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

Team-Based Strategies for Hypertension Management in Health Centers

Thursday April 30th, 2026

2:00-3:00pm Eastern / 11:00am-12:00pm Pacific

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

Continuing Education Credits (CEUs)

Through MWHS, the Weitzman Institute can award continuing education credit (CEUs) to physicians, nurse practitioners, pharmacists, nurses, physician associates/assistants, dentists, psychologists, social workers, and dietitians. Please note that continuing education credit requirements differ by state, jurisdiction, and licensing agency. It is your responsibility to confirm if your licensing/credentialing agency will accept the credits offered by Weitzman Education activities.

To learn more, please visit:
https://education.weitzmaninstitute.org/content/about-us

JOINTLY ACCREDITED PROVIDER™

INTERPROFESSIONAL CONTINUING EDUCATION

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

Disclosure

- With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the party listed above (or spouse/partner) and any for-profit company in the past 12 months which would be considered a conflict of interest.
- The views expressed in this presentation are those of the presenters and may not reflect official policy of Community Health Center, Inc. and its Weitzman Institute.
- We strive to create a respectful and welcoming learning environment. If anything in today's session makes you feel uncomfortable, please let us know via email at nca@chc1.com.
- We are obligated to disclose any products which are off-label, unlabeled, experimental, and/or under investigation (not FDA approved) and any limitations on the information that we present, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion.
- This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $550,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

MOSES/WEITZMAN
Health System
Always groundbreaking. Always grounded.

MORE THAN
WHAT WE DO.
IT'S WHO WE
DO IT FOR.

MOSES/WEITZMAN
Health System
Always groundbreaking. Always grounded.

Community Health Center, Inc.

A leading Federally Qualified Health Center based in Connecticut.

CeCN

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.

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

Locations & Service Sites

Community Health Center, Inc.

Overview

- Founded: May 1, 1972
- Staff: 1,400
- Active Patients: 150,000
- Patients CY: 107,225
- SBHCs across CT: 152

Year	2022	2023	2024
Patients Seen	102,275	104,917	107,225

National Training and Technical Assistance Partners (NTTAP)
Clinical Workforce Development

Provides **free** training and technical assistance to federally funded health centers and look-alikes across the nation through webinars, activity sessions, communities of practice, trainings, publications, and more!

To learn more, please visit https://www.weitzmaninstitute.org/nca.

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

Speakers

- Eric R. Vaught, DO, MPH, MBA – Chief Medical Officer, Community Health Center, Inc. (CHC)
- Mary Blankson, DNP, APRN, FNP-C, FAAN – Chief Nursing Officer (CNO) for Community Health Center, Inc. (CHC)

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

Learning Objectives

- Explain how team-based care models contribute to improved hypertension management.
- Identify key considerations and potential challenges when adopting team-based hypertension strategies in health center settings.
- Summarize available tools to support team-based hypertension care.

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

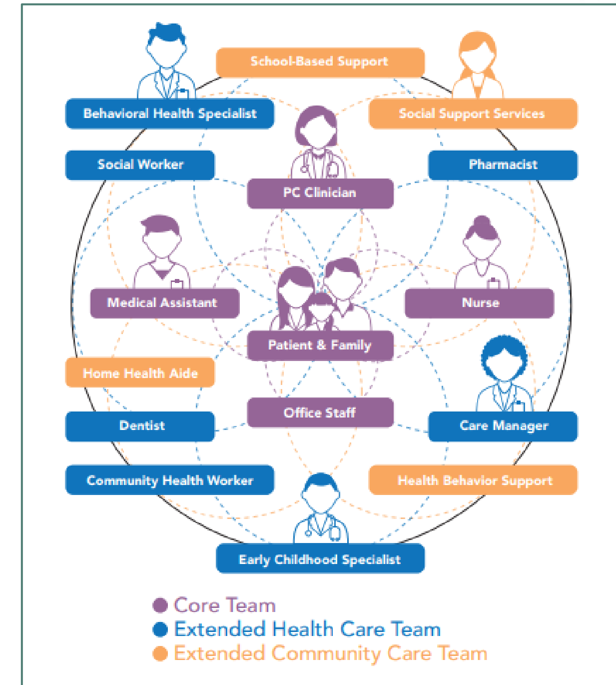
Foundations of Team-Based Care

Leveraging the Team to Improve the Management of Hypertension

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

Interprofessional Care Teams

- **Provider:** Leads clinical decision-making and prescribes medications.
- **Nurse:** Implements care plans, monitors vitals, and provides education.
- **Pharmacist:** Manages medications and ensures safe drug interactions.
- **Behavioral Health:** Supports mental health and stress management.
- **Dietitian:** Guides nutrition choices to improve cardiovascular health.
- **Social Worker:** Connects patients to social services.
- **Community Team:** Builds trust, assists with navigation, and addresses social barriers.



