Target: BP Evidence-Based Activities Resources & Examples

A Toolkit for Understanding & Attesting to All Pillar Questions

Rev. January 2025

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Additional questions? Please Contact Us.

At-A-Glance Overview of the Evidence-Based Activities Pillars

This overview provides a summary of the existing Measure Accurately (M) and the new Act Rapidly (A), Partner with Patients (P), Self-Measured Blood Pressure (SMBP), and Equitable Health Outcomes (EHO) 'pillars' for quality improvement.

- Each pillar contains:
  - an element of **institutional policy** to promote the formal definition of systematic care
  - an element of **practice assessment** to examine team performance and identify areas for quality improvement
  - specific **content with strong scientific evidence** to improve BP control
- The complete attestation questions, supporting scientific references, existing tools and resources, and examples of what would or would not meet the criteria to support achievement can be found on the remainder of the document.
  - Each attestation question will require a Yes/No/Unsure answer option

Measure Accurately	Act Rapidly	Partner with Patients	Self-Measured Blood Pressure	Equitable Health Outcomes
Calibrate devices per guideline	Adopt a treatment algorithm	Adopt a modifiable lifestyle risk factor policy	Adopt a policy to prepare patients for SMBP	Adopt a policy to gather race / ethnic data
Check device validation	Monitor care team adherence to algorithm	Monitor care team adherence to policy	Monitor care team adherence to policy	Adopt a policy to gather SDOH
Train team in BP measurement	Specify a treatment goal of <130 / 80 mm Hg*	Assess modifiable lifestyle risk factors - nutrition, physical activity, weight	Train patients in measurement technique and device use	Train care team to gather data per policy
Test team in BP measurement	Intensify treatment if not at goal	Intervene with modifiable lifestyle risk factors - nutrition, physical activity, weight	Establish a measurement schedule	Monitor care team adherence to policy(s)
Adopt protocol for repeat measurement	Use single pill combos or other Rx adherence strategies	Assess modifiable lifestyle risk factors – alcohol and tobacco use	Receive and average readings to inform diagnosis and treatment decision	Stratify BP control rate data by 2 sub-groups
Post infographic where BP is measured	Follow-up within 1 month if not at goal	Intervene with modifiable lifestyle risk factors - alcohol and tobacco use	Use SMBP with 30 or 10% of patients with hypertension*	Examine data for gaps and take action

**for adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher*

**whichever is larger*

MEASURE ACCURATELY ("M" PILLAR)

"M" Questions

Measure Accurately - Evidence-Based Blood Pressure Measurement Activities:

I attest that my organization:

- ☐ Calibrates all BP measurement devices per manufacturer recommendation including manual aneroid or oscillometric, semi-automated, or fully automated devices.
- ☐ If using semi/fully automated devices, check the US Blood Pressure Validated Device Listing (VDL™) or other reliable source to see if they are validated for clinical accuracy. Report the percent of devices that are currently validated.
- ☐ Strengthens BP measurement knowledge every 6-12 months for all staff who measure blood pressure or train staff to measure blood pressure using *Achieving Accuracy BP Measurement e-learning module*, OR *Measuring Blood Pressure Accurately – Step 1 in Hypertension Control* (free webinar), OR another structured curriculum.
- ☐ Tests staff's BP measurement skills every 6-12 months (using the Technique Quick Check Tool OR similar objective assessment).
- ☐ Uses a blood pressure measurement protocol to consistently obtain accurate BP measurements, including confirmatory repeat in-office BP measurements – OR – ambulatory blood pressure monitoring – OR – home blood pressure monitoring with self-measured blood pressure when indicated.
- ☐ Posts a positioning graphic, such as the In-Office Measuring Blood Pressure Infographic, next to every place where blood pressures are taken.

"M" Examples

Examples of what actions would satisfy the intent of the attestation criteria.

These examples are not the only ways that the criteria can be met or not met but help illustrate the intent of the criteria and provide ideas for achieving these evidence-based practices.

"M" Attestation Criteria	✓ Example(s) that meets the intent of the criteria	✗ Example(s) that does not meet the intent of the criteria
Calibrate all BP measurement devices per manufacturer recommendation including manual aneroid or oscillometric, semi-automated, or fully automated devices.	✓ My clinic has 30 regularly used BP devices: 20 home BP devices (Omron 3 series, model BP710N) used for a self-measured blood pressure loaner program, and 10 wall-mounted clock aneroid sphygmomanometers. Every year, we ship the 20 home BP devices to Omron for recalibration. We do regular in-house checks of our wall-mounted devices, and every 6 months, we ship the wall- mounted devices to their manufacturer, Welch Allyn, for re-calibration. This counts as completing 1 activity, because ALL devices are calibrated per the recommended timelines.	✗ My clinic has 12 regularly used BP devices: 12 mobile aneroid sphygmomanometers. Once a year, we pass off to our parent hospital's biomedical engineering department for calibration. This does not count as completing 1 activity – mobile aneroid devices should be calibrated every 2-4 weeks. ✗ My clinic has all oscillometric devices - 10 in-office and 20 loaner devices. We calibrate the in-office devices annually per manufacturer recommendation. This does not count since the loaned devices (which are owned by the HCO) are not calibrated.

"M" Attestation Criteria	✓	✗
If using semi/fully automated devices, check the US Blood Pressure Validated Device Listing (VDL™) or other reliable source to see if they are validated for clinical accuracy. Report the percent of devices that are currently validated.	✓ My clinic has 15 home BP devices (Omron 3 series, model BP710N) and 10 wrist BP monitors (Omron 3 series, model BP6100) for a total of 25 automated devices. Looking at ValidateBP.org, I see that my 15 home devices are on the list (BP7100 is the newer model of BP710), but the 10 wrist cuffs are not. 60% of my devices (15/25) are validated. I'll select "51-60" as the percentage in the data platform. **– OR –** ✓ My clinic has 10 wireless upper arm BP monitors (Omron Evolv®, model BP7000). These devices are not listed on ValidateBP.org or similar resources. 0% of my devices are currently validated. I'll enter "0" as the percentage in the data platform. **– OR –** ✓ My clinic has no semi/fully automated devices, but we have reviewed the validated device listing for consideration of future oscillometric device purchases.	✗ My clinic has not checked to see if our devices are validated for clinical accuracy so I selected "Unsure."
Strengthen BP measurement knowledge of all staff who measure BP and who train staff to measure BP in your clinic every 6-12 months.	✓ My clinic has hosted a series of watch parties of the "Measure Accurately" webinar during our monthly lunch-n-learns in March 2023. Staff were also given the option to watch on their own and submit their CE certificate so we could track completion. All of our staff either attended in person or completed the on-demand webinar.	✗ My clinic only has new employees attend a 1-time orientation session on blood pressure measurement.
Test staff BP measurement skills every 6-12 months.	✓ My clinic has an annual competency evaluation that includes BP measurement, blood glucose monitoring, and other skills. All staff have to demonstrate each skill to a peer for sign off and then give the completed checklist to their manager.	✗ My clinic only completes a one-time competency test for newly licensed or graduated healthcare professionals.

