Version 1.5
12/3/2018

Hypertension Toolkit

Table of Contents

San Francisco Health Network

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We would like to acknowledge and thank the members of the Hypertension Equity Workgroup for their dedication and support in building this Hypertension Toolkit.

1) Why Home Blood Pressure Monitoring?

Home blood pressure measurements are more accurate and reliable.
There is a rapidly growing literature showing that blood pressure (BP) measurements taken by patients at home are more reproducible than office readings and show better correlations with measures of target organ damage.[1, 2] Recent meta-analyses of prospective studies in the general population, in primary care and in hypertensive patients, indicate that the prediction of cardiovascular morbidity and mortality is significantly better with home BP than with office BP.[3, 4]

Home blood pressure monitoring, especially if supported by coaching, can improve medication adherence and timely management of hypertension.
In addition to more accurate and reliable measurements, home BP monitoring (HBPM) offers additional advantages of potentially improving medication adherence[5] and reducing clinical inertia[6] in treatment of HTN. One study using home BP cuffs with coaching showed improved BP control, even without active titration of medication.[7] Patients are more likely to participate in home BP monitoring programs if there is motivational patient education and follow up from their clinical provider.[8]

Numerous national and international guidelines recommend the use of home BP monitoring in management of hypertension.
This includes the European Society of Hypertension and European Society of Cardiology,[9] the American Society of Hypertension,[10] and the American Heart Association.[11] In 2008, the American Heart Association, American Society of Hypertension, and Preventive Cardiovascular Nurses Association issued a joint scientific statement as a call to action on use and reimbursement for home blood pressure monitoring.[10]

In general, home BP monitoring is recommended for confirming the diagnosis of HTN, suspicion of white –coat hypertension, suspicion of masked hypertension, and assessing response to antihypertensive medications.[9,10] HBPM may be of particular benefit and prioritized in patients with higher likelihood of white-coat HTN, higher cardiovascular risk, and in whom tight BP control is of paramount importance: Elderly patients with diabetes, patients with kidney disease, and African-American patients.

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2a) Candid Conversations Exercise

Let's read some conversations between coaches and patients. We will have a discussion after each conversation.

Telling Coach

The coach is working with Ms. Richards whose blood pressure is high.

1. **Coach:** Ms. Richards, this is your current blood pressure measurement.

2. Ms. Richards: Oh, ok.

3. **Coach:** Your blood pressure is 160/100. We want to bring it down to around 140/90. It is very important to your health.

4. Ms. Richards: OK.

5. **Coach:** That means you need to improve your diet, get more exercise, and take the extra pills that your doctor will prescribe. All of this will help you lower your blood pressure.

6. Ms. Richards: Ok.

7. **Coach:** So, please put this graph up on your refrigerator to keep you motivated.

8. Ms. Richards: I don't have a refrigerator.

Discussion

- How did Ms. Richards feel?
- What should the coach do differently?

Key Messages

1. Using tell-tell-tell does not engage patients.
2. Using tell-tell-tell the coach knows nothing about the patient

2a) Candid Conversations Exercise *(continued)*

Scare-Tactic Coach

The coach is working with Mr. Johnson whose A1C level is high.

1. **Coach**: Mr. Johnson, this is your current blood pressure measurement.

2. Mr. Johnson: Oh, ok.

3. **Coach:** (points to chart) I am very worried. Your blood pressure is 160/99. Mr. Johnson, that is too high! You know, it's supposed to be less than 140/90. You really need to bring your blood pressure down! If it stays high for too long, you may have a heart attack or stroke! You could even die!

4. Mr. Johnson: Oh.

5. **Coach:** Yes, high blood pressure, also called hypertension, is very bad for your health and can be dangerous. You have to take the medication the doctor prescribed. And you need to eat better and exercise more.

6. Mr. Johnson: I will try. However, is it OK if I start eating better after my niece's party tomorrow? Also, I can't get my medication until I am paid next week.

7. **Coach:** Mr. Johnson, it's up to you. You have to control your hypertension.

8. Mr. Johnson: What? I have hypertension?!

Discussion

- How did Ms. Richards feel?
- What should the coach do differently?

Key Messages

1. Most of the time, scaring patients doesn't work.
2. Not only did the coach scare Mr. Johnson, the coach also did tell-tell-tell and knows nothing about Mr. Johnson.

2a) Candid Conversations Exercise *(continued)*

Collaborative Coach

1. **Coach:** Would it be ok if we talk about your blood pressure now?

2. Senora Romero: Yes, it's Ok.

3. **Coach**: What do you know about blood pressure or hypertension?

4. Senora Romero: Not much.

5. **Coach:** That's fine. Let's go over it together. Your blood pressure measurement tells us about the flow of blood inside your blood vessels. It tells us how hard your heart has to work. High blood pressure, also called hypertension, means that your heart has to work extra hard to pump blood throughout your body. Just to make sure I was clear, what does your blood pressure measurement mean?

6. Senora Romero: It measures how hard my heart has to work to pump the blood. Is that right?

7. **Coach:** Yes, that's correct! Why do you think we care about your blood pressure numbers?

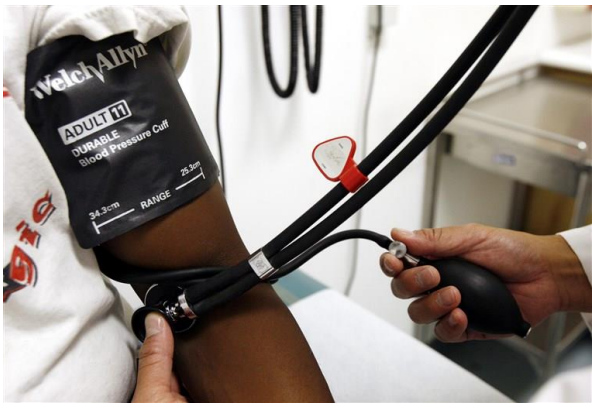
8. Senora Romero: I'm not sure. I think you said it shows something about my heart.

9. **Coach:** Yes! Your blood pressure number is another way to measure how your heart is doing. Can you tell me what your blood pressure number is?

10. Senora Romero: I think it is fine. I feel fine.

11. **Coach:** I am happy you feel fine! We hope that you continue to feel good. Sometimes, your blood pressure can be high and you still feel good. One way to keep feeling great is to lower your blood pressure.

    Let's look at your blood pressure together.



12. Senora Romero: It says 160/100.

13. **Coach:** Right. What is your goal?

14. Senora Romero: Less than 140/90.

15. **Coach:** Yes, your blood pressure is 160/100 now. You want your blood pressure to be around 140/90 or below to keep feeling good. What do you think about that?

16. Senora Romero: I was there in November. I don't know what happened.

17. **Coach**: What do you think you were doing before to keep your blood pressure at your goal?

