

Improving Patient and Provider Engagement in Hypertension Control

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Abstract

Hypertension is the second leading cause of death and costs the United States over \$130 billion annually. The Centers for Medicare and Medicaid promote control through the star rating system and primary care reimbursement. The project site's hypertension control rate for Medicare patients was 70%, with a goal of 85% or more, and the follow-up rate was only 30%. A need was identified to improve follow-up in Medicare patients with uncontrolled hypertension.

The project implementation included strategies to increase follow-up frequency, decreasing the number of prescribers and implementing a standardized protocol hypertension follow-up. The current approach includes increasing follow-up frequency, decreasing the number of prescribers, and implementing standardized protocols. In a 15-week implementation period, 238 Medicare patients' charts were reviewed. Overall, the control rate improved from 70% to 95%. The follow-up rate improved to 75% of patients with a scheduled follow-up visit. Implementation of a standardized protocol in follow-up improved hypertension control among Medicare patients. Recommendations are to expand the project to other hypertensive patients in primary care. Increasing continuity, implementing hypertension follow-up protocol, and reinforcing to the providers to schedule a follow-up appointment were effective at improving hypertension control.

Keywords: Adults, Medicare, Primary Care, rural, uncontrolled hypertension, improvement strategies, follow-up

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Section I. Introduction

Background

North Carolina's second leading cause of death is cardiovascular disease, with over 500 thousand associated deaths annually (Centers for Disease Control and Prevention [CDC], 2021). One in every two adults has a hypertension diagnosis, with 75% of those classified as uncontrolled hypertension (CDC, 2021). The United States spends over \$130 billion annually on hypertension and over two thousand dollars more per person than those without hypertension (CDC, 2021).

Uncontrolled hypertension increases the risk for heart disease, renal failure, myocardial infarctions, cerebral vascular accidents, and sexual dysfunction (Kirkland et al., 2018). Therefore, the best treatment is prevention by hypertension control. The recommended intervention for hypertension control includes continued follow-up until a medication regimen appropriately controls blood pressure (Kirkland et al., 2018).

The project partner is a family physician who owns and runs a family practice in rural North Carolina. The practice's mission is to provide medical excellence to all people, assisting them in achieving their health goals ([REDACTED], 2021). The goals for the project site include practicing excellent, safe, and compassionate care ([REDACTED], 2021).

Organizational Needs Statement

The site champion identified the primary issue at the practice as uncontrolled hypertension in their Medicare population ([REDACTED], personal communication, June 30, 2021). The uncontrolled rate of hypertension affects the star rating of the practice from Medicare, which is a quality measure (Centers for Medicare and Medicaid Services [CMS], 2019a). The star rating from CMS allows the consumers to see if the physicians are meeting the benchmarks and

rate their performance based on them (CMS, 2017). The better the chronic conditions are controlled, the better the star rating of the practice. Medicare requires the practice to be under 80% controlled. Various Accountable Care Organizations evaluate the practices and provide recommendations to meet these requirements. The rationale for this project relates to the practice's star rating. The office is a privately owned, for-profit facility caring for a large percentage of Medicare patients. The practice sees approximately 22,000 patients annually, with 19,000 covered by Medicare or Medicaid (██████████, personal communication, October 13, 2021). The practice currently has a 70% hypertension control rate (██████████, personal communication, June 30, 2021).

Furthermore, the Centers for Medicare and Medicaid Services (CMS) requires an annual screening for hypertension with a scheduled follow-up (CMS, 2019b). Unfortunately, 30% of those with uncontrolled hypertension do not have a scheduled follow-up appointment (██████████, personal communication, June 23, 2021). Thus, the project site champion relayed the need to improve hypertension control and improve the scheduled follow-up visits for patients with uncontrolled hypertension and Fee for Service (FFS) Medicare.

The challenge with uncontrolled hypertension for the practice is the adverse effect on the star rating by Medicare. The star rating affects how the practice is recommended to the community by Medicare and affects the office's reimbursement. For example, if the control rate of the patients with hypertension falls below 80%, the rating is negatively affected. This process is managed by two Accountable Care Organizations (ACO), Aledade and Duke (██████████, personal communication, October 13, 2021).

The CMS and ACOs defined controlled hypertension as a systolic blood pressure less than 140 mmHg and diastolic less than 90 mmHg (CMS, 2019a; Aledade, 2017). The CMS and

ACO's purpose for controlling hypertension is to decrease the cost associated with uncontrolled hypertension sequela and hospitalizations. These sequelae increase community expenditure and debility (CMS, 2019b; Aledade, 2017). Therefore, the definition of controlled hypertension for the project will be based on CMS's definition of systolic blood pressure of less than 140 mmHg and diastolic blood pressure of 90 mmHg.

The benchmarks are determined by local, state, and national organizations. Quality Improvement Committee at the privately-owned practice established the benchmark for controlled hypertension at greater than 85% ([REDACTED] personal communication, June 30, 2021). The Duke and Aledade ACOs set the benchmark at 80% of the patient population with controlled hypertension (CMS, 2019a, Aledade, 2017). Finally, Healthy People 2030 set the benchmark for controlled hypertension at greater than 60%, with the United States' average rate at 45% (Healthy People 2030, 2020).

In the Institute for Health Care Improvement (IHI) (2021), Triple and Quadruple Aim's goals contain healthcare improvement methods. The IHI's focus encompasses creating a better patient experience, a better provider experience, creating a healthier population, and decreasing the burden of healthcare costs (Bachynsky, 2019; Whittington et al., 2015). For example, improving hypertension prevents sequelae, enhances patient and provider experiences, and increases the population's health, ultimately decreasing healthcare costs. Improving hypertension control will meet the IHIs and Healthy People 2030 objectives and improve the star rating for the project site (Bachynsky, 2019; Whittington et al., 2015).

Problem Statement

The project site's hypertension control rate for Medicare patients is 70% and does not meet the site's benchmark of greater than 85% ([REDACTED], personal communication, June 30,

2021). Among the patients with uncontrolled hypertension, the follow-up rate is low at 30%. As a result, uncontrolled hypertension leads to other chronic health conditions for the Medicare population and affects the star rating of the practice.

Purpose Statement

The quality improvement project aims to educate providers to improve hypertension control through provider education on hypertension guidelines, prompts for follow-up appointments, and improving continuity of care. The project aims at implementing a standardized hypertension guideline to improve the rate of uncontrolled hypertension and the number of no follow-up visit schedules in Medicare patients. The goal is to improve hypertension control for 85% or more of Medicare patients treated in a rural primary care office. In addition, improving follow-up will improve the patient outcomes and the star rating at the project site.

Section II. Evidence

Literature Review

Hypertension is the underlying cause of heart disease and the second leading cause of death in North Carolina (Macon, 2018). The topic of hypertension is a vast topic with an abundant amount of information and research. With the development of keywords, the search narrows to relevant articles. The PICOT format was used to develop the keywords and stands for patients (or population and problem), interventions, comparison, outcome, and time (East Carolina University Libraries, 2021). For the project, keywords included adults, older adults, Medicare, primary care, doctor's office, family practice, rural, underserved, uncontrolled hypertension, high blood pressure, hypertension, and elevated blood pressure. In addition, the concept words were identified for review in the literature database. The databases accessed included ProQuest, PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Google Scholar.

For this project, the Pyramid Model Hierarchy of Evidence was used to evaluate the articles and accepted levels of evidence from Levels I-V, including systematic reviews, critically appraised topics, critically appraised articles, randomized controlled trials, and cohort studies (East Carolina University Libraries, 2021). The inclusion criteria consist of full text in English, dating from 2017 to current, and topics related to hypertension control or management. The exclusion criteria included dates before 2017, unrelated to hypertension in primary care, inpatient management, and not applicable in the practice setting. The total number of articles from the search was 274. After getting these results, the abstracts were reviewed for content. This process eliminated 220 additional documents, leaving 54 articles for review. Finally, the remaining articles were printed, and the full-text documents were read in their entirety. During this phase,

28 documents were excluded leaving the final number of articles at 26. They consisted of nine from ProQuest, four from PubMed, five from CINAHL, and eight from Google Scholar.

In reviewing the levels of evidence, of the 26 documents, eleven were level IV, ten were level V, two were level III, and the remaining three were level II, VI, and VII. Unfortunately, no articles were considered level I. Interestingly, six articles resulted were unpublished doctoral dissertations from various universities. The information on hypertension control in primary care was limited, including methods to improve the control rate within the office. After applying the filters, the remaining articles provided a finite amount of feedback on best practices for rural primary care practices.

