

Partnering For Better Blood Pressure Control

What if your health depended on taking your own blood pressure and interpreting the results but you lacked the knowledge and training? This is a real issue for many people, and community paramedics (CPs) in Fargo-Moorhead are addressing it by teaching patients how to take their own blood pressure with a blood pressure cuff in their own home.

In January 2016, Sanford Health's F-M Ambulance (FMA) Service Community Paramedic Program met with PartnerSHIP 4 Health (PS4H) to brainstorm how to support patients with high blood pressure. PS4H offered funds and guidance to develop and implement the Self-Measured Blood Pressure (SMBP) Monitoring Program, which includes loaning a blood pressure cuff for home use until the patient's readings are consistently below 140/90. FMA partnered with a clinical pharmacist and pharmacy students from Family Healthcare in Fargo, North Dakota to develop policies and procedures, promoted the program in conjunction with Sanford Health, and started offering it to their patients in August 2016.

According to Jason Jordahl, FMA Community Paramedic, "Many patients did not realize they could check their blood pressure at home. Now that they are doing it, seeing their numbers on a daily basis gives them peace of mind." Patients are encouraged to bring their daily pressures to their medical appointments and share them with their medical team. Sherm Syverson, FMA senior director, understands the value of this program for vulnerable populations and explains, "Many of the patients in the SMBP program are not able to access care due to mobility or transportation issues. This program offers another way these patients can partner to manage their own care in their own home."

Referrals to the program are made through Sanford Health's primary care clinics, walk-in clinic, and inpatient settings, and have resulted in varying outcomes. One patient – an 89-year-old female – was seen at the walk-in clinic. She had a history of high blood pressure identified during an inpatient stay. She did not have a primary care provider and had not regularly seen a doctor in many years. Before meeting with a CP, she was on a medication to control her blood pressure with little effect. After enrolling in SMBP, she had consistent morning readings of 179/90-190/110 with slightly lower readings in the evening of 150/90-160/100. She learned about the effects of long-term uncontrolled blood pressure and was urged to connect with a provider to manage her blood pressure. CPs continue to visit her, monitor her blood pressure readings and encourage her to manage her high blood pressure.

Another patient, a 78-year-old female, was referred to CPs by an Internal Medicine provider who wanted some insight into the patient's home environment. The patient's blood pressure readings varied widely and the patient had experienced heart failure, heart attack, enlarged heart, post-gastric bypass, pacemaker insertion, atrial fibrillation, memory loss and cognitive issues. During the initial home visit, the CP showed her how to use the home monitoring equipment. Initially, she had difficulty using the blood pressure cuff, but the CP continued to help. After a few days of home blood pressure monitoring, her readings decreased from 190/100 to 130/80. The CPs continue to track her results and talk with her and her provider.

The third example is a 74-year-old female referred after numerous visits to the emergency room and walk-in clinic. This patient had moderate to severe anxiety triggered by high blood pressure readings. The patient had an older wrist-style blood pressure cuff at home that resulted in higher readings when compared to the cuff used by the CP. The patient received a new cuff through the loan program and has reported consistently well-controlled pressures. Her doctor adjusted her medication during this process. The CPs worked with the doctor to establish a new regimen and keep her blood pressure controlled. Her clinic readings had regularly been above 170/90. Her new average reading is now 120/70. Her controlled daily pressures along with the bi-weekly CP visits lowered her anxiety level.

According to Syverson, "Prolonged unmanaged high blood pressure often leads to stroke and prolonged nursing home stays, which is an expensive way to manage health care. PartnerSHIP 4 Health promotes preventive care, innovatively bringing community paramedics, pharmacists and clinics together to make an impact on blood pressure. PartnerSHIP 4 Health connects the dots, and together, we are teaching patients how to manage their care at home. It also increases patient satisfaction and lowers overall health care costs."

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