Hypertension: Improving Patient Care

Practice Assessment

METRIC — Measuring, Evaluating, and Translating Research Into Care

Organization of Our Practice: *Planned care is more effective if the office practice in which care is provided has clearly defined strategies and protocols.*

1. The way we seek to improve hypertension care in our practice *(select one):*
   - ❍ is not well organized and we are unable to consistently give patients the time, effort and resources that are needed.
   - ❍ focuses on problems as they emerge or as they become an emphasis of insurers, state efforts or other outside influences.
   - ❍ involves the use of protocols and practice tools.
   - ❍ includes an overall improvement strategy and we use it proactively to meet our practice goals.

Community Linkages: *Linkages between your practice and community resources play important roles in managing your patients' care.*

2. In our practice, partnerships with community organizations focusing on hypertension *(select one):*
   - ❍ do not exist.
   - ❍ are being considered but have not yet been implemented.
   - ❍ are formed to develop supportive programs and policies.
   - ❍ are actively sought to develop formal supportive programs and policies across the entire system.

Self-management Support: *Effective self-management support can help patients and families learn to manage blood pressure on a daily basis. It can improve patients' overall sense of health and well-being.*

3. In our practice, self-management support for patients who have hypertension *(select one):*
   - ❍ involves distribution of information (pamphlets, booklets).
   - ❍ includes referral to self-management classes or educators.
   - ❍ is provided by personnel in our practice who are designated to do self-management support.
   - ❍ is provided by trained personnel in our practice, who are trained in self-management skills, and who see most of our patients who have hypertension.

4. In our practice *(select one):*
   - ❍ we do not consistently address self-management concerns of patients who have hypertension, their families or caregivers.
   - ❍ we address self-management concerns of only the specific patients who seem to need it.
   - ❍ addressing self-management issues is part of the philosophy of the practice and is a part of each patient's visit.
   - ❍ we offer peer support groups in the practice or by referral to well-established programs.
   - ❍ we systematically assess patients' self-management needs and we use peer support groups routinely.

5. In our practice, support for behavior change interventions *(select one):*
   - ❍ is not available.
   - ❍ is limited to the distribution of pamphlets, booklets or other written information.
   - ❍ is available by referral to others who are skilled in this area.
   - ❍ is available from the physicians and staff of our practice, who use proven techniques to affect behavior change.
   - ❍ is available from the physicians and staff, who are trained in behavior change techniques and use these skills as an integral part of routine care.

Decision Support: *Effective planned care programs assure that physicians have access to evidence-based information necessary to care for patients and to assist them in decision making. This might include evidence-based practice guidelines or protocols and other information sources that are readily available at the point of care.*

6. In our practice, evidence-based guidelines *(select one):*
   - ❍ are not available at the time of patient visits.
   - ❍ are available in our practice, but not easy to access rapidly.
   - ❍ are available and integrated into our charting system (e.g. flow sheets with embedded guidelines, PDAs).
   - ❍ are available, supported by physician education and integrated into care through reminders and other proven behavior change methods.

7. Our practice follows the following protocol regarding informing patients about guidelines *(select one):*
   - ❍ we do not regularly inform patients about guidelines.
   - ❍ we give patients guideline handouts if they ask for them.
   - ❍ we routinely give patients a copy of guidelines pertinent to their care.
   - ❍ we routinely give patients guidelines with personalized targets and recommendations for how to achieve the targets.

Delivery System Design: *Effective planned care usually requires changes in the way offices provide care for patients — that is, changes in your office systems, your way of doing daily business. Teamwork and follow-up are two important elements of effective planned care.*

8. In our practice *(select one):*
   - ❍ I have to do almost everything if I want to be sure our patients who have hypertension receive the care they need.
   - ❍ although we don't talk about "teams," I do have competent staff to assist me in providing excellent care for our patients who have hypertension.
   - ❍ we have regular staff meetings in which we discuss specific isses to improve care of our patients who have hypertension.
   - ❍ we have a finely tuned "team" in which everyone understands his or her role in caring for patients who have hypertension.

continued

9. In our practice, patient follow-up *(select one):*
   - ❍ is scheduled by the patient or the practice as needed.
   - ❍ is scheduled by the practice in accordance with guidelines.
   - ❍ is ensured by always scheduling a return visit and contacting patients if they do not show.
   - ❍ is customized to patient needs, and we are proactive in calling and/or e-mailing patients to check up on them between visits.

10. In our practice, planned visits for patients who have hypertension *(select one):*
    - ❍ are not used.
    - ❍ are used if patients are not doing well or need medication refills.
    - ❍ are implemented for certain patients. Reminder cards are used but there is no long-term planning for regular visits. Checklists and flow sheets are used, as well as other tools to assure key elements of care are provided.
    - ❍ are used for all patients and include regular assessment, preventive interventions and attention to self-management support.
    - ❍ are used systematically to optimize patient follow-up; in addition, missed elements of planned care are easily spotted through an alert system.

11. In our practice, coordination of care between our office and subspecialists *(select one):*
    - ❍ is not done well.
    - ❍ is done reasonably well, but depends mostly on written communication between our office and subspecialists, case managers or disease management companies.
    - ❍ is done quite well, with adequate oral and written communication between our office and subspecialists and other relevant providers.
    - ❍ is a high priority and includes active coordination between our office, subspecialists and other relevant groups.

Clinical Information Systems: *Timely, useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective programs, especially those that employ population-based approaches.*

12. In our practice, a registry of patients who have hypertension *(select one):*
    - ❍ is not available.
    - ❍ is used to maintain patient information such as name, diagnosis, contact information and date of last contact, either on paper or in a computer database.
    - ❍ is used to identify patients regarding specific clinical information (for example, data collection for measuring/ tracking or identifying patients for planned visits or group visits).
    - ❍ is tied to guidelines and provides prompts and reminders about needed services (for example, lab and other testing) and/or is an integral function of our electronic health record.

13. Reminders to physicians and other team members *(select one):*
    - ❍ are not available.
    - ❍ include general reminders about patients who have hypertension based on birth date, but do not describe needed services at time of encounter.
    - ❍ include indications of needed services for populations of patients trhough periodic reporting.
    - ❍ include specific information for the team about guideline adherence at the time of individual patient encounters.

14. In our practice, performance feedback regarding care of patients who have hypertension *(select one):*
    - ❍ is not available.
    - ❍ is provided to the physicians at infrequent intervals and/or about a limited number of patients.
    - ❍ occurs at frequent enough intervals to monitor performance, and is specific to each physician.
    - ❍ is timely, specific to each physician, and we routinely review the reports and strive to remedy any deficiencies as rapidly as possible.

15. Specific treatment targets and goals *(select one):*
    - ❍ are not ususally part of the chart.
    - ❍ are noted in each patient's chart.
    - ❍ are established collaboratively and include self-management as well as clinical goals.
    - ❍ are established colloabroatively and included self-management as well as clinical goals. Individual treatment goals and targets are discussed and adjusted frequently, with input from patients.

Copyright © 2009 American Academy of Family Physicians