Hypertension in Nova Scotia

A Newsletter of CVHNS, DCPNS, and NSRP

NOVA SCOTIA

From the Editors...Know Your Blood Pressure!

This newsletter is intended to provide you with an overview of some of the initiatives that have taken place in Nova Scotia in recent years, including our very own **Come on Nova Scotia...Check it!** Campaign. We wanted to share with you what is working and profile a few of the unique/innovative features that we can all learn from.

Saturday, May 17th is World Hypertension Day (WHD). The purpose of this day is to promote public awareness of hypertension and to encourage citizens of all countries to prevent and control this silent killer. The theme for 2014 is **Know your Blood Pressure.**

For the past few years, Cardiovascular Health Nova Scotia (CVHNS), Diabetes Care Program of Nova Scotia (DCPNS), and the Nova Scotia Renal Program (NSRP) have been working together on hypertension intitiatives to help prevent and better manage hypertension through public and provider awareness efforts and to promote the importance of "knowing your blood pressure." The three programs were the recipients of the 2013 Hypertension Canada Certificate of Excellence Award that is presented to individuals or organizations in recognition of their outstanding efforts and contributions in Canada through increased public awareness, prevention, or control of hypertension. This was awarded during Hypertension Canada's 2013 Annual General Meeting in Montreal this past October.

We also want to take the opportunity to share the good work that has resulted from the joint Provincial Program Hypertension Grants that were awarded in 2013. Most of these projects are complete, with one just ramping up. These teams of individuals have been ever gracious in providing insights into their projects, including lessons learned, and providing us access to the tools/resources that have been developed to support their work. The hope is that others will learn from, adapt, adopt, and move forward from where these projects left off. We are very proud of our provincial accomplishments and think you will be too!

Award Recipients:

Back Row (Left to Right): Karen Norris, DCPNS; Kathy Harrigan, CVHNS; Barb Patterson, DCPNS; Denise Hubley, CVHNS; Julee Adams, NSRP

Front Row (Left to Right): Cheryl Stevenson-Gillis, NSRP; Neala Gill, CVHNS; Susan MacNeil, NSRP; Peggy Dunbar, DCPNS

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In this Issue

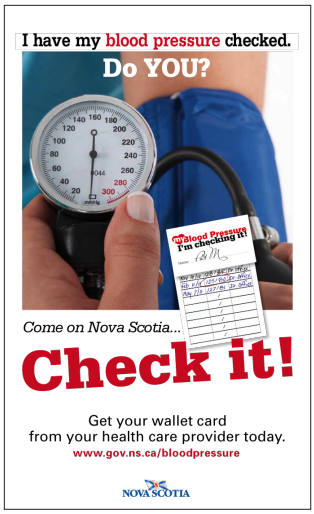
Come on Nova Scotia...Check it! Challenge
1276 South Park Street, Bethune Bldg., 5th Floor
Halifax, NS B3H 2Y9
E-mail: info@nsrp.nshealth.ca
Website: www.novascotia.ca/bloodpressure/

CardioVascular HEALTH NOVA SCOTIA

over 20 yrs Partnerships, Quality, and Innovation (since 1991) Diabetes Care Program of Nova Scotia

Nova Scotia Renal PROGRAM

Blood Pressure Challenge



The Come on Nova Scotia… Check It! Blood Pressure Challenge is spearheaded by the Diabetes Care Program of Nova Scotia, Cardiovascular Health Nova Scotia, and the Nova Scotia Renal Program in the month of May each year. Employers throughout Nova Scotia are encouraged to challenge their employees to have their blood pressures checked, learn more about blood pressure, and use provincial My Blood Pressure Tools (wallet card, pamphlet, and posters). Challenge Kits contain instructions on how to implement a challenge in the workplace and also include tools and educational materials required to support the Challenge. The very first Challenge was held in the province in 2012 and repeated again in 2013. We are currently promoting the 3rd annual Challenge in the province for May 2014 (see page 8).

