PATIENT VISITS	
Conducting initial patient visits	
Questions / Process	**Tips / Suggestions**
Before you start patient visits:	• Review roles and responsibilities with your team, as outlined in your Program Action Plan • Ensure all materials are set up and everyone knows where they are • Review the documentation setup (e.g. custom form, flowsheet, chart add-ins) as a visit progress guide and ensure your team is comfortable with how to complete it
First 1 – 2 patient visits:	• Try to book 1 – 2 patient visits for the first day after the team education and orientation session, so that you can immediately put into practice what you learned and what is in your Program Action Plan • Once you have completed a couple of patient visits, used the tools and worked out your process, you will be more confident and the visits will go more smoothly and quickly
Initial Visit Process: 1. Take BP, explain program	• Use of an automated office blood pressure (AOBP) monitor (e.g. a BpTRU) on all patients helps obtain accurate BP readings • The AOBP monitor should be set up next to a straight-back chair and small table, where the patient will sit and rest his / her arm • Follow the recommended technique for measuring BP with the AOBP monitor ○ Is the technique new for your team? Consider an in room prompt, such as a mouse pad insert to keep best practice information close at hand • If BP reading is high, or patient has a diagnosis of hypertension, explain the program, its purpose and benefits to the patient • Answer any patient questions about the program and how it will work (e.g. specific to your clinical environment) • Make a note of the final, average BP reading in the patient's records (e.g. chart, custom form, flowsheet, etc.)

2. Complete the visit process, follow the designated documentation method (e.g. custom form, flowsheet, etc.)	• "Flag" the patient's chart, if they are joining the program.
	  ○ If you are using an EMR, identify the program patients using agreed-upon key word(s) in an agreed-upon data field, flag or reminder
	  ○ If you are using paper charts, a chart sticker placed in a consistent, visible area on the outside of the chart folder can help highlight which patients are in the program for the team's convenience
	• As you go through the visit with the patient, follow the documentation method your team is using and fill in data required. This includes recording the patient's medical history, risk factors, physical measures and current medication information.
	• An essential part of the visit is discussing BP, HTN and the importance of lifestyle changes and how they can help a patient manage his / her hypertension

3. Use effective behaviour change and self-management support strategies	• Use the 5 A's (Assess, Advise, Agree, Assist and Arrange) and behaviour change tools and techniques, such as motivational interviewing within this visit to help your patient consider a lifestyle change and goal setting, according to his / her readiness to change
	• Educate the patient on their condition or potential condition (e.g. use the 'What is BP/Hypertension?' handout), risk factors, risk factors that can be changed and discuss options for self-management plans
	  • If the patient is ready to choose a healthier lifestyle focus, note which one and the current assessment. Provide a copy for the patient (e.g. use the lifestyle goal handouts like 'Sodium Reduction') so they too, have a record of their choice of goal and plan.
	  • Provide the patient with support in their self-management of this lifestyle change. Identify resources and refer to programs available within your healthcare team or community that are relevant / appropriate to the patient's selected healthier lifestyle focus
	• Various resources are also available with the Hypertension Management Program - Getting Started Toolkit for Primary Care, and you may have others

	• If the patient is not ready, simply note their stage of change and leave them to think about it. You can provide education on risk factors and point out how small changes can make a big difference to his / her BP **What is Motivational Interviewing (MI)?** • A collaborative, goal oriented method of communication which focuses on the resolution of ambivalence about changing behaviour • Described as "…a collaborative, person-centred form of guiding to elicit and strengthen motivation for change" • Differs from traditional directive approach, e.g. "*You need to lose 20 lbs.*" – healthcare providers work with clients to influence them to consider making changes • The examination and resolution of ambivalence is key to MI
4. Agree on and book a follow-up visit with patient before the patient leaves	• The frequency of follow-up visits should be determined by the level of the patient's BP control, consistent with Hypertension Canada recommendations, however medical judgement may indicate another timeframe • Discuss and agree to timing and meeting objectives for the next patient visit and ensure it is booked before he / she leaves the clinic / health centre • Note that follow-up visits generally can fit a regular 15 minute visit timeframe, assuming that the AOBP monitor is set to 1 minute intervals. Ideally, the BP cuff can be placed on the upper arm by a trained, non-clinical team member • A key part of patient support, and keeping your program organized, is setting the next follow-up patient appointment during every visit. If you and your team follow this plan, your patients with chronic conditions will always be well served. As part of your Program Action Plan, you may wish to assign team members to follow up on bookings with reminders to patients

Prepare for patient's next visit	
Questions / Process	**Tips / Suggestions**
Who will do what part of the visit?	• You and your team may want to review and / or revise roles and responsibilities as you plan how to handle follow-up visits. You may also want to involve various allied healthcare professionals to assist in helping patients with their needs. Update your Program Action Plan accordingly as you move into this phase of follow-up Consider: • Your existing internal process e.g. setting appointments and ensuring they are kept • Lifestyle change support for patients e.g. which resources or professionals do you use / call upon to help? • How can you use metrics, key performance indicators and other data to help you plan visits and programs to help patients?
How is the follow-up visit process different?	• There are elements that are not repeated, such as explaining the program. Patient visits can return to a more normal time length • The emphasis now is on supporting the patient in self-management of his / her high blood pressure, as well as managing the pharmacologic side of treatment where applicable

Follow Up Visits & Processes

- Each visit should begin with taking the patient's BP using the automated office blood pressure (AOBP) monitor.

  Assessing BP and diagnosing hypertension in patients with elevated BP readings is one aspect of follow-up.

  - Is the patient's BP controlled or not?
  - Are lab results from the previous visit available, do they indicate a change in treatment plan is needed?
  - Does the patient need to see the physician/NP to have medications reviewed? Or do you need to discuss medication adherence tips?
- Document BP, risk factor assessments, goals and progress in every visit. Even short visits where the goal is monitoring only BP after medication or other treatment has been altered should include documentation to ensure that your reports (data, KPI, searches, etc.) and patient chart contains the most recent information.
- A portion of the visit process and discussion depends on where the patient is in their stage and process of self-management. Always use behaviour change tools and techniques, such as motivational interviewing with patients in order to elicit "change talk"

Determine:

- Has the patient chosen a lifestyle goal? If so, then the visit can assess success, issues or next steps he / she may have in their action plan. You might suggest referral to an allied health professional, such as a dietitian, mental health worker, pharmacist, etc.
- If the patient has not yet chosen a lifestyle goal, then probing, to determine if the patient has progressed in their stage of change relative to choosing a goal, can be explored using motivational interviewing
- You may wish to consider group visits for patients. Some patients find it helpful to hear how others are successfully managing and achieving BP control. Consider grouping people with the same lifestyle goals who might benefit from such a session. These sessions can include brief presentations by allied health professionals; e.g. cooking with less fat, replacing salt in the diet, indoor physical activities for the winter months, etc.

Follow up on patient "no-shows"	
Questions / Process	**Tips / Suggestions**
How do I increase the likelihood of patients attending their scheduled hypertension appointments?	• When patients do not show up for their appointments, call and follow up to determine the reason for the "no-show" • Whenever possible, rebook the appointment • Discuss with the team the common reasons encountered for no-shows and determine solutions, either for group issues or individual ones. For instance, one way to avoid no-shows amongst "snowbird" patients in winter is to be sure to schedule them for a visit before they leave and another when they return. Be sure to discuss how they will carry on their lifestyle change efforts while away • It is important to help patients understand the importance of hypertension and how you will work with them to help them achieve their goal of BP control for a healthier life