COMMUNITY HEALTH CARE ASSOCIATION of New York State

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HYPERTENSION AND CARDIOVASCULAR DISEASE PROMISING PRACTICES

April 2021

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Activities by Role

Role	Activities
 Medical Assistant/ Licensed Practical Nurse	• Pre-visit plan for telehealth/face-to-face patient visits • **Take confirmatory BPs for any BP > 140/90** • **Discuss alerts** in huddle ✓ Elevated BP and no HTN dx ✓ Missing ASCVD criteria ✓ No Statin ✓ No Self-Management
 Registered Nurse	• **Schedule BP follow up within 2 weeks of medication change** • Conduct virtual BP check (visit or home BP monitoring results) • **Provide home BP monitoring instruction/teach back** • Evaluate clinical inertia when conducting prescription refills
 Pharmacist	• **Review/discuss/manage patients with treatment inertia** • Participate in **Care Team huddles**
 Medical Provider	• Utilize evidence-based guidelines for treatment intensification • **Diagnose the undiagnosed** • **Review MAP hypertension management dashboard** • Review uncontrolled patients on panel • **Use ASCVD Risk Registry** to guide treatment when labs returned • Collaborate with care team and facilitate warm hand-offs for more in-depth education

Care Manager	• **Actively oversee/manage patients with changes in medication (cohort)** • Provide home BP monitoring instruction/teach back • **Self management goal setting/care planning** • Conduct SDOH screens • Provide education or enabling resources • Participate in **Care Team huddles**
Registered Dietitian	• **Self management focus on nutrition and weight loss** • Identify patients with out of range BMI • Participate in Care Team Huddles
Care Coordinator/ Community Health Worker	• Identify patients with undiagnosed hypertension, high risk ASCVD without treatment, hypertensive tobacco users
Front Office or Call Center	• Schedule visits for hypertensive patients with no follow up appointments (or others as identified by Care Coordinator/CHW/Care Manager)
Quality Improvement Team	• **Review panel reports with providers** (academic detailing) • **Monitor practice/, team, provider performance** • **Create cohorts** based on focus for intensification, pharmacy intervention, care management engagement

Source: Azara Healthcare and CHCANYS Webinar: Improving Patient Outcomes Through Data – Cardiovascular Tools in CPCI DRVS ASCVD and Hypertension – December 3, 2020

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2018 Guideline of the Management of Blood Cholesterol: Top 10 Take Home Messages

1. In all individuals, emphasize a heart-health lifestyle across the life course.

2. In patients with clinical ASCVD, reduce low-density lipoprotein cholesterol (LDL-C) with high-intensity statin therapy or maximally tolerated statin therapy.

3. In patients with very high-risk ASCVD, an LDL-C threshold of 70 mg/dL is used for consideration of the addition of nonstatins to statin therapy.

4. In patients with severe primary hypercholesterolemia (LDL-C $\geq$ 190 mg/dL), begin high-intensity statin therapy without calculating 10-year ASCVD risk.

5. In adults with diabetes and LDL-C $\geq$ 70 mg/dL, start moderate-intensity statin therapy without calculating 10-year ASCVD risk.

6. In adults evaluated for primary ASCVD prevention, have a clinician-patient risk discussion before starting statin therapy.

7. In adults without diabetes and a 10-year ASCVD risk of $\geq$ 7.5%, start a moderate-intensity statin if a discussion of treatment options favors statin therapy.

8. In adults 40 to 75 years of age without diabetes and 10-year risk of 7.5% to 19.9% (Intermediate risk), the presence of risk-enhancing factors favors initiation of statin therapy.

9. In adults 40 to 75 years of age without diabetes and at a 10-year ASCVD risk of 7.5% to 19.9%, if a decision about statin therapy is uncertain, consider measuring CAC.

10. Assess adherence and percentage response to LDL-C- lowering medications and lifestyle changes with repeat lipid measurement 4 to 12 weeks after statin initiation or dose adjustment, repeated every 3 to 12 months as need.

