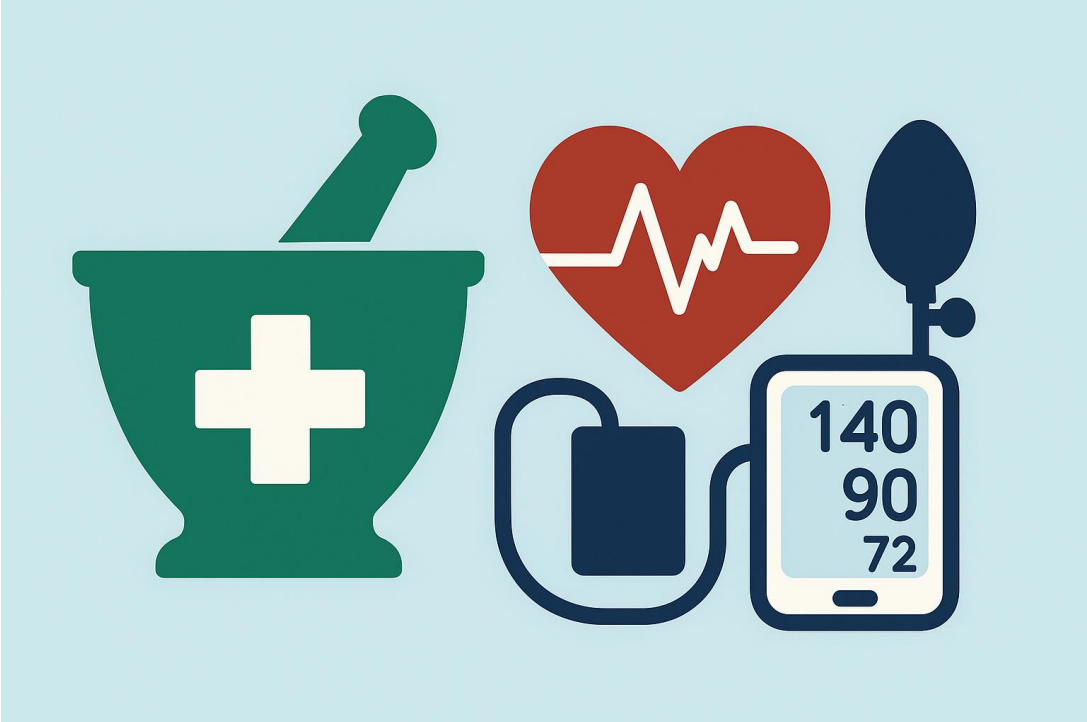

Hypertension Screening Service: A Toolkit for Community Pharmacists

Developed by:

Tara McGeehan, PharmD
Katie Trotta, PharmD
Eric Lee, PharmD
Beth Mills, PharmD

Campbell University College of Pharmacy & Health Sciences

For questions about this toolkit, please contact Beth Mills at mills@campbell.edu

Updated December 10, 2025

Acknowledgement:

This toolkit was developed to support the NC DHHS, Division of Public Health, Community and Clinical Connections for Prevention and Health Branch's efforts for the **North Carolina Cardiovascular Health (CVH) Learning Collaborative**, which convened between December 2023 and June 2025 with support from a team at the Department of Health Behavior within The Gillings School of Global Public Health at The University of North Carolina at Chapel Hill.

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A. Background

Cardiovascular disease (CVD) remains a leading cause of death in the United States, with heart disease ranked as the top cause and stroke as the fifth. Both conditions are significant contributors to disability and reduced quality of life.

Healthy People 2030 emphasizes the importance of improving cardiovascular health and reducing deaths from heart disease and stroke through prevention, early detection, and effective management of risk factors such as hypertension. Among its objectives, the initiative seeks to increase the proportion of adults with controlled blood pressure and reduce stroke deaths, which stood at 39.5 per 100,000 population in 2022, with a target reduction to 33.4 per 100,000.[1,2]

Community pharmacists are uniquely positioned to support these goals by providing accessible hypertension management services.[3] Through patient education, blood pressure monitoring, and medication management, pharmacists can address key risk factors for cardiovascular disease.

This toolkit aligns with Healthy People 2030's focus on improving health equity and promoting preventive care by equipping pharmacists with the resources to develop, implement, and sustain hypertension management programs in their communities.

The purpose of this toolkit is to assist community pharmacists with the development and implementation of a hypertension management clinical service that will improve patient care through improvements in CVD outcomes, enhance pharmacist involvement in preventative care, and increase revenue for the pharmacy.