In 2013, we received 53 requests for Blood Pressure Challenge Kits. All nine District Health Authorities and the IWK participated in the Challenge, as did seven businesses in Nova Scotia, three of which were pharmacies. Thirty-three hundred (3,300) blood pressures were measured during the 2013 Challenge, an increase of 1,417 measurements from the previous challenge. Approximately 22% of all blood pressures were over 140/90 mmHg!

Each year we ask organizations who participate in the challenge to tell us their Blood Pressure Challenge story; half of the 2013 participants sent in a "Tell Us Your Story" form along with their blood pressure tally sheets. We awarded three participating organizations certificates of commendation for their innovative ideas and challenge results.

1st Prize: Colchester East Hants Health Authority (CEHHA) focused on improving awareness and access. They kicked off their campaign by doing a radio spot and held seven blood pressure clinics during the month of May, two of which were in a community setting. They also challenged staff to have blood pressures checked and awarded prizes for largest volume and highest percent of staff pressures checked in a department. On World Hypertension Day, a special team (the Hypertension Honeys) travelled to areas of the facility that did not have blood pressure machines to screen people in their work area. Upon completion of the events, they had completed 801 blood pressure checks (surpassing last year's winner by 316 readings).

2nd Prize: South West Health (SWH) set up a challenge committee to brainstorm ideas for their three facilities as well as their community. Businesses were encouraged to participate, and restaurants were asked to offer low sodium options on their menus and to provide sodium information on May 17th for World Hypertension Day. Local leaders within SWH were challenged to offer blood pressure screening for staff on a designated day for one hour. Blood pressure checks were offered over lunch hour in the cafeteria area, and low sodium meal options were available. A local business offered a blood pressure clinic on site for their staff. In total, 635 blood pressures were checked in the Challenge. The committee met to reflect on successes and challenges and submitted a report to senior leadership for moving forward with this work in the coming years.

3rd Prize: Cape Breton District Health Authority (CBDHA) recruited champions in all their facilities to promote a District-wide Challenge in 2013. Staff was encouraged to have blood pressure checked. Blood Pressure clinics were held at various sites and throughout most of the hospital Units. Participants were able to fill out a ballot for a chance to win two green fees and a rented power cart at a local golf course. A total of 554 blood pressures were recorded and plans are underway to expand to the community in 2014.

The Challenges are growing yearly in numbers of participants due to the innovative ideas that Challenge organizers come up with each year. Here are a few of the consistent messages we heard from "Tell Us Your Story" documents:

- Start a Challenge committee in your institution; start early and involve champions from different work areas.
- Partner with others to increase reach (e.g., Occupational Health, local businesses, Foundation, employee committees, cafeteria staff, local radio stations, senior homes/halls, nursing schools, etc.).
- Make it easy to get blood pressure checked by holding multiple clinics or, better still, a travelling clinic (e.g., Hypertension Honeys in CEHHA - see First Prize).
- Advertise in advance (e.g., email distribution, posters in high traffic areas, Facebook, local TV or radio, etc.).
- Challenge others within your organization.
- Involve senior managers and communicate results.

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- Link with other events in the community (e.g., Senior's Expos, Health and Safety Week, teaching Rounds, local walk/run events, Quality Week, etc.).
- Put displays in busy areas (i.e., cafeteria and/or front entrance of hospital).
- Communicate results with employees/participants (e.g., email distribution list, local newsletters, local papers, etc.).
- Offer incentives to participate (e.g., treats such as a yogurt bar, door prizes [Low sodium cookbooks, t-shirts, green fees/golf games, fitness passes, pedometers, low sodium food basket, sodium 101 magnets, road race registration], or prizes for most blood pressures checked or highest percent of staff participating, etc.).

If you have questions about a Challenge, or want to share an idea, contact Kathy Harrigan directly (Kathy.Harrigan@cdha.nshealth.ca).

