Managing Non-attending Hypertensive Patients Aged 40-55 between April 23 and March 24

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Aim:

Identify and complete enhanced clinical management of known hypertensives for those that have not responded to annual health check invites between April 2023 and March 2024 to reduce cardiovascular risk, improve patient adherence to treatment, and early detection of complications.

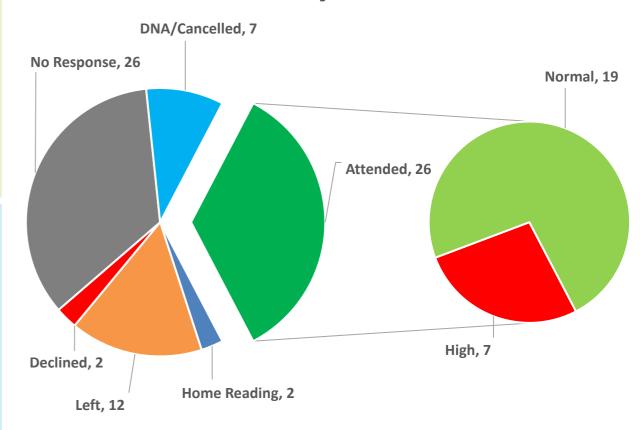
Method:

- Use of multiple methods of targeted communication (automated reminders, phones calls, text messages, emails or letters) to improve attendance to health checks (regular clinic visits, mobile clinics, community health centres, or home visits).
- Education: Use materials such as brochures, videos, or interactive sessions.

Summary of results:

- 75 patients who had not attended in the last 12 months were invited
- 26 attended following intensive invitations
- Pulse checks on those who attended were all normal
- Opportunistic Lipid blood test & Smoking Status check done
- Patients who had raised BP (either Systolic or Diastolic) (7) medication optimisation and review appointment arranged.
- Regularly analysed the data to identify trends, high-risk patients, and overall program effectiveness.

Summary of Results



Pie chart 1: Number of patients invited for a review

Pie chart 2: Blood pressure results for patients who attended a review

Sustaining the change:

- Regularly gather feedback from patients and staff to identify areas for improvement.
- Conduct regular audits to ensure that protocols are being followed and that the program is meeting its objectives.
- Feedback Mechanisms: Establish channels for patient feedback to understand their experiences and barriers to participation. Use this feedback to refine and improve the program.
- Provide ongoing training for staff to keep them updated on the latest guidelines and best practices.
- Policy Integration: Integrate the program into the broader healthcare policy framework to ensure it receives ongoing support.
- Consider expanding the program to include other age groups or risk factors over time, based on the success and learnings from the initial target group

Learnings:

- Patient-Centred Approach Engaging patients in their care, through education and personalized communication, increases participation and adherence. Empowering patients with knowledge and tools to manage their health is crucial.
- Importance of Regular Monitoring Continuous and regular monitoring of blood pressure, pulse, and cholesterol is essential in managing hypertension effectively. It helps in early detection of potential complications and timely interventions.
- Barriers to Participation Common barriers include lack of awareness, time constraints, and accessibility issues. Addressing these through flexible scheduling, telehealth options, and community-based services is important.
- Data Utilization Leveraging data to drive decisions allows for targeted interventions, such as identifying high-risk patients who need more frequent monitoring. Data also helps in evaluating the program's effectiveness.
- Collaboration and Integration A multidisciplinary approach, integrating various healthcare professionals and community resources, enhances the program's effectiveness by addressing the broader aspects of patient health.
- Continuous Improvement Regular feedback loops, audits, and patient outcome tracking enable the program to evolve and improve over time, ensuring it remains relevant and effective.
- Sustainability Focus Long-term success depends on sustainable funding, integration into health policies, and the ability to scale or adapt the program to changing needs.

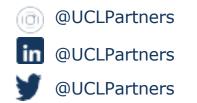
Staff feedback

I learned the importance of understanding how to communicate with patients.

Patient feedback

The nurse was so helpful in explaining why I need to have the check and the importance of taking my tablets regularly.

Contact Details



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