18. Senora Romero: I was exercising more. I remember I used to go on walks every day.

19. **Coach**: That's great. Physical activity is one way to keep your blood pressure down. Is there anything else that helps keep your blood pressure down?

20. Senora Romero: Not that I can think of.

21. **Coach**: There are three things you can do to bring down your blood pressure – being active, healthy eating, and taking medications. Which one of those sounds like something you want to do to bring down your blood pressure?

22. Senora Romero: Maybe, I can start walking again.

23. **Coach**: That sounds like a great idea.
Maybe, we can make an action plan together to help you start walking.

Discussion

- Refer back to line 1, what was the purpose of the question? What was the coach asking for?
- What was the coach doing in lines 3 and 9?
- What was the coach doing in line 5?
- In line 11, how did the coach handle Senora Romero's beliefs about feeling good?
- What was the coach doing in line 15?
- What is the coach giving Senora Romero in line 21?

Key Messages

- Ask permission to start a conversation (line 1)
- Ask questions to find out what the patient already knows (line 3 and 9)
- Closing the loop (line 5)
- Assess the patient's motivation (line 15)
- Give the patients option for improving their health (line 21)

2b) Blood Pressure Teaching Role Plays

Scenario #1

1. ***Team Member****:* Hello Ms. Ramirez. My name is Alicia, and I'm here to teach you how to use this blood pressure cuff.
2. Ms. Ramirez: Oh. Okay.
3. ***Team Member****:* You sit with your feet on the floor, and your upper arm exposed.
4. Ms. Ramirez: (seems confused) Okay
5. ***Team Member:*** Wrap the cuff around your upper arm and rest your arm on a table so the cuff is level with your heart.
6. Ms. Ramirez: Okay.
7. ***Team Member****:* Press start. The cuff will inflate. Review your results in about 30 seconds. Do this every day for your high blood pressure. Got that?
8. Ms. Ramirez: Sure. What's this thing for again?

Discussion
1. What did the coach do well?
2. What technique did the coach use?
3. How did the patient feel?
4. What should the coach do differently?

2b) Blood Pressure Teaching Role Plays

Scenario #2

1. ***Team Member****:* Hello Mr. Johnson! My name is Alicia. How are you feeling today?
2. Mr. Johnson: Not too good. My legs are hurting and I still have that pain in my back. Can you give me something for that? You a doctor?
3. ***Team Member***: No, I'm not a doctor. I'm actually a (your role) and I work with your healthcare team. You're scheduled to see Dr. Miller after our visit today, so let's both remember to tell her about the pain in your legs and back. In the meantime, Dr. Miller has asked me to talk a little bit about your high blood pressure today. Would that be alright with you?
4. Mr. Johnson: Yeh. Cuz this pain is really messing me up.
5. ***Team Member*****:** I'm so sorry to hear that you're in so much pain, Mr. Johnson. Sounds like it's been really difficult for you. We're going to make sure that Dr. Miller addresses your pain in today's visit. Now before we begin, are there other health issues that you're concerned about?
6. Mr. Johnson: That's it I think.
7. ***Team Member*****:** Okay, well you let me know if anything comes up in the course of our conversation and we can add it to your agenda with Dr. Miller. Let's get started, what can you tell me about your blood pressure?
8. Mr. Johnson: I know it's high.
9. ***Team Member*****:** Well, the last time you came to the clinic, your blood pressure was 190/80, so you're right, that is a bit high. Why do you think we care if your blood pressure is high?
10. Mr. Johnson: Hmm. Something about heart attacks I guess.
11. ***Team Member*****:** That's right! Your blood pressure is actually a measure of how hard your heart is working to pump blood to your body, so when your blood pressure is high, it puts you at a greater risk for heart attacks and strokes. What do you think your blood pressure goal is?
12. Mr. Johnson: I don't know man, I just know that every time I come here, you guys tell me it's high. I feel fine!
13. ***Team Member*****:** Right, so we'd like for your blood pressure to be less than 140/90. The interesting thing about blood pressure is that you wouldn't actually feel very much of anything if it's high. That's why high blood pressure is called the "silent killer" and why it's important for us to keep track of how our blood pressure is so you won't have a heart attack or stroke. We definitely don't want that. What do you think effects your blood pressure?
14. Mr. Johnson: Yeah, no heart attacks for me. Dr. Miller gave me some blood pressure medicines but they make me pee all the time so I don't always take it. But man, that pain I've been telling you about, that makes my blood pressure go up.
15. ***Team Member*****:** Of course! I always like to tell people that there are three things you can do: take your medications as prescribed, exercise, and nutrition. The other thing that can help with your blood pressure, is daily monitoring with a blood pressure cuff, which would help us know what your blood pressure may be like at home and also help you keep track of it as well. Would you be interested in checking your blood pressure at home?
16. Mr. Johnson: Oh yea, I can definitely do that. I don't want to have a heart attack. Dr. Miller gave me some blood pressure medicines but they make me pee all the time so I don't always take it. Other than this pain I've got, I feel fine.

2b) Blood Pressure Teaching Role Plays *(continued)*

17. ***Team Member:*** That's great! I'm happy to give you a blood pressure cuff today and show you how to use it, so you can keep track of what your blood pressure is like when you're at home. Remember we don't always feel something immediately if it's high so the blood pressure log will be good for us to see what it might look like on a daily basis. The other thing though, in the meantime, I highly encourage you to take all your medications just as Dr. Miller prescribed it. Your blood pressure medication helps to keep your blood pressure at goal, but now coupled with the blood pressure log we're keeping, it will show us how it's helping your blood pressure or if we need to try something different. We can also definitely talk to Dr. Miller today about the peeing with the blood pressure medication as well, how does that sound?
18. Mr. Johnson: Yea ok, I want to talk to Dr. Miller about it, but I think I can take the medicine. So are we going to get started with the machine? How do I use this thing?
19. ***Team Member:*** Of course, let's do it! Now Mr. Johnson do you remember what your blood pressure goal is again?
20. Mr. Johnson: I think you said it had to be under 140/90.
21. ***Team Member***: Wonderful! (Slowly explains and demonstrates, dispense HTN education)
22. Mr. Johnson: Doesn't look too hard. I think I understand what blood pressure is now.
23. ***Team Member***: It's not too hard, huh? Just to make sure I was clear on my part, do you mind explaining to me what the top (systolic) and bottom (diastolic) numbers mean again?
24. Mr. Johnson: Oh sure! The top number is the pressure at which my heart is squeezing and the bottom number is the pressure at which my heart is relaxing. Did I get that right?
25. ***Team Member:*** You did! Awesome job. Now before I let you go, how do you feel about demonstrating to me how to use your BP cuff and log as if you were at home?
26. Mr. Johnson: No problem. (demonstrates and writes measurement/time down) How was that?
27. ***Team Member***: Perfect! You're a pro at this. And once again, just to double check I was clear, what are the three ways you can do to help your blood pressure?
28. Mr. Johnson: Oh now you're just testing me! Let's see…medicine is one, diet is another, and is the last one exercise?
29. ***Team Member***: All correct! Gold star for you, Mr. Johnson. We talked about your blood pressure medicine and in trying to take all your medications. Is there another one of the three you would also like to try? It's more than okay if you want to just work on one this time.
30. Mr. Johnson: I would like to just focus on getting my medications right for me before I make any more changes, so maybe not this time. Diet might be the next thing I want to tackle, but I do love my food, so we'll see.
31. ***Team Member***: Of course, I support whatever you want to do, because after all, it is YOUR health we are talking about. I'll be sure to bring it up next time we check in. Looks like Dr. Miller is about ready to see you. Do you mind if I go let her know that we are ready?
32. Mr. Johnson: No problem!