Current State of Knowledge

Worldwide, hypertension continues to lead the way in cost and mortality. Uncontrolled hypertension has killed over one million people globally, with the remaining suffering from multiple morbidities (Harris, 2019). The prevalence in the United States varies by location, ethnicity, and gender due to diet, genetics, and hormones (Harris, 2019). The areas of higher prevalence are in a region that contains 11 states and is called the Stroke Belt. North Carolina is included in the Belt and has a 10% higher mortality rate than those outside the Stroke Belt region. The prevalence varies based on gender, with men under 50 years higher than women under 50 years and women over 50 years higher than men over 50 years (Harris, 2019). The prevalence differs based on ethnicity, with 32% African Americans, 23% Caucasian, and 22% Hispanic Americans (Harris, 2019).

The approximated price for uncontrolled hypertension alone is over \$100 billion U.S. dollars. Improving hypertension control will reduce costs by reducing morbidity and mortality,

which will improve outcomes and insurance reimbursement (Bliss, 2021; Harris, 2019). The two high-risk populations for uncontrolled hypertension are 18 to 39 and older adults. The rural communities are also at high risk for uncontrolled hypertension (Bliss, 2021; Harris, 2019).

Understanding uncontrolled hypertension is essential to developing control strategies. The factors to consider consist of the physiologic causes, contributing factors, and resultant complications. The physiologic cause of hypertension relates to the cardiac output, amount of blood volume, the viscosity of the blood, and the resistance from the blood vessels (Harris, 2019). With aging, the biological compensatory mechanism fails, which contributes to the cause of hypertension. A change in each of these factors contributes to hypertension and control. The contributing factors associated with hypertension include tobacco use, gender, hypercholesteremia, obesity, and chronic inflammation. These not only contribute to hypertension but also contribute to uncontrolled hypertension. As these factors increase, so do the blood pressure and risks of complications, including death. Hypertension contributes to ischemic heart disease, myocardial infarction, stroke, congestive heart failure, arrhythmias, thromboses, aortic aneurysm, peripheral arterial disease, and sudden death (Bliss, 2021; Harris, 2019).

The definition of hypertension determines the aggressiveness of the treatment plan (Harris, 2019). A research study performed by the Systolic Blood Pressure Trials (SPRINT) evaluated the correct definition for the treatment of hypertension. Two groups were formed, with group one patients being controlled to a systolic of less than 120 mmHg and group 2 patients being controlled to a systolic of less than 140 mmHg (Harris, 2019). Patients in both groups were all over 50 years of age and did not have diabetes. The results concluded that less than 120 mmHg control decreased cardiovascular events by 27%. Unfortunately, the study did not

consider the complication of hypotension and organ damage with a blood pressure control of less than 120, which led to the exclusion of this definition in major organizations like the American Association of Family Practitioners (Harris, 2019). Therefore, the determining standard for controlled hypertension is a systolic blood pressure of less than 140 mmHg and 90 mmHg diastolic (Bliss, 2021; Harris, 2019).

Current Approach

The current approach for the management of uncontrolled hypertension is limited. The literature review provided three methods to improve uncontrolled hypertension in primary care. These approaches include developing a therapeutic relationship, using office guidelines, and increasing follow-up visits. Overall, the studies reviewed did not use a single intervention to improve hypertension control. Instead, a mixed-method approach was noted, promoting continuity of care and trust to decrease uncontrolled hypertension in rural primary care.

Chaddha et al. (2018) conducted a retrospective analysis to determine the rates and predictions of uncontrolled hypertensive patients achieving control in a year following a cardiac event. Electronic health records and data from Medicare of 343 patients were used for the review. The results concluded that of the 343 patients with uncontrolled hypertension, 76% obtained hypertension control using standard guidelines and increased frequency of follow-up.

An additional study by Meltzer et al. (2018) examined increasing trust in the medical professionals to promote control in uncontrolled hypertension patients. This study was a cross-sectional survey of 201 adults in California. The study aimed to examine the idea that trust with health care providers promotes hypertension control through improved medication adherence and resilience. The study results reported an association between trust and improved uncontrolled

hypertension. As trust increases, so do the patient's medication adherence, resilience, and hypertension control. However, this cross-sectional study did not reveal the qualities of improved trust other than the patient's visit was with the same provider. This suggests that improved continuity with the same provider improves trust, thus improving uncontrolled hypertension.

Lastly, a study conducted by Maciejewski et al. (2020) reported similar results: improved continuity of care and patient follow-up decreases uncontrolled hypertension. This study performed a retrospective cohort analysis on 299,949 hypertensive patients, 100,191 diabetic patients, and 243,598 dyslipidemia patients. The study aimed to determine if there was an association between all-cause admits, outpatient expenditures, total expenditure, and the number of prescribers for a patient. The study was conducted on older adults with Medicare. The results revealed an increased cost of 6% in hypertension patients with multiple prescribers, a 10% increase with diabetes, and a 3% increase in dyslipidemia patients. There was an association between prescribers and outpatient cost, total cost, and inpatient admissions. As the number of prescribers increases, so do the cost and admission rates. This data supports decreasing the number of prescribers to promote continuity of care.

Evidence to Support the Intervention

Findings from the review to improve the rate of uncontrolled hypertension consisted of promoting continuity of care and improving patient follow-up with their primary care providers. Evidence from the literature support that increased continuity of care promotes a trusting relationship, improves medication adherence and promotes resilience. As these factors improve, so does uncontrolled hypertension. This method is associated with improved trust and hypertension control. The standard guideline improved uncontrolled hypertension within a year of patients with a history of one cardiac event. The three approaches together, increasing follow-

up visits, improving hypertension control, and guideline-based management, can decrease the rate of uncontrolled hypertension in patients with Medicare.

Promoting regular follow-up visits improve hypertension control. Patients who were seen at regular intervals had better control and outcomes than those seen infrequently (Bliss, 2021; Chaddha et al., 2018). Improving continuity is associated with decreased missed appointments and increased patient retention. The use of continuity of care, which means for the patient to see the same provider at each visit, assists with patient education and promotes trust in the patient-provider relationship (Maciejewski et al., 2020). Decreasing the number of providers involved in care improves patient outcomes and lowers healthcare costs (Maciejewski et al., 2020). The literature reviewed supports that increasing continuity of care increases hypertension control and patient retention.

Guideline-based management among the office providers improved hypertension control and the patient-provider relationship. Patient care should first be evidence-based and tailored to meet patients' needs and improve patient outcomes (Chaddha et al., 2018). A guideline will standardize follow-up visits and improve continuity of care and communication in the office. This project will implement a protocol for hypertension follow-up to improve the Medicare patient outcomes at this rural primary care office.

Evidence-Based Practice Framework

The Pender Health Promotion Model is the chosen framework for this project. This project aims to improve hypertension control within a rural primary care practice by influencing the patients, thus promoting health promotion practices. In addition, this model provides a guide and understanding of the factors that lead up to health promotion behaviors.

The framework is divided into three major sections: individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcomes (Pender, 2021) (Appendix A). The unique features and experiences comprise a person's knowledge base and other personal factors related to their biology, psyche, and sociocultural background (Pender, 2021). The behavior-specific cognitions and affect consist of internal and external motivators. The internal motivators are a person's perception of the benefits and barriers, self-esteem, and activity or motivation. The external motivators include interpersonal influences like societal norms, support systems, and role models, situational influences like various options, competing demands, and esthetics of the possibilities (Pender, 2021). Finally, the behavioral outcomes consist of the individual's competing stresses and preferences that compete with their commitment and behavior.

Health care providers aim to encourage health-promoting behaviors that move patients toward better health and wellness (Gorbani et al., 2020). The actionable area in health promotion is the interpersonal and situational influences. By increasing the follow-up, providers have ample opportunities to promote healthy behaviors with their patients. The framework provides a guide that will assist the providers on the importance of close follow-up to influence perceived barriers of patient volume to the perceived benefit, which is the long-term benefits of controlled hypertension increasing insurance reimbursement.

Ethical Consideration & Protection of Human Subjects

Principles of ethics and human rights were addressed before beginning this project. The facility owner and the site champion were contacted to discuss the needs of the facility and the community. The site champion identified the topic of hypertension control. After confirming this topic, the evaluation began with the project lead completing the Collaborative Institutional

Training Initiative (CITI) program on "Biomedical Investigators and Key Personnel" and "Social/Behavior Research Investigators and Key Personnel." These classes discussed the core concepts of human research and ethics. The principles around the protection of persons included informed consent and voluntarism (Cohen, 2018). The principle of beneficence ensures benefits with minimal harm to the group or community involved (Cohen, 2018). Finally, learning about justice involves eliminating bias, how the participants are selected, and benefits received versus burden for all involved (Cohen, 2018). The concepts learned are vital to ensure no violation of moral or human rights.

The traits of beneficence, justice, and informed consent were incorporated into this project. Beneficence is addressed by incorporating a process that will cause no harm and, if successful, will improve the community's health. Justice was addressed in the project through the incorporation of advocating for the health of vulnerable populations. The project aimed to improve the quality of health and wellness while improving the practice's star rating by Medicare. To address informed consent and voluntarism, the providers were educated on the objectives and benefits associated with this project. The providers maintained their authority with the plan of care and follow-up appointments for their patients.

