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National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
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Enhancing Access to Comprehensive Care: A Hands-On Guide to Implementing Standing Orders

Thursday, October 26th, 2023

12:00pm-1:00pm Eastern / 9:00am-10:00am Pacific

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National Training and Technical Assistance Partnership

Clinical Workforce Development

Provides free training and technical assistance to health centers across the nation through national webinars, learning collaboratives, activity sessions, trainings, research, publications, etc.

Team-Based Care

- Fundamentals of Comprehensive Care
- Advancing Team-Based Care

Training the Next Generation

- Postgraduate Residency and Fellowship Training
- Health Professions Training

Emerging Issue

- HIV Prevention

Advancing Health Equity

Preparedness for Emergencies and Environmental Impacts on Health

Speakers

- **Mary Blankson, DNP, APRN, FNP-C, FAAN**
  - Chief Nursing Officer, Community Health Center, Inc.
- **Veena Channamsetty, MD, FAAFP,**
  - Chief Medical Officer, Community Health Center, Inc.

Objectives

- Summarize the key components of standing orders using CHCI's hypertension standing orders as a model
- Execute the practical implementation of standing orders for effective hypertension management through a step-by-step walkthrough
- Assess understanding and seek clarification through active participation by posing questions during designated discussion segments

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Standing Order Basics

- Policy Name & Tracking
- Policy Statement
- Rational
- Procedure
- Resources
- References
- Other tools to promote success: templates, order sets, job tools, etc.

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Policy

- The Chief Medical Officer of CHC, Inc. has established a standing order for consistent comprehensive nursing visits for patients with Hypertension. Referrals may be received from the patient's Primary Care Provider (PCP). Nurses may also proactively identify appropriate patients via the care management dashboard or the Hypertension Dashboard.
- These visits may include nurses assessing the degree of blood pressure control based on blood pressure (BP) measurements collected at CHC, by the patient at home or in the community. In addition, nurses may complete medication titration as delegated by the PCP and documented in the Electronic Health Record (EHR) along with other outlines hypertension related care discussed below. Nurses play a key role in managing patients in addition to provider visits and providing value added care through ensuring home blood pressure monitoring (including prescribing a home blood pressure monitoring cuff via this standing order), medication monitoring, laboratory ordering, engaging interdisciplinary team members, disease self-management, and lifestyle education.

Rationale

- Hypertension is one of the most important preventable contributors to disease and death in the United States, leading to myocardial infarction, stroke, and renal failure when it is not detected early and treated appropriately. Nearly 50 million Americans are affected by hypertension, and the prevalence of this common chronic illness is likely to increase alongside the country's obesity epidemic. Existing evidence demonstrates that "the relationship between BP and cardiovascular disease (CVD) is continuous, consistent, and independent of other risk factors. The higher the BP, the greater is the chance of heart attack, heart failure, stroke, and kidney disease."

Procedure: Think Menu

Under this standing order, nurses are able to complete the following (examples):

1. Take a full set of vital signs (should be done at each visit)
2. Order home blood pressure monitoring cuff
3. Refer patients to the Registered Dietician
4. Schedule follow up nursing visits for continued HTN related care
5. Perform medication reconciliation
6. Order regular/chronic hypertension medication refills at the time of the visit if due (See The Nurse Management of Medication Refills standing order policy)

Procedure: Think Menu Continued

Under this standing order, nurses are able to complete the following (examples):

7. Order routine point of care testing as noted as due on the Planned Care Dashboard
8. Set patient specific Self-Management goals (SMG's) with Confidence Intervals (CI) and have follow up to these SMG's with tracked progress toward goals using the accepted CHCI SMG template
9. Provide Hypertension education and strategies for lifestyle modification, including completing a nutrition assessment, addressing medication adherence and others
10. Complete routine applicable screens and data collection as due on the Planned Care Dashboard such as SDoH, SBIRT and others to ensure effort toward closing care gaps
11. Support smoking cessation efforts if applicable (See **Standing Order and Protocol for Tobacco Cessation Counseling and Standing Order for RN provision of Nicotine Replacement Therapy**)
12. Access BH services for group care for tobacco cessation, or other applicable care that may impact HTN control

Procedure: Required Care & Documentation

- <u>Initial and every Hypertension Nursing Visit</u>
  - Nurse will take a complete set of vital signs (including smoking status) and record in the appropriate vitals field in the Electronic Health Record (EHR).
  - A focused history should be obtained using the EHR HPI HTN template and should include:
    - Medication adherence
    - Medication reconciliation (contact the pharmacy to compare medication pick up history): including over-the-counter medications (including cough medication) and herbal supplements.
    - Dietary practices: sodium, caffeine, cholesterol, saturated fats, appetite suppressants, and licorice consumption.
    - Exercise habits
    - Substance Use: tobacco, alcohol, street drugs
    - Current symptoms: headache, blurry vision, dizziness, chest pain, palpitation, shortness of breath, confusion, nocturia, snoring, and edema.
    - Routine Health Maintenance (RHM): immunizations, cancer screening, depression screening, etc. (Nurses shall utilize the Planned Care Dashboard)

