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STROKE NETWORK of Southeastern Ontario

Primary Care: Vascular Health Tools & Resources

Primary Care: Hypertension Update

March 9, 2016

Faculty/Presenter Disclosure

- Faculty: Stephen Sundquist & Colleen Murphy
- Relationships with commercial interests:
  - Grants/Research Support: None
  - Speakers Bureau/Honoraria: None
  - Consulting Fees: None
  - Other: None
- Potential for conflict(s) of interest: None

Objectives

1. Provide overview & connection to:
   - Ontario Stroke Network (OSN) Primary Care Priority Activities:
     - Hypertension Management Program (HMP)
     - Initiatives: Vascular Health Assessment & Support Tool (VHAST), Vascular Health QI Toolkit & Medical Directives
   - SEO Health Collaborative
   - Vascular Health Resource on SouthEasthealthline.ca
2. Seek feedback on resources/tools

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OSN Primary Care Focus March 2016

Advancing Integrated Vascular Health Care Capacity, Quality and Efficacy

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Hypertension Management Program (HMP)

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HMP Overview

Evidence-informed program developed to improve diagnosis, management & control of primary hypertension

- Education, practice support, provider tools to improve detection, management & treatment + resources promoting patient self-management
- HCP- and Patient-focused content developed & maintained by HMP team with input from Hypertension Canada, Heart & Stroke, CDA, & other partners
  - Content relevancy: always reflects current evidence, guidelines & best-practices
  - Health information consistency & minimal content redundancies/duplicate resources achieved through collaborations
- Program evaluations have repeatedly shown **significant reductions in SBP/DBP** as well as **positive changes in** relevant **labs** (E.g. cholesterol, glucose, A1c)

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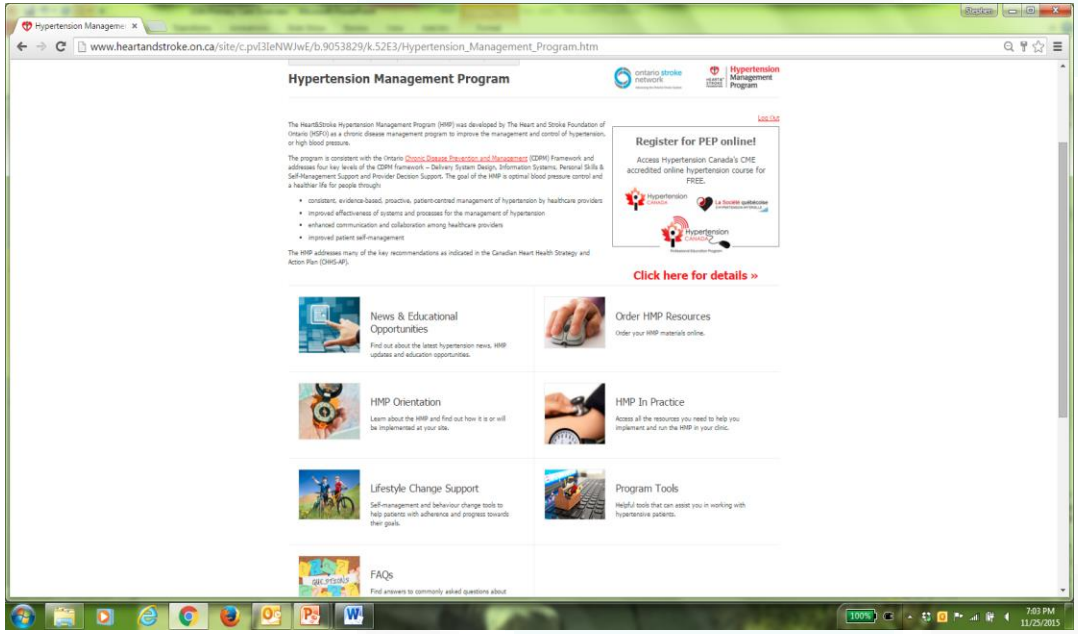
HMP Overview – cont'd

- Operational infrastructure functions on a fully scalable, web-based delivery platform enabling sustainable program mgmt. & clinic support processes



- Use of Client Relationship Management software
  - Standardized program data - embedded forms/workflows, enhance internal communications
  - Embedded workflows & tracking for: engagement, implementation, operational status, site's unique configurations & requirements, clinical services delivery & technical support
  - Program metrics reporting
  - Dashboard view of staffing-, site-, program-level performance

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HMP Resources & Tools

Making Connections to the OSN-Led HMP

www.heartandstroke.on.ca/hmp

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HMP – Sites

- **Current Participation: >55 primary care clinics** (incl. 14 First Nations)