Discussion
1. What did the coach do well?
2. What technique did the coach use?
3. How did the patient feel?
4. What should the coach do differently?

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2c) Script for BP Cuff Follow Up

Introduction	
"Hello, my name is _(your name)_, I am a _(medical assistant/health worker/RN/etc)_ at _(clinic)_ Health Center. I am calling to speak with Ms/Mr. _(patient name)_.	
Not at home:	**Answering machine/voicemail:**
"When would be a better time to reach her?" "Thank you, I will call back then." **↘PROCEED TO "After Work"**	"Hello, my name is _(your name)_ ,I am a (medical assistant/health worker/RN/etc) at _(clinic)_ Health Center. This message is for Ms/Mr. (patient name). I am calling to check in on the equipment we gave you a couple weeks ago and how you are using it. Please give me call me at xxx-xxx-xxxx at your earliest convenience. Thank you and I look forward to talking with you." **↘PROCEED TO "After Work"**

Patient On the Phone	
"Is this a good time for you to talk?"	
➔ Yes	**➔ No**
"I'm calling to check in on how your blood pressure has been at home lately. Have you been able to use the blood pressure machine we gave you at your last visit?" **↘PROCEED TO either "If Yes…" or "If No…"**	"When would be a better time for me to call you back? "Thank you, I will call back then." **↘PROCEED TO "After Work"**

If Yes, using machine	
"That's great. So glad you have been able to put it to use. How often have you been able to take your blood pressure at home?"	
→As prescribed	"Wonderful. What have your blood pressure numbers looked like since you've started logging it?" "Could you please read out your numbers to me?" [Write down all blood pressure numbers.] **↘PROCEED TO "Health Coaching"**
→Using, but not as often as prescribed	"That's alright, I am glad you are able to take it at least some of the times. For all the times you were able to take your blood pressure, what do the numbers look like?" Could you please read out your numbers to me?" [Write down all blood pressure numbers on a separate sheet. *You do not need to document all BP#s in TE during documentation. Only document high, low and average in TE. Scan all numbers into chart.] **↘PROCEED TO "Health Coaching"**

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2c) Script for BP Cuff Follow Up *(continued)*

If No, not using machine	
→Not using at all	That's alright. What seems to be preventing you from being able to take your blood pressure at home?" **↘PROCEED TO "Ask = Problem Solve"**

Health Coaching	
"Thank you for sharing your numbers with me. Do you remember what your goal for blood pressure is?" Provide teach back as necessary regarding: • Patient's BP goal? • Why BP is important? • BP medication/nutrition/exercise?	
"How do you feel about the blood pressures you have been recording at home?" [Either positively affirm or let patient know if they are right in thinking their BP is high or normal.]	
→If blood pressure is at goal	"Your blood pressure at home is at goal. What do you think you've been doing to help keep it at goal?" Encourage positive behavior. If patient cannot think of anything that they are doing, remind them of BP medication/nutrition/exercise as applicable. **↘PROCEED TO "Conclusion"**
→If blood pressure is not at goal	"Your blood pressure at home is above goal. What do you think you can do to help get it to goal?" Action plan with patient. • Let patient know you will be calling in xxx time frame to check back to see how new plan is working. **↘PROCEED TO "Conclusion**

2c) Script for BP Cuff Follow Up *(continued)*

ASK = PROBLEM SOLVE	
"What seems to be preventing you from being able to take your blood pressure at home?"	
Patient Says:	You Say:
→"I don't know/remember how to use the machine."	"Oh that's completely fine. I understand that with new devices and things, it can get a little complicated. I would be more than happy to schedule a time with you to come back with the machine so we can go through it together once more. Would that be alright with you?" Schedule time with patient to come in for BP cuff teaching. • Normalize not being able to remember to use machine • Emphasize teach back at return visit. **↘PROCEED TO "Conclusion"**
→ "I am too busy."	"I completely understand that with a busy schedule it may be hard to stop and take your blood pressure. However, the reason we want to keep track of what your blood pressure is at home is because we want to make sure you stay healthy so that you may continue to do the activities you do like. The blood pressure numbers we get from you are important in helping Dr. _____ and his/her team here at _(clinic)_ to come up with the best care plan for you." "Is there a time you could think of in your schedule where you might have a moment to sit down and take your blood pressure?" Problem solve and action plan with patient. • Find a schedule that fits to patient's schedule. Do not force a timeline for patient. • Emphasize that the blood pressure measurement should take no more than 5 mins. • Maybe suggest leaving the blood pressure machine where patient sits and watches TV or eats breakfast, etc. • Let patient know you will be calling in xxx time frame to check back to see how new plan is working. **↘PROCEED TO "Conclusion"**

2c) Script for BP Cuff Follow Up *(continued)*

Conclusion
"Thank you _(patient name)_ very much for taking the time to talk to me today. I will let Dr. _(provider)_ know what your blood pressure has been so that everyone is all on the same page and we can all work together to get/keep you at goal with your blood pressure." "Before I let you go, what other questions do you have for me? [answer questions]." "Thank you again. _(reiterate action plan and/or any follow up appointment date/times)_. Please feel free to give me a call back at xxx-xxx-xxxx if you have any more questions come up!" **↘PROCEED TO "After Work"**

After Work
• Document encounter, BP numbers, action plan, etc. in eCW [Please reference eCW documentation workflow] • Set Actions as necessary for follow up call/work as necessary
**If you have left multiple messages and have been unable to contact patient do the following: • Call Emergency Contact to see if they might have a more current number. (wait for reply) • Send letter of unsuccessful notification (wait for reply) • If all fails, send TE to provider: Unable to Contact: Numerous attempts by phone/letter to follow up with patient regarding BP Cuff, no reply. Please re-refer patient at next visit for follow up.