Procedure: Delegated Laboratory Orders

- Management of Hypertension
  - Nurses shall order labs or point of care testing as appropriate.
    - Lipid Panel, if not done in the past 12 months.
    - Basic Metabolic Panel, if not done in the past 12 months.
    - Hemoglobin A1C for patients with DM, if not done in the past 6 months.
    - Urine microalbumin and creatinine ratio for patients with DM, if not done in the past 1 year.
    - INR for patients on Coumadin, if patient is due.

Procedure: Strategies for Lifestyle Modification

- Disease Process
- Disease Process
- Weight Reduction
- Healthy eating (dash diet)
- Moderate to vigorous physical activity
- Moderation of alcohol consumption

- Smoking cessation counseling in appropriate **(See Standing Order and Protocol for Tobacco Cessation Counseling and Standing Order for RN provision of Nicotine Replacement Therapy)**
- Patient specific hypertension patient education in ECW (Health Wise) should be given to patients.

Procedure: Strategies for Lifestyle Modifications

- Use Teach Back: Have patient/parent complete return demonstration of the following
- Home blood pressure monitor (HBPM) use
- HBPM frequency
- HBPM results documentation
- Education as to HBPM critical result levels and appropriate interventions to be taken by the patient
- Others?

Strategies for Nurse Management of Hypertension: Medication titration

- Nurses may titrate blood pressure medication as prescribed by the PCP according to patient-specific goals-defined by the PCP under delegation
- This requires a patient specific order at CHC, however, some organizations do have algorithms that nurses or pharmacists can use!
- The nurse shall send refills according to **The Nurse Management of Medication Refills** standing order policy
- Nurses should ensure medication reconciliation is done with the patient at any visit where medications are refilled or modified; This is also important to confirm medication adherence before implementing any medication changes (even if changes are not initiated by the nurse!)
- Proactive scripting for support team members

Strategies for Nurse Management of Hypertension: Care Management

When to consult with the PCP during a nurse visit:

- BP is critically uncontrolled
- Patient is now pregnant
- Patient is taking OTC nonsteroidal anti-inflammatory drugs (NSAIDS), illicit drugs, or consuming alcohol
- Patient is taking herbal supplements
- Patient is on the maximum dose of current BP medications and has not achieved BP control (proactive scripting needed here!)

Follow-up:

- Instruct the patient to continue home BP monitoring twice per day and to record results
- Review potential side effects with patient according to type of medication titrated: including increased fatigue, dizziness, diuresis, etc. depending on type of

Strategies for Nurse Management of Hypertension: Care Management

- The nurse will schedule follow up with the patient two weeks after the initiation of HBPM.
  - Nurses may engage in management of hypertension at an in-person nurse visit for patients for whom the PCP has already initiated medications.
  - Nurse visits may occur through provider-referral, nutritionist or CDCES referral, and through patient self-referral
  - Although in-office visits are preferred, telephonic or video nurse visits may be conducted for patients who have reliable measurement in the community – including a skilled homecare nurse or a home blood pressure cuff that has been calibrated by a CHC Nurse
  - Potential patients may be identified during panel management and from lists with uncontrolled HTN that are sent to care teams for review

Strategies for Nurse Management of Hypertension: Care Management

- Complex Care Management
  - Identify poorly controlled patients via the Care Management Dashboard such as those who have been in the emergency department or hospitalized for asthma and outreach to patients for both PCP appointment and Hypertension Nursing Visit appointment.
  - Collaborate with insurance case managers for patients who are seeking emergency department or inpatient care on a frequent basis.
  - Coordinate referrals to medical specialists such as Cardiology as needed and directed by the patient's provider.
  - Ensure that referrals ordered by the PCP have been executed, that patient is aware of upcoming appointments, and facilitates the scheduling and rebooking of appointments in collaboration with the Referral Coordinator.
  - Coordinate with pharmacy and other home care services to including home delivery and pillboxes, and convey medication changes to any homecare service providers.
  - Include family members in the patient's care plan, as desired by the patient.
  - Delegate appropriate care to other CHC team members as appropriate per their expertise/role on the care team

Strategies for Nurse Management of Hypertension: Care Management/Planned Care

- Self-Management Goal Setting
  - Utilize motivational interviewing to establish and document self-management goals with patients who verbalize “readiness for change.”
  - Set patient specific Self-Management Goals with Confidence Interval. Progress toward these goals should be address at follow up visits.
  - Self-Management goals should be documented in CHCI’s structured Self-Management template within HPI.
- Further Planned Care: When appropriate, the Planned Care Dashboard may be used to deliver further due planned care as consistent with the “Plan of Care for CHC Patients”.