"M" Attestation Criteria	✓	✗
Use a blood pressure measurement protocol to consistently obtain accurate BP measurements including confirmatory measurements through repeat in-office BP measurements – OR – ambulatory blood pressure monitoring – OR – home blood pressure monitoring with self-measured blood pressure (SMBP) when indicated.	✓ My clinic follows a written, standardized protocol for in-office measurement including rest periods and repeat measurements for elevated BPs. We don't have 24-hour Ambulatory Blood Pressure monitoring, but we use Self-Measured Blood Pressure when confirming a diagnosis.	✗ My clinic allows each staff member to take blood pressures based upon their preferred technique and if they have time for a repeat measurement.
Post the In-Office BP Measurement Infographic next to every place where blood pressures are taken.	✓ My clinic posts the English and Spanish poster in every exam room next to the wall-mounted blood pressure devices. **– OR –** ✓ My clinic hangs a laminated poster on every wheel-mounted AOBP device that are used to take routine blood pressures. **– OR –** ✓ My clinic uses the positioning graphic as our screen saver on every exam room computer.	✗ My clinic posts the positioning graphic in the waiting room and staff break room.

"M" Rationale & Frequently Asked Questions

Specific Recommendations from the 2017 AHA/ACC Hypertension Guideline:

4.1 Accurate Measurement of BP in the Office

COR	LOE	Recommendation
I	C-EO	For diagnosis and management of high BP, proper methods are recommended for accurate measurement and documentation of BP (Table 8 in the Guideline).

- The 2019 AHA Scientific Statement Blood Pressure Measurement in Humans provides additional details regarding the causes of inaccurate measurement (such as device accuracy, cuff fitting, and proper positioning), the risks associated under/over estimation (such as under/over diagnosis and treatment), and strategies to increase accuracy.

Calibration FAQs

Which devices should be evaluated for validation and calibration?
At a minimum, the devices used in outpatient or ambulatory settings for the purpose of diagnosing and managing patients with hypertension at the locations for which you are submitting data should be evaluated for validation and calibration for the purpose of this award. However, we recommend all devices in your HCO be validated and calibrated.

Our aneroid wall mounted BP devices per the manufacturer have a lifelong certified calibration. Our biomedical department does not calibrate them. Is it OK to answer "Yes" to this question?
Many aneroid devices have a lifetime warranty for calibration. When they are tested and found to be out of calibration, the repair/replacement is warrantied and free. However, that does not mean the device will be forever in calibration, as that is physically impossible for an aneroid device. These devices should still be checked for accuracy regularly and re-calibrated or replaced if found to be out of calibration, a service that could be provided by internal biomed/clinical engineering personnel or the device manufacturer or a 3rd party calibration provider. If the devices are checked for accuracy per the recommended timeline, then answering "Yes" to this question is appropriate.

Do the calibration and validation criteria apply to SMBP devices that patients are using at home to manage their hypertension?
You should include SMBP devices if your HCO is giving or loaning devices to patients for home blood pressure monitoring. Devices that patients are acquiring on their own and using for home blood pressure monitoring do not need to be included as part of this assessment. However, we highly encourage you to advise patients to choose validated devices to ensure equitable access to the standard of care.

If my manual device is mounted on wheels, is it considered handheld or wall-mounted for the purpose of calibration frequency?
Consult your device instructions or the manufacturer for guidance on the device calibration frequency. This will typically be closer to that of a wall-mounted aneroid device than a handheld aneroid device. If the device is automated and mobile, follow the guidance for calibrating automated devices.

How can I figure out if my devices are oscillometric or aneroid?
Aneroid sphygmomanometers typically have a dial gauge and require manual cuff inflation, deflation and auscultation with a stethoscope to render a BP reading. Oscillometric devices typically have a digital screen and have automated cuff inflation. Consult the BP Scientific Statement and/or the manufacturer for additional clarification.

What if my devices are neither oscillometric or aneroid (e.g., wearable devices)?
Per the BP Scientific Statement, "Although current noninvasive techniques for cuffless BP monitoring have demonstrated substantial advances, the lack of accuracy and calibration issues limit their current utility." Please select "No aneroid devices" and "No oscillometric devices" on Q10(a) and Q10(b).

What if my HCO uses wrist cuffs?
Per the BP Scientific Statement, "although convenient for the consumer, wrist monitors provide many challenges with precision, and strong reservations have been raised about their use in routine clinical practice, unless measurements in the upper arm are not feasible." Refer to https://targetbp.org/tools_downloads/using-a-wrist- cuff-to-measure-blood-pressure/. Please include your wrist cuffs when considering your answers to the calibration and validation questions. Of note, several wrist cuffs have been added to the VDL.

Do blood pressure kiosks count?
Per the BP Scientific Statement, "Kiosk measurements, which are a form of self-measured BP, can be useful, especially for BP screening, as long as the device is appropriately validated and calibrated." Please include your kiosks when considering your answers to the calibration and validation questions.

When devices are out of calibration, or due for calibration, we order new devices from the validated list. Does this count as a 'Yes?'
The spirit of the calibration criteria is to ensure that the devices being used for BP measurement are routinely checked/ adjusted for accuracy through normal use, wear and tear. Typically, this is achieved through routine

maintenance, but replacing devices according to the needed calibration frequency satisfies the spirit of the criteria.

Who should I ask within my HCO to verify that devices are calibrated?
Biomedical or clinical engineers typically inventory and check equipment or check with Equipment and Supplies Manager. Of note, calibration involves a visual assessment of the:

- Cuff to ensure that the sizing markers are visible, the Velcro is functional, etc.
- Tubing and bladders to ensure they are free of cracks or leaks
- Dial on an aneroid device, which typically has calibration window that can be used as a visual indicator of calibration status

In addition to visual assessment, calibration involves a pressure assessment to evaluate inflation and deflation control and exhaust time. Consult with your biomedical / clinical engineering professionals about the protocols they use to assess the internal function of the aneroid device. For oscillometric devices consult with the device manufacturer.

What resources exist to help with device calibration?
Start by contacting your biomed professional or department. If this expertise doesn't exist in-house, contact your device manufacturer for calibration requirements and training resources that are specific to your devices. The manufacturer might also have recommendations for reputable or certified local, 3rd party biomedical engineering service providers

If we do not have the resources to send devices out for calibration, what are our calibration options?
First, contact the BP manufacturer for guidance. They may offer calibration services. If this is not available, consider making this a quality improvement opportunity and evaluate options to prioritize resources in the future through different budgetary allocation or grant-seeking opportunities.

Validation FAQs

What if my device is not on any list of validated BP devices?
The intent of asking if devices are validated for clinical accuracy is to raise awareness regarding the importance of using validated devices and provide reference resources for checking your equipment. When HCOs need to or can replace or expand their BP devices, the VDL can be a useful resource. HCOs are asked to report on the percentage of devices that are validated (estimates acceptable).
However, this award criterion does NOT require meeting a minimum threshold or target percentage of validated devices. HCOs will not be penalized for not having validated equipment. This criterion highlights an opportunity for improvement to strengthen BP measurement accuracy.

What if my exact model number is not on the VDL?
If the exact model number cannot be matched on any validated device list, then you cannot assume it has been validated. It is possible that the device is validated, and the manufacturer has not submitted validation data to the VDL. Of note, the VDL is fairly new, so more devices are being added over time as manufactures submit their validation data to be reviewed for listing.
FDA clearance is not the same as validation.

Can I use more than one list to verify my devices are validated?
Yes, you can use any/all of these lists to see if your devices are validated: ValidateBP.org, Hypertension Canada, Stride BP, and/or British and Irish Hypertension Society

I do not have access to the information needed to determine if our devices are validated or not. What should I enter?
Work with other knowledgeable staff, including clinical and biomed colleagues to determine an estimate. If you are unable to determine any estimate, select "Not sure." We hope this will be an opportunity to advocate within your organization for determining whether or not devices are validated for clinical accuracy.