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2d) Health Coach Observation

Health Coach: _____ **Date: _____**

Preparation (Ask prior to visit)	
☐	Coach knows that preventive and chronic care patient is due for
☐	Coach has made warm reminder call and reminded patient to bring in medication bottles
☐	Coach knows patient's latest numbers
☐	Coach can describe patient's most recent action plan
☐	Coach can name his/her goals for the visit
Comments:	
Greeting	
☐	Coach gives the patient a VIP greeting.
Comments:	
Setting the Agenda	
☐	Coach asks patient what s/he want to talk about.
☐	Coach restates what s/he heard patient say
☐	Coach ssks to saturation (until the patient has no more to say).
☐	Coach asks patient if it OK to talk about things coach wants to talk about (setting the agenda).
☐	Coach asks which 2-3 items are most important to the patient and writes list for provide that shows those items first.
☐	Coach and patient set the agenda for the visit using both patient and coach items
☐	Coach takes things off the list that s/he can address.
Comments:	

2d) Health Coach Observation *(continued)*

Ask-Tell-Ask
Coach listens without interrupting
Coach's comments, tone, and facial expressions are friendly and not judgmental
Coach engages in reflective listening – uses patient's words as cue for the next sentence
Coach asks patient questions relevant to the topic at hand.
Coach provides information or advice ONLY when patient asks or patient doesn't know.
Coach provides accurate information.
Coach did not know the information and said, "I don't know but I will find out and get back to you".
Coach takes advantage of learning moments to ask questions ("What is your goal for your blood pressure?")
Comments:
Medication Reconciliation (med-rec)
Coach reviews one medication at a time
Asks name
Asks dose;
Asks what med is for;
Asks how often to take it;
Asks if they take it as prescribed;
Discusses reasons not taking as prescribed;
Asks if patient needs refills
Coach repeats process for each medication
If patient needs help with and is interested in improving medication adherence, asks if patient wants to make an action plan.
Comments:

2d) Health Coach Observation *(continued)*

Action Plan
Coach asks the patient what they want to work on.
Coach helps patient plan…
What
How
Which days
Where
With whom
Coach asks when the patient wants to start.
Coach asks the patient about their confidence on a scale of 1–10 (7 or higher means patient is feeling confident).
Coach sets date/time to follow up.
Coach helps patient troubleshoot barriers.
Comments:
Closing the Loop
Coach asks patient to retell the information, in a respectful manner.
Coach asks patient close the loop about…
Medications
Action plans
Health education (e.g., Know your numbers)
Care plan
Appointments
Coach closes the loop around patient's agenda
Coach closes the loop when uncertain about what the patient said
Comments:

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2d) Health Coach Observation *(continued)*

Coach/Patient Interaction	
☐	Coach warmly greets patient
☐	Coach makes eye contact
☐	Coach smiles
☐	Coach is relaxed
☐	Coach speaks slowly and clearly
Comments:	

Health Coach Role	
☐	Coach does NOT provide qualitative judgment (Rather than "Your blood pressure is <u>good.</u>" Health coach can use "Know your numbers" questions.
Comments:	

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2d) Health Coach Observation *(continued)*

Main points from medical visit that health coach should close loop on (check off as you hear coach close the loop):

Appointments/labwork/referrals:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Medications:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Provider advice:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Health coach follow up:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Take home messages

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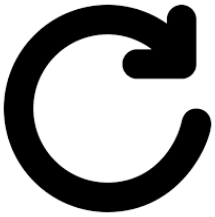
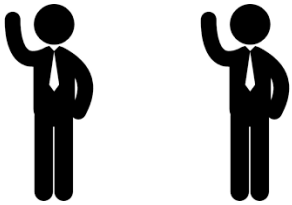
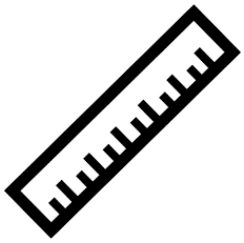
3a) Home BP Cuff Instruction

My Blood Pressure Goal:

SBP LOWER THAN DBP LOWER THAN

 **In front of a table with back and leg support**	 **Sit quietly for 5 minutes**	 **Repeat if high, after 3-5 minutes**
 **Check in AM and PM**	 **Check the same arm each time**	 **Measure arm size for correct cuff size and placement**
 **Measure on bare arm Avoid tight clothing**	 **Do not talk while measuring**	 **Do not measure immediately after coffee, smoking, or with a full bladder, or in pain**

	**Call the clinic when blood pressure is higher than 180/110 after repeated checks** **Bring your home blood pressure machine to your next visit. Our staff can check your machine's accuracy, and teach you how to use your machine correctly. <u>Share your home blood pressure readings</u> by bringing them to your next clinic visit**

Images obtained on the internet using Google Image search

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3b) Blood Pressure Log

Name: _____

My blood pressure goal is:	**Systolic**	
	Diastolic	

Date	Time	Blood Pressure	Pulse	Notes
		/		
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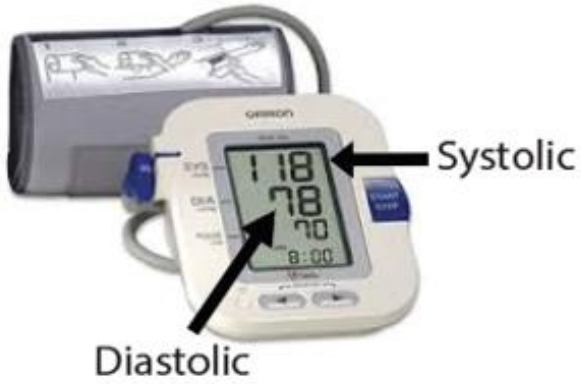
Please remember to bring your completed blood pressure logs to your next provider appointment.

3c) General HTN Education Handout

Your Hypertension Worksheet



What is blood pressure?

- **Blood pressure** is a measure of how hard your heart is working to pump blood
- **Systolic** (Sys) – pressure when your heart squeezes
- **Diastolic** (Dia) – pressure when your heart relaxes

Date: _____

Your Blood Pressure Today: _____/_____

Your Target Blood Pressure is **below:** 140/90 or _____

Your Health Coach/RN: _____

Your Next Blood Pressure

Check Appointment: _____

- Please take your Blood Pressure medication on the day of your appointment
- We may change your medication at the visit; please bring all your current medications with you
- Please bring your Blood Pressure Cuff, Machine, and Log

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3d) HTN Action Plan

My action plan to improve my high blood pressure (pick one, and be specific)
When, how much, and how often? How confident are you (1-10)?

