HYPERTENSION EXPERT CLINICAL PANEL

RECOMMENDATIONS FOR HYPERTENSION MANAGEMENT IN WISCONSIN
NOVEMBER 2017 (REVISED 12/5/17)

This WNA panel developed recommendations designed to identify and treat persons with undiagnosed or uncontrolled hypertension through the use of **patient-centered team-based care.** The experts emphasize the **importance of sustainable linkages between health systems and the community.**

WNA
WISCONSIN NURSES ASSOCIATION

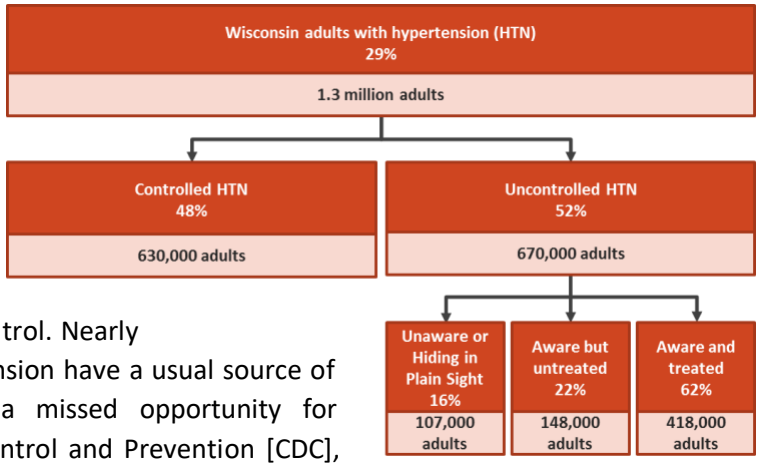
Wisconsin Nurses Association
Concepts and Recommendations to Practical Action

BACKGROUND

Problem/Issue

Heart disease is the leading cause of death in Wisconsin and the United States (Wisconsin Department of Health Services, 2016). Hypertension is a major contributor to heart disease. Untreated and uncontrolled hypertension leads to stroke, heart failure, kidney disease, and myocardial infarction. Identifying and defining populations with hypertension can lead to appropriate treatment and control. Treatment and control of hypertension improves outcomes and reduces costs to the health care system and to the economy.

One of every three adults in Wisconsin has hypertension or approximately 1.3 million Wisconsin adults. Less than half of adults with hypertension are adequately in control (48%). Among those with uncontrolled hypertension, adults (16%) are unaware they have it, and another 62% of adults with uncontrolled hypertension are seeking treatment, but it is still not in control. Nearly 90% of U.S. adults with uncontrolled hypertension have a usual source of health care and insurance, representing a missed opportunity for hypertension control (Centers for Disease Control and Prevention [CDC], 2012).



On November 13, 2017, revised national hypertension guidelines were issued by the American College of Cardiology and the American Heart Association, among others. The 2017 guideline is an update of the *Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure* (JNC 7), published in 2003. The 2017 guideline is a comprehensive guideline incorporating new information from studies regarding blood pressure related risk of cardiovascular disease, ambulatory blood pressure monitoring, home blood pressure monitoring, blood pressure thresholds to initiate antihypertensive drug treatment, blood presure goals of treatment, strategies to improve hypertension treatment and control, and various other important issues (see https://targetbp.org/guidelines17/). The Wisconsin Nurses Association (WNA) documents provided in this release are consistent with the new national guidelines.

Approach

Starting in 2014 and continuing to the present, WNA has worked with the Wisconsin Department of Health Service's Division of Public Health, Chronic Disease Prevention Program (CDPP) under funding opportunity No. CDC-RFA-DP-1305 for chronic disease prevention from the CDC, U.S. Department of Health and Human Services. This statewide grant focuses on chronic disease prevention, with an

emphasis on the prevention and control of hypertension, diabetes, and obesity. WNA's efforts specifically focus on:

- Hypertension prevention, detection, treatment, and control.
- Improving systems of chronic disease prevention, including community linkages.
- Advancing a Wisconsin-centric model of patient-centered team-based care.

The three priority target populations were identified by the CDC and Wisconsin Division of Public Health's CDPP:

- Patients with undiagnosed hypertension, those hiding in plain sight (16%);
- Patients whose hypertension is not controlled (52%); and
- Patients whose hypertension is controlled (48%).