We have not tracked device validation in our Health Care Organization previously. Do you have a sample tracker or process for making sure that none are missed?
Consider tracking through an existing asset inventory system used by your HCO (often with unique device ID's or barcodes). If this is not available, consider a simple spread sheet can be used to track devices such as the example on the next page:

	Date of Purchase	Manufacturer	Model Name	Model #	Type	Asset Inventory #	Location of Use	Validated	Device Listing Used	Frequency of Calibration Needed	Last Calibrated On Date	Next Calibration Due Date
Response Format (Device ID or Barcode)	Date: X/X/XXX	Name	Name	#	Hand-held Aneroid, Wall-Mounted Aneroid, Oscillometric, ABPM, Wrist Kiosk, Other	#	Dept, Clinic, Exam Rm #	Y/N	US VDL, HTN Canada, British & Irish HTN Society, StrideBP	q2-4 wks if handheld aneroid; q6 mo if wall-mounted aneroid; usually q1-2 for oscillometric; other	Date: X/X/XXX	Date: X/X/XXX
1												
2												
3												
4												
5												
Etc.												

Knowledge & Skills

What is the difference between knowledge and skills?
Strengthening BP measurement knowledge improves individuals' understanding of the importance of accurate BP measurement, factors that contribute to inaccurate measurement, and approaches for improving accuracy. Skills testing ensures that individuals can translate knowledge into practice by demonstrating the psychomotor skills to perform a BP measurement and the cognitive skills to operate the equipment and assess/guide proper positioning.

Can the curriculum be provided by internal staff or an external source?
Yes, the structured curriculum can be delivered through internal or external sources.

Can the curriculum be live, recorded, written, or through a computer-based learning module?
Any format is acceptable, but completion of training should be systematically tracked. For example, many HCOs document training in employee files.

Does annual training need to be a CME/CE-accredited event? Can I claim credit more than once from an event recording?
CME/CE credit is not required as part of annual BP measurement training, but certainly provides a welcome incentive for health professionals. Due to ACCME and AACN continuing education regulations, CME/CE credit is typically claimed once for a specific live or enduring/recorded event, unless the event has been recertified by the accredited host organization. However, the event can be re-watched without claiming CME/CE credit to satisfy the spirit of annual BP measurement training for Target: BP award achievement.

How can I tell if my institution is carrying out these educational activities?
Refer to your HCO's continuing education or skills/competency requirements. Often these records are tracked through staff managers and/or human resources departments.

What does skill assessment entail?
Skill assessment means that the skill is demonstrated to an observer using a BP measurement device on a patient or actor/ standardized patient. Common formats for skills assessments include competency or skills fair, individual skills competencies checklist with a mentor or peer sign-off, initial staff orientation, annual skills assessment, or simulation/practice lab stations.

BP Measurement System of Care

Does the positioning graphic need to be a particular size or color?
It needs to be legible to providers, staff, and patients from a few feet away. It does not need to be in color.

What are other examples of infographics that serve as a visual reminder?
The visual reminder needs to be legible and clearly identify proper protocol according to Table 4 and 5 in the BP Scientific Statement, "Body Position and BP Measurement". For example, the visualization should address the importance of an empty bladder, feet on the floor, back supported (not seated on exam table), legs uncrossed, cuff over BARE arm, proper cuff size, arm supported with cuff at heart level, and silence and stillness during readings.

Can the infographic contain text only, or does it need to include a drawing or photo of an individual in the proper BP measurement position?
We highly recommend using a picture as the strongest visual reminder to patients and professionals alike.

What if my organization cannot post anything on the walls due to safety criteria (e.g., need frames, etc.)?
There needs to be a visual reminder adjacent to the BP device or measurement station. It does not have to be on the wall. For example, it could be placed on the surface where the patient's arm rests, on the desk, used as a computer screen-saver, or it could be laminated and hanging from the BP monitor stand.

What if my practice can only post graphics that have been branded by our health system? Can we add our logo to the Target: BP positioning graphic?
Target: BP materials cannot be co-branded, but they are freely available for download, printing, and use. They could be put in a 'frame' that has your HCO logo or identity.

What if my practice does not have a 24-hour ambulatory blood pressure monitor?
BP measurements can also be confirmed using in-office repeat measurement or using home BP monitoring with SMBP.

What constitutes an appropriate in-office confirmatory measurement?
If the initial BP reading is high, take 1-3 additional readings one to two minutes apart and average those repeat measurements. Document both the initial BP readings and the average of the confirmatory measurements in the vitals field in the EHR. If only one confirmatory BP measurement is taken, average the initial with the confirmatory per the 2017 ACC/AHA Guideline for High Blood Pressure in Adults.

"M" Resources

Recommendations for timing of device calibration:

- For aneroid devices:
  - Wall-mounted devices: Every 6 months
  - Mobile devices: Every 2-4 weeks
  - See 2019 BP Scientific Statement – see sub-section "AneroidSphygmomanometers" under "BP Measurement in the Office" on page e38.
- For oscillometric devices: Every 1-2 years (follow manufacturer's guidance)
  - See 2019 BP Scientific Statement – see section "DeviceCalibration" on page e55.
- Consult with the site's biomedical engineering resource or the equipment manufacturer for device- specific guidance.

Resources for reporting validating BP devices:

Ensure that model #'s match, especially if using international resource when products may have different names:

- US Blood Pressure Validated Device Listing (VDL™) – this new list has a limited, but growing # of devices, so you might need to check additional lists below
- Hypertension Canada
- Stride BP
- British and Irish Hypertension Society

Resources for strengthening staff knowledge every 6-12 months:

- Achieving Accuracy: BP Measurement e-learning module (small fee), OR
- Measuring Blood Pressure Accurately – Step 1 in Hypertension Control (free webinar), OR
- Another structured curriculum (must be 30 minutes at a minimum)
  - Similar trainings could include (but are not limited to): Internal or external educational event lasting a minimum of 30 min addressing the content included in Table 1-5 of the BP Scientific Statement.

Resources for testing staff BP measurement skills every 6-12 months:

- Technique Quick Check Tool
- Similar objective skill demonstration assessments could include (but are not limited to):
  - New Employee Blood Pressure Measurement Initial Competency Checklist (HealthPartners) from Million Hearts
  - Quarterly Blood Pressure Auditing Tool (HealthPartners) from Million Hearts
  - Table 8. Checklist for Accurate Measurement of BP. 2017 ACC/AHA Guideline for High Blood Pressure
  - Another internally or externally developed skills checklist for an observer to assess a staff member demonstrating BP measurement skills that are addressed in Tables 1-5 of the BP Scientific Statement
  - Common formats for skills assessments include competency or skills fair, individual skills competencies checklist with a mentor or peer sign-off, initial staff orientation, annual skills assessment, or simulation/practice lab stations.

Resources for using a guideline-driven BP measurement protocol:

Examples of BP measurement protocols include (but are not limited to):

- Target: BP Blood Pressure Measurement Policy & Procedure Template
- Standard Workflow for BP Check, ThedaCare from Million Hearts
- Walk-in Medical Assistant Blood Pressure Check Protocol, Kaiser Permanente from Million Hearts

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ACT RAPIDLY ("A" PILLAR)

"A" Questions

Act Rapidly - Evidence-Based Hypertension Treatment Protocol Adoption & Use:

I attest that my organization uses a practice-wide[1] hypertension treatment protocol that includes (at a minimum):

- ☐ Formal approval and systematic[2] implementation into clinical practice
- ☐ Monitoring[3] to assess the use of the protocol in practice
- ☐ A blood pressure control treatment goal of <130 /80 mm Hg for adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher
- ☐ Prompts for clinicians/prescribers to intensify treatment with additional medication classes or increased doses for patients with/who have uncontrolled hypertension
- ☐ Strategies designed to improve patient adherence such as once-daily dosing and single-pill combinations when appropriate
- ☐ Follow-up contact within a 1-month period for patients with Stage 1-2 hypertension who have not yet reached their hypertension treatment goal

1- The intent of "practice-wide" protocol means that the protocol (or algorithm) has been formally adopted, is systematically available across care settings where the patient population being reported in your control rate is receiving care, which could be, for example, an individual clinic site or an entire health system.

