Performance Improvement Team presents:

Accelerated Learning Education Program

Controlling High Blood Pressure

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

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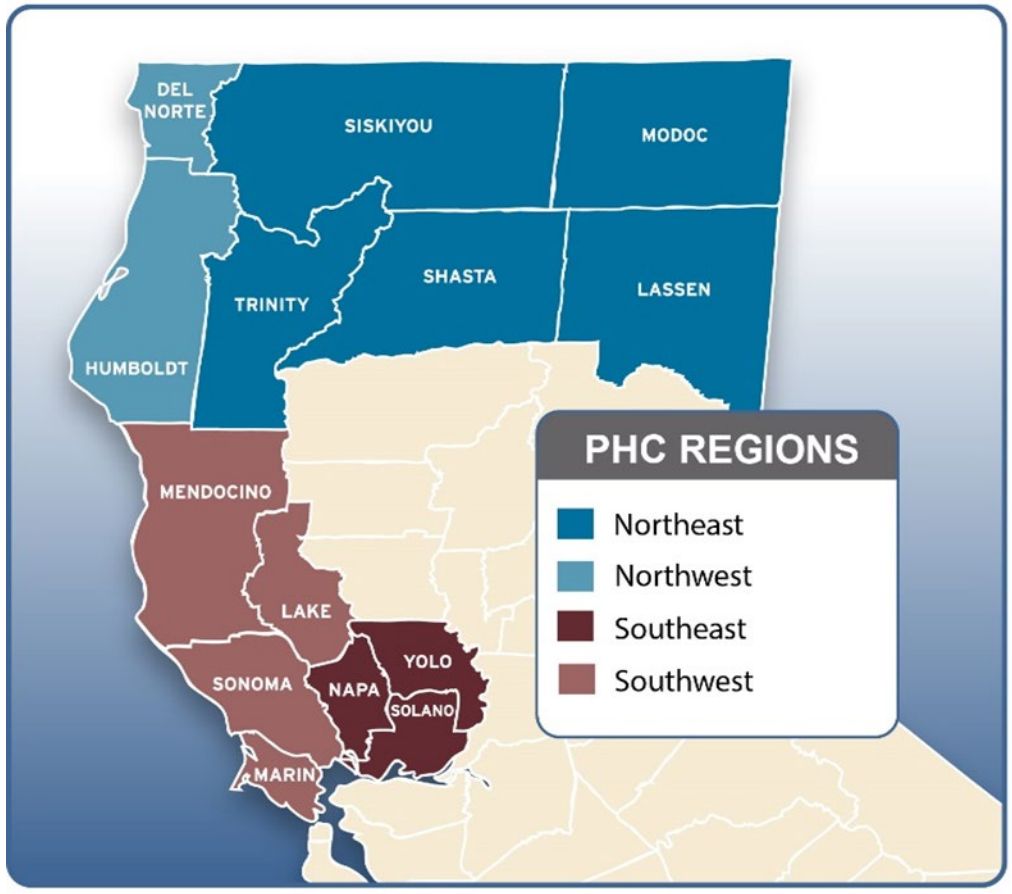
Partnership HealthPlan of California (PHC) Regions



Mission

To help our members, and the communities we serve, be healthy

Vision

To be the most highly regarded managed care plan in California

Objectives

At the end of this activity, you will be able to:

- Provide an overview of clinical measure background, specifications, and performance threshold definitions for the 2023 QIP PCP *Controlling High Blood Pressure* measure.
- Examine disproportionate prevalence and/or rates of hypertension across PHC regions and populations and how culture and lifestyle factors (i.e. diet) of groups experiencing risk may contribute to ineffective management.
- Review documentation requirements, including those related to telehealth updates and remote blood pressure monitoring, to maximize adherence and measure performance.
- Identify best and promising practices including, successful clinical workflows, member and staff education, outreach, and technical tips to improve *Controlling High Blood Pressure* rates.
- Provide an overview of Partnership HealthPlan of California's Medical Equipment Distribution Services and the Medi-Cal Rx blood pressure monitor program.

Overview of Hypertension

CT

- Clinical diagnosis of hypertension
- Importance of controlling high blood pressure
- Treatment options for achieving blood pressure control
- Examine disproportionate rates of hypertension control rates and how culture and lifestyle factors may contribute to ineffective management
- PHC benefits to support blood pressure control

Hypertension Overview

CT

Epidemiology

- Affects ~50 million people in the U.S.
- The most common reason for office visits in the U.S.
- About 50% of people with hypertension are not at adequate control of their blood pressure

Types

- Primary – the most common form of hypertension
  - Without a source or associated with any other disease
- Secondary
  - Associated with another disease such as kidney disease

Blood Pressure Targets

CT

Blood Pressure Levels

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (2003 Guideline)[2]		*The American College of Cardiology/American Heart Association Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (2017 Guideline)*[1]	
Normal	Systolic less than 120 mm Hg diastolic: less than 80 mm Hg	Normal	Systolic less than 120 mm Hg diastolic: less than 80 mm Hg
At risk (prehypertension)	Systolic 120 - 139	Elevated	systolic: 120–129 mm Hg diastolic: less than 80 mm Hg
High Blood Pressure (hypertension)	systolic: 140 mm Hg or higher diastolic: 90 mm Hg or higher	High blood pressure (hypertension)	systolic: 130 mm Hg or higher diastolic: 80 mm Hg or higher

Center for Disease Control and Prevention

Hypertension
Sustained High Blood Pressure

CT

- The force from high blood pressure causes the heart to work harder to pump blood to the body
- When the force of blood flow stays high, the tissue around the arteries stretch
- Stretching weakens the blood vessels making them prone to rupture
- High pressure damages blood vessels and allows fat and cholesterol to build up, causing plaques
- Plaques break off and cause heart attacks and strokes

Hypertension - A Silent Killer

CT

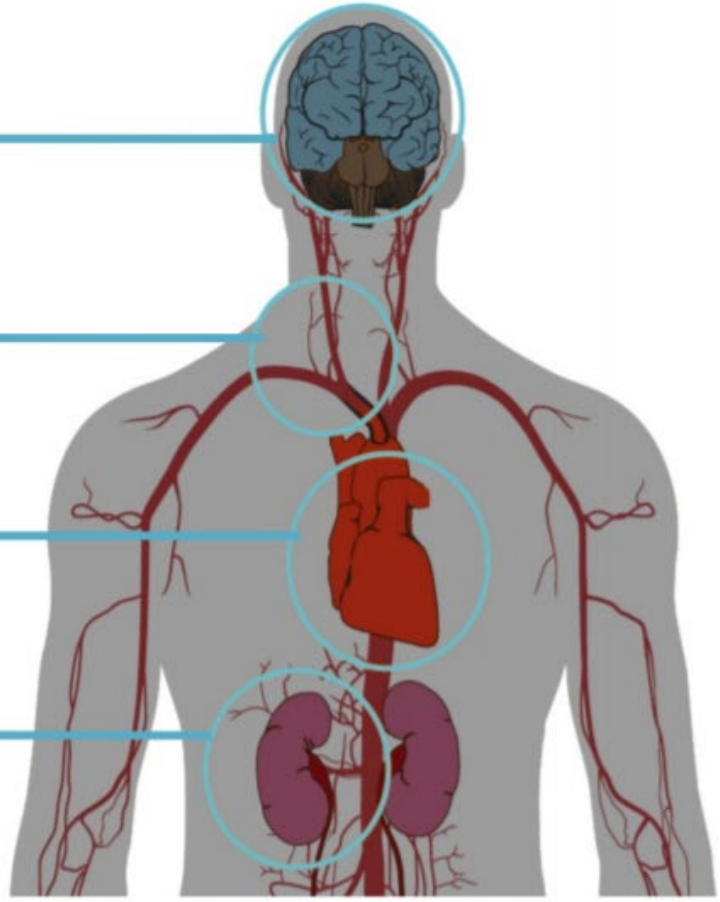
Hypertension can cause:

Brain
- Stroke
- Dementia

Arteries
- Artery damage and narrowing
- Aneurysm
- Leg amputation

Heart
- Coronary artery disease
- Heart attack
- Congestive heart failure

Kidneys
- Kidney failure
- Kidney artery aneurysm



cdc.gov/globalhealth/healthprotection

Factors that Contribute to Hypertension

CT

Age

- Hypertension rates increase in older populations

Race – Black Populations

- Hypertension is more common, more severe and occurs at younger age
- More impact overall and more end organ disease