+ **Planned:** Active engagement with an **additional 27+ primary care sites & 8 aboriginal communities** seeking program adoption through FY16/17

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OSN Vascular Health Primary Care Initiatives

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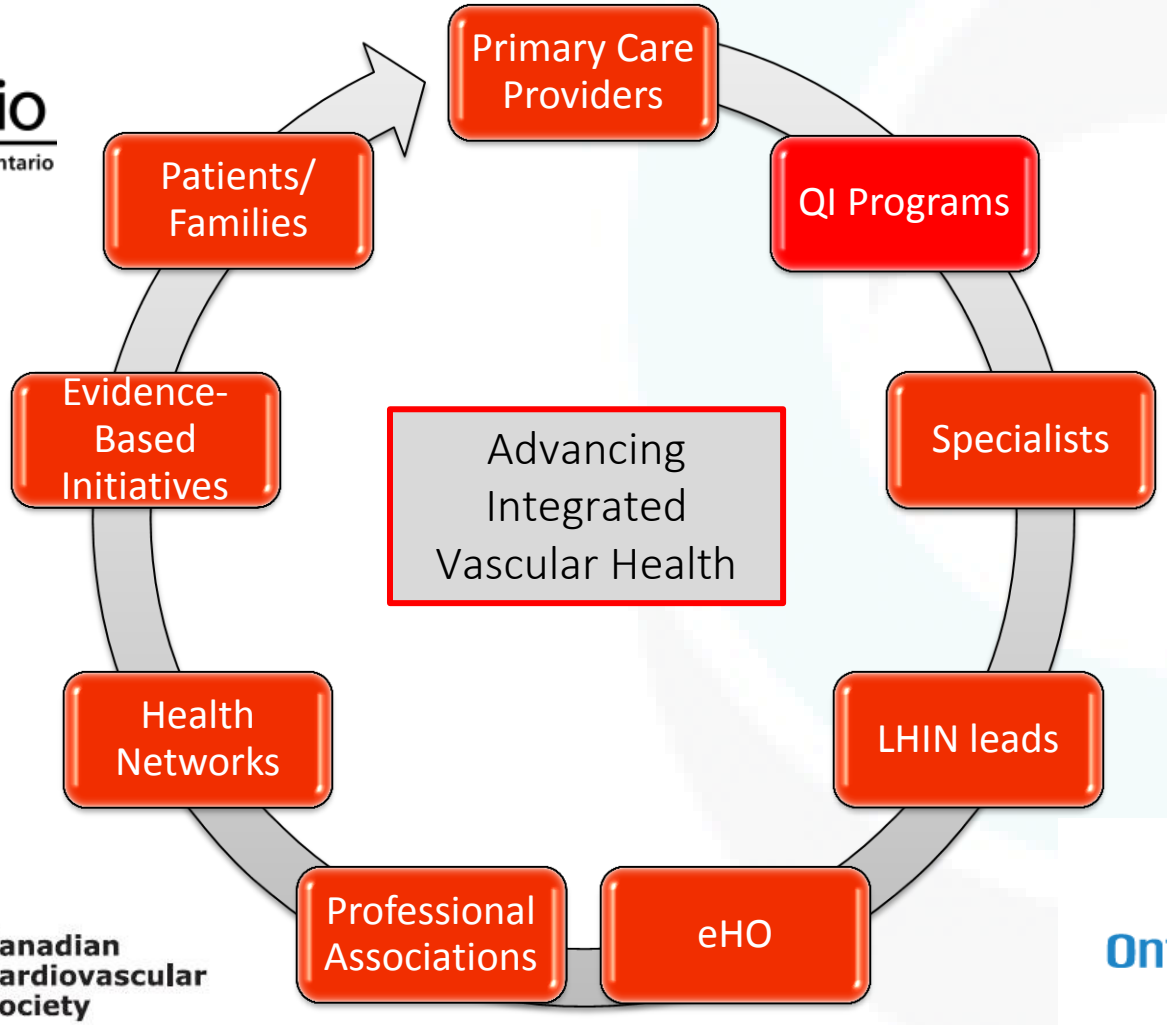
OSN – Leadership
Primary Care Work Group (PCWG)

Following the 2012 *Vascular Health Blueprint for Ontario,* the **PCWG** was established to *improve quality & access to continuum of vascular services by:*

- Referencing HMP experience, evolving e-health technology & current system barriers/enablers to support implementation of Vascular Health (VH) best practices
- Recommending & disseminating targets, tools and strategies to:
  - *Enhance use of best practices*
  - *Increase access to current, high-quality health information*
  - *Support collaboration between Specialists & Primary Care HCPs*

PCWG & Key Stakeholder Engagements



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Primary Care Priority Activities

- OSN-Hypertension Management Program (HMP)
- OSN-Led Primary Care Work Group Initiatives
  - Vascular Health Assessment & Support Tool (VHAST)
  - Vascular Health QI Toolkit
  - Vascular Health Medical Directives

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PCWG Priority 1: VHAST

Building on a "Proof of Concept" model & alpha prototype designed with primary care providers and stakeholders, the VHAST proposes to function within Ontario EMRs with embedded capability for clinical data to be compared against best practice guidelines, including C-CHANGE guidelines, at point of care.