2 – "Systematic implementation" could be through integration into the EMR, a paper-based record or tool, or other means that provide consistent access to the standard of care for every patient.

3 - "Monitored/Monitoring" can be achieved through means such as but not limited to manual chart review sampling or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a level of adherence to the policy/protocol.

NOTE: For each new evidence-based pillar, HCOs must attest "Yes/No/Unsure" to each.

"A" Examples

Examples of what actions would satisfy the intent of the attestation criteria.

These examples are not the only ways that the criteria can be met or not met but help illustrate the intent of the criteria and provide ideas for achieving these evidence-based practices.

"A" Attestation Criteria	✓ Example(s) that meets the intent of the criteria	✗ Example(s) that does not meet the intent of the criteria
Formal approval and systematic[2] implementation into clinical practice	✓ The administrative and/or clinical leadership that oversees the entity for which the data are submitted has approved and endorsed the use of a specific standard of care for the diagnosis and treatment of hypertension (i.e., protocol, algorithm, order set). **– AND –** This standard is made systematically available through electronic or paper distribution channels to all clinicians who diagnose and treat patients with hypertension.	✗ The standard has not been approved through the process in which other clinical standards are defined and implemented in your HCO. **– OR –** ✗ The standard is not implemented in all locations where clinicians are diagnosing and treating patients with hypertension in the entity for which the data are submitted (i.e., a few primary care sites, but not all).
Monitoring[3] to assess the use of the protocol in practice	✓ Using electronic health record or population health tools to examine if the standard is being followed using 1 or more of the other attestation criteria in this pillar (i.e. using a BP goal of <130/80, evidence of adding a medication class if a patient is not at goal, using single-pill combinations with patients on 2 or more medications, scheduling a f/u visit within 1 month if not at goal). **– OR –** ✓ Performing manual chart review on a sample of records that includes all clinicians who diagnose and treat patients with hypertension for the entity submitting data and examining 1 or more of the attestation criteria in this pillar.	✗ Implementing a standard of care, but not examining if the standard is being followed. **– OR –** ✗ Monitoring adherence to a standard of care without the intent to improve performance. **– OR –** ✗ Sampling charts of only some of the clinicians who care for patients with hypertension. **– OR –** ✗ Having no way to measure if the standard of care is being performed.

	NOTE: This does NOT require a specific level of adherence to the standard. The intent is that HCOs are examining adherence to the standard with the goal of minimizing variation in practice.	
A blood pressure control treatment goal of <130 /80 mm Hg for adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher	✓ Stating thresholds for the diagnosis and treatment of hypertension that align with the 2017 AHA/ACC Hypertension Guideline. **NOTE**: This patient treatment goal (<130/80 mmHg) is NOT the same threshold that is used in the current performance measure (CMS 236 / NQF 18) for reporting population control rates (<140/90mmHG).	× Stating thresholds for the diagnosis and treatment of hypertension that align with the JNC 8 or earlier Hypertension Guideline.
Prompts for clinicians/prescribers to intensify treatment with additional medication classes or increased doses for patients with/who have uncontrolled hypertension	✓ An algorithm or clinical standard that prompts a clinician to add a class of medication if the current regimen is deemed to be insufficient in achieving a patients BP goal.	× Having no systematic approach to nudge clinicians to intensify treatment if a patient is not at their BP goal.
Strategies designed to improve patient adherence such as once-daily dosing and single-pill combinations when appropriate	✓ An order set that includes single-pill combinations that are available on your pharmacy formulary or are commonly covered by the payers serving your patient population. **– OR –** ✓ A protocol that prompts clinicians to simplify drug regimens when possible. **– OR –** ✓ A protocol that includes providing patients with education (from a physician, nurse, or pharmacist) to understand the actions and importance of their medications as well as insights into possible side effects. **– OR –** ✓ An order set that considers the relative cost of medications and assesses patients for their ability to afford their medication. **– OR –** ✓ Prescribing and pharmacy procedures that synchronize prescription refills and/or offer a 90-day supply.	× A hypertension protocol that does not include any stated or embedded strategies to improve medication adherence.

"A" Attestation Criteria	✓	✗
Follow-up contact within a 1-month period for patients with Stage 1-2 hypertension who have not yet reached their hypertension treatment goal	✓ An automatic prompt to reschedule patients for follow-up within 1 months' time if they are not at their BP goal.	✗ A clinical process that prompts patients to return in a period longer than 1 month if their BP is not at goal (i.e., in 6 weeks, 6 months, or annually). **– OR –** ✗ No standardized approach to follow-up for patients not at their BP goal.

'A' Frequently Asked Questions

What is the difference between the diagnosis threshold, treatment goal, and performance measure for hypertension?

Each number has a different systolic and diastolic blood pressure, purpose, and role:

- **Diagnosis threshold:** <120 / <80 mmHg is the threshold for determining normal blood pressure in clinical practice.
- **Treatment goal:** <130 / 80 mmHg is the recommended treatment goal for *individual adult patients* with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher as defined by the 2017 ACC/AHA Hypertension Guideline. Treatment algorithms should include this stated goal in order to attest "yes" to the new evidence-based criteria.
- **Performance measure:** <140 / 90 mmHg is the threshold defined by the National Committee for Quality Assurance used in performance measures CMS 165 or MIPS 236 to determine blood pressure control rates for a patient population. This national standard will continue to be the metric used for reporting BP control rates for Target: BP awards.

What if our older patients can't tolerate a goal of systolic blood pressure <130?

The 2017 ACC/AHA Hypertension Guideline does recommend (COR-1 LOE-A) treatment of hypertension with a SBP treatment goal of less than 130 mm Hg for noninstitutionalized ambulatory community-dwelling adults (≥65 years of age) with an average SBP of 130 mm Hg or higher. However, each patient should be assessed individually for their tolerance. Guidelines and algorithms are not a substitute for clinical judgement.

"A" Rationale & Guideline Recommendations

Rationale:

The 2017 AHA/ACC Hypertension Clinical Practice Guideline recommends:

- Use of systematic, team-based, stepped-care protocols to improve BP control (12.4.2)
- An organized system of regular review to improve quality of care (12.4.2)
- Using a BP target of <130/ <80 mmHg for adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher AND for adults with confirmed hypertension, without additional markers of increased CVD risk. (8.1.2)
- Intensifying treatment with additional medication classes or increased doses to achieve BP control (8.1.2)
- Use of once daily and combination pills to improve medication adherence (12.1.1)
- Monthly follow-up and reevaluation of patients with Stage 1-2 hypertension who are not yet at their BP goal (8.1.3)

Specific Recommendations from the 2017 AHA/ACC Hypertension Guideline:

12.4.2. Quality Improvement Strategies

COR	LOE	Recommendation
IIa	B-R	Use of quality improvement strategies at the health system, provider, and patient levels to improve identification and control of hypertension can be effective.