B. Objectives

The objectives of the service include:

1. Identify patients with elevated blood pressure or hypertension who are good candidates for enrollment in the service.
2. Promote health equity through patient education and evaluation of social determinants of health.
3. Improve blood pressure control in patients by optimizing lifestyle and medication management.
4. Facilitate collaboration and interprofessional care of patients.
5. Increase revenue for the pharmacy.
6. Utilize pharmacists, technicians, student pharmacists, and other non-pharmacist personnel to aid in facilitating this service.

C. Patient Identification & Risk Stratification

1. Patient Identification

Patients with elevated blood pressure or diagnosed hypertension (HTN) may be good candidates for enrollment in the service.

ACC/AHA Categories of BP in Adults

Patients at high risk for the development of hypertension include:

- Overweight or obese
- People who use tobacco products
- Family history of HTN
- Physically inactive
- High risk races and ethnicities include Black Americans and Hispanic people
- High sodium diet
- Pregnant
- See Appendix A for a validated Hypertension Screening Tool.[4]

Additionally, the US Preventative Services Task Force recommends screening adults ≥ 18 years old without known hypertension with in-office and at home blood pressure monitoring:

- Adults 18-39 years should be screened every 3-5 years
- Adults ≥ 40 years should be screened annually.

Ideas for ways to identify patients include:

a. Medication chart review:
    i. Patients with medications indicating other chronic diseases may be at increased risk of having elevated BP or HTN
        1. Examples: diabetes, hyperlipidemia, obesity/overweight, thyroid disease
    ii. Medications which can increase BP or impair BP control
        1. Examples: NSAIDs, decongestants, SNRIs, steroids, stimulants, triptans
    iii. Using pharmacy software to identify and screen eligible patients.

b. Blood pressure screening events:
    i. Community outreach events
    ii. Health department
    iii. Churches.

c. Blood pressure checks as a part of other services, such as medication therapy management.

d. Review of patient chart notes and vitals from provider visits and/or hospitalizations, if available.

e. Connecting or partnering with local providers to refer patients to the pharmacy:
   i. Utilize a secure data exchange network (NC Health Information Exchange Authority, NCHealthConnex) to access and share health-related information.
   ii. Market your services by:
      1. Sending "Dear Doctor" letters/emails (see Appendix B for an example letter and Appendix C for a link to a brochure template you can edit to align with your pharmacy information)
      2. Doctor detailing: Doctor detailing is the process of educating and engaging prescribers about the services, expertise, and value your pharmacy provides.
      3. Distributing email blasts from doctors' offices.
   iii. National Alliance of State Pharmacy Associations (NASPA) Resources
      1. Collaborative Practice Agreements (scroll down webpage to 'An Introduction to Collaborative Practice Agreements: a Brief Webinar')
      2. Advancing Team-Based Care through Collaborative Practice Agreements: A Resource and Implementation Guide for Adding Pharmacists to the Care Team

2. Risk Stratification

a. Accurate blood pressure measurement
   i. Checklist for Accurate Measurement of BP
   ii. Ensure proper technique for measuring blood pressure, with at least two readings on two separate occasions to confirm the diagnosis of elevated blood pressure or hypertension.
   iii. If patient checks BP at home (Home BP Measurement), ask for a log or record from their machine.
   iv. AHA Blood Pressure Log

b. Classify blood pressure level and next steps for management
   i. Complete risk calculator: AHA PREVENT Online Calculator
      1. Information needed includes: age, sex, BP, lipid panel, BMI, renal function, zip code (for SDOH), DM history, smoking history, use of statin, use of antihypertensive
   ii. Note: ASCVD Risk Estimator Plus calculator was recommended in previous versions of the ACC/AHA High Blood Pressure Guidelines and may still be preferred by some institutions

iii. Determine blood pressure thresholds and ACC/AHA recommendations for treatment: BP Thresholds for Initiation of BP Treatment in Adults, and utilize Recommendations for Treatment and Follow-Up.