Care provided by teams of clinicians and other professionals fit to the needs of communities, working to the top of their skills, and in coordination leads to better health.[1]

1. National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundationof Health Care. Was.hington, DC: The National Academies Press. https://doi.org/10.17226/25983.

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

Clinical Practice Guidelines

Management of Hypertension 2025 Updates

Hypertension
Volume 82, Issue 10, October 2025; Pages e212-e316
https://doi.org/10.1161/HYP.0000000000000249

CLINICAL PRACTICE GUIDELINES

2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/N Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

Writing Committee Members, Daniel W. Jones, MD, FAHA, Chair, Keith C. Ferdinand, MD, FACC, FAHA, FASPC, Vice Chair, Sandra J. Taler, MD, FAHA, Vice Chair, Heather M. Johnson, MD, MS, FAHA, FACC, FASPC, JC Liaison, Daichi Shimbo, MD, JC Liaison, Marwah Abdalla, MD, MPH, FAHA, FACC, M. Martine Altieri, PA-C, MHSc, Nisha Bansal, MD, MAS, FAHA, Natalie A. Bello, MD, MPH, FACC, Adam P. Bress, PharmD, MS, Jocelyn Carter, MD, MPH, Jordana B. Cohen, MD, MSCE, FAHA, Karen J. Collins, MBA, Yvonne Commodore-Mensah, PhD, MHS, BSN, RN, FAHA, FPCNA, Leslie L. Davis, PhD, ANP-BC, FACC, FAHA, Brent Egan, MD, FAHA, Sadiya S. Khan, MD, MSc, FACC, FAHA, Donald M. Lloyd-Jones, MD, ScM, FAHA, FACC, Bernadette Mazurek Melnyk, PhD, APRN-CNP, FAANP, Eva A. Mistry, MBBS, MSCI, FAHA, Modele O. Ogunniyi, MD, MPH, FACC, FAHA, Stacey L. Schott, MD, MPH, Sidney C. Smith Jr, MD, FAHA, MACC, Amy W. Talbot, MPH, Wanpen Vongpatanasin, MD, FAHA, FACC, Karol E. Watson, MD, PhD, FACC, FAHA, FASPC, Paul K. Whelton, MB, MD, MSc, FAHA, and Jeff D. Williamson, MD, MHS, AGSF

Aim: The "2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults" retires and replaces the "2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults."

A comprehensive literature search was conducted from December 2023 to June

Circulation

CLINICAL PRACTICE GUIDELINES

2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

Developed in Collaboration With and Endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation, Association of Black Cardiologists, American College of Preventive Medicine, American Diabetes Association, American Geriatrics Society, American Pharmacists Association, American Society for Preventive Cardiology, National Lipid Association, and Preventive Cardiovascular Nurses Association

Writing Committee Members*

Roger S. Blumenthal, MD, FACC, FAHA, FASPC, FNLA, Chair; Pamela B. Morris, MD, FACC, FAHA, FASPC, FNLA, Vice Chair; Mario Gaudino, MD, FAHA, FACC, JC Liaison†; Heather M. Johnson, MD, MS, FAHA, FACC, FASPC, JC Liaison‡; Timothy S. Anderson, MD, MAS§; Vera A. Bittner, MD, MSPH, FACC, FAHA, MNLA, MAACVPR‖; Ron Blankstein, MD, FACC; LaPrincess C. Brewer, MD, MPH, FACC, FAHA; Leslie Cho, MD, FACC¶; Sarah D. de Ferranti, MD, MPH, FAHA; Eugenia Gianos, MD, FACC, FAHA, FNLA; Ty J. Gluckman, MD, MHA, FACC, FAHA, FASPC; Kristen F. Gradney, MHA, RDN, LDN#; Ijeoma Isiadinso, MD, MPH, FACC**; Donald M. Lloyd-Jones, MD, ScM, FACC, FAHA, FASPC; Joel C. Marrs, PharmD, MPH, FAHA, FNLA††; Seth S. Martin, MD, MHS, FACC, FAHA, FASPC; Kellie H. McLain, ANP-BC, CLS, FNLA, AACC; Laxmi S. Mehta, MD, FACC, FAHA, FNLA; Samia Mora, MD, MHS, FACC, FAHA; Wudeneh M. Mulugeta, MD, MPH, MS, FACP, FACPM‡‡; Pradeep Natarajan, MD, MMSCFACC, FAHA; Ann Marie Navar, MD, PhD, FAHA, FACC, FASPC; Carl E. Orringer, MD, FACC, MNLA; Tamar S. Polonsky, MD, MSCI; Harmony R. Reynolds, MD, FACC, FAHA; Joseph J. Saseen, PharmD, MNLA, FACC, FAHA§§; Michael D. Shapiro, DO, MPH, FACC, FAHA, FASPC, FNLA‖‖; Daniel E. Soffer, MD, MNLA, FACP‡; A. Tynes, MHA, PMP¶¶; Chloé D. Villavaso, MN, APRN, ACNS-BC, FPCNA, AACC##; Virani, MD, PhD, FACC, FASPC***; John T. Wilkins, MD, MSc, FAHA

