How to Manage Hypertension Virtually in Health Centers during COVID-19 and Beyond
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Transcription

Elizabeth Breidenbach:

Hello everyone. And welcome to today's webinar, How to Manage Hypertension Virtually in Health Centers during COVID-19 and Beyond. Sponsored by the National Association of Community Health Centers. My name is Elizabeth Breidenbach a meeting and events specialist based in the clinical affairs division here in NACHC. And I'm pleased to bring you this webinar along with my colleague, Meg Meador, Director of Clinical Integration and Education.

Before we get started, I would like to review a few housekeeping announcements. You have joined this event by using either calling in or using computer audio. All attendee lines have been automatically muted for the duration of this webinar. The duration of this webinar is approximately 60 minutes, including introductions, presentations and Q&A. Please note, during today's webinar, the Q&A box will be up and live for the duration of this webinar. You should see on your screen, an image and a popup, a visual of the Q&A box. Please type your questions, comments, or concerns at any time during the webinar. We will answer questions throughout the Q&A box directly in the Q&A box from the panelists. We have also built in a Q&A portion at the end of today's webinar. Again, please place your questions, comments, or concerns into the Q&A box located in the lower right hand side of your computer screen at any time.

Let us remind you that today's event is being recorded and will be available in approximately one week on the NACHC COVID-19 webinar page. And it will also be available on the SMBP community of healthcare communities. After today's webinar, you'll be presented with a brief four question survey. This survey lets us know how we did, how valuable this webinar was to you and helps us capture data to form our future events. We value your feedback and encourage you to complete this survey. At this time, I would like to turn things over to my colleague, Meg, who will be introducing our speakers and taking it from here, Meg?

Meg Meador:

Thank you everybody. Thank you, Elizabeth. And thanks to all who were able to join us today. I'll be quick so that we can learn about and discuss the important and timely topic of How to Manage Hypertension Virtually in Health Centers during COVID-19 and Beyond. So here's the call agenda. First we'll be hearing from two community health centers who are out there on the front lines, and they're going to share how they have adapted their processes during this really unique time to continue providing high quality care to their hypertension patients.

And then we'll be hearing from our colleagues at the American Medical Association on key aspects of virtual hypertension management, namely Self-measured blood pressure monitoring, or SMBP, reimbursement codes to support SMBP, and then the new 2020 UDS measure on blood pressure control.

So we have a great lineup of speakers today and in the interest of time, and so we can allow time for you to ask your questions, I'm going to introduce each of them now, so we can transition quickly between presentations.

Our first speaker will be Kate Milone, who serves as Director of Quality and Compliance for Elaine Ellis Center of Health in Washington DC. She'll be followed by Kathleen Felezzola, Director of Nursing from Zufall Community Health Centers in New Jersey. Linda Murakami is our first speaker from the American Medical Association. She serves as the AMA Senior Program Manager for Quality Improvement. And finally, Linda will be followed by Dr. Mike Rakotz, Vice President of Health Outcomes for the AMA. All right, Kate, let me turn it over to you.

Kate Milone, MA, MS:

Okay, great. Thank you. I appreciate you inviting me to share a story. As Meg said I'm Kate Milone, the Director of Quality and Compliance in Elaine Ellis Center of Health. In our response to this pandemic, I don't believe Elaine Ellis is doing anything different or any better than any other healthcare center. We've just been doing what feels right for us and for our patients. I think every one of you has what I call the BC story. It's a before COVID-19 story of what processes and workflow were like before COVID-19 came into play.

So at Elaine Ellis Center of Health, we were already doing telehealth with our behavioral health and substance use disorder patients for counseling and for checking in. For our hypertension patients, our case manager was doing monthly checking calls with our patients. Our care team was discussing patient needs during morning huddle. We use the sticky notes in the EMR to communicate with our healthcare team and our patients came into the center for their appointments as scheduled and for their blood pressure checks.

So specifically talking about our hypertensive patients, what has helped us through this is that we know our patients. We know who they are, what their needs are, their level of compliance with their provider recommendations for medications, for diet, exercise, activity, how well they're doing following up on referrals and their home management of their blood pressure. So in short, we know who our patients are and we know who's on what we call our hypertension protocol.

So then enter COVID-19 and we find our workflow changing as the situation evolves. Every week, there was something new. Sometimes even every day, there was something different we were having to do. So we knew we had to take a different approach with all of our patients, but especially those with chronic health conditions. We didn't want to run the risk of losing them to follow up and losing the momentum that we've gained up to this point. When we started with the million hearts project just 16 months ago, 40% of our patients had controlled blood pressures. And as of May, this year, we achieved a 60% blood pressure control. So we didn't want those efforts and gains to be lost.

Can I have the first slide please? So we took a look at all of our patients. We started with a list of everyone with a diagnosis of essential hypertension. And we looked at their numbers, their blood pressure numbers, they might mean something to us. They might not mean that much to the patient, but we wanted to take a look back and track and trend them over time to really get a very clear picture of what our patients were doing as far as their blood pressure.

