Q&A - How to Manage Hypertension Virtually in Health Centers during COVID-19 and Beyond Webinar
Wednesday, May 20, 2020 | Clinical Affairs Division
Q&A

Q: How do you cover the cost of blood pressure devices? Our state insurances generally do not, and have not, covered blood pressure units for home self-monitoring (rare exceptions). None of our Medicaid MCOs are paying for automated BP cuffs. The Medicare companies have told us that patients have to use their OTC benefit online catalog to order one.

Are there resources/grants that you are aware of that could provide BP devices for uninsured patients?

A: Some of the health centers have been able to use the recent funding from HRSA to purchase monitors: https://bphc.hrsa.gov/emergency-response

Local departments of health and some health insurers have helped provide funding to health centers for covering the cost of monitors as well as primary care associations, donations from insurance companies, and grants from organizations like the American Heart Association.

Q: Are you having patients return the home blood pressure monitors (are they loaners)?

A: Each health center has different programs. Some are sending the monitors out as loaners and some allow patients to keep the monitors indefinitely. Health centers have had success with both approaches.

We are not expecting them to be returned.

Q: How many participants are doing home BP monitoring at your health centers and how many BP machines do you provide or loan out?

A: Kate: Approximately 20% are using home BP monitors and we have given out SMBP devices to about half of them.

A: Kathleen: For Zufall's current program, we have 40 patients who have received monitors. We loaned monitors to all of these patients and they have been returned within 2 to 4 weeks of enrollment.

Q: For loaned home BP monitors, how are you cleaning/disinfecting them? Are there any device cleaning guidelines for COVID-19?

A: Kate: We allow the patients to keep the device. If we have any returned, we would use disinfectant wipes and allow them to dry.

A: Kathleen: At Zufall, we disinfect home BP monitors with wipes and allow them to air dry, making sure that all surfaces are wiped clean.

Q: How do you validate patients' home BP monitors? Also, how do you calibrate them?

A: www.ValidateBP.org is a good source for validated devices sold in the U.S. We calibrated our monitors against an office BP machine using our staff before giving them to a patient.

Q: What home blood pressure monitors are you using? Are there any devices that the presenters recommend that are user friendly for patients?

A: Kate: We like the OMRON model 7 or 10 series wireless

Q: Are there any home blood pressure monitors that work with larger arm sizes?

A: The Welch Allyn Home has an XL cuff that can be purchased as an addition. In NACHC's SMBP project with health centers (201-2018), we found that 50% of health center patients who would benefit from SMBP needed the XL cuff. Most models come with a "large" (adult-sized) cuff, but not the XL many patients need. It's important to check the device specifications carefully.

Q: Do you know which devices integrate with eClinicalWorks?

A: Kate: We use Athena, so sorry – I can't advise here.

A: Kathleen: We have tried the Welch Allyn devices that integrate with eCW; however, we did not find them easy to set up and use for our patients. We are actively trying to find a new device that integrates well with eCW.

Q: Is anyone using 24-hour ambulatory blood pressure monitoring (ABPM) devices or devices that do sequential readings and average?

A: None of the presenting health centers are using the 24-hour ABPM devices.

All 24-hour ABPM devices can be programmed to measure BP every 15-30 minutes for use during awake hours and can be programmed for measurements during sleep as well. Averages calculated by most ABPM device software include averages for

1. 24-hour BP
2. Awake BP
3. Asleep BP

Kate: The Omron Platinum averages the BP for morning and afternoon.

Q: How do you assess health literacy?

A: Kate: We use two methods – asking and teach/tell back.

Ask: How often do you need to have someone help you when you read instructions, pamphlets, or other information from your doctor or pharmacy?

Teach/Tell back: Show me/tell me what I need you to do and why it is important for you to do this.

A: Kathleen*:* As Kate mentioned during the presentation, we know our patients well and we choose teaching methods appropriate to their language needs and literacy level. We are careful to choose culturally, language-appropriate literature. We also use the teach back method to assess patient understanding. Our materials, including the Patient Self-Management Care Plan, are easy to read, include picture cues, and have limited text.

Q: Can the Self-management Care Plan be sent out?

A: Kate: Our Self-Management Plan is included through the EMR Athena Health (ThoroughCare)

Q: What criteria were used to choose the 39 patients and what were the assumptions on "suitable candidates"?

A: Kathleen: We chose our 39 patients based upon our Blood Pressure Dashboard which looks at patient demographics, blood pressure control, and co-morbidities. We also choose and attempt to engage patients with noted poor adherence to medication and/or visits by offering them the one-on-one attention that this program allows and encouraging them to take an active part in their care through SMBP and Care Planning

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Q: Did Kate Milone mean clinical pharmacist when speaking of team-based care?