c. **Social Determinants of Health (SDOH)** – SDOH play a critical role in hypertension management by influencing access to care, medication adherence, and lifestyle choices. Factors such as income, education, neighborhood environment, and systemic inequities can have significant impact on a person's ability to manage blood pressure.
   i. Screening questions
   ii. NCCARE360 – Statewide network (all 100 counties) that helps electronically connect individuals with needed support:
      1. Become a Network Partner – Join NCCARE360
      2. Monthly information sessions are held every third Friday of the month from 12 to 1 pm. Register here.
      3. For immediate assistance, patients may call 2-1-1 or submit the Assistance Request Form – Patients or legal guardians complete the form for urgent need to connect to services.
   iii. Food insecurity:
      1. NC State Nutrition Action Coalition (SNAC)
      2. NC Food and Nutrition Services (FNS) – provides benefits through a debit card to purchase food. Apply online ePASS.
      3. North Carolina food and nutrition resource programs:
         a. NC211: Information and referral service provided by United Way of NC.
         b. Food access maps: Emergency food assistance maps for NC.
      4. Seniors 60+:
         a. Senior Nutrition Program – Provides nutritious, home-delivered meals and socialization to older adults.
         b. Senior Farmers' Market Nutrition Program – Provides eligible seniors with benefits to purchase fruits and vegetables at local farmers' markets. The program runs seasonally from July to September and is not available statewide.
   iv. Housing insecurity:
      1. Lifeline – Helps you pay for phone bills.
      2. Low Income Energy Assistance Program – Helps you pay heating bills.
      3. Affordable Connectivity Program – Provides a discount on internet services.
   v. Transportation:
      1. Seniors 60+:
         a. NCDHHS.
         b. Transportation Provider Directory.
         c. Medical Transportation Provider Directory .

2. Contact local Area Agency on Aging or Department of Social Services (DSS) for information on local programs.
3. Medicaid beneficiaries – Contact health plan or NC Medicaid to schedule a ride for medical appointments.
4. Local Transit Search – Public transportation is available in all NC counties.

D. Prevention & Risk Reduction

1. Lifestyle Modifications & Patient Education

Note that per the 2025 ACC/AHA guidelines, patients who have elevated blood pressure or Stage 1 HTN with an ASCVD risk score <10% are candidates for lifestyle modifications without pharmacotherapy.

Lifestyle and Stress Interventions That Lower BP

Utilize the AHA Life's Essential 8: key measures for improving cardiovascular health with actionable steps patients can take:

a. **Eat Better**
   i. Healthy recipe ideas:
      1. Med Instead of Meds
      2. DASH Diet
   ii. Check patients' insurance plan (Medicare Advantage) for meal delivery benefits.
   iii. Potassium-rich foods play a crucial role in managing hypertension by helping to lower blood pressure through several mechanisms. Potassium works to counteract the effects of sodium by increasing sodium excretion through urine, which helps reduce fluid retention and blood pressure. Additionally, potassium relaxes blood vessel walls, further contributing to improved blood flow and lower blood pressure levels.[5]

      Foods high in potassium include: bananas, spinach, sweet potatoes, beans, and avocados.

      For most adults, the recommended daily potassium intake ranges from 2,600 mg for women to 3,400 mg for men, with higher levels (3,500–5,000 mg) suggested for those managing high blood pressure.[6]

b. **Be More Active:** Adults should get 2 ½ hours of moderate or 75 minutes of vigorous physical activity per week. Kids should have 60 minutes every day, including play and structured activities.

   Adults should also aim to limit sedentary time to <60 minutes and break up long bouts of sitting with micro-workouts (short bursts of activity that can be completed in a few minutes). Examples include a 2–3-minute walk, 10 squats, 50 soleus push-ups.
   i. Patients on Medicare Advantage Plans may have coverage for gym memberships and fitness programs

c. **Quit Tobacco:** Smoking can increase BP in the short term and increase risk of developing HTN in the long term
   i. Rx for Change: Clinician-assisted Tobacco Cessation
   ii. Learn How to Quit Tobacco Fact Sheet
   iii. 1-800-Quit-Now
   iv. QuitlineNC
      1. Patients can enroll online or text "ready" to 34191
      2. Become a QuitlineNC Referral Site - registration
         a. Receive individual and aggregate reports of your patients
         b. Receive ongoing assistance and training

d. **Get Healthy Sleep:** Patients with poor sleep quality can experience elevated blood pressure due to disruptions in the body's autonomic nervous system and hormone regulation. Consider obstructive sleep apnea (OSA) and its impacts on BP control.
   i. Healthy Sleep Habits
   ii. Sleep apnea screening questionnaire for patients:
      1. http://www.stopbang.ca/osa/screening.php

e. **Manage Weight:** Every 1 kg (2.2 lbs.) of weight loss can reduce SBP by about 1 mmHg

f. **Control Cholesterol**
   i. How to Control Cholesterol

g. **Manage Blood Sugar**
   i. How to Manage Blood Sugar

h. **Manage/Monitor Blood Pressure**
   i. How to Manage Blood Pressure
   ii. Home Blood Pressure Monitoring - AHA
      1. Blood Pressure Management Instruction Sheet - English
      2. Blood Pressure Management Instruction Sheet - Spanish
   iii. Validated Device Listing – American Medical Association (AMA).

