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, email Ashley Biscardi or call **1.800.642.8686, Ext. 137**.

Electronic Health Record (EHR) Actions

	Create and execute an EHR report of patients 1) with hypertension-related diagnosis including, but not limited to, Stage 1 hypertension, and 2) who did not have a scheduled appointment in the past six months. Participate in an outreach campaign via the patient portal to provide appointment reminders.
	If EHR is capable, execute NQF reports at race and ethnicity levels. Partner with Quality Insights to participate in an outreach campaign via patient portal to provide appointment reminders.
	Submit NQF 0018 and CMS 347/MIPS 438/ACO 42 quarterly and annually. Submit NQF 0059 annually.
	Activate CDS reminder for providers reminding them to refer patients with hypertension and/or are on medications for hypertension to 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.
	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

	Engage with the Healthy Heart Ambassador Blood Pressure Self-Monitoring Program (HHA-BPSM): 1) Refer all patients with hypertension and/or prescribed medications for hypertension to the Delaware Division of Public Health's HHA-BPSM Program. Referrals should exclude those who have had a cardiac event in the last year, afib/arrhythmia diagnoses, or have/are at risk for lymphedema. 2) Establish a HHA-BPSM referral process to track volume of referrals and feedback. This may be done by utilizing the EHR, a tracking spreadsheet, or other established method. 3) Patients may enroll by calling (302) 208-9097.
	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 (see page 10 of the SMBP Practice Module).

Practice & Clinical Solutions

Using the 2022 SMBP Practice Module as a guide:

	Share/discuss provider level hypertension quality reports on a regular basis (NQF 0018).
	Partner with Quality Insights to increase patient portal engagement.
	Partner with Quality Insights to submit an application for Target:BP™ (NQF 0018 > 70%) and/or Million Hearts® Hypertension Control Champion (NQF > 80%; anticipated to be available in 2022) recognition programs.
	Implement a home blood pressure monitor loaner program. Identify 1) a staff member who can act as a program champion, and 2) roles for other members of the team.
	If participating in a home blood pressure loaner program, identify specific dates/times for follow-up and obtaining both patient and provider assessments.
	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).
	Enroll in and complete EDISCO™ Medication Therapy Management learning course for additional information.
	Engage in Quality Insights Hypertension Academic Detailing.
	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.

	Evaluate the PRAPARE Tool or Social Determinants of Health (SDoH) template questions for future use within the practice.
	Implement the PRAPARE Tool.

Patient Education Actions

	Utilize and share self-management of blood pressure (SMBP) instructional videos with patients (i.e. waiting room, patient portal, email, text messages). Get started with this Quality Insights video series available in English and Spanish.
	Share community resources with patients promoting CDC-approved programs (i.e. Weight Watchers [WW], 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 included Interpretation Guide to enhance medication adherence. Access Quality Insights 2022 Medication Adherence Practice Module for more information.
	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.

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