The Institutional Review Board (IRB) approval for the site and university was obtained before the implementation of the project. The privately-owned office did not have an IRB board, which only needed IRB approval from the university. After meeting with the course faculty member, a proposal was created and presented to the faculty member and the College of Nursing Doctor of Nursing program director. Once the project was approved, a formal Qualtrics survey was completed as part of the university's IRB review process. A review of the project

certification was received, deeming the project as a quality improvement project, and no further IRB review was required.

The project lead performed chart reviews on identified patients with Medicare and uncontrolled hypertension. All identifiable data was removed to protect the patients' rights. If identifiable information was obtained, the data was secured under a password-protected document and was not shared. The demographic data excluded was anything that contained identifiable data, like name and birth date will be utilized. The demographic information used consisted of age, race, diagnosis codes, and follow-up. The purpose of collecting this data was to monitor and evaluate the project's progress related to meeting the project's goals.

Section III. Project Design

Project Site and Population

The project site is a rural health primary care office in Henderson, North Carolina. The project population consists of the health care providers at the office. This project focused on educating and making changes in the providers' practice to promote changes in the community.

Description of the Setting

The project site is the largest privately owned practice in the area and serves four counties. The office is located within northeastern North Carolina, which has a high crime and poverty rate. The majority of the patients are Medicare and Medicaid. The practice's patient population is 22,000, with approximately 19,000 being Medicare and Medicaid (██████████, personal communication, October 13, 2021). The population in county was 42,000 people, which has decreased from the 44,000 reported in the 2010 Census. The county is diverse, with over 50% African American, 45% Caucasian, and over 7% Hispanic or Latino (Macon, 2018). The second leading cause of death is heart disease in the community, second to cancer.

Barriers to this office include the size of the office versus the number of patients seen per day, the number of practitioners, and a paper-free facility. The office accepts appointments and walk-ins, creating a primary office, urgent care, and a COVID testing site. The average number of patients seen in a day is approximately 300. The office has 20 patient care rooms, allowing one room per provider, except for the COVID testing area. The providers have limited time to see patients due to the facility's high patient volume and low capacity. Another challenge is that the office is paper-free. The initiated changes or teachings must include a paper-free option for the project to be conducted. The driving force behind the project consists of the vast variations in

the patient population and the critical need for an improved process for heart disease within the community.

Description of the Population

The target population for the project is healthcare providers. The providers consist of three physicians, 13 full-time physician assistants, and one full-time nurse practitioner. The experience level varies from less than a year to over ten years of experience. Some providers have a non-clinical background before becoming a healthcare provider, and four with doctorate education levels. The variation of providers poses challenges in suggesting a change in the practice. Facilitators for this population include the owner of the office and the site champion. Both are open to and support projects that improve the practice and patient outcomes. The site champion identified the proposed project as a need for the facility.

Project Team

A project team contains individuals working toward the same goals. These members include the project lead, faculty member, project site owner, and project site champion. The team members include the owner of the office and the site champion, who has opened the door to allow an improvement project to be conducted at the site. The owner continues to support students through their academic journey by precepting students and supporting improvement projects at the site. The site champion is a physician's assistant, alumnae of the university, and oversees the Quality Improvement Committee. She spends hours outside of her patient care performing chart reviews and collaborating with Duke's and Aledade ACOs for the office. In addition, she ensures the office meets the requirements for health care prevention and educates the providers on appropriate billing codes for reimbursement from the various insurance

companies. The project lead is responsible for the project's collaboration, planning, development, implementation, and evaluation. Other responsibilities of the project lead include the data collection, analysis, and dissemination of the findings. The university advisor is a mentor for the project guiding the project phase.

Project Goals and Outcomes Measures

This quality improvement project aims to improve patient and provider engagement in hypertension control through provider education and implementation of standardized hypertension guidelines. The education aims to standardize and influence improvements in hypertension management among Medicare patients. The project specifically address to improve the following outcomes: 1, 2, & 3.

Outcome 1. Use of the Hypertension Follow-Up Protocol (Appendix B).

Outcome 2. Increase the rate of scheduled follow-up appointments in Medicare patients.

Outcome 3. Improve the continuity of care, meaning patients scheduling the follow-up with the same provider.

Description of the Methods and Measurement

For this project, the methods include monthly education/update sessions, weekly meetings with the site champion, and chart reviews. The education and follow-up sessions occurred monthly at staff meetings and lasted no more than five minutes. The use of PowerPoint provided visuals and summaries of the project's progress. The monthly updates provided information on the goal and the status of achievement. The site champion meetings occurred weekly on Tuesdays for approximately four hours. At this meeting, a list of Medicare patients

classified as uncontrolled was provided for the project lead to conduct chart reviews. The Plan, Do, Study, Act (PDSA) cycle was used to evaluate the project monthly and as needed.

The Hypertension Follow-up Protocol was created in collaboration with the site champion. The protocol was given to each provider and placed in every exam room as a reference tool. The protocol's design was created in a flow chart format and included recommendations on the frequency of follow-up based on the blood pressure results (Appendix B). The follow-up visit was every six months for pressures less than 140/90 mmHg. For example, a patient with a high blood pressure of 140-159 mmHg systolic or 90-99 mmHg diastolic would follow up in one month, and a patient with severely high blood pressures greater than or equal to 160 mmHg systolic or greater than or equal to 100 mmHg diastolic would return in two weeks.

The measurements for this project were those relevant to the outcomes and demographic data. The demographic data collected included age, ethnicity, and gender. Insurance data was not collected since only Medicare patients' charts were reviewed. Information collected from the chart reviews included the following: positive for uncontrolled hypertension (yes or no), a scheduled follow-up (yes or no), if the guideline was followed (yes or no), the provider, and if patient follow-up was with the same provider (yes or no). All the data collected was used to evaluate the project's progress and for improvements. Additionally, the site champion obtained the rate of uncontrolled hypertension from the Duke and Aledade ACOs every Tuesday. This data was another measure of success utilized.

Discussion of the Data Collection Process

The site champion provided a weekly list of Medicare patients with uncontrolled hypertension to the project lead. The patient demographic data was entered into the data collection tool, minus the identifiable data (Appendix C). A chart review was conducted on each eligible patient over 15 weeks. The data collection tool contained the necessary data, including demographics and information related to the project for data analysis.

Implementation Plan

The implementation plan was from January to April. Due to COVID, education was provided through an email because the January staff meeting was deferred. The education session was scheduled for the last five minutes. The session's content included information on blood pressure measurement, the Hypertension Follow-up Protocol, reinforcing the importance of increasing continuity of care, and encouraging the use of the hypertension CPT codes. In addition, the ratings were provided by the ACOs were at pre-implementation and post-implementation instead of weekly as initially planned. This rating was the total percentage of patients with controlled hypertension.

The accuracy of blood pressure measurement is essential in determining the treatment plan, so part of the education included selecting the blood pressure cuff and the timing of taking the blood pressure, ensuring the patient has had a chance to sit and relax for five minutes. The follow-up protocol outlined when to schedule a follow appointment based on the obtained blood pressure reading. The protocol included the following: a two-week follow-up for pressures greater than 160/100, a one-month follow-up for blood pressures greater than 140/90, and a three-month follow-up for pressure of less than 140/90. Lastly, the education session stressed the

importance of continuity of care, emphasizing the importance of maintaining the same provider for the follow-up visit when possible. A PowerPoint was used to reinforce the presentation (Appendix E).

After the initial staff meeting, the Hypertension Follow-Up Protocol was posted in each exam room (Appendix B). Following the presentation, the project lead and site champion began weekly meetings. The Medicare patients with uncontrolled hypertension list were provided, and chart reviews were conducted. Data collected was analyzed weekly, and a PDSA cycle was conducted monthly. These results were summarized and emailed at pre-implementation, mid-implementation, and post-implementation.

Timeline

The timeline for this project was from January to April for implementation. Each week, the data was reviewed and analyzed to observe the trends. This information was evaluated during the monthly PDSA cycle to determine ways to improve to make the process easier for the providers. Data collection was completed at the end of April, allowing 15 weeks of data to be reviewed. From June to July, an analysis of the project findings were completed with the dissemination of findings in a paper and poster presentation. The dissemination of the project was in July and occurred at the project site and the university. The finalized paper was posted in the University Scholarship Repository in July (see Appendix D).

Section IV. Results and Findings

Results

The results are divided by the three outcomes measured during the implementation. These include the implementation of a standardized Hypertension Follow-up Protocol, improving scheduled follow-up for patients with uncontrolled hypertension to greater than 30%, and improving the continuity of care within the practice. Detailed results of the demographic data are displayed in charts (see Appendix F).