Date: _____

	Increase physical activity *(e.g.,walking for 10 minutes Mon, Wed, Fri after breakfast, confidence 8)*	Very Confident 10  0 Not Sure
	Take my medications	
	Lower salt in food	
	Improve my food choices	
	Check my home blood pressure	
	Reduce stress	
	Cut down on smoking	
	Your own idea	

Notes

Images obtained on the internet using Google Image search

Lowering Your Blood Pressure with Healthy Foods!

Choose MORE of These!

examples below

Whole Grains:

- Whole grain bread, cereal, pasta, etc.
- Oatmeal
- Brown or wild rice
- Corn

Fruits (fresh, frozen, or unsweetened dried):

- Oranges, apples, dates, bananas, raisins, prunes, apricots, mango, melons, peaches

Vegetables (fresh or frozen):

- Tomatoes, broccoli, bell pepper, zucchini, spinach, cauliflower, greens, mushrooms, sweet potatoes, squash, Brussels sprouts, cabbage, string beans, plantains, potatoes

Nonfat or low fat milk or milk products:

- Nonfat or low fat (1%) milk or yogurt
- Low fat cheese with no salt added
- Unsweetened milk alternatives (soy, almond, etc.)

Nuts, Seeds, and Beans *(plant proteins)*

- Unsalted peanuts, almonds, walnut, pistachios, cashews
- Unsalted sunflower seeds, pumpkin seeds, flax seeds, chia seeds
- Beans/peas: Pinto beans, split peas, black beans, lentils chickpeas

Choose SOME of These!

Good sources of protein (6 oz. or less per day):

- Fish
- Chicken or turkey (no skin)
- Eggs or egg whites
- Baked or roasted beef and pork

Healthy fats (use in small amounts):

- Olive Oil or Canola Oil
- Soft (tub) margarine from canola or corn oil
- Avocado

Choose Fewer of These!

High salt foods: bacon, sausage, ham, canned foods, frozen dinners, processed cheese, lunch meats

Did you know? *More than 75% of the sodium we eat comes from processed, prepackaged, and restaurant foods!*

High salt seasonings: salt, soy sauce, teriyaki sauce, fish sauce, oyster sauce, BBQ sauce, bouillon, lemon pepper

Alcohol: no more than 1-2 drinks (12oz beer or 5oz wine) in a day

Desserts, sweets, sweetened drinks:

- Candy, pie, cookies, cake, ice cream, pastries
- Soda, juice, sweet tea, sports drinks, lemonade

Fried food:

- Chips, donuts, pork rinds, instant noodle soup

The more vegetables, fruits, and whole grains you eat, the healthier your ♡ will be.

If you have trouble getting healthy food, ask your clinic nurse or provider.

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3e) DASH Diet Handout *(continued)*

Lowering Your Blood Pressure with Healthy Foods: How Much?

Whole Grains: 6 servings per day

- **What's a serving**
  - 1 slice wheat bread; ½ cup cooked whole grain rice, pasta, corn, quinoa, or cereal; 1 ounce dry cereal (varies ½ - 1 cup), 3 cups popcorn, 1 small (about 6-inch) tortilla
- **Your portion may be more than one "serving"**
  - 1 cup of brown rice is 2 servings
  - 1 large (12-inch) tortilla is about 4 servings
  - 1 large bagel is about 4 servings

Fruits: 4 servings per day

- **What's a serving**
  - 1 medium fruit; ¼ cup dried fruit; ½ cup fresh, frozen, or canned fruit
- **Your portion may be more than one "serving"**
  - 1 large (12-inch) banana is about 2 servings

Vegetables: 4-5 servings per day

- **What's a serving**
  - 1 cup raw leafy vegetables; ½ cup raw or cooked vegetables
- **Your portion may be more than one "serving"**
  - An entrée-size green salad is 2-3 servings

Nonfat /low fat milk products: 2-3 servings/day

- **What's a serving**
  - 1 cup milk or yogurt
  - 1 ½ ounces of low fat cheese
- **Your portion may not be one "serving"**
  - Some individual yogurt cups are ¾ cup
  - A slice of cheese is usually about 1 ounce

Nuts, Seeds, and Beans: up to 1 serving/day average

- **What's a serving**
  - 1/3 cup nuts
  - 2 Tbsp. peanut butter/nut butter
  - 2 Tbsp. seeds
  - ½ cup cooked legumes (beans, lentils, peas)

Healthy Fats: 2-3 servings/day

- **What's a serving**
  - 1 tsp oil (olive, canola, sunflower, soy, etc.)
  - 1 tsp tub margarine or regular mayo
  - 1 Tbsp. light mayonnaise
  - 2 Tbsp. salad dressing

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KNOW YOUR RISK!

Take this self-test to find out if you are at risk for heart disease.

The following things can put you at risk for heart disease.
Check all your risk factors that apply and follow up with your doctor:

☐ High blood pressure	☐ Not sure
☐ High cholesterol	☐ Not sure
☐ Diabetes	☐ Not sure
☐ Chronic kidney disease	☐ Not sure
☐ Family history *(father or brother with heart disease before age 55 or mother or sister with heart disease before age 65)*	☐ Not sure
☐ Cigarette smoking	
☐ Age *(older than 45 for men, over 55 for women)*	
☐ Being overweight	
☐ Lack of physical activity	☐ Not sure
☐ Unhealthy diet	☐ Not sure
☐ Depression, stress, mental health conditions	☐ Not sure

HEALTHY LIFESTYLE AND PHYSICAL ACTIVITY RESOURCES

Community Wellness Center at Zuckerberg
San Francisco General Hospital (ZSFG)
(415) 206-4995

American Heart Association
http://heart.org/healthyliving

For FREE physical activities, go to
http://sfrecpark.org/recreation-community-services/rec-programs/

Write the name and phone of your healthcare provider here:

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COMMUNITY HEALTH EQUITY & PROMOTION

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Produced by 510media

Sources: 1) National Heart, Lung, and Blood Institute; National Institutes of Health; U.S. Department of Health and Human Services. 2) Mozaffarian D, Benjamin EJ, Go AS, et al. Heart Disease and Stroke Statistics—2015 update: A report from the American Heart Association. Circulation. 2015; 131(4):e29-322. | August 2016

STEPS TO

Prevent Heart Disease At All Ages

Heart disease is a serious health problem. Family history and habits can make you more likely to develop heart disease.

Most people do not know that they might be at risk for heart disease, even though it is the number one killer of Americans. Nearly 44% of African American men and 48% of African American women have some form of heart disease, which includes heart attack and stroke.

The good news is that you can take steps now to lower your risk of heart disease. Lowering your blood pressure, blood sugar, and cholesterol can decrease your chances of a heart attack and stroke. Heart healthy changes are good for your whole body. ***Turn the page for ideas!***

KNOW YOUR RISK!

Take the **self-test** on the back of this booklet to find out if you are at risk for heart disease.