We also considered their comorbidities, obesity, cholesterol, diabetes. We assessed language barriers. And if I was rewriting this slide, I would probably also add in health literacy challenges. And we looked at their last one site visit with us, what brought them in? Was it for a blood pressure check? Was it a problem visit? Are they a newly diagnosed hypertensive patient? Were they here for something entirely different?

We did a round table discussion with the key members of our care team. We talked about our current level of compliance, the patient's current level of compliance with their provider recommendations. And we focused on which patients we felt could pretty much be on their own during this time with just some check-ins here and there. And those patients that maybe needed a more hands on approach.

Few of our patients were very new to us, but most had been with us since we opened in 2012. So in short, we know our patients, we know who needed some extra attention, some handholding and who had a good support system in place at home to help them navigate the changes that we were planning on putting in place. We reached out to each patient and assessed whether they had a blood pressure monitor at home, were they currently using it? Was it working? Did the arm cuff fit? It may have fit when they got it, does it still fit? And our patients over time have come to rely on us and their ability to pretty much just drop in and have their pressure checked.

So for those who are prescribed a home blood pressure machine, even though they had one, they may have still come in here to have their pressure checked by our staff here. So we found that some devices needed an upgrade. Some patients needed a refresher on how to use the machine. And for those without a machine, we worked with our primary care, PCA, to secure some machines for them. We made sure they were validated and we train the patient on how to use them through a telehealth visit. We also determined on who would benefit from a telehealth visit versus a checking call and who we felt still needed to come for an onsite visit. Next slide please.

So this is our care team. Based on our interview with the patient and our knowledge of their level of compliance, we formulated a patient specific plan for the majority of our patients. We kind of fell back on our patient centered medical home training and implemented a care team based approach. The ultimate goal was not to lose patients or have them lose their momentum in gaining control of their blood pressure.

So we started with our scheduler. The scheduler basically sets up the telehealth or the check-in call. They work with the patient on downloading and logging into Zoom for healthcare. Any patient who doesn't already have a telehealth consent on file, we created just an abbreviated consent. And then the scheduler will message the provider that they did the abbreviated, but they need to get maybe the more detailed consent. The scheduler talks to the patient about the need for a quiet and a private space for their visit. And I bring this up because we learned from one of our first telehealth visits, when the patient attempted to visit, they were actually riding on a Metro bus and that was not the optimal situation.

We also remind the patient during their scheduling to have their blood pressure monitoring device handy, to have their log of measurements, if they haven't already sent it through to the portal. And the prep for the call is really helpful in case the provider needs to see how home measurements are being

done. We have a medical assistant who may reach out to the patient and go over medication lists and triage questions. They're also familiar with using the blood pressure devices and can assist the patient. The provider logs on and conducts the visit.

And I will share with you, one of our initial challenges was that after the visit with the provider, the patient would normally stop by the front desk to do a checkout and make their next appointment and get their referrals, but with a telehealth visit, there was no front desk. So we missed this step in the continuum of care. So through our EMR now, we have the provider message the front desk, and then they'll reach out to the patient to schedule their next appointment and make sure that they have any referrals that they need to follow up on.

So our case manager and care coordinator has a role to address any advocacy issues or any other patient needs. She also continues to conduct her monthly checking calls with the patient that we have found over time have been very valuable and very important for us. As the director of quality, I collect track and report the data and pretty much oversee and manage the process. And I included our extended care team members here because I think that they play a very important role and should not be left out of the process.

So for behavioral health, if a patient presents with a behavioral health need, then there will be a warm handoff between the provider and the behavioral health nurse practitioner will get involved. We've also found that we've had the need for a few three way calls between the provider, the patient and the pharmacy to get medication straightened out without having the patient has to go into the pharmacy and then have the pharmacist call us, or the patient call us. We have been working these things out using three way calling. The nutritionist is included if needed.

And I think often a forgotten member of the extended care team is the insurance company. So our case manager has had to make some three way calls between her, the pharmacy and the insurance provider to resolve disputes over whether or not the insurance coverage is for the blood pressure machine. So we've been very helpful with everything, looking for everyone on our team, having a part to play as well as our extended or expanded care team. And the next slide.

So basically that's our approach. I wanted to leave you with one last slide, and this is a quote that those of us in quality like to use. I'm sure for all of you at your healthcare centers, there have been so many changes and processes and things will continue to evolve. So in this setting, this quote about change also applies to our patients. This has been a very big transition for them as it has been for us. So we have those who complain. We have those who make the best of the situation and those who go with the flow and accept this as the new normal, at least for now.

So our best advice is to stay in touch with your patients, stay engaged with them. Like Elaine Ellis Center of Health, I believe you've made some great strides in working with your patients throughout this process. And we've found that maintaining that momentum through our care team approach and our patient engagement is important. So I thank you for your time and attention. And I have the pleasure now of passing the Baton to Kathleen Felezzola from Zufall Community Health Centers, Kathleen.