Family History

- Individuals with one or two parents with hypertension carry twice the risk

Environmental or Behavioral Factors

- Obesity
- Inactivity
- Caffeine
- Tobacco use
- Alcohol
- Medications
- High sodium diet

Less Common Factors

- Kidney anatomy
- Genetic conditions

Controlling Blood Pressure ~ Rates by Region
PHC QIP MY2022

CT

NE	NW	SE	SW
62.64	62.57	64.91	66.78

NW

Asian/Pacific Islander	58.82
Black	60.98
Hispanic	67.09
Native American	56.41
Other	53.13
Unknown	69.44
White	62.10

NE

Asian/Pacific Islander	63.16
Black	60.87
Hispanic	63.33
Laotian	66.67
Native American	39.10
Other	56.41
Unknown	60.58
White	63.93

75th% 62.53
50th% 55.35
25th% 50.61
below 25th%

SW

Asain Indian	73.53
Asian/Pacific Islander	70.00
Black	66.80
Chinese	73.81
Filipino	54.10
Hispanic	74.92
Native American	55.65
Other	68.18
Unknown	66.76
Vietnamese	72.34
White	65.69

SE

Asain Indian	62.10
Asian/Pacific Islander	61.54
Black	59.37
Chinese	74.51
Filipino	69.41
Hispanic	67.63
Native American	67.50
Other	64.47
Unknown	61.00
Vietnamese	64.18
White	62.54

Eureka | Fairfield | Redding | Santa Rosa

Race and Ethnicity Trends by County

CT

- The PHC Northeast Region has the lowest rates of blood pressure control
  - The “other” category represents the lowest rate which may speak to the need to better capture race/ethnicity data moving forward

- Poorer control in the Northern rural/frontier counties vs. Southern Region with a combination of rural and urban communities

Medications that Can Raise Blood Pressure

CT

Common medications that can increase blood pressure:

- Corticosteroids
- NSAIDs
- Combined oral contraceptive pills
- Select antidepressant medications (TCAs, SNRIs)
- Decongestants (pseudoephedrine)
- Stimulants (ADHD, weight loss medications)

Hypertension Treatment: More than Medications

Lifestyle Changes for Prevention and Treatment

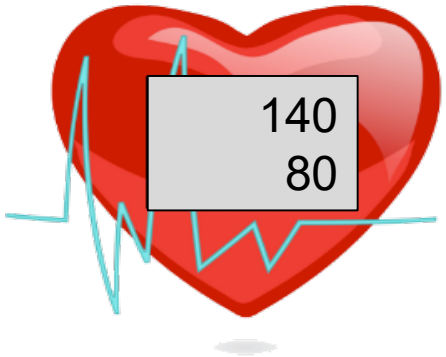
- Diet changes
- Regular physical activity and exercise
- Regular primary care provider (PCP) consults to address modifiable risk factors, early detection, and initiation of treatment

Home Self Monitoring

- Self-monitoring empowers patients for self-management

Medication Management

- Next slides



Nutrition Education and Counselling

CT

- Provided by Registered Dietician (RD) or Certified Diabetes Educators (CDE)
  - Offers dietary recommendations to control BP and limits impact of hypertension by controlling other potential risk factors

- Individual or Group Visits
  - PHC benefit no RAF required

- Covered PHC Benefit for Adult and Pediatric Patients with Diagnosis of
  - Hypertension, hyperlipidemia
  - Cardiovascular disease or CVD risk
  - Diabetes/prediabetes
  - Chronic renal disease
  - Eating disorders, undernutrition or risk of dietary deficiency
  - Overweight and obesity by BMI

PHC Policy MCUP 3052 Medical Nutrition Services

Home Blood Pressure Monitoring

Improves patient engagement in self management

- PHC Medical Equipment Distribution Services Program
  - PCPs order a blood pressure monitor to be sent to their PHC patient.
    - Includes BP digital monitor, cuffs, user instructions in the member's preferred language.
  - How to request:
    - Request form and guidelines are available through PHC's Provider Resources section at partnershiphp.org
    - Providers can send request form via
      - Secure email to request@partnershiphp.org or
      - Secure fax to (707) 420-7855

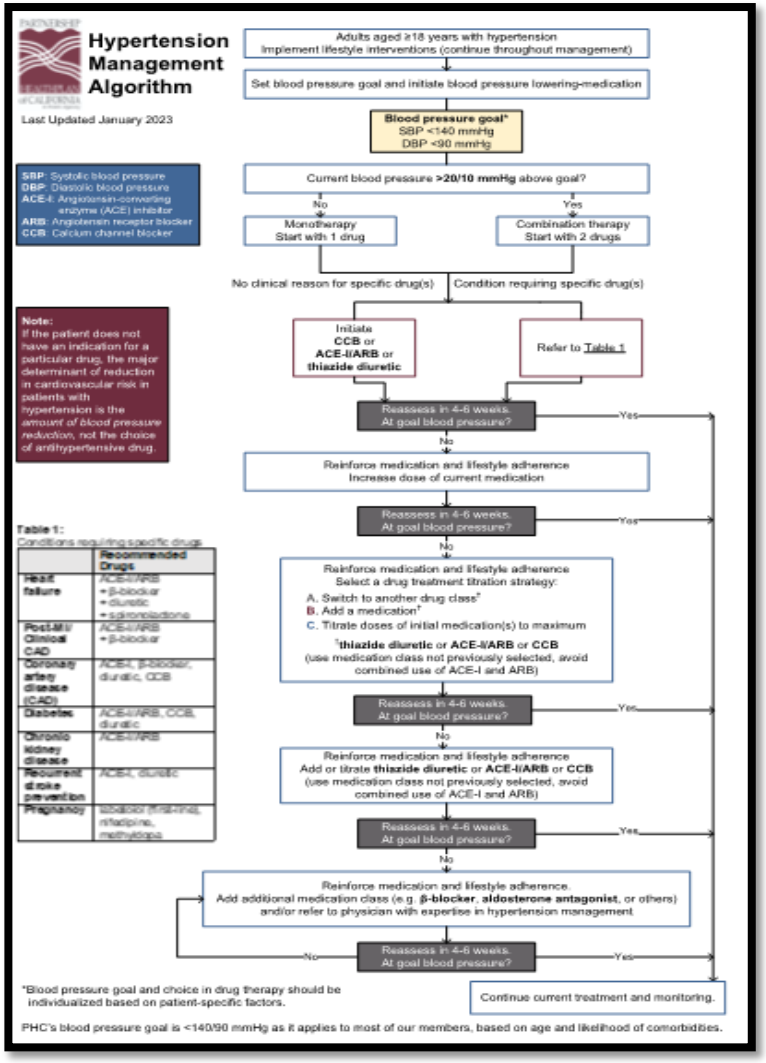
RX and Workflow Resources

KV

- Hypertension management algorithm
- Medi-Cal Rx Contract Drugs List: Oral medications for treatment of hypertension
- Please refer to:

  Medi-Cal Rx Contract Drugs List – Therapeutic Classifications for full list of covered legend drugs

https://medi-calrx.dhcs.ca.gov/home/cdl/



Academic Detailing

Pharmacy claims data and analysis

- Provide pharmacy claims data that clinics may not have
- Provide actionable data analysis:
  - Identify discrepancies between prescription fill records in EMR vs what is actually filled at the pharmacy.
  - Identify gaps in medication adherence (90-days supply or use of single-pill combo).
  - Identify suboptimal therapy (dose increase or addition of another therapeutic class) to help patient reach treatment goal.

Academic Detailing

Example of Pivot table created from Pharmacy Claims Data:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Day Supply Total
Patient #1			**30**						**60**				**90**
HYDROCHLOROTHIAZIDE			**30**						**30**				**60**
25 MG			30						30				60
LISINOPRIL									**30**				**30**
20 MG									30				30
Patient #2			**90**			**90**			**90**			**90**	**360**
LOSARTAN POTASSIUM			**90**			**90**			**90**			**90**	**360**
25 MG			90			90			90			90	360

Patient not at goal (BP >140/90). PHI information removed.

