

Evaluation of a nursing led chronic disease management program

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Background and Objectives:

- Improve chronic disease care
- Increase role of RN's in care
- Reach out to "poorly controlled" patients with chronic diseases

Setting: Urban Ottawa FHT, 15,000 patients

Methods:

- Registry of hypertensive patients built using cumulative profile in EMR
- BP >150/90 or not seen in > 1 yr or provider referral
- 2 face to face visits and 1 phone call with RN over a 2 month period
- Focus on self-management /patient goals, lifestyle, stress medication compliance, referrals to resources

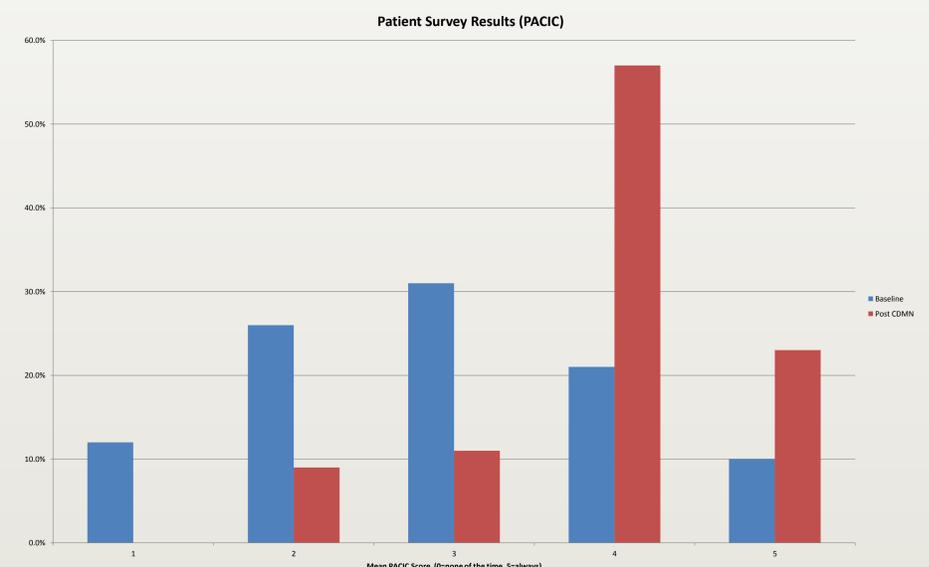
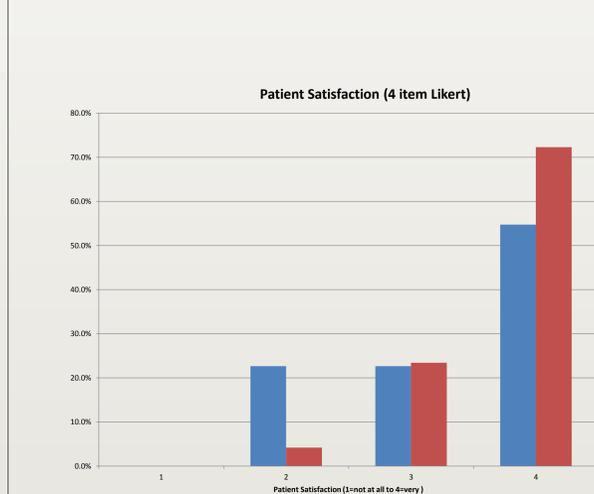
Characteristics: n=178 identified

- n=70 (39%) excluded (15=MD refused, 28=no contact, 27=declined)
- n=93 attend 1st visit, n=77 attend/booked 2nd visit

Clinical Data:

- Blood pressure change (Mean) : - 0.8 mmhg systolic
+ 0.6 mmhg diastolic
- Weight Change (Mean) : - 0.46 kg
- Referrals: 39 referrals within FHT (dietician (41%), social worker (23%), pharmacist (15%))
- Patient goals: exercise (74%), dietary (68%), stress reduction (32%), alcohol reduction (17%)
- Medication compliance (patient reported): no change

Patient Experience:



Conclusion: This brief RN led intervention successfully improved chronic disease care, patient satisfaction and use of allied health services for patients with hypertension. We also created a system that can be applied to other diseases.