Kathleen Felezzola, BSN:

Good afternoon. Thank you so much for including me. I am going to talk a little bit about RPC. As Kate said, our time before COVID we have been engaged on ... I'm going to change my slide. I could get it to change. I'm sorry, I'm not getting my slides to advance. And I think they're not.

So some of our backgrounds, we have been engaged for about the past almost 18 months now in a collaboration through a grant through the New Jersey Department of Health, where we were working on self measured blood pressure at home. We were identified in one of our smaller sites 39 patients that we felt would benefit from having self measured blood pressure. And we did that through our dashboards. We took a look, as Kate mentioned before, at their comorbidities and their health literacy and their track record of compliance at home.

And we identified those patients. We provided them with an electronic blood pressure cuff and provided them education about the proper way in which to take their blood pressure. We encouraged those patients to take their blood pressure every morning and every evening. We were hoping by asking them to take it twice, we could at least get them to take it once.

We further engage with patients in the process by helping them to develop a self-management care plan, which you can see down here. It's a little small, but we made it very simple, very pictorial. They were asked to choose two self-management goals and it could be take their blood pressure every day. It could be increased their exercise. It could be to stop smoking, improve their diets. Take their medications daily, make an appointment for a follow up exam, make an appointment with their other referral providers. We ask them to choose just two of them. We wanted to start small and give them the opportunity to see that success.

We have a designated patient navigator at our site... performed all follow up calls, helped with the education. And they too would do during their pieces of planning, take a look at our dashboards to see who would be a suitable candidate for this program. BC again, before COVID, 49% of the 39 patients enrolled in the program showed improvement in blood pressure numbers by the next visit.

So important thing about this is that it informed of important keys to our success. We're making sure that we're informing our patients about their readings and what those readings mean, teaching patients skills to maintain their own health by using the self-management forms, helping them to establish their self-management goals, and using motivational interviewing techniques using self-management forms.

Our providers are very aware of things that make our patients perhaps noncompliant. So whenever possible, we use a once daily regimen. We are participating in the 340B prescription program, and we try to choose medications that will both work and are affordable for our patients.

We also schedule frequent followup visits until they're at goal. And before COVID, we were asking them to come in and have a blood pressure check, even if it was not time for their regular examination. Our patient navigator or our nurse would call the patients and check in, some reminders, have you been checking your blood pressure? Is everything doing okay? And we too, as Kate mentioned earlier, utilize that team approach. Providers, patient, navigator, who is a MA or an LPN, depending on what site they're at.

We utilize our clinical pharmacists and our dietician. And we too are including integrated behavioral health for our patients. So of course then, COVID came and we had to shift our strategy. We too had just started to use tele-health for some of our behavioral health visits. So we had a small first steps and then we too had to really switch over completely to telehealth visits.

So some of our strategies that we were using to improve our assessment management blood pressure outcomes using the portal, and we also utilize Luma Health, which is our online patient communication system. It assisted with scheduling visits, messaging to check in, provide reminders, return and review of the blood pressure log or the self-management goal form. We did video check ins with our patient navigators and our patients to provide further education, to observe technique if it looked like our patients were having difficulties, verifying that they had enough medication, that they had a means to get that medication.

And then our providers were doing telehealth visits, which actually works out well for our patients. It eliminates transportation barriers and removes that need for office visits and potential exposure to infectious disease, which was a concern of ours as well as of our patients. And moving forward, once everybody is back to work and hopefully we get to our new normal, it will eliminate the need for our patients to take an extended time from work.

So we have some challenges as to be expected when you're very quickly instituting a new system. First of all, we would love to have a blood pressure cuff that interacted smoothly with ECW. And we have tried some out. Unfortunately, they're a little bit difficult to set up and we were finding it was difficult for our patients to manage that connection.

That is something we're still working on. Currently, we're just using a regular electronic blood pressure cuff that we were able to purchase from our medical supply company. It does have a memory. It is easy to use. It has color coding, so red if your blood pressure's elevated, green if your blood pressure's within range. Our patients are maintaining a good old fashion printed log right now, and that's working for them.

Another problem that we were having was that our ECW virtual visit platform was crashing. And I think that was just because there was too many people trying to institute this at one time. Fortunately, we were able to move to that Zoom platform. And we were allowed to use that under HIPAA. We were having an overloading of our phone lines. So we began making calls using our iPads rather than our external phone lines.

We're still continuing to have a problem that patients are having difficulty navigating Zoom, much like Kate's team. Our MAs are having a pre visit to assist them in downloading the app and walking through the setup. And again, we're continuing to look to see if there is another HIPAA, excuse the typo there. I apologize, compliance and user friendly telehealth solution. And then we continue to have patients that do not have smartphones, which continues to be a challenge.

