From a Basic Hypertension Clinic to a Complex CV Program - Challenges and Successes

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A Trip Down Memory Lane

- First opened in June 2009 as a pilot program with two doctors participating
- Patients were “farmed” from the EMR (100 pts)
- Basic vitals, lifestyle counselling and health education
- The short term evaluation was positive and the SFHT Hypertension Program opened to all doctors in Sept 2009 with a standard EMR based referral system

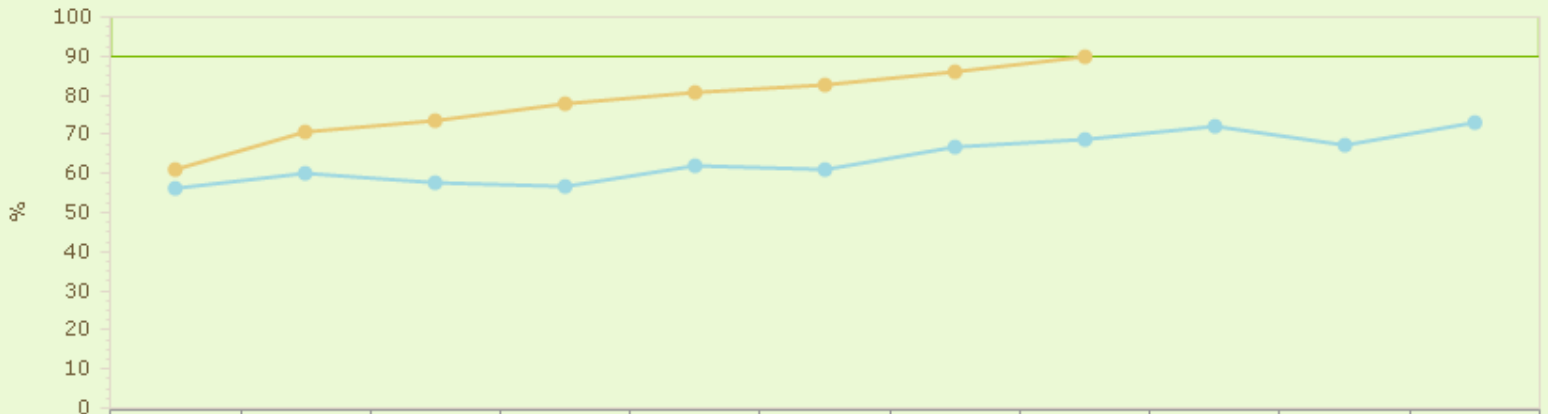
2010

- 24 hr BP monitor purchased and 1st pt assessed in July
- Signed on for QIIP Learning Community HTN program with new physician partner in Aug
- Presented original pilot data at International Hypertension Society's Scientific Mtg in Vancouver
- Hired second nurse (cardiac)

Benefits of QIIP Partnership

- Drop in BP clinics started for mass screening
- Learned to more effectively farm the EMR
- Standardized teaching materials (Heart and Stroke and Sodium 101)
- Database built

BP Screening Data from QIIP



	2010-09	2010-10	2010-11	2010-12	2011-01	2011-02	2011-03	2011-04	2011-05	2011-06	2011-07
Value	61	70.5	73.4	77.8	80.9	82.5	86.2	89.7	0	0	0
Action Group Aggregate	56.4	60.3	57.8	56.8	62.1	61.2	66.6	68.7	72.1	67.5	72.9

Challenges Experienced with QIIP

- Huge numbers - 340 HTN pts plus 1200 more to be screened (1 office RN and 1 FHT RN)
- EMR does not have database capability
- Extracting data can be tricky

The Great Hunt

- EMR search for HTN pts using Problem code '401' (essential NOS & benign essential HTN)
- Also search EMR for pts with systolic BP >140 and diastolic BP >100. Determine if need problem code added or appropriate for the 'Watch List'
- Problems with the hunt – slow and tedious, data entered by hand, and updated monthly: EMR search for all pts with BP checked in Drs office within the previous month with problem code 401

