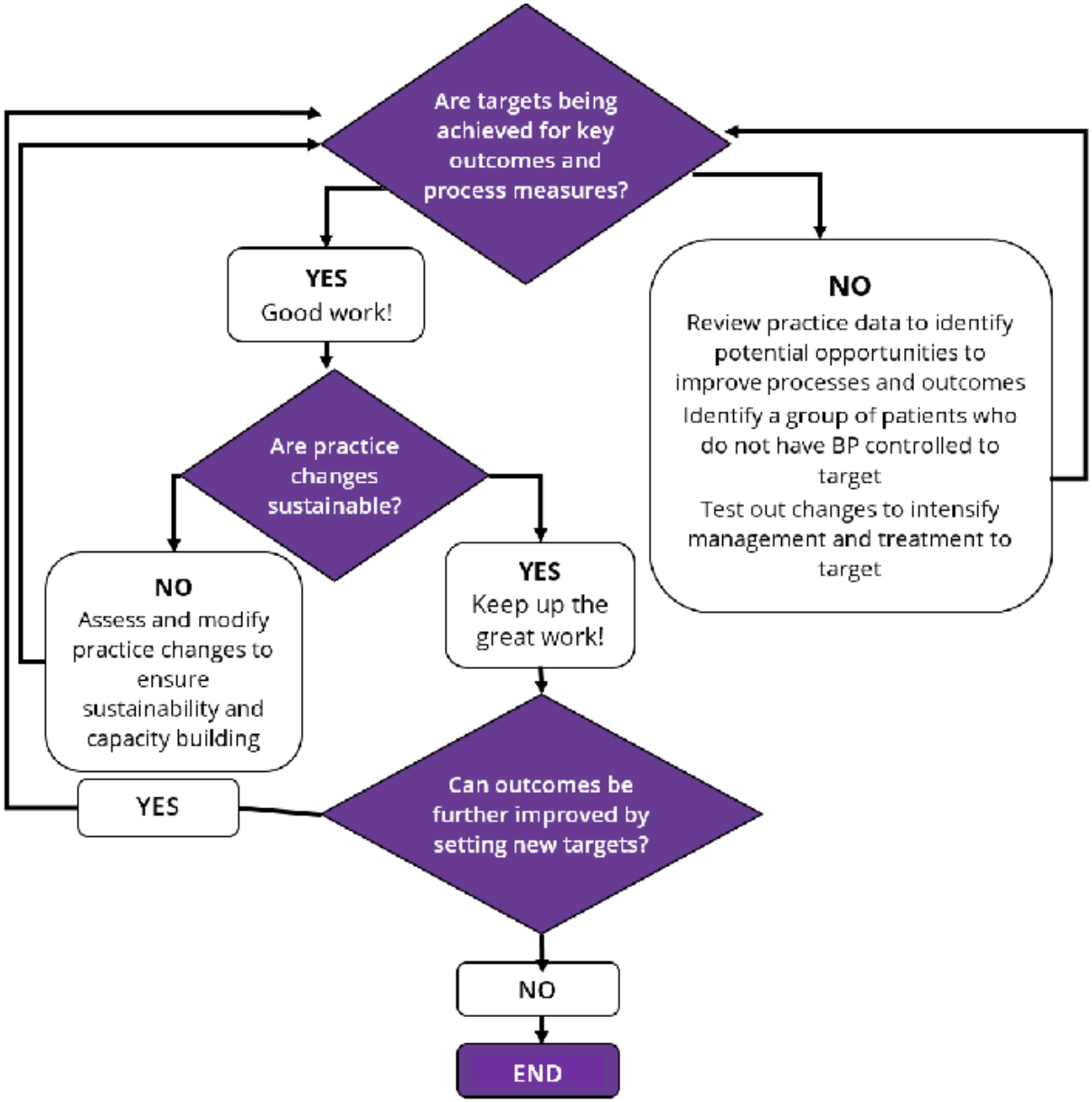
HYPERTENSION MANAGEMENT PROGRAM
Quality Improvement & Sustaining the Program
Helpful Tips & Suggestions

