

ONTARIO STROKE NETWORK HYPERTENSION MANAGEMENT PROGRAM

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NURSE PRACTITIONER**

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.

PRESENTATION OUTLINE

OBJECTIVES:

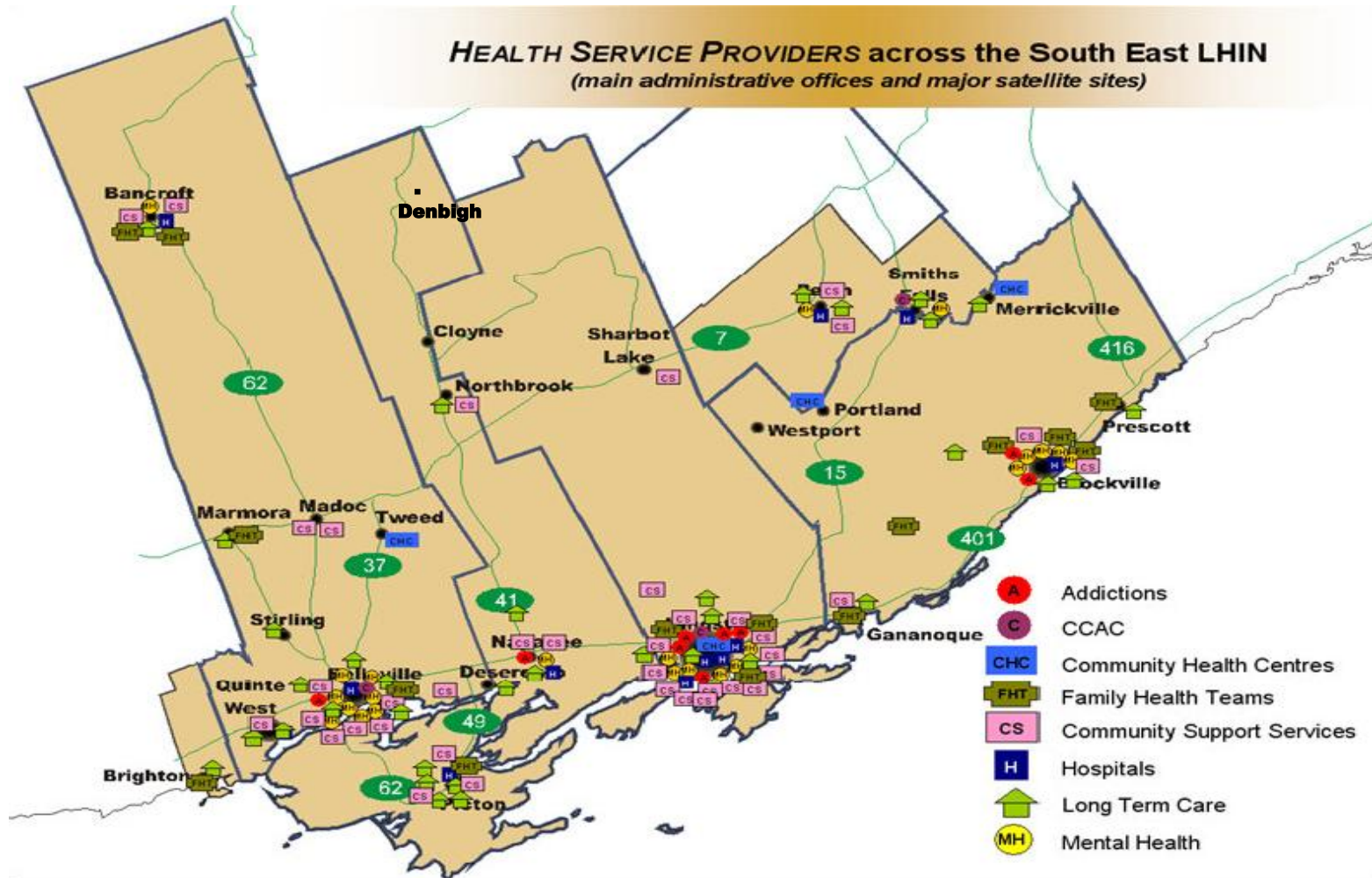
- Describe the HMP at Lakelands Family Health Team
- Success Story
- Lessons Learned towards Program Improvement
- Next Steps in Program Development