VHAST:
Comprehensive point-of- care, patient-centred, decision support resource building on effective elements of the OSN's **Hypertension Management Program (HMP)**

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VHAST Prototype Goals

- Have straightforward, feasible specifications
- Include the following diseases/conditions:

Hypertension	Diabetes	Dyslipidemia	PAD
Angina/MI	CHF	CKD	Stroke/TIA

- Function within OSCAREMR Connecting Care, Creating Community. Ontario MD funding-eligible eMR
- Leverage published **C-CHANGE** (2014) guidelines

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VHAST Prototype Demo

Place Demo Here

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Prototype Achievements

- VHAST prototype completion achieved October 2015

  "Proof of concept" features -
  - ability to pull existing data from an EMR offering
  - integrate care elements for the 8 vascular conditions
  - link data to relevant C-CHANGE recommendations
  - introduce value-added data transformations (Rx categorizing)
- Key milestones achieved including-
  - clinical and functional requirements gathered & logged
  - Usability Assessment Testing with 5 test cases by 12 different health care professionals at 7 Ontario PC organizations
  - report on findings including lessons learned

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  - report on findings including lessons learned

"Covers a large number of patients in my practice & covers patients with more than one disease!" (PC physician)

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Future VHAST Benefits & Value Proposition

Value	Current Environment	Future State-VHAST
Capacity	▪ Data elements & flowsheets for 3 vascular conditions ▪ Not easily scalable	▪ Data elements for any combination of 8 vascular conditions ▪ Design scalable
Integration & Quality Improvement	▪ Search disparate, disease-centred views ▪ ↓Integrated CDM ▪ User-customized forms required	▪ Easily access common care elements within an integrated, patient-centred view ▪ Capacity to manage multiple CDs concurrently
	▪ Non-standardized data elements reside on individualized forms	▪ Common data elements displayed in data fields within a consistent, standardized view

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Future VHAST Benefits & Value Proposition

Value	Current Environment	Future State-VHAST
Clinical & Patient Decision Support	▪ Disease-specific CBPGs dissemination vary ▪ Limited access to integrated CBPG's in EMRs ▪ Data alerts vary	▪ Point of care decision support via EMR-embedded, harmonized guidelines (including C-CHANGE) ▪ Integrated care plan prompts for 8 vascular conditions
	▪ Rx not categorized by class ▪ Rx compliance per CBPGs not flagged consistently	▪ Categorizes vascular drugs Comparisons of patient Rx & CBPG-recommended drug therapy
Support Patient Self-Management	▪ No standard tracking of patients' readiness for modifying risk factors, lifestyle goals, or progress	▪ Incorporates tracking of patient lifestyle goals, priorities, behaviour change, progress & supports ▪ Links to patient education resources

VH: Vascular Health; CDM: Chronic disease management; CQI: Continuous quality improvement; KT: Knowledge translation; QIP: Quality improvement plan; CBPG: Clinical best practice guideline; C-CHANGE: Canadian Cardiovascular Harmonized National Guideline Endeavour; Rx: Prescription; HCP: Health care provider

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PCWG Priority 2: Vascular Health QI Toolkit

- PCPs ID'd need for *"Go To"* VH QI Toolkit to assist in developing & implementing QI Plans or projects
- Drafted "companion" QI resource & overarching AIM
- Initial complimentary Vascular Health topics chosen:

Hypertension Screening & Management	Smoking Cessation
Abdominal Aortic Aneurysm (AAA) Screening	CKD Screening (patients with diabetes)

- Completed draft QI elements templates for AAA screening hypertension screening & management, smoking cessation, CKD screening (patients with diabetes)
- Future Plans: Test & evaluate with interested PC sites

Hypertension Management – Improving screening, identification and management of hypertension for adult patients in Ontario

How might our primary care team improve the processes within our clinic to support hypertension management for more patients?

Imagine having access to information on patients in your practice/organization that facilitates identification of those whom would most benefit from hypertension interventions? Who would that patient be and how might the improvement change their care experience, their health journey, their life?