THINGS YOU CAN DO TO IMPROVE YOUR BLOOD PRESSURE

If you already have high blood pressure, take your medications as agreed upon with your doctor. ***Check all your goals that apply:***

- [ ] **1. How can I reach and maintain a healthy weight?**
  - Set a healthy weight goal for yourself.
  - Drink water. Try to avoid soda and juice with added sugars.
  - Eat smaller portions. Eat healthy foods and snacks.
- [ ] **2. How can I get a least 30 minutes of physical activity each day?**
  - Walk with family, friends, or neighbors.
  - Take the stairs instead of elevator.
  - Make time to exercise in addition to your usual activity.
- [ ] **3. How can I eat less salt and saturated fat?**
  - Minimize pre-prepared and processed food.
  - Cook and prepare your own food as often as you can.
  - Use herbs and spices while cooking and less salt.
  - Try to avoid frying food.
- [ ] **4. How can I eat heart healthy foods every day?**
  - Eat more fresh fruits, vegetables, and whole grains.
  - Buy fresh, frozen, or no-salt-added canned vegetables and sauces.
- [ ] **5. How can I reduce stress in my life?**
  - Try deep breathing. It can help you relax and lower your stress level.
  - Think about the positive aspects of your life.
  - Talk to friends and family.
- [ ] **6. How can I limit alcohol and enjoy living smoke-free?**
  - Talk to your doctor about cutting back or quitting.
  - Try to avoid places or situations that may trigger you to drink or smoke.
- [ ] **7. How do these goals affect my blood pressure numbers?**
  - Check your blood pressure at home, as agreed upon with your doctor.
  - Pay attention to the influence that physical activity, diet, and stress have on your blood pressure.

CHECKING YOUR BLOOD PRESSURE AT HOME

My blood pressure goal (If you don't know, ask your doctor):

My heart healthy goal for this month is:

KNOW YOUR RISK!

High blood pressure is called the "silent killer". It can have no warning signs or symptoms and leads to heart attack and stroke.

HEART ATTACK SYMPTOMS

- Crushing or squeezing chest pain
- Back, neck, or left arm pain
- Weakness
- Shortness of breath
- Sick to the stomach or stomach pain

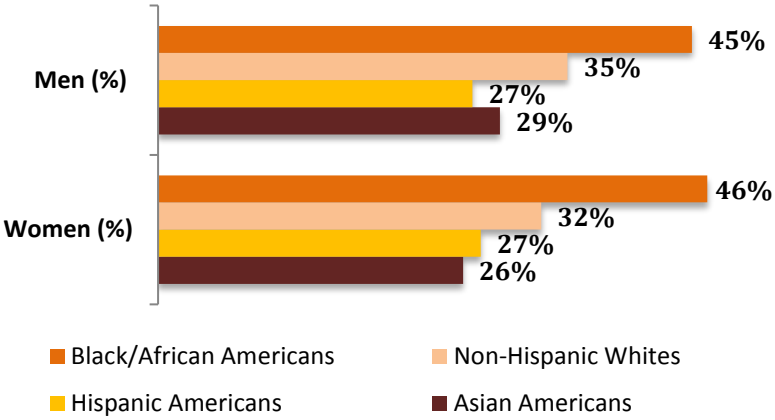
STROKE SYMPTOMS

- Face drooping or numbness
- Arm or leg weakness or numbness
- Trouble talking
- Confusion
- Balance problems
- Severe headache

IF YOU FEEL ANY OF THESE SYMPTOMS, CALL 911 IMMEDIATELY

Black/African Americans & Heart Disease

Percentage of adults with hypertension in the US

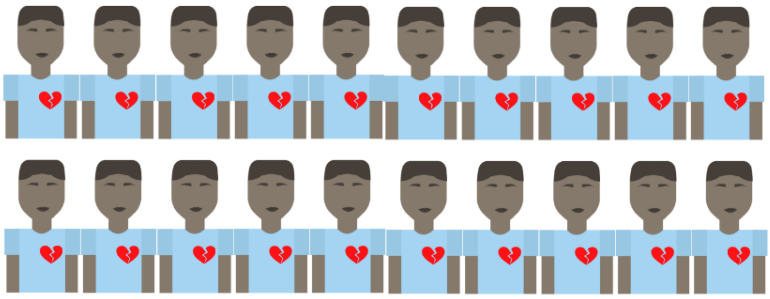


Black/African Americans have:

- the **highest rates of hypertension in the world**
- High blood pressure **earlier** and **with higher numbers**
- Higher rates of **hospitalization**
- Earlier **disability**

Hypertension leads to heart disease and stroke.

Heart failure is 20 times more common in Black/African Americans below 50 years old than in Whites.

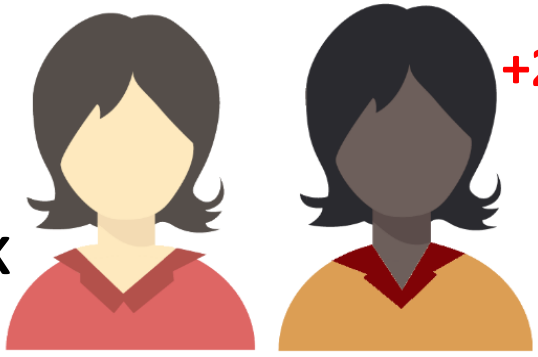


vs.

Black/African Americans aged 45-64 are **2 to 3 times more likely to have a stroke** than Whites.
Black/African Americans are **almost 2 times more likely to die from a stroke** than Whites.

For each **10 mmHG increase in Systolic Blood Pressure,**

+8% STROKE RISK



+24% STROKE RISK

Whites = non-Hispanic Whites

7/26/18

-Benjamin, E. J., Blaha, M. J., Chiuve, S. E., Cushman, M., Das, S. R., ... & Gillespie, C, et. al. (2017). Heart disease and stroke statistics—2017 update: a report from the American Heart Association. *Circulation*, *135*(10), e146.
- Gilbert, C. (2005). Foundation Confronts Disparities for African Americans Suffering from Heart Failure. *Journal of the National Medical Association*, *97*(2), 142.
-Sharma, A., Colvin-Adams, M., & Yancy, C. W. (2014). Heart failure in African Americans: disparities can be overcome. *Cleve Clin J Med*, *81*(5), 301-11.