Editors: Kathy Harrigan, CVHNS, and Peggy Dunbar, DCPNS

Hypertension Grants (2013)

Project Summary

South West Health Inter-Professional Outreach Hypertension Clinic

Pam Robichaud, Nurse Manager
E-mail: PRobichaud@swndha.nshealth.ca

Project Objectives:

- To develop a sustainable Hypertension Clinic as part of the Cardiovascular Clinic in South West Health using existing staff and resources.
- Provide education and training to team members to develop specialized skills in hypertension, self-management, and inter-professional team collaboration.
- To partner with other chronic disease programs, such as Kidney and Diabetes Education, in the identification, management, and follow up of patients with hypertension.
- To develop patient self-management support strategies to include patient engagement to self-manage through setting of goals and action plans.
- To increase awareness, prevention, and early detection of hypertension.

Outcomes - What was accomplished?

At the beginning of the project, a literature review was conducted, team planning meetings were held, and locations chosen for the outreach clinics (Weymouth/Digby, Freeport, Yarmouth, and Shelburne). Resources were reviewed, including the ordering of print materials and travel containers. A shadowing opportunity at the QEII Hypertension Clinic was explored. Questions were developed for patient and provider surveys. Unfortunately, the project had to be put on hold due to human resource challenges.

Learnings/Advice:

1. We learned that the project required key expert staff to implement the plan. Our system is fragile and vulnerable to resource challenges and staff mobility.
2. The project involved many stakeholders, but we neglected to tap into VON, Public Health, and other local multidisciplinary service providers in the rural/remote areas.
3. The District Health Authority (DHA) has a large geographical area, and rural areas tend to work in silos and need to be better connected to the resources within their DHA.

Next Steps:

South West Nova DHA has overcome human resource challenges, and a nurse will coordinate the project over the next few months. South West Nova will submit an updated plan and aim to complete the project by September 2014. A one-page summary will be provided to the Provincial Programs for inclusion in their newsletters.

Tools Developed (available for sharing):

- Patient Survey Post Assessment
- Provider satisfaction survey to assess degree of knowledge translation among team members and outreach staff

For more information on the project and to access specific tools contact Pam Robichaud.

Project Summary

Hypertension Quality Collaborative

Susan Miles, Chronic Disease Management Coordinator
E-mail: smiles@avdha.nshealth.ca
and
Brad Osmond, Community Health Planner
E-mail: bosmond@avdha.nshealth.ca

Project Objectives:

- To establish a quality collaborative initiative with Primary Care physicians and inter-professional teams that support improved hypertension management.
- To work more closely with physicians who are not already part of Collaborative Teams.
- To utilize this opportunity to integrate medical residents in new District initiatives.
- To highlight and encourage the use of existing resources to support chronic disease management (My BP cards/ brochures, Your Way to Wellness, 4 the Health of It).
- To establish or strengthen relationships between inter-professional teams and physicians.

Outcomes - What was accomplished?

An Advisory Committee was formed and has met five times in the past year (March 2013 to January 2014). Members of the Committee include: a Primary Care Physician, a Family Practice Resident, a Nurse Practitioner, a Dietitian, a Family Practice Nurse, a Community Health Planner, a Librarian, a Community Pharmacist, the Ambulatory Care Assistant Manager, a Community Health Centre Clinic Nurse, the Director of Primary Health Care, the PC Team Facilitator – Project Lead, the Chronic Disease Management (CDM) Coordinator, and a representative from Provincial Programs.

A subgroup of "worker bees" was established to review, investigate, and prepare information for the larger group between meetings as well as develop the project plan. Four meetings of this subgroup were held in this same time frame.

Communication about the project (project progress) has been shared through the VP Community and Continuing Care (monthly), the CDM Working Group (every two months), and the CDM/Cardiac Rehab Planning Group (on an ad hoc basis).