So where are we going to go from here? Again, as I said, we'd really like to purchase those devices that integrate directly with ECW. We will be expanding our self monitoring blood pressure program to... There are remaining five medical sites that will be at six. We're going to work on doing some outreach in the community and see if we can get them into our blood pressure monitoring program. We're hoping

to set up for virtual monitoring and public housing so we can reach some of our lesser served populations. And we're looking into some programs such as the barbershop program or reaching out to churches to see if we can, again, expand our efforts to get a wider range of patients who are in need. Thank you. And I am going to pass the ball to Linda.

Linda Murakami, RN, MSHA:

Okay, great. Thank you, Kathleen. All right. Sorry about that. Okay. Thanks Kathleen. Hi everyone. Dr. Rakotz and I are going to talk more about self-measured blood pressure while covering the following objectives. We will review key aspects of the virtual management of hypertension using self-measure blood pressure monitoring, review 2020 CPT codes to support SMBP and the virtual management of hypertension. And lastly, review recent changes to the HRSA uniform data system and controlling high blood pressure eCQM for 2020. So self-measure blood pressure, or SMBP refers to blood pressure measurements obtained by the patient outside of a clinical setting. This includes adult patients taking blood pressures at home.

Clinical guidelines recommend two or more BP readings be averaged during an office encounter. So the same thinking should be used outside of the office using more than one reading to evaluate a patient's hypertension control. You can treat it as a vital sign during the virtual visit, making a single point in time, or use it to evaluate how well the current treatment plan is managing blood pressure control.

SMBP measurements are often taken for a week prior to an in person office encounter, following an encounter, or two to four weeks after a medication class or a dosing change. These readings guide when changes to treatment may be indicated. Plus, patients are more likely to become engaged in managing their high blood pressure by performing SMBP and it can improve adherence to medications. So all of this leads us towards the goal of lower BP and better blood pressure control.

So we refer to this as the seven steps for SMBP and the quick guide document on the right hand side of the slide there is summarizing these steps and that will be available in early June. So we'll be sure that all the attendees on this web conference get the link when it's available.

So the first step is identifying patients who will benefit from SMBP. These include patients already diagnosed with hypertension to assess blood pressure control, assess those who remain uncontrolled, or to evaluate the effectiveness of medications. Patients without a diagnosis of hypertension may benefit from SMBP if you're evaluating recent higher blood pressure measurements to confirm a diagnosis. You may also use it when to rule out masked or white coat hypertension, for patients with labile blood pressure, or any patient needing closer monitoring. And your electronic health record can be used to develop the queries needed to identify the patients who would benefit from SMBP as discussed by our previous two presenters.

So next, the patient should be advised on what BP device to use. So when you help patients choose the blood pressure monitor, make sure the devices are automated and validated for accuracy. Validatebp.org is the US validated BP device listing, which launched on April 29th of this year. Dr. Rakotz is going to speak more on the website and validation shortly. So it's important to ensure that the device uses an upper arm cough and the cough is sized appropriately for the patient. And please don't advise finger devices. They're not recommended for clinical use due to inaccuracy.

And I want to mention cuff size because using the incorrect cuff says will lead to inaccurate blood pressure readings. You can measure the arm in the clinic, or if the patient's at home, they may need someone to help them, but use a tape measure to find the midpoint between the acromion process and the olecranon process. And then just measure the circumference of the arm at that midpoint. So BP cuffs for home usually fit arms from eight inches up to 14 to 18 inches. Each manufacturer is a little different, but there are also options for extra-large cuffs on some devices.

And you want to be sure to verify the patient's understanding and share patient education resources. To properly prepare them for and perform SMBP using an evidence-based protocol is essential to obtain accurate results. So this infographic prepares the patient for self-measurement, advising them to avoid stimulants, tobacco, and exercise for 30 minutes before the measurement and patients should also have an empty bladder and perform SMBP measurements before taking antihypertensive medications.

Next, the patient should sit in a chair with her back supported, legs uncrossed, and the feet flat on the floor. The cuffs should be placed on the upper arm over bare skin. And the middle of the cuff should be at heart level. And this should be done by supporting the arm on a table or in an armrest, but know that improper positioning can cause BP readings to be falsely higher.

The patient should rest for five minutes in a quiet environment and remember to have them log the results after the measurement. So, as I mentioned earlier, we realized some may choose to have the patient do one to two readings during a telehealth visit in an effort to mimic the in person clinical experience. And others may take readings for a week prior to an encounter.

The 2017 guidelines for high blood pressure in adults from the American College of Cardiologists and the American Heart Association, as well as the scientific statement from the AHA and measurement of blood pressure in humans that was published in 2019 suggests seven days of SMBP with measurements taken twice daily and with two measurements each time, one minute apart.