The Reason for the Effort

- *Carol, age 67, was unaware that her blood pressure was uncontrolled and this has resulted in the decline of kidney function. Imagine being able to screen and follow the 'Carols' in your practice to ensure this does not happen?*
- *Ahmed, age 38, has a family history of high blood pressure but was shocked to learn that he has high blood pressure at his age. The screening program offered at his primary care clinic enabled him to learn about treatment options and self-management approaches to reduce risks for his cardiac and vascular health.*

Background

Hypertension is a major risk factor for cardiovascular morbidity and mortality and is the highest ranking diagnostic category for drug expenditures in Canada [1]. In 2000, hypertensive heart disease, which includes high blood pressure and any conditions due to high blood pressure, was the leading contributor to cardiovascular disease drug costs (60.2%). Hypertensive heart disease accounted for 26.5% of physician costs [2]. In 2003, the estimated direct healthcare cost of hypertension in Canada was $2.4 billion. In 2007, 21.1 million visits to community physicians were attributed to hypertension. With the current demographic changes due to the aging of the 'Baby Boomer' generation and an unusually large cohort born between 1946 and 1965, provincial health plans are grappling with how to plan for the 'silver tsunami' as this generation become senior citizens over the next 23 years.

Epidemiologic studies have indicated that, for people aged 40–69 years, each increase of 20 mm Hg in usual systolic blood pressure is associated with a doubling of mortality rates for stroke and ischemic heart disease. Hypertension also referred to as the 'silent killer', affecting 21.3% of the adult population (23.8% of men and 19.0% of women). Prevalence increases with age, from 3.4% among people 20–39 years of age to 51.6% among those 60–79 years of age. According to the Heart and Stroke Foundation of Ontario 2006 Ontario Survey on the Prevalence and Control of Hypertension (ON-BP), [3] there has been a significant improvement in the treatment and control rate since the Canadian Heart Health Survey: among those with hypertension, 65.7% are treated and controlled. However, one-third of Ontarians with hypertension are still not treated and their blood pressure is not well controlled. In a recently published study of hypertension management in Ontario primary care practices, screening, treatment and control rates were 92.5%, 86.4% and 44.9% respectively [4].

QI Initiative Elements

QUALITY DIMENSIONS: Effectiveness; Population health

AIM: Improve the screening, identification and management of hypertension for adult patients in primary healthcare teams in Ontario with a focus on patients at high risk for development of vascular diseases.

MEASURES: **General Focus –** Screening & Identification

Outcome Measures	Process Measures	Balance Measures
	% of adult patients 18 years of age or older with a B/P value in the EMR *	
% of adult patients diagnosed with hypertension and w B/P value ≤140/90	% of adult patients 18 years of age or older with a diagnosis of hypertension	

*B/P values may be obtained during regular scheduled office visits or may be provided by patients in follow-up to B/P measurement at another location, e.g. community pharmacy.

MEASURES: **High Risk Factor Focus –** Screening, Identification & Management

Outcome Measures	Process Measures	Balance Measures
	- % of adult patients 18 years of age or older with identified risk factors such as diabetes*	
% of adult patients w identified risk factor(s)* w B/P value ≤ 140/90 in EMR	% of adult patients w identified risk factors such as diabetes* w B/P value in the EMR	

* Risk factors include:

- Diabetes
- Vascular diseases – cerebral vascular disease (CVD), chronic kidney disease (CKD), peripheral arterial disease (PAD), coronary artery disease (CAD)
- Behavioural activities - smoking
- Other – Obesity
- Ethnicity - Southeast Asian, African, Aboriginal

CHANGE IDEAS:

1. *Focus on **data discipline** to support primary care providers to screen populations with the intent to measure blood pressure*

    - Implement an evidence-informed hypertension flow sheet (e.g., OSN Hypertension Management Program Flowsheet; Vascular Health Assessment and Support Tool (VHAST) when available) for standardized, consistent assessment and documentation in electronic medical record (EMR)
    - Map the hypertension patient journey from diagnosis including anti-hypertensive medications where relevant

2. **Decision support aids** *for patients*

    - Implement the provision of website links, online and paper-based information tools to support self-management and increase awareness of hypertension risks and/or management of B/P, e.g. patient resources from the Ontario Stroke Network, **Hypertension Management Program (HMP)** (http://ontariostrokenetwork.ca/hmp/)