Learnings/Advice:

- Learned the difference between evidence formed decision making and decision informed evidence – thanks to the Librarian who has been a member of our steering committee.
- Gained an understanding of quality collaboratives.
- Learned about hypertension interventions that have documented efficacy.
- Limited existing resources made it challenging to do something different.
- Importance of engaging family physicians and incorporating their recommendations.
- Challenge of moving some District staff to working in a different way with patients (educational role).
- Time it takes to reach consensus and to move projects forward.
- Restraint to not jump into doing the intervention as we plan for the process.

This planning has taken longer than expected. Finding time to bring people together has been challenging, but we are confident that this initiative will provide a basis for further work in both hypertension management as well as physician engagement in other CDM projects. The opportunity that was presented through the Provincial Programs' grant has pushed us to try something new. We have learned from each other re: the challenges of providing best practice care and how we work together.

Next Steps:

At this point, the project is not complete; but we are continuing to work through the last steps of the process and hope to begin a trial run this spring (2014).

Tools Developed (available for sharing):

- *Evidence Informed Decision Making? Or Decision Informed Evidence*. Article by Michelle Helliwell, with help from Brad Osmond
- AVH Hypertension Quality Collaborative Initiative Group Terms of Reference
- Overview of AVH Hypertension Collaborative, including plans for physician engagement, patient education/ hypertension education, and home blood pressure monitoring

For more information contact Susan Miles or Brad Osmond.

Project Summary

Primary Health Care "Empowering the Hypertensive Patient"

Susan Atkinson, Nurse Coordinator, Cardiovascular Health
E-mail: SAtkinson@ssdha.nshealth.ca

Project Objectives:

South Shore Health
Partnering with Our Community

- Empower the hypertensive patient through education and further development of their self-management skills.
- Enhance the Primary Health Care Collaborative Teams' ability to provide patients with education and self-management support.
- Aid in the implementation of a smoking cessation program for patients in the Primary Health Care setting (thus addressing this risk factor for hypertension).

Outcomes - What was accomplished?

A module called "Hypertension: All About Blood Pressure," a facilitator's guide, and a slide set were developed by a dietitian and a nurse working together as members of the Chronic Disease Management (CDM) team. The module was based on the most recent Canadian Hypertension Education Program (CHEP) guidelines. The aim was for the patients who attended the sessions to gain confidence in their ability to manage their hypertension by:

- Increasing their basic knowledge of how hypertension affects their health.
- Practicing reading food labels for sodium content.
- Practicing measuring their own blood pressure and logging the same.
- Addressing barriers to medication adherence.
- Setting realistic attainable goals.

The module was delivered in 2 separate 1.5 hrs sessions, 1 week apart, and in 2 Collaborative Practices (Lunenburg and North Queens) with a total of 17 participants, including family members/support people. Initially, the dietitian and nurse who developed the module facilitated, so they could see firsthand what, if any, changes should be made. In the Lunenburg practice, the Family Practice Nurse co-facilitated with an alternate dietitian. Having the Family Practice Nurse facilitate is important for sustainability.

The patients who attended the sessions were asked to evaluate the experience. Patients found the label reading and sodium information most useful. The practical help with blood pressure monitoring was identified as the second most helpful part of the sessions.

Attendees also completed a questionnaire that measured the degree of self-efficacy. Patients self-reported their confidence level in their ability to perform tasks related to self-management with regards to their hypertension; improvements were seen in more than one area of confidence.

Data was also collected in two different Family Practices for the first phase of the Ottawa model for smoking cessation project.

Learnings/Advice:

1. Allow the Primary Care Practices more time to identify and refer appropriate patients to the module sessions.
2. Schedule more regular, predictable sessions and avoid scheduling during the summer months.
3. Consider using a larger community venue for the sessions to accommodate larger numbers of participants.
4. Focus on the practices where existing staff can take on the role of facilitator.
5. Collaborative Primary Care Practices are interested in having more sessions of this kind offered in the future.
6. Data collection for the smoking cessation project is time consuming, so in the future, would allow more time for this phase of the project.