So this can be done to confirm a diagnosis of hypertension or the patient should continue to self measure every two to four weeks until BP is controlled. It's important patients know when and how to communicate their blood pressure readings back to the office. You can set up processes that include review of the measurements during a virtual or in person visit, a phone call, via patient portal, or through electronic transmission. You can determine which method to be used and should base it on each patient's individual capabilities.

So once the results are received from the patient, you want to make sure there are at least three days of readings or 12 measurements with seven days preferred. Calculate the average systolic and average diastolic pressures separately and document this result in the medical record.

And document this result in the medical record. Some clinics document these in an SNBP field, which is ideal, or they may be documented in the notes or the vital signs field, especially for virtual visits. But the average of these results that should be used to make treatment decisions for the patient.

And you'll want to continue to encourage patients to be engaged by communicating with the patient and discussing the treatment plan and always be sure the patient understands and agrees with the

treatment plan that's been developed. And remember that follow up with the patient is recommended every two to four weeks until the patient's blood pressure is controlled. So now I'll pass it over to Mike.

Michael Rakotz, MD, FAHA, FAAFP:

All right, thanks very much, Linda. I'm just going to let you know upfront, I'm going to talk about three things today relatively quickly. We've got about 10 minutes to cover several topics and then we'll have a 15 minute Q&A afterwards to address all the speakers.

The first thing that I want to talk about are SMBP CPT codes for submitting for services, for training people and educating them to effectively do SMBP and then for managing their SMBP over time. Give me a second here to advance the slide.

The first code that I'm going to talk about really is for training and education. In order to get the most out of SMBP when you're managing hypertension remotely, we know from multiple studies that you've got to educate and train the patient to do this effectively. So this first code 99473 education and training for SMBP is about using a device validated for clinical accuracy to do patient training and device calibration. So this is a code that came about January of 2020. It's for non-provider staff. So staff can do this code to train patients to learn how to correctly perform SMBP at home.

You need to use a device validated for clinical accuracy, which I'll talk about a little more in a few minutes. This can be done once per device and is a key component of getting the most out of SMBP to actually lower blood pressure and improve blood pressure control this. So when this is submitted, it is typically reimbursed about $11 and 19 cents. And that's something that can vary depending on payer. We just throw that out so that you a basic idea.

One of the things that has happened during the public health emergency during COVID-19 is that education can be delivered via telehealth in a telehealth encounter or telehealth visit. And device calibration is normally done in person when an SMBP measurement device is calibrated against an office standard device to make sure that it's accurate in the individual who's using it. But if you think about what happens in a telehealth visit, there's no way for that to happen, so this has been waived as a requirement for submitting CPT code 994734 for this service during the pandemic. So 994734 can be submitted strictly for education that occurs during a telehealth visit, or either a video visit or a telephone call by non-provider staff.

The other requirement in this code is that a validated device is used, a device validated for clinical accuracy. And for people who don't know what that means, typically that's when a manufacturer has a device that's tested by whether they do their own testing or tested by a third party, an independent third party uses an international validation protocol to make sure that the device is accurate, and then they make sure that data is publicly available. Unfortunately, around the world, most devices haven't gone through that process and made that information available. So here in the United States and around the world, there are validated device lists that exist that have this information. For blood pressure measurement devices that have been tested, the data has been publicly shared and independently reviewed and these lists happen in many countries and the first US device list, as Linda mentioned, went up on April 24th, and we'll talk a little bit more about that in a few minutes. But for this code, since the requirements for a validated device, you've got to make sure that you're using one.

I've listed the URL for the validated device list in the United States at validatebp.org. I've also listed a couple other validated device lists. The validated device list in the United States, the US validated device list has about 16 self measured blood pressure monitors. We're hoping that that list grows rapidly over time as manufacturers make do the validation protocol testing and make the data publicly available, and an independent review committee reviews that data, and if it meets the criteria, it gets put up on that listing. But for those that are not currently on that list, it doesn't mean that the device isn't validated, but you need to find out whether it's been tested and it is a validated device that perhaps the manufacturer just hasn't submitted the data to the US validated device list yet. So we've listed a few other validated device lists, one in Canada, and one in Europe that may have that device.

The code is more of a management code for self measure blood pressure monitoring. The code language itself says that you need to use validated device for clinical accuracy again, and then it really goes into a measurement protocol... Let me just get the light changed here. All of the things that Linda talked about using an evidence based measurement protocol, two readings taken one minute apart, twice daily, over a 30 day period, a minimum of 12 readings, they need to be collected and reported by the patient or their caregiver and given to the physician or other qualified healthcare professional from the clinical team. The average systolic and diastolic blood pressure need to be reported and a treatment plan needs to be communicated back to the patient.