INTRODUCTION

WNA is pleased to provide two foundational concepts for clinical and community settings to use to improve prevention, detection, and management of hypertension:

1) **Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model**
2) **Interprofessional Clinical Hypertension Expert Panel Recommendations**

These two concepts were designed to address hypertension, but can be applied to other conditions and even preventive initiatives.

The concepts also represent a ***call to practical action*** by health systems (herein known as parent organizations) and interprofessional patient health care teams, as well as state and local health departments, institutions of higher education, professional organizations/societies, and others. We strive for systemwide collaboration and partnerships between health systems and communities to accelerate improvements in the prevention, detection, and management of hypertension throughout Wisconsin.

CONCEPTS

Concept 1: Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model (WNA, 2016)

Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model builds upon the existing and emerging work of many partners in Wisconsin and the nation to foster health care transformation that advances patient-centered team-based care and to move toward value-based care, improved patient health and safety, and improved health of the population. WNA, in collaboration with a community of partners and reviewers, developed the model. The model relies on the dynamic interplay of an engaged patient, three core elements, three influencing factors, and durable linkages and connections to communities.

Engaged Patient:

- Empowered by the team and parent organization to be active, informed, and engaged
- The central focus of the model
- Aspires to achieve *care by me* and not just *care to me* (Okun et al., 2014)

Core Elements:

- The parent organization

- The interprofessional health care team
- A diverse workforce

Influencing Factors:

- Core principles and shared values
- Hallmarks of Wisconsin Practice
- Triple (quadruple) Aim of Health Care™

Community Linkages and Connections:

- Mutual investment in durable linkages and connections between health systems and communities is critical. Patients (caregivers, family, and support systems) live, grow, work, learn, and play in communities. Investing in durable connections by health systems contributes to healthy people in healthy communities.

The Interprofessional Clinical Hypertension Expert Panel Recommendations focus on two of the core elements: parent organizations and patient-centered health care teams.

Concept 2: Interprofessional Clinical Hypertension Expert Panel Recommendations

In September 2016 and again in May 2017, WNA convened a diverse clinical expert panel representing five distinct health care provider groups with extensive experience in providing frontline care (physicians, advanced practice registered nurses, pharmacists, physician assistants, and registered nurses). Their work was supported by key collaborating organizations, including Wisconsin Department of Health Services-Division of Public Health, Wisconsin Collaborative for Healthcare Quality, MetaStar Inc., Wisconsin Primary Health Care Association, University of Wisconsin-Madison School of Nursing, University of Wisconsin School of Medicine and Public Health, and the Wisconsin Academy of Family Physicians. Additional collaboration was sought from experts from the Medical College of Wisconsin / Milwaukee Veterans Administration Hospital and Marshfield Clinic (Attachment 1).

As experienced frontline clinicians, the panel possesses expert understanding of both health care systems and patient care. These clinicians work together as interprofessional teams that include certified medical assistants, licensed practical nurses, and other health care team members. The expert panel was charged to develop recommendations to improve systems of care for the prevention, detection, and management of hypertension, focusing on the three priority target populations described earlier.

The panel was unanimous in its belief that patient-centered teams cannot move toward value-based care and achieve quality metric payment without the leadership and dynamic engagement of parent organizations and interprofessional patient health care teams.

RECOMMENDATIONS* *[*Refer to the Recommendations section for the complete set of recommendations]*

Interprofessional Clinical Hypertension Expert Panel Recommendations - Highlights:

- Establish a culture of patient-centered team-based care for hypertension prevention, detection, and control.
- Allow all team members to practice to their top of license or top of education for non-licensed team members.

- Establish a systemwide principle: All health providers are involved in the prevention, diagnosis, and treatment of hypertension.
- Improve information technology and the electronic health record dashboard to support efficiencies in care delivery and patient safety.
- Establish systemwide goals to manage hypertension using state and national quality metrics.
- Establish hypertension management teams to champion excellence in the prevention and control of hypertension for patients who are undiagnosed and patients who have uncontrolled hypertension.
- Improve communication within and among team members.
- Collaborate with the parent organization and information technology services to develop registries, dashboards, and other system improvements that work for teams.
- Acknowledge and disseminate team successes shown to improve efficiencies and effectiveness of operations and patient care.
- Provide leadership to create durable linkages between health systems and communities to improve hypertension outcomes that benefit the health of Wisconsin's population through effective partnerships.