4b) RN CCV Template (*CCV HTN)

***BP Chronic Care**

RN BP Visit:

Pt accompanied by: *Self Family Member Other (specify in notes)*
Interpreter used? *Yes No*
Discussed physiology of HTN? *Yes No*
Discussed possible barriers of getting BP controlled and acknowledge disparities? *Yes No*
Discussed possible consequences of uncontrolled HTN? *Yes No*
Discussed low-salt diet, exercise, med adherence with educational material given? *Yes No*
History of CVA, Renal Disease, DM, or MI? *Yes No*
Discussed BP goal? *< 140/90 Identified differently by PCP (specify in notes)*
BP at goal? *Congratulated pt on achieving BP goal Positive reinforcement of med adherence, low-salt diet, or exercise as appropriate*
BP not at goal? *Informed pt of BP not at goal Discussed pt's main concerns of challenges (specify in notes) Reinforced adherence to medicine, low-salt diet, and/or exercise*
Pt checks BP at home? *Yes No*
If reviewing BP log, are values within goal? *Mostly Some Rarely*
Education materials given accordingly? *Yes No*
Calcium Channel Blockers: Lower extremity edema Dizziness Headache
ACEI/Angiotensin Receptor Blocker (+Basic Metabolic Panel): *ACEI-induced dry cough Dizziness Electrolyte imbalance (High K/Creatinine)*
Diuretic (+Basic Metabolic Panel): *Frequent Urination Electrolyte imblance (low sodium) Dizziness*
Aldosterone Receptor Antagonist (+Basic Metabolic Panel): *Electrolyte imbalance (higher K) Dizziness*
Beta Blocker: *Decreased Heart Rate Dizziness*
Other Meds? (specify in notes):
Do you miss taking your medications? *Yes No*
If yes, how many times do you miss taking your medications?
Provider Standing Order Charted in eCW? *Yes, BP at goal, no need to adjust meds Yes, adjusted meds per provider's standing order Yes, but not applicable per RN assessment. Consulted POD or Pharmacist. No, consulted provider for prescription (specify Provider's name in notes) No, consulted pharmacist for prescription (specify Pharmacist's name in notes) Other (specify in notes)*
Next Step(s): *Referral to nutritionist Referral to PCB Return visit to Nurse Clinic Return visit to Provider Return visit to Pharmacist Discharge from RN HTN Clinic Refer to MEA/HW/Coach to do home BP cuff teaching Refer MEA/HW/Coach to do home BP check home monitor Other (specify in notes)*
Diet (specify in notes):
Exercise (specify in notes):
Med(s) (specify in notes):

4c) Home BP Cuff Calibration Tips/Techniques

Checking the Accuracy Of Home Blood Pressure Machines

When to check the Home BP machine for accuracy:

- Once per year. The European guidelines recommend every 6 months.
- When there is a reported difference of > 10 mmHg between reported home BP measurements and the clinic BP

Protocol for checking the accuracy of a home BP machine

1. Have the patient sit down with his or her arm at heart level. The arm should be completely relaxed, and feet should rest on the floor
2. Allow the patient to rest for 5 minutes.
3. Avoid any conversation during the measurements to prevent an increase in blood pressure.
4. Have the patient take two consecutive readings with his or her device no more than one minute apart. If needed, assist the patient to use proper technique for the second measurement.
5. The healthcare provider should use the clinic BP machine to immediately (≤ 1 min) take a third reading using the standard method used in clinic.
6. Observe the difference between the reading from the clinic BP cuff and the lowest of the two readings from the patient's home BP cuff.
    - If the difference is ≤10 mmHg, stop.
    - If the difference is >10 mmHg, the home BP machine is inaccurate.
        i. Ensure the correct cuff size for the patient. (See BP measurement protocol for appropriate sizes)
        ii. If the BP cuff size is correct, instruct the patient to stop using the machine until further notice.
        iii. If patients have a faulty home BP monitor, they can call customer support to troubleshoot and it will be replaced, if necessary. Patient needs the unit and serial numbers (located on the device), but will have to pay for shipping. Turn around is estimated at two weeks.
        iv. Omron customer support: https://omronhealthcare.com/contact-us/

4d) Information on SFHP Blood Pressure Monitor Coverage

SFHP BP monitor coverage & home BP documentation in eCW/CareLinkSF

What is the benefit of checking BP at home?

- Home BP monitoring is a reasonable alternative to ambulatory BP monitoring to confirm a diagnosis of hypertension.
- Home BP predicts cardiovascular events and mortality.
- Reducing overtreatment in patients with white coat hypertension, and improving diagnosis and treatment in those with masked hypertension.
- Home BP monitoring improves control and adherence in patients with hypertension.
- Home systolic and diastolic BP goal should be 5mmHg lower than clinic BP goal.

Who can get a BP machine covered by SFHP?

Covered	NOT covered
• SFHP Medi-Cal patients • Medicare/Medi-Cal dual-eligible patients with SFHP Medi-Cal	• Healthy San Francisco / Sliding Scale • SFHP Healthy Workers • Medicare w/wo fee-for-service Medi-Cal • Anthem Blue Cross

Which BP machine is covered?

With standard-to-large cuff for arms 9 to 17 inch in circumference

- **Omron 3 series BP710N** (NDC 73796-0271-04) – 1-user, detects irregular heartbeat, battery-operated
- **Omron 5 series BP742N** (NDC 73796-0274-24) – dual-user, detects irregular heartbeat, battery-operated
- **Omron 7 Series BP760N** (NDC 73796-0276-04) ***preferred*** – multi-user, detects irregular heartbeat, battery-operated
- **Omron 7 Series- Bluetooth BP761N** (NDC 73796-0267-61) – dual-user, can sync readings to smartphone
- **Omron 10 series BP785N** (NDC 73796-0278-54) - multi-user, AC adaptor & battery-operated
- **Walgreens Automatic Arm** (NDC 11917-0144-84)
- **Walgreens Premium Arm** (NDC 11917-0144-87) - dual-user, detects irregular heartbeat, AC adaptor, connects to smartphone
- **Walgreens Deluxe Arm** (NDC 11917-0144-85) - dual-user, detects irregular heartbeat, battery-operated
- **CVS Series 100** (NDC 50428-0535-60)

With extra-large cuff for arms 16.5 to 23.6 inch in circumference (by **prior authorization** only)

- **A&D UA-789AC** (NDC 93764-0600-62) – detect irregular heartbeat, AC adaptor, w/o battery

Where can my patient get a BP machine?

- Any pharmacy where SFHP Medi-Cal patients can receive prescription benefits EXCEPT
  - SFGH Outpatient Pharmacy can only dispense Omron 5 series BP742N for SFHP Medi-Cal patients – refer dual-eligible patients to other pharmacies.
  - Safeway Pharmacy is unable to process claim for BP machines.

How do I order a BP machine for a SFHP Medi-Cal patient in eCW/CareLinkSF?

- Search for: [BP Machine (Omron 5 series)], [BP Machine (Omron 10 series)], [BP Machine (Omron 3 series)]. [BP Machine (Large Cuff AND UA789AC)] [BP Machine (Omron 7 series)], [CVS Series 100 Blood Pressure]

Who can coach my patient on how to use a home BP machine?