Circulation
Volume 148, Issue 20, 14 November 2023; Pages 1606-1635
https://doi.org/10.1161/CIR.0000000000001184

AHA PRESIDENTIAL ADVISORIES

Cardiovascular-Kidney-Metabolic Health: A Presidential Advisory From the American Heart Association

Chiadi E. Ndumele, MD, PhD, FAHA, Chair, Janani Rangaswami, MD, FAHA, Vice Chair, Sheryl L. Chow, PharmD, FAHA, Vice Chair, Ian J. Neeland, MD, FAHA, Katherine R. Tuttle, MD, Sadiya S. Khan, MD, MSc, FAHA, Josef Coresh, MD, PhD, Roy O. Mathew, MD, Carissa M. Baker-Smith, MD, MPH, FAHA, Mercedes R. Carnethon, PhD, FAHA, Jean-Pierre Despres, PhD, FAHA, Jennifer E. Ho, MD, FAHA, Joshua J. Joseph, MD, MPH, FAHA, Walter N. Kernan, MD, Amit Khera, MD, MSc, FAHA, Mikhail N. Kosiborod, MD, Carolyn L. Lekavich, PhD, Eldrin F. Lewis, MD, MPH, FAHA, Kevin B. Lo, MD, Bige Ozkan, MD, ScM, Latha P. Palaniappan, MD, MS, FAHA, Sonali S. Patel, MD, PhD, Michael J. Pencina, PhD, Tiffany M. Powell-Wiley, MD, MPH, FAHA, Laurence S. Sperling, MD, FAHA, Salim S. Virani, MD, PhD, FAHA, Jackson T. Wright, MD, PhD, Radhika Rajgopal Singh, PhD, FAHA, and Mitchell S.V. Elkind, MD, MS, FAHA on behalf of the American Heart Association

Abstract: Cardiovascular-kidney-metabolic health reflects the interplay among metabolic risk factors, chronic kidney disease, and the cardiovascular system and has profound impacts on morbidity and mortality. There are multisystem consequences of poor cardiovascular-kidney-metabolic health, with the most significant clinical impact being the high associated incidence of cardiovascular disease events and cardiovascular mortality. There is a high prevalence of poor cardiovascular-kidney-metabolic health in the population, with a disproportionate burden seen among those with adverse social determinants of health. However, there is also a growing number of therapeutic options that favorably affect metabolic risk factors, kidney function, or both that also have cardioprotective effects. To improve cardiovascular-kidney-metabolic health and related outcomes in the population, there is a critical need for (1) more clarity on the definition of cardiovascular-kidney-metabolic syndrome; (2) an approach to cardiovascular-kidney-metabolic staging that promotes prevention across the life course; (3) algorithms that include the exposures and outcomes most relevant to cardiovascular-kidney-metabolic health; and (4) strategies for the prevention and management of cardiovascular disease in relation to cardiovascular-kidney-metabolic health that reflect

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

2025 AHA/ACC Hypertension Guideline: Key Updates

- Blood pressure (BP) goal of <130/80 mmHg is now universal
- Stage 2 hypertension (HTN): start with two agents, single-pill combination preferred for adherence
- Treatment intensity guided by individual cardiovascular disease (CVD) risk using the PREVENT calculator — not BP numbers alone
- Race removed from prescribing decisions — treatment is individualized
- Out-of-office monitoring, including self-measured blood pressure (SMBP) and remote patient monitoring (RPM), now a standard component of diagnosis and management