Dr. Weir-Hypertension Patient List

Date of Birth	DM?	Baseline BP	Baseline BP Date	Latest Dr Office BP	Latest Date of Dr BP	BP Drop-In Calls	Visit #	HTN Clinic Last BP	HTN Clinic Last BP Date	Notes
7/28/1941	IGT	110/62	Aug 24/11							
4/1/1964	no	134/80	April 5/11							
3/21/1957	no	124/70	Sept 20/10							
2/16/1944	IGT	140/92	April 21/11	122/70	Oct 6/11		2	129/78	July 7/11	
3/23/1957	no	118/78	June 16/11							
1/29/1938	CRF	132/74	July 11/11							
2/8/1960	no	130/86	Mar 28/11							
6/29/1932	no	138/94	Dec 16/09	136/72	Mar 2/11		1	166/83	Jan 25/11	
4/28/1953	IGT	132/80	Sept 19/11							
3/21/1933	no	130/70	July 21/11							
5/9/1958	no	142/80	Mar 8/11							
1/20/1937	yes	142/70	Sept 27/11							
6/30/1935	IGT	120/60	Sept 13/11							
4/20/1933	no	130/80	July 17/10							
10/4/1933	no	130/80	May 30/11							
4/17/1928	no	130/80	May 6/11							
5/5/1934	no	130/80	Dec 20/10							
5/10/1958	yes	130/74	July 29/11							
12/19/1923	yes	122/64	July 19/11							
12/19/1948	no	160/88	April 12/11	135/77	Oct 3/11		2	139/78	July 7/11	
7/17/1955	no	126/70	Feb 25/11							
6/28/1956	IGT	130/85	Oct 4/11							

2011

- Most doctors now referring and databases built for 11 of 12 doctors totalling almost 4000 pts
- Monthly BP drop in Clinics
- More comprehensive visit – CV risk for all pts including Framingham calculation and family hx of early heart disease, medical directives for blood work including lipids, BP TRUs,
- Congestive Heart Failure and Atrial Fibrillation added to the CV Program

Part of the Team

- Utilizing the benefits of all members of the SFHT – referrals are made as needed. Available programs are:
- NRT program/smoking cessation counselling
- Dietary education with our Dietitian for weight loss, lipids, DASH diet- both classes and one on one available

Now we have available:

- 24 hr BP monitor, several take home BP cuffs (large cuffs and wrist), 3 BP TRU monitors for clinic use
- These assist in the diagnosis and management of HTN
- Pedometers, gym passes, cookbooks

Means to the End- Goals

- The goal of the CV risk reduction program is to empower pts the strive to reduce their risk factors thru motivational interviewing and ongoing support in collaboration with a multidisciplinary team of Drs, nurses and dietician. It encompasses a holistic approach focusing on lifestyle modification and medication management that is individualized to each unique patient. Utilizing standards based upon Nursing Best Practice Guidelines.

Is it working?

- Reaching our pts
- Being available outside of bankers hours- evenings, and Sat mornings too
- Helping it all to make sense- Broken leg and the Garden hose analogies
- Providing support, encouragement, reinforcement and motivation
- It is a process, not an event. With setbacks and accomplishments to reach the goal of healthier lifestyles

What's Next ….

- Piloting new CV screening program – Birthday Letters
- Continuing to 'track down' and assist in the diagnosis and management of HTN and CV risk pts

Dear _____:

Happy Birthday!

We haven't seen you lately. We hope you are keeping well.

Birthdays are a chance to reflect on the past and plan for the future.

In order for you to have a long and healthy future we'd like to offer you some preventive health care.

We are offering a private health check with one of our nurses. She will update your health record and check your blood pressure. It is also an opportunity for you to discuss any questions or concerns regarding your health and well being.

We have enclosed a lab request form for you to have some screening blood work done. This needs to be a fasting test (please see instructions on top of form). Even if you do not come for an appointment, please do have the blood work done at your earliest convenience.

If this letter was sent to you in error and you have another family doctor, please call the office and let us know, and we will remove you from our list.

Healthy Regards,

Case Study #1: Mr R

- 60 yr old male with April 2008 BP 156/86 pulled from EMR for QIIP
- 1st visit Nov 2010: BP 167/101; Weight 113.3kg; Framingham calculated risk >30%; fasting Glu 5.9
- 8 visits in 12 months-diet classes, exercise, sodium reduction, medication management/changes with Dr
- Latest visit Sept 2011: BP 114/72; Weight 109kg; fasting Glu 5.0; Framingham calculated risk 11.2% (up a point d/t recent birthday)
- Pt continues to be receptive and is actively working to decrease his risks and be healthier

Case Study #2 – Mr O

- First seen June 2009- DM, wt 229lbs,AIC.08,BP 152/78, Chol 4.75, LDL 2.56, inactive and “self adjusting” meds
- Referred to dietitian, pharmacist and chiropodist, encouraged to walk (1 activity he felt he could do) and arranged new BP monitor through a pharma program
- Within 1 yr his wt had dropped 36lb, A1C .06, BP 128/73 Chol 3.8, LDL 1.77, regular home monitoring of BP and BGs, adherent to medication regimen

Special Thanks

- We would like to thank the team we work with…
- Our director is a visionary. He encourages and rewards us for trying the new and innovative
- Our physicians are supportive and willing to let us "give it a try"
- Our MOAs make 1000s of calls for us
- Our clinic RPNs – hunt down BPs for us from the EMR
- Our students

Contact us

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- (we'd love to share – that's how we got started too)