Strategies for Nurse Management of Hypertension: Care Management

- Documentation
  - Nursing visits should be fully documented in ECW using the accepted CHCI nursing visit template for nursing visits for hypertension
  - PCP communication regarding the visit and any concerns identified should be documented via telephone encounter
  - Develop and Update of patient's hypertension care plan
- Billing
  - The visit will be coded and billed as a nursing visit, incidental to the provider order (under standing order).
  - Diagnosis code should be from the problem list or updated in collaboration with PCP.
  - Billing codes to be used are italicized below:
  - *99211-for the nursing visit-billed*

Additional Resources/ Job Tools

- Use NACHC Million Hearts work and resources!
- Use AHA
- Others?

JNC 8 Hypertension Guideline Algorithm

Adult aged ≥ 18 years with HTN
Implement lifestyle modifications
Set BP goal, initiate BP-lowering medication based on algorithm

General Population (no diabetes or CKD)

- **Age ≥ 60 years** → **BP Goal < 150/90**
- **Age < 60 years** → **BP Goal < 140/90**

Diabetes or CKD present

- **All Ages Diabetes present No CKD** → **BP Goal < 140/90**
- **All Ages and Races CKD present with or without diabetes** → **BP Goal < 140/90** → **Initiate ACEI or ARB, alone or combo w/another class**

Nonblack

Initiate thiazide, ACEI, ARB, or CCB, alone or in combo

Black

Initiate thiazide or CCB, alone or combo

At blood pressure goal?

- **Yes** → **Continue tx and monitoring**
- **No** →

Reinforce lifestyle and adherence
Titrate medications to maximum doses or consider adding another medication (ACEI, ARB, CCB, Thiazide)

At blood pressure goal?

- **Yes** → **Continue tx and monitoring**
- **No** →

Reinforce lifestyle and adherence
Add a medication class not already selected (i.e. beta blocker, aldosterone antagonist, others) and titrate above medications to max (see back of card)

At blood pressure goal?

- **Yes** → **Continue tx and monitoring**
- **No** →

Reinforce lifestyle and adherence
Titrate meds to maximum doses, add another med and/or refer to hypertension specialist

Initial Drugs of Choice for Hypertension
- ACE inhibitor (ACEI)
- Angiotensin receptor blocker (ARB)
- Thiazide diuretic
- Calcium channel blocker (CCB)

Strategy	Description
A	Start one drug, titrate to maximum dose, and then add a second drug.
B	Start one drug, then add a second drug before achieving max dose of first
C	Begin 2 drugs at same time, as separate pills or combination pill. **Initial combination therapy is recommended if BP is greater than 20/10mm Hg above goal**

Lifestyle changes:
- Smoking Cessation
- Control blood glucose and lipids
- Diet
  - ✓Eat healthy (i.e., DASH diet)
  - ✓Moderate alcohol consumption
  - ✓Reduce sodium intake to no more than 2,400 mg/day
- Physical activity
  - ✓Moderate-to-vigorous activity 3-4 days a week averaging 40 min per session.

Reference: James PA, Ortiz E, et al. 2014 evidence-based guideline for the management of high blood pressure in adults: (JNC8). JAMA. 2014 Feb 5;311(5):507-20

Card developed by Cole Glenn, Pharm.D. & James L Taylor, Pharm.D.

Hypertension Treatment

Compelling Indications	
Indication	**Treatment Choice**
Heart Failure	ACEI/ARB + BB + diuretic + spironolactone
Post –MI/Clinical CAD	ACEI/ARB AND BB
CAD	ACEI, BB, diuretic, CCB
Diabetes	ACEI/ARB, CCB, diuretic
CKD	ACEI/ARB
Recurrent stroke prevention	ACEI, diuretic
Pregnancy	labetolol (first line), nifedipine, methyldopa

Beta-1 Selective Beta-blockers – possibly safer in patients with COPD, asthma, diabetes, and peripheral vascular disease:
- metoprolol
- bisoprolol
- betaxolol
- acebutolol

