

## Success Story Example

### **Story Title:**

Chart Your Start; To a Healthy Heart

### **Problem/Issue Overview:**

Hypertension (HTN) among Wisconsin residents is a major health concern for adults of all ages. The Stoughton Community Clinic (SCC) has made improving blood pressure (BP) control a quality improvement (QI) focus. Recent outcomes for the clinic show that our team has improved patient engagement for making clinic appointments. As a team we began including patient education in the proper technique to taking accurate self-measured BP readings regularly with a measurement device at home. Initially team members had difficulty identifying effective approaches to discussing BP medication regimen and adherence with patients. We found our team needed additional skills to be more effective in patient education and counseling that focused on lifestyle changes with patients. Our patients gave feedback in interviews that they left the clinic with too much information and did not completely understand HTN and its implications. They did not feel supported to make successful lifestyle changes. By using QI processes (PDSA) we were able to implement a HTN control change package across all systems in our clinic. Our success story is titled after the name of our program “Chart Your Start; To a Healthy Heart!” Within 6-9 months our clinic found a substantial number of patients had improvements in their BP control and more than half (52.3%) had controlled BP.

### **Activity/Strategy/Intervention:**

Our aim was to equip direct care staff to facilitate patient self-management for heart health. Our team-based care clinic trains staff to work well together. We selected the Million Hearts *HTN Control Change Package for Clinicians* and the *WCHQ HTN toolkit* to move us forward. These resources offered implementation tools. The team was trained in QI processes and incorporated Plan, Do, Study, Act (PDSA) cycles in our BP improvement efforts. We completed a QI process form. Through PDSA cycles, the team developed a flowchart for working with hypertensive patients and proactively tracked and managed them by using a registry. Dr. Worthington became our HTN “Champion” making HTN control a practice priority! Through his leadership, the clinic implemented policies and processes to address BP for every patient at every visit. The PDSA cycles also established a patient self-management process for all staff to engage patients and families. Staff completed training in how to take accurate BP measurement and educate patients to take their own BP readings. Within nine months our clinic found a substantial number of patients had improvements in their BP control and more than half (52.3%) had controlled BP.

### **Success/Solution:**

A flow chart for managing patients with HTN was developed and posted in multiple places in the clinic for all staff to reference. We placed patient education posters in exam rooms and waiting areas that explained, in plain language, ways to control BP and the importance of knowing BP numbers and what they mean for a person's health. Staff were trained in motivational interviewing and the teach-back method. These skills gave us ways to guide discussions to help patients create their own plans for making changes. Working together, patients are now able to develop their own self-management plans to use at home. We go over a “Planning Worksheet.” These self-managed plans become a *Charted Map* that guides patients in learning new behaviors (changes), such as starting an exercise program to increase their physical activity. Clinic teams divide up HTN patients. Each team member makes a

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weekly check-in to support patients and determine how well they are doing with their action plans. Finally, our clinic offers times for drop-in BP checks and partners with the fire and public health departments and a senior center to offer times for patients and community members to drop in and get their BP taken. Patients access our clinic website or use AHA Heart 360 to record their BP readings. Our approaches are proving to be successful. Several patients showed remarkable and improved control with their high BP. As one patient, Martha, stated, “I feel so much healthier. I take my medications as prescribed because I now understand how essential they are to my health. I walk five days a week for 30 minutes and I have lost 10 lbs.” Attached is a photo and brief patient story.

#### **Challenges/Barriers:**

There were a few challenges for the clinic and the staff: 1) It was difficult to find enough time for patient education. We had to divide education topics among staff to enable us to cover areas with the patient and family; 2) Follow-up became critical and was completed by the team (pharmacists and parish nurses were very helpful); 3) Some patients were very difficult to reach and the team incorporated texting and emails in addition to calling; 4) BP cuffs are not covered by insurance; and 5) We had to keep patients motivated to continue efforts with lifestyle changes. Often patients start out being active and then slip back into old habits or routines.

#### **Conclusion/Summary:**

Our clinic is energized by the reduction made in BP in a relatively short time. Working as an effective and results-oriented team there have been stressful times, however in the long term we have been successful in reducing and controlling HTN.