8.1.2. BP Treatment Threshold and the Use of CVD Risk Estimation to Guide Drug Treatment of Hypertension

COR	LOE	Recommendations
I	SBP:A DBP: C-EO	Use of BP-lowering medications is recommended for secondary prevention of recurrent CVD events in patients with clinical CVD and an average SBP of 130 mm Hg or higher or an average DBP of 80 mm Hg or higher, and for primary prevention in adults with an estimated 10-year atherosclerotic cardiovascular disease (ASCVD) risk of 10% or higher and an average SBP 130 mm Hg or higher or an average DBP 80 mm Hg or higher.
I	C-LD	Use of BP-lowering medication is recommended for primary prevention of CVD in adults with no history of CVD and with an estimated 10-year ASCVD risk <10% and an SBP of 140 mm Hg or higher or a DBP of 90 mm Hg or higher

12.1.1. Antihypertensive Medication Adherence Strategies

COR	LOE	Recommendations
I	B-R	In adults with hypertension, dosing of antihypertensive medication once daily rather than multiple times daily is beneficial to improve adherence.
IIa	B-NR	Use of combination pills rather than free individual components can be useful to improve adherence to antihypertensive therapy.

8.1.3. Follow-Up After Initial BP Evaluation

COR	LOE	Recommendations
I	B-R	Adults with an elevated BP or stage 1 hypertension who have an estimated 10-year ASCVD risk less than 10% should be managed with nonpharmacological therapy and have a repeat BP evaluation within 3 to 6 months.
I	B-R	Adults with stage 1 hypertension who have an estimated 10-year ASCVD risk of 10% or higher should be managed initially with a combination of nonpharmacological and antihypertensive drug therapy and have a repeat BP evaluation in 1 month.
I	B-R	Adults with stage 2 hypertension should be evaluated by or referred to a primary care provider within 1 month of the initial diagnosis, have a combination of nonpharmacological and antihypertensive drug therapy (with 2 agents of different classes) initiated, and have a repeat BP evaluation in 1 month.

I	B-R	For adults with a very high average BP (e.g., SBP ≥180 mm Hg or DBP ≥110 mm Hg), evaluation followed by prompt antihypertensive drug treatment is recommended.
IIa	C-EO	For adults with a normal BP, repeat evaluation every year is reasonable.

8.3.1. Follow-Up After Initiating Antihypertensive Drug Therapy

COR	LOE	Recommendation
I	B-R	Adults initiating a new or adjusted drug regimen for hypertension should have a follow-up evaluation of adherence and response to treatment at monthly intervals until control is achieved.

Source: 2017 AHA/ACC Hypertension Clinical Practice Guideline

Additional "A" Resources

- Act Rapidly Quick Start Guide
- VA/DoD Clinical Practice Guidelines
- AMA Hypertension Medication Treatment Protocol
- 2022 Medication Adherence and Blood Pressure Control - A Scientific Statement from the American Heart Association

PARTNER WITH PATIENTS ("P" PILLAR)

"P" Questions

Partner with Patients (P) - Modifiable Lifestyle Risk Factor Assessment and Non-Pharmacological Intervention:

I attest that my organization provides risk-factor assessment and non-pharmacological interventions for patients with hypertension to support positive lifestyle changes that includes a systematic[2]:

- ☐ Policy and/or procedure for the assessment of risk-factors and use of non-pharmacological interventions
- ☐ Monitoring[3] to assess the use of the policy in practice
- ☐ Assessment of nutrition, sodium, and potassium intake, physical activity, weight, and body mass index or other indicators of obesity
- ☐ Intervention[4] to improve nutrition, reduce sodium intake, and increase dietary potassium intake, increase physical activity and reduce weight
- ☐ Assessment of alcohol consumption and tobacco use
- ☐ Intervention to address alcohol moderation/cessation and tobacco cessation

2 – "Systematic implementation" could be through integration into the EMR, a paper-based record or tool, or other means that provide consistent access to the standard of care for every patient.

3 - "Monitored/Monitoring" can be achieved through means such as but not limited to manual chart review sampling or analysis of EMR or population health data, at least annually to assess If the policy/protocol is being followed. This requirement does not specify a level of adherence to the policy/protocol.

4 – "Intervention" includes, but is not limited to education, counseling, and/or referral such as educational hand-outs, consultation with a Registered Dietitian, participation in an exercise or cooking class, use of physical activity and nutrition prescriptions, or referral to tobacco cessation program.

"P" Examples

Examples of what actions would satisfy the intent of the attestation criteria.

These examples are not the only ways that the criteria can be met or not met but help illustrate the intent of the criteria and provide ideas for achieving these evidence-based practices.

"P" Attestation Criteria	✓ Example(s) that meets the intent of the criteria	✗ Example(s) that does not meet the intent of the criteria
Policy and/or procedure for the assessment of risk-factors and use of non-pharmacological interventions	✓ A clinical policy and procedure that defines a standard of care to assess every patient with hypertension for modifiable lifestyle risk factors at least annually. **– AND –** A standardized assessment tool (i.e., a history form or structured electronic health record fields) to assess modifiable risk factors. **– AND –**	✗ No defined standard of care to systematically assess patients for modifiable risk factors. **– OR –** ✗ No structure approach to gather assessment. **– OR –** ✗ No defined standard of care for intervening.

	A standard to intervene in response to the identified risk factors (i.e., motivational interviewing techniques, patient education materials, referrals for dietary, physical activity, or substance use counseling).	
"P" Attestation Criteria	✓	✗
Monitoring[3] to assess the use of the policy in practice	✓ Using electronic health record or population health tools to examine if the standard is being followed such as documentation of risk factor assessments and documentation of interventions when risk factors are identified. **– OR –** ✓ Performing manual chart review on a sample of records that includes all care team members who are responsible for risk factor assessments and interventions. **NOTE:** This does NOT require a specific level of adherence to the standard. The intent is that HCOs are examining adherence to the standard with the goal of minimizing variation in practice.	✗ Implementing a standard of care, but not examining if the standard is being followed. **– OR –** ✗ Monitoring adherence to a standard of care without the intent to improve performance. **– OR –** ✗ Sampling charts of only some of the care team members who are responsible for risk facto assessment and intervention. **– OR –** ✗ Having no way to measure if the standard of care is being performed.
Assessment of nutrition, sodium, and potassium intake, physical activity, weight, and body mass index	✓ Using a standardized assessment tool to identify modifiable risk factor for patients with hypertension that includes nutrition, sodium, and potassium intake, physical activity, weight, and body mass index.	✗ Not assessing modifiable risk factors. **– OR –** Only assessing for some, but not all the modifiable risk factors including nutrition, sodium, and potassium intake, physical activity, weight, and body mass index.
Assessment of alcohol consumption, and tobacco	✓ Using a standardized assessment tool to identify modifiable risk factor for patients with hypertension that includes alcohol consumption and tobacco use.	✗ Not assessing modifiable risk factors. **– OR –** ✗ Only assessing for some, but not all the modifiable risk factors including alcohol consumption and tobacco use.