PHC's Quality Incentive Program

KR

- **2023 threshold and targets**
- **Compliant vs. non-compliant documentation**
- **Exclusions**

PCP QIP Measure Spotlight Controlling High Blood Pressure

Sub-Region	County	MY2022
NE	Lassen	66.27
	Modoc	55.26
	Shasta	64.76
	Siskiyou	55.69
	Trinity	64.47
NW	Del Norte	54.76
	Humboldt	65.18
SE	Napa	62.47
	Solano	67.49
	Yolo	61.65
SW	Lake	64.26
	Marin	72.02
	Mendocino	61.13
	Sonoma	72.43

NE	NW	SE	SW
62.64	62.57	64.91	66.78

- The northern region has more variation in measure success

75th% 62.53
50th% 55.35
25th% 50.61
below 25th%

Measure Specifications

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Measure Description

The percentage of members 18 - 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

- **Denominator:** Members 18 - 85 years of age by December 31, 2023, who had at least two visits on different dates of service on or between 1/1/2022-6/30/2023 with a diagnosis of hypertension.
- **Numerator:** The number of members whose most recent blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

2023 PCP QIP

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Controlling High Blood Pressure

PCP QIP 2023	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Medicine Internal Medicine	6 points 10 points	65.10%	75th
Partial Points	Family Medicine Internal Medicine	4 points 8 points	59.85%	50th

Relative Improvement

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for IR points on the measure **AND**
- Have an RI score of 10% or higher, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.
  Please note: If a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through the relative improvement in the current measurement year.

QIP Compliant Documentation

A second diagnosis of hypertension must occur prior to counting the most recent BP reading.

- Eligible readings include:
  - Outpatient visit
  - Telephone visit
  - E-visit or virtual check-in
  - Remote monitoring taken by any **digital device**

- Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation.

- Multiple readings for a single date – use the lowest systolic and lowest diastolic BP.

  Example: BP reading on 5/30/20 were 140/**80**, 138/90 and **130**/87

  → Use **130/80**

Compliant Documentation (continued)

BP readings taken on the same day as a low-intensity or preventive procedure are eligible for use.

Examples: ***(list is not exhaustive)***

- Vaccinations
- Injections (i.e., allergy, insulin, steroid, etc.)
- TB test
- IUD insertion
- Eye exam with dilating agents
- Wart or mole removal

PHC will accept BP readings recorded at a dental office provided the EHR systems are integrated.

QIP Non-Compliant Documentation

The following BP readings **do not** meet the measure:

- Acute inpatient stay or ED visit
- Taken by the member using a non-digital device
- BP reading is ≥140/90
- No BP/incomplete reading during the measurement year
- Documented Pulmonary HTN
- Taken the same day as a diagnostic test or therapeutic procedure that requires a change in diet or medication regiment **on or one day before** the day of the test or procedure. (Example: colonoscopy)

Controlling High Blood Pressure Measure Exclusions

Exclude from the eligible population members with evidence of the following during the measurement year:

- Evidence of end-stage renal disease, dialysis, nephrectomy, or kidney transplant or dialysis
- Pregnancy
- Hospitalization or skilled nursing facility, rehabilitation center, or long term acute care facility
- Palliative care or hospice
- Diagnosis of frailty and advanced illness

Questions

Best and Promising Practices

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- **Strategies from a high-performing organization**
- **Promising practices to decrease high blood pressure rates**

Voices from the Field

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Mendocino Coast Clinics

Tracy LeGris, Quality Improvement Manager
Mendocino Coast Clinic

Approaches for Blood Pressure Control

- MA training/ competence testing for B/P
- Protocol for 3 B/P's for all patients with hypertension
- MA follow up – out reach for patients with uncontrolled HTN
- "Missed opportunities" pushed out by QI staff to all MA's weekly

Best and Promising Practices

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Key Points

- Making hypertension control a system priority
- Implement a policy or process to address BP with *every patient* with HTN at *every visit*
- Complete regular trainings for clinical support teams on BP collection best practices (including repeat BP readings within an appointment)
  - Measure BP at **each** visit and repeat if out of the normal range
  - Perform a manual BP Measurement if elevated after second measurement
  - Assign and train a designated medical assistant to perform manual BP checks

BP Measurement Workflows

- Schedule BP short term follow-up appointment in real time to reassess after treatment changes
- Use a defined process for outreach (e.g., via phone, mail, email, text message) to patients with uncontrolled high blood pressure and those otherwise needing follow-up
- Establish a self-measured BP monitoring program (see resource section)
- Provide patient educational materials as part of your workflow (language availability, see resources)

Best and Promising Practices

Practice Workflows

- Reassess BP every three months after target is achieved
  - Follow-up on no shows
  - Run registry of patients with hypertension to ensure follow up

- Establish standardized processes in your practice site (see A Million Hearts Action Guide in resource section)
  - Use of multidisciplinary team members (RN, RD, Pharmacist)
  - Standing orders
  - Treatment algorithms

- Refer/enroll with chronic case management

Best and Promising Practices

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Patient Education

- Provide education on the importance of BP control and the role of self monitoring (language availability, see resources)
  - Review steps and goals of BP management
- Reinforce the importance of smoking cessation, increased physical activity, low sodium diets, and medication management

Outreach

- Member outreach for routine follow up (phone call, text, email, member portal, post card/letter)
- Prepare patients before the office visit via pre-visit outreach

Claims Submission

- Submit claims encounter data with 90 days of service

Questions

Evaluation

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Please complete your evaluation.
Your feedback is important to us!

Contact Us

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- **Regional Medical Director:**
  Dr. Colleen Townsend
  ctownsend@partnershiphp.org
- **Academic Detailing:**
  RxConsult@partnershiphp.org
- **QI/Performance Improvement Team:**
  ImprovementAcademy@partnershiphp.org

Resources

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- Upcoming trainings and events
- Quick guide to starting QI projects
- Summary of 2023 QIP
- RX and workflow resources
- Health education materials
- Contacts and links

Upcoming Trainings

Accelerated Learning Webinar Series

Target Audience: Clinicians, practice managers, quality improvement team, and staff who are responsible for participating and leading quality improvement efforts within their organization.

The Accelerated Learning Series offers Quality Improvement teams the opportunity to take the next step towards improving quality service and clinical outcomes around specific measures of care. These learning sessions will cover Partnership HealthPlan of California's Primary Care Provider Quality Incentive Program measures with a focus on direct application on best practices with examples from quality improvement teams who are doing the work.

Sessions will be offered during the lunch hour and will be approximately 60-90 minutes in length. CME/CEs will be offered for live attendance.

Planned sessions include:

- 03/15/23 - Diabetes Management - HbA1c Control
- 03/29/23 - Asthma Medication Ratio
- 04/25/23 - Early Cancer Detection: Cervical, Colorectal, Breast Cancer Screening

Register: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx
Contact: improvementacademy@partnershiphp.org

Upcoming Trainings

Mapping Your Way to Improvement: Using Process Maps to Chart the Patient Experience

Target Audience: Quality improvement staff, team leaders, managers, and front-line staff.

Presented by: The Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN)

This webinar will continue to build skills in using lean thinking and tools to understand the patient experience and identify opportunities for improvement. The session will include overviews of different types of process mapping strategies including value stream mapping to support PDSAs and improvement projects.

Planned session: Thursday, March 2, 2023, noon – 1 p.m.

Register: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx
Contact: improvementacademy@partnershiphp.org

Quality Improvement Trainings

On-Demand Courses

http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx

- Accelerated Learning
- PCP QIP High Performers - How'd They Do That?
- Project Management 101
- Tools for Prioritizing Quality Measures
- Understanding the Benefits Delivery System

PHC QI Resources

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A Quick Guide to Starting Your Quality Improvement Projects

PHC QI Resources

DHCS Formulary Search Tool
https://medi-calrx.dhcs.ca.gov/provider/drug-lookup/
Quality Improvement Program email: QIP@partnershiphp.org