During the 15-week implementation period, 238 Medicare patients were identified as having uncontrolled hypertension with only 197 (83%) office visits and 41 (17%) virtual or COVID visits. Of the 238, 156 (66%) identified as female, and 82 (34%) identified as male. The majority of the patients were black at 144 (61%), followed by white, with Hispanic and others being the least at 3 (1%) and 8 (3%) respectively. The patients' ages were categorized in three ranges: 18-44, 45-64, and 65 years and up. Of the 238 patient, 7% (16) were 18-44 years old, 16% (37) were 44-64 years old, and 77% (184) were 65 years or older. In summary, the majority of the patient with uncontrolled hypertension were African Americans, women, and over 65 years of age in practice with uncontrolled hypertension (See Appendix F).

Outcome 1

The first outcome addressed was implementing the Hypertension Follow-Up Protocol to improve hypertension control and was based on the 199 office visits including COVID visits with a blood pressure. The blood pressure level consisted of level I (140-159 mmHg/90-99 mmHg) and level II (>160/90). Of the 199 patients, level I comprised 157 (79%) patients and

level II were 42 (21%). The protocol usage entailed 63 (32%) out of the 197 chart reviews, with the highest usage mid-implementation at 53% and toward the end of the implementation being 17%. At the end of the implementation, hypertension control improved to 95% controlled compared to 70% pre-implementation at the project site. These results include patients with Medicare, Medicaid, and private insurance.

Outcome 2

The second outcome was to improve the scheduled follow-up appointments for Medicare patients with uncontrolled hypertension. The number of follow-up appointments was based on the number of office visits of 197. The total rate of scheduled follow-up appointments was 117 (59%), with 80 (41%) not having a scheduled follow-up appointment. Initially, the follow-up percentage rate was 5 (25%) and at the end of fifteen weeks increased to 10 (83%), leaving 2 (17%) without a scheduled follow-up appointment.

The number of follow-up visits recommended by providers were evaluated during the 15-week implementation. Of the 197 office visits, the provided recommended follow-up visits to 118 (60%) patients, with 79 (40%) patients not having a follow up recommended. The total number of uncontrolled hypertension decreased from 28 to 13 patients. The numbers were based on the office visits of 197 versus the total amount of charts reviewed at 238.

The Duke Accountable Care Organization (ACO) tracked the total number of patients with uncontrolled hypertension and met with providers in the office to provide recommendations for improving hypertension. The Duke ACO reported that the hypertension control of those with blood pressures greater than 160/100 mmHg improved by 64%. Initially, the plan was to obtain a pre-, mid-, and post-implementation but was only able to obtain the pre-and post-

implementation. The pre-implementation rate of overall hypertension control for the office went from 85%, to 95% at the end of the implementation.

Outcome 3

For the third outcome, the goal was to improve the continuity of care to promote a therapeutic relationship and decrease overprescribing. The total number of patients with a follow-up scheduled appointments with the same provider were 88 (77%), with 27 (23%) scheduled with a different provider. The continuity of care increased from 15% at the beginning of implementation to 67% at the end of fifteen weeks.

Discussion of Major Findings

The findings for the project were measured by three outcomes: the use of the hypertension protocol, an increase in the rate of follow-up visits, and an increase in the continuity of care. These outcomes were based on the information identified in the literature review to implement a standardized process, decrease prescribers, and increase the continuity of care to improve hypertension control. The office's overall hypertension control improved from 85% to 95%, controlled per the Duke ACO. In addition, the scheduled follow-up rate and recommended follow-up among Medicare patients improved to 75% from 25%.

Implementing the hypertension protocol was beneficial and increased the follow-up of patients with uncontrolled hypertension. The protocols were posted in each exam room that may have led to additional follow-up appointments scheduled without a provider recommending a follow-up appointment. Several patients scheduled a follow-up visit even when the provider did not recommend a follow-up. The control rate improved to 83% which is an increase from a study by Chaddha et al. (2018) where the rates improved to 76% with a protocol-only approach.

The outcomes for increasing continuity were to promote adherence to follow-up appointments and the scheduling of follow-up appointments. According to Meltzer et al. (2018) and Maciejewski et al. (2020), limiting the number of different providers reduces cost, promotes trust, improves follow-up, and increases hypertension control. An evaluation of costs savings, perception of trust and adherence to follow-up appointments were beyond the scope of the project. However, the number of scheduled follow-up appointments and hypertension control rates improved with the implementation of strategies to standardize hypertension protocol and decreasing the number of prescribers. Increasing continuity, implementing hypertension follow-up protocol, and reinforcing to the providers to schedule a follow-up appointment were effective at improving hypertension control.

Section V. Interpretation and Implications

Costs and Resource Management

The project's total cost was estimated at approximately \$1,500 for the implementation. The project's cost consists of the printing supplies and lamination of the Hypertension Follow-up Protocol. These costs were associated with purchasing a printer, ink, paper, and laminator. Additional costs included manpower hours and labor costs. Once the process was implemented, the cost consisted of the labor hours to conduct chart reviews to monitor and evaluate the progress of the project and the time spent to update the staff.

In the U.S., the annual cost of uncontrolled hypertension and the sequelae exceed \$130 billion annually (CDC, 2021). The cost per person for hypertension is two thousand dollars more annually than those without hypertension (CDC, 2021). To improve cost, hypertension control is vital to reduce costs and prevent complications. The project is cost-effective and would save healthcare thousands of dollars in medical expenses by reducing underlying conditions associated with uncontrolled hypertension and cause hospital admissions. For a detailed list of the cost and resources, see Appendix H.

Implications of the Findings

The implications of the findings are divided into three categories: the implications for the patients, the implications for nursing, and the implications for the healthcare system. The implications for the patients entail improved autonomy, improved patient-provider relationships, and the prevention of sequelae. The nursing implications entail improving standard practice, consistency, and collaboration, and establishing therapeutic relationships with patients. Finally,

the implications for the healthcare system include reducing costs, decreasing the burden of the diseases, and improvement in the outpatient management of hypertension control.

Implications for Patients

The implications for the patients include improving hypertension control, improved patient-provider relationships, and preventing sequelae. The processes implemented increased the frequency of the follow-up and improved continuity. These strategies have increased hypertension control by improving the patient's trust and promoting autonomy. Promoting autonomy allowed the patient to take control of their care in hypertension management and increased accountability by reducing the time between follow-up visits. In addition, the improved continuity between providers and patients, builds trust with the patients promoting improved medication adherence and adherence to follow-up appointments. These factors can improve hypertension control, preventing costly sequelae from this condition. In addition, this process that builds trust will open the communication between patients and providers and can lead to preventing costly hospitalizations and emergency room visits.

Implications for Nursing Practice

The nursing implications consist of establishing collaborative relationships between patients and providers; and improving standard protocol, consistency, and collaboration. The project continued to build on the foundation of interdisciplinary collaboration with the providers and nursing staff at the site. Using standardized protocols provides more autonomy and consistency in nursing. The processes are common in acute inpatient healthcare but not as common in outpatient primary care. Nursing can assist in developing standardized processes in primary care to improve consistency and outcomes. With advanced practice nurses leading the development of standardized protocols within primary care can provide opportunities for future

quality improvement projects that improve processes and practices to promote safe, cost-effective, and quality care to patients in primary care. Finally, the last implication is to spread accountability and responsibility across the disciplines to promote better care and patient outcomes through collaboration and standardization.

Implications for Healthcare System(s)

The implications for the healthcare system for this project were to decrease costs related to uncontrolled hypertension, decrease the strain on the emergency department, and prevent the readmission rate to the hospital. The project highlights the importance of standardizing processes within a practice to assist in improved patient outcomes. Uncontrolled hypertension leads to cardiovascular disease, heart failure, renal disease, cerebral vascular accidents (CVA), and myocardial infarctions (MI). Due to the extraordinary cost of these complications, healthcare has transitioned to health promotion and disease prevention which starts in primary care. Increased follow-up visits for hypertension patients in primary care can prevent emergency department visits and promote increased hypertension control. An increase in people with controlled hypertension will decrease the cost, improve the allocation of resources, and improve access to emergency services.

Sustainability

The project site quality improvement committee is committed to continuing the quality initiatives to improve hypertension control. Incorporating the hypertension protocol within the electronic medical record (EMR) was discussed, but the system did not support this. The standard protocol continues to be promoted with use of the laminated posters in each exam room, continued chart reviews, and monitoring of those with uncontrolled hypertension.

Dissemination Plan

The plan for dissemination occurred at the project site and the university. The first dissemination occurred on July 12th at the university and was open to the university faculty, students, families, and project members. The second dissemination is scheduled at the project site and open to the nursing staff and providers. A poster was used to support the dissemination of the project. This poster contains a summary of the background, purpose, methodology, results, and implications. In addition, a graph of the weekly progress was provided to display the general progression of this project and the improvement in follow-up appointments and hypertension control. Finally, the final paper was submitted to the university Scholarship Repository for public access.

