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 Specialist (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 (HTN) by utilizing self-measurement of blood pressure (SMBP). 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.
	Execute an EHR report of patients with blood pressure (BP) readings of ≥ 140/90, but with no diagnosis of HTN. Perform outreach utilizing phone calls, text messaging, and/or patient portal to schedule follow-up appointment for a BP check.
	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. Utilize the CMS Disparities Impact Statement to address disparities.
	Submit the National Quality Forum (NQF) 0018 measure and CMS 347/MIPS 438/ACO 42 quarterly and annually. Utilize NQF 0018 denominator to determine the number of patients with HTN.
	Activate CDS reminder for providers reminding them to refer patients with HTN and/or are on medications for HTN to community-based resources such as the Healthy Heart Ambassador Blood Pressure Self-Monitoring Program (HHA-BPSM), Weight Watchers (WW), TOPS, Curves, and Expanded Food and Nutrition Education Programs (EFNEP).
	Identify opportunities for HTN and high cholesterol 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.

	Review and implement the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool EHR template. If already utilizing PRAPARE, document current workflow and utilization of information gathered in the tool.
	Evaluate and report use of social determinants of health (SDOH) ICD-10 codes.
	Partner with Quality Insights to mitigate barriers related to use of SDOH identification tools and ICD-10 coding.
	Implement process for documenting all referrals (including BP 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 HHA-BPSM Program: 1) Refer all patients with HTN and/or prescribed medications for HTN to the Delaware Division of Public Health's HHA-BPSM Program. Referrals should exclude those who've 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) Utilize a closed-loop referral process in the EHR through Unite DE to HHA-BPSM. Patients may enroll by calling (302) 208-9097.
	Review/develop a HTN office protocol, including evaluation of patients with HTN and elevated low-density lipoprotein cholesterol (LDL-C) >100mg/dL, that promotes current guidelines, SMBP, medication adherence, healthy diet, physical activity, and promotion of community lifestyle change programs.
	Implement annual staff training to review appropriate procedures for obtaining an accurate BP (see the SMBP Practice Module).

Practice & Clinical Solutions

Using the 2023 Screening, Measurement, and Self-Management of Blood Pressure Practice Module as a guide:

	Share/discuss provider level HTN 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%*) Recognition Programs.
	Implement a home BP 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 the Quality Insights' Home BP Monitor 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.

** Represents BP control rates at or above 70 percent or 80 percent within the populations served.*

Patient Education Actions

	Utilize and share SMBP instructional videos with patients through the practice's preferred method (e.g., waiting room, patient portal, email, telehealth wait times, and text messaging).
	Share community resources with patients promoting CDC-approved programs (i.e., WW, SNAP-Ed, EFNEP, TOPS, YMCA, and Curves).
	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 Adherence Estimator® and included Interpretation Guide to enhance medication adherence. Access Quality Insights' Medication Adherence Practice Module for more information.
	Explore and promote the use of HTN apps to improve self-management of BP. See the Hypertension Management Apps flyer from Quality Insights 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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