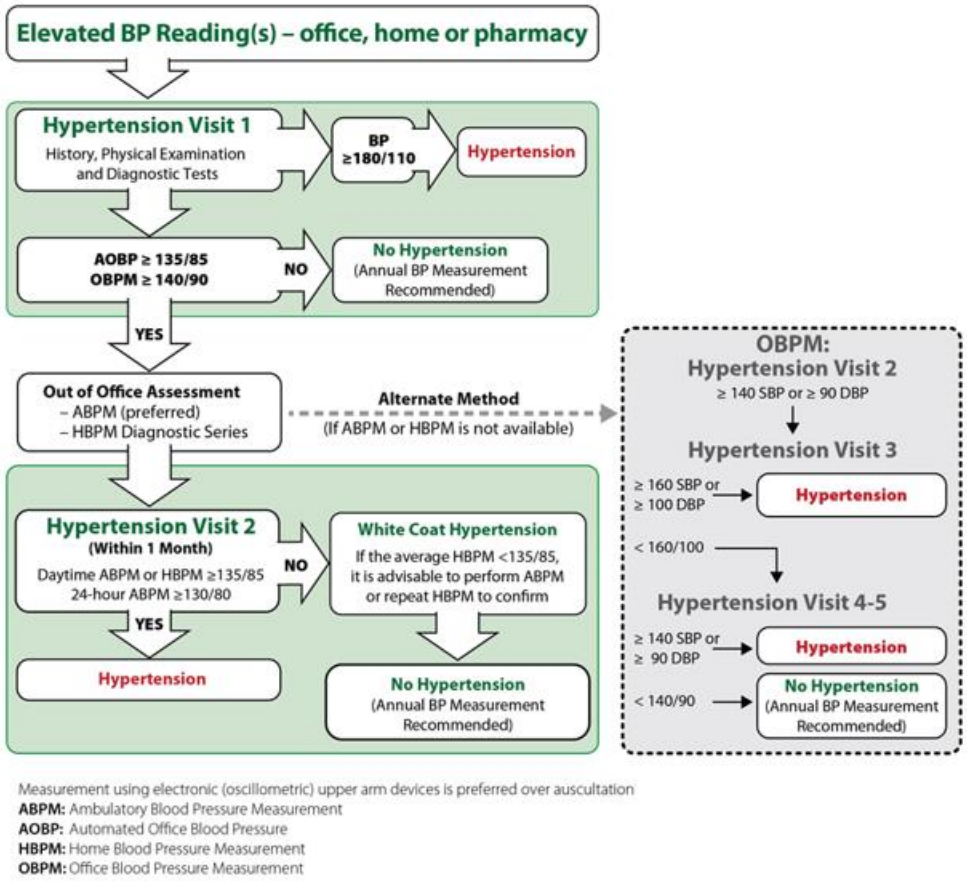
    - Implement the provision of website links, online and paper-based information tools to support self-management related to behavioural modification such as related to smoking cessation, weight loss, exercise programs

3. ***Decision support aids** for health care professionals*
    - HCP and staff training/education
    - Use of a hypertension medical directive (e.g., Vascular Health Medical Directives when available) to enhance capacity for interprofessional team collaboration in care delivery.

AIM		Measure				Change			
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2015/16**	**Target Justification**	**Planned improvement initiatives (Change Ideas)**	**Process measures**	**Change ideas (2015/16)**	**Comments**
Effective/Population Health	**Improve the screening, identification and management of hypertension for adult patients in primary healthcare teams in Ontario with a focus on patients at high risk for development of vascular disease such as diabetes.**	• % of adult patients diagnosed with hypertension and w B/P value < or = to140/90 • % of adult patients w identified risk factor(s) w B/P value < or = to 140/90 in EMR				**PROVIDER** - EMR-Focused change ideas **PATIENT** - Patient decision-support-focused change ideas	1. % of adult patients 18 years of age or older with a B/P value in the EMR 2. % of adult patients 18 years of age or older with a diagnosis of hypertension	1. EMR reminder/recall systems 2. Decision support aids 3. Pharmacological prescribing 4. Behavioural support	
						PROVIDER - EMR-Focused change ideas **PATIENT** - Patient decision-support-focused change ideas	1. % of adult patients 18 years of age or older with identified risk factors 2. % of adult patients w identified risk factors w B/P value in the EMR	1. EMR reminder/recall systems 2. Decision support aids 3. Pharmacological prescribing 4. Behavioural support	
Integrated									
Patient-Centered									

Quality Improvement Tools

Process Map



Hypertension Canada. (2015) Criteria for diagnosis of hypertension. Retrieved from http://guidelines.hypertension.ca/diagnosis-assessment/diagnosis/