Future consideration would be to present the project strategies and findings to other primary care offices in the county of the project site due to the high rate of uncontrolled hypertension. Presenting the findings along with the poster or paper could be shared with other organizations in the community and nationally to reach other primary care offices. For example, the concept could be presented at NCNA DNP Symposium. This will introduce this project to other advance practice nurses for implementation in other rural communities.

Section VI. Conclusion

Limitations and Facilitators

Limitations

The quality improvement project had several limitations consisting of internal and external factors to the site. The internal factors included limitations with the providers, office procedures, and scheduling. During implementation, some providers were resistant to changing how they practiced and increasing the frequency of follow-up. Patients with a history of poorly controlled hypertension, the providers were resistant to increasing the frequency of their follow-up. Another limitation was changes in the office procedure during the COVID-19 pandemic. The office staff usually met monthly for staff meetings; however, due to the pandemic, these meetings were reduced, and the contents shared were limited. The education sessions and provider updates took place via email instead of live meetings. Another limitation consisted in scheduling the follow-up appointments. With the provider recommending a follow-up based on the Hypertension Follow-Up Protocol, some patients still did not have a follow-up scheduled. The 15-week period may have been a potential limitation leading to a small sample size.

The external factors resulted from causes outside of the office, including the COVID-19 pandemic and variability of patient influx due to the pandemic. The COVID-19 pandemic brought in new patients with other offices in the area not providing walk-in COVID testing. When presenting in the COVID clinic, a history, temperature, pulse rate, and pulse oximetry was obtained, but no blood pressure obtained. During the initial implementation, the COVID numbers were high and the Medicare patients with hypertension were considered uncontrolled if there was not any blood pressure recorded. Many patients did not seek primary care at the office

but were seeking COVID testing only and did not return for a follow-up, which negatively affected the office star rating. The pandemic affected the influx of regular patients with some weeks very busy with COVID testing and other weeks somewhat slow. Many patients were unwilling to go out due to the fear of contracting COVID-19, which affected the rate of kept follow-up appointments. The number of visits each week was relatively small, and many were excluded due to presenting for COVID testing.

Facilitators

Facilitators consist of factors that promoted or strengthened the project. These included the quality improvement committee, providers' cooperation, the project champion's support, and the EMR system. The project site, including the owner, supports students and quality improvement projects within the office. This provided the opportunity for quality project initiatives to improve hypertension control within the office. The project champion oversees the quality improvement committee and is passionate about improving the practice and patient care, which provided a positive environment and supportive team throughout the implementation process. Although the providers were resistant to changing their practice, they accepted the teaching sessions and quality improvement project at the site. The EMR allowed messaging and emailing, which were utilized to provide education and updates during the implementation period. Posters displayed in the exam rooms assisted in facilitating patient engagement. These factors supported a successful project and led to positive outcome of improved hypertension control within the office. Some providers failed to recommend a follow-up visit; however, the patient scheduled the follow-up within the recommended time frame.

Recommendations for Others

The implementation went well; however, few adjustments should be made for future projects. Recommendations for others desiring to perform a similar project includes adjustments to the education session and improving the process of scheduling appointments. The education session should be live or virtual to ensure participation. The email provided a barrier because some providers may not have read the email. Also, the project would benefit from increased face time with the providers by rounding in their offices to answer questions and reinforce the education. Finally, there was a gap between recommending a follow-up and the patient scheduling the follow-up appointment before leaving the office. Future process improvements may provide better results in hypertension control. Also, incorporating the protocol in the EMR system would assist in improved compliance with the appointment scheduling.

Recommendations for Further Study

The project could be implemented with all patients to improve hypertension in other practice sites. For example, the process could be implemented in the emergency department to increase follow-up with primary care and prevent readmissions to the hospital. Promoting a protocol to increase follow-up to primary care will identify individuals with hypertension, newly diagnosed or poorly controlled. If providers could identify patients with hypertension early, they could schedule follow-ups with local practices, including the rural health group, which has a sliding scale for those without insurance. Encompassing more of the community will assist in alleviating the burden of complications that result from chronic uncontrolled hypertension. This project could be expanded to other practices to further reach more of the community.

Final Thoughts

Hypertension is the leading cause of death and debility in the United States (CDC, 2021). The cost exceeds \$130 billion annually and will continue to rise if steps are not taken to improve hypertension in communities (CDC, 2021). This quality improvement project focused on improving follow-up in Medicare patients with uncontrolled hypertension. After performing a literature review, the strategies consisted of implementing a standardized follow-up protocol and improving continuity of care. The Hypertension Follow-up Protocol implemented resulted in improved hypertension control and the number of scheduled follow-up visits. This quality improvement project hopes to promote further studies in hypertension control in primary care. Future projects would improve hypertension control and reduce emergency room visits, hospitalizations, and costly complications. Further research and future DNP projects would be beneficial for closing the gap between scheduling and patient compliance with follow-up.

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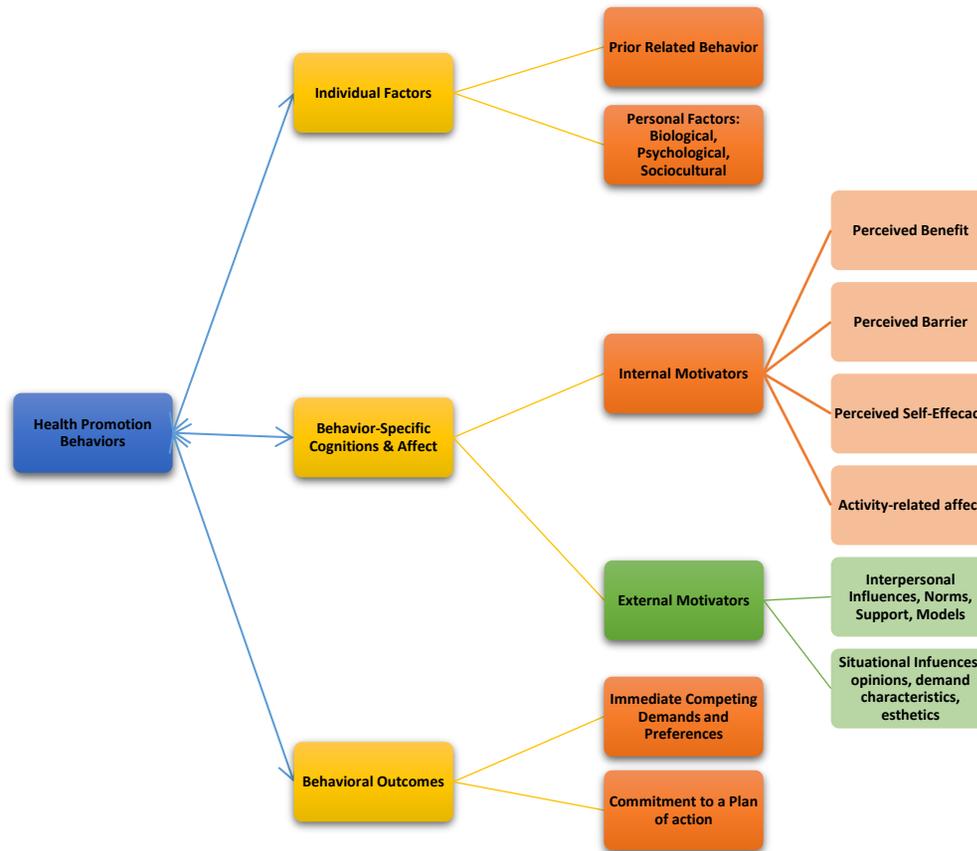
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Appendix A

