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Life-Saving Lessons in High Blood Pressure Education from Nurse Care Coordinators

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When Florence, an older New Yorker with a history of uncontrolled hypertension (high blood pressure) and obesity, recently joined a managed long-term care (MLTC) insurance plan, the nurse care coordinator/nurse practitioner assigned to her by the plan was faced with an immediate challenge: Florence was a frequent visitor to the emergency room, driven there by recurrent bouts of dizziness related to her chronically elevated blood pressure. Besides being expensive and avoidable, her repeated ER visits were also doing nothing to improve her underlying blood pressure issues.

May is National High Blood Pressure Education Month, and a good time to share insights from nurse care coordinators like Marian Unterman, M.S.N., A.N.P.-C., who cares for patients like Florence, making a difference by simply taking the time to help people learn, change and adopt new healthier lifestyles.

Once she understood what the problem was, Marian immediately arranged an appointment for Florence to see her physician in order to review her medication regimen. She also set up a home healthcare program that included visits by a nurse to monitor Florence's medication management and side effects, in-home blood pressure monitoring, and a consultation with a nutritionist on how to maintain a diet that would support Florence's hypertension treatment.

With the steps above in place, things improved rapidly for Florence: To minimize any drug side effects while still managing her blood pressure, Florence's physician lowered the dose of her current medication and added a second low-dose hypertension drug to be taken in combination with the first. New telehealth technology was installed in the home

so that blood pressure readings could be sent automatically to a central monitoring hub and recorded in Florence's electronic medical record. And with support from Marian, Florence was able to shift to a healthier, low-sodium diet — using herbs and spices in place of salt — and begin losing weight.

Marian's approach is in sync with the collective wisdom and experience of the nurses and social workers who form the clinical backbone of VNSNY CHOICE Health Plans, where I work. Because hypertension often can be controlled with the right treatment, guidance, and education about lifestyle choices, it's a perfect example of how home- or community-based care administered by a nurse can forestall the ravages of one of our most devastating diseases and keep an individual safe and independent in her or his home.

When It Comes to Treating High Blood Pressure, Collaboration is Key

The facts about blood pressure speak for themselves: an estimated one in three adults has high blood pressure, and more than 50 percent of people over the age of 65 suffer from the disease. Left untreated, high blood pressure can lead to life-altering and potentially fatal incidents and conditions, among them heart disease, stroke, kidney and peripheral artery disease and, as research is increasingly suggesting, dementia. Equally clear is the knowledge that when individuals with high risk for hypertension and high blood pressure — especially those in African American and Latino communities — receive managed long-term care coordination and education from a skilled clinician, they live much more stable and independent lives. And that's where collaboration between nurses and those they care for becomes key.

As part of our care coordination model at CHOICE Health Plans, we ensure that all of our hypertensive members get a comprehensive exam and testing to determine what's causing their elevated blood pressure and to determine a baseline. In addition, we educate them about the importance of ongoing lab monitoring of cardiac and kidney function as well as proper meal management and diet, stress reduction, and exercise. We'll also set up high-risk members with in-home blood pressure monitoring and refer them as needed for physical therapy, nutrition counseling, and home counseling for stress reduction.

Today, thanks to her nurse care coordinator's skillful interventions, Florence is no longer experiencing any drug side effects and is fully compliant in taking her blood pressure medication. Her blood pressure is well-controlled and she has had no further trips to the emergency room. Most important, adds Marian, "I was able to establish a rapport between Florence, her doctor and myself, where Florence felt she could call up one of us with any issues she was dealing with, and we would immediately help her address them."

Changing the Patient's Perspective through Measured Progress

In the case of Jessie, another plan member suffering from hypertension, CHOICE care coordinator Shawne Brown-Delaney had to work through some strong initial resistance: "I'm 82, and I'll eat what I want to eat," the member told Shawne at first. As Shawne got to know Jessie better, she learned that part of her "food insecurity" was economic: Although Jessie knew the appropriate foods for her condition, she couldn't afford them. So Shawne contacted a social worker on the CHOICE team, who connected Jessie with community resources that helped subsidize her meals. Once again, the collaborative team effort successfully supported the health of a vulnerable but capable person.

Shawne notes the importance of understanding that change comes gradually, and that even minor improvements can lead to important and lasting successes. "Jessie had a lot of weight to lose, so I encouraged her to exercise just by walking back and forth in her apartment," she recalls. "When she lost a few pounds, she noticed that she was breathing more easily. Her blood pressure numbers improved, too. She's learning to become attuned to her own health and how to manage it."

Nurse care coordinators like Shawne and Marian also work with experts in other areas as needed. For example, if Florence's blood pressure spikes cause her anxiety and symptoms of depression going forward, Marian might link her to classes on meditation or water aerobics for their calming effect. Continued distress might lead to a referral for in-home behavioral health therapy. "Our collaborative approach enables us to set up a team-based "safety net" for vulnerable

individuals," says Marian. "That security gives them the stability to play an increasingly active part in maintaining their health."

Keeping high blood pressure in check means taking your health seriously, and being mindful and consistent with nutrition, medication and fitness regimens. But that's often easier said than done — especially for people with increased risk factors. Nurse care coordinators like Marian and Shawne can be real difference makers in the lives of people with chronic health vulnerabilities. Their commitment is evidence that not only can debilitating diseases such as high blood pressure or hypertension be understood and addressed, but through nurse-led health collaborations, they can also be overcome.