Next Steps:

South Shore Health plans to integrate this module into CDM programs such as Cardiac Rehab and Diabetes Education. It will continue to be available to all clinicians in the CDM Program, with plans for further sessions in the spring of 2014.

Tools Developed (available for sharing):

- Module: Hypertension, All About Blood Pressure, facilitator's guide, and slide set
- Self-Efficacy Questionnaire
- Client Evaluation Form
- Script for administrative staff to use when contacting patients and inviting them to the sessions

For more information on the project and to access specific tools, contact Susan Atkinson.

Project Summary

Hypertension Education: A Pilot Project to Address Issues of Hypertension in Multiple Populations

Matthew Murphy, Risk Management and
Decision Support Coordinator
E-mail: matthew.murphy@gasha.nshealth.ca

Project Objectives:

Introduce participants to modifiable risk factors (diet, exercise, etc.) through interactive class sessions.

Outcomes - What was accomplished?

The project ran officially from February 2013 to September 2013.

The grant was used to fund a multi-community education program that targeted individuals with, or at risk for developing, hypertension. The program session was run as a series, focusing on topics such as medication management, exercise, nutrition, and wellbeing. Each of the topics focused on modifiable risk factors and provided relevant information promoting healthy living.

In total, seven, four-week education sessions were provided to multiple populations with, or at risk for, hypertension. Using the principals of patient/family-centered care, participants were encouraged to bring a support person with them to the classes. In total, 79 people attended the sessions. The sessions were offered in six communities - Port Hastings, Antigonish, Guysborough, Saint Mary's, Canso, and St. George's Channel.

Collaborative partners in helping to develop and deliver the program included Primary Health Care, Public Health, Your Way to Wellness Program Coordinator(s), Guysborough Recreation Department, and St. George's Channel Community Association.

Learnings/Advice:

Perhaps the most important thing we learned was that there is an incredible thirst for knowledge among those individuals living with, or at risk for, hypertension. While many people possessed a certain degree of background knowledge concerning their condition, everyone came prepared with a multitude of questions spanning topics from food, to medication, to exercise. We also discovered that from one geographic region to another within the District there was not a significant difference in baseline knowledge, nor was there a difference in baseline knowledge between those people living with hypertension compared to those who were at risk. In addition, we learned that the format of the group could make a huge impact on the enjoyment of the participants as well as the self-reported gains in knowledge. As part of the program, we offered regular classroom style group education sessions and community kitchens for the sessions relating to nutrition. In the community kitchen sessions, individuals were responsible for preparing a heart healthy meal (meal plan designed by a knowledgeable dietitian) to sit down and enjoy as a group. We received an overwhelmingly positive response to the community kitchen sessions with requests to continue provision of them in the future.

The majority of our participants were women (n = 50) and the age range for participants was 13 – 73, with a mean age of 61.3.

Participants were asked to rate their knowledge on a variety of topics related to hypertension prior to the beginning of the sessions and again once the sessions ended (pre-post). Greater than 90% of participants indicated an increase in knowledge, with a mean gain of 2 points on a five point Likert scale. The highest gain on individual sub-scales was on knowledge relating to the role of food and hypertension with participants gaining a mean increase of 2.7 points on a five point Likert scale.

Next Steps:

The funding for this project served as a catalyst for the forging of new partnerships between existing programs within Guysborough Antiognish Strait Health Authority (GASHA) as well as with community partners and organizations. These partnerships will be able to continue long after the funding has ended and will enable similar programs to be offered in the future.

Tools Developed (available for sharing):

- Module Content (4 sessions). Session content was adapted from the Diabetes Care Program's Hypertension Module and the Heart and Stroke Hypertension Toolkit

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- Demographic Collection Tool and Consent Form
- Pre/Post Assessment of Knowledge Questionnaires
- Recruitment Posters/Information

For additional information, or to request copies of tools listed above, please contact Matthew Murphy or Allison Kelly, Cardiovascular Health Coordinator for GASHA (allison.kelly@gasha.nshealth.ca).