Pender's Health Promotion Diagram

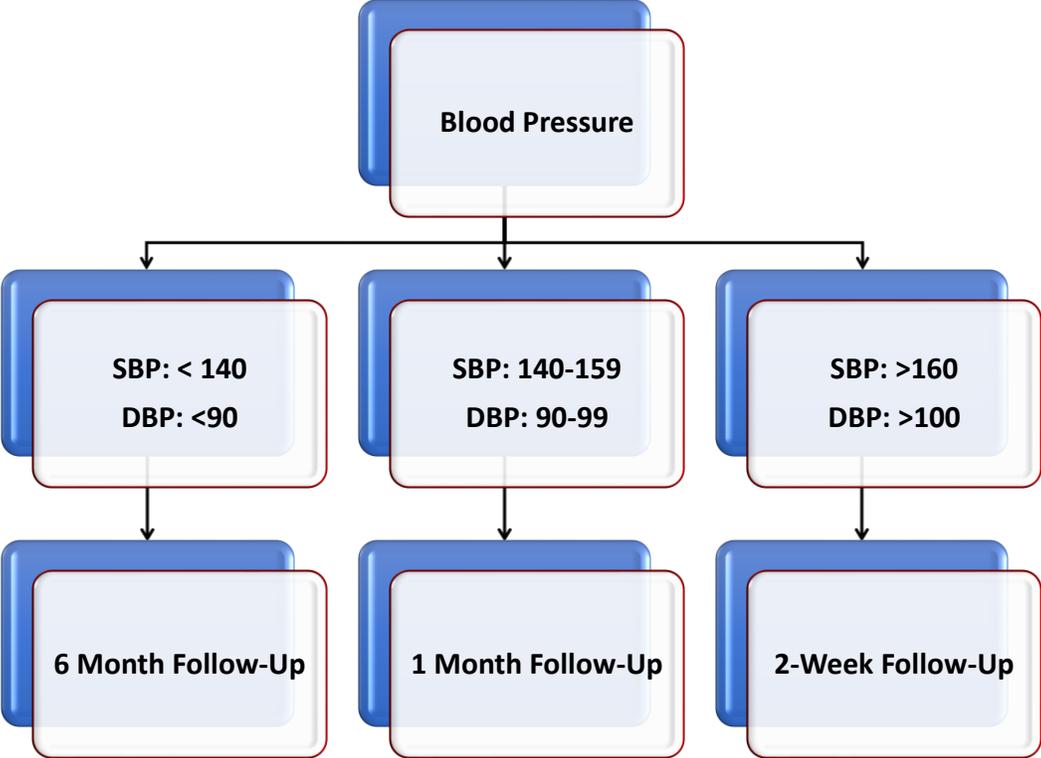


Note: The figure is based on the Health Promotion. From “The health promotion model: Manual,” by N. Pender, 2021, *The University of Michigan*.

Appendix B

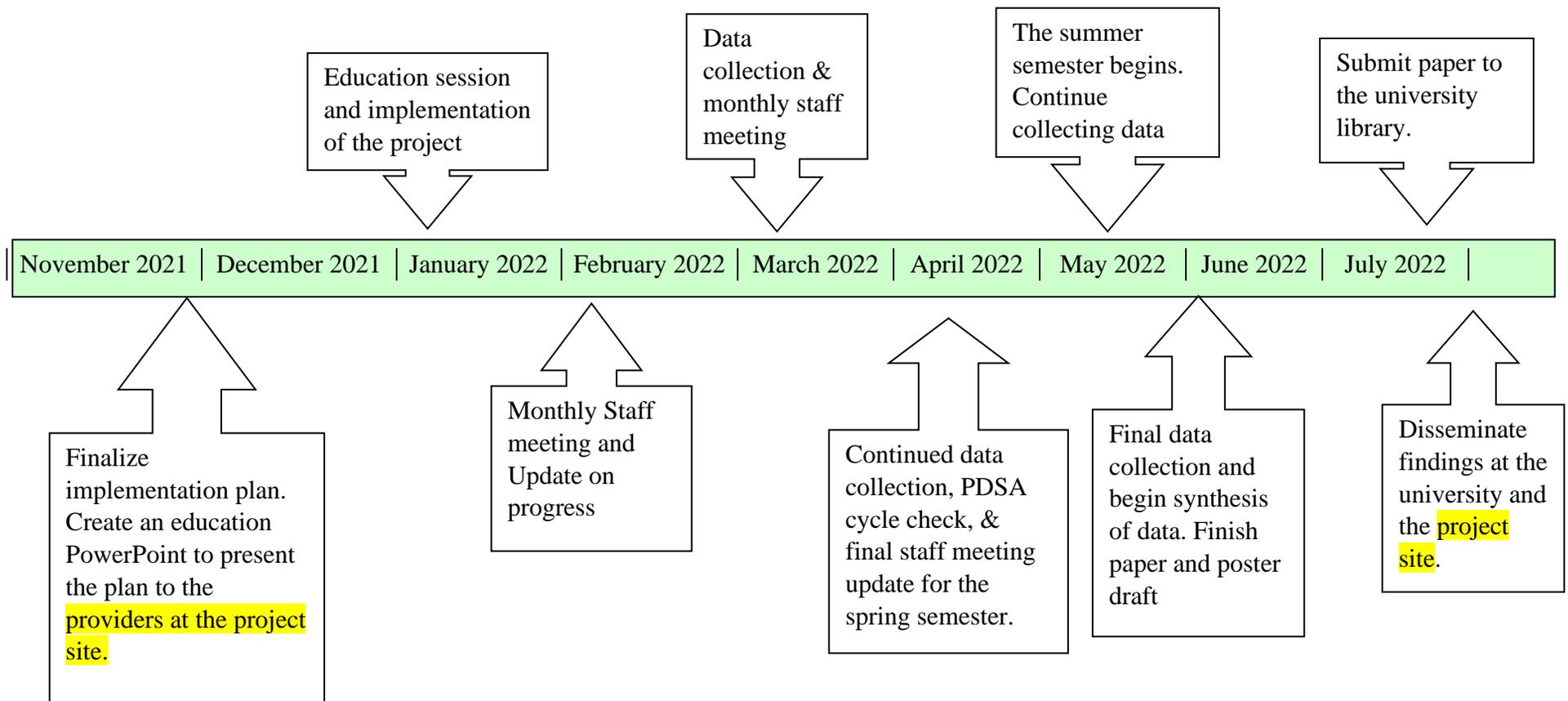
Hypertension Follow-Up Protocol

Hypertension Follow-up Protocol



Appendix D

DNP Project Timeline



Appendix E

Education PowerPoint

IMPROVING PATIENT ENGAGEMENT IN HYPERTENSION MANAGEMENT

Alyssa Long

HYPERTENSION

2nd leading cause of death for Granville, Franklin, and Vance counties



- Hypertension Defined:
 - Systolic Blood Pressure > 140
 - Diastolic Blood Pressure > 90
- Cost:
 - \$130 Billion each year
 - \$2,000 more per person

BENCHMARKS

Centers for Medicare and Medicaid Requirements:

- Annual Blood Pressure Screen
- Planned Follow-Up
- Documented Control of 80%

Hypertension Control Rate:

- Healthy People 2030: > 60%
- Vance Family Medicine: >85%



"If you aim at nothing, you will hit it every time"

Author Unkown

This Picture by Unknown Author is licensed under CC BY

PLAN FOR IMPROVEMENT

1. Improve scheduled Follow-Up
2. Use Standard Follow-Up for all Medicare Patients
3. Increase Continuity of Care

PLAN BIG
IF YOU FAIL TO PLAN,
THEN YOU
PLAN TO FAIL.

This Photo by Unknown Author is licensed under CC BY-NC-ND

Blood Pressure

SBP: < 140 DBP: <90	SBP: 140-159 DBP: 90-99	SBP: >160 DBP: >100
6 Month Follow-Up	1 Month Follow-Up	2-Week Follow-Up

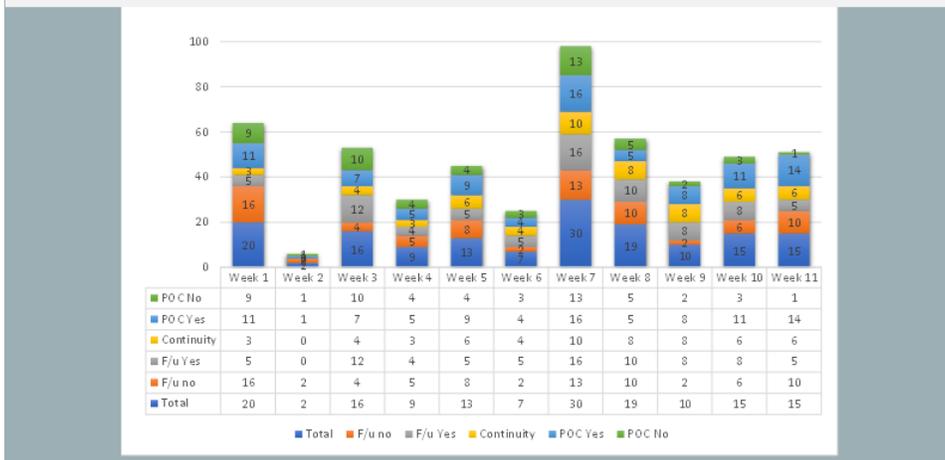
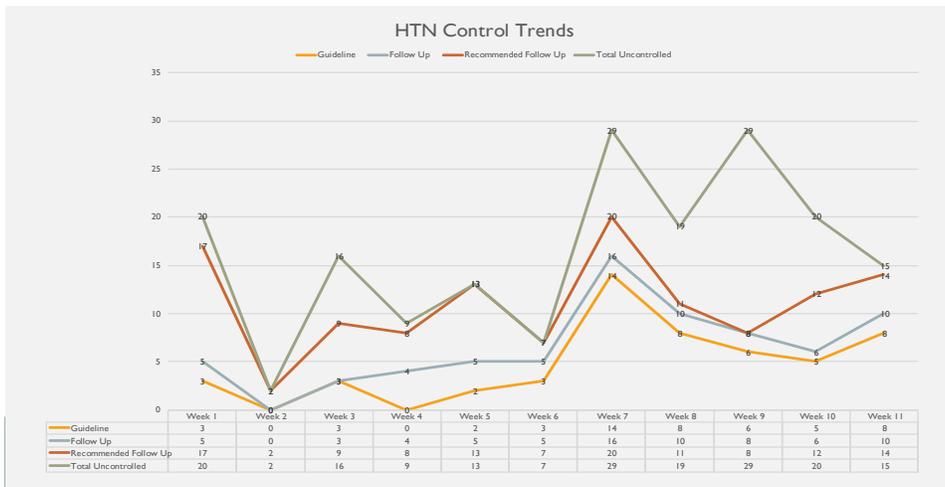
**GUIDELINE
FOR
FOLLOW -UP**



IMPROVING CARE & CONTINUITY

Drop down appointment prior to leaving the exam room

Write: Follow-up in ____ weeks/months with (Provider name).