Jones, D. W., Ferdinand, K. C., Taler, S. J., Johnson, H. M., Shimbo, D., Abdalla, M., Altieri, M. M., Bansal, N., Bello, N. A., Bress, A. P., Carter, J., Cohen, J. B., Collins, K. J., Commodore-Mensah, Y., Davis, L. L., Egan, B., Khan, S. S., Lloyd-Jones, D. M., Melnyk, B. M., Mistry, E. A., Ogunniyi, M. O., Schott, S. L., Smith, S. C., Jr., Talbot, A. W., Vongpatanasin, W., Watson, K. E., Whelton, P. K., & Williamson, J. D. (2025). 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM guideline for the prevention, detection, evaluation and management of high blood pressure in adults: A report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation, 152(9), e212–e316. https://doi.org/10.1161/CIR.0000000000001356

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

Poll A – Current State

- Which staff levels currently support patient management of hypertension at your health center?
  - Provider
  - Registered Nurse (RN)
  - Medical Assistant
  - Community Health Worker (CHW)
  - Dietitian
  - Pharmacist

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

Poll B – Ideal State

- Which staff members would ideally support patient management of hypertension at your health center?
  - Provider
  - Nurse (RN)
  - Medical Assistant
  - CHW
  - Dietitian
  - Pharmacist

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

The Role of the Primary Care Provider

- Confidence in the competence of their team
  - Support the team in developing cardiovascular-related treatment order sets and SMBP protocol
- Review health-related needs screening and the support provided by team members
- Enter follow-up, recalls, referrals, and treatment orders as appropriate
- Initiate combination therapy (two first-line agents) for Stage 2 HTN rather than starting with a single agent — ideally in a single-pill combination to improve adherence (CDC, 2020)
- Implement rapid titration protocols — intensify treatment at follow-up rather than waiting; treatment is intensified in only 1 in 6 visits for patients with uncontrolled BP (Wall et al., 2023)

Centers for Disease Control and Prevention. (2020). Hypertension control change package (2nd ed.). U.S. Department of Health and Human Services. https://millionhearts.hhs.gov/files/HTN_Change_Package.pdf
Wall, H. K., Ritchey, M. D., Gillespie, C., Omura, J. D., Jamal, A., & George, M. G. (2023). Improving blood pressure control in the United States: At the heart of Million Hearts 2027. American Journal of Hypertension, 36(8), 462–465. https://doi.org/10.1093/ajh/hpad029

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

The Role of the Pharmacist

- To support hypertension management, a clinical pharmacist can:
  - Conduct comprehensive medication reviews to identify drug interactions, side effects, and adherence barriers
  - Recommend and titrate antihypertensive agents in collaboration with the provider
  - Provide patient education on medication purpose, proper use, and expected side effects
- Support medication adherence through motivational interviewing, pill organization strategies, and coordination of refills
  - Coordinate with home care services, insurance case managers, and specialty pharmacy as needed
- Review food-drug interactions and over the counter (OTC) supplement use (e.g., NSAIDs, herbal supplements) that may affect BP control
  - Participate in collaborative drug therapy management (CDTM) agreements where state law permits

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

The Role of the Registered Dietician

- To address health-related needs, a RD can:
  - Assess usual intake for diet adequacy and areas for improvement.
  - Provide necessary education regarding heart healthy food choices, food selection, label reading.
  - Provide resources, including printed materials and accurate online nutrition resources
  - Review eligibility for home services- Meals on wheels or participation in congregate/ senior meals
  - Support patient goal setting specific to food choices and physical activity
  - Create a patient centered nutrition plan to improve blood pressure
  - Review medication related factors (such as timing) to food and food/drug interactions, including OTC supplements.

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

The Role of the Registered Nurse

- To support management of hypertension, RNs can use standing orders and delegated orders
  - Standing order
    - Hypertension Follow-Up Protocol
    - Lifestyle Education
    - Self-management and goal setting using motivational interviewing
    - Referrals to other team members
- Delegated order
  - Patient-specific diet education
  - Patient-specific medication initiation and titration
- Conduct nurse visits to provide care management services, including patient education and use of SMBP monitors
- Medicare Complex Care Management
- Proactive Scripting---ask the provider for exactly what is needed!