"P" Attestation Criteria	✓	✗
Intervention[4] to improve nutrition, reduce sodium intake, and increase potassium intake, increase physical activity, reduce weight, and reduce body mass index	✓ Responding to an identified modifiable risk factor by: • providing patient education materials in written or video form, ***or*** • using collaborative communication to set goals for lifestyle change, ***or*** • referring a patient for dietary counseling • prescribing physical activity, ***or*** • providing access to fresh fruits and vegetables	✗ Not responding to any identified modifiable risk factors related to nutrition, intake, physical activity, weight, or body mass index.
Intervention to address alcohol moderation and tobacco cessation	✓ Responding to an identified modifiable risk factor by: • providing patient education materials in written or video form, ***or*** • using collaborative communication to set goals for lifestyle change, ***or*** • referring a patient for substance use disorder counseling or quit lines, ***or*** • prescribing smoking cessation medications	✗ Not responding to any identified modifiable risk factors related to alcohol or tobacco use.

"P" Frequently Asked Questions

What are examples of "interventions" in response to an identified modifiable risk factor?
"Interventions" in response to an identified modifiable risk factor could include, but are not limited to:

- Providing patient education, handouts or videos
- Using collaborative communication to set goals for lifestyle change
- Referring a patient to an expert for care and counseling
- Referring to a group or community resources for support
- Prescribing food, exercise, or medications

"P" Rationale & Guideline Recommendations

Rationale:

The 2017 AHA/ACC Hypertension Clinical Practice Guideline recommends:

- Use of systematic, team-based, stepped-care protocols to improve BP control (12.4.2)
- An organized system of regular review to improve quality of care (12.4.2)
- Nonpharmacological interventions to lower BP, with the most important interventions being weight loss, the DASH (Dietary Approaches to Stop Hypertension) diet, sodium reduction, potassium supplementation, increased physical activity, and a reduction in alcohol consumption. (6.2)
- Evidence-based interventions to achieve lifestyle change (12.1.2)

Specific Recommendations from the 2017 AHA/ACC Hypertension Guideline:

12.4.2. Quality Improvement Strategies

COR	LOE	Recommendation
IIa	B-R	Use of quality improvement strategies at the health system, provider, and patient levels to improve identification and control of hypertension can be effective.

6.2. Nonpharmacological Interventions

COR	LOE	Recommendations
I	A	Weight loss is recommended to reduce BP in adults with elevated BP or hypertension who are overweight or obese.
I	A	A heart-healthy diet, such as the DASH (Dietary Approaches to Stop Hypertension) diet, that facilitates achieving a desirable weight is recommended for adults with elevated BP or hypertension.
I	A	Sodium reduction is recommended for adults with elevated BP or hypertension.
I	A	Potassium supplementation, preferably in dietary modification, is recommended for adults with elevated BP or hypertension, unless contraindicated by the presence of CKD or use of drugs that reduce potassium excretion.
I	A	Increased physical activity with a structured exercise program is recommended for adults with elevated BP or hypertension.
I	A	Adult men and women with elevated BP or hypertension who currently consume alcohol should be advised to drink no more than 2 and 1 standard drinks* per day, respectively

12.1.2. Strategies to Promote Lifestyle Modification

COR	LOE	Recommendation
I	C-EO	Effective behavioral and motivational strategies to achieve a healthy lifestyle (i.e., tobacco cessation, weight loss, moderation in alcohol intake, increased physical activity, reduced sodium intake, and consumption of a healthy diet) are recommended for adults with hypertension.

Source: 2017 AHA/ACC Hypertension Clinical Practice Guideline

Additional "P" Resources

- Partner with Patients Quick Start Guide:
- 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease
- 2021 Weight-Loss Strategies for Prevention and Treatment of Hypertension
- Life's Essential 8 – professional journal publication
- Life's Essential 8 - patient resources

SELF-MEASURED BLOOD PRESSURE ("SMBP" PILLAR)

"SMBP" Questions

Self-Measured Blood Pressure (SMBP) - Evidence-based Use of Self-Measured Blood Pressure

I attest that my organization utilizes self-measured blood pressure to confirm a diagnosis, guide treatment intensification, or support longer-term lifestyle change and/or medication adherence for hypertension. Our self-measured blood pressure program includes (at a minimum), systematic[2]:

- ☐ Policy and/or procedure defining the steps to prepare patients for SMBP monitoring
- ☐ Monitoring[3] to assess the use of the policy in practice
- ☐ Assessment to ensure the appropriate BP cuff size for the patient and education to prepare patients to use SMBP including, at a minimum, measurement training to properly position and use the device
- ☐ Approach to establishing a measurement schedule, ideally two times in the morning and two times in the evening for 3-7 consecutive days
- ☐ Receipt of readings from the patient via any means[5] and review and averaging of a minimum number of 12 SMBP readings from a month of home monitoring to help inform diagnostic and treatment decisions
- ☐ A minimum of 30 patients or 10% of our patient population with hypertension per year (which ever number is larger) utilize SMBP monitoring as described above

2 – "Systematic implementation" could be through integration into the EMR, a paper-based record or tool, or other means that provide consistent access to the standard of care for every patient

3 - "Monitored/Monitoring" can be achieved through means such as but not limited to manual chart review sampling or analysis of EMR or population health data, at least annually to assess If the policy/protocol is being followed. This requirement does not specify a level of adherence to the policy/protocol.

5- "Means" including but not limited to return of paper recording logs, review of readings stored on the device, use of device app or remote patient monitoring (RPM) platform, or direct transmission into the electronic health record (EHR)

"SMBP" Examples

Examples of what actions would satisfy the intent of the attestation criteria.

These examples are not the only ways that the criteria can be met or not met but help illustrate the intent of the criteria and provide ideas for achieving these evidence-based practices.

"SMBP" Attestation Criteria	✓ Example(s) that meets the intent of the criteria	✗ Example(s) that does not meet the intent of the criteria
Policy and/or procedure defining the steps to prepare patients for SMBP monitoring	✓ A clinical policy and procedure that defines a standard of care to prepare patients for successful use of SMBP monitoring including the steps and resources needed. **– OR –** ✓ A protocol with a checklist with steps to equip the patient with a validated device with a properly sized cuff, training on how to operate the device, prepare and position properly, and record and relay readings.	✗ No defined standard of care to systematically prepare patients for successful SMBP monitoring.

"SMBP" Attestation Criteria	✓	✗
Monitoring[3] to assess the use of the policy in practice	✓ Using electronic health record or population health tools to examine if the standard is being followed such as documentation of preparing patients for SMBP monitoring. **– OR –** Performing manual chart review on a sample of records that includes all care team members who are responsible for preparing patients for SMBP monitoring. **NOTE:** This does NOT require a specific level of adherence to the standard. The intent is that HCOs are examining adherence to the standard with the goal of minimizing variation in practice.	✗ Implementing a standard of care, but not examining if the standard is being followed. **– OR –** ✗ Monitoring adherence to a standard of care without the intent to improve performance. **– OR –** ✗ Sampling charts of only some of the care team members who are responsible for preparing patients for SMBP monitoring. **– OR –** ✗ Having no way to measure if the standard of care is being performed.
Assessment to ensure the appropriate BP cuff size for the patient and education to prepare patients to use SMBP including, at a minimum, measurement training to properly position and use the device	✓ Using a standardized training checklist to equip patients with a validated device with a properly sized cuff, training on how to operate the device, prepare and position properly, and record and relay readings. **– OR –** ✓ Using a teach back or return demonstration approach to ensure comprehension and improve retention.	✗ Not using a standardized approach. **– OR –** ✗ Not ensuring the patient is using an appropriately sized cuff. **– OR –** ✗ Not teaching a patient how to operate the devices. **– OR –** ✗ Not teaching a patient how to prepare and position properly.
Approach to establishing a measurement schedule, ideally two times in the morning and two times in the evening for 3-7 consecutive days	✓ Having patients use a recording log for taking 2 measurements every morning before medications and 2 measurements every evening over 3-7 consecutive days.	✗ Not guiding patients with a recommended monitoring schedule to help inform diagnostic and treatment recommendations.

