Hypertension Fact Sheet
- Normal: 120-140mmHg/80-90mmHg
- Hypertension: >140/90 mmHg
- Malignant Hypertension: >180mmHg/120mmHg
- Uncontrolled Hypertension: average >140mmHg/90mmHg among those with hypertension (even with medication prescription)
- Risk factor for hypertensive heart disease, coronary artery disease, stroke, aortic aneurysm, peripheral artery disease, and chronic kidney disease
- First line of treatment should be lifestyle changes in diet and exercise
- DASH diet = Dietary Approaches to Stop Hypertension
- Second line of treatment is medication, when BP DASH Diet = Dietary Approaches to Stop Hypertension

Standardization of Nurse Visit
Goal: standardization of nurse visit, with concrete goals for each visit as well as standardization of script and information to be covered by the nurse
- If uncontrolled: nurse visits every 1-2 weeks
- If controlled: nurse visit every 3-6 months

Nurse Visits Types (SEE HANDOUTS):
- Alcohol intake
- Smoking Cessation
- Physical activity assessment and education
- BMI/Weight, abdominal circumference and education
- DASH Diet education
- Stress Assessment and questionnaire, including behavioral therapist or mental health service referral if needed

Background on HTN Project
ADD PHW HTN PREVALENCE DATA HERE
- Hypertension Project at Family Health Center of Worcester: goal to better control hypertension in patients with uncontrolled hypertension using an integration of clinic and community aspects.
  - Clinical Aspects:
    - Education of patient on basic pathophysiology of hypertension
    - Nurse Visit Standardization
    - Loanable-at-home BP machines
    - Chronic Disease Self-Management Programs (CDSMP)
  - Community Aspects:
    - Education from community healthcare workers who have similar background to patient
    - Partnerships with community resources: Elderly Center, Mas Audubon, YMCA/YWCA, Mosaic for nutrition, CDSMP

Quality Improvement Work
HTN Registry:
- Review of registry consistently every 2-3 weeks with updates, status changes, BP and other readings.

Questionnaires:
- Provider Questionnaire on care of hypertensive patients
- Questionnaire on "My Health, My Life" Chronic Disease Self-Management Program

Future Work: Guidelines for Providers
- Education from clinical pharmacists
- What medications to use. What are bad combos
- When to do an EKG (before Beta or Ca blocker)
- Drug-drug interactions with psych meds
- Pharmaceutical review/education for nurses, MA, providers, NPs
- Nurse visit frequency

Physician Questionnaire (n=19)
- Will Loanable At-Home Blood Pressure Machines for Patients with High Blood Pressure in Clinic; Not Versus Group w/ HTN, see Handout
- How Often Do You Follow-up on Patients with Uncontrolled Hypertension?
- How Often Do Your Patients Have a Follow-up Nurse Visit?
- What Do You Consider the Purpose of a Nurse Visit? (select one answer)
- How Do You Follow up on Patients Who Miss Their Appointment? (select one answer)

Patient Questionnaire for the “My Life, My Health” Workshop (n=5)
- How Many Sessions Did You Attend?
- What was the Most Helpful Part of the Program for you?
  - “I became alive again”
  - “Action Plans”
  - “Speaking in front of a group”
  - “Having a problem- talk it out, breath, exercise”
  - “Help control [blood] pressure”
- How Did You Feel About Dealing with Your Chronic Condition After the 6 Week Program?
- How Do You Feel About Your Health Progress After the 6 Week Program?
- What was the Most Challenging Part of the Program for you?
  - “Reading Labels, Eating Less”
  - “Sitting for a long time in one place, it is difficult for me”
  - “Driving 45 minutes to get to [each] class”
  - “To keep with the walking”
  - “The walking”

Did You Notice Any Other Changes in your Daily Life After Doing the 6 Week Program?
- “I lost weight [10lbs], also walk five miles”
- “Better Mood”
- “I was more motivated and felt better about myself”
- “Better mood, handling situations differently, talking more”
- “Walked [more] and dealt [with] controlling pressure better”

Do You Have Any Further Comments or Feedback?
- “The size of the group was an asset. Smaller groups be covered by the nurse”
- “Driving 45 minutes to get to [each] class”
- “To keep with the walking”
- “The walking”

Community Health Worker Role
- motivational interviewing
- discussion of diet
- discussion of exercise
- home visits as needed

The Hypertension Project at Family Health Center of Worcester
Jacob Modest, University of Massachusetts Medical School Class of 2018
Summer Assistantship Program
Hypertension Project Team: Dr. Rola Saab, Thuha Le, and Louisa Asiamah