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

Nurse Visit Standing Orders

- **Standing Order for Nursing Management of Hypertension**
  - -Full set of vitals
  - -Medication reconciliation
  - -Collect risk factor history
  - -Prescribe home BP Cuff (SMBP)
  - -Education on lifestyle modifications
  - -Labs as appropriate (Lipids, Kidney Health, etc.)
- **Tobacco Cessation Counseling and RN provision of Nicotine Replacement Therapy (NRT)**
  - -Tobacco use history
  - -Current/past NRT
  - -Counseling and goal setting
  - -Review and prescribe NRT medication
  - -Refer to other team members (Nutrition, Behavior Health, Pharmacist)
  - -Regular follow up based on quit date
- **Nurse Managed Refills**
  - -Refill chronic medications- supports safety and adherence
- **Standing Order for Nutrition Services**

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

The Role of the Medical Assistant

- To address health-related needs, a MA can review screening response and/or ICD-10 codes noted in the health record
  - Complete logistics of health-related services needed (transportation form completion, connection to internal resources)
  - Follow up with patients on social services connections (could also be non-clinical staff)
- Blood pressure screening
  - Identify elevated blood pressure, ensure repeat readings if elevated
  - Alert provider and nursing staff of abnormal readings
  - Identify if patient has a SMBP monitor and uses it regularly

- Conduct Pre-visit planning/planned care Alerts
  - Preventative Care (Cancer screenings, Depression screenings, Immunizations)
  - Body mass index (BMI) calculations and diet and physical activity education
  - Uncontrolled blood pressures
  - Urine Microalbumin
  - HemoglobinA1c
- Coordinate activities among the primary care team, specialists, and community services
  - Scheduling visits with social service organizations
  - Following up on specialty or social service referrals
- Use proactive scripting to ask patients about SMBP monitor use, medication side effects, and barriers to adherence at every rooming encounter — a key HCCP strategy for maximizing the MA touchpoint (Million Hearts HCCP)

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

Community Health Workers

- **What is a CHW?** Frontline public health workers who share lived experience with the patients they serve — bridging the gap between individuals and health and social services through outreach, navigation, and support.
- **Role in Hypertension and Cardiovascular Care**
  - Support patients with home BP cuffs and Remote patient monitoring (RPM) devices to stay engaged between visits
  - Identify and address barriers to care: transportation, communication, appointment anxiety
  - Conduct pre-visit check-ins to prepare patients for upcoming appointments and follow-up
  - Assist patients with high cholesterol with lifestyle change goals
  - Identifies and assists to overcome barriers to treatment engagement
- **Building Your CHW Program:**
  - Reflects the community and language of the population served
  - Located in the geographic region they serve
  - Sustained through grant funding or a defined staffing model

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

Barriers to Building Interprofessional Teams

- Unable to recruit the personnel needed
- Only practitioners are reimbursed
- Unpredictable alternative payment schedule
- No time to train and mentor staff in their enhanced roles
- Scope of practice laws
- Will patients accept their care?

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

Overcoming Barriers

Barrier	Strategy
Can't recruit the staff needed	Start with roles you have; expand MA and RN scope before adding full-time equivalents (FTEs)
Only practitioners are reimbursed	Leverage incident-to billing and grant-funded positions (HRSA, state public health funding (PHFs); Bill where you can!
Unpredictable payment schedules	Pilot with a defined patient cohort; build the case for value-based arrangements
No time to train staff	Use standing orders and scripted workflows to reduce cognitive load, not add to it
Scope of practice laws	Know your state's rules; many states allow RN prescriptive authority under delegation
Will patients accept team-based care?	Warm handoffs and provider introductions dramatically improve patient trust in the team

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

Self-Measured Blood Pressure (SMBP) Implementation

Practical Steps for Implementing Self-Measured Blood Pressure Monitoring

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

What is SMBP?

- Self-measured blood pressure monitoring (SMBP): blood pressure measurements taken outside of the clinical setting, usually at home.
- SMBP helps with both diagnosis and management of hypertension (HTN)
    - Supports provider rapid titration protocols
- Increases patient participation in their own care.
- SMBP, when combined with other clinical supports, improves hypertension control.

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

Implementation Activities

- Consider a Hypertension Control Advisory Team-Champions
- Understand your baseline data: current blood pressure control, overall and by population
- Determine the community you aim to serve
- Identify a path for appropriate, accurate and affordable blood pressure monitors
- Define the workflows for patient identification and patient outreach
- Implement a process for blood pressure monitor delivery, training, and follow up

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

Hypertension Control Advisory Team-Champions

- Consider a Hypertension Control Advisory Team
  - Project Manager
  - Clinical Leaders
  - Operational Leaders
  - Dedicated information technology (IT) and electronic health record (EHR) staff
  - Business Intelligence Leader
  - Community Health Leader
  - Frontline Staff (Provider, Medical Assistant, Nurse)
- Others: National contact/advisor such as from American Heart Association (AHA), Million Hearts, etc.

