Title:
Starting the Conversation on Hypertension Self-Management in Primary Care to Improve Cardiovascular Outcomes

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Session Title:
Evidence-Based Practice Poster Session 2

Slot (superslotted):
EBP PST 2: Saturday, 29 July 2017: 12:00 PM-1:30 PM
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Keywords:
Hypertension Self-Management, Primary care - blood pressure and Quality Improvement for Cardiovascular Risk Reduction

References:


Abstract Summary:
A nurse-led quality improvement project was designed to improve the clinical performance of hypertension management with a focus on self-management support for adult patients at a primary care clinic in rural North Carolina. Greater than 80% of the patients set self-management goals for risk reduction of cardiovascular disease.

Learning Activity:

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<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
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<td>1. Describe the present prevalence of the leading cardiovascular disease risk factors in the USA, the Million Hearts target goals and the clinical quality measure used for blood pressure control.</td>
<td>The learner will be able to - 1. describe the prevalence of CVD in terms of demographics and risk factors and goals of Million Hearts in the Clinical Quality Measures to reduce the burden of CVD. Example: Hypertension (HTN): Controlling High Blood Pressure – Clinical Measurement Percentage of patients aged 18 through 85 years who had a diagnosis of HTN and whose blood pressure was adequately controlled (&lt;140/90) during the measurement year.</td>
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<td>The learner will be able to - 2. critique strategies use in this QI project focused on supporting patients in self-management and medication adherence to improve blood pressure control and reduce the burden of CVD.</td>
<td>Strategies included • provider and staff quality improvement training for the use of supporting patients in SMS goal setting, the use of team based care and evidence based guidelines around HTN. • patient education and healthy lifestyle goal setting for self-management support (SMS) of HTN and CVD risk reduction. • the use of electronic health information and technology to monitor goal setting and clinical quality measures.</td>
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Abstract Text:

Background

Cardiovascular disease (CVD) – heart disease and strokes - caused one in three deaths in the USA in 2014 and The American Heart Association (AHA) projects that by 2030, 40.5% of the U.S. population will have some form of CVD, with an estimated cost to the national health care system of $1 trillion per year.
Hypertension (HTN) is the single most independent and modifiable risk factor for cardiovascular disease (CVD), stroke, congestive heart failure, and chronic renal disease (CRD) (Chobanian et al., 2003). The Million Hearts campaign set a clinical quality measure for blood pressure control goal at 70% in the clinical population with a diagnosis of hypertension; the measurement was defined as the “percentage of patients 18 to 85 years of age with a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year”. In the Southeast Region of the United States, it is currently reported by the Department of Health and Human Services (2016) that only 53% of the of the population has achieved the clinical control blood pressure (BP < 140/90) - a large gap from the 70% goal (http://millionhearts.hhs.gov/data-reports/cqm.html, 2016).

The Centers for Disease Control and Prevention (CDC, 2013) Hypertension Control: Action Steps for Clinicians recommends to:

• Provide patients who have hypertension with a written self-management plan at the end of each office visit.
• Encourage or provide patient support groups.
• Use all staff interactions with patients as opportunities to assist in self-management goal-setting and practices.
• Print visit summaries and follow-up guidance for patients.

Purpose:

The aim of this nurse led quality improvement (QI) project was to improve the clinical performance in the management of hypertension (HTN) with a focus on self-management support (SMS) among adult patients (18-75 years) at a rural primary care clinic with an exceptionally high rate of cardiovascular disease. The six-month QI initiative was designed with a goal to have 80% or more of the adult patients with a diagnosis of HTN actively setting goals in collaboration with their providers for CVD risk reduction.

Data Sources and Implementation:

The study design was a six month long quality improvement study. Data included a retrospective baseline of meaningful use population data (N = 1210) generated six months prior to the QI study start date and an analysis of the data during the six-month QI study (N = 1409). Interventions included provider and staff quality improvement training along with patient education and lifestyle goal setting for self-management support (SMS) of HTN. All adult patients with a diagnosis of HTN or an elevated BP reading at their office visit were offered the brochures Starting the Conversation on Blood Pressure by the NC Prevention Partners(2011) and Start with Your Heart Prescription for Better Healthfrom the NC Department of Health and Human Services(2011) in English and Spanish. Questions were answered on hypertension and risk reduction by all health care providers throughout the office visit. Specific, Measurable, Attainable, Realistic and Time specific (SMART) goal setting and action plans were encouraged and a written self-management plan was given at the end of each office visit. Electronic medical record data was used to compile population statistics for blood pressure (BP), LDL cholesterol, tobacco use, body mass index, and self-management goals monthly throughout the QI study. Pre and post results of the QI six month period were compared.
Results
The primary objective, > 80% of adults aged 18 to 75 years would have documented self-management goals, was achieved and significantly improved from baseline. SMART goals discussed included following the recommendations for the Dietary Approaches to Stop Hypertension (DASH) diet, aerobic physical activity, weight loss for healthy body mass index, tobacco cessation, moderate alcohol consumption, stress reduction, medication adherence, home BP monitoring, and, as applicable, blood sugar control. A secondary objective was to see significant improvement in controlled HTN (BP < 140/90) for this population, but this did not occur. A limitation of this QI study was the short length (six months) of observation time.

Implications for Practice:
The goal of this QI project to help patients in self-management support for modifiable risk reduction of HTN was achieved to help reduce the burden of CVD in this population. Nurses can have a vital role in meeting the current demand for HTN management in primary care, to support patients in their self-management. Working with patients to achieve healthy lifestyle CVD risk reductions and medication management could help reduce the burden of CVD at a population level.