CALL TO PRACTICAL ACTION

The foundational concepts have been developed and are ready for practical action.

- **Adopt the Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model**
- **Utilize the Interprofessional Clinical Hypertension Expert Panel Recommendations**
- **Apply Concepts Beyond Hypertension to Other Chronic Conditions**

These recommendations have the potential to be applied beyond the condition of hypertension to diabetes and other chronic conditions. The electronic health record is the central tool to target population groups within health systems regardless of condition/disease. Team care management can then develop structured systems to improve management and subsequent outcomes of chronic medical conditions. Successful improvement in health system performance and population health outcomes calls for explicit collaboration and shared leadership between parent organizations and interprofessional health care teams. Systems-oriented shared leadership can move us beyond treatment and cure to creating health for patients, populations, and communities.

- **Develop and Sustain Durable Community Linkages**

The recommendations stress the importance of leadership from Wisconsin's health systems to mutually develop and sustain durable linkages with communities and the community organizations that serve those communities. Patients simply do not live in clinics and hospitals; as such, it is critical that the resources of health systems and communities work together. Durable linkages can improve patient access to preventive and chronic care services; enhance health care delivery, public health, and community-based activities to promote healthy behaviors; engage patients to get help to change unhealthy behaviors; and support clinicians to get help for services they cannot provide themselves (Agency for Healthcare Research and Quality, 2016).

Next Steps

On November 9, 2017, WNA will begin statewide dissemination of these recommendations. Our intent is to stimulate dialogue, clarification, and improvement of the recommendations using patient-centered

team-based care approaches. We believe this will accelerate implementation and improvement within Wisconsin health systems and our public health system to benefit the people of Wisconsin and the communities where we live, grow, work, learn, and play.

Acknowledgement and Recognition
WNA expresses its gratitude to the Wisconsin Division of Public Health's Chronic Disease Prevention Program for funding and participating in the development of these recommendations. WNA also expresses its deep gratitude to the members of the Interprofessional Hypertension Clinical Expert Panel, collaborating partner organizations, and WNA grant leadership (Appendix 1).

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RECOMMENDATIONS
Interprofessional Clinical Hypertension Expert Panel

Definitions:

(1) Parent organization:
The parent organization provides leadership and infrastructure, which is a crucial element to accomplishing system transformation that results in organizational culture change. This leadership promotes team and workforce success and positive patient outcomes. In addition, the parent organization is active in connecting health system services to communities to promote health and to build healthy communities. The parent organization has a critical leadership role in creating health for the patients it serves (WNA, 2016).

(2) Interprofessional patient health care team:
The team is prepared, proactive, and strives to achieve a high-functionality through knowledge, skills, and attitudes. The team owns and exemplifies a set of adopted team-based principles, processes, and actions. Each patient (family & support system) has a relationship with a team prepared to provide first contact, continuous, and comprehensive care (WNA, 2016).

Recommendation 1. Establish a culture of patient-centered team-based care for hypertension prevention, detection, and control – to achieve quality outcomes, long-term cost reductions to health care systems, and improved population health in Wisconsin.

	Parent Organization	Interprofessional Teams
I. Invest in patient-centered team-based care as the delivery standard.		
• Primary care settings that adopt patient-centered team-based care offer powerful benefits to patients, team members, population groups, and health systems because of the investment in prevention and health promotion.		
• Provide inter-professional education and training with clear definition* of patient-centered team-based care and how team-based care can/will be implemented. *"Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated high-quality care" (Mitchell et al., 2012, p. 5).	X	

		Parent Organization	Interprofessional Teams
	• Work with health care teams and key administrative champions to create buy-in on the benefits of patient-centered team-based care.	X	
II.	Develop and support a culture that holds teams accountable to accurately measure blood pressures and provide interventions to patients at every appointment/ contact.	X	
III.	Create and allow adequate time for educational programs to support continuous learning by all team members. This must include initial training and retraining when there is turnover.	X	
IV.	Develop clear expectations for all team members. • Annually, test personnel for blood pressure measurement proficiency and competency. • Calibrate and assure blood pressure equipment is in good working order. • Measure annual evaluation of blood pressure equipment for accuracy.	X	
	• Provide leadership to assure licensed professionals and team members practice at the *top of license* or *top of education*. • Provide consistent patient care at each visit (from check-in to check-out), regardless of available care providers. • Allocate sufficient time to room patients in order to provide accurate blood pressure measurement, including patient positioning. • Allocate sufficient time to perform two blood pressure measurements manually or three blood pressure measurements unattended (1-2 minutes apart). If averaged blood pressure is equal to or above 120/80, follow the 2017 Hypertension Clinical Guidelines (See Resources: 2017 Guidelines). • Use automatic blood pressure machines for accuracy.	X	X
	• Use protocols for reporting and acting upon elevated blood pressure readings as part of each visit to prevent clinical inertia. • Allow sufficient time for staff to educate, coordinate, and engage patient (caregivers/supports).		X