Summary Comments:

This is a grant that has demonstrated the value of collaborative partnerships in reaching the community. The inclusion of community kitchens helps to profile the joy of learning together (from and with each other). Participants demonstrated sizable gains in knowledge through participation and learned small ways to make big changes in their life, leading to healthier lifestyles.

Project Summary

Building Community Capacity: Engaging Individuals in Knowledge Transfer on the Determinants of Hypertension

Tierney McIsaac, Primary Health Care Dietitian
E-mail: mcisaactierney@cbdha.nshealth.ca

Project Objectives:

Cape Breton District HEALTH AUTHORITY
Making Healthier Choices Together

- Provide accessible education to individuals within the communities of Glace Bay, New Waterford, Sydney, and North Sydney on hypertension, its determinants, monitoring, and prevention.
- Reduce hypertensive program participants' systolic blood pressure by 10% by engaging these individuals in knowledge transfer on the determinants of hypertension.
- Facilitate improvements in dietary intake, physical activity, sleep quality, and stress management by engaging program participants in knowledge transfer on the determinants of hypertension.

Outcomes - What was accomplished?

Between the months of January and April 2013, a set of three (3) free educational sessions focusing on hypertension, its determinants, monitoring, and prevention were provided within the communities of Sydney, Glace Bay, and North Sydney (in central community settings such as the Legion Hall, Sobeys Community Room, the Public Library, etc.). Participants were recruited using community advertisements (public service announcements; posters in grocery stores, drug stores, and libraries; inserts in church bulletins, etc.) and an advertisement and/or referral option from physicians as well as Diabetes, Renal, and Cardiovascular Clinics within the CBDHA. A total of 29 individuals took part in 1 or more sessions.

The program's design included blood pressure monitoring and recording using Nova Scotia's, "My Blood Pressure" cards, along with information sharing and facilitated discussion on hypertension, its risks, blood pressure targets, blood pressure monitoring technique, and lifestyle management or prevention of hypertension. Prevention and management focused on improved sleep hygiene, reduced sodium intake, healthy eating, increased physical activity, stress management, and medication adherence. Sleep hygiene was featured in the program's curriculum due to the emerging data supporting the relationship between sleep duration and risk of hypertension and the ease in which individuals can implement improvements in this area. Pre-existing and community resources and programs were advertised during the program including, among others, Your Way to Wellness, Cape Breton University's Cape Breton Health Recreation Complex (i.e., 50+ walk and tone), several physical activity options available within the community (from walking tracks to skating and swimming schedules), etc.

All content was developed utilizing research and information from the DCPNS Hypertension Module, Canadian Hypertension Education Program (CHEP), Health Canada, Dietitians of Canada, Canadian Society for Exercise Physiology, Nova Scotia Heart and Stroke Foundation, and Claudette Taylor, BA BN MN PhD (c) (with her expertise in sleep).

As blood pressure awareness and monitoring were key components of the project, participant blood pressures were measured and recorded at each session with assistance from volunteer Cape Breton University nursing students.

To enhance self-learning on the topics covered, take-home activities were given to participants with follow-up assistance provided via telephone and/or e-mail by the Project Coordinator.

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Learnings/Advice:

As a group, the program audience had a clear deficit of knowledge in the areas of blood pressure monitoring, prevention, and management, despite previous contact with health care providers for monitoring and diagnosis of hypertension. The knowledge deficit was evident with informal observations; however, baseline and final assessments of knowledge regarding the determinants of hypertension confirmed this finding as well.

Although many resources, including websites and pamphlets, are available around the topic of blood pressure monitoring, prevention, and management, individuals taking part in the program indicated a preference for relying on discussion and education from a credible health care provider as the primary method of obtaining information about the topic.

