NTTAP
National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Improving Hypertension Management: Applying Standing Orders and the Role of Medical Assistants

Wednesday, November 6th, 2024
2:00pm-3:00pm Eastern / 11:00am-12:00pm Pacific

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At the Weitzman Institute, we value a culture of equity, inclusiveness, diversity, and mutually respectful dialogue. We want to ensure that all feel welcome. If there is anything said in our program that makes you feel uncomfortable, please let us know via email at nca@chc1.com

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MOSES/WEITZMAN Health System

Always groundbreaking. Always grounded.

Community Health Center, Inc.

A leading Federally Qualified Health Center based in Connecticut.

ConferMED

A national eConsult platform improving patient access to specialty care.

The Consortium for Advanced Practice Providers

A membership, education, advocacy, and accreditation organization for APP postgraduate training.

National Institute for Medical Assistant Advancement

An accredited educational institution that trains medical assistants for a career in team-based care environments.

The Weitzman Institute

A center for innovative research, education, and policy.

Center for Key Populations

A health program with international reach, focused on the most vulnerable among us.

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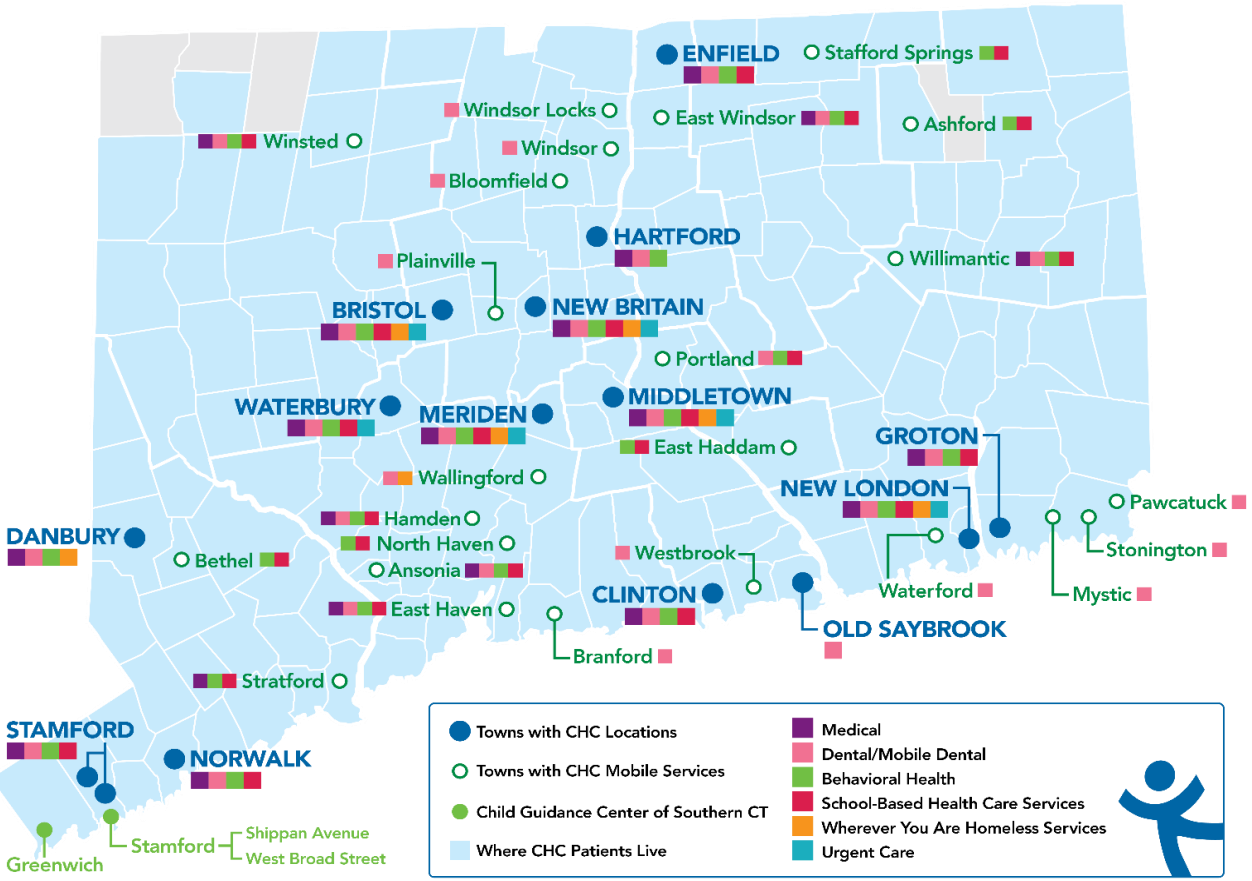
Locations & Service Sites



Community Health Center, Inc.

