**POLICIES AND PROCEDURES**

***DEPARTMENT:***

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| Title: | **Self-Blood Pressure Monitoring (SBPM)** |
| Effective Date: |  |
| Policy No. |  |
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**POLICY:**   
[ORGANIZATION] offers intensive self-blood pressure monitoring (SBPM), treatment adjustments, and education for patients with uncontrolled blood pressure (BP)/hypertension (HTN) using multiple approaches. These approaches include:

* Two week intervals of patient recorded BP readings
* Nurse/Care Coordinator telephone calls to patients to review Self-Management Goals (SMGs), lifestyle changes and BP readings
* Follow up visit with Nurse/Care Coordinator (in person) for monitoring, education and self-management
* Medication adjustment by provider (if applicable)
* Home VNA visit may be ordered as needed by referral

The PCP and clinical team will proactively plan patient specific interventions and follow-up prior to scheduled visits during Panel Management sessions.

**PURPOSE:**

Uncontrolled BP is a significant risk factor for stroke, heart attack and heart and kidney failure. Self-blood pressure monitoring is a better predictor of outcomes than office blood pressure monitoring because it identifies masked and white coat hypertension. Team based care coordination, including close follow-up and support from a specially trained Nurse/Care Coordinator working individually with patients to set their own goals and learn how to monitor their own BP, helps patients attain BP control more rapidly and effectively than they otherwise would. Self-management results in better BP control with patients with uncontrolled hypertension.

**PROCEDURE:**

1. Patients in need of SBPM are identified by the PCP and Nurse/Care Coordinator (N/CC).
2. The PCPs and/or N/CCs outreach to their patient and offer the opportunity to participate in the SBPM program, scheduling an initial nursing office visit for patients who wish to participate.
3. The initial contact and all subsequent contact is documented in the EHR or other medical record tool.
4. A home BP monitor is procured for patient utilizing methods that may include:
   1. Patient is given a donated monitor to use during the self-monitoring period and return when monitoring is completed.
   2. PCP calls in prescription for monitor and, if covered by insurance, is filled and delivered to the clinical site.
   3. PCP gives prescription to patient who has it filled and takes monitor to the initial nursing visit.
5. The initial nurse visit includes:
   1. Assessment of medication adherence and smoking cessation desire if applicable.
   2. Education regarding the disease process and lifestyle modifications including diet and exercise
   3. Provision and review of educational materials including a *My Path to Healthy Numbers* booklet which patient is instructed to take to all office visits for review.
   4. Provision of a home BP monitor (if not already obtained by patient).
   5. Instruction on SBPM including encouragement to take BP readings in the morning and evening and record them in the *My Path to Healthy Numbers* booklet.
6. N/CC uses Motivational Interviewing techniques to determine readiness and encourage the patient to set a Self-Management Goal(s).
7. N/CC schedules a follow-up appointment with the patient two weeks after initiation of the SBPM; this appointment can be face-to-face or a telephonic virtual visit.
8. N/CC documents the patient visit and management in the EHR or other medical record tool and informs PCP of the visit via Telephone Encounter (TE), progress note, or other established method of communication.
9. Patients receive weekly phone calls from the N/CC to review BP readings, SMGs, and care plan with the patient. Phone calls are documented in the EHR or other medical record tool.
10. N/CC communicates any changes and/or concerns to the PCP via TE, progress note, or other established method of communication.
11. N/CC calculates the average morning and evening BP result and documents in the EHR or other medical record tool.
12. N/CC reviews the established SMG and works with the patient to problem solve or establish a new goal.
13. Self BP result information is sent to the PCP for review through a TE, progress note, other established method of communication, or during Panel Management sessions.
14. The PCP documents medication and/or other adjustments to be implemented in the EHR or other medical record tool.
15. The N/CC informs patient of recommended medication changes and schedules a nursing visit or telephone virtual visit in two weeks.
16. One month following the original nursing visit, patient attends a follow-up office visit. Again, BP logs and SMGs are reviewed and education related to BP monitoring, disease process, lifestyle modifications, and medications is reinforced.
17. Following the second office visit, patient is encouraged to follow-up with his/her PCP for routine medical care as needed.
18. Process is repeated until hypertension control is achieved.