STANDING ORDER FOR HYPERTENSION CARE

POLICY:

Under this standing order, medical assistants and RNs with proper training may support the care of patients with hypertension under the supervision of clinicians, as outlined below.

PURPOSE:

Hypertension, or high blood pressure, is known as the "silent killer." An estimated 1 in 3 people in the United States has high blood pressure as indicated by at least 3 readings of a systolic pressure of 140 mmHg or higher and a diastolic pressure of 90 mmHg or above. Less than half of those diagnosed with high blood pressure have it under control. Patients with uncontrolled blood pressure are at greater risk of having heart attacks, stroke, heart failure, and kidney disease.

According to a 2010 article in the American Journal of Preventive Medicine, lowering blood pressure is the leading clinical preventive service that saves the most lives. 46,000 deaths might be averted each year if patients were treating according to current recommended guidelines. Using recommended medications, monitoring disease goals regularly, quitting smoking and other lifestyle modifications can improve blood pressure control.

PROCEDURE:

- 1. This protocol applies to all patients with a diagnosis of hypertension
- 2. At every visit, take and record the patient's blood pressure.
 - a. Check blood pressure according to the following:
 - a. Have patient sit for 5 minutes, relaxed
 - b. Have patient roll up sleeve
 - c. Place cuff 1/2 inch above crease of elbow
 - d. Have patient bend elbow comfortably and rest on table or other surface at the level of heart
 - e. Inflate cuff
 - f. Ask patient not to speak while the cuff is inflating
 - g. Drinking caffeine or smoking 30 minutes prior can also affect blood pressure
- 3. At every visit, ask patient about their smoking status, document in the chart, and offer resources to quit
- 4. Identify if patient is due for labs:
 - a. Fasting Lipid Panel: Repeat every 12 months
 - b. Serum Potassium and Creatinine (basic metabolic panel): Repeat every 12 months

- c. <u>Urine Microalbumin Test</u>: (not part of routine guidelines; order based on provider direction). Repeat every 12 months
- d. If patient is due for a lab, prepare lab requisition or enter requisition into EMR.
- e. Draw blood or provide urine specimen cup if time allows during the visit
- 5. Provide basic patient education as needed
 - a. Deliver education based on the patient's baseline knowledge level.
 - b. Include information on disease, lifestyle changes, and medication
- 6. Offer self-management support and goal setting at each visit
 - a. Create an action plan with patient around:
 - i. Improving nutrition
 - ii. Increasing physical activity
 - iii. Quitting smoking
 - iv. Taking medications exactly as prescribed
 - b. Document verbal or written action plan in chart or electronic medical record
 - c. Ask patient about action plan progress at next visit or establish follow-up date
- 7. Offer referral to the following as needed:
 - a. Smoking cessation
 - b. Nutrition
 - c. Exercise group
 - d. Blood pressure group
 - e. Pharmacist
 - f. Behavioral Health
- 8. Refer to community resources
- 9. Document the visit and procedures taken in patient chart.

Medical Directo	r	_	
	Printed Name		Signature
Effective date			
Date reviewed		Date revised	