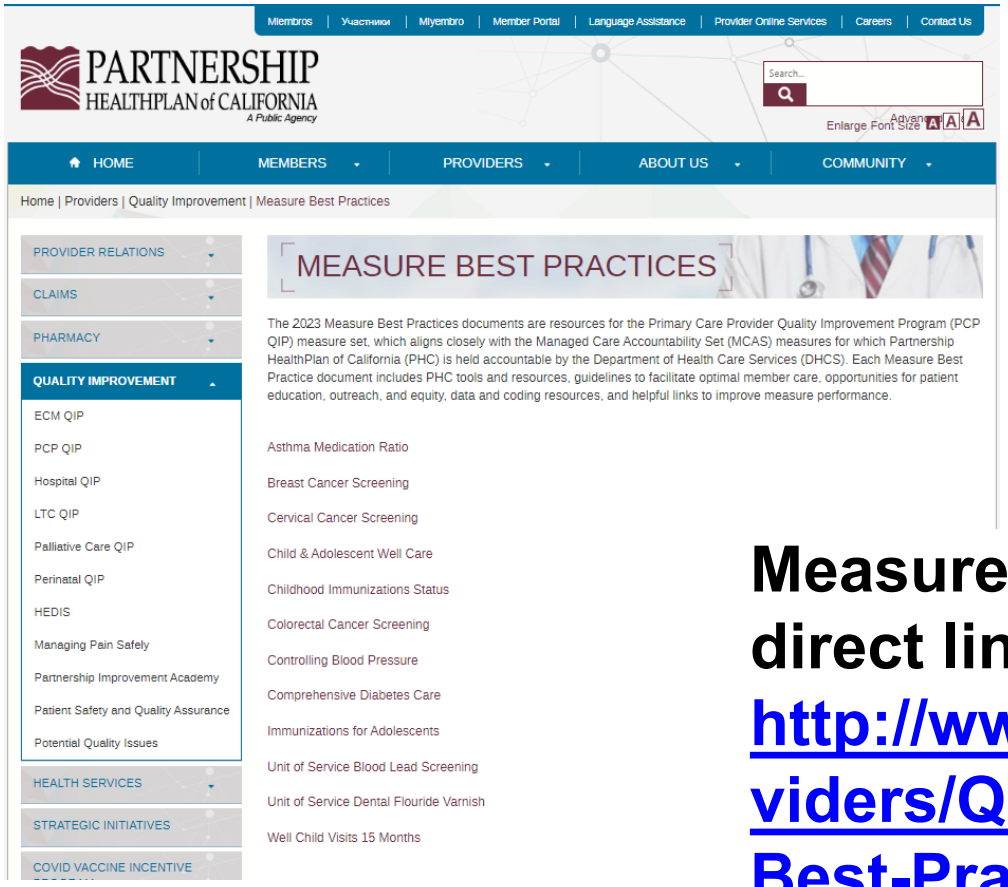
2023 PCP QIP Webpage:
http://www.partnershiphp.org/Providers/Quality/Pages/PCP-QIP-2022.aspx

Measure Highlights:
http://www.partnershiphp.org/Providers/Quality/Pages/Quality-Measure-Highlights.aspx

QI Monthly Newsletters:
http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPMonthlyNewsletter.aspx

eReports: https://qip.partnershiphp.org/

Specifications & Measure Best Practices



Measure Best Practices direct link:
http://www.partnershiphp.org/Providers/Quality/Pages/Measure-Best-Practices.aspx

2023 eReports Upload Schedule

2023 PCP QIP - *Projected eREPORTS UPLOAD SCHEDULE

CLINICAL MEASUREMENT SET:

Cervical Cancer Screening Childhood Immunization Status - Combo 10 Comprehensive Diabetes Care - Retinal Eye Exams Colorectal Cancer Screening Immunizations for Adolescents - Combination 2	May 01, 2023 - JAN 31, 2024
Comprehensive Diabetes Care - HbA1c Control (A1c) Controlling High Blood Pressure Well-Child Visits in the First 15 Months of Life	OCT 01, 2023 - JAN 31, 2024
Breast Cancer Screening Child and Adolescent Well Care Visits	JAN 10, 2024 - JAN 31, 2024
*Asthma Medication Ratio	N/A *

** Asthma Medication Ratio – Data is captured through claims and pharmacy data only. Uploads are not accepted for this measure.*

*Impacted by new claims system (Health Rules Payor, HRP) implementation

2023 PCP QIP targets

CLINICAL DOMAIN											
Practice Type			Measure	Measure Category	Age Range	Targets		Full / Partial Points		
Family	Internal	Peds				Full	Partial	Family	Internal	Peds
✓	✓	✓	Asthma Medication Ratio	CHRONIC DISEASE MANAGEMENT		69.67%	64.26%	6 / 4	8 / 6	13 / 10
✓	✓		Comprehensive Diabetes Care: HbA1c Control			64.48%	60.10%	6 / 4	11 / 8	–
✓	✓		Comprehensive Diabetes Care: Retinal Eye Exams			56.51%	51.06%	5 / 3	5 / 3	–
✓	✓		Controlling High Blood Pressure			65.10%	59.85%	6 / 4	10 / 8	–
✓		✓	Childhood Immunization Status: Combo 10	PREVENTATIVE SCREENING		42.09%	34.79%	6 / 5	–	16 / 12
✓		✓	Immunizations for Adolescents: Combo 2			41.12%	55.72%	6 / 5	–	16 / 12
✓	✓		Breast Cancer Screening			56.52%	50.95%	6 / 5	12 / 9	–
✓	✓		Cervical Cancer Screening			62.53%	57.64%	6 / 4	12 / 9	–
✓	✓		Colorectal Cancer Screening			40.23%	32.80%	5 / 4	12 / 9	–
✓		✓	Child and Adolescent Well Care Visits	UTILIZATION		57.44%	48.93%	9 / 7	–	16 / 12
✓		✓	Well-Child Visits in the First 15 Months of Life			61.19%	55.72%	9 / 7	–	16 / 12

Summary of 2023 QIP

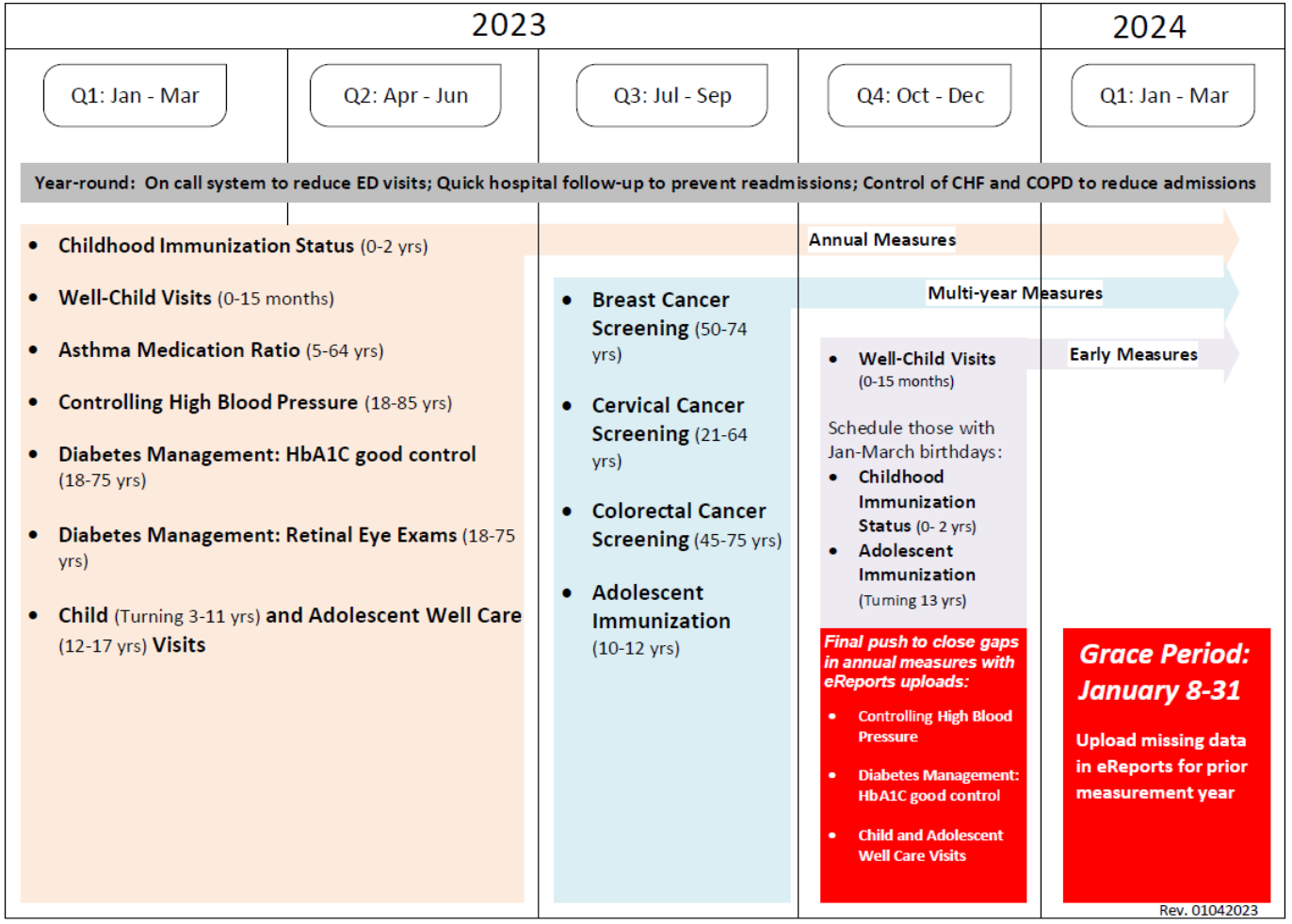
Practice Type			NON-CLINICAL			Full / Partial Points		
Family	Interna	Peds				Family	Internal	Peds
Access and Operations								
✓	✓	✓	Avoidable ED Visits	Full Point Target TBD	Partial Point Target TBD	5 / 4	5 / 4	7 / 5
✓	✓	✓	PCP Office Visits	Greater than 1.8 visits PMPY on average	Between 1.5 and 1.8 visits PMPY on average	5 / 3	5 / 3	6 / 4
Appropriate Use of Resources								
✓	✓	✓	Ambulatory Care Sensitive Admissions	Full Point Target TBD	Partial Point Target TBD	5 / 4	5 / 4	–
✓	✓	✓	Risk Adjusted Readmission Rate	Full Point Target TBD	Partial Point Target TBD	5 / 4	5 / 4	–
Patient Experience								
✓	✓	✓	Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	10 / 8	10 / 8	10 / 8
✓	✓	✓	Patient Experience (Survey)	Submits Parts 1 and 2	Submits Parts 1 or 2	–	–	–

