Register Now!

In-Person PHASE Convening

Thursday, November 29
8:30 a.m. – 4 p.m.
Preservation Park, Oakland

Please Register by November 12:
Call Agenda & Objectives

• SMBP Program Measures (15 minutes)
  ▪ Understand options/approaches taken
  ▪ Compare results across sites?

• Peer Sharing around SMBP Workflows (35 minutes)
  ▪ Share approaches/challenges – enhance local efforts

• Next steps (10 minutes)
  ▪ Assess today’s call, plan for next
  ▪ How to make best use of Dropbox?
  ▪ Connect at convening?
SMBP Program Goals/Measures

Model for Improvement
• What are we trying to accomplish?
• How will we know change is improvement?
• What change will cause improvement?

Measure Options
• SMBP Recommended
• SMBP Used
• BP Control Rate
• Pre/post Patient Surveys
• Others

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# Measures From Implementation Guide

## Appendix B: Million Hearts® Accelerating SMBP Project Measure Specifications

**Source:** National Association of Community Health Centers

<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Measure Name</th>
<th>Measure Definition</th>
<th>Numerator</th>
<th>Denominator</th>
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<tbody>
<tr>
<td>Short-term Outcome</td>
<td>Recommendation of SMBP</td>
<td>% of patients with a diagnosis of primary/essential HTN and a recommendation to use SMBP in the past 12 months</td>
<td>Number of patients in denominator who have a recommendation to use SMBP documented in the past 12 months.</td>
<td>Patients ages 18 to 85 with a diagnosis of essential HTN recorded in the EHR as an encounter assessment or in a structured field on the problem list anytime during or prior to the measurement period and seen for at least one medical visit in the past 12 months. Excludes pregnancy and ESRD.</td>
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<tr>
<td>Short-term Outcome</td>
<td>Referral to Community SMBP Support Program</td>
<td>% of patients with a diagnosis of primary/essential HTN and a referral to a community SMBP support program in the past 12 months</td>
<td>Number of patients in denominator who have a referral to a community SMBP support program (e.g., the YMCA BPSM Program) documented in the past 12 months.</td>
<td>Patients ages 18 to 85 with a diagnosis of essential HTN recorded in the EHR as an encounter assessment or in a structured field on the problem list anytime during or prior to the measurement period and seen for at least one medical visit in the past 12 months. Excludes pregnancy and ESRD.</td>
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<tr>
<td>Intermediate Outcome</td>
<td>Use of SMBP among HTN Patients</td>
<td>% of patients with a diagnosis of primary/essential HTN who used SMBP in the past 12 months. Individual measurements will be averaged to generate a mean systolic and a mean diastolic SMBP reading.</td>
<td>Number of patients in denominator who supplied at least 6 SMBP measurements to the health center in the past 12 months. The 6 measurements must have occurred over a continuous 3-day period with one measurement in the morning and one in the evening (2 per day total).</td>
<td>Patients ages 18 to 85 with a diagnosis of essential HTN recorded in the EHR as an encounter assessment or in a structured field on the problem list anytime during or prior to the measurement period and seen for at least one medical visit in the past 12 months. Excludes pregnancy and ESRD.</td>
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SMBP Measure Discussion

• What measures are you using?

• How are you tying SMBP efforts/measures to PHASE activities/goals (and broader transformation efforts)?

• Should we track/compare SMBP measures across grantees?
Workflow Overview Diagram from Implementation Guide

Diagram 6: Key Individual Patient Support Activities

- Recommend patient for SMBP
- Patient agrees to do SMBP (shared decision-making)
- Refer patient to SMBP program
- Enroll/train patient in SMBP
- Provide/loan/validate BP monitor
- Pre-visit planning – flag patients identified as SMBP users
- Patient uses home BP monitor in their usual environment
- Provide outreach support to patient using SMBP
- Leverage SMBP data for care decisions
- Optional Activities Based on Model Design
  - Conduct inventory, cleaning, and validation of home BP monitors (for loaner program)
  - Refer SMBP patient per protocol to internal/community/public health resources for lifestyle/self-management support
SMBP Workflow Details

1. Criteria and Logistics for Recommending SMBP
   • What are the selection criteria?
   • How are patients identified as meeting criteria? (e.g. pre-visit planning, encounter, registry, etc.)

2. Enroll, Train, and Provide Monitor
   • What does enrollment look like?
   • When & how does patient training happen?
   • How is the monitor validated & provided?

3. Capturing and Using SMBP data
   • How do you track which patients have used or are using SMBP? (How is ‘use’ defined?)
   • How does data get from monitor to EHR?
   • How is data used for care decisions (protocol?)?

For Sharing/Discussion:
• How have you addressed?
• Success pearls?
• Questions/challenges?

Suggested Order:
• SFHN
• Livingston
• Camarena
• SNAHC
• RCHC
• Other?
Next Steps

• Assess today’s call, plan for next (timing/structure)

• Best use/organization of Dropbox?

• Discussion/sharing between calls?

• Connect at convening on November 29th?