American College of Lifestyle Medicine 6 Pillars of Lifestyle Med: another framework for prevention of chronic conditions and disease management. ACLM's nutrition component has a strong focus on plant-based eating but can be modified for any whole food diet with a heavy emphasis on plants.

Nutrition: Food As Medicine: jumpstart with lots of recipes (ACLM login required, but free account gives access to this booklet).

Patient education resources:

- National Heart, Lung, and Blood Institute
- American Heart Association

Home blood pressure monitoring:

- AHA – How to use a Home BP Monitor
- CDC Home Blood Pressure Monitoring

2. Behavior Change

Help patients with behavior change through use of motivational interviewing and goal setting

a. **Motivational interviewing**
   i. ACCP book chapter on Motivational Interviewing (MI) for behavior change
   ii. How to Use MI in Your Pharmacy
   iii. Example video on use of MI with a patient with HTN

b. **Goal setting** (Appendix D)
   i. Use SMART goals, ensure goals have a measurable outcome and the outcome can be reasonably reached in the set timeframe. Consider smaller benchmarks for larger goals.

c. **Commitment Contracts** (Appendix E)
   i. A behavior contract (e.g. smoking cessation, healthy eating, increased physical activity) is a formal agreement between the pharmacist and the patient that outlines a plan and goals for change.

E. Follow Up and Referral

1. Documentation

a. eCare Plans (CPESN) *(Note: not accessible by outside stakeholders/vendors)*
b. Documentation within pharmacy software
c. Documentation within providers' electronic health record (EHR)
    i. EPIC read/write privileges to update medication lists, look at labs, update vitals, add notes.
d. Document in NC HealthConnex

2. Follow Up

a. Establish Care Goals with the patient and log them in the software or through another mechanism to keep track of when to f/u with the patient, recheck BP, assess progress towards SMART goals, etc.
b. Follow-up timeframe should be patient specific; consider f/u with patient and provider

3. Referral

a. Referring out to other providers
    i. Pharmacy Dispensing Software
        1. Pharmacies can utilize their dispensing software (e.g. Pioneer Rx) to send messages and relevant patient information to providers as needed for referral purposes
            a. Using E-Care plans with relevant CPT and SNOWMED codes can aid in the documentation process of referrals
        2. Other methods such as phone and fax can be used to communicate and share relevant information between providers
    ii. NC HealthConnex
        1. Pharmacies can sign up and utilize the NCDIT HEI to refer to providers
        2. Providers can utilize NC HealthConnex to refer patients to specific pharmacy services (HTN management, medication synchronization, immunization services, medication delivery, adherence packaging)
b. Referring out to community resources through NCCARE360
    i. Pharmacies can provide information to patients on how to access community resources following any referrals from a provider related to NCCARE360. See social determinants of health screening questions here.

F. Reimbursement Options & Revenue Streams

1. Reimbursement Options

a. Remote Patient/Physiologic Monitoring (RPM)

i. For patients who are already diagnosed with HTN; can set patient up with an at-home BP cuff which will track their BP over time. Pharmacist, patient, and provider determine how many monthly BP-checks are needed for the patient.
ii. The pharmacist can check the patient portal with the BP values and follow up with the patient over time.
iii. Clinical impact: improved patient care, decreasing healthcare expenditures (reductions in provider visits, hospitalizations, and complications), enhanced care coordination, and increased patient engagement and satisfaction with the pharmacy
iv. Only billable through the provider currently.
v. Validated Device Listing – American Medical Association (AMA)
vi. RPM Billing Codes

CPT Code	***Description***	***Maximums***
99453	RPM Education and Device Set-up	Once per episode of care
99454	RPM Kit Supply, collection/ transmission of data, report/summary to a clinician	Every 30 days
99457	Initial 20 minutes of treatment management services; interactive communication with patient or caregiver	Every 30 days; cannot be billed in the same period as 99091
99458	Additional 20 minutes of treatment management services	Every 30 days, no limit to the number of times per month it can be billed in the calendar month
99091	Collection and interpretation of physiologic data transmitted to a physician or other qualified healthcare professional. Must reach a 30-minute threshold.	Every 30 days; cannot be billed in the same period as 99457

b. Medicaid provider

i. Registering with NC Tracks to become a Medicaid Provider
   1. Follow the enrollment process for Medicaid via NC Tracks

a. See NCAP's Medicaid provider enrollment resources for guidance navigating the credentialing process

ii. Note that pharmacies will need to have medical billing capability to bill Medicaid directly

iii. For patient looking to enroll in Medicaid, use the instructions on the NC DHHS website (ePASS)

c. **Medication Therapy Management (MTM):** Patients enrolled in Medicare Part D meeting certain qualifications are required to have a Comprehensive Medication Review (CMR) once per year. One of the qualifications is diagnosis with at least 2 core disease states, and hypertension is one of the disease states.