"SMBP" Attestation Criteria	✓	✗
Receipt of readings from the patient via any means[5] and review and averaging of a minimum number of 12 SMBP readings from a month of home monitoring to help inform diagnostic and treatment decisions	✓ Receiving SMBP readings from patients through remote digital transmission or reviewing stored reading on the devices or reviewing a paper log on a monthly basis. **– AND –** Averaging all the systolic blood pressure readings and averaging all of the diastolic blood pressure readings through automatic or manual means. **– AND –** Using the data to inform diagnostic or treatment decision.	✗ Not receiving readings from the patients. **– OR –** ✗ Not averaging the readings. **– OR –** ✗ Not using the data to inform clinical decisions for diagnosis and treatment.
A minimum of 30 patients or 10% of our patient population with hypertension per year (which ever number is larger) utilize SMBP monitoring as described above	✓ Using SMBP monitoring for at least 30 patients if you have fewer than 300 patients with hypertension per year in your practice to confirm a diagnosis, inform medication intensification, or support medication adherence of lifestyle change. **– OR –** ✓ Using SMBP monitoring for 10% of your patients with hypertension if you have more than 300 per year in your practice to confirm a diagnosis, inform medication intensification, or support medication adherence of lifestyle change.	✗ Using SMBP monitoring with fewer than 30 patients if you have fewer than 300 patients with hypertension per year in your practice to confirm a diagnosis, inform medication intensification, or support medication adherence of lifestyle change. **– OR –** ✗ Using SMBP monitoring for <10% of your patients with hypertension if you have more than 300 per year in your practice to confirm a diagnosis, inform medication intensification, or support medication adherence of lifestyle change.

"SMBP" Frequently Asked Questions

What meets the criteria of "receipt of readings from the patient via any means" to inform diagnosis and treatment decision?

"Means" for relay of readings from the patient to the care team include, but are not limited to receipt and review of:

- Hand-written paper recording logs
- Electronic readings stored on the device, an app or remote patient monitoring (RPM) platform, or transmitted directly into the electronic health record (EHR)

Why do you ask for a minimum threshold of 30 patients or 10% of our patient population with hypertension per year (which ever number is larger) utilize SMBP monitoring?

The intent is to reflect a systematic practice or program and recognize the wide range of HCO sizes that participate in data submission.

"SMBP" Rationale & Guideline Recommendations

Rationale:

The 2017 AHA/ACC Hypertension Clinical Practice Guideline recommends:

- Use of systematic, team-based, stepped-care protocols to improve BP control (12.4.2)
- An organized system of regular review to improve quality of care (12.4.2)
- Use of SMBP to confirm a diagnosis and guide medication titration (4.2)
- Training patients to perform SMBP with proper positioning, equipping them with automated, validated devices and an appropriately sized cuff, and establishing a schedule to take and relay multiple readings (4.2 Table 10)

Specific Recommendations from the 2017 AHA/ACC Hypertension Guideline:

12.4.2. Quality Improvement Strategies

COR	LOE	Recommendation
IIa	B-R	Use of quality improvement strategies at the health system, provider, and patient levels to improve identification and control of hypertension can be effective.

4.2. Out-of-Office and Self-Monitoring of BP

COR	LOE	Recommendation
I	A SR	Out-of-office BP measurements are recommended to confirm the diagnosis of hypertension (Table 11) and for titration of BP-lowering medication, in conjunction with telehealth counseling or clinical interventions.

Table 10. Procedures for Use of HBPMS4.[2-5–S4.2-7]

Patient training should occur under medical supervision, including:
Information about hypertension
Selection of equipment
Acknowledgment that individual BP readings may vary substantially
Interpretation of results
Devices:
Verify use of automated validated devices. Use of auscultatory devices (mercury, aneroid, or other) is not generally useful for HBPM because patients rarely master the technique required for measurement of BP with auscultatory devices.
Monitors with provision for storage of readings in memory are preferred.
Verify use of appropriate cuff size to fit the arm (Table 9).
Verify that left/right inter-arm differences are insignificant. If differences are significant, instruct patient to measure BPs in the arm with higher readings.
Instructions on HBPM procedures:
Remain still:
Avoid smoking, caffeinated beverages, or exercise within 30 min before BP measurements.
Ensure ≥5 min of quiet rest before BP measurements.

The table continues on the next page.

Table 10. Procedures for Use of HBPMS4.[2-5–S4.2-7] *(Continued)*

Sit correctly:
Sit with back straight and supported (on a straight-backed dining chair, for example, rather than a sofa).
Sit with feet flat on the floor and legs uncrossed.
Keep arm supported on a flat surface (such as a table), with the upper arm at heart level.
Bottom of the cuff should be placed directly above the antecubital fossa (bend of the elbow).
Take multiple readings:
Take at least 2 readings 1 min apart in morning before taking medications and in evening before supper. Optimally, measure and record BP daily. Ideally, obtain weekly BP readings beginning 2 weeks after a change in the treatment regimen and during the week before a clinic visit.
Record all readings accurately:
Monitors with built-in memory should be brought to all clinic appointments.
BP should be based on an average of readings on ≥2 occasions for clinical decision making.
The information above may be reinforced with videos available online.

Additional "SMBP" Resources

- SMBP Quick Start Guide
- 2020 Self-Measured Blood Pressure at Home – A Joint Policy Statement from AHA/AMA
- NACHC SMBP Implementation Toolkit

EQUITABLE HEALTH OUTCOMES ("EHO" PILLAR)

"EHO" Questions

EQUITABLE HEALTH OUTCOMES IN BLOOD PRESSURE CONTROL

I attest that my organization collects and uses patient population data to assess for equitable health care improvements and outcomes in blood pressure control that includes:

- ☐ Adoption of a policy and procedure to systematically gather race/ethnicity (R/E) data
- ☐ Adoption of a policy and procedure to systematically assess Social Determinants of Health (SDoH)
- ☐ Monitoring of team adherence to policy and procedure(s)
- ☐ Training our team to gather data per policy (s)
- ☐ Stratification[6] of control rate data at least annually by 2 sub-groups at risk for inequitable health outcomes such as patients from racial or ethnic groups, without insurance, by zip code and/or by SDoH elements
- ☐ Examination and use of data for care / quality improvement opportunities and takes action to address gaps and outcomes across groups.

6 – "Stratification" includes but is not limited to examining control rates review by age, sex, gender identity, race, ethnicity, primary language, insurance status, zip code, or housing status.

"EHO" Examples

Examples of what actions would satisfy the intent of the attestation criteria.

These examples are <u>not</u> the only ways that the criteria can be met or not met but help illustrate the intent of the criteria and provide ideas for achieving these evidence-based practices.