PLAN

- Continue utilizing guideline
- Reinforced when and who to schedule to next appointment
- Document the ICD-10 Code and CPTII codes for Hypertension

Appendix F

Results

Figure F1

Race Demographics

Race

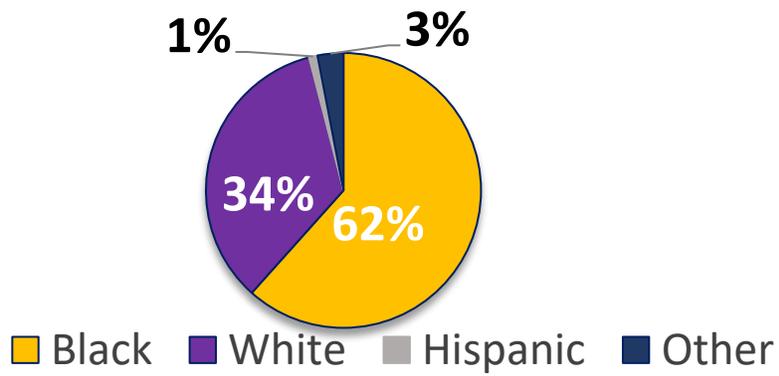


Figure F2

Gender Demographics

Gender

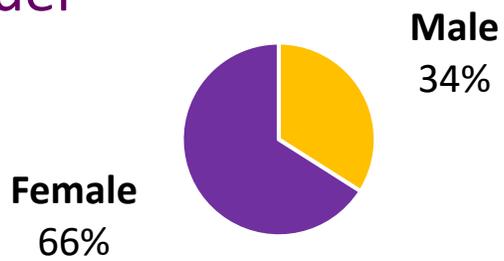
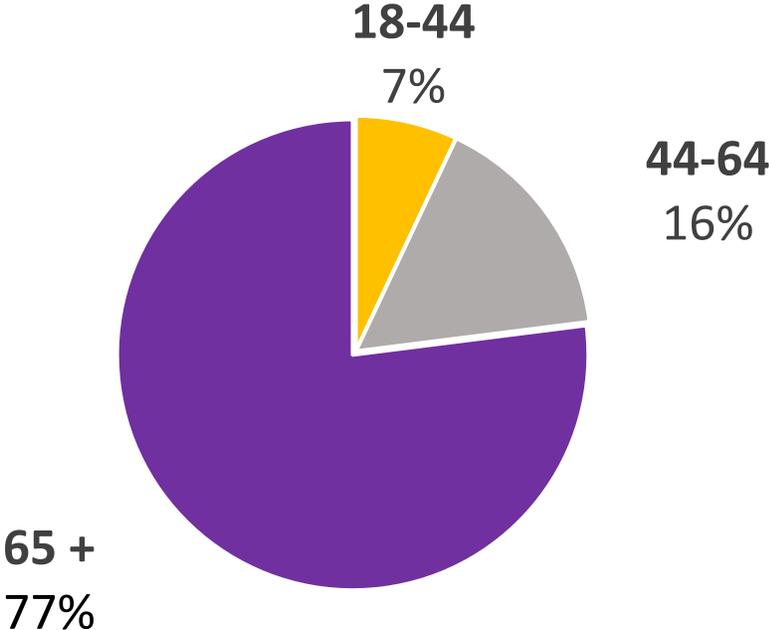


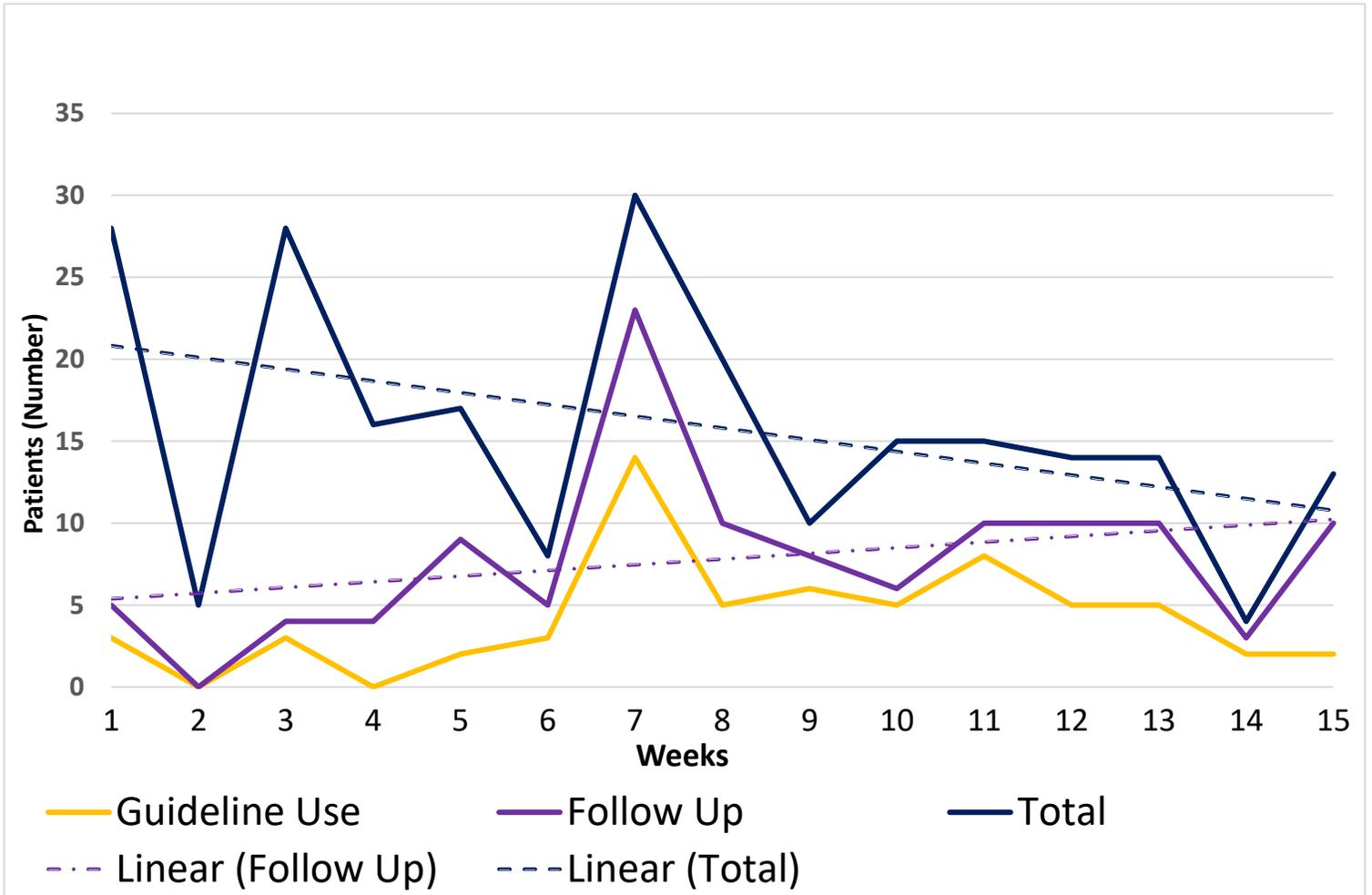
Figure F3

Age Demographics

Age



Appendix G
Hypertension Control Trends



Appendix H
Budget

Supplies	Quantity	Cost	Totals
Paper	20lb	\$34	\$34
Ink laser toner	3 pack	\$33	\$33
Laminator	1 with 20 laminator pouches	\$ 48	\$48
Staffing Costs			
Provider Hours	20 hours/month	\$50/hour	\$1,000
Staffing Hours	20 hours/month	\$15/hours	\$300
Total			\$1,530

Appendix J

Doctor of Nursing Practice Essentials

Essentials	Description	Demonstration of Knowledge
Essential I <i>Scientific Underpinning for Practice</i>	<p>Competency – Analyzes and uses information to develop practice</p> <p>Competency -Integrates knowledge from humanities and science into context of nursing</p> <p>Competency -Translates research to improve practice</p> <p>Competency -Integrates research, theory, and practice to develop new approaches toward improved practice and outcomes</p>	<ul style="list-style-type: none"> • Performed a literature review for improving hypertension control in primary care. • Integrated the pathophysiology to discuss the complications of hypertension. • Discussed the current evidence on hypertension control to create a process to improve uncontrolled hypertension rate in primary care. • Integrated the Pender’s Health Promotion Model to formulate a plan to motivate providers to make changes in their practices.

