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 Pennsylvania Department of Health's Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke program 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 (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 with blood pressure (BP) readings of >= 140/90, but with no diagnosis of HTN. Partner with Quality Insights to schedule BP follow-up appointments with identified patients. Ensure diagnosis of HTN is added to the medical record, home blood pressure monitoring is validated and/or discussed, and patient is enrolled in a Home BP Monitor Loaner Program as appropriate.
	Execute an EHR report of patients with 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. Consider Quality Insights' Home BP Monitor Loaner Program.
	Report quarterly and annually National Quality Forum (NQF) #0018 measure. Utilize NQF #0018 denominator to determine number of patients with HTN.
	Partner with Quality Insights to review ability to report NQF #0018 at race and ethnicity level.
	Review dashboards within EHR to identify opportunities for HTN and high cholesterol management in subsets of patients. Determine EHR capabilities for identification and reporting on priority populations (underserved) and disparities.
	Partner with Quality Insights to identify patient lifestyle change program referrals by querying relevant EHR fields and community-based programs and resources. Educate all members of the care team on referral programs including the providers who are key in patients accepting the recommendations. Explore EHR capabilities to add clinical decision support (CDS) alerts or prompts for eligible patients.

Quality Insights

	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

	Review practice protocols with focus on disparate populations for sharing and discussing BP control and cholesterol management among clinicians and providers.
	Review/develop a HTN office protocol (include 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 page 10 of the SMBP Practice Module).

Practice & Clinical Solutions

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

	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.
	Utilize and share SMBP instructional videos with patients (i.e. waiting room, patient portal, email, text messaging).
	Implement a home blood pressure monitor loaner program or participate in Quality Insights' Home Blood Pressure Monitor Program. Identify 1) a staff member who can act as a program champion, and 2) roles for other members of the team. See pages 15-16 of Quality Insights SMBP Module for implementation resources.
	If participating in the Quality Insights' Home Blood Pressure Monitor Loaner Program, identify specific dates/times for follow-up and obtaining both patient and provider assessments.
	Utilize apps, Bluetooth, and patient portals to improve SMBP results reporting by patients to clinicians.
	Review capability and use of telehealth for the management of HTN and high cholesterol.
	Identify and refer eligible patients to CDC-approved lifestyle change programs, including, but not limited to: Weight Watchers (WW), Supplemental Nutrition Assistance Program Education (SNAP-Ed)

	programs, Expanded Food and Nutrition Education Programs (EFNEP), TOPS, YMCA and Curves Complete.
	Establish a closed-loop referral process with CDC-approved lifestyle change program. Partner with Quality Insights in a referral letter, portal message, or text campaign for referrals to TOPS, Curves, YMCAs, or other PA DOH/CDC-approved programs.
	Participate in an in-person or virtual presentation to learn more about WW, TOPS, and/or YMCA lifestyle change programs.

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

Patient Education Actions

	Share community resources with patients promoting CDC-approved programs (i.e. WW, Snap-Ed, EFNEP, TOPS, YMCA, and Curves Complete).
	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 HTN apps to improve SMBP. 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.

Funding provided by the Pennsylvania Department of Health through the Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke federal grant from the Centers for Disease Control and Prevention. Publication number PADOH-HD-031422B

Quality Insights