Baseline Data: Current Blood Pressure Control

- Clinical and Operational Data
  - Overall blood pressure control
  - Blood pressure control by stage
  - Blood pressure control by population
  - Other co-existing conditions (i.e., diabetes, kidney disease)
  - Rate of BP recheck post high reading
  - % of medication regimens meeting evidence-based standards
  - % of patients with an appropriate recall
  - Others?

Determine the Communities You Aim to Serve

- Analyze the data to understand each population
- Focus population vs all patients with hypertension
  - Stage of blood pressure and hypertension
  - HTN with other co-existing chronic conditions
  - Newly diagnosed HTN
  - Patients with challenges in coming to office visits
  - Patients already engaged in medical technology (E.H.R. portal, other devices)
- Examine resources and staffing available to address each sub-group

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

Appropriate, Accurate, and Affordable Blood Pressure Monitors

- E.H.R. Compatibility
- Bluetooth vs Standard Blood Pressure Monitor
- Associated application to store/upload data
- Full range of cuff size options (ex. XL option)
- Device included on one of the validated lists recommended by American Heart Association
  - Home | Validate BP
- Cost and availability with current supplier
- Determine if loaned to patient vs permanently given

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

Workflows for Patient Identification and Patient Outreach

- Patient population specific
- E.H.R. registries, community health data
- Patient identification/outreach
  - Identify at medical visit
    - Clinical decision support
    - Patient questionnaire/survey for eligibility
    - Pre-visit planning
- Provider or clinical team recommendation
- Patient request
- Patient text campaign

HPI Notes TESTPATIENT, ATC 2 - DOB: 04/03/1973 - ATC EL30 05/31/2018 10:00 AM

Free-form | Structured

Home BP Monitoring — Default | Default for All | Clear All

Name	Value	Notes
Do you have a blood pressur	No	
Do you have a smart phon	Yes	
Are you able to downloa	Yes	
Are you able to access	Yes	
Is your phone set tc	Yes	
Is the patient corr	Yes	
At this time, we a	Yes	

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

Blood Pressure Monitor Delivery, Training, and Follow-up

- Staff training
- Store and deliver on site, in the office
- Deliver to patient home or pick up at pharmacy
- Loan vs given to patient
- Patient visit for education and training
- Follow up visits for data sharing (BP monitor App, E.H.R. portal, manual cuff readings)
- Consider workflow for interim BP reading review (based on resources)
- Utilize SMBP data to adjust treatment plans

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

Blood Pressure Measurement & Remote Patient Monitoring

Understanding Measurement Types and the Case for RPM

2025 American Heart Association Publications

HealthSnap

Dual Chronic Care Management and Remote Patient Monitoring Enhances Blood Pressure Reductions in a Real-World Cohort Analysis of Hypertensive Adults

HealthSnap

Higher Engagement in Remote Patient Monitoring is Correlated with a Dose-Dependent Reduction in Systolic Blood Pressure from Stage 2 Cohorts

HealthSnap

Clinical Improvements in Remote Patient Monitoring Regress After Discontinuation and Resume Upon Reinitiation

HealthSnap

American Heart Association. Scientific Sessions

Concordance Between In-Office versus At-Home Systolic Blood Pressure Reductions in RPM-Engaged Patients with Uncontrolled Hypertension

Craig Flanagan[1,2], Olivia Osborne[1], Brett Colbert[1], Wesley Smith[1,2]

Methods

In Office

At Home

HealthSnap

American Heart Association. Scientific Sessions

Remote Patient Monitoring is Associated with a 30.6% Reduction in Annual Total Cost of Care Among Hypertension and Diabetes Patients

Wesley Smith [1,2], Olivia Osborne [1], Brett Colbert [1], Craig Flanagan [1,2]

Results

Annualized Total Cost of Care in Prior Year and First Year on Remote Patient Monitoring Program

HealthSnap

American Heart Association. Scientific Sessions

Remote Patient Monitoring Lowers Healthcare Expenditures and Utilization

Wesley Smith [1,2], Olivia Osborne [1], Brett Colbert [1], Craig Flanagan [1,2]