Participant-identified barriers to obtaining blood pressure education included: being unaware of another opportunity to attend an education session on the topic of blood pressure, other health priorities taking precedent in medical or clinic appointments, and/or feeling rushed during visits with health care providers and, therefore, not feeling comfortable to ask questions.

Results of the final assessments demonstrated a successful knowledge-transfer rate with increased identification of blood pressure targets and the modifiable risk factors of hypertension, along with an increased ability to elaborate on relationship between and recommendations for the risk factors listed. Final program evaluations (13 of 22) also captured that 100% of participants who completed the evaluations had already made or were contemplating lifestyle changes influenced by program attendance.

Next Steps:

As the group of individuals who took part in this program demonstrated a clear need for an accessible blood pressure education program to be provided in the communities of industrial Cape Breton, the hope is that a similar service may be offered within the Cape Breton DHA in the future.

Collaboration between various healthcare departments would allow physicians and clinics such as Renal, Cardiovascular and Diabetes, the ability to direct clients to a centralized hypertension-specific education service. It would also benefit those with limited access to health care services (such as education clinics) by allowing individuals within the community to self-refer according to readiness and interest.

Tools Developed (available for sharing):

For the following tools and/or other information regarding this project, please contact Laurie MacLellan, Manager Renal Dialysis, CBDHA, (902) 567-7816 or maclellanl@cbdha.nshealth.ca.

- Activity and Medication Challenges, modified from DCPNS Hypertension Module. These handouts provides physical activity benefits and challenges, ability for clients to track physical activity, and to understand their blood pressure medication.
- My Blood Pressure Card Challenge – this handout challenges clients to reflect on blood pressure recordings taken and variables that may have influenced readings.
- Sodium Challenge – this handout challenges clients to do a "sodium hunt" by recording and interpreting sodium amounts found on labels of food in various locations in their kitchen.
- Demographic Collection Tool and Consent Form
- Pre/Post Assessment of Knowledge Questionnaires
- Sleep Quality Assessment (Pittsburg Sleep Quality Index)
- Recruitment Posters/Information

Summary Comments:

This grant benefited from strong project management, as part of a larger initiative, with a focus on a variety of recruitment strategies and participant engagement activities. Sessions were developed using a variety of resources with a focus on modifiable risk factors, including sleep hygiene. They were accompanied by take-home activities to foster the uptake of new knowledge, and follow-up was provided by phone and/or email. Evaluation efforts include pre/post knowledge, blood pressure measurement, patient satisfaction, etc. An extended version of this project, funded by the Cape Breton Health Research Grant Fund (CBHRGF), will continue work in this area with a specific focus on sleep hygiene.

Come on Nova Scotia… Check It! Blood Pressure Challenge Kits

The "Come on Nova Scotia...Check it! Blood Pressure Challenge" Kits are now available. Help us surpass our goal of reaching over 4000 Nova Scotians in 2014. **Order a Challenge package from** info@nsrp.nshealth.ca.

Project Summary

Blood Pressure Education Class

Tracy Selway, Cardiac District Coordinator
E-mail: Tracy.Selway@cehha.nshealth.ca

Project Objectives:

- To provide a comprehensive class covering the medical and lifestyle aspects of blood pressure management.
- To evaluate participant knowledge pre and post class.
- To provide physicians with materials, so messaging across the District is consistent and consistent with national guidelines.
- To conduct a physician survey identifying their satisfaction with the program.

Outcomes - What was accomplished?

The project ran from February 2013 to March 2014. Initially, the grant committee spent time meeting with stakeholders to ensure this project received satisfactory uptake within the District and that the logistics of the project were suitable and user friendly for the referring source. We met with senior leadership and our Steering Committee and consulted with Information Management about information for physician dissemination. We identified the human resources required to provide the blood pressure education and worked on recruitment for participation. We made a plan for community promotion, secured health professionals to teach the class, and identified the information to disseminate to those who attended the class.