For 2025, Medicare changed the eligibility criteria for patients from a cost threshold of $6,000 to a cost threshold of $1,623. This is the estimated annual cost for patients on 8 or more generic medications. This change is estimated to increase CMR eligibility from 4.5 million to 11 million people.

i. For patients looking to enroll in Medicare, direct them to the Social Security Administration website for directions

ii. Identify patients for enrollment in the BP management service while completing a CMR

iii. Utilize the CMR as a time to check BP and counsel on management

iv. Eligible patients also can receive quarterly Targeted Medication Reviews (TMRs) to follow-up on drug therapy problems identified during the CMRs.

1. Patients who are identified as uncontrolled and have a dose increase or new medication added are good candidates for a TMR. A 3-month f/u visit with a pharmacist can help to determine efficacy of the new regimen and is eligible for reimbursement as a TMR.

v. Pharmacies can bill for MTM services with a third-party platform (i.e. Outcomes® MTM) or directly to avoid paying the third-party

CPT Code	Description	Maximums
99605	MTM services provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient	One per year
99606	MTM services provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient	Five per year

CPT Code	Description	Maximums
99607	Each additional 15 minutes spent with the patient (List separately in addition to code for primary service) This code must be used in conjunction with either 99605 or 99606 for additional time beyond the initial 15 minutes	Three units per claim when billed with above

d. More Than a Script

i. In partnership with community pharmacies across North Carolina and health care technology vendor, DocStation, "More Than a Script" is an innovative value-based initiative developed by Blue Cross NC to improve patient health outcomes by allowing pharmacists to practice at the top of their license to conduct enhanced services.

ii. Read more about this program here.

iii. If interested, begin the process by registering for DocStation to streamline your billing workflow.

iv. Listen to the story of a local NC pharmacy currently implementing this program here.

e. Additional information on medical billing was compiled by ASHP.

f. Other billing platforms other than pharmacy dispensing software

i. EQUIPP

1. Register and utilize EQUIPP's Enhanced Services feature to bill for blood pressure control and other disease state management services offered by the pharmacy

ii. DocStation

1. Utilize DocStation's medical billing feature to perform medical billing from the pharmacy
2. Third party insurers and payers may also utilize the Custom Clinical Programs feature to collaborate with pharmacies for reimbursement for clinical services

iii. Medical EHR platforms

1. Collaborate with local providers to be granted access to primary care EHR's such as EPIC to document interventions within the prescriber's software

2. Additional Revenue Streams

a. Contracting with employer groups: work with employers who are self-insured to help improve management of chronic conditions to decrease spending on complications

i. Using direct contracting to facilitate the sustainable delivery of prescriptions and clinical services to an employee group

b. **Add-on service** as part of Medication synchronization (Med Sync), especially if the pharmacy collects data showing they can increase PDC, EQUIPP scores, or other payable metrics (see Section G-2 for more information on Med Sync).

c. **Cardiovascular-related supplements:** recommending the use of complementary and alternative medicine (CAM) in conjunction with prescription medications or as an initial therapy for those who are borderline without an actual hypertension diagnosis may be an option for increasing care for patients and driving revenue for the pharmacy. Some supplements with blood pressure-lowering benefit include:
   i. Berberine: A meta-analysis shows that taking berberine 0.9 grams daily in combination with amlodipine for 2 months reduces systolic blood pressure (SBP) by 5 mmHg and diastolic blood pressure (DBP) by 2 mmHg when compared with amlodipine alone.[7]
   ii. Fish oil: Oral fish oil seems to reduce systolic and diastolic blood pressure in adults with moderate or severe hypertension. Clinical trials showing blood pressure-lowering effects have used fish oil 4-15 grams daily, in single or divided doses, for up to 36 weeks, or fish oil providing EPA 2.04 grams and DHA 1.4 grams daily. Effects are greater in those with higher baseline BP. Use caution if recommending >4g of fish oil daily, as antiplatelet effects can be seen.[8]
   iii. Flax seed: Daily oral flaxseed consumption, especially for longer than 12 weeks, seems to modestly reduce both systolic and diastolic bp.[9,10] One study indicates that the BP lowering effects are dose and time dependent.
   iv. Garlic: Garlic supplementation may reduce bp in those with and without hypertension. One meta-analysis of clinical studies shows that taking garlic can reduce systolic and diastolic blood pressure by about 5 mmHg and 3 mmHg more than placebo, respectively, in patients supplementing.[11] Dosing for garlic ranges, but the average is 2400 mg daily.
   v. Vitamin C: Vitamin C seems to modestly reduce SBP by about 5 mm Hg without meaningful effects on DBP. Median doses were 500 mg daily, which is generally regarded as a safe dose for most of the population.[12]

   Pharmacists should be aware that natural supplements can impact patient safety by interacting with prescription medications and exacerbating underlying health conditions, necessitating thorough patient history-taking and use of evidence-based guidance.