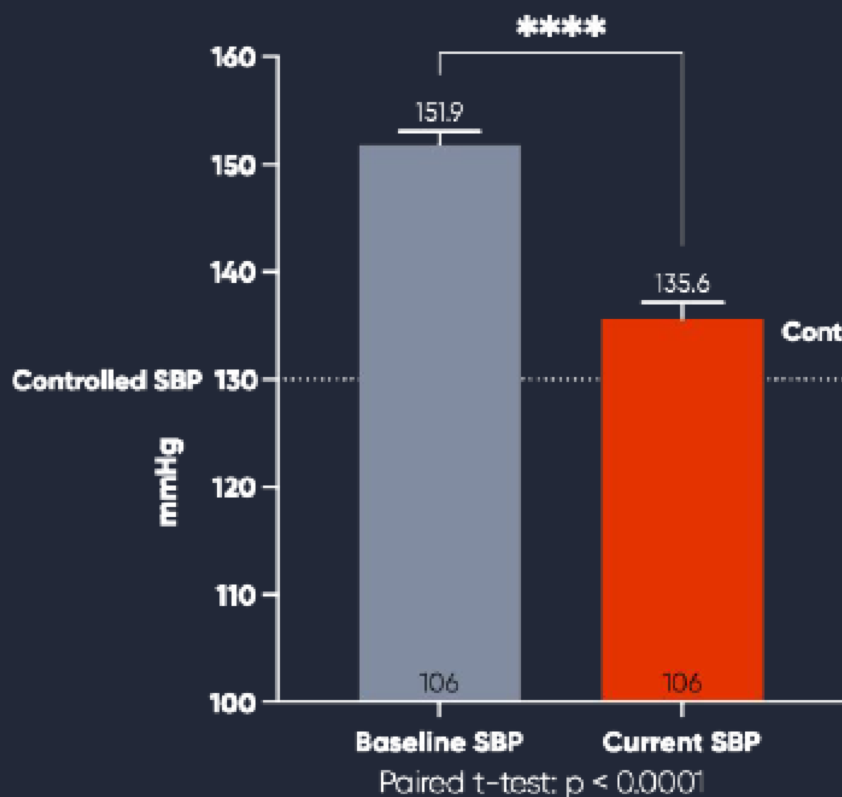
Results

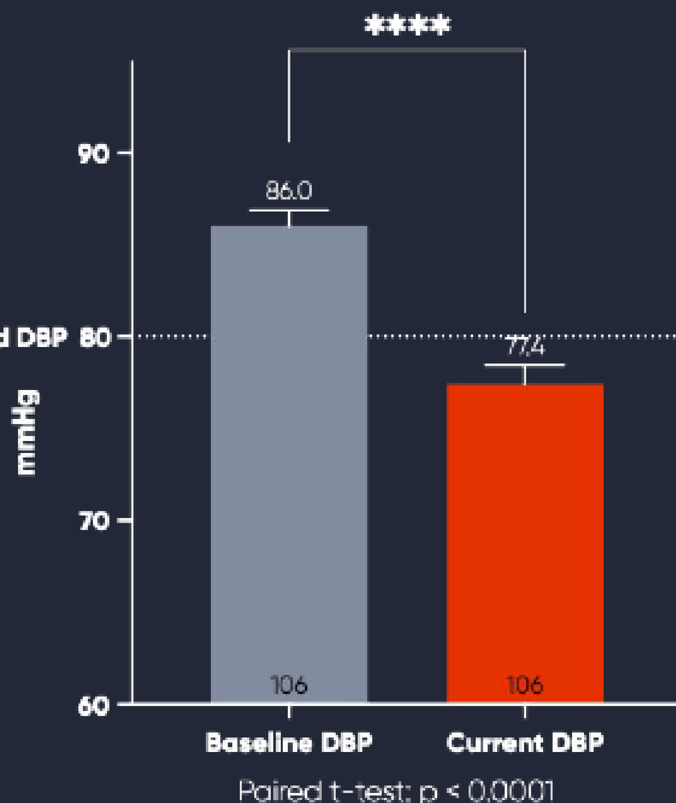
Impact of RPM in ACO Patients

Patients with Baseline SBP ≥140 mmHg OR DBP ≥90 mmHg

Stage 2 Hypertension

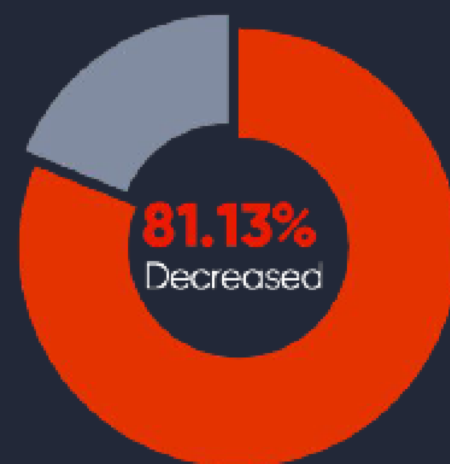
First 2 Transmitting Days vs Recent 2 Transmitting Days





Mean Arterial Pressure

-11.1 mmHg



Count of Patients

106

Avg. Program Duration

480 Days

≤7d between initial and recent transmitting days, ≥4 days with readings

HealthSnap

Community Health Center, Inc.

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

Nursing Standing Orders & Care Management

Expanding the Nurse Role in Hypertension Management

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

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)

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

Procedure: Think Menu Continued

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

7. Order routine point-of-care testing 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 applicable routine screenings and data collection as due on the Planned Care Dashboard such as health-related needs, 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

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: Nurses and MAs use standardized scripts to open conversations about medication side effects, adherence barriers, and home BP monitoring — enabling consistent, team-wide engagement without waiting for provider direction (Million Hearts HCCP)

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

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.

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

Key Tools & Takeaways

- The team is your most powerful tool. BP control improves when every member — provider, pharmacist, nurse, MA, dietitian, and CHW — works to the top of their scope in a coordinated model.
- Protocols unlock the team's potential. Standing orders, SMBP programs, and RPM give non-provider team members the structure to act independently and consistently between visits.
- Barriers are real. Start small. Build your interprofessional team one role at a time, use your data to identify your patient population, and let the evidence guide your approach.
- Resources are available. The Million Hearts HCCP, NACHC SMBP Toolkit, and AMA 7-Step Quick Guide are ready to use. You do not have to build from scratch.

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

Resources

Clinical Practice Guidelines AHA/ACC. (2025). Guideline for the prevention, detection, evaluation and management of high blood pressure in adults. https://doi.org/10.1161/CIR.0000000000001356

ACC/AHA. (2026). Guideline on the management of dyslipidemia. https://doi.org/10.1016/j.jacc.2025.11.016

