2025 Best Practices
Controlling High Blood Pressure

Partnership Tools, Programs, and Promising Practices:

- Partnership's Pharmacy Department offers **Academic Detailing** analysis of Controlling Blood Pressure measure performance and opportunities for improvement based on prescribing and pharmacy fill data. Please contact the Pharmacy Department at RxConsult@PartnerhipHP.org if you would like to request Academic Detailing for your practice.
- Attend or view Partnership's **Improving Measure Outcomes training** on *Chronic Disease Management.*
- Refer/enroll members/patients with uncontrolled hypertension to **Partnership's Care Coordination** department. Care Coordination can assist members/patients needing additional assistance navigating the health care system to ensure they are accessing prescribed medications and follow up on referrals to nutrition therapy and other specialty care. You can refer a Partnership member to Care Coordination by calling or having the member/patient call (800) 809-1350, or by sending a secure email to CareCoordination@partnershiphp.org.
- Provider health education materials are accessible on Partnership's website or by contacting CLHE@partnershiphp.org. Providers can access flyers and member/patient materials for distribution in multiple languages.
- Partnership members can access transportation for non-emergency medical services for assistance in traveling to and from appointments. Members can access services by calling **Partnership Transportation Services** at (866) 828-2303, Monday – Friday, 7 a.m. – 7 p.m.
- Partnership's **Medical Equipment Distribution Services** offers electronic blood pressure monitors for members/patients with qualifying diagnoses from a clinical provider. Equipment can be requested by filling out a Request Form (option 2) or by contacting Request@PartnershipHP.org.
- Blood pressure monitors along with multiple cuff sizes are a covered benefit using **Medi-Cal Rx**. Ensure members/patients are equipped with blood pressure monitors and educated on the use of the monitor.

Patient Care:

- Use **Medi-Cal Rx's Contract Drug List** for a list of covered hypertensive medications.
- Measure blood pressure at all appointments, not just hypertension visits. Include repeat blood pressure readings within an appointment if out of the normal range and use the lowest diastolic and systolic measurements for recording.
- Complete regular training for clinical support teams on blood pressure collection best practices.

- For provider offices with dental services, train dental teams to take and chart blood pressure in EMR/EHR for patients with hypertension before procedures.
- Perform a manual blood pressure measurement if elevated after second measurement.
- Re-assess blood pressure every three months after the target is achieved.
- Follow-up on appointment no shows.
- Offer telehealth visits for blood pressure follow-up or hypertension management visits as appropriate.
- Run registry of patients with hypertension to ensure follow up.
- Establish a designated medical assistant to perform manual blood pressure checks when the digital monitor readings are consistently high.
- Use of multidisciplinary care team (RN, RD, pharmacist) for hypertension management.
- Implement pre-visit planning or daily huddles.
- Use standing orders for refills of blood pressure medications.
- Train care teams on treatment algorithms for patients with hypertension.
- Monitor members/patients with close systolic numbers.
- Schedule blood pressure follow-up appointment in real time for members/patients not at target within 1-2 weeks to re-assess and titrate management.
- Reassess patients at goal every three months or sooner depending on other risk factors/co-morbidities.
- Offer walk-in blood pressure checks with multidisciplinary care team/staff (e.g. RN, RD, pharmacist).
- Consider blood pressure clinics to increase opportunities to obtain multiple readings throughout the year for members with hypertension.
- Rule out if patient has white coat hypertension to ensure in office blood pressure values are evaluated in a holistic manner.
- Assess medication adherence before making treatment changes.
- Provide proper counseling of home blood pressure monitoring (e.g. not crossing legs, urinating before checking blood pressure, deep breaths before check, no talking while machine is active, arm is at resting chest level.
- Review medications (e.g. nasal decongestants) or dietary changes to rule out causes of hypertension.

Patient Education:

- Provide education on the importance of blood pressure control and the role of self-monitoring.
- Remind patients that high blood pressure is almost always silent as is control. Continuous treatment leads to control but is not a cure for hypertension.
- Remind patients to take daily blood pressure values to ensure treatment decisions are made based upon the most comprehensive data.

- Remind members/patients that some medications (namely non diuretics) are more effective when taken in the evening versus the morning.
- Remind patients to avoid using wrist-based blood pressure cuffs.
- Review steps and goals of blood pressure management.
- Emphasize the importance of adherence to medications, address barriers to adherence, and develop behavioral strategies that lead to good adherence.
- Reinforce the importance of smoking cessation, increased physical activity, low sodium diets, and medication management.
- Reassess patient's knowledge of blood pressure control (target blood pressure readings), assess barriers to adequate control (e.g., cultural, financial, language and literacy, social support, health beliefs).

Outreach:

- Conduct member/patient outreach for routine follow-up (phone call, text, email, member portal, post card/letter).
- Ensure member/patient is informed of blood pressure results and next steps.

Equity Approaches:

- Consider reviewing Controlling Blood Pressure measure compliance rates by such factors as race, ethnicity, gender, location (i.e., zip code), and preferred language, to assess if there are any barriers that affect specific communities, and plan interventions to address these barriers.
- Consider reviewing the most up to date guidelines to learn which interventions are considered safe and effective for addressing specific racial groups experiencing hypertension.
- Consider using two agents, from different drug classes, for first-line management for the majority of patients with hypertension.
- Consider calculating a patient's ASCVD 10-year risk to assess the full risk and determine treatment recommendations.
- The Disparity Analysis Dashboard in eReports provides a comparison of screening rates by race/ethnicity. This view can help you identify inequities.
- Additionally, the **Drilldown Clinical tab** in the Partnership Quality Dashboard section of eReports shows race/ethnicity information for each patient included in the measure. Export this dashboard to look at high blood pressure control rates by race and ethnicity to learn more about inequities within your patient community.
- Ensure patient educational material is consistent, welcoming, plain, and person-centered, language appropriate, and delivered in traditional and electronic applications, per patient's preference.
- Each visit should include a conversation with the patient to confirm that health information, medication management, and the next steps covered in the visit are mutually understood; patients agree with any plans made; and they have the opportunity to ask questions.

- Consider literacy and health literacy barriers, and alternative ways of providing blood pressure management and medication management instructions.
- Use approaches and partnerships that align with your practice's demographics (partner with local schools, faith-based organizations).
- Identify and address barriers to care (transportation, hours of operation, access to pharmacy services).

Data and Coding:

- Submit claims and encounter data within 90 days of service.
- Use CPT-II coding to document the systolic and diastolic blood pressure results.
- Upload blood pressure data for measure cohort during Partnership's annual upload period (10/1/2025 –1/31/2026). This is especially important if CPT-II coding for blood pressure results is not consistently completed by the provider team.
- Exclude patients as appropriate and use coding to document reason for exclusion.
- Convert narrative blood pressures into structured data to review with patient.

Helpful Links:

2025 PCP QIP Technical Specifications:

- Measure Description
- Exclusions
- PCP QIP Full Points, Partial Points, Relative Improvement Definitions
- Notes for eReports and PQD

QIP eReports Portal:

- Measure Reports
- Diagnosis Code Crosswalk Report
- QIP Member Report

Medi-Cal Rx's Contract Drug List:

- List of Covered Blood Pressure Medications and Medical Supplies
- List of Covered Blood Pressure Monitors & Cuffs (PartnershipHP.org, as of 10/2023)