Objectives - Focused on Modifiable Risk Factors

The objectives of the DNP project were to assist patients with self-management support in modified risk factors with the intent of improving cardiovascular outcomes. Specifically:

1. Provide patients who have hypertension with a written self-management plan at the end of each office visit and encourage goal setting.

2. Encourage or provide patient support groups.

3. Use all staff interactions with patients as opportunities to assist in self-management setting and practices.

4. Print visit summaries and follow-up guidance for patients.

METHODS: QUALITY IMPROVEMENT USING EVIDENCE BASED GUIDELINES

JNC 7 & Hypertension Guidelines

1. All patients with a diagnosis of HTN or an elevated BP reading at their office visit were offered interventions included patient education and lifestyle goal setting.

2. Patients were offered options to improve their cardiovascular outcomes.

3. A written self-monitoring plan was developed.

4. Follow up with patients at each visit.

JNC 8 - Lifestyle Guidelines

1. Screen all patients with a diagnosis of HTN or elevated BP for additional risk factors.

2. Refer patients to community resources and support groups.

3. Provide resources for evidence-based strategies to improve cardiovascular outcomes.

QI Implementation... Collaborative Team-work Staff Interventions

Correct Blood Pressure Measurement

The secondary objective, improvement in controlled BP (BP < 140/90), did not occur. Contrasted was achieved in those with elevated BP (140/90). A limitation of this QI study was the short length (six months) of observation time.

RESULTS

Objectives of 6 month QI Initiative

September through March

1. To have 65% or more patients actively engaging in weight loss goals in collaborative practice settings following CDC guidelines for weight loss (N = 1409).

2. To have 65% or more patients actively engaging in increased physical activity goals in collaborative practice settings following CDC guidelines for increased physical activity (N = 1409).

3. To have 65% or more patients actively engaging in tobacco cessation goals in collaborative practice settings following CDC guidelines for tobacco cessation (N = 1409).

4. To have 65% or more patients actively engaging in alcohol consumption goals in collaborative practice settings following CDC guidelines for alcohol consumption (N = 1409).

5. To have 65% or more patients actively engaging in stress reduction goals in collaborative practice settings following CDC guidelines for stress reduction (N = 1409).

6. To have 65% or more patients actively engaging in medication adherence goals in collaborative practice settings following CDC guidelines for medication adherence (N = 1409).

7. To have 65% or more patients actively engaging in cholesterol management goals in collaborative practice settings following CDC guidelines for cholesterol management (N = 1409).

CONCLUSIONS

1. Self-management Goal Setting: 80% was achieved and improved significantly from baseline.

2. With short 6-month intervention – significant improvement in controlled BP (< 140/90) was not achieved in the patient population with dox of HTN (< 140/90).

3. In this population there were high rates of tobacco use (30%) with 60% asked to quit. Also high rates of obesity (65%) for the patients with a BMI of 30.

Data Collected after IRB Approval:

Prevent 6 months QI intervention "Dox of essential HTN (401)

18 - 75 years old and not pregnant

- Data included a retrospective baseline of meaningful use population data (N = 1410) generated six months prior to the QI study start date and an analysis of the data during the six-month QI study (N = 1450).

- Self-management Goals set (yes, no, not documented)

- Systolic And Diastolic Blood Pressure

- Body Mass Index

- Weight Loss

- Physical Activity

- Tobacco Use

- Alcohol Consumption

Implications for Practice

Healthcare professionals can use the current guidelines for HTN and make sure to follow the AHA recommendations for medication adherence and lifestyle intervention.