THREE FOUNDATIONAL PILLARS

1	2	3
Clinical Excellence	Research and Development	Training the Next Generation

Profile

- Founding year: 1972
- Annual budget: $140M
- Staff: 1,140
- Active Patients: 150,000
- SBHCs across CT: 153
- Students/year: 14,522

Year	2021	2022	2023
Patients Seen	99,598	102,275	107,225

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National Training and Technical Assistance Partners (NTTAP)

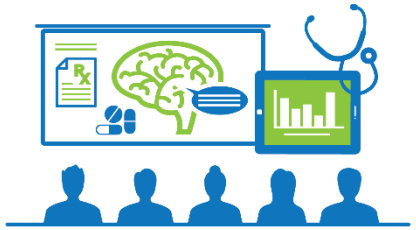
Clinical Workforce Development

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

Speaker

- **Mary Blankson, DNP, APRN, FNP-C, FAAN**
  - Chief Nursing Officer, Community Health Center, Inc.

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Objectives

- Summarize the key components of standing orders using hypertension standing orders as a model to explore team member support, including a focus on the medical assistant workforce
- 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 (generally who can do what)
- Rational (why is it important that they can do these activities)
- Procedure (what are the expectations on how they perform these items, including appropriate documentation)
- Resources (other standing orders, templates, order sets, etc.)
- References
- Other job tools to promote success

Policy

- The Chief Medical Officer has established a standing order for consistent comprehensive visits for patients with Hypertension. Referrals may be received from the patient's Primary Care Provider (PCP). Support staff such as Nurses (RNs, and LPNs) and Medical Assistants may also proactively identify appropriate patients via the care management dashboard or the Hypertension Dashboard.
- These visits may include RNs 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, RNs 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. LPNs and MAs play a key role in supporting patients in addition to provider visits and providing value added care through ensuring home blood pressure monitoring, medication reconciliation and monitoring through collection and review of pharmacy data, collecting evidence based laboratory measures, supporting the engagement of other interdisciplinary team members, completing disease self-management through motivational interviewing and goal setting, and general lifestyle education.

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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, appropriate staff 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 other team members (Registered Dietician, Pharmacist, etc.)
4. Schedule follow up RN visits for HTN assessment & management
5. Perform medication reconciliation (this may be look different depending on who is performing the service)
6. Order regular/chronic hypertension medication refills at the time of the visit if due (See The Medication Refill standing order policy)

Procedure: Think Menu (Continued)

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

7. Complete 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 diet recall, and addressing medication adherence and other items
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 Visit</u>
  - MA 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. completed by appropriate team members

Procedure: Delegated Laboratory Orders

- Management of Hypertension
  - Staff may 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
    - Others?
  - Results should be assigned to the PCP for final assessment of the results, and treatment planning. ***This doesn't necessarily need to be on the spot!

Procedure: Strategies for Lifestyle Modification

- Increase Health Literacy
- Medication adherence
- Adherence to routine HTN health maintenance
- Weight Reduction
- Healthy eating (dash diet)
- Moderate to vigorous physical activity
- Moderation of alcohol consumption
- Smoking cessation counseling in appropriate patients
- Patient specific hypertension patient education in ECW (Health Wise) should be given to patients.

Procedure: Additional Strategies for Lifestyle Modifications

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

Strategies for Management of Hypertension: Medication Titration

- Staff members such as RNs or Pharmacists 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 from a provider or an approved/evidence-based algorithm for these staff members to follow by standing order
- Staff may send medication refills according to an approved procedure—this may include updating chronic medications to 90-day refills
- Staff 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
- Proactive scripting for support team members to ensure asks to the provider are as specific as possible!

Strategies for Management of Hypertension: Care Management

When to consult with the PCP during a visit/interaction:

- 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
  - Use RPM programs if you have them!
- Review potential side effects with patient according to type of medication titrated: including increased fatigue, dizziness, diuresis, etc.
- Check-in routinely every 2-4 weeks until patient achieves control

Strategies for Management of Hypertension: Care Management

- Don’t forget Telehealth
  - This includes:
    - Video Visits
    - RPM programming
- Allow opportunities for interprofessional teams to huddle together to discuss uncontrolled patients and plans moving forward
- Track and report progress—make it public!
  - This allows high performers to be identified so that other teams can collaborate and learn from them

Strategies for Management of Hypertension: Coordination of Care

- Parties to coordinate care with:
  - Interprofessional team members (pharmacists, nurses, RDs, MAs, CHWs, others)
  - Specialists
  - Homecare Organizations (where applicable)
  - Payers
  - Family & Friends
  - Others?

