DRAFT

Hypertension Roadmap

Goals

Define goals for a hypertension management program using evidence-based guidelines

CQMs

Utilize the appropriate CQM measures needed to track hypertension

Documentation

Define the key types of documentation required in the EHR and claims

Optimizing

Implement best practices for managing hypertension within the practice

Population Health

Identify and effectively manage your hypertensive patient population

Provider Tips

Tips and tricks to better manage your hypertensive population

Managing Disparities

Know and address the challenges of patients with or at risk of hypertension

Coding Considerations

Document social determinants of health and use of Health Care Common procedure Coding System (HCPCS) Codes

Federal & State Initiatives

Federal and state programs to increase hypertension prevention and management

Resources

Available hypertension resources for providers and patients

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Hypertension Roadmap

Goals

- Improve preventive services regarding hypertension
- Reduce risk factors causing hypertension
- Improve patient's health literacy about hypertension

Documentation

- Document risk factors such as family history, environmental factors, damage of immune system, weight, inactivity, race, age, history of high blood
- Document blood pressure readings

Population Health

- Clinical Information Systems (e.g. registries) that can provide patient-specific and population-based support to the care team
- Assess social context (i.e. food insecurities, housing stability, and financial barriers) and apply that information to treatment decisions
- Adopt a patient-centered communication style that includes patient preferences, assesses health literacy, and addresses cultural barriers to care

Managing Disparities

- Address specific groups in the community
- Wellness programs
- Educational programs
- Preventive care services

Federal & State Initiatives

- State Public Health Actions to Prevent and Control Chronic Diseases
- Million Hearts
- WISEWOMAN (Well-Integrated Screening and Evaluation for WOMen Across the Nation)

For more information on the project and additional resources, please visit the HealthARCH project website at: www.healtharch.org/improvingthehealthoffloridians

CQMs

- **Quality ID: 317:** Percentage of patients aged 18 years and older seen during the submitting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated
- **Quality ID 236:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

Optimizing

- Identify barriers in the EHR system
- Optimize health literacy/education
- Defining workflow
- Develop EHR templates

Provider Tips

- Personal Care Plan addressing personal goals, clinical goals, including healthy lifestyle changes that include exercise plan, diet plan, medication adherence, and modifying habits such as smoking and reducing use of caffeine, alcohol, salt and stress
- Provide patient with appropriate self-management tools

Coding Considerations

- Use combination codes for hypertension
- Use Z codes for family history & social determinants with complications
- Use HCPS Codes for documenting blood pressure readings

Resources

- Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians – https://millionhearts.hhs.gov/files/MH_SMBP_Clinicians.pdf
- Hypertension Prevalence Estimator Tool – https://nccd.cdc.gov/MillionHearts/Estimator/
- Hypertension Tools and Training – https://www.cdc.gov/bloodpressure/materials_for_professionals.htm
- TARGET:BP™ Tools and Downloads – https://targetbp.org/tools-downloads/?sort=topic&