Summary of 2023 QIP

UNIT OF SERVICE - ALL PRACTICE TYPES	
Measure	**Criteria**
Advance Care Planning	Minimum 1/1000th (0.001%) of the sites assigned monthly membership 18 years and older for: · $100 per Attestation, maximum payment $10,000. · $100 per Advance Directive/POLST, maximum payment $10,000
Extended Office Hours	Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification).
PCMH Certification	$1000 yearly for achieving or maintaining PCMH accreditation.
Peer-led Self-Management Support Groups	$1000 per group, either new or existing. (Maximum of 10 groups per parent organization).
Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. This incentive is available at the parent organization level.
Health Equity	$2000 per parent organization for submission of a report of their implementation of their Health Equity initiative.
Blood Lead Screening	Tier 1-3, $1000, $3000, $5000 per parent organization for the number of children between 24 to 72 months who had capillary or venous lead blood test for lead poisoning.
Dental Varnish	$1000 per parent organization for sucmission of proposed plan to implement fluoride varnish application in the medical office.
Tobacco Screening	$5.00 per tobacco use screening or counseling of members 11-21 years of age after 3% threshold of assigned members screened.
Electronic Clinical Data System (ECDS)	$5,000 per parent organization for participating in Electronic Clinical Data System (ECDS) implementation by the end of the measurement year. For parent organizations that submitted initial data for ECDS in prior year, they are also eligible for the $5000 incentive if they continue to submit an ECDS file for 2023 data monthly, starting no later than Jun of 2023.

Timeline for Addressing 2023 and 2024 PCP QIP Measures

Timeline for addressing 2023 and 2024 PCP QIP Measures



Medi-Cal Rx Contract Drugs List: Oral Medications for Treatment of Hypertension

Oral antihypertensive drugs covered by Medi-Cal

Drug Class	Generic Name		
ACE-I	benazepril captopril	enalapril lisinopril	ramipril
ARB	irbesartan losartan	telmisartan	valsartan
CCB (dihydropyridine)	amlodipine isradipine	nicardipine nifedipine (long-acting)	nisoldipine
thiazide & related diuretics	chlorthalidone	hydrochlorothiazide	indapamide
β-blocker ***preferred in the treatment of heart failure***	acebutolol atenolol bisoprolol* carvedilol*	labetalol metoprolol succinate* metoprolol tartrate	pindolol propranolol timolol
α2-adrenergic agonist	doxazosin	prazosin	terazosin
centrally-acting agent	clonidine	guanfacine	methyldopa
vasodilator	hydralazine		
loop diuretic	furosemide		
potassium-sparing diuretic	spironolactone		

Medi-Cal Rx Contract Drugs List: Oral Medications for Treatment of Hypertension

Oral antihypertensive combination products covered by Medi-Cal

Drug Class	Generic Name
ACE-I – thiazide diuretic	benazepril – hydrochlorothiazide
	lisinopril – hydrochlorothiazide
ARB – thiazide diuretic	losartan – hydrochlorothiazide
	telmisartan – hydrochlorothiazide
	valsartan – hydrochlorothiazide
CCB – ACE-I	amlodipine – benazepril
CCB – ARB	amlodipine – valsartan
CCB – ARB – thiazide diuretic	amlodipine – valsartan – hydrochlorothiazide
centrally-acting agent – thiazide diuretic	methyldopa – hydrochlorothiazide
diuretic combinations	spironolactone - hydrochlorothiazide
	triamterene – hydrochlorothiazide

List provided does not include all covered legend drugs used for treatment of hypertension. Legend drugs not listed may be covered subject to authorization from a Medi-Cal consultant.

Please refer to Medi-Cal Rx Contract Drugs List – Therapeutic Classifications for full list of covered legend drugs.

https://medi-calrx.dhcs.ca.gov/home/cdl/

ACE-I: Angiotensin-converting (ACE) inhibitor
ARB: Angiotensin receptor blocker
CCB: Calcium channel blocker

Last updated January 2023

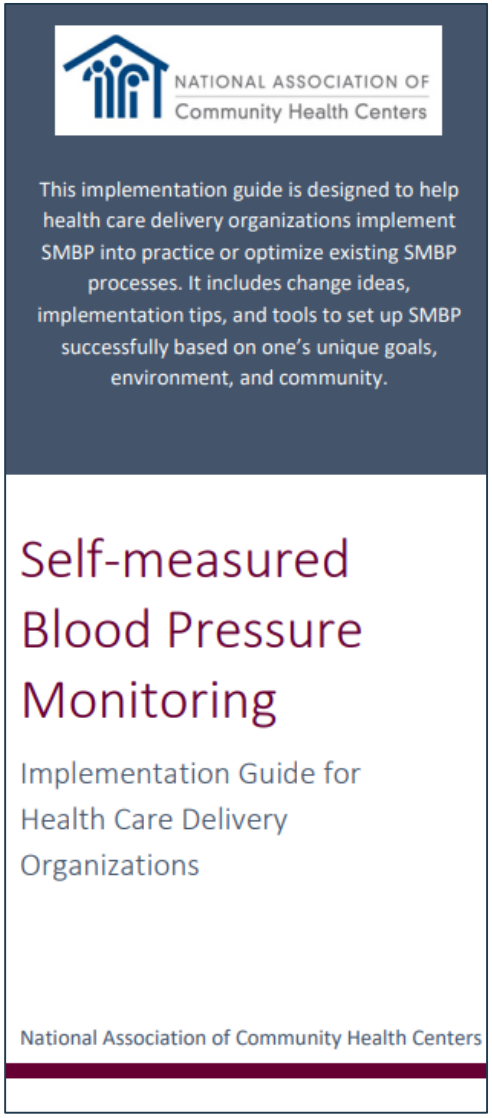
Resources

KR

- Implementing change for Controlling High Blood pressure practice-wide
- https://millionhearts.hhs.gov/

