Controlling High Blood Pressure

Performance Measure Set: ☐CCO Incentive Metric ☒ CCO Non-incentivized Medicaid Metric ☒Medicare Star Measure

Quality Measurement Type: ☐Structure ☐Process ☒Outcome ☐Patient Experience

Medicaid Data Type: ☐Claims ☐Chart Documentation ☒eCQM ☐Survey ☐Other

Medicare Data Type: ☐Claims ☒Chart Documentation ☐eCQM ☐Survey ☐Other

Medicaid State Benchmark: N/A

HEDIS Benchmarks National Percentile: 76.40% (75th), 81.27% (90th)

Who: All members age 18–85 years who had an essential hypertension diagnosis and at least one PCP visit in 2021.
Medicare Star Measure: All members age 18–85 years with a diagnosis of hypertension, who had at least two outpatient visits with a diagnosis of hypertension in the first six months of the measurement year and the prior year.

Why: Monitoring blood pressure for control has been shown to significantly reduce the probability of undesirable outcomes, such as heart disease, stroke, and death. High blood pressure and hypertension are the leading cause of death for Americans.

What: Percentage of members with an essential hypertension diagnosis whose most recent blood pressure reading is below 140/90 mmHg. Please note:

- only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure.
- If a member does not have a blood pressure reading recorded during 2021, their blood pressure is considered out of control and not numerator compliant.
- ***Medicare Star Measure:*** The blood pressure reading must occur on or after the date of the second diagnosis visit (only one of the two visits can be a telephone visit, an online assessment or a telehealth visit.)

How: Some ideas to improve Controlling High Blood Pressure rates:

- Re-take blood pressure at the end of each visit if the initial reading is elevated and document repeat values in vital flowsheets.
- Ensure training of clinical staff to maintain skills and accurate readings.
- Ensure the members whose blood pressure is above 140/90 mmHg have a scheduled follow-up visit with a care team member to work toward controlled bloodpressure.

Exclusions: Members with end-stage renal disease, chronic kidney disease, dialysis or renal transplant, are pregnant, or in hospice or using hospice services are excluded. Additionally, members age 66 or older who are living long-term in an institutional or enrolled in an I-SNP, or those with frailty and advanced illness are excluded, and members 81 years or older with frailty.

Medicaid Data reporting: This measure aligns with **NQF 0018/CMS 165v9**. Even though the measure is not incentivized for 2021, CareOregon must still collect data from each clinic's EHR to submit to OHA as required in the state's Medicaid Demonstration Waiver from CMS. The data is then aggregated across all clinics in the CCO region and submitted to OHA. Please note the following reporting requirements:

- Member-level detail, for CareOregon members only, is preferred.
- Reporting must be for the full calendar year of 2021; mid-year reports preferred in a rolling 12-month timeframe.
- Data must be formatted in Excel.

Please email your Quality Improvement Analyst or Primary Care Innovation Specialist with any questions about data reporting.

Controlling High Blood Pressure FAQ

Q: How do I pull the necessary EHR-based reports?

A: This measure follows the eCQM specifications used by CMS. To find out how to pull this report from your EHR please visit: https://chpl.healthit.gov/#/search and search for your EHR product, or reach out to your Primary Care Innovation Specialist.

Q: How do I submit EHR-based reports to CareOregon?

A: Reports are generally submitted to the CareOregon by SFTP or secure email. Reach out to your Quality Improvement or Primary Care Innovation Specialist for more information.

Q: What if I can't report with the necessary specifications?

A: Unfortunately, we cannot accept data that doesn't align with the eCQM or HEDIS specifications. Reach out to your Primary Care Innovation Specialist if you are concerned about reporting or have questions about the specifications.

Q: What if a patient has more than one blood pressure reading on a single day?

A: Use the lower of the two readings.

Q: The Medicaid measure doesn't align with JNC 8 recommendations for the treatment of hypertension. What if I have a large population of patients over 60 years old?

A: Although we understand the JNC 8 guidelines represent best practices and that sometimes best practices and metrics don't always align, we are accountable to the guidelines and specifications that OHA requires. We cannot provide clinical recommendations and can only provide support in reporting measures that are outlined by OHA. Reach out to your Primary Care Innovation Specialist for assistance with population reporting.

Q: What if a patient doesn't have a blood pressure recorded during the measurement period?

A: The patient's blood pressure is assumed "not controlled" if there are no blood pressure reading during the measurement year and will fall into the gap for this measure (i.e. remain in the measure denominator but not numerator compliant).