**Cardiovascular Disease Prevention**

[](http://www.bing.com/images/search?q=blood+pressure+photos&id=2F4FB389A8521B43D68C0C9363977926AA6D5BF7&FORM=IQFRBA&adlt=strict#view=detail&id=EB87FB61C1122F37DF20DC2911DD36C138B6AB2E&selectedIndex=3)

Self-Blood Pressure Monitoring Playbook

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**Overview:**

Cardiovascular disease is the leading cause of morbidity and mortality in the U.S. and affects many populations including the medically underserved who are often affected to a greater extent than other patients. Hypertension and diabetes are two of the most common and modifiable risks for cardiovascular disease.

This Playbook lays out details of a team-based approach to improving hypertension control using Panel Management sessions and Care Coordination. Panel Management involves a core team of PCPs, Nurse/Care Coordinators, practice managers, etc. setting time aside each week (or biweekly) to review their panel of patients with poorly controlled blood pressure, and making plans to help improve their control. The key steps are scheduling the meeting, using panel management dashboards, registries or patient lists; developing care plans for patients; and individual care coordination. Teams working together in this way, with each other and their patients, have been shown to substantially improve patient outcomes.

This Playbook lays out, step-by-step, each element of Panel Management and each team member’s role in the process. Team members may include a Primary Care Provider (PCP) (i.e. doctor, physician assistant, nurse practitioner), Nurse/Care Coordinator (N/CC), Practice Manager, Receptionist, etc.



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**Play #1- Identify Potential Patients**

**Overview:** Patients with uncontrolled hypertension are identified through Electronic Medical Record (EMR), registries or other manual processes.

**Key Players:**

* Primary Care Provider (PCP) (i.e. doctor, physician assistant, nurse practitioner)
* Nurse/Care Coordinator (N/CC)
* IT Staff (if needed to set-up registry/generate list of patients from EMR/medical record)

**Key Steps:**

1. Generate a list of patients with uncontrolled hypertension (BP > 140/90 mm Hg at most recent office visit) using the best available resources as listed above.  
   Note: Consider filtering by ICD9 code of 401.9
2. Sort the list by PCP if in a multiple provider practice and submit list of patients to each participating PCP for review.

**Play #2 – Establish Panel Management (PM) Meeting Schedule**

**Overview:** PCP and N/CC establish a weekly or biweekly Panel Management meeting schedule. The Practice Manager blocks the PCP’s and N/CC’s schedules for the same time each week/biweekly, giving them time to meet for Panel Management. This time is dedicated to reviewing each patient’s medical history and clinical data, establishing/modifying care plans, discussing medication adjustments, etc.

**Key Players:**

* PCP
* Nurse/Care Coordinator
* Practice Manager or other appropriate staff member

**Key Steps:**

1. The PCP and N/CC work together to determine the best date/time for Panel Management meetings, either weekly for 20 minutes or every other week for 40 minutes.
2. The PCP or N/CC notifies the Practice Manager of the meeting time and updates the Practice Manager if there are any schedule changes.
3. Practice Manager blocks a 20 minute weekly appointment slot or a 40 minute biweekly slot for “Panel Management” in the PCP’s and N/CC’s schedules.
4. Practice Manager creates a reminder in Outlook (or similar scheduling software) indicating the Panel Management meeting time and location, updating the schedule as needed.

**Play #3 – Select Patients**

**Overview:** PCP and N/CC review the list of potential patients and identify patients for the SBPM program.

**Key Players:**

* PCP
* N/CC
* Other appropriate staff

**Key Steps:**

1. PCP and N/CC review the list (from **Play #1**) and identify patients for inclusion in the Self-Blood Pressure Monitoring (SBPM) Program. Inclusion is at the discretion of the PCP. Exclusionary factors may include dementia or serious mental illness, dialysis, pregnancy, etc.
2. As the program progresses, additional patients may be identified during routine office visits, Panel Management sessions, or provider/specialist referrals.

**Play #4 – Initial Patient Contact and Scheduling**

**Overview:** Once patients are identified, a designated team member contacts patients to introduce the SBPM program and schedule appointments for patients who wish to participate. PCPs may also talk to patients during routine visits and introduce the program.

**Key Players:**

* PCP
* N/CC
* Practice Manager or other designated team member

**Key Steps:**

1. PCP or N/CC contacts patient, provides a brief description of the SBPM program and extends the opportunity to participate.
2. During routine patient visits, PCPs may introduce the SBPM program to patients.
3. If patient chooses to participate, he/she is transferred to the Practice Manager/designated team member who schedules patient for an office visit with the N/CC.
4. PCP or N/CC documents a Telephone Encounter (TE), progress note, or other established method of communication in the EMR/medical record, indicating the nature of the call and whether or not the patient agreed to participate in the SBPM program.
5. PCP develops an initial care plan for the N/CC to review prior to the visit.

**Play #5 – Panel Management**

**Overview:** Prior to each Panel Management session, the N/CC will prepare for the meeting. He/she will open the EMR dashboard or similar registry and select patients to be discussed. N/CC will review the medical history and develop a suggested care plan if not already completed by the PCP. During Panel Management the PCP, N/CC and other core team members discuss each patient and adjust care plans accordingly.

**Key Players:**

* N/CC
* PCP
* Other core team members

**Key Steps:**Pre-Work:

1. Prior to the PM meeting: N/CC logs into a dashboard/registry and reviews selected patients’ medical records to be discussed.
2. N/CC develops a suggested care plan which will be used during the panel management meeting, if not already completed by the PCP (**Play #4, Step 5**), and identifies needed tests (ex. labs, diagnostic tests, etc.) including any instructions for the patient.
3. The N/CC documents his/her review in the appropriate section of the EMR/medical record.