For ongoing management, this code can be submitted once a month, and you need to document in the chart. The average systolic and diastolic blood pressure and the reimbursement is approximately $15.16 and that is for the service of reviewing the average systolic and diastolic blood pressure and communicating a treatment plan back to the patient. And I'll note that the communication back to the patient doesn't have to happen by the provider. It can happen by the clinical staff. Again, the requirements here are that the device is validated for clinical accuracy, that an evidence based medicine protocol described here is used, twice in the morning and twice at night, minimum of 12 readings, that the results are reported to the clinical team. And I'll note here that they can be either transmitted or relayed verbally to the team. So when we heard earlier about a tracker being used on paper, that would suffice to count for this code to be submitted. This is not a transmission requirement for this CPT code. And that was intentional knowing that not everybody had transmission capabilities. And finally, communication of a plan must be transmitted back to the clinical team from the patient.

So just very briefly, I mentioned that the US validated device list is now alive at validatebp.org. This is a place where you can go to look up one of the 16 devices validated for clinical accuracy, and we're hoping to rapidly see this list expand. And again, manufacturers can submit device validation testing data for independent review by the independent review committee, and if it meets the criteria that's been established, they will be listed. Not going to go into too much more detail here, but that's definitely a very useful site to have to look up validated device list.

I'll say, again, that if a device that somebody is using is not on that list now, it doesn't mean that it's not validated, but it's certainly worth checking with the provider or on one of the other validated device list to see. It may be a validated device and the manufacturer just hasn't gotten around to submitting the data to the independent review committee yet. It's a brand new listing, and again, we're hoping to expand it rapidly.

The next slide I really just wanted to talk about when we were talking about telehealth and virtual management of hypertension, the AMA has put out a lot of coding advice here with scenarios. There's 26 scenarios that have been created for COVID and non COVID diagnosis, for tele-health and visits, for managing conditions remotely. And this has been an extremely popular resource. It now includes 26 scenarios that shows providers the applicable CPT codes and ICD 10 codes that go with them for visit-based CPT codes to be submitted for actions performed during the services. There's summed up an easy to understand one page scenarios, they have a lot of information on them, but you can very quickly go to, if you're looking for COVID antibody testing, or if you're looking for SMBP coding with tele-health, which is the example that I'm going to show you now, just to give you one example of those 26 scenarios.

If you look at the next slide, it's a busy slide. Don't try to read it all, but this just shows the scenario of self measured blood pressure services. And what you can see here is just very high level. You've got your ENM codes and telephone visit codes for a provider to use communicating with the patient, having a virtual encounter. And then if training is to be done as not part of that encounter, but by the clinical team, you could submit a code for 99473 for education and training of that person, and then subsequently whether it's a week later, 10 days later, when you have your 12 measurements, you could submit and that number is communicated back to the clinical team, and a treatment plan is communicated back to the patient, you can submit a 99474. And you can see here, there are ICD 10 codes and modifier codes and place of service codes that can be added to make this a little bit easier to understand what you want to do. And again, there's 26 of these scenarios that I think are extremely helpful for tele-health and remote monitoring and SMBP.

So finally, I want to finish up by talking about the recent changes made to the UDS measure controlling high blood pressure. I don't want to confuse you. You may know that in February, HRSA sent out a letter saying that they had modified the UDS measure for controlling high blood to now align with the CMS 165 version 8 measure. And that's a significant change in that, normally for the UDS measure, only blood pressures that are measured by a clinician count towards this measure. The added language that you can see in the first box here is that they can be performed by a clinician or a remote monitoring device is acceptable to be used in the numerator for this quality measure. So that's a very big change, more consistent now with the heatest measure, so I'm breaking the tradition that only office based measurements can be used.

So as long as you have a remote monitoring device, which implies that the blood pressure will be digitally stored in the device and then transmitted to the provider, that that would be able to be used potentially in the vitals field, as long as there's documentation that the blood pressure was digitally stored and transmitted, that's traditionally what that means.

There's a little bit of confusion around this measure. Again, it was recently released and there wasn't a lot of communication that came with it to clarify it, but we know monitoring device can be used. There's some question about reporting the measurement by the patient being excluded, so if a patient reports verbally or on paper what their blood pressures are, cannot be used in this situation.

There's also a exclusion of blood pressures taken by the patient, which is a little bit unclear since they're on the one hand in the first box saying that it's okay to use a remote monitoring device, and in the second paragraph here, they're saying you can't use a blood pressure taken by the member, but in

general, that's understood to mean that the remote monitoring device needs to transmit the data. The patient can't take their own blood pressure, record it and report it. So that is what's being assumed for now, but we're seeking the NAC, the CDC and the AMA are working hard to get clarification on that, to make it easier to understand, but the measures to NCQA for all of the blood pressure control measures being used nationally right now has that same language in it about having to have blood pressures transmitted by a remote monitoring device. This one just doesn't have that language, but it's probably going to be a requirement.