- Check with your clinic regarding who at the clinic can coach patients – home BP monitoring is more effective if staff provide motivational interviewing around measurement and medication adherence related to hypertension. Proper BP checking technique is also required so you can trust your patient's home BP readings. Your clinic can purchase a demonstration home BP machine to engage patients before you prescribe the cuff. Ask your patient to bring back the BP machines to clinic for validation. This ensures readings are reliable and is an opportunity for the patient to show staff how they are using the cuff at home.

How do I record my patient's home BP readings in eCW/CareLinkSF?

- Home BP readings can be recorded as free-text in the HPI section, or in the Vital section using the "home" qualifier. **Please make sure the last recorded BP is an office measurement.** For reporting, the system chooses the last BP recorded, and it should not be a home BP reading.

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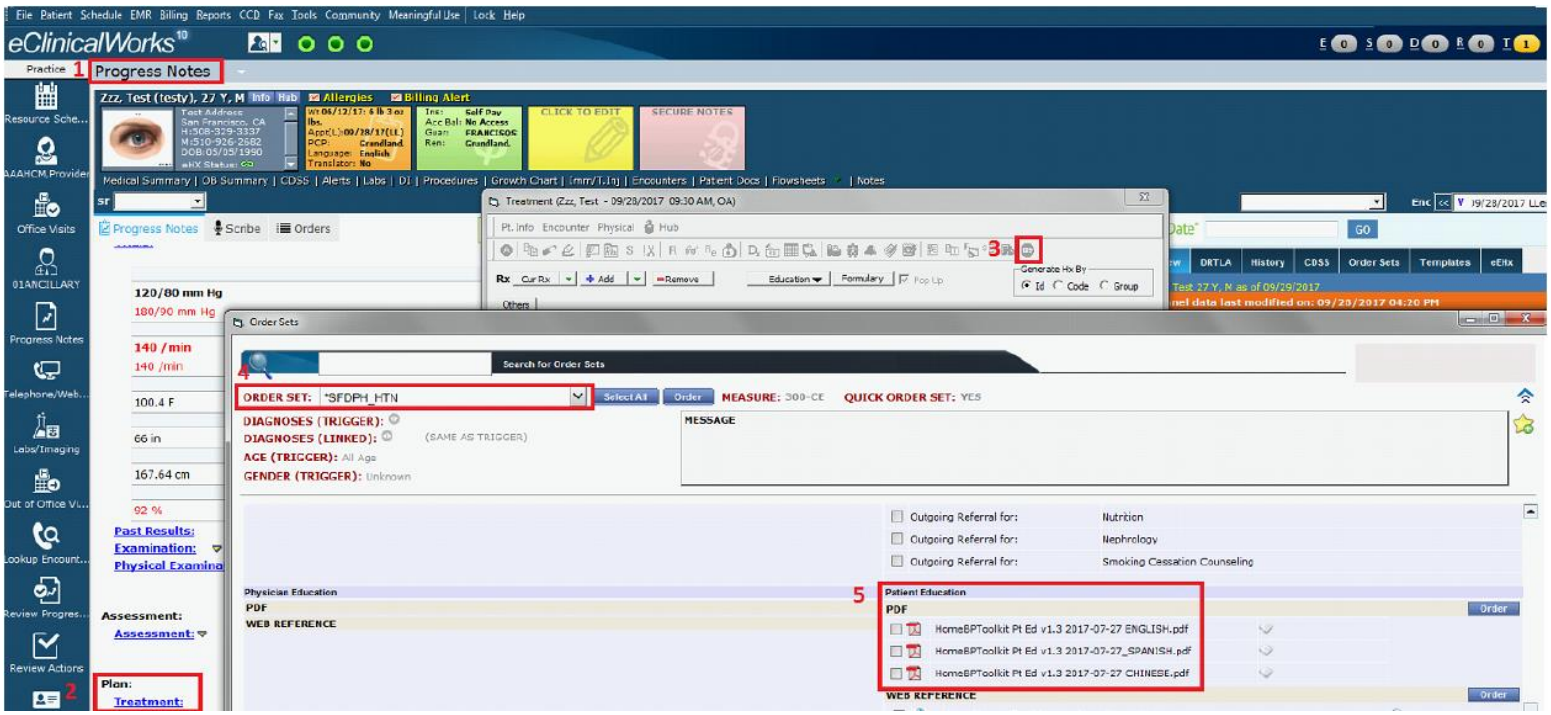
4e) How to Access Home BP Monitoring Patient Education Materials in eCW

Progress Notes > Treatment > Order Set >*SFDPH_HTN > Patient Education



5) Q&A for home blood pressure monitoring

Summary

1. Measure the blood pressure in the morning and evening daily for 7 days
    a. Take two measurements (1-2 min apart)
    b. Ideally, take morning measurement before drug intake and evening reading before meal
2. Discard the 1st day's BP and average all the rest
3. Treat with medication if average BP ≥ 135/85
4. Automated BP devices should be used for BP measurements
5. Readings should be immediately recorded in logbook or stored in device memory
6. Patient should be trained by a healthcare professional prior to beginning home BP monitoring.

Measurement Devices

- Validated automated BP devices (calibrated every 6 months) can be used to take BP measurements.
- Machines with a range of cuff sizes should be preferred

Cuff Size

- The cuff bladder should encircle 80 – 100% of the arm circumference and the cuff width should cover 40% of the arm circumference

BP Measurement Techniques

1. Ideally, the patient should sit for 3-5 minutes before taking BP measurements
    a. Patient should be seated with back supported, legs uncrossed and upper arm bared.
    b. Patients arm should be supported at heart level during measurement to avoid incorrect systolic BP measurements.
    c. Take reading before medications in the morning. Avoid exercise or emotional stress prior to reading.
    d. Discourage urge to take reading when patient is anxious because BP will be high.

2. Place lower edge of BP cuff 3 cm above the elbow crease and the bladder centered on the anterior surface of the arm over the brachial artery – most cuffs have an indication of proper placement.

Differences between 2 arms

- There is no need to routinely perform BP measurements in both arms.
- Encourage patient to check on the same arm each time, ask patient if they have medical conditions that may affect which arm is preferred.
- If there is a consistent difference between arms (>10mmHg), notify the primary care team.

What if he/she misses a day?

- If there is no medication change, we would like consecutive days of measurements, but it's ok if they miss one day. Go ahead and keep taking measurements for at least 5 to 7 days.
- If there is a medication change, instruct the patient to take measurements for 7 days prior to the next appointment.

What about after the 7 days?

- The patient can take measurements once a week (morning and PM) to reinforce adherence
- Overuse and self-modification of treatment based home BP measurements should be avoided
- Isolated home measurements can be misleading. The patient should be instructed not to be alarmed by one high or low measurement because BP may vary between measurements