Panel Management:

1. The N/CC leads the discussion based on his/her pre-work.
2. PCP may order a home blood pressure cuff for the patient to expedite the workflow. Having a home blood pressure monitor available at the initial visit (**Play #6)** is ideal and teams should make every possible effort to have a monitor available. Methods of procuring monitors may include:
   1. Request donations from manufacturer and give monitor to patient to use during the self-monitoring period and return it when monitoring is completed.
   2. PCP calls in a prescription for the monitor and, if covered by insurance, is filled and delivered to the clinical site.
      1. N/CC can contact local pharmacies and attempt to arrange for delivery to the PCP’s office prior to the initial visit
      2. Delivery to patient’s home is also an option, requiring patient to take the cuff to initial visit.
      3. If delivery is not available, patient may pick up monitor at pharmacy and take to initial visit.
   3. PCP gives prescription to patient who has it filled and takes monitor to the initial visit.
3. The PCP reviews the cases with the N/CC and other core team members and orders tests, medications, referrals, and follow-up visits including referral to the VNA as needed during the SBPM phase.
4. All activity is recorded in the patient’s medical record and the appropriate staff member (N/CC, Practice Manager, etc.) carries out the orders, scheduling, and/or follow-up care.

**Play #6 – Care Coordination**

**Overview:** During visits, N/CCs will educate patients on home BP monitoring and education regarding medications and lifestyle changes. N/CCs will use Motivational Interviewing (MI) techniques to engage patients in disease management discussions and then establish Self-Management Goals (SMGs). N/CCs will monitor patient progress with SBPM and the established SMG at least every two weeks during the intervention period or until BP goal has been achieved. Follow-up visits will be scheduled by the N/CC.

**Key Players:**

* N/CC
* PCP
* Patients

**Key Steps:**INITIAL VISIT:

1. N/CC meets with patient during the initial Nursing/Care Coordination appointment (scheduled during **Play #4**) and gives the patient a welcome packet of information including the *My Path to Healthy Numbers* booklet. The initial visit includes:
   1. Education regarding the disease process
   2. Instruction on SBPM
   3. Medication management (if applicable)
   4. Lifestyle modifications including development of a Self-Management Goal(s)
2. N/CC gives a home blood pressure monitor to the patient, if one has not already been provided to the patient, teaching him/her how to use it including initial set-up and BP monitoring. In settings where the patient will not have access to a Home monitor, patients will be encouraged to use a cuff/machine located in their community. Patients are encouraged to perform BP readings with the N/CC or other resources assisting until patient can demonstrate ability to measure BP without assistance.
3. N/CC instructs patient to monitor BP two times per day (morning and evening) and record results in the *My Path to Healthy Numbers* booklet. When the patients must use a community cuff, they should be instructed to monitor daily.
4. The N/CC, using Motivational Interviewing (MI) techniques, determines the patient’s readiness for learning and change then helps to establish SMGs when appropriate.
5. The N/CC schedules a virtual/telephone follow-up visit with the patient every week or two as needed to obtain the SBPM results and to review the established SMGs which will be reassessed until patient meets goal(s).
6. N/CC shares SBPM results with the PCP by creating a TE, progress note, or other established method of communication and documentation in the EMR/medical record, informing him/her of the visit and any issues or concerns.
7. PCP adjusts medications as needed based on the SBPM results.
8. The N/CC contacts the patient with any treatment plan changes.
9. All interventions are documented in EMR/medical record (**See Play #7**).

FOLLOW-UP VISITS

1. Patients receive a weekly virtual visit/telephone call from the N/CC to review BP readings, SMGs and overall care plan with the patient. All phone calls are documented in the EMR/medical record and assigned to the PCP for review.
2. Patient has a one-month follow-up visit to review BP trends, SMGs, and reinforce medication usage and lifestyle changes with the N/CC. The patient schedules a follow-up PCP appointment (per PCP’s timeframe recommendations). N/CC creates a TE, progress note, or other established method of communication to the PCP to inform him/her of patient’s SBPM results.
3. Process is repeated until hypertension control is achieved.

**Play #7 – Care Coordination Documentation**

**Overview**: Accurate and timely documentation streamlines communication between patient, N/CC, and PCP. Documentation of patient contact in the EMR/medical record will allow the team to track patient progress during the SBPM program.

**Key Players:**

* PCP
* N/CC

**Key Steps:**

1. N/CC documents patient visits in the EMR under Nurse Care Coordination tab if applicable or in other designated areas of the medical record.
2. The documentation includes:
   1. Any education provided regarding HTN management
   2. Medications
   3. Use of the self-blood pressure monitor including readings
   4. Lifestyle changes
   5. Self-Management Goals (SMGs)
3. After each visit or phone call the N/CC will send a TE to the PCP regarding SBPM results and note if any concerns were identified.

**Play #8 – PCP**

**Overview**: The PCP leads the SBPM team to improve self-management in patients with poorly controlled HTN.

**Key Players:**

* PCP

**Key Steps:**

1. Through EMR TE, progress note, or other manual process, PCP reviews N/CC visit notes and BP trends.
2. PCP determines medication titration, tests to order and/or referrals to make.
3. PCP contacts patient to discuss any medication changes, tests, or additional N/CC visits that are ordered.
4. PCP communicates via TE, progress note, or other established method of communication back to N/CC to reinforce medication changes and reasons for tests or referrals. May include request for N/CC to contact patient to discuss in lieu of Step #3 above.

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