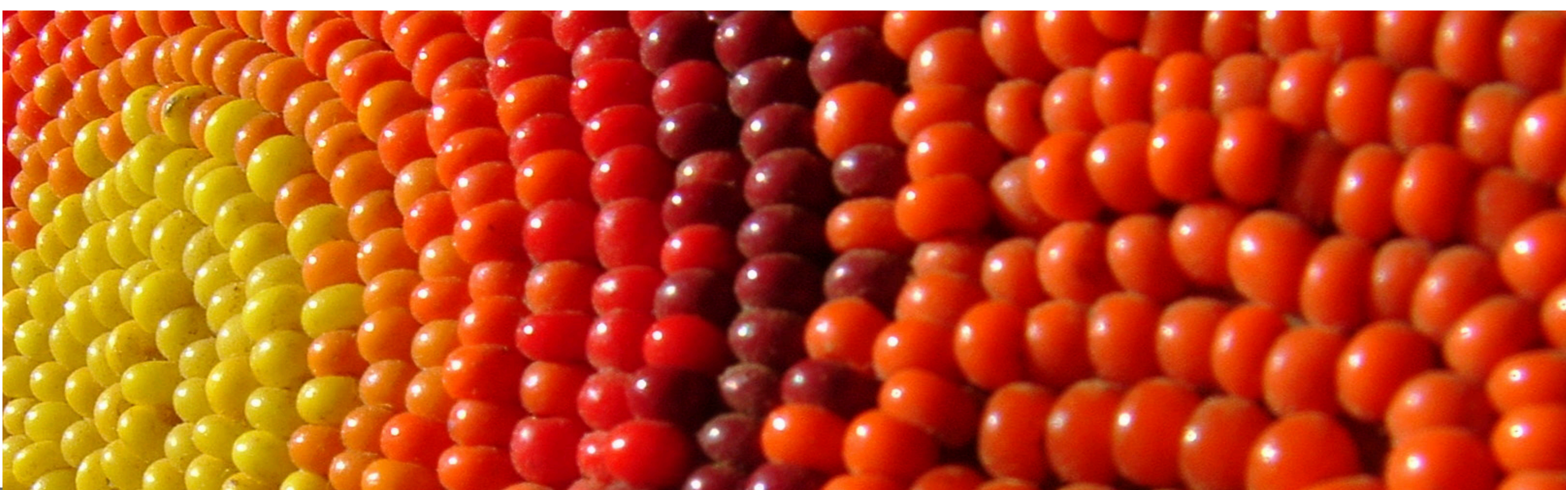

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