G. Workflow Considerations

1. Implementing Clinical Services into Pharmacy Workflow

a. Buy-in from pharmacy staff is critical before implementing a new clinical service in pharmacy workflow. Communicate to staff the benefits of a new service to both the patient and the pharmacy. Services like Med Sync can streamline the workflow process and make dispensing more organized. Other services like CVD prevention provide a needed clinical service to patients which can open future avenues for reimbursement outside of regular dispensing.
b. Utilize student pharmacists, technicians, and additional pharmacy staff to run this program.
c. Take advantage of other preexisting pharmacy services and provider relationships to jump-start implementation of CVD prevention services.

2. Medication Synchronization (Med Sync)

a. Incorporate a Med Sync program inro your pharmacy's workflow if not already doing so.
b. There are many guides and best practices to implementing a Med Sync program. Check your pharmacy dispensing software for Med Sync functionality and pre-built standard operating procedures (SOPs) offered by your software vendor.
c. Utilize all pharmacy staff to keep an organized and efficient Med Sync program.
d. Couple other services such as adherence packaging and delivery to your Med Sync program to make it more impactful for patients.
e. Incorporate clinical services such as CVD prevention initiatives during regular Med Sync calls and check-ins to easily integrate them into workflow.

3. E-Care Plans

a. Utilize E-Care plans within your pharmacy dispensing software to document interventions and tag patients for follow-up. Using E-Care plans can also keep track of referrals. Make sure to label and tag E-Care plans with relevant SNOMED codes if collaborating with another compatible health system software in another location.

4. Screening Patients

a. Leveraging Your Pharmacy Dispensing Software
    i. Make the most of your pharmacy dispensing software by using a Categories feature or other screening tool to identify patients. Set regular intervals to query your software for eligible patients. Most systems will also allow you to create custom alerts to notify other pharmacy staff during normal workflow of any patient care items

that need to be addressed. Try performing at minimum weekly or monthly queries using a pharmacy software's filtering function.

b. Using technicians in screening
    i. Using your pharmacy software's screening and filtering functionality can be a very streamlined process. Have technicians assist in performing regular patient screenings using your dispensing software on a regular basis.

5. Documentation Within Workflow

a. Encourage all pharmacy staff to document patient interventions within your pharmacy dispensing software.
b. Utilize E-Care plans to document patient interventions and track follow-up.
c. You can also utilize your pharmacy software's free text note-taking feature within patient profiles to manage and track interventions.
d. Document relevant patient lab values within your dispensing software's patient profiles (e.g. Pioneer's lab values feature within the patient profile).
    i. Reach out to partnering providers to regularly update labs such as BP within patient profiles within the pharmacy. Additionally, add BP readings to your pharmacy software if the patient reports them to the pharmacy or if it is measured in the pharmacy.
e. Document and track any changes in adherence measures such as Proportion of Days Covered (PDC), Medication Possession Ratio (MPR), and Gap (GAP) for relevant patients.
    i. Report significant changes in these metrics to partnering providers
f. Attach and link CVD-related notes to any other services your pharmacy may be utilizing such as Med Sync or adherence packaging.

Appendix A: Hypertension Screening Tool

1. How old are you?
    a. Younger than 60 (0 points)
    b. 60 or older (12 points)
2. Does someone in your immediate family have a diagnosis of high blood pressure?
    a. No (0 points)
    b. Yes (11 points)
3. Do you have diabetes?
    a. No (0 points)
    b. Yes (6 points)
4. Measure your waist circumference.
    a. Men: less than 37 inches, women: less than 31.5 inches (0 points)
    b. Men: 37 inches or more, women: 31.5 inches or more (4 points)
5. What is your weight category?
    a. 0 points
    b. 4 points
    c. 8 points

Total Score:

