Support for the Clinical Areas of Focus

Hypertension Blood Pressure Control

Reportable to:

- Partnership HealthPlan Quality Improvement Program (QIP)
- Annual HRSA UDS Report
- Redwood Community Health Coalition Performance Improvement Program (PIP)
- Million Hearts
- Redwood Community Health Coalition Preventing Heart Attacks and Strokes Everyday (PHASE) Grant

Workflows to know

The following workflows are important to know as they directly relate to the measure:

- CTMA Charting Chief Complaint and Vitals
- Obtaining an Accurate BP protocol
- Blood Pressure Competency Evaluation
- RN PHASE Case Management
- RN Diabetes Care Plan
- Referral to FWC
- BH Warm Hand offs
- Transfer Care protocol
- Deceased patient protocol
- Non-WCHC Patient protocol

Quality Assurance reports available

HTN Pop Recall list — **HTN Dash/Pop Management Tab**

These are HTN patients seen in the last 12 months and can be filtered for 'uncontrolled' and 'Not Measured in Period'. These patients can be called in for a CTMA Blood Pressure check.

BP QA — **HTN Dash/ Quality Assurance Lists**

These are BPs that have been incorrectly entered.

Hiding in Plain Sight — **HTN Dash/Hiding in Plain Sight Tab**

These are lists of potential HTN patients based on co-morbid conditions, 2 high BP readings or HTN assessment code without HTN documented in their problem list.

Resources available

- FWC Lifestyle and movement classes
- Integrated Behavioral Health
- Center for Wellbeing

Measure definition

Percentage of active primary care patients, aged 18 and older, with at least 1 primary care appt in the last 12 months, who have been dx with HTN at least 6 months ago, whose most recent BP recorded is 'in control'.

'In Control' is defined as:

-age 18-59 BP systolic <140 AND diastolic <90

-age over 60 BP systolic <50 AND diastolic <90

-age over 60 with Diabetes BP systolic <140 AND diastolic <90