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Strategies for Management of Hypertension: Documentation & Billing

Documentation

- RN visits should be fully documented in the E.H.R. with appropriate provider order
- MA documentation should be either in non-visit or incident to provider visit
- Development and Updating of patient's hypertension care plan

Billing

- RN visits will be coded and billed, incident to the specific provider order (or under standing order). 99211
- Diagnosis code should be from the problem list or updated in collaboration with PCP
- Billing codes to be used are italicized below:
- MA actions are non-billable, but should include CPT codes and other items that should be included in the provider progress note to ensure communication to the payer.

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Additional Resources/ Job Tools

- Use NACHC Million Hearts work and resources!

https://www.nachc.org/about-nachc/our-work/clinical-affairs-and-care-team-support/nachc-million-hearts-initiative/

- AHA
- Others

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.

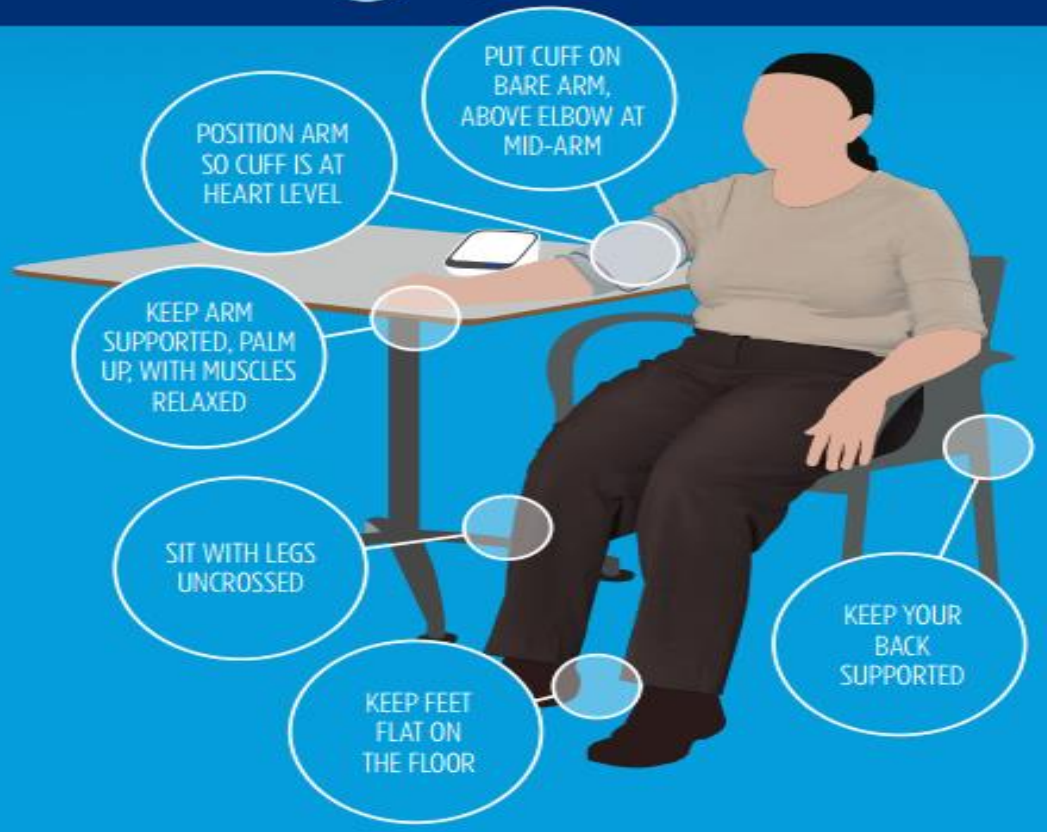
Wait at least 30 minutes after a meal.

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

Evaluation: Medical Assistant Scorecards

- Measures: 2nd BP measured when first is elevated
- SMBP cuff prescribed
- Delegated labs ordered/completed (particularly if POC)
- Smoking cessation discussed/offered (for applicable patients)
- Others?

Evaluation: Medical Assistant Scorecards

- Ensure that all staff know:
  - Who the measure applies to and how often
  - What actions or documentation is required to meet the measure
- Compare individual MA metrics:
  - Across each site
  - Compared with the agency average
- Inform teams of their progress across the measurement period to encourage rapid cycle performance improvement

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Questions?

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Wrap-Up

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Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/

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Contact Information

For information on future webinars, activity sessions, and learning collaboratives: please reach out to nca@chc1.com or visit https://www.chc1.com/nca