American Heart Association. (2023). Cardiovascular-kidney-metabolic health: A presidential advisory. https://doi.org/10.1161/CIR.0000000000001184

Team-Based Care & Protocols Centers for Disease Control and Prevention. (2020). Hypertension control change package (2nd ed.). https://millionhearts.hhs.gov/files/HTN_Change_Package.pdf

Centers for Disease Control and Prevention. (2025). *Measuring your blood pressure*. https://www.cdc.gov/high-blood-pressure/measure/index.html

Million Hearts. (2023). Tools and protocols. https://millionhearts.hhs.gov/tools-protocols/index.html

National Association of Community Health Centers. (2024). *Self-measured blood pressure monitoring (SMBP) implementation toolkit*. https://www.nachc.org/resource/smbp-toolkit_final-2/

American Medical Association. (n.d.). *The 7-step self-measured blood pressure (SMBP) quick guide*. https://www.ama-assn.org/public-health/prevention-wellness/7-step-self-measured-blood-pressure-smbp-quick-guide

Remote Patient Monitoring (RPM) HealthSnap. (2024). Remote patient monitoring platform. https://www.healthsnap.io

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

Questions?

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

Wrap-Up

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

Explore more resources!

National Learning Library: Resources for Clinical Workforce Development

National Learning Library

CHC has curated a series of resources, including webinars to support your health center through education, assistance and training.

Learn More

The National Training and Technical Assistance Cooperative Agreements (NCAs) provide free training and technical assistance that is data driven, cutting edge and focused on quality and operational improvement to support health centers and look-alikes. Community Health Center, Inc. (CHC, Inc.) and its Weitzman Institute specialize in providing education and training to interested health centers in Transforming Teams and Training the Next Generation through;

National Webinars on advancing team based care, implementing post-graduate residency training programs, and health professions student training in FQHCs.

Invited participation in Learning Collaboratives to advance team based care or implement a post-graduate residency training program at your health center.

Please keep watching this space for information on future sessions. To request technical assistance from our NCA, please email NCA@chc1.com for more information.

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/

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

Contact Information

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