Thank you for your interest and decision to investigate and potentially implement a Hypertension Management Program for your patients! Before you get started there are many things to consider. This planning tool and its parent Hypertension Management – Getting Started Toolkit for Primary Care are intended to help you think through and plan the steps necessary to implement.

Site Level Program Support

It is important to obtain support for implementation of the program from physicians and health centre administrative leaders, as well as the clinical team. The decision to participate in the program should be made by everyone, to ensure there is commitment, support for the resources needed to run the program and an awareness of the benefits of implementing. Planning sessions should include both executive/administrative leaders, as well as members of the clinical team. This assures that there is a common understanding of the organization's goals and there is team-wide engagement in the planning activities to support the successful implementation of the program at your Practice.

Identify the Core Team – THE 'WHO'

To support the implementation of the program and help sustain the program in the long run, it is important that program Champions be identified at your organization. Ideally, these individuals would lead the implementation; have the respect of their team and an interest in chronic disease management and teaching. The Champions aid in obtaining buy-in for the program, foster motivation and ensure that there is regular team discussion, assessment and planning of the program.

In addition, the core multidisciplinary (program core team) team will need to be identified and each of their roles within the patient visit will need to be determined. Allied health staff such as dietitians, social workers and pharmacists can play an important role in patient counselling on such topics as lifestyle and behaviour changes.

IDENTIFY THE 'WHO'

Who in your healthcare team will the **core program** team members be? Team size and composition will depend on the estimated number of patients you will have in the program (e.g. how many patients with elevated BP or Hypertension do you have in your roster?). Consider the Champions or leads to the program, in addition to the clinical & administrative processes.

CHAMPION	Champion 1		These individuals will be the main point of contact for the program and will be responsible for sharing program news with their clinical team and helping to resolve any related issues.
	Champion 2		
CORE TEAM	a) Who will be involved in patient engagement/registration?		
	b) Who will take patient BP measures with the AOBP? (will take 5-10 mins.)		
	c) Who will explain the program to patients?		
	d) Who will take and record measurements, i.e. height, weight, waist circumference?		
	e) Who will perform the initial visits and complete the flowsheets? (average 1st visit takes 30-45 min to allow sufficient time for patient education and lifestyle risks/goals discussions)		
	f) Who will provide patient education and initiate lifestyle change discussions?		
	g) Who will arrange follow-up visits?		
	h) Who will perform follow-up visits? (Average follow-up visit take 15 mins.)		
	i) Who on your team will set patients up with/track 'loaner' BP units if you are also implementing this aspect in your organization? NOTE: having a set of BP units that patients can borrow is a great way to evaluate initial elevated BP and consider diagnosis, as well as monitoring patients who don't have their own unit when making medication changes or working to stabilize treatment plans		
	j) Can administrative personnel or volunteers be involved in the program?		
	k) Who will track patient/provider materials and order, print or acquire additional supplies when needed?		

Identifying Potential Patients

Identifying potential patients to participate in the program is an important first step. There are many ways that this can be done, from searching your EMR based on the eligibility criteria (e.g. patients 18 years of age or older with a diagnosis of hypertension or history of elevated BP readings), to involving physicians and other healthcare providers in identifying patients who might be appropriate. Many patients with diabetes also have hypertension, so review your Diabetes Education Program participants to determine if there are any potential patients for the hypertension management. Remember that both those with high blood pressure, as well as those with diagnosed hypertension can see improvements in their BP by participating. Even patients whose BP is 'controlled' gain benefits from the monitoring aspects of a hypertension management program.

Planning Awareness Activities

By broadly raising awareness of the program and its benefits you won't only be pursuing potential clients; clients will learn about the program and come to you! Some past ideas have been placing an ad in the local newspaper or putting up a poster in your clinic waiting room. It's a good idea to start awareness activities right after your team's education and orientation session.

IDENTIFY POTENTIAL PATIENTS	1. What is the best way to identify potential patients for the program in your organization?	
	2. How will the identified patients be approached to arrange their first visit? (i.e. phone call, letter, email, approach them while they're at the clinic for another purpose)	
	3. Who will make the contact with the patient to initiate the process?	
INCREASE PATIENT AWARENESS	1. How could you raise awareness about the program amongst your patients?	
	2. What types of awareness activities might work best for your clients?	

Program Set-up

There are many details to be considered when preparing to roll out programs at your clinic. The questions below will help you to address some of these matters for a Hypertension Management Program.

PATIENT VISITS	1. Where will patients be seen in the clinic?	
	2. How will patients be referred to other providers (e.g. dietitian)?	
	3. Will group appointments be used?	
MATERIALS	1. Where will the patient materials and/or resources be stored? (e.g. print on demand when patient is present, use pre-printed resources, etc.)	
	2. Where will provider focused materials be stored, or will items only be accessed online (and providers require regular reminders where materials are available)?	
FLOWSHEETS & DATA	1. Will the flowsheets be in your EMR (e.g. custom form or fillable .pdf), or used as a paper form?	
	2. How/when and what data be reviewed and reported back to the team? (see companion resources such as Hypertension Program Key Performance Indicators to assist planning)	
OTHER	3. Is there anything else to consider in integrating this program into your unique organization?	

STEPS TO 'GET THERE'

Program Action Plan

The Program Action Plan will help your team develop initial and ongoing goals for your program outcomes, including who will be responsible for which steps, resources that may be needed, potential barriers and strategies to mitigate barriers to succeed in these goals in identified timelines. By working through this guide, you have already addressed many of the important steps in implementing a program. It is essential to be flexible when developing your Program Action Plan, so that you can make changes and adapt the plan as needed along the way.

With your team, begin working to complete the Program Action Plan now. Consider the following when creating your plan:

- Existing health clinic processes
- How to integrate hypertension program processes and tools within your current practice, i.e. who does what, where to put things so they are easy to access
- How to incorporate the hypertension management program into other chronic disease management programs at your clinic
- How to modify and sustain processes to support optimal integration and use of program tools
- How to enhance communications among providers to help accomplish hypertension management

After your plan is complete, you should have a clear understanding of roles, responsibilities and timing and a plan to ensure that the program can be effectively rolled out. Additional plans should be considered as your program matures, to look at next steps such as broader enrollment, fine turning clinical processes, attaining enhanced clinical outcomes and setting quality improvement goals.