		Parent Organization	Interprofessional Teams
	• Distribute after-visit summaries and patient education materials that are consistent with the patient's culture, health literacy, language, and other accommodating needs.		X
V.	Recognize and disseminate best practices and apply innovations systemwide (including specialty clinics).	X	
VI.	Allocate time for regular team meetings to grow, nurture, and develop high-functioning teams.	X	
VII.	Allocate time for health promotion and disease prevention in support of the Triple (Quadruple) Aim of Healthcare™.	X	
VIII.	Develop, support, and educate staff in lifestyle and health promotion interventions beyond medication, which includes non-clinical staff. Information must be readily available. Examples include: • Food choices • Activity levels • Stress management • Rest/sleep	X	

Recommendation 2. Allow all team members to practice to their *top of license* or *top of education* for non-licensed team members.

		Parent Organization	Interprofessional Teams
I.	Encourage innovation by effectively using all team members. For example: • Pharmacist management of first-line medication for hypertension protocol. • RN assessment of blood pressure measurement at subsequent visits. • Diagnostic (lab) ordering by protocol dependent on medication ordered and patient co-conditions.		X
II.	Allow data entry into the medical record by all team members.		X

		Parent Organization	Interprofessional Teams
III.	Refer for patient education and support programs (Self-Management Resource Center, 2017; Wisconsin Institute for Healthy Aging, 2013a, 2013b).		X
IV.	Follow-up with patient (caregivers/supports) regarding understanding of educational offerings, including self-management of blood pressure.		X
V.	Solicit patient (caregivers/supports) understanding of instructions (after-visit summary): • Provide information that is health literate. • Provide information by clinical staff.		X
VI.	Incorporate community health workers (CHW) into the team-based care approach. **Note.** CHWs are important members of the team. They have expertise in home visits, patient teaching, and addressing the determinants of health in the context of the family (e.g., housing, employment, literacy, environment, transportation follow-up appointments, access to nutritious foods).		X

Recommendation 3. Establish a systemwide principle: All health providers are involved in the prevention, diagnosis, and treatment of hypertension.

		Parent Organization	Interprofessional Teams
I.	Create a system for same-day, rapid-access appointments for any patient with a blood pressure greater than or equal to 130/80, including: • Patients identified from the uncontrolled hypertension registry. • Patients referred from specialty providers. • Patients presenting for care unrelated to hypertension. • Patients who need education on home blood pressure monitoring to further evaluate elevated blood pressure (greater than or equal to 130/80) in order to identify white coat hypertension and/or masked hypertension.	X	

		Parent Organization	Interprofessional Teams
II.	Develop improvements to: • Schedule appointments and make referrals. • Facilitate the next step of blood pressure management promptly, such as modify medication(s); revisit nonpharmacological interventions. • Designate a hypertension provider or hypertension team for the day (with open slots for same day visits). Registered nurses or case managers are ideally suited for this role.	X	

Recommendation 4. Improve information technology and the electronic health record *DASHBOARD* to support efficiencies in care delivery and patient safety.

		Parent Organization	Interprofessional Teams
I.	Create/utilize *dashboard* alerts for all providers and team members, systemwide.	X	
II.	Assure that *dashboard* alerts allow easy access to: • Informational sources. • Guidelines for treatment. • Goals for blood pressure control. • Appropriate medications for treatment.	X	
III.	Establish and provide real-time hypertension registries and data flows. • Generated by system information technology services for local teams to outreach patients at risk and in need of follow up.	X	
IV.	Assure patients (caregivers/supports) have a plan and method to communicate self-measured blood pressure readings to their provider.	X	
V.	Establish a policy and procedure to incorporate self-measured blood pressure readings into the electronic health record (EHR).	X	

		Parent Organization	Interprofessional Teams
VI.	Teams may need to create a system to enter home/outside office blood pressure readings into the EHR with alerts if the parent organization or EHR system provider is unable or unwilling to provide this function.	X	X

Recommendation 5. Establish systemwide goals to manage hypertension using state and national quality metrics.

