QUALITY STANDARDS

Placemat for Hypertension

This document is a resource for clinicians and summarizes content from the *Hypertension* quality standard.

Screening, Assessment, and Diagnosis

Quality Statement (QS) 1: Culturally Responsive Care

People with hypertension or at risk for hypertension (and their families and care partners) receive care from health care teams in a health care system that is culturally responsive and free from discrimination and racism. Health care teams work to build trust, address misconceptions about hypertension, remove barriers to accessing care, and provide equitable care.

Treat people with or at risk for hypertension (and their families and care partners, as appropriate) with respect, dignity, and compassion, and work to establish trust.

Ensure that you are equipped with the appropriate education, knowledge, and skills to provide care in a culturally responsive, antiracist, and anti-oppressive way. See each person as an individual, engage in active listening, and work to understand people's needs. Be an advocate and an agent of change if structural factors of discrimination need to be addressed.

QS 2: Accurate Measurement of Blood Pressure

People receive automated office blood pressure measurement when in-office blood pressure measurement is performed.

Use automated office blood pressure (AOBP) measurement in-office. Ensure that you are trained in standardized techniques and the interpretation of readings, and review your skills and performance periodically. When measuring blood pressure, consider the following:

- The office environment (temperature, comfort, privacy)
- Appropriate cuff size (possibly a wrist cuff for large arm circumferences)
- Patient position or posture

QS 3: Out-of-Office Assessment to Confirm a Diagnosis

People with a high in-office blood pressure measurement receive ambulatory blood pressure monitoring to confirm a diagnosis of hypertension. Home blood pressure monitoring can be used if ambulatory blood pressure monitoring is not tolerated or not readily available, or if the patient prefers home monitoring.

Offer ambulatory blood pressure monitoring (ABPM) to confirm a diagnosis of hypertension in people with a systolic blood pressure of 135 to 179 mm Hg or a diastolic blood pressure of 85 to 109 mm Hg (or both) using AOBP measurement. Offer home blood pressure monitoring (HBPM) if ABPM is not tolerated, not readily available, or if the patient prefers it. Educate patients about how to use the ABPM or HBPM device and record their blood pressure readings. Refer patients to Hypertension Canada's Home Blood Pressure Log to help them select and use an HBPM device.

Self-Management

QS 4: Health Behaviour Changes

People with hypertension or at risk for hypertension (and their families and care partners) receive information and supports for health behaviour changes that can reduce their blood pressure and risk of cardiovascular disease, including physical exercise, alcohol consumption, diet, sodium and potassium intake, smoking cessation, and stress and weight management.

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Ask patients about their health behaviours. Provide culturally appropriate information and education about changes that can reduce blood pressure. Work with people to set goals and connect them to programs that support health behaviour changes. Consider referral to a dietitian for diet and nutrition changes, or to a psychologist or counselling.

QS 5: Care Planning and Self-Management

People with hypertension (and their families and care partners) collaborate with clinicians and use shared decision-making to create a care plan that includes a target blood pressure range, goals for health behaviour change, medication selection and adherence, recommended diagnostic testing, management of concurrent conditions, and when to follow up.

Collaborate with the patient to develop a care plan that includes key components of care. Discuss the care plan with the patient and provide it in writing. Review the care plan regularly, depending on the person's risk factors and other individual factors.

Monitoring and Follow-up

QS 6: Monitoring and Follow-Up After a Confirmed Diagnosis

People with hypertension who are actively modifying their health behaviours but not taking blood pressure medication are assessed by their clinician every 3 to 6 months. Shorter intervals (every 1 to 2 months) may be needed for people with higher blood pressure. People who have been prescribed blood pressure medication are assessed every 1 to 2 months until their target blood pressure has been met on 2 consecutive visits, and then every 3 to 6 months.

Follow up with patients every 3 to 6 months if they are actively modifying their health behaviours but not taking blood pressure medication. If patients have been prescribed blood pressure medication, follow up every 1 to 2 months until their target blood pressure has been met at 2 consecutive visits; then, follow up every 3 to 6 months.

QS 7: Improving Adherence to Medications

People who are prescribed blood pressure medication (and their families and care partners) receive information and supports to help them take their medication regularly and as prescribed. At every follow-up visit for hypertension, they have discussions with their clinicians about medication use, possible side effects, and any barriers they experience in taking their medications as prescribed.

Discuss adherence to blood pressure medication with patients. Offer multiple support strategies to help them improve their medication adherence and address any barriers they may face (e.g., the cost of the medication, stopping their medication when they feel fine, or cultural beliefs). The quality of your communication with the patient (i.e., the length of the conversation, your tone, and a patient-centred approach) and the involvement of family or care partners (if appropriate) are important facilitators for medication adherence.

Resources

- *Hypertension* quality standard and patient guide
- Ontario Online Self-Management Program and Regional Chronic Disease Self-Management Programs
- Hypertension Canada's List of Recommended Devices
- American Medical Association/American Heart Association's In-Office Blood Pressure Measurement Graphic and Self-Measured Blood Pressure: Patient Training Checklist
- CorHealth's Hypertension Management Program: Medication Adherence Counselling Tips

Additional tools and resources are on Quorum

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