Self-Measured Blood Pressure Monitoring

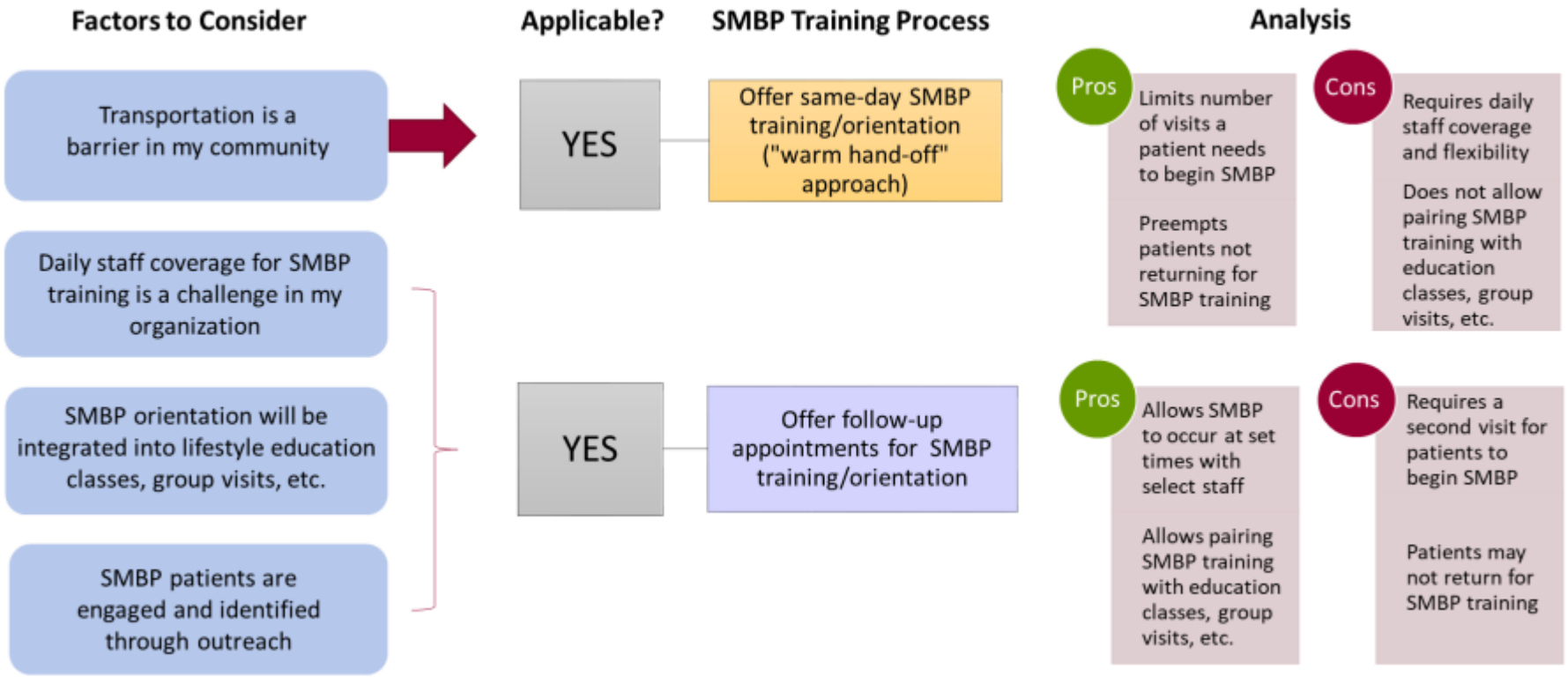
- Available at https://www.nachc.org/wp-content/uploads/2018/09/NACHC-Health-Care-Delivery-SMBP-Implementation-Guide-08222018.pdf



Implementation Checklists

Key SMBP Staff	SMBP Patient Identification/ Support Activities	SMBP Data Management
SMBP Coordinator ❑ Does she/he have the authority, time, and skills to coordinate all aspects of the program? If not, how will you address? **SMBP trainers** ❑ Do you have enough trainers to be available daily? **SMBP Clinical Champion** ❑ Do you have a champion for every implementation site? ❑ Do they have the time to invest to facilitate program success? ❑ Is he/she open to change and new ideas? ❑ Is he/she a key influencer to others?	**Patient Identification** ❑ How will patients be identified? Registry queries and outreach calls? And/or at the point of care based on selection criteria? ❑ How will you know if appropriate patients are being identified and offered SMBP? **Patient Communication** ❑ Who on the care team recommends SMBP? ❑ Who will provide outreach support for SMBP patients? **SMBP Training and Follow-up** ❑ Who trains the patient on SMBP? ❑ How will the patient connect with the SMBP trainer (e.g., warm hand-off, follow-up visit)? ❑ Is the initial follow-up appointment a telephone encounter or a face-to-face visit?	**How will SMBP Data be Recorded, Transmitted, and Managed?** ❑ How will patients record/share data back with the care team? ❑ Do providers want SMBP averages only or individual BP readings as well? ❑ Who is responsible for preparing and managing SMBP data? ❑ Where will staff document SMBP data? EHR? Population health management system? Spreadsheet?

Factors for Implementing SMBP



Distribution of Tasks

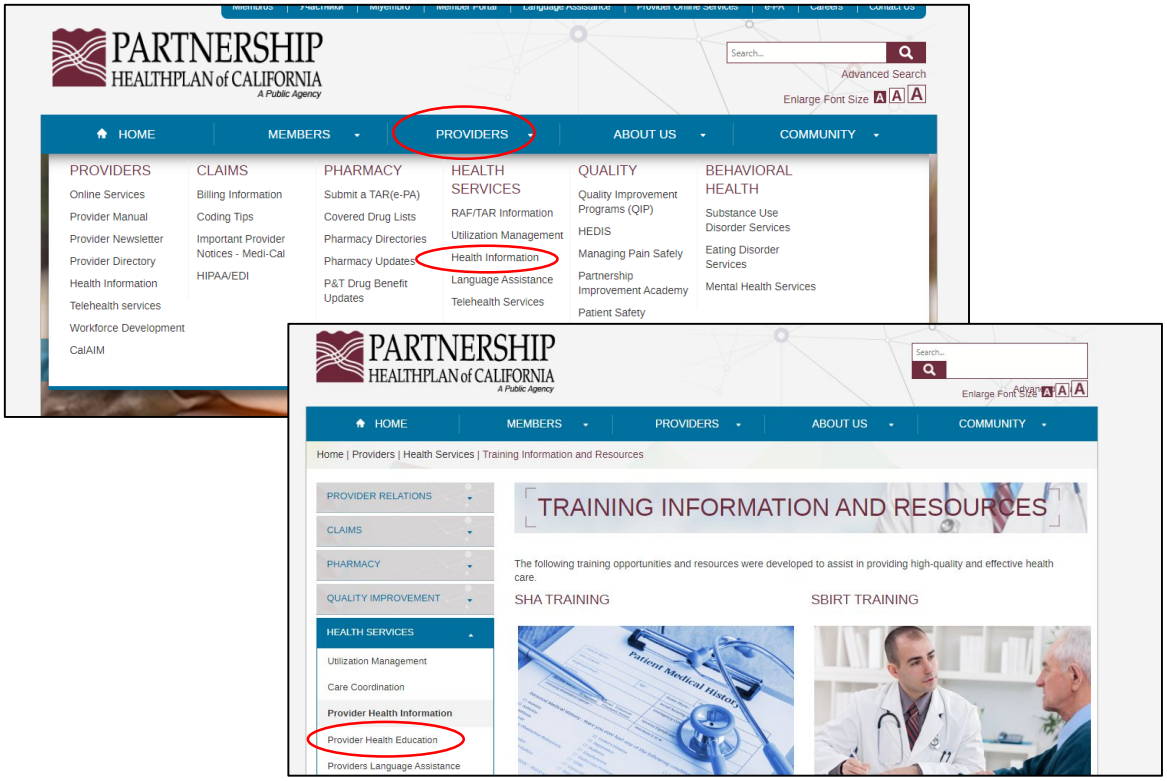
Diagram 4: SMBP Essential and Optional Tasks by Role

Must Be Done by a Licensed Clinician	Can Be Done by a Non-licensed Person (e.g., medical assistant, local public health department, community health organization, community health workers)	Must Be Done by Patient
1. Diagnose hypertension 2. Prescribe medication(s) 3. Provide SMBP measurement protocol 4. Interpret patient-generated SMBP readings 5. Provide medication titration advice 6. Provide lifestyle modification recommendations	1. Provide guidance on home blood pressure (BP) monitor selection 2. If needed, provide home BP monitor (free or loaned) 3. Provide training on using a home BP monitor 4. Validate home BP monitor against a more robust machine 5. Provide training on capturing and relaying home BP values to care team (e.g., via device memory, patient portal, app, log) 6. Reinforce clinician-directed SMBP measurement protocol 7. Provide outreach support to patients using SMBP 8. Share medication adherence strategies 9. Provide lifestyle modification education	1. Take SMBP measurements 2. Take medications as prescribed 3. Make recommended lifestyle modifications 4. Convey SMBP measurements to care team 5. Convey side effects to care team

Optional Tasks – Can be Done by a Non-licensed Person
1. Reinforce training on using a home BP monitor
2. Reinforce training on capturing and relaying home BP values to care team (e.g., via device memory, patient portal, app, log)

Health Education

- Provider health education materials are accessible on PHC's website partnershiphp.org