		Parent Organization	Interprofessional Teams
I.	Measure blood pressure accurately at each visit systemwide. • Use accurate equipment (automatic oscillometric devices are recommended). • Use upper arm for blood pressure measurement, as recommended by AMA. • Use AMA recommendations for cuff placement. • Provide initial and ongoing training for new and current staff.	X	
	• Conduct competency/proficiency testing at least annually for staff measuring blood pressure. • Use evidence-based training materials and resources to improve blood pressure measurement and eliminate clinical inertia (see Resources to Improve Blood Pressure Measurement and Prevent Clinical Inertia).	X	X
II.	Educate and disseminate evidence-based standardized processes and protocols for medication management of hypertension.	X	
III.	Educate and disseminate evidence-based materials/information beyond medication: • Motivational interviewing. • Teach-back processes and protocols. • DASH diet. • Physical activity level. • Stress management. • Rest and sleep hygiene. • Sodium limitation to <1500 mg/day.	X	

	Parent Organization	Interprofessional Teams
• Avoidance/limiting tobacco use. • Avoidance of over-the-counter medicines (such as NSAIDS). • Evaluation for other reasons for elevated blood pressure, such as obstructive sleep apnea.	X	
IV. Offer and encourage blood pressure measurement for all visitors (caregivers/supports accompanying the patient).	X	
V. Determine if patient understands the desired goal and range of self-measured blood pressures.	X	
VI. Assure that every patient (caregivers/supports) has access to accurate electronic blood pressure measurement equipment for personal use. **NOTE**. Parent organizations should consider purchasing equipment in bulk for distribution.	X	
VII. Assure every patient (caregivers/supports) can: • Demonstrate use of blood pressure measurement equipment. • Identify how and where to report results. • Identify individual goals for results. • Recognize out-of-range results.	X	
VIII. Refer patients (caregivers/supports) to community education programs and support groups on self-management of hypertension (see Resources to Improve Blood Pressure Measurement and Prevent Clinical Inertia).	X	

Recommendation 6. Establish hypertension management teams (at both the health system and community levels) to champion excellence in the prevention and control of hypertension for patients who are undiagnosed (*hiding in plain sight*) and patients who have uncontrolled hypertension.

		Parent Organization	Interprofessional Teams
I.	Actively and regularly manage patient population registries to identify and outreach patients.		X
II.	Promote and allow appropriate scheduling time for all team members.		X
III.	Schedule appointments and/or labs.		X
IV.	Provide advice and counseling.		X
V.	Follow up with patients to determine medication changes, as needed.		X
VI.	Follow up with patients (caregivers/supports) to provide further education and medication adjustment, as needed.		X
VII.	Provide automatic referral through clinical decision support.		X
VIII.	Refer patients for self-management education (see Wisconsin Institute for Healthy Aging, 2013b).		X

Recommendation 7. Improve communication within and among team members.

		Parent Organization	Interprofessional Teams
I.	Hold regular team meetings to discuss strategies for improving patient compliance.		X
II.	Consider physical proximity of team members to day-to-day care.		X
III.	Incorporate evidence-based and best practices into team-based care.		X
IV.	Establish EHR alerts, prompts, and updates to allow rapid interactions within the team and with patients.		X
V.	Support and encourage quick changes in therapy by all appropriate team members.		X
VI.	Identify patients' health literacy level to support improved adherence.		X

	Parent Organization	Interprofessional Teams
VII. Assess and address issues that may impact the patient's adherence with their treatment plan. • Use interpreters when English is a second language and for those who are deaf or hard of hearing. • Evaluate social, emotional, economic, spiritual, and cultural barriers.		X
VIII. Review and update registries on a regular basis.	X	X

Recommendation 8. Collaborate with the parent organization and informational technology services to develop registries, dashboards, and other system improvements that work for teams.