Provider Resources

The Ontario Stroke Network's Hypetension Management Program (HMP)

http://ontariostrokenetwork.ca/hmp/

Hypertension Canada

https://www.hypertension.ca/en/chep

Patient Resources

The Heart and Stroke Foundation of Canada-Blood Pressure Action Plan

https://etools.heartandstroke.ca/HeartStroke/BPAP.Net/Tracker.aspx

Hypertension Canada

http://guidelines.hypertension.ca/patient-resources/

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Vascular Health Medical Directives

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Priority 3: Medical Directives

- Task Group established
- Survey circulated & completed to inform the Medical Directives topics & work
- Work plan developed and approved by PCWG
  - Compiled and organized sample medical directives received from PCWG members including ones collected from South East
  - Conducting Environmental Scan for additional medical directives
  - Reviewing & selecting smoking cessation & hypertension management medical directives
  - Reviewing plans with professional associations
  - Ensuring alignment with PC activities

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SEO Health Collaborative: Primary Care Focus

Improving Vascular Health Through Integrated Approaches to Risk Factor Management

Vascular Health Profile

Health Profile	2012 KFL&A	2012 SE	2012 Ontario	2014 KFL&A	2014 SE	2014 Ontario
Obesity %	22.6	22.0	18.0	16.7 ↓	20.7 ↓	18.3
Diabetes %	8.9	8.7	6.8	7.0 ↓	7.0 ↓	6.6
Hypertension %	18.7	19.8	17.4	21.7 ↑	21.7 ↑	17.6
Current Daily Smoker %	15.7	20.0	14.5	15.8 ↑	19.0 ↓	14.4
Heavy Alcohol %	17.1	18.3	15.9	18.3 ↑	19.4 ↑	16.9
Physical Activity %	63.4	60.5	50.5	62.5 ↓	59.9 ↓	53.8
Hospitalized Heart Attack (per 100,000 population)	210	218	207	180 ↓	200 ↓	198
Hospitalized Stroke (per 100,000 population)	108	127	125	111 ↑	122 ↓	119

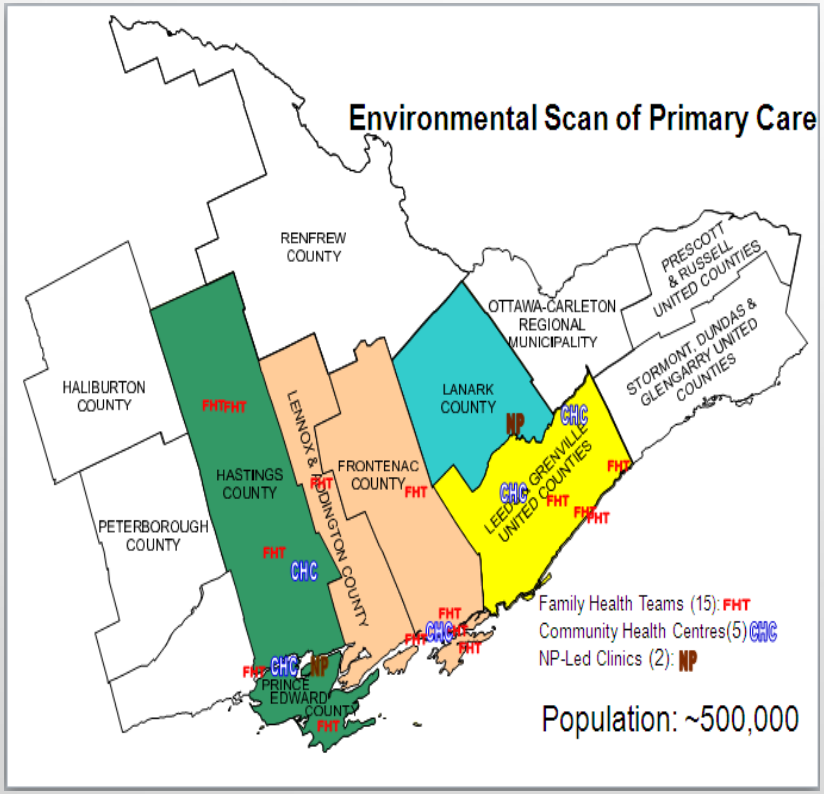
Adapted from "Health Profile, June 2012 and 2014: South East Health Integration Network Ontario" by Statistics Canada, 2014. Retrieved from www.statcan.gc.ca

Background

- SEO continues to have high rates of vascular diseases and risk factors
- SEO Health Collaborative
  - formed in Jan 2011
  - includes many partners: health networks, Primary Healthcare (PHC) organizations & public health
  - supports PHC in vascular disease risk reduction