A: Kate: Yes, we call the clinical pharmacist at the pharmacy where the individual patient gets their prescriptions.

Q: Great presentations! Is there a self-tracker that patients should use for tracking their numbers? Were these forms tested with different populations to assess whether they understood how to track their information, monitor their progress, etc.?

A: Mike: For paper trackers, there are several available on www.TargetBP.org. These trackers were user-tested and are being used in health centers across the country.

For mobile apps, several trackers are available. Most device manufactures have free apps to be used with their devices (e.g. A&D, Omron, Welch-Allyn). There are also some free apps developed by third parties (e.g., AHA BP tracker, SphygmoHome). I am not aware of how these existing app self-trackers have been tested.

Q: Would the speakers please share the EHR systems they are using and the TH platforms they are using? FYI, the South Carolina Telehealth Alliance has purchased Doxy. Me for all of our providers to use free the rest of the year; all patient needs are a Smartphone (text, reply, start video visit).

A: Zufall uses eClinicalWorks and Elaine Ellis uses Athena. Both use Zoom Healthcare as their telehealth vendor.

Q: How are you dealing with logging home blood pressure readings taken for vitals during a remote visit vs. SMBP averages (2 readings AM and PM for 3 to 7 days, averaged) in the EHR?

A: Kate: We have the MA contact the patient before the visit and work out the best way to get the data. If the patient is using a device that will average the readings and send it to the patient's phone, then they can save it and send it to us through the portal. If not, then we ask the patient to keep a manual log and upload it to the portal or read it to the MA before the visit with the provider. On occasion we have the provider get the info from the patient and record it in the chart, but we try to get this data ahead of time.

A: Kathleen: We are asking patients to maintain a log of blood pressure readings and use an online calculator to calculate an average, entering it under SMBP in the EHR vitals field.

Q: For community health centers: what strategies have you used to provide telehealth services to patients who do not have internet access, have limited cell phone minutes, or otherwise do not have consistent access for virtual connection?

A: One strategy is to set up a Wi-Fi hot spot in the parking lot of the health center that allows for internet access from a vehicle. If the telephone is not an option, we work to bring the patient onsite for a visit.

For the patients with limited access to smartphones – do you find it is a generational issue or a socio-economic issue?

A: Kate and Kathleen: It is both a generational and socioeconomic issue.

Kate: If we cannot use telehealth for any reason we bring the patient in for an onsite visit. Sometimes the patient has a neighbor or family member with a tablet or phone and we can coordinate a visit through them.

Q: Is lack of internet access a barrier for virtual services?

A: Kate: yes, it can be a barrier. We ask if the patient has access through family or friends before we set them up for an onsite visit.

A: Kathleen: In some cases, yes. However, I don't think that we have a significant number of patients who have a lack of internet as a primary barrier. Barriers are more likely due to a lack of devices capable of virtual visits.

Q: How do you do your schedule for telehealth patients, in blocks? Alternating in office with telehealth?

A: Kate: We have one provider for medical and one for behavioral health who are designated the telehealth providers for the day. Our OBGYN does telehealth at a block time in the morning or evening depending on her schedule.

A: Kathleen: For many providers, telehealth visits are much more efficient when scheduled in blocks; however, some of our providers prefer to alternate with in-office visits. We allow them to determine what is best for their schedule.

Q: Is SMBP always accompanied by medication, or do patients participate who are not on BP medication?

A:

For making a new diagnosis:

- SMBP can be used to confirm a suspected diagnosis of white coat, masked, or sustained hypertension. When used to confirm a diagnosis, patients are not being treated with antihypertensive medication.

To assess blood pressure control in a patient with a diagnosis:

- After a diagnosis of hypertension has been confirmed, a patient may be treated with non-pharmacologic, or both nonpharmacologic and pharmacologic treatments. As a result, SMBP is not always accompanied by medication use.

Q: What is the age average of the patients that have successfully done a SMBP program?

A: In NACHC's SMBP project with 10 health centers (2016-2018), patients who successfully completed SMBP (collecting readings AM and PM over 3 or more days) were of all ages; 27% were 18 – 44, 55% were between 45-64, and 18% were 65+

Q: Do any of the clinics embed CHWs in this remote hypertension care?

A: Kate: Not currently. We have a Case Manager/Care Coordinator, but she does not go into the community/patient's homes.

A: Kathleen: We will be expanding our program to include patients at all of our sites as well as our outreach communities and will be utilizing our outreach team to assist in this process. This will hopefully include CHWs in public housing complexes and perhaps beginning a barber shop-based program.

Q: How have you addressed diet in your programs?

A: Kate: Our providers prescribe the DASH diet mostly. We have a handout available through the