12.2. Structured, Team-Based Care Interventions for Hypertension Control

Recommendation for Structured, Team-Based Care Interventions for Hypertension Control References that support the recommendation are summarized in Online Data Supplement 62.		
COR	**LOE**	**Recommendations**
I	**A**	**1. A team-based care approach is recommended for adults with hypertension (1-7).**

Synopsis

Team-based care to improve BP control is a health systems–level, organizational intervention that incorporates a multidisciplinary team to improve the quality of hypertension care for patients (8-10). Various team-based hypertension care models have been demonstrated to increase the proportion of individuals with controlled BP and to reduce both SBP and DBP (1-7, 11, 12). A team-based care approach is patient centered and is frequently implemented as part of a multifaceted approach, with systems support for clinical decision making (i.e., treatment algorithms), collaboration, adherence to prescribed regimen, BP monitoring, and patient self-management. Team-based care for hypertension includes the patient, the patient's primary care provider, and other professionals, such as cardiologists, nurses, pharmacists, physician assistants, dietitians, social workers, and community health workers. These professionals complement the activities of the primary care provider by providing process support and sharing the responsibilities of hypertension care. Section 13 contains a comprehensive, patient-centered plan of care that should be the basis of all team-based care for hypertension.

Team-based care aims to achieve effective control of hypertension by application of the strategies outlined in Online Data Supplement H (3). Delineation of individual team member roles on the basis of knowledge, skill set, and availability, as well as the patient's needs, allows the primary care provider to delegate routine matters to the team, thereby permitting more time to manage complex and critical patient-care issues. Important implementation aspects, such as type of team member added, role of team members related to medication management, and number of team members, influence BP outcomes (3, 13). Team member roles should be clear to all team members and to patients and families.

Team-based care often requires organizational change and reallocation of resources (14, 15). Systems-level support, such as use of electronic health records (EHR) (see Section 12.3.1), clinical decision support (i.e., treatment algorithms), technology-based remote monitoring (see Section 12.3.2), self-management support tools, and monitoring of performance, are likely to augment and intensify team-based care efforts to reduce high BP.

Recommendation-Specific Supportive Text

1. RCTs and meta-analyses of RCTs of team-based hypertension care involving nurse or pharmacist intervention demonstrated reductions in SBP and DBP and/or greater achievement of BP goals when compared with usual care (1, 2, 4, 5). Similarly, systematic reviews of team-based care, including a review of studies that included community health workers, for patients with primary hypertension showed reductions in SBP and DBP and improvements in BP control, appointment keeping, and hypertension medication adherence as compared with usual care (3, 12).

References

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Data Supplement H. Responsibilities and Roles of the Hypertension Team

Hypertension Team Responsibilities	
• Communication and care coordination among various team members, the patient and family members or other support persons. • Effective use of evidence-based diagnosis and management guidelines • Regular, structured follow-up mechanisms and reminder systems to monitor patient progress • Engage patients in their care by shared decision making • Medication adherence support and appropriate education about hypertension medication • Medication addition and titration using evidence-based treatment algorithms • Use of evidence-based tools and resources designed to maximize self-management (including health behavior change, lifestyle modification, etc.) • Follow a single, personalized plan of care based upon patient characteristics and needs	
Individual Hypertension Team Members	**Roles (examples)**
Primary Care Physician, Physician Assistant, Advanced Practice Nurse	Routine and complex hypertension care, managing primary care issues.
Cardiologist	Routine and complex hypertension care, especially for patient with cardiac disease or high risk for major cardiovascular events.
Nephrologist, Endocrinologist, Hypertension Specialist	Management of complex hypertension care, especially due to secondary causes, and/or resistant hypertension.
Nurse (including in-office, home care, internal and external population health personnel)	Accurate assessment of BP, medication reconciliation, patient education, self-management, lifestyle modification and adherence.
Clinical Pharmacist	Comprehensive medication management, which involves identification and documentation of medication-related problems, initiating, modifying, and discontinuing medication to address identified problems, and educating patients on their medication regimen.
Dietician	Ongoing patient-centered counseling to assess dietary habits and preferences, set and monitor goals for healthy lifestyle
Social Worker	Assess for psychosocial, cultural and financial barriers, find solutions to overcome these barriers.
Community Health Providers	Assess for psychosocial, cultural and financial barriers, identify and promote acceptable community-based resources to overcome these barriers.

BP indicates blood pressure.

8.3. Follow-Up of BP During Antihypertensive Drug Therapy

Appropriate follow-up and monitoring enable assessment of adherence (see Section 12.1) and response to therapy, help identify adverse responses to therapy and target organ damage, and allow assessment of progress toward treatment goals. High-quality RCTs have successfully and safely developed strategies for follow-up, monitoring, and reassessment from which recommendations can be made (Figure 4) (1, 2). A systematic approach to out-of-office BP assessment is an essential part of follow-up and monitoring of BP, to assess response to therapy; check for evidence of white coat hypertension, white coat effect, masked hypertension, or masked uncontrolled hypertension; and help achieve BP targets (see Sections 4 and 12).

References

1. Ambrosius WT, Sink KM, Foy CG, et al. The design and rationale of a multicenter clinical trial comparing two strategies for control of systolic blood pressure: the Systolic Blood Pressure Intervention Trial (SPRINT). Clin Trials. 2014;11:532-46.
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8.3.1. Follow-Up After Initiating Antihypertensive Drug Therapy

Recommendation for Follow-Up After Initiating Antihypertensive Drug Therapy References that support the recommendation are summarized in Online Data Supplement 28.		
COR	**LOE**	**Recommendation**
I	**B-R**	**1. Adults initiating a new or adjusted drug regimen for hypertension should have a follow-up evaluation of adherence and response to treatment at monthly intervals until control is achieved (1-3).**

Recommendation-Specific Supportive Text

1. Components of the follow-up evaluation should include assessment of BP control, as well as evaluation for orthostatic hypotension, adverse effects from medication therapy, adherence to medication and lifestyle therapy, need for adjustment of medication dosage, laboratory testing (including electrolyte and renal function status), and other assessments of target organ damage (1-3).

References

1. Ambrosius WT, Sink KM, Foy CG, et al. The design and rationale of a multicenter clinical trial comparing two strategies for control of systolic blood pressure: the Systolic Blood Pressure Intervention Trial (SPRINT). Clin Trials. 2014;11:532-46.
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