Height	Weight (lbs.)		
4'10"	119 or less	120-143	144+
4'11"	124 or less	125-147	148+
5'0"	128 or less	129-152	153+
5'1"	132 or less	133-157	158+
5'2"	136 or less	137-163	164+
5'3"	141 or less	142-168	169+
5'4"	145 or less	146-173	174+
5'5"	150 or less	151-179	180+
5'6"	155 or less	156-185	186+
5'7"	159 or less	160-190	191+
5'8"	164 or less	165-196	197+
5'9"	169 or less	170-202	203+
5'10"	174 or less	175-209	210+
5'11''	179 or less	180-215	216+
6'0"	184 or less	185-220	221+
6'1"	189 or less	190-226	227+
6'2"	194 or less	195-232	233+
6'3"	200 or less	201-239	240+
6'4"	205 or less	206-245	246+
	0 points	**4 points**	**8 points**

If you scored 20 or higher, you are high risk for having high blood pressure and may have hypertension. However, only your medical provider can tell you for sure if you have high blood pressure. Talk to your provider or pharmacist to see if additional testing is needed.

Source: Jiang Q, Gong D, Li H, Zhang D, Hu S, Xia Q, Yuan H, Zhou P, Zhang Y, Liu X, Sun M, Lv J, Li C. Development and Validation of a Risk Score Screening Tool to Identify People at Risk for Hypertension in Shanghai, China. *Risk Manag Healthc Policy*. 2022 Mar 30;15:553-562. doi: 10.2147/RMHP.S354057. PMID: 35386277; PMCID: PMC8977866.

Appendix B: Example Dear Doctor Letter

Use official pharmacy letterhead or pharmacy logo

Dear [Physician's Name],

I'd like to introduce you to our "Hypertension Specialized Care Program", designed to support your patients in achieving better blood pressure control and reducing their risk of cardiovascular events. This program offers an evidence-based, patient-centered approach to hypertension management—delivered conveniently through your local community pharmacy.

As part of this service, our trained pharmacists provide individualized care that includes blood pressure screening, medication adherence support, lifestyle counseling, and ongoing monitoring. We work closely with patients to identify barriers to control, educate them on diet, physical activity, and reinforce the importance of routine follow-up.

Our program is ideal for:

- Patients newly diagnosed with hypertension
- Individuals with poor control despite current therapy
- Patients needing additional support in self-monitoring and adherence
- Patients needing solutions for social determinants of health affecting health outcomes

Through collaborative communication with you, we can share blood pressure trends, identify potential medication-related problems, and reinforce treatment plans—all with the goal of enhancing outcomes and minimizing complications.

Enclosed is a brochure that outlines our services. *(Note: Appendix C includes a link to a template to create a brochure about your pharmacy)* If you have any questions or would like to discuss how we can work together to support your patients, please don't hesitate to contact me at [enter contact information here].

Thank you for your dedication to patient care, and I look forward to the opportunity to partner with you in improving hypertension outcomes in our community.

Sincerely,

[name], PharmD

Pharmacist/Manager

**Enter photo of pharmacist here*

Appendix C: Sample Brochure (can be edited)

Click on the link below to access a pharmacy services brochure template, created in the Canva platform.

You can edit the template, save a version that includes information about your pharmacy (including changing images used in the brochure), and use the brochure when marketing your pharmacy's high blood pressure management (or other) services.

Click on this link to access the 2-page brochure template

Note: To access the Canva design via this shared link, click on the link provided. If you have a Canva account, the design will open directly in your Canva workspace. If you don't have an account, you'll be prompted to create one or log in, using various login methods such as email, Google, Facebook, Apple, or other supported services.

Appendix D: Example SMART Goals Sheet

Crafting SMART goals helps you identify the aspects of your project that are realistic and achievable; this exercise also helps you set a deadline. When writing SMART goals, use concise language and include only relevant information. This worksheet is designed to help you succeed, so be positive when answering the questions. Free SMART goals worksheet

INITIAL GOAL	Enter the goal that you have in mind.

SPECIFIC S	What do you want to accomplish? Who needs to be included? When do you want to do this? Why is this a goal?
MEASURABLE M	How can you measure progress and know if you've met your goal?
ACHIEVABLE A	Do you have the skills required to achieve the goal? If not, can you obtain them? What is the motivation for achieving this goal? Is the amount of effort required on par with what the goal will achieve?
RELEVANT R	Why am I setting this goal now? Is it aligned with our overall objectives?
TIME-BOUND T	What's the deadline and is it realistic?

SMART GOAL	Review your answers above and craft a new goal statement based on them.

Free download from SMARTSHEET accessed July 11, 2025

Appendix E: Example Commitment Contract

Name: Date:

Behavior Change Commitment Contract

Once you have chosen a behavior you wish to change and have identified ways to change it, your next step is to sign a behavior change contract. Your contract should show your commitment to changing your behavior and include details of your program. Use the contract shown below or devise one that more closely fits your goals and your program.

