OUTREACH & REFERRAL

Adult is identified to be at risk for high blood pressure

Health Screening & Results Counseling

- Inform client of their blood pressure reading *(See the Blood Pressure Classification Chart).*

Elevated BP, Cholesterol, BMI, smoker, diabetes

Referral to Primary Care Provider/Medical Clinic for formal diagnosis

- If client does not have a primary care provider offer to help link them to a primary care provider/medical clinic

COMMUNITY COACHING/COORDINATION

Coaching/Case Management with CHW

- Identify health goals
- Create manageable self-management action plans
- Assist with overcoming barriers
- Link/refer to community and social service support programs
- Provide on-going support/coaching to help clients adhere to health goals, action plans, medication treatment plans, & lifestyle modifications

Reassess & Follow Up

- Recheck and review blood pressure readings with patient every 2-4 weeks.
- Advise patient to continue primary care visits as clinically appropriate.
- Reassess health goals every 6 months according to prescribed treatment
- Communicate with primary care provider & health care extenders (e.g. pharmacists, nurse, care coordinator, etc.) about goal progress and additional support if needed.

HEALTH IMPROVEMENTS

Increase Access to Primary Care and Provider Use of Evidence-Based Guidelines

Improve Chronic Disease Risk Factors

Improve Diet and Physical Activity

Community-Based Healthy Living Programs & Resources

- National Diabetes Prevention Program (NDPP)
- Living Well
- Living Well with Diabetes
- Weight Watchers
- Take Off Pounds (TOPS)
- SNAP Outreach, Food Banks, Access Nebraska