And finally, the last thing I'll say about this quality measure here is that you can use a single blood pressure. The most recent blood pressure from home can be submitted if it's taken by the remote monitoring device and it can be put in the chart into the vitals field and used, and if it's less than 140 over 90, it will be compliant with the numerator. And why that's an issue is it's a little bit different than what we've been talking about, using an evidence based approach for averaging multiple blood pressures over multiple days, which is what we've been talking about doing, and that's what guidelines and scientific statements have been recommending for more than a decade. This is a little bit of a departure from that, just saying you can use a single home reading to be put into the quality measure.

So I know that's confusing, and we can talk about that in the Q&A. And just to summarize the changes to the quality measure, for the first time, UDS is allowing blood pressure measurements obtained with the remote monitoring device that can be used and put into the medical record as long as their documentation, how that blood pressure was obtained, using a remote monitoring device, blood pressure, it needs to be less than 140 over 90, which is a little different than normal out of office measurement thresholds, which are usually lower than that at 135, over 85, so another source of confusion. But for now, knowing that it came from a remote monitoring device can be used, and if multiple BPs are measured on the same day, this hasn't changed. You would use the lowest systolic and the lowest diastolic from multiple measurements.

What's not clear is the requirement for the blood pressure needing to be digitally stored and transmitted to the provider. I don't want to comment on that too much...

And transmit it to the provider. I don't want to comment on that too much now because we're seeking clarification, but like all of the other blood pressure measures that are very similar to UDS, this usually requires this statement to be here, that it was digitally stored and transmitted to the provider. In other words, you can't have the patient verbally report it or submit it on paper. So I'll stop there, and we can move to questions. I hope this wasn't too confusing. We're hoping to get more clarity on the change in this measure for UDS for this year, but it is a departure from the past. But it's very exciting that blood pressures from a remote monitoring device are now allowed to be used towards the numerator and the quality measure. So I'm going to turn it back over to Meg.

Meg Meador:

Thanks Mike. And while you're passing me the ball, I just want to say thank you to Dr. Ray Cotsen, to all of our presenters today. I have a couple more slides. I want to quickly share with you some additional opportunities to connect around SMBP, and also some additional resources. So Liz, if you can grab the ball, thank you. I will advance the slides here. So these are the opportunities for you to connect around SMBP. I'm not going to stay on this slide long, but you'll have access to this later. If you look at these two websites, they'll give you the connection information. One is actually sort of a learning community. And

one is a forum where we meet quarterly to connect around SMBP topics. So very much invite you to participate in both of those. And then just wanted to let you know that here's a page that has some additional resources for you.

So we have an implementation guide for SMBP, the seven steps for SMBP, something that Linda mentioned that's coming soon. That'll be out in June. And then there's several videos that you can use with patients, helping them to learn how to use their home blood pressure monitor both in English and Spanish. So just wanted to let you know about those. Let's get going with Q&A. So I know we had a lot of questions here, and I wanted to let folks know that we will answer those that we don't answer verbally in writing later. So we'll post that for you later if we don't get to your question now. But there are a couple of big themes. So let me surface those. So one of the themes has to do with strategies for patients who may not have access to internet. So here's a question that says, for health centers who have patients that don't have internet access or have limited cell phone minutes, or otherwise don't have consistent access, what are your strategies to connect them remotely? So that's probably a question best for Kate or Kathleen or even Michelle.

Kate Milone, MA, MS:

Hi, this is Kate. For those patients that don't have a phone or opportunity to talk with us electronically, we will go ahead and bring them in. We tried to provide some phones or tablets for patients. And for us, that just did not work out very well. So if they have a need to come in and see us, then we do bring them in.

Kathleen Felezzola, BSN:

And we do the same here at Sioux Falls.

Meg Meador:

Thanks Kate and Kathleen. And I can also mention anecdotally from other health centers, some have even set up hotspots around their health center just for those who might have a device, but they don't have internet or wifi where they are. So they'll come to the parking lot even and access that way. Another theme, I know Michelle Trapper is from our health center control network that is in New York and in the East coast region, she answered a few folks who had questions around cost and coverage for monitors, but it seems like a question that a lot of people might have in their minds. So I'd like to do that one verbally as well. So can you share, to our speakers today and even to Mike and team, how are you covering monitors? So what are some of the ways that you can do that?

Michelle:

So you wanted me to hop in there, Meg?

Meg Meador:

Sorry, go ahead, Michelle. Thanks.

Michelle:

Yeah. So, our members have been engaged in self measured blood pressure monitoring for a while now. We had a health system learning collaborative that we had done with our New York members several years ago. And through some funding from New York state department of health, we were able to

provide blood pressure cuffs to our members. And they're still using those to this day with our blood pressure loaner program. And then more recently, with the emergency funding being made available through HERSA to the health centers, a number of them have been able to use that funding to purchase devices that they could send home with the patients. So a number of them are just sending the blood pressure cuffs home with the patients now. Some are still doing loaner programs. But a number are just giving those out to patients so that they have that at home.