Drug Class	Agents of Choice	Comments
Diuretics	HCTZ 12.5-50mg, chlorthalidone 12.5-25mg, indapamide 1.25-2.5mg triamterene 100mg *K+ sparing* – spironolactone 25-50mg, amiloride 5-10mg, triamterene 100mg furosemide 20-80mg twice daily, torsemide 10-40mg	Monitor for hypokalemia Most SE are metabolic in nature Most effective when combined w/ ACEI Stronger clinical evidence w/chlorthalidone Spironolactone - gynecomastia and hyperkalemia Loop diuretics may be needed when GFR <40mL/min
ACEI/ARB	*ACEI:* lisinopril, benazapril, fosinopril and quinapril 10-40mg, ramipril 5-10mg, trandolapril 2-8mg *ARB*: candesartan 8-32mg, valsartan 80-320mg, losartan 50-100mg, olmesartan 20-40mg, telmisartan 20-80mg	SE: Cough (ACEI only), angioedema (more with ACEI), hyperkalemia Losartan lowers uric acid levels; candesartan may prevent migraine headaches
Beta-Blockers	metoprolol succinate 50-100mg and tartrate 50-100mg twice daily, nebivolol 5-10mg, propranolol 40-120mg twice daily, carvedilol 6.25-25mg twice daily, bisoprolol 5-10mg, labetalol 100-300mg twice daily,	Not first line agents – reserve for post-MI/CHF Cause fatigue and decreased heart rate Adversely affect glucose; mask hypoglycemic awareness
Calcium channel blockers	*Dihydropyridine*s: amlodipine 5-10mg, nifedipine ER 30-90mg, *Non-dihydropyridine*s: diltiazem ER 180-360 mg, verapamil 80-120mg 3 times daily or ER 240-480mg	Cause edema; dihydropyridines may be safely combined w/ B-blocker Non-dihydropyridines reduce heart rate and proteinuria
Vasodilators	hydralazine 25-100mg twice daily, minoxidil 5-10mg terazosin 1-5mg, doxazosin 1-4mg given at bedtime	Hydralazine and minoxidil may cause reflex tachycardia and fluid retention – usually require diuretic + B-blocker Alpha-blockers may cause orthostatic hypotension
Centrally-acting Agents	clonidine 0.1-0.2mg twice daily, methyldopa 250-500mg twice daily guanfacine 1-3mg	Clonidine available in weekly patch formulation for resistant hypertension

How to measure your blood pressure at home

Follow these steps for an accurate blood pressure reading

1 PREPARE

Avoid caffeine, cigarettes and other stimulants 30 minutes before you measure your blood pressure.

Wait at least 30 minutes after a meal.

If you're on blood pressure medication, measure your BP **before** you take your medication.

Empty your bladder beforehand.

Find a quiet space where you can sit comfortably without distraction.

2 POSITION

3 MEASURE

Rest for five minutes while in position before starting.

Take two or three measurements, one minute apart.

Keep your body relaxed and in position during measurements.

Sit quietly with no distractions during measurements—avoid conversations, TV, phones and other devices.

Record your measurements when finished.

TARGET:BP™

American Heart Association. | AMA

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Questions?

Wrap-Up

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Comprehensive and Team-Based Care Learning Collaborative

- Free eight-month participatory experience designed to provide knowledge, tools, and coaching support to help health centers and look-alikes implement advanced models of team-based care.
- In this Collaborative, teams will learn how to:
  - Use quality improvement concepts and skills to facilitate their implementation of a model of high-performing team-based care
  - Conduct self-assessments of their current team-based care model to identify areas for process improvement and role optimization
- Outcomes of the learning collaborative:
  - Identified a clinical team to work on a quality improvement project
  - Implemented pre-visit planning and morning huddles
  - Integrated behavioral health with warm welcomes/handoffs
  - Increase UDS measures, such as hyptertension, cancer screenings, etc.
- Apply Here! For more information/questions, please reach out to Meaghan Angers (angersm@mwhs1.com)

Team-Based Care

- **Fundamentals of Comprehensive Care**
- **Advancing Team-Based Care**

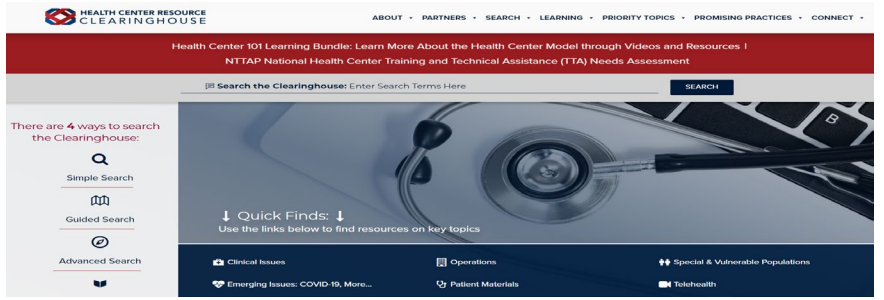
Our NTTAP also offers learning collaborative opportunities in Postgraduate NP Residency Programs, Health Professions Student Training, and HIV Prevention!

Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse



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Contact Information

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