Background

- In order to identify PHC needs and learn more about resources provided
  - Environmental scan & Think Tanks conducted

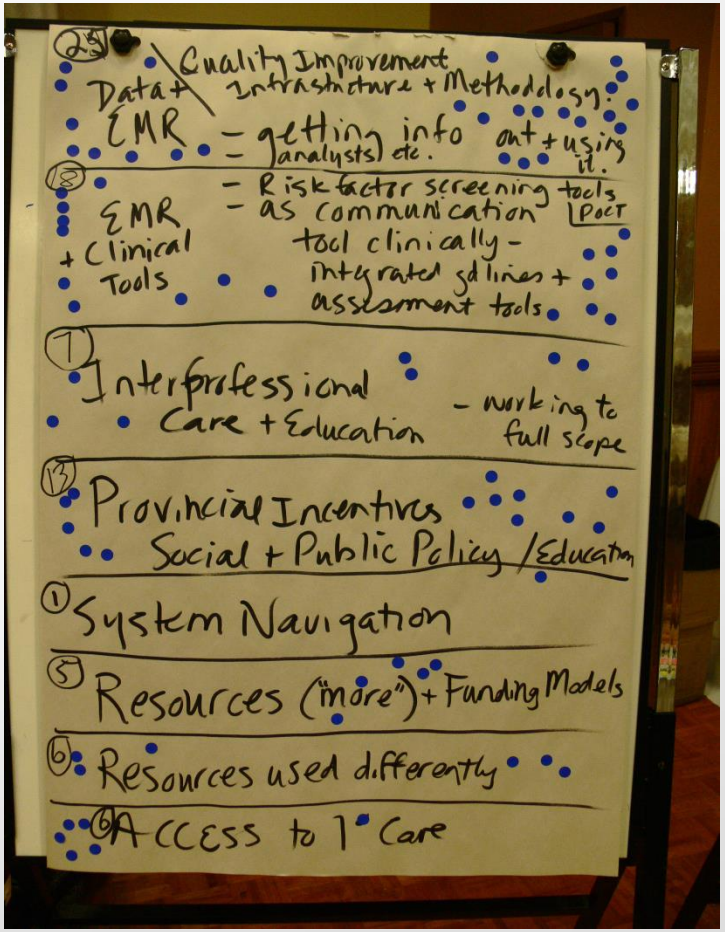


Findings

- Sharing information between PHC organizations
- Facilitate consistency (e.g., documentation)
- Innovative ways for providing vascular health updates
- Improve connections
- Increase awareness/promotion of established resources

Findings

- Use EMR to facilitate integrated vascular health
- One integrated patient-centred vascular health service (e.g., Global Risk Reduction program at the Upper Canada FHT)



Southeastern Ontario Health Collaborative – FY 2015-16 Action Plan- March 2016

PRIORITY	ACTION	MRP	Timeline	Status Mar 2016
1. Support integrated vascular health QI initiatives within SE primary care- Focus on hypertension	i. **Prepare to pilot the provincial Vascular Health QI Toolkit (Hypertension component)** in a 2016-17QIP • Identify at least one Primary Care agency willing to partner with the SEOHC to pilot the tool • Encourage FHTs to consider a "hypertension challenge" i. **Promote awareness of other components of Vascular Health QI Toolkit (e.g.; medical directives) and related QI Toolkits**	C. Murphy, SE LHIN QI facilitators QIDSs and M. Alden With support from Data Leads Group	Promote in 2015-16 to embed in a Primary Care QIP in 2016-17 Presentations given at QIDSs and PHCC May 2015	√ underway √ underway
2. One vascular health integrated guideline; integrated vascular disease prevention program with Community Partnerships	i. **Promote opportunities within SE LHIN to trial new integrated vascular guidelines and tools** • Promote awareness of Ontario Vascular Health Assessment and Support Tool (VHAST) • Presentations at QIDSs and PHCC • Deliver a demo at Primary Care Forum when ready, likely 2016 • Pilot VHAST with at least one Primary Care agency in SE LHIN when ready- likely 2016 ii. **Promote related resources** such as Queen's *Exercise is Medicine* toolkit, C-CHANGE	C. Murphy and A. Steacie with Primary Care workgroup of OIVHS and SE LHIN Primary Care Leads All members of SEOHC.	VHAST prototype developed in OSCAR. Awaiting availability for trial. Presentations given at QIIDSs and PHCC May 2015 Display table at Primary Care Forum Sept 2015	√ ongoing
3. System Navigation:– on-line SE Vascular Resource Directory	i. **Pilot test and launch an on-line community resource directory of vascular health services** within HealthLine www.SouthEastHealthLine.ca • Pilot summer 2015 • Work with CCAC to refine in response to pilot • Develop promotional material • Launch at Primary Care Forum display table Sept 2015	Workgroup: Dr Steacie, C. Murphy, M. Jaquith with R. Phillips, CCAC	Pilot the directory summer 2015; refine Prepare communications material – e.g. bookmark; Launch Sept 2015 at Primary Care Forum	√
4. Support SE Indigenous Health Council (IHC) vascular health initiatives	i. **Maintain communication with and support for Indigenous Health Council (IHC) Initiatives:** ii. **ICHAP and Social Cultural Circles** • Salmon River Health Link & Stroke Network support • Present to other indigenous communities; consider spread iii. **Promote unique needs within Health Links** • Learn from Salmon River Health Link's workgroup	M. Buchanan, M. O'Leary with IHC and SR Health Link and Stroke Network SEO	Sustain ICHAP protocol within Salmon River HL Meet with IHC fall 2015 to discuss opportunities for spread to other communities	√ √ ongoing