And then we have other members that have worked with their health insurers, so the health insurers that are covering their patients. They've seen the value in being able to provide blood pressure cuffs to those patients to help them manage their blood pressure, and they have also been a great source of funding and helping to provide the blood pressure cuffs to patients to be able to monitor their BP at home. And Kate and Kathleen, if you want to share how you were able to get cuffs in your health center as I think folks are interested in that as well.

Kate Milone, MA, MS:

This is Kate. We relied on the kindness of strangers. We basically went to our DCPCA, our primary care association, and said we have a need. Do you guys have anybody that can help us? And they hooked us up with a local pharmacy that was able to provide five cuffs for us. We also were able to go to the insurance companies and ask them for some help. So I know AmeriHealth came through with some. And then we have a quality grant that we had applied for through HERSA. Then we were also able to take some of those funds and purchase some on our own.

Kathleen Felezzola, BSN:

And we too were able to use some grant money that was earmarked for increasing our electronic integration for our patients to purchase some of our blood pressure cuffs as well.

Meg Meador:

Thank you. And so Kate and Kathleen, can you also say a word or two about the patient demographics that you are serving, both for SMBP and for telehealth and whether there are differences in who's able to engage with those?

Kate Milone, MA, MS:

Yeah, this is Kate. So [inaudible 00:55:39] center of health has two centers. We have one in DC and one in College Park, Maryland. Our DC center is primarily African American population. And our College Park center, interestingly enough, which is about 15 minutes away, has a largely Hispanic population. So that's our demographics. And we're finding that just across where everybody is in terms of their healthcare center, we're finding the same types of disparities in care based upon race and ethnicity. And being able to, I think I mentioned, knowing our patients and what they're identifying what their needs are has been very helpful in being able to respond to them and see what they need as far as technology, the language barrier. I mentioned that during my presentation, using the language line to be able to assist us in reaching out to our patients,

Kathleen Felezzola, BSN:

Yeah. Our patients, currently in our West Orange site where we sort piloted this program, we have a larger population of African American patients, which is of course a target area for us. And we, let's see, 90.8% of our patients are low income. The majority of our patients are an ethnic or a racial minority. We

also have a large percentage of homeless population. So we're pretty diverse and need to accommodate for health literacy. A lot of our patients cannot afford technology. We have patients who don't have smart phones, and so we're trying to accommodate for all of that as well.

Meg Meador:

Thank you. And a quick question here for Mike and team. So regarding the CPT codes, a couple of questions around them. And one is, are they only for Medicare or does this also include Medicaid? And are these codes only for health centers?

Michael Rakotz, MD, FAHA, FAAFP:

So the codes are not only for health centers. There was a CMS coverage determination, and they are covered. They're covered by Medicare, and Medicaid may be covered as well. Some coverage depends state by state. And the same is true for private payers who typically look to CMS, as they will likely, if CMS covers, they may cover and they may cover it at a different reimbursement rate, sometimes higher. It's hard to say. But the answer basically is it doesn't have to be only for community health centers. It can be anywhere. And yes, CMS does cover both of these SMBP codes, and Medicaid may as well.

Meg Meador:

I have a final question for you. I know we have a lot of questions and we'll try to get to those in a written format if we can't verbally. So the question, Mike, is if a single SMBP reading can be used for quality measure, why would one have the patient go through the trouble of doing multiple measurements over a week and the healthcare provider averaging it?

Michael Rakotz, MD, FAHA, FAAFP:

Yeah, I mean, that's a really, really important question. I wish I had had time to address that then, but I'll address it now. So single blood pressure reported is for performance reporting. It's the way that somebody's looking how you're taking care of your patients and deciding whether or not you meet a set of specifications for a quality measure. But that's very different than an evidence based recommendation from a guideline or a guideline directed best practice for taking care of a patient to improve their health and have better outcomes. And so what we advise is to follow the evidence, to provide the best care you can to patients to reduce their risks of heart attack, stroke and death by controlling their blood pressure. The HEDIS measure, the UDS measure, all of the performance measures that may use a single blood pressure are not designed to improve patient outcomes.

They're designed to score provider performance. So hopefully that explains to the difference. So, they're not meant to be the same. The quality measures are not meant to drive patient care. They're meant to score provider performance. And those are two different things. I know they sound like they're the same. And we in our country have put such a high emphasis on achieving high scores, potentially sometimes at the cost of taking the best care of patients, but we have to advise how to improve health outcomes. And so for that, we know for home blood pressure monitoring for SMBP, the evidence based protocol is to measure a minimum of three days up to seven days of readings averaged. And that will give you the best blood pressure to make clinical decisions on to improve outcomes.

Meg Meador:

Thanks, Mike. And I know we're at time, Liz.

Elizabeth Breidenbach:

Yes, we are at time. Again, thank you everybody on behalf of NACHC. We want to thank you for attending today. And just as a reminder, that today's event is being recorded or was recorded and will be available in the NACHC COVID-19 webinar page, as well as the SMBP community healthcare page. Thank you so much. Have a great day. We'll talk to you soon.