<p>Essential II</p> <p><i>Organizational & Systems Leadership for Quality Improvement & Systems Thinking</i></p>	<p>Competency –Develops and evaluates practice based on science and integrates policy and humanities</p> <p>Competency –Assumes and ensures accountability for quality care and patient safety</p> <p>Competency -Demonstrates critical and reflective thinking</p> <p>Competency -Advocates for improved quality, access, and cost of health care; monitors costs and budgets</p> <p>Competency -Develops and implements innovations incorporating principles of change</p> <p>Competency - Effectively communicates practice knowledge in writing and orally to improve quality</p> <p>Competency - Develops and evaluates strategies to manage ethical dilemmas in patient care and within health care delivery systems</p>	<ul style="list-style-type: none"> • Used the current knowledge gleaned from the literature review with the information from the project site champion to develop a Hypertension Follow-Up Protocol for the site. • Developed a quality improvement project plan and presented before the university faculty and project site for approval. • Demonstrated critical thinking through translating the information from the literature review into a plan to improve hypertension. • Developed a cost-benefit analysis for the project taking into account the project site’s paper free policy. • Utilized the Pender’s Health Promotion Model and the PDSA cycle to evaluate and implement changes throughout the implementation period. • Communicated the project plan to the project champion and educated the staff of the project goals and plan through email. • Prior to implementation an Qualtrics survey was completed as part of the university’s IRB review process and the project was deemed a quality improvement project.
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<p>Essential III</p> <p><i>Clinical Scholarship & Analytical Methods for Evidence-Based Practice</i></p>	<p>Competency - Critically analyzes literature to determine best practices</p> <p>Competency - Implements evaluation processes to measure process and patient outcomes</p> <p>Competency - Designs and implements quality improvement strategies to promote safety, efficiency, and equitable quality care for patients</p> <p>Competency - Applies knowledge to develop practice guidelines</p> <p>Competency - Uses informatics to identify, analyze, and predict best practice and patient outcomes</p> <p>Competency - Collaborate in research and disseminate findings</p>	<ul style="list-style-type: none"> • Analyzed the literature to determine the best practices that included increasing hypertension follow-up, decreasing prescribers through increasing continuity, and the use of standardized protocols. • Performed chart reviews and analyzed the data placing it in tables to evaluate the processes implemented. • Designed a improve process to increase hypertension control in a rural primary care office to prevent sequelae of longstanding uncontrolled hypertension in Medicare patients. • Developed a protocol to improve the frequency of follow-up in Medicare patients with uncontrolled hypertension. • Used informatics including excel and graphs to analyze the outcomes. • Collaborated with colleagues at the university to prepare for dissemination of the findings. • Plan to disseminate the findings at the project site and the university.
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<p>Essential IV</p> <p><i>Information Systems – Technology & Patient Care Technology for the Improvement & Transformation of Health Care</i></p>	<p>Competency – Design/select and utilize software to analyze practice and consumer information systems that can improve the delivery & quality of care</p> <p>Competency - Analyze and operationalize patient care technologies</p> <p>Competency - Evaluate technology regarding ethics, efficiency, and accuracy</p> <p>Competency - Evaluates systems of care using health information technologies</p>	<ul style="list-style-type: none"> • Utilized the EMR system and processes the project site had in place for the project like ease of dropping down the ICD-10 and CPT-II codes. • Utilized Microsoft Word, Excel, and PowerPoint to enhance, evaluate, and disseminate the project. • Used the ECU library to access CINHALL PubMed, ProQuest, and Google Scholar. • Used email, the project sites intranet, and Zoom throughout implementation and for communication with the project champion. • Used a laminator to laminate the Hypertension Follow-Up Protocol and placed them into each exam room.
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<p>Essential V</p> <p><i>Health Care Policy of Advocacy in Health Care</i></p>	<p>Competency- Analyzes health policy from the perspective of patients, nursing, and other stakeholders</p> <p>Competency – Provides leadership in developing and implementing health policy</p> <p>Competency –Influences policymakers, formally and informally, in local and global settings</p> <p>Competency – Educates stakeholders regarding policy</p> <p>Competency – Advocates for nursing within the policy arena</p> <p>Competency- Participates in policy agendas that assist with finance, regulation, and health care delivery</p> <p>Competency – Advocates for equitable and ethical health care</p>	<ul style="list-style-type: none"> ● Evaluated the recommendations suggested to ensure cost effectiveness and durability for the patient population. ● Implemented a change in process and provided a project for others to build on. ● Discussed the project with other students and providers in the community. ● Encouraged the project site owner to implement these changes to improve the hypertension control to improve the star rating at the office. ● Advocated for advanced practice nurses and the quality improvement practices at the project site. ● Participated in changes in processes in the office to promote continuity of care, promote communication with follow up appointments, and increase the frequency in follow-up appointments to promote better patient outcomes. ● Advocated for improving follow-up appointments and increasing frequency to prevent emergency department visits and hospital admissions related to uncontrolled hypertension and hypertensive crisis.
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<p>Essential VI</p> <p><i>Interprofessional Collaboration for Improving Patient & Population Health Outcomes</i></p>	<p>Competency- Uses effective collaboration and communication to develop and implement practice, policy, standards of care, and scholarship</p> <p>Competency – Provide leadership to interprofessional care teams</p> <p>Competency – Consult intraprofessionally and interprofessional to develop systems of care in complex settings</p>	<ul style="list-style-type: none"> • Met weekly with the project champion to collaborate in the development of a standardized protocol to ensure they matched the one the office agreed upon. • Provided leadership to interprofessional care teams through the dissemination of the project. • Discussed current processes and practices with providers and the nursing staff to understand current practices at the office prior to implementation.
<p>Essential VII</p> <p><i>Clinical Prevention & Population Health for Improving the Nation’s Health</i></p>	<p>Competency- Integrates epidemiology, biostatistics, and data to facilitate individual and population health care delivery</p> <p>Competency – Synthesizes information & cultural competency to develop & use health promotion/disease prevention strategies to address gaps in care</p> <p>Competency – Evaluates and implements change strategies of models of health care delivery to improve quality and address diversity</p>	<ul style="list-style-type: none"> • Reviewed the community assessment to gain insight into the community at the project site. • Evaluated the demographics of the patient population at the project site and compared to the national statistics noted in the literature review. • Utilized the Pender’s Health Promotion Model to assist in implementing this transition in practice with the providers.

<p>Essential VIII</p> <p><i>Advanced Nursing Practice</i></p>	<p>Competency- Melds diversity & cultural sensitivity to conduct systematic assessment of health parameters in varied settings</p> <p>Competency – Design, implement & evaluate nursing interventions to promote quality</p> <p>Competency – Develop & maintain patient relationships</p> <p>Competency – Demonstrate advanced clinical judgment and systematic thoughts to improve patient outcomes</p> <p>Competency – Mentor and support fellow nurses</p> <p>Competency- Provide support for individuals and systems experiencing change and transitions</p> <p>Competency – Use systems analysis to evaluate practice efficiency, care delivery, fiscal responsibility, ethical responsibility, and quality outcomes measures</p>	<ul style="list-style-type: none"> • Evaluated the cultural and ethical aspects of this project to ensure that there were no bias. Removed names of the providers when discussing the progress and challenges with the site champion. • Performed chart reviews to evaluate the use of the protocol, continuity, and hypertension control. • Developed professional relationships with some of the providers and nursing staff at the project site. • Developed processes to improve the patient-provider relationship to improve trust through encouraging continuity of care. • This project supports future advanced practice nursing opportunities in the office. • Provided education on hypertension, taking blood pressures, and growth opportunities in the management of hypertension via email. • Provided email updates to the providers in the office. • On site once weekly for 8 hours in the office to provide support if needed, meet with the project champion, and to perform chart reviews. • Project improved the hypertension control rate began the development of standardized practices in the office.
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