Health Education Example

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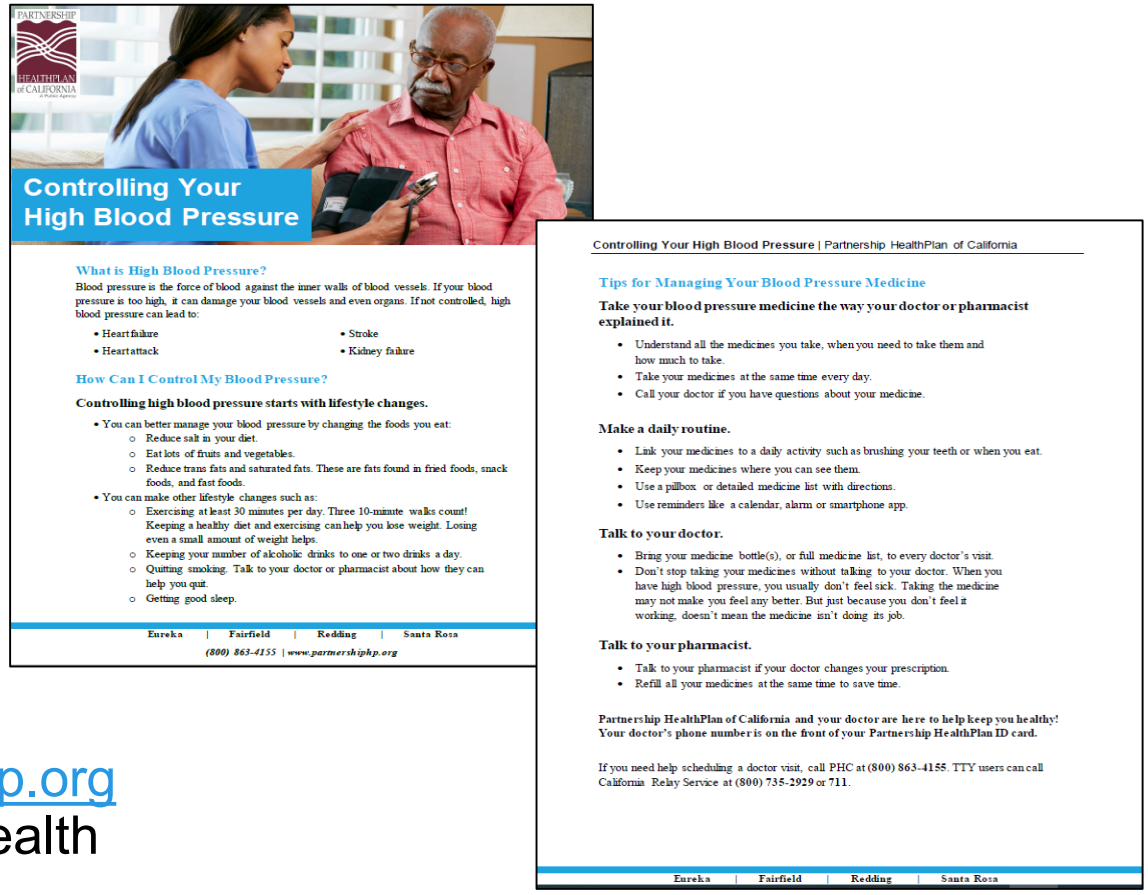
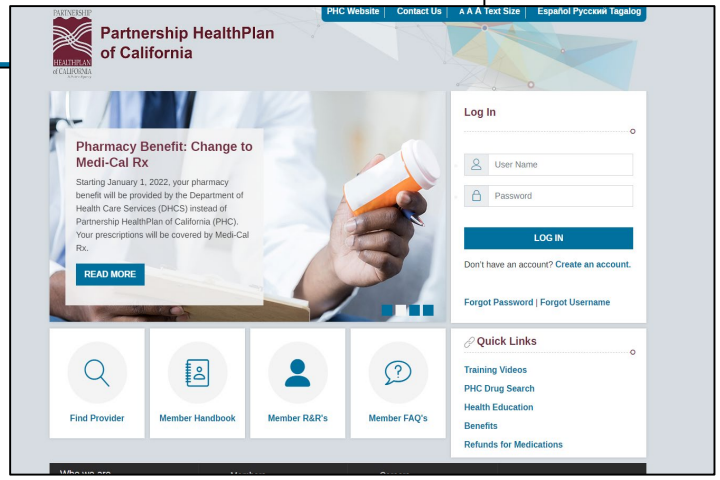


- Hypertension Flyer

- Contact CLHE@partnershiphp.org for access to more health education topics

Healthy Living Tool

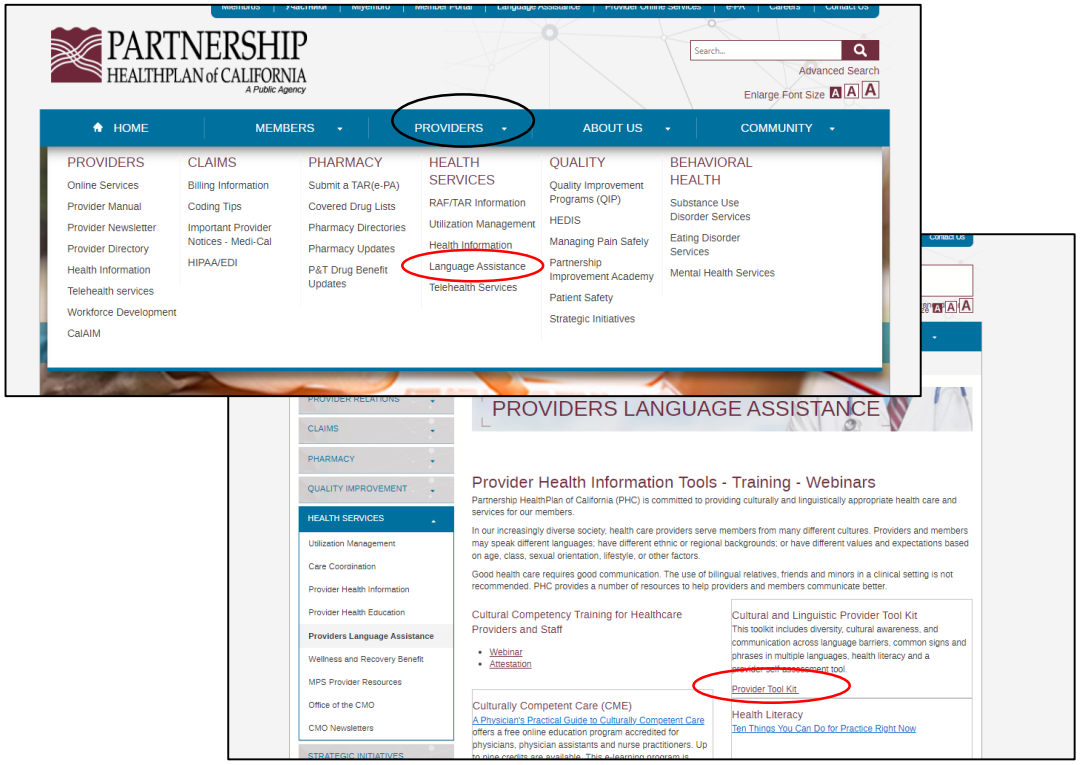
- Members can access the healthy living tool through the member portal.



- Members can call Population Health at (855) 798-8764 if they need help.

Provider Language Assistance

- Provider language assistance materials are also accessible on PHC's website, partnershiphp.org



