ONTARIO STROKE NETWORK
HYPERTENSION MANAGEMENT PROGRAM

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Lakelands Family Health Team
DISCLOSURE FOR POTENTIAL CONFLICT OF INTEREST

FINANCIAL DISCLOSURE:
From pooled funds of the Southeast Local Health Integration Network (LHIN).

Other:
None.
OBJECTIVES:

• Describe the HMP at Lakelands Family Health Team
• Success Story
• Lessons Learned towards Program Improvement
• Next Steps in Program Development
Lakelands

Family Health Team

- As of January 2013, we have 2,800+ rostered patients
- 4 MDs/2 NPs / Executive Director
- 1 RN(Program Manager) /2 RPNs
- 1 Dietician (0.4 FTE)/1 Social Worker/Counsellor (0.4 FTE)
- Chiropodist (0.2 FTE)
- 5 clerical staff (FT)
- Electronic Medical Records: Bell EMR
- 378 patients with a diagnosis of HTN
- 450 patients with a diagnosis of DM
- HMP currently has 61 registered patients.
LAKELANDS FAMILY HEALTH TEAM: NORTHBROOK AND DENBIGH
RURAL PRIMARY CARE
MODIFIABLE AND NON MODIFIABLE RISK FACTORS FOR STROKE AS IDENTIFIED IN HMP

Modifiable Risk Factors:

• High Blood Pressure *
• High Cholesterol
• Diabetes Mellitus
• Obesity/BMI
• Stress
• Physical Inactivity
• Smoking
• Alcohol Abuse

Non Modifiable Risk Factors:

• Age
• Ethnicity
• Family History
• Gender
• Previous History of Stroke or TIA

RNAO Best Practice Guidelines for Stroke (2012)
HMP GOALS

• Optimal Blood Pressure Control and Healthier lifestyle through:
  • Evidence Based patient-centred management by HCP
  • Improved effectiveness of systems and processes for the management of hypertension
  • Enhanced communication and collaboration among HCP
  • Improved Patient Self-Management.
ELIGIBILITY CRITERIA FOR HMP

INCLUSION CRITERIA

Adults, aged 18 yrs +
HTN diagnosis or hx of elevated readings
Understands and signs the consent

EXCLUSION CRITERIA

Secondary HTN
Major mental health illness or cognitive impairment
Language barrier
Lives in LTC
PROGRAM RESOURCES ALIGNED TO OCDPM FRAMEWORK

**SOLUTION:**

**Personal Skills & Self-Management Support**
- Reach Your Goal Fact Sheet
- DASH Diet Fact Sheet
- Take the Pressure Off, patient resource book
  - Patient-Provider Agreement
  - Patient Log Book
- Heart & Stroke Blood Pressure Action Plan™ (BPAP), patient web-based e-tool with e-mail support and log/tracking capability

**Community Action**
- Activated communities & prepared, proactive community partners
- Improved clinical, functional, and population health outcomes
  - Outcomes at multiple levels:
    1. **Individual**: Better control of blood pressure
    2. **Organization**: Primary care providers will have important information regarding their own practice
    3. **System**: Local system change including enhanced interprofessional collaboration

**HEALTHCARE ORGANIZATIONS**

**INDIVIDUALS**
- Healthy Public Policy
- Personal Skills & Self-Management Support
- Information Systems

**SUPPORTIVE ENVIRONMENTS**
- Delivery System Design
- Provider Decision Support

**Information Systems**
- Heart & Stroke Blood Pressure Action Plan™ (BPAP), patient web-based e-tool with e-mail support and log/tracking capability
- BPAP flow sheets with timely clinical reminders/prompts and tracking
- HSP Practice Audit Reports (confidential)

**Provider Decision Support**
- Program based on CHEP Recommendations
- RNAO-HSP Development of Hypertension Nursing Best Practice Guidelines
- Heart & Stroke Hypertension Flowsheet/HMI Template with evidence-informed clinical reminders and prompts
- Pocket Reference Guide (includes stages of change algorithm)

**Optical Character Recognition**
- HSFO Data Repository (Web-based)
- Audit Reports (Browser)
- Web Form
- EMR
- XML

**Healthcare Providers**
- Paper Form
Custom Form (Flow sheet) is available in the selected EMRs
CV RISK FACTORS IDENTIFIED WITHIN OUR HMP

88.3 % Physical Activity
80.0 % Weight
76.7 % Diet (high use of salt)
60.0 % Stress
25.0 % Smoking
25.0 % Alcohol
0.0 % None of these
LIFESTYLE MODIFICATION

• Assessment for Readiness to Change.
• Patient chooses a Lifestyle Goal.
• BP, WC graphed as reinforcement to self-management.
• BP taken at each visit by AOBP.
• Referral to allied health professional as indicated to assist with BP action plan.
PROGRAM RESOURCES

• AOBP Loan Program
  • Flash Cards for Home Blood Pressure Monitoring
  • Personal Health Tracker Log Book

• Heart and Stroke “Take the Pressure Off” Book or Audio Book

• Healthy Eating (DASH and Sodium) Fact Sheets

• Online Resources or Printed Resources:
  • “My Heart and Stroke Blood Pressure Action Plan”
  • “My Heart and Stroke Healthy Weight Action Plan”
Dietician (Nutrition Counselling and Cooking Classes)

Social Worker/Counsellor

Smoking Cessation Program - Ottawa Heart Institute Model/STOP Program through CAMH for free NRT for patients.

Exercise Program (Theraband Class)

Stress and Relaxation Program (Yoga)
SUCCESS STORY

• 70 year old patient with Family History of DM and Stroke. No other documented comorbidities. Enrolled with BP 160/80 LDL-C 2.68. BMI 28.32 Wt. 74.8 kg. WC 99.0 cm.

• One medication only for control of BP (calcium channel blocker).

• Life style intervention chosen was sodium reduction. Four individual visits with RN for lifestyle counselling.

• Last visit 6 months later BP 136/72 BMI 27.64
  Wt. 73.3 kg WC 96.5 cm

• Lifestyle goal has now switched to increased Physical Activity.
LESSONS LEARNED

Patient knowledge is power.
Gained acceptance through success.
Physician engagement is key.
NEXT STEPS

Ultimate HMP Recruitment Goal is 50% of all patient with a diagnosis of HTN.

Engaging all health care providers for referrals.

Utilizing EMR search for “potentials”.

Advanced Directives for BW for RN.

Using the HMP Repository to the fullest potential to enhance call backs and “buy in”.
THANK YOU.

Thank you to Marg, Wendy and Kishan at Heart and Stroke for their support.

Thank you to Colleen for linking us with Heart and Stroke.
REFERENCES


