Quality Provider Program: Primary Care

Controlling High Blood Pressure (CBP): Frequently Asked Questions

Q: Why does this measure matter?

A: Hypertension, or high blood pressure is also known as the "silent killer." High blood pressure increases the risk of heart disease and stroke, the leading causes of death in the United States. Controlling high blood pressure will help prevent heart attacks, stroke, and kidney disease as well as being an important step for decreasing other serious conditions.

Insurance companies as well as healthcare providers can help individuals manage their high blood pressure by:

- Prescribing medications and encouraging low-sodium diets
- Encouraging increased physical activity and smoking cessation
- Providing discounted or free blood pressure cuffs for those with a hypertension diagnosis

Q: What is Select Health doing to help?

A: Outreach to Select Health members includes:

- Mailing information to members on coverage for blood pressure cuff costs and connecting to a Select Health hypertension blog and a downloadable/printable blood pressure tracker.
- Using computer-generated calls for hypertension care reminders as well as education on monitoring blood pressure at home and sharing results with their providers. In addition, Medicare members receive live hypertension appointment reminder calls.
- A hypertension blog that features helpful, updated medical information and a link for blood pressure trackers for reporting home blood pressure readings to providers.
- Pilot programs for increasing hypertension education and treatment in rural areas

Outreach to providers: The Quality Provider Program maintains an up-to-date registry of patients who have hypertension and are included in the controlling high blood pressure measure, including compliance status.

Q: What are best practices for this measure?

A: Best practices include:

- Using collaborative, team-based care focused on evidence-based guidelines to create workflow processes (e.g., diabetes care reminders, follow-up appointments).
- Partnering with patients on an individualized plan based on medical history, preferences, comorbidities, and individual prognosis and risk.
- Supporting positive lifestyle changes, including using available education for weight loss and nutrition, medication management, or medical visit follow up.
- Evaluating social determinants of health (SDoH) and community resources that support diabetes management (e.g., access to food, medications, transportation).
- Using payor or electronic medical record patient registries or reports, decision-support tools, or clinic huddles to identify patients missing screenings or services.[1]
- Measuring progress toward patient goals and adjusting process as needed by:
  - Establishing a baseline screening rate and setting an ambitious goal
  - Discussing how the screening system is working during staff meetings
  - Making process adjustments as needed to ensure success.

Reference:

[1] American Diabetes Association. Standards of medical care in diabetes—2019 abridged for primary care providers. *Clinical Diabetes*. 2019;37(1):11-34.