"EHO" Attestation Criteria	✓ Example(s) that meets the intent of the criteria	✗ Example(s) that does not meet the intent of the criteria
Adoption of a policy and procedure to systematically gather race/ethnicity (R/E) data	✓ A policy and procedure that defines a standard process to gather a patient's race and ethnicity that includes explaining why this information is important and asking a patient to self-identify their race and ethnicity. **– AND –** Defining the personnel who are responsible for gathering the information and the training they should receive to perform the task.	✗ No defined process for systematically gathering race and ethnicity data. **– OR –** ✗ Not defining responsible personnel **– OR –** ✗ Not defining required training

"EHO" Attestation Criteria	✓	✗
Adoption of a policy and procedure to systematically assess Social Determinants of Health (SDoH)	✓ A policy and procedure that defines a standard process to assess social determinants of health including a standardized assessment tool. **– AND –** Defining the personnel who are responsible for gathering the information and the training they should receive to perform the task.	✗ No defined process for systematically gathering social determinants of health data. **– OR –** ✗ Not defining responsible personnel **– OR –** ✗ Not defining required training
Training our team to gather data per policy (s)	✓ As part of orientation, training front office reception staff on the policy and approach to gathering race/ethnicity data from patients including practice of scripts for explaining why the information is important for their care and asking patients to self-identify. **– OR –** ✓ As part of annual competency training, provide clinical staff with to administer a standardized SDoH assessment tool.	✗ Do not provide training for the responsible staff to gather race/ethnicity data in accordance with policy. **– OR –** ✗ Do not provide training for the responsible staff to gather social determinants of health data in accordance with policy.
Monitoring of team adherence to policy and procedure(s)	✓ Using electronic health record or population health tools to examine if the standard is being followed such as documentation of race/ethnicity or Social Determinants of health. **– OR –** ✓ Observe all staff who are responsible for gathering race/ethnicity data or social determinants of health for adherence to the policy. **NOTE:** This does NOT require a specific level of adherence to the standard. The intent is that HCOs are examining adherence to the standard with the goal of minimizing variation in practice.	✗ Implementing a standard of care, but not examining if the standard is being followed. **– OR –** ✗ Monitoring adherence to a standard of care without the intent to improve performance. **– OR –** ✗ Sampling charts of only some of the care team members who are responsible for data gathering. **– OR –** ✗ Having no way to measure if the standard of care is being performed.
Stratification[6] of control rate data at least annually by 2 sub-groups at risk for inequitable health outcomes such as patients from racial or ethnic groups, without insurance, by zip code and/or by SDoH elements	✓ Stratifying your control rate by race so you can compare your overall control rate to your American Indian / Alaskan Native population control rate. **– AND –** Stratifying your control rates by insurance status so you can compare your overall control rate to your uninsured patients' control rate.	✗ Not stratifying your control rate data. **– OR –** ✗ Only stratifying your control rate data by 1 group at risk for inequitable health outcomes.

"EHO" Attestation Criteria	✓	✗
Examination and use of data for care / quality improvement opportunities and takes action to address gaps and outcomes across groups.	✓ Examining your stratified control rate data, finding a disparity between groups, and taking a CLAS-standard informed action to address the gap such as using patient education material in a patients primary language or recruiting bi-lingual staff to support patient engagement and education for the population experiencing disparate outcomes.	✗ Not examining the data. **– OR –** ✗ Not taking any actions to address gaps.

"EHO" Frequently Asked Questions

What can "stratification" include?
It can include, but is not limited to, examining control rates by characteristics such as age, sex and/or gender identity, race and/or ethnicity or primary language, insurance status, and/or geography/zip code.

"EHO" Rationale & Guideline Recommendations

Rationale:

The 2017 AHA/ACC Hypertension Clinical Practice Guideline recommends:

- Use of systematic, team-based, stepped-care protocols to improve BP control (12.4.2)
- An organized system of regular review to improve quality of care (12.4.2)
- Using performance measures at the patient, provider, and system level to improve hypertension control (12.4.1)
- Strengthening local partnerships to address social circumstances that support hypertension care through community services (13.3)

The 2015 Social Determinants of Risk and Outcomes for Cardiovascular Disease a Scientific Statement from the American Heart Association:

- Addresses socioeconomic position (SEP), race, ethnicity, social support (including social networks), culture (including language), access to medical care, and residential environments
- Considers the psychological, behavioral, and biological mechanisms through which social determinants precipitate and perpetuate CVD
- Recommends collection and assessment of social determinants to identify potential bias and barriers to equitable outcomes
- Recommends efforts interventions to address health disparities related to social determinants

The 2009 Institute of Medicine Race, Ethnicity, and Language Data: Standardization for Health Care

Quality Improvement report recommends:

- Standardized approaches for accurate and compete race and ethnicity data collection
- Efforts to inform patients on the importance of F/E data and train staff in data collection procedures
- Use of R/E variables to stratify health data to assess for equitable outcomes

Specific Recommendations from the 2017 AHA/ACC Hypertension Guideline:

12.4.2. Quality Improvement Strategies

COR	LOE	Recommendation
	B-R	Use of quality improvement strategies at the health system, provider, and patient levels to improve identification and control of hypertension can be effective.

12.4.1. Performance Measures

COR	LOE	Recommendation
IIa	B-NR	Use of performance measures in combination with other quality improvement strategies at patient-, provider-, and system-based levels is reasonable to facilitate optimal hypertension control.

Additional "EHO" Resources

- Race & Ethnicity Data Collection Essentials
- Social Determinants of Risk and Outcomes for Cardiovascular Disease. A Scientific Statement from the American Heart Association
- Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE)
- AMA Steps Forward: Racial and Health Equity: Concrete STEPS for Health Systems: Translate Your Commitment to Racial and Health Equity into Action in Your Health System
- AMA Steps Forward: Racial and Health Equity: Concrete STEPS for Smaller Practices: Translate Your Commitment to Racial and Health Equity into Action in Your Practice
- Spotlight Series: Unmet Needs in Hypertension Treatment Options
- Health Equity and Hypertension Treatment
- AMA National Health Equity Grand Rounds Series
- AMA Prioritizing Equity video series
- AMA Historical Foundations of Racism in Medicine
- AMA Basics of Health Equity
- AMA Advancing Equity Through Quality and Safety: Five Focus Areas

Resources & References

The following resources provide guidance on the underlying evidence base, practice assessment tools, professional education webinars, quality improvement resources, and patient education tools to support the achievement of the new criteria. Organizations are not limited to these examples to support their attestation and award achievement:

General Resource:

- 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines

Act Rapidly:

- Act Rapidly Quick Start Guide
- VA/DoD Clinical Practice Guidelines
- AMA Hypertension Medication Treatment Protocol
- 2022 Medication Adherence and Blood Pressure Control - A Scientific Statement from the American Heart Association

Partner with Patients:

- Partner with Patients Quick Start Guide
- 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease
- 2021 Weight-Loss Strategies for Prevention and Treatment of Hypertension
- Life's Essential 8 – professional journal publication
- Life's Essential 8 - patient resources

Self-Measured Blood Pressure

- SMBP Quick Start Guide
- 2020 Self-Measured Blood Pressure at Home – A Joint Policy Statement from AHA/AMA
- NACHC SMBP Implementation Toolkit

Equitable Health Outcomes

- Race & Ethnicity Data Collection Essentials
- Social Determinants of Risk and Outcomes for Cardiovascular Disease. A Scientific Statement from the American Heart Association
- AMA Steps Forward: Racial and Health Equity: Concrete STEPS for Health Systems: Translate Your Commitment to Racial and Health Equity into Action in Your Health System
- AMA Steps Forward: Racial and Health Equity: Concrete STEPS for Smaller Practices: Translate Your Commitment to Racial and Health Equity into Action in Your Practice
- Spotlight Series: Unmet Needs in Hypertension Treatment Options
- Health Equity and Hypertension Treatment
- AMA National Health Equity Grand Rounds Series
- AMA Prioritizing Equity video series
- AMA Historical Foundations of Racism in Medicine
- AMA Basics of Health Equity
- AMA Advancing Equity Through Quality and Safety: Five Focus Areas