HEALTH SERVICES FOR SOUTH EAST

March 2, 2016

Health Care Options
- Health Care Facilities
- Health Care Professions
- Home and Community Care
- Public Health

Health Topics
- Abuse and Sexual Assault
- Addictions
- Diseases and Conditions
- End-of-Life Care
- Environmental and Workplace Health
- Mental Health
- People with Disabilities
- Residential Care
- Sexual and Reproductive Health

Your Health
- Aboriginal
- Children and Parenting
- Men
- Seniors
- Women
- Youth

Making Choices
- Basic Needs and Social Supports
- Blood, Organ and Tissue Donations
- Health Coverage and Care Planning
- Healthy Living
- Information Services
- Legal Services

Services by Location
Search by Location

Services Listed Alphabetically
A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

NEWS

Tuesday February 23, 2016
2016 KFL&A Family Advocacy Award winner announced

Tuesday February 23, 2016
Brockville General Hospital Cardiovascular Program

Tuesday February 23, 2016
Chief Medical Officer of Health on Zika Virus

EVENTS

Wednesday March 2, 2016
50+ Senior Centre - Stitches, Mahjong, VON Falls Prevention - Belleville

Wednesday March 2, 2016
VON Canada's SMART Exercise Program - The Royal RH - Kingston

Wednesday March 2, 2016
VON Canada's SMART Exercise Program - Knights of Columbus -

CAREERS

Monday February 29, 2016
Registered Nurse (RN/RPN)

Monday February 29, 2016
Registered Practical Nurse

Monday February 29, 2016
Personal Support Worker

More Careers...

Find services in other areas

Connecting you with care
Votre lien aux soins

Need Help finding health & support services? Call CCAC 310-2222

Follow @SEhealthline
Follow @SEhealthlineHPE
Follow @healthlineKFLA
Follow @SEhealthlineLLG

Vascular Health Resources

Stroke Resources

Vascular Health Resources

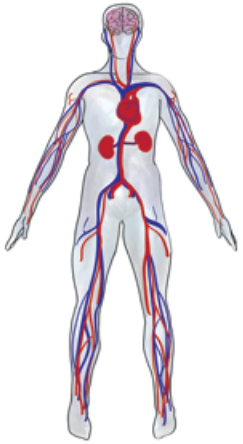
The goal of this initiative is to provide a user-friendly online resource for health professionals and health care consumers in their efforts to improve vascular health and system navigation.

Vascular diseases is a term for a wide range of diseases that affect the vascular or blood vessel systems of your body. They can include certain heart diseases such as coronary artery disease, kidney disease, stroke, diabetes and dementia. These diseases are different but are linked by common risk factors such as hypertension, physical inactivity and poor nutrition. This directory helps users navigate the services available for reducing their risk, managing vascular diseases, and living with the disease.

Vascular Health Promotion
Reducing Risk

Managing Vascular Disease
Assessment, Treatment and Secondary Prevention

Living with Vascular Disease
Support Services



This Vascular Health Resources listing in the Health Library of SouthEasthealthline.ca was created in collaboration between the Southeastern Ontario Health Collaborative and the South East Community Care Access Centre.

South East CCAC Community Care Access Centre | CASC Centre d'accès aux soins communautaires du Sud-Est

SEO Health Collaborative

Let’s Visit the Site

- Vascular Health Resources

Contacts

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Resources

- Ontario Stroke Network: www.ontariostrokenetwork.ca
  - Hypertension Management Program
  - Primary Care Programs
- Stroke Network of Southeastern Ontario: www.strokenetwork.ca
- SouthEasthealthline.ca