The Canadian Hypertension Education Program (CHEP) slide deck was used to guide the class. This class complements the current Heart Health services offered by the Nutritional Counseling service in Primary Care. Pre and post knowledge evaluation was done to establish that learning had occurred. The classes were delivered onsite at the Colchester East Hants Health Centre (CEHHC). In terms of recruitment, we used community resources such as news releases, the hospital internet site, and advertisement through the existing Heart Health Class, which is offered through Nutritional Counseling.

We offered our first class in December 2013; and although a total of six classes were scheduled, we were only able to offer three classes to date due to inclement weather. A total of six people participated in the classes, and evaluations were favorable. All participants agreed that the environment was very good in terms of suitability for learning, staff knowledge, and the information being of interest. Patient evaluation results suggest attendees gained valuable knowledge around medication, food choices, and blood pressure.

Learnings/Advice:

We utilized existing patient education materials from the CHEP, as it was felt that the information was standardized by a recognized group of experts, would meet the content requirement for literacy levels, and could be rolled out across the District or province without modification by individual practitioners (www.hypertension.ca/images/2013_EducationalResources/2012_HighBP_PublicEducationSlideKit_EN.ppt).

We provided information about local supports and services that complemented the material taught (i.e., smoking cessation, stress reduction, etc.).

Our cardiovascular services within the District, in terms of education and programming, are relatively new and require ongoing monitoring and support. It is felt that there are a number of residents within the District who would benefit from the information; however, due to demographic, geographic, and social determinant factors, practitioners need to establish a variety of tools and techniques to address these factors and provide necessary support. We have had some success with things like satellite clinics for diabetes and programs such as Your Way to Wellness, so we may need to adapt some of these approaches to ensure ongoing success. Based on participant feedback, we have established a good foundation for programming; we now need to determine how best to expand upon it to meet the needs of the population we serve.

Next Steps:

- Continue to recruit for the program, expanding the linkages between community resources such as the Community Health Boards, local pharmacies, etc.
- Work with existing resources to further collaborate and embed the information.
- Establish community locations outside of CEHHC to facilitate program offerings.

Tools Developed (available for sharing):

- Pre and Post Participant Knowledge Evaluation
- Participant Survey (to evaluate delivery of information)
- Physician Evaluation

For additional information or to request copies of the tools listed above, please contact Tracy Selway.

Why measure and record my blood pressure?

Knowing your blood pressure numbers and how they compare to your blood pressure target will help you when you talk to your doctor or health care provider. You are the most important member of your health care team.

What should my blood pressure target be?

Most people	**Less than 140/90 mmHg**
Most people with Diabetes or Kidney Disease	Less than 130/80 mmHg

Your physician and health care team will advise you on your target blood pressure.

- The only way you will know if you have high blood pressure is to check it regularly.
- Ask your doctor or health care professional for a **My Blood Pressure** card to record your readings.

For more information on…

Activity
- www.walkaboutns.ca
- www.phac-aspc.gc.ca
- www.heartandstrokedirectory.ns.ca

Blood Pressure
- www.myBPsite.ca
- www.hypertension.ca
- www.heartandstroke.ca/actionplan

Diet
- www.dietitians.ca
- www.healthcanada.gc.ca/nutrition
- www.lowersodium.ca
- www.sodium101.ca
- www.freshcannedfrozen.com
- www.dashdiet.org

Coping with Stress
- www.cmha.ca

Quitting Smoking
- Smokers Help Line: 1-877-513-5333
- www.smokershelpline.ca
- www.addictionservices.ns.ca

If you have questions or concerns about your blood pressure and how to control it, talk to your doctor, health care professional, or call **NS HealthLink 811**.

NOVA SCOTIA

I have my blood pressure checked.

Do YOU?

Come on Nova Scotia...

Check it!

Healthcare providers can obtain copies of the My Blood Pressure Card, Poster, and Pamphlet by completing the Order Form found on the "My Blood Pressure" website (www.novascotia.ca/bloodpressure/).