Chronic Care HTN Home Monitoring Pilot – MA Standard Work

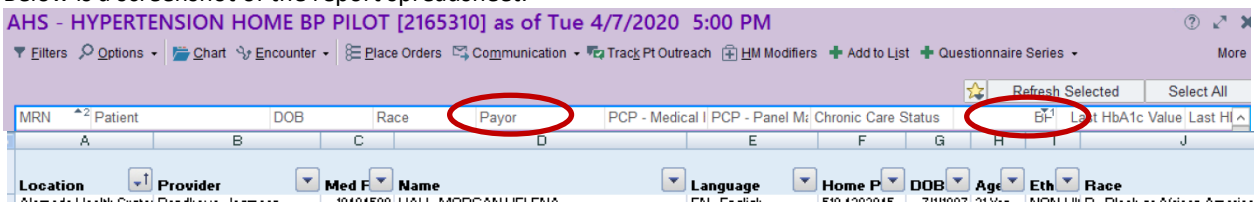
For our Chronic Care MA:

- Open the AHS* HYPERTENSION HOME BP PILOT Outreach list
    - The outreach list can be sorted and filtered to display the appropriate patients. We are planning on reaching out to all patients with last BP not at goal who have had some contact with chronic care (active, discharged, etc).

*Placeholder for specific clinic location (HGH, HWC, EWC, etc)

Spreadsheet Orientation

Below is a screenshot of the report spreadsheet.



Please note the column that specifies BP. Please filter the spreadsheet so that values in the hypertensive range are sorted (i.e. BP higher than 140/90). Patients who fall in this range will be the patients called for this pilot.

Details on Outreach

MA will call patient and follow instructions based on the patient's insurance plan/payor. Please see below for a sample script when calling patients.

"Hello, [patient name]. We are reaching out to all chronic care patients who have high blood pressure. In addition to working on diabetes control, we are also working on a project to help our patients better control their blood pressure. Due to COVID19 we are trying to keep patients away from the hospital and clinic if possible but still think blood pressure control is important. To make sure that we continue to treat your blood pressure we would like to make sure you own a home blood pressure cuff. After you get the cuff we will make sure you have follow up to learn how to use it"

Please see below for instructions based on the patient's payor.

Blue Cross, Alameda Alliance (and currently HPAC too)

Please contact the patient on the list and ask them whether or not they own a blood pressure cuff. If they own a blood pressure arm cuff, please ask them if they know how to use the cuff.

Patient knows how to use the BP cuff:

If the patient does not need BP cuff teaching, please schedule the patient for an appointment with **chronic care** next available. Reason for visit should be **"BP Pilot New."**

Patient does not know how to use the BP cuff:

If the patient does not know how to work the blood pressure cuff, please schedule them for a telephone appointment with the in-clinic RN to discuss how to use the cuff. Reason for visit should be **"BP Pilot New."**

Patient does not own a BP cuff:

If the patient does not own a blood pressure cuff please do the following:

Send a message to the patient's PCP or Chronic Care RN/PharmD requesting that he or she order their patient a BP cuff. Please create a telephone encounter within the patient's chart using the following dot phrase

".CCCHTNPILOTMA." Please schedule a visit with a member of the chronic care team in 1-2 weeks with reason for visit **"BP Pilot New."**

Dear @PCP@

Your patient, @NAME@, is part of a pilot to monitor blood pressure from home. Can you please order your patient a blood pressure cuff? You may order it via the "general supply request order." Please specify arm blood pressure cuff in the comments.

If you have any questions about the pilot, please feel free to reach out to Natalie Curtis.

Thank you,

@ME@

HealthPac (NOTE it appears that during COVID19 HPAC is covering BP cuffs – please see above re: instructions)
Please ask the patient if he/she owns a blood pressure cuff. If the patient owns a BP cuff, please schedule an appointment chronic care next available. Reason for visit should be "**BP Pilot New**." If the patient does not own a BP cuff please schedule them for an appointment with an in-clinic RN for BP cuff pickup and teaching. During this visit the patient will be provided a blood pressure cuff and taught how to use it. Reason for visit should be **"BP Pilot Pickup."**