	Parent Organization	Interprofessional Teams
I. Apply quality improvement processes to enhance team-based care and patient outcomes. • Capture metrics at all levels to measure the results of team-based care. • Evaluate and assess metrics. • Survey staff and patients. • Share results of satisfaction surveys with all team members.	X	X

Recommendation 9. Acknowledge, disseminate, and celebrate team successes shown to improve efficiencies and effectiveness of operations and patient care.

Recommendation 10. Provide leadership that results in the creation of durable linkages between health systems and communities to improve hypertension outcomes that benefit the health of Wisconsin's population through effective partnerships. The following listing of practices and processes are examples for Wisconsin health systems to develop and/or enhance community-based linkages and partnerships to prevent and control hypertension.

		Parent Organization	Interprofessional Teams
I.	Establish clear roles for all team members to assure care coordination with linkages to community resources.		X
II.	Explore successes and barriers of existing linkages and partnerships.		X
III.	Establish relationships with community-based providers and organizations to support identification and reporting of patients with undiagnosed hypertension and uncontrolled hypertension.	X	X
IV.	Collaborate with and convene health care and community partners to identify potential actions that may include: • Partner with local health departments to develop community health improvement plans. • Collaboratively assess barriers and strengths, including the determinants of health, in support of community health improvement planning. • Engage discussion groups with community leaders and members to identify barriers to keep communities involved and motivated. • Recognize and replicate innovations carried out by other organizations and teams. • Offer free on-site blood pressure screenings within health systems for patients, caregivers, significant others, support persons, and visitors. • Offer free community-based blood pressure screenings at well-known locations (pharmacies, emergency medical centers, local health departments, housing). • Refer to community educational and support groups on self-management of hypertension.	X	X

	Parent Organization	Interprofessional Teams
• Explore the HUB model for highest risk patients (see HUB Model for High Risk Patients).		
• Work with partners to improve care coordination and management systems linked to the community.		
• Encourage local employers and businesses to use the Wisconsin Worksite Wellness Assessment (see Resources).		
• Demonstrate that the present and future *cost of care* can be reduced with appropriate prevention and control of hypertension at worksites.		
○ Exercise and physical activity at work.		
○ Nutrition interventions and education (e.g., eliminating soda dispensers, providing healthy food choices).		
○ Blood pressure monitors (preferably programmable/automatic) are available for blood pressure measurement.		
○ Stress reduction programs at work.	X	X
• Involve community agencies, faith communities, health clubs, schools, and other organizations.		
○ Provide periodic blood pressure screening/check days.		
○ Disseminate evidence-based health literature in regionally appropriate/ specific languages.		
• Engage key community personnel who can increase access to care coordination for at-risk or high-risk patients and families.		
○ Parish and public health nurses.		
○ Pharmacists.		
○ Behavioral health providers.		
○ Community health workers.		
• Assure quick, easy, and bi-directional access for referrals (health system to community, community to health system).		

	Parent Organization	Interprofessional Teams
• Support, with community partners, self-measured blood pressure monitoring by patients (see Million Hearts Tools and Protocols for Hypertension).	X	X
V. Expand EHR capability. • Extend community health care provider access to EHR platforms (e.g., Epic Care Link), thereby improving continuity of care.	X	X
VI. Assure EHR provides: • Quick data access. • Rapid appointment scheduling. • Community provider access to shared EHR.	X	X
VII. Advocate and champion evidence-based educational programs for persons with chronic disease (see Resources for the following). • Living Well with Chronic Conditions • Diabetes Self-Management Programs • Diabetes Empowerment Education Program • See Resources for additional programs	X	X

Resources

Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model.
http://wisconsinnurses.org/wp-content/uploads/2016/11/WNA-Publication-TeamBasedCare.pdf

Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model builds upon the existing and emerging work of many partners in Wisconsin and the nation to foster health care redesign that advances patient-centered team-based care and moves toward value-based care, improved patient health and safety, and improved health of the population.