Source: New York State Cholesterol Management Forum Presentation - September 25, 2019

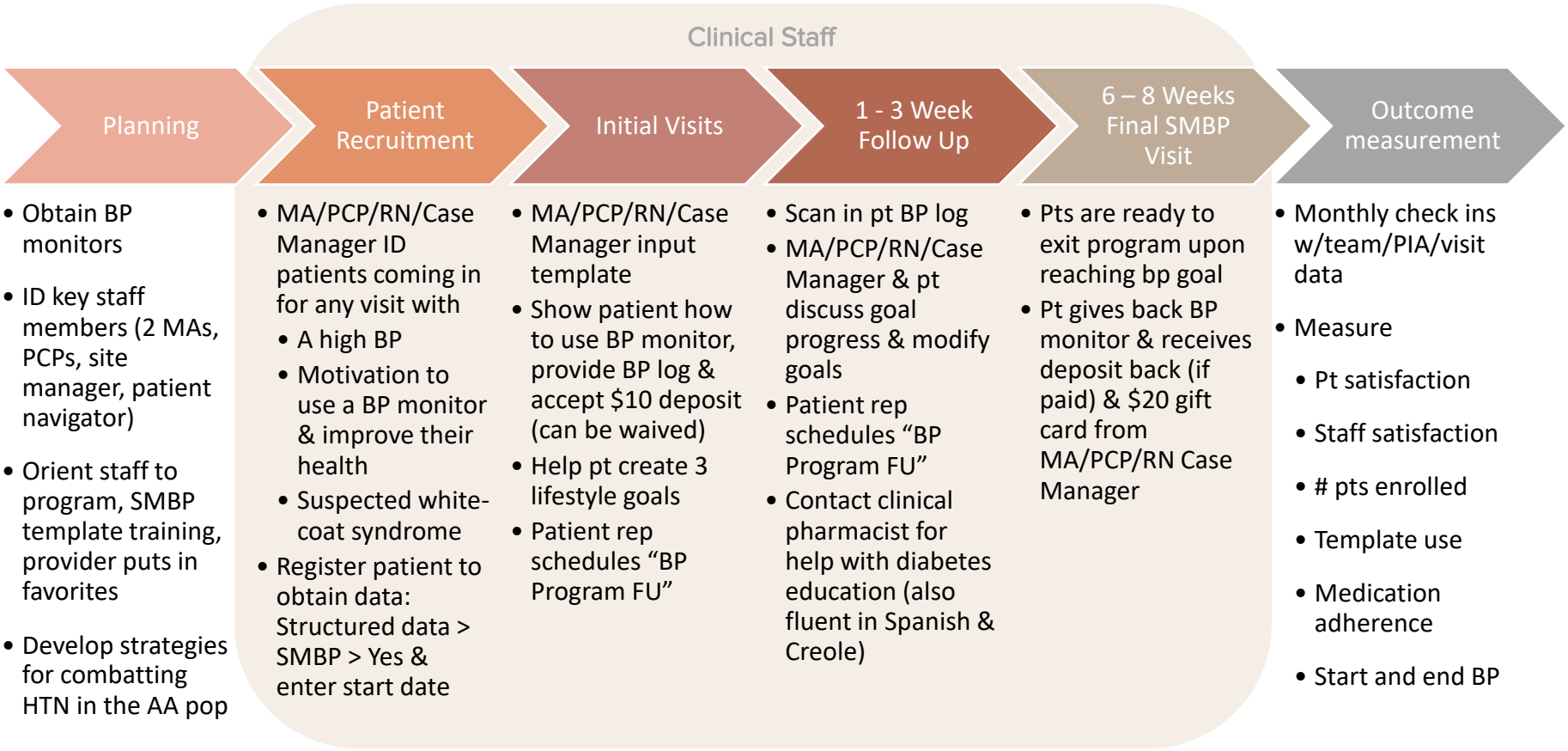
AMERICAN COLLEGE of CARDIOLOGY

NEW YORK STATE Department of Health

American Heart Association.

Zufall Health Center Self Monitored Blood Pressure (SMBP) Workflow

Presented on in the DCPC SMBP Peer-Learning Webinar – March 26, 2021



New 2020 CPT® Codes for SMBP

99473: SMBP using a device validated for clinical accuracy; patient education/training and device calibration

- Can be submitted once per device
- Must use device validated for clinical accuracy
- Often used prior to initiating SMBP with patients receiving training for the first time

99474: SMBP using a device validated for clinical accuracy; separate self-measurements of two readings, one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

- Can be submitted once monthly per patient
- Data reporting can be done in any manner
- Communication of treatment plan to the patient required

Source: Million Hearts® 2022 Value-Based Insurance Design: Opportunities for Cardiovascular Disease Prevention - February 16, 2021; Michael Rakotz, MD FAHA FAAFP, American Medical Association