Using reports to improve process and outcomes (Quality Improvement)	
Questions / Process	**Tips / Suggestions**
What data do you have?	• Identify the data you have available. You can use the Hypertension Management Program Key Performance Indicators (KPI, these cover population metrics, clinical process and clinical outcomes measurements) as a guide to build a robust reporting criteria that will aid in measuring both population, clinical performance/clinical processes as well as patient outcomes. ○ You can use Patient Management KPI criteria to report and take action to close gaps, such as addressing patients with overdue visits. • These data show who your program patients are (population), how your team is doing with the meeting best practice guidelines (e.g. volume of patients with a BP recorded in the past 6 months), and how your patients are doing against best practice targets (e.g. volume of patients whose BP is within target). • Are you tracking patient experience feedback? What are patients' concerns or success stories and how can they motivate advancements in the program? • What are the staff involved saying? Is it time to refresh training on BP technique or motivational interviewing? Are more staff interested in playing a role in the program, or taking lessons from this program to enhance another program in the organization?
How can data help us manage our patients with hypertension or elevated BP?	• Gather the team together on a regular (i.e. monthly) basis to review and discuss the data and what they indicate about the progress being made with the patient group • What you see may help you to decide as a team where you wish to concentrate your efforts over the next period. Example: patients not seen in the past 6 months, patients with uncontrolled hypertension or diabetic patients who have not had an HbA1C in the past 6 months, etc. • You can also get an impression of how your site is doing on improving patient outcomes

How do we use this information to improve our practice and help our patients?	• Review results, then set a timeline, targets and team roles, based on your choice of focus, so you can measure your team progress.
	• For example:
	  ○ you may choose to reduce the volume of patients who have not been seen in >6 months by 20% over the next 3 months. As a team, determine the steps needed to achieve this such as adding reminder calls before appointments by a student to combat no shows.
	  ○ You may choose to introduce additional elements now that the program visits are running well, such as adding weight, waist and height measurements so you have the elements to detect 'waist' as an independent CV risk factor and BMI to help elicit change talk with patients
	  ○ You may choose to add a Medical Directive to empower the nursing team to address medication changes for non-complex patients
	• Document these in a Program Action Plan so you can review it later and track your progress
	• Meet at regular intervals to review progress with data and to update your Program Action Plan

How can the Population KPI information help us?	• On a less frequent basis, you and your team may wish to review the Population KPI criteria/data. On a higher level, it indicates some key health indicators for the patients in your hypertension program that may help you and your team decide on areas of focus, or where allied health professionals can help your patients, or why some conditions exist. Examples: if your practice has a high proportion of smokers, you may want to consider setting up a program for them, or if your practice has a high proportion of patients with stress as a risk factor, this could be a factor in collaborating with a community program targeting stress reduction. • If you view data early during program enrollment of your patients, it can also help you check your overall enrollment, and percentage of patients being monitored or screened for hypertension (e.g. Percentage of patients with Elevated BP as their diagnosis).

Assess / Evaluate program implementation, successes and challenges and identify opportunities to sustain and expand the program	
Questions / Process	**Tips / Suggestions**
How do we assess / evaluate the program implementation?	• As you review the data and process with your team on an ongoing basis, identify and address any issues that may affect longer term sustainability of the program, e.g. what to do to ensure that if a team member is sick, or leaves, that the program can carry on uninterrupted • Be sure to also get together to celebrate the program successes, e.g. patients enrolled, patients with BP controlled, etc. Sharing success stories among staff AND (without names) with patients can help keep everyone motivated • Identify opportunities to improve your process, add more patients, expand to other communities, etc. • Use the Program Action Plan to document your goals and plans with timing and resourcing as necessary
How do we ensure and plan for sustainability?	Necessary elements include: • Active, ongoing participation / engagement of the clinical champion / lead, such as regularly scheduled meetings and data reviews • Front line staff involved in the program implementation and in determining and testing any changes to evolve and enhance the program • Capacity-building and ensuring the necessary resources and infrastructure to sustain the program, such as space to perform visits, equipment like AOBP units, ABPM access/interpretation access, and patient loaner BP units, building reporting of data using key performance indicators or other queries to support program reviews • Training of all involved staff and a succession plan in place to deal with staff departures and the training / orientation of new staff



CONTINUOUS QUALITY IMPROVEMENT DIAGRAM

You can't manage what you can't measure! Measurement is a critical part of implementing change in your practice. Measures, driven by evidence-based guidelines, tell a team whether the changes they have implemented have actually led to improvement. Teams are encouraged to work with the data available to problem solve and target improvements so that they ultimately improve healthcare delivery and health outcomes for their patients.