

Success with Hypertension Management Among Older Adults

with support from SASH®

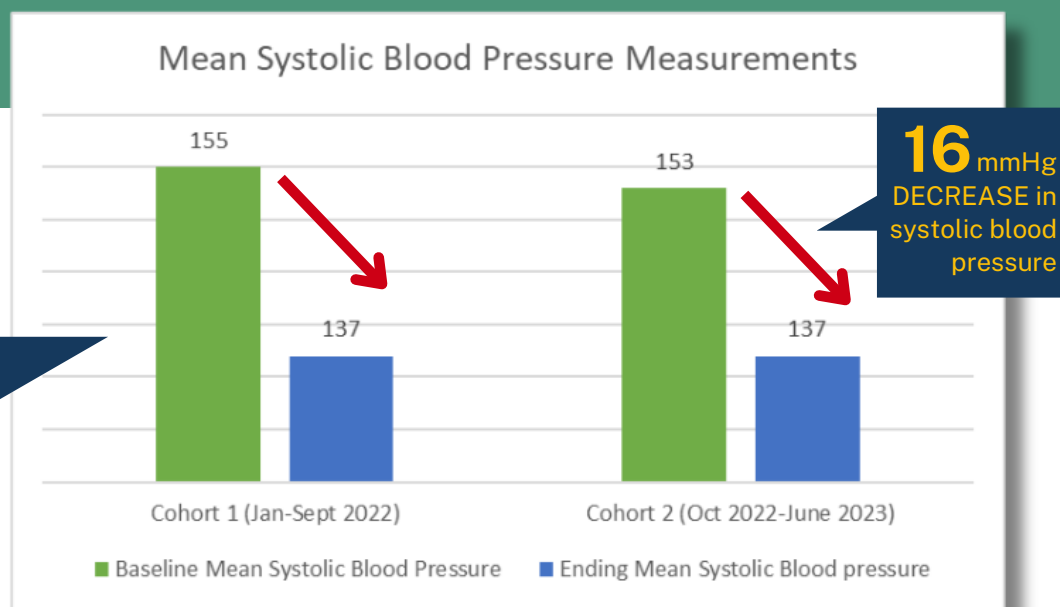
Following a highly successful initiative promoting hypertension self-management among SASH participants funded by the Vermont Department of Health, SASH received additional 1815 funds to continue this work in year five of the grant.

Two separate nine-month cohorts of participants with Stage 2* Hypertension were supported by SASH, from January 1, 2022, to September 30, 2022, and October 1, 2022, to June 30, 2023, in cohorts one and two respectively. Participants received one-on-one education and support in self-managing their condition. Final data obtained on those who completed the intervention groups show a consistent reduction in systolic blood pressure of 18 mmHg and 16 mmHg for cohorts one and two respectively.

**Stage 2 hypertension as defined by the American Heart Association as systolic blood pressure of 140 or higher or blood pressure diastolic of 90 or higher.*

RESULTS

18 mmHg
DECREASE in
systolic blood
pressure
in cohort one



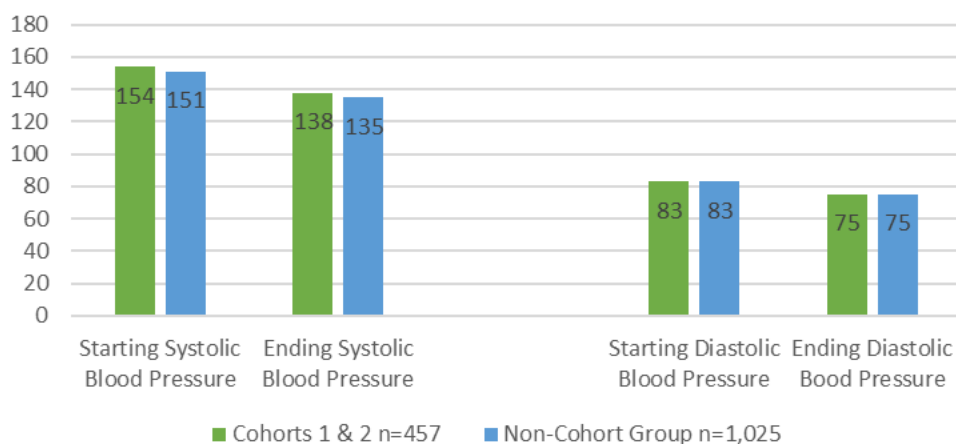
How much of an impact have the targeted blood pressure management groups made compared to their non-targeted peers?

While SASH supports participants to manage their hypertension and other chronic conditions as a standard part of the SASH program, the individuals that have been selected to be a part of the CDC/VHD intervention groups had more focused attention, more frequent visits and more follow-ups with their SASH team as a part of the project. This concentrated work with selected participants benefits all SASH participants as the nurses learn and practice the SASH hypertension management protocol.

PARTICIPANT COMPARISON

The interventions for managing hypertension are not limited to the targeted group and improvement in blood pressure can be seen across all SASH participants. A six-year lookback on blood pressure within SASH showed both targeted and non-targeted intervention groups had a decrease in both systolic and diastolic blood pressures while in the program, however, the targeted group had an additional 4 mmHg systolic and 1 mmHg diastolic decrease in blood pressure over the non-targeted group during this time frame.

Cohort and Non-Cohort Blood Pressure Results
2022 through 2023



The work wellness nurses practice with targeted participants is crossing over into their work with non-targeted participants. This graph illustrates that non-targeted participants also had a reduction in their blood pressure during the last 18 months from January 2022-June 2023.

PARTICIPANT SUCCESS

Here's one participant's success story:

A Bristol SASH coordinator and wellness nurse worked with a participant who was part of the targeted hypertension group. She had presented to a blood pressure clinic with elevated blood pressure, and no other symptoms, but did have a diagnosis of hypertension with one medication. The coordinator suggested she should call her PCP for advice. The participant called her PCP office that day, was able to be seen, again with elevated blood pressure, and had a follow-up visit for the following week where they started her on an additional medication to control her blood pressure. The participant was thankful and happy to have this addressed so well.

INTERVENTIONS THAT SUPPORTED OUR RESULTS

Community health workers and wellness nurses support participants hypertension management through various interventions.

Blood Pressure Checks

Wellness nurses support blood pressure checks by hosting **blood pressure clinics**, one-on-one blood pressure checks in participants home, and through **lending automatic home blood pressure cuffs**.



Goal Setting

Wellness nurses and community health workers supported participants with goal setting. At the end of cohort two, **46% of cohort participants** had **created a healthy living plan** within the past year.

Food Support

109 participants in the combined cohorts **received food support** assisted by SASH staff.

Staff Check-ins

Participants in the cohorts received more staff visits than all participants. In cohort two, **participants in the hypertension cohort had an average of 7.1 staff visits** compared to an average of 5.4 visits for all SASH participants.

Other Services

For all SASH participants in the last year, staff assisted with: referrals to **smoking cessation** (59), **dental services** (145), **exercise program** (638), **self-management program** (64); and completed 3,322 **medication adherence screens**.

Hypertension Protocols

SASH wellness nurses utilize the SASH **Hypertension Management Protocol** and the SASH community health workers utilize the **Coordinator Workflow for Heart Disease and Diabetes Prevention and Management** to guide their work with participants.

Continuous Communication

Staff receive monthly and bi-monthly communication regarding participants within their panel on targeted and non-targeted participants with hypertension and **ongoing educational resources and trainings**.