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

HMP GOALS

- **Optimal Blood Pressure Control and Healthier life style 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



www.heartandstroke.ca/bp

- Over 200,000 users
- 80% of users found that it helps them make lifestyle changes

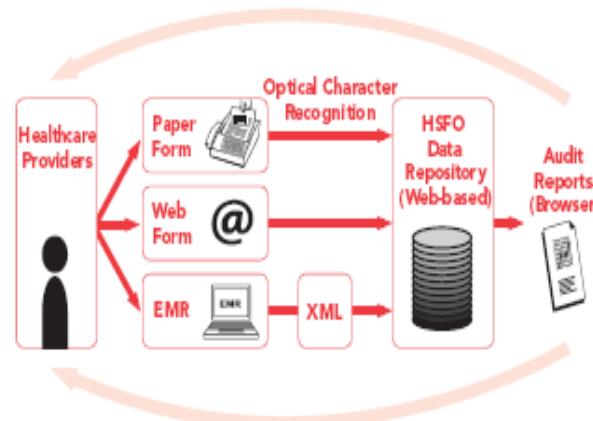
Delivery System Design

- BpTRUs
- Rx/Dx Script Pads
- Interprofessional education and development



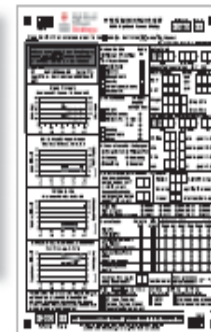
Information Systems

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



Provider Decision Support

- Program based on CHEP Recommendations
- RNAO-HSFO 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)



Flowsheet/Data collection form (available in paper, web form, and EMR)

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

HYPERTENSION FLOWSHEET: EMR TEMPLATE

HSF Hypertension Visit: Harold Vipper

Hypertension Visit | Hypertension Flowsheet

Heart&Stroke Hypertension Management Program

Status Enrolled Not enrolled Date: Today

Primary hypertension was diagnosed (fill ONE)

>= 1 yr ago
 < 1 yr ago
 Not (yet) diagnosed

Ethnicity (self-reported) (fill all that apply)

White Japanese
 Black Korean
 E.Indian Hispanic
 Pakistani N.American First Nations
 Sri Lankan Other
 Bangladeshi Refused
 Chinese Unknown

Medical Dx & Hx

Primary Hypertension
 Elevated BP readings
 Dyslipidemia
 Diabetes
 Kidney disease
 Obesity
 Coronary heart disease
 Stroke or TIA
 Depression

Family Hx

Physical exam

SBP DBP

Automated Office BP Monitor? Yes No

Metric Imperial

Height (cm): (in): Confirm
Weight (kg): (lbs):
Waist (cm): (in):

Lab work Include in note

LDL mmol/L (goal < 2.0)
TC:HDL ratio (goal < 4.0)
HDL mmol/L (goal > 1.0)
Trig mmol/L (goal < 1.7)
A1C % (goal < 7.0%)
FBS mmol/L (goal 4-7)
eGFR mL/min
ACR mg/mmol

Order Labs

CV Risk Factors (All fields required)

Weight Yes No
Physical activity Yes No
Diet/Nutrition - Salt Yes No
- DASH
Smoking Yes No
Alcohol intake Yes No
Stress Yes No

Pt Selected Lifestyle Goal

Patient view of selected lifestyle goal

Uninterested Thinking Deciding Taking Action Maintaining Relapsed

Custom Form (Flow sheet) is available in the selected EMRs

Figure 6: Hypertension Visit (Part 1)

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”

ALLIED HEALTH PROFESSIONAL REFERRAL



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

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