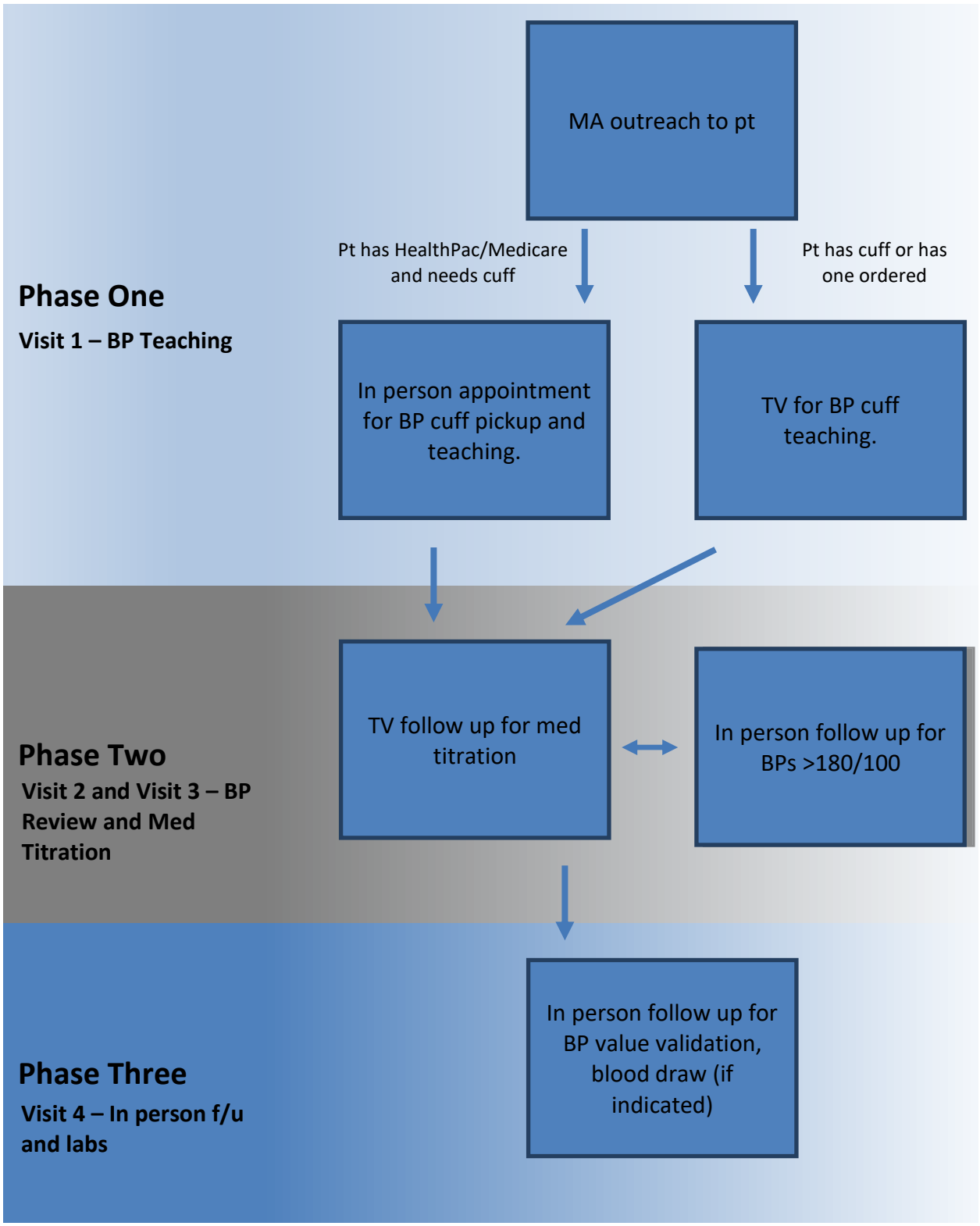
Medicare:
Please check the patient's demographic information in EPIC. If patient also has Alameda Alliance or Blue Cross as secondary insurance, please see the section for patients with Blue Cross and Alameda Alliance. If the patient does not have a secondary insurance plan, please see instructions under HealthPac.

Plan for Follow-Up:
Once patients have a blood pressure cuff and know how to use it, they will have telephone visits to review BP measurements every 1-2 weeks with one of the chronic care team members. After about 6-8 weeks we will have the patients come to the clinic for an in-person appointment. For all in person appointments, patients will need to bring their blood pressure cuff and medications with them.

Documentation:
Please document within the outreach sheet. Please be sure to document the following:

1) If the PCP was asked to order a BP cuff → we will need to track this and follow up to make sure it happened
2) If the patient was scheduled for a visit
3) If the patient was able to pick up the BP cuff when indicated
4) If the patient successfully completed the visits

Tracking of outreach attempts should be done in the workbench report. Outcomes of the outreach can be done on the sharepoint Excel sheet for QIP. Please contact Natalie if you cannot access the sharepoint:


MA outreach to pt
Pt has HealthPac/Medicare and needs cuff
Pt has cuff or has one ordered
Phase One
Visit 1 – BP Teaching
In person appointment for BP cuff pickup and teaching.
TV for BP cuff teaching.
Phase Two
Visit 2 and Visit 3 – BP Review and Med Titration
TV follow up for med titration
In person follow up for BPs >180/100
Phase Three
Visit 4 – In person f/u and labs
In person follow up for BP value validation, blood draw (if indicated)