(1) I_____ agree to _____
(name) (specify behavior you want to change)

_____

(2) I will begin on_____ plan to reach my goal of _____
(start date) (specify final goal)

_____

by_____.

(3) In order to reach my final goal, I have devised the following schedule of mini goals. For each step in my program, I will give myself the reward listed.

_____ (mini goal I)	_____ (target date)	_____ (reward)
_____ (mini goal 2)	_____ (target date)	_____ (reward)
_____ (mini goal 3)	_____ (target date)	_____ (reward)

My overall reward for reaching my final goal will be _____

(4) I gathered and analyzed data on my target behavior and have identified the following strategies for changing my behavior:

_____

_____

(5) I will use the following tools to monitor my progress toward reaching my final goal:

_____
(list any charts , graphs , or journals you plan to use)

_____

(6) I have recruited a helper who will witness my contract:

_____
(list any way in which your helper will participate in your program)

_____

I sign this contract as an indication of my personal commitment to achieve my goal.

Source: Insel/Roth, *Core Concepts in Health,* Tenth Edition © 2006 The McGraw-Hill Companies, Inc. Chapter I Insel/Roth, *Core Concepts in Health,* BriefTenth Edition © 2006 The McGraw-Hill Companies, Inc. Chapter I

References

1. Healthy People 2030. *Heart Disease and Stroke*. Available at: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/heart-disease-and-stroke

2. American Heart Association (August 18, 2020). *American Heart Association Praises Healthy People 2030 Objectives*. Available at: https://newsroom.heart.org/news/american-heart-association-praises-healthy-people-2030-objectives

3. Fleming S, Atherton H, McCartney D, Hodgkinson J, Greenfield S, Hobbs FD, Mant J, McManus RJ, Thompson M, Ward A, Heneghan C. Self-Screening and Non-Physician Screening for Hypertension in Communities: A Systematic Review. *Am J Hypertens*. 2015 Nov;28(11):1316-24. doi: 10.1093/ajh/hpv029. Epub 2015 Mar 23. PMID: 25801901; PMCID: PMC4506785.

4. Jiang Q, Gong D, Li H, Zhang D, Hu S, Xia Q, Yuan H, Zhou P, Zhang Y, Liu X, Sun M, Lv J, Li C. Development and Validation of a Risk Score Screening Tool to Identify People at Risk for Hypertension in Shanghai, China. *Risk Manag Healthc Policy*. 2022 Mar 30;15:553-562. doi: 10.2147/RMHP.S354057. PMID: 35386277; PMCID: PMC8977866.

5. American Heart Association. *A Primer on Potassium*. Available at: https://www.heart.org/en/healthy-living/healthy-eating/eat-smart/sodium/potassium

6. American Heart Association. *What is High Blood Pressure?* Available at: https://www.heart.org/en/health-topics/high-blood-pressure/changes-you-can-make-to-manage-high-blood-pressure/how-potassium-can-help-control-high-blood-pressure

7. Lan J, Zhao Y, Dong F, et al. Meta-analysis of the effect and safety of berberine in the treatment of type 2 diabetes mellitus, hyperlipemia and hypertension. *J Ethnopharmacol*. 2015;161:69-81.

8. FDA. RE: Petition for a Health Claim for Eicosapentaenoic Acid and Docosahexaenoic Acid and Reduction of Blood Pressure in the General Population (Docket No. FDA-2014-Q-1146). June 2019. Available at: https://www.fda.gov/media/128043/download.

9. Li L, Li H, Gao Y, Vafaei S, Zhang X, Yang M. Effect of flaxseed supplementation on blood pressure: a systematic review, and dose-response meta-analysis of randomized clinical trials. *Food Funct 2023*;14(2):675-690.

10. Toulabi T, Yarahmadi M, Goudarzi F, Ebrahimzadeh F, Momenizadeh A, Yarahmadi S. Effects of flaxseed on blood pressure, body mass index, and total cholesterol in hypertensive patients: A randomized clinical trial. Explore (NY) 2021.

11. Ried K, Frank OR, Stocks NP, et al. Effect of garlic on blood pressure: A systematic review and meta-analysis. *BMC Cardiovasc Disord* 2008;8:13.

12. Juraschek, S. P., Guallar, E., Appel, L. J., and Miller, E. R., III. Effects of vitamin C supplementation on blood pressure: a meta-analysis of randomized controlled trials. *Am J Clin.Nutr* 2012;95(5):1079-1088.