Self-Measured Blood Pressure Monitoring: Workflow Modifications Your Practice Can Implement to Help Patients Improve Hypertension Management

Providers and practices who are actively engaged in the Delaware Division of Public Health's Implementation of Quality Improvement Initiatives to Improve Diabetes and Hypertension project have the benefit of scheduling a no-cost Workflow Assessment (WFA) with a local Quality Insights Practice Transformation Specialists (PTS). WFAs are completed annually and designed to initiate a future state of processes that will move the needle on clinical quality improvement activities.

The following list includes workflow adjustments that can be implemented to help your patients better manage their hypertension by utilizing self-measurement of blood pressure. We encourage you to partner with your Quality Insights PTS to discuss scheduling a WFA and implementing at least ONE of the recommendations listed below. If you are not currently working with a PTS and would like assistance, please email Robina Montague or call **1.800.642.8686, Ext. 7814**.

Electronic Health Record (EHR) Actions

	Create and execute an EHR report of patients with Stage 1 Hypertension - elevated BP (between 130/80 mmHg and 139/89 mmHg) and add a reminder to the EHR to outreach for appointment or address during next visit.
	Execute an EHR report of patients with blood pressure readings of >=140/90, but with no diagnosis of hypertension. Perform outreach to schedule an appointment for a blood pressure a check of these patients to determine next steps in diagnosis, treatment and referral.
	Activate CDS reminder for providers reminding them to refer patients with hypertension and/or are on medications for hypertension to the Delaware Division of Public Health's Healthy Heart Ambassador - Blood Pressure Self-Monitoring Program (HHA-BPSM) (excluding those who've had a cardiac event in the last year, afib/arrhythmias, or have/are at risk for lymphedema) or community-based resources (Weight Watchers, SNAP-ED programs, EFNEP programs, TOPS, and Curves Complete).
	Identify opportunities for high blood pressure management in subsets of patients. Evaluate EHR capabilities for identification and reporting on priority populations (underserved). Identify patients in Million Hearts® priority populations at-risk and monitor for management and tracking over time.
	Execute report for site of patients with hypertension and did not have an appointment in the last six months and outreach for appointment.
	Implement process for documenting all referrals (including blood pressure and lifestyle change programs) in structured data fields or via non-EHR tracking method for monitoring of feedback and participation.

Protocol & Workflow Actions

	Review/develop a hypertension office protocol (include evaluation of patients with HTN and elevated LDL-C >100mg/dl) that promotes current guidelines, SMBP, medication adherence, self-monitoring of BP levels, healthy diet, physical activity, and promotion of community lifestyle change programs.
	Implement annual staff training to review appropriate procedures for obtaining an accurate blood pressure.
	Refer all patients with hypertension and/or are on medications for hypertension (excluding those who've had a cardiac event in the last year, afib/arrhythmias, or have/are at risk for lymphedema) to the Delaware Division of Public's Healthy Heart Ambassador - Blood Pressure Self-Monitoring Program (HHA-BPSM) or community-based resources (i.e.,Weight Watchers, SNAP-ED programs, EFNEP programs, TOPS, and Curves Complete).

Practice & Clinical Solutions

Using the Screening, Measurement, and Self-Meanagement of Blood Pressure Practice Module as a guide:

	Participate in Target:BP™ Recognition Program (if eligible and as able to enroll). ***Note:*** *The 2021 Million Hearts® Hypertension Control Champion Challenge was cancelled due to COVID-19 challenges.*
	Evaluate and identify potential areas of collaboration that may exist to enhance and expand the process of cardiovascular prevention and management (i.e. inpatient settings, ambulatory clinics, other transitions of care, etc.). See Care Teams Interventions to Implement American Heart Association CVD Primary Call Prevention Guidelines for more information.
	Implement Home Blood Pressure Monitor Loaner program. Review and initiate procedure. Include patient agreement process.
	If participating in Blood Pressure Monitor Loaner program, identify specific dates/times for follow-up and obtaining both patient and provider assessments.
	Evaluate the PRAPARE Tool or Social Determinants of Health (SDoH) template questions for future use within the practice.
	Implement the PRAPARE Tool.
	Share/discuss provider level hypertension quality reports on a regular basis (NQF 0018).
	Create a complete referral process that ensures: • Referral volume can be monitored; AND • Referral reports are received and reviewed by provider, and patient if necessary.
	Educate all members of the care team on referral programs including the providers who are key in patients accepting the recommendations.
	Enroll in and complete EDISCO™ Medication Therapy Management learning course.

Patient Education Actions

	Share community resources with patients promoting approved programs (i.e., Weight Watchers, EFNEP programs, HHA-BPSM program, TOPS, and Curves Complete).
	Promote the free BP check locations in your county to patients. Lists are available from Quality Insights for locations in New Castle County, Kent County, and Sussex County.
	Implement use of the Medication Adherence Estimator® and suggested patient conversations to enhance medication adherence.
	Explore and promote the use of hypertension apps to improve self-management of blood pressure. See Keep Hypertension Under Control with these Smartphone Apps to get started.
	Provide patient education on how to take their own BP.
	Offer free annual validation of home BP machines with the medical office BP machine.
	Implement protocol for patients to communicate their home BP readings to the practice (i.e., tracker app, EHR app, fax, telephone or patient portal messaging).

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