Education Materials

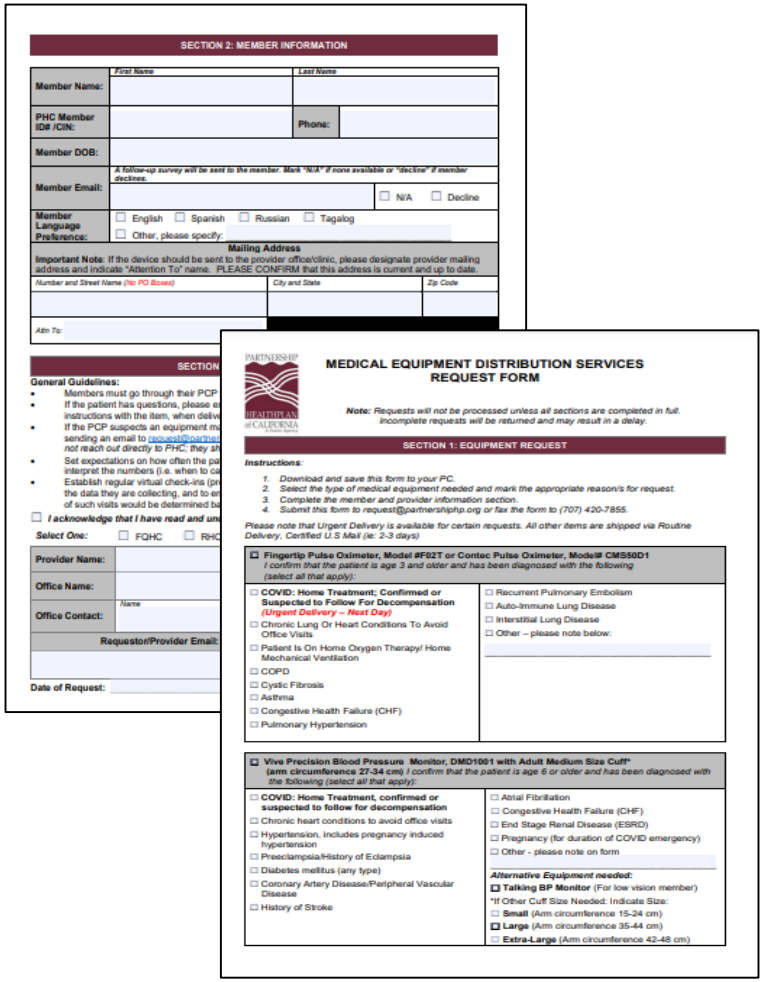
Systolic (upper number)		Diastolic (lower number)	Take Action	Follow-up	My Blood Pressure Plan
Lower than 90	**or**	Lower than 60	Do not take your blood pressure (BP) medicine.	Call your PCP today.	
90-139	and	60-89	Take your medicines as directed.	Continue checking your BP weekly.	
140-179	**or**	90-110	If you have not taken your BP medicines, take them now. Wait 1 hour and recheck your BP.	Recheck BP later today Check your BP daily	
180-199	and/or	Higher than 110	If you have not taken your BP medicines, take now. Wait 1 hour and recheck your BP.	If your BP is high 1 hour after taking BP medicine, call the advice nurse or your PCP.	
200	and/or	Higher than 120	Call advice nurse or your PCP.		

Home Blood Pressure Cuffs
How to Submit Requests

- Providers can submit requests to PHC:
  - Via secure email to: request@partnershiphp.org
  - By secure fax to: (707) 420-7855

- The request form and guidelines are available through:
  - PHC's Provider Resources page on our website
  - http://www.partnershiphp.org/Providers/Medi-Cal/Pages/default.aspx

- Contact request@partnershiphp.org for any questions



SECTION 2: MEMBER INFORMATION

Member Name: First Name / Last Name

PHC Member ID# /CIN: Phone:

Member DOB:

Member Email: A follow-up survey will be sent to the member. Mark "N/A" if none available or "decline" if member declines. N/A Decline

Member Language Preference: English Spanish Russian Tagalog Other, please specify:

Mailing Address

Important Note: If the device should be sent to the provider office/clinic, please designate provider mailing address and indicate "Attention To" name. PLEASE CONFIRM that this address is current and up to date.

Number and Street Name (No PO Boxes) | City and State | Zip Code

Attn To:

SECTION

General Guidelines:

- Members must go through their PCP
- If the patient has questions, please e
- If the PCP suspects an equipment ma
- Set expectations on how often the pa
- Establish regular virtual check-ins (pr

I acknowledge that I have read and un

Select One: FQHC RHC

Provider Name:

Office Name:

Office Contact: Name

Requestor/Provider Email:

Date of Request:

MEDICAL EQUIPMENT DISTRIBUTION SERVICES REQUEST FORM

Note: Requests will not be processed unless all sections are completed in full. Incomplete requests will be returned and may result in a delay.

SECTION 1: EQUIPMENT REQUEST

Instructions:

1. Download and save this form to your PC.
2. Select the type of medical equipment needed and mark the appropriate reason/s for request.
3. Complete the member and provider information section.
4. Submit this form to request@partnershiphp.org or fax the form to (707) 420-7855.

Please note that Urgent Delivery is available for certain requests. All other items are shipped via Routine Delivery, Certified U.S Mail (ie. 2-3 days)

☐ Fingertip Pulse Oximeter, Model #F02T or Contec Pulse Oximeter, Model# CMS50D1
I confirm that the patient is age 3 and older and has been diagnosed with the following (select all that apply):

- ☐ COVID: Home Treatment; Confirmed or Suspected to Follow For Decompensation (Urgent Delivery – Next Day)
- ☐ Chronic Lung Or Heart Conditions To Avoid Office Visits
- ☐ Patient Is On Home Oxygen Therapy/ Home Mechanical Ventilation
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Asthma
- ☐ Congestive Health Failure (CHF)
- ☐ Pulmonary Hypertension
- ☐ Recurrent Pulmonary Embolism
- ☐ Auto-Immune Lung Disease
- ☐ Interstitial Lung Disease
- ☐ Other – please note below:

☐ Vive Precision Blood Pressure Monitor, DMD1001 with Adult Medium Size Cuff* (arm circumference 27-34 cm) I confirm that the patient is age 6 or older and has been diagnosed with the following (select all that apply):

- ☐ COVID: Home Treatment, confirmed or suspected to follow for decompensation
- ☐ Chronic heart conditions to avoid office visits
- ☐ Hypertension, includes pregnancy induced hypertension
- ☐ Preeclampsia/History of Eclampsia
- ☐ Diabetes mellitus (any type)
- ☐ Coronary Artery Disease/Peripheral Vascular Disease
- ☐ History of Stroke
- ☐ Atrial Fibrillation
- ☐ Congestive Health Failure (CHF)
- ☐ End Stage Renal Disease (ESRD)
- ☐ Pregnancy (for duration of COVID emergency)
- ☐ Other - please note on form

Alternative Equipment needed:
☐ Talking BP Monitor (For low vision member)
*If Other Cuff Size Needed: Indicate Size:
☐ Small (Arm circumference 15-24 cm)
☐ Large (Arm circumference 35-44 cm)
☐ Extra-Large (Arm circumference 42-48 cm)

Resources on Health and Racial Equity

California Improvement Network (CIN): https://www.chcf.org

Toolkit to Advance Racial Health Equity in Primary Care Improvement https://www.chcf.org/publication/toolkit-racial-equity-primary-care-improvement/

American Medical Association: https://www.ama-assn.org/about/ama-center-health-equity AMA Center for Health Equity: The AMA Center for Health Equity works to embed health equity across the AMA organization so that health equity becomes part of the practice, process, action, innovation, and organizational performance and outcomes. Also jointly released with Association of American Medical Colleges, led by its Center for Health Justice, a new health equity guide to language, narrative, and concepts entitled, "Advancing Health Equity: A Guide to Language, Narrative, and Concepts."

Center for Health Care Strategies : https://www.chcs.org/

Diversifying Medicaid's Leaders to Better Address Health Equity - Highlights strategies for ensuring a robust pipeline of strong and diverse Medicaid leaders. See also a related **infographic**.

Words Matter: How Language Used in Health Care Settings Can Impact the Quality of Pediatric Care - This webinar featured perspectives on the impact of language used during care and in medical records, and how provider interactions rooted in respect can support health and well-being. This is not exclusive to pediatric delivery.

Health Begins: https://healthbegins.org

Health Equity Strategies from the AHC Model: Working with Mathematica on behalf of the Centers for Medicare & Medicaid Services (CMS), Health Begins has this tip sheet provides a multi-level framework for understanding health equity, including actionable strategies related to social needs interventions that organizations such as health systems, payers, and community service providers can leverage to improve health equity.

Resources on Health and Racial Equity

Implicit Bias Association Test
https://implicit.harvard.edu/implicit/takeatest.html.

Tool for showing bias and how our unconscious drives our day to day decision making. This tool was developed by a group of researchers from Harvard University and has proven validity. The test is free and results are kept confidential, but tagged for research purposes. Please refer to the disclaimer.

Diversity Science: https://www.diversityscience.org/equal-perinatal-care/

Developed an interactive training courses and resources for perinatal providers focused on implicit bias and reproductive justice. These resources are developed in accordance with the training requirements outlined in the California Dignity in Pregnancy and Childbirth Act (Senate Bill 464).

Resources

- *Northwest Regional Telehealth Resource Center, Quick Start Guide to Telehealth During the Current Public Health Emergency. March 2020.* https://nrtrc.org
- California Telehealth Resource Center, http://www.caltrc.org/knowledge-center/best-practices/sample-forms
- California Primary Care Association, www.CPCA.org
- Center for Care Innovations, https://www.careinnovations.org/wp-content/uploads/Sample-Remote-Visit-Workflow.pdf