Behavioral Health and Motivational Interviewing:

- Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. **A meta-analysis of motivational interviewing: Twenty-five years of empirical studies.** *Research on Social Work Practice, 20*(2), 137-160. doi:10.1177/1049731509347850

- Michie, S., Ashford, S., Sniehotta, F. F., Dombrowski, S. U., Bishop, A., & French, D. P. (2011). **A refined taxonomy of behaviour change techniques to help people change their physical activity and healthy eating behaviours: The CALO-RE taxonomy**. *Psychology & Health, 26*(11), 1479-1498. doi:10.1080/08870446.2010.540664

- VanBuskirk, K. A., & Loebach Wetherell. J. (2013). **Motivational interviewing with primary care populations: A systematic review and meta-analysis.** *Journal of Behavioral Medicine, 37*(4), 768-780. doi:10.1007/s10865-013-9527-4

Resources (including evidence-based) to Improve Blood Pressure Measurement and Prevent Clinical Inertia:

- **2017 Hypertension Clinical Guidelines**
https://targetbp.org/guidelines17/

- **Self-Measured Blood Pressure Guide**
https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/iho-bp-engaging-patients-in-self-measurment_0.pdf

https://targetbp.org/wp-content/uploads/2017/07/How-to-measure-your-blood-pressure_patient.pdf

https://targetbp.org/blood-pressure-improvement-program/patient-measured-bp/

- **7 Simple Tips to get an Accurate Blood Pressure**
http://targetbp.org/wp-content/uploads/2017/02/Measuring-blood-pressure-new.pdf

- **Technique Quick Check**
http://targetbp.org/wp-content/uploads/2017/02/Technique-quick-check-new.pdf

- **Measuring Blood Pressure Accurately Positioning Poster**
https://targetbp.org/map_framework/blood-pressure-measurement-measure-accurately/

- **Reducing Clinical Inertia**
https://targetbp.org/map_framework/reducing-clinical-inertia/

- **Learning Module: Improving Blood Pressure Control**
https://www.stepsforward.org/modules/hypertension-blood-pressure-control

- **Million Hearts® Tools and Protocols for Hypertension**
https://millionhearts.hhs.gov/tools-protocols/index.html

- **Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling**
https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd

- **Beyond the 50%: It Starts with Accurate Blood Pressure Measurement**
http://wisconsinnurses.org/beyond-the-50/
(Note: This is free of charge and takes 1 hour. Nursing Contact Hours are granted to registered nurses and a certificate of attendance is awarded to other professions, including students and medical assistants, pending completion of the on-line evaluation.

- **MetaStar, Inc., e-Learning Blood Pressure Module**
https://www.metastar.com/providers/elearning-modules/

Patient Education and Support Programs

- **HUB Model for High Risk Patients:**
http://www.cjaonline.net/pathways-community-hub-model-of-care-coordination/

Note: The Pathways Community HUB Model is a care coordination system that aids community health workers (CHWs) and care coordinators to find those at risk, treat the whole person with evidence-based care, and measure the progress and outcomes of individuals and communities. In Milwaukee, Dane, Rock, and La Crosse counties, communities have begun use or are exploring use. The Pathways Model utilizes best practices, a payment-for-outcomes process, and services that successfully identify, provide services coordination, and measure for families in at-risk neighborhoods. The process and software are unparalleled in the community health industry. Learn more about the Pathways Community HUB Model at:
http:/carecoordinationsystems.com/ or https://pchcp.rockvilleinstitute.org/

- **Million Hearts:**
https://millionhearts.hhs.gov

- **Wisconsin Institute for Healthy Aging**
https://wihealthyaging.org/living-well

- **Chronic Disease Self-Management Programs (Stanford)**
https://www.ncoa.org/healthy-aging/chronic-disease/chronic-disease-self-management-programs/#intraPageNav0

- **The Lake Superior Quality Innovation Network – Representing Michigan, Minnesota and Wisconsin – Diabetes Empowerment Education Program**
http://www.whcawical.org/files/2016/07/LSQIN_B2_DEEP_flier.pdf

- **Wisconsin Worksite Wellness Assessment**
https://www.dhs.wisconsin.gov/physical-activity/worksite/kit.htm

References

Agency for Healthcare Research and Quality. (2016). *Clinical community linkages.* Retrieved from https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

Centers for Disease Control and Prevention. (2012, September 7). Vital signs: Awareness and treatment of uncontrolled hypertension among adults – United States, 2003 -2010*. Morbidity and Mortality Weekly Report, 61(35); 703-709.* Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6135a3.htm

Institute for Healthcare Improvement. (2015). *IHI triple aim initiative. Better care for individuals, better care for populations, and lower per capita costs.* Retrieved from http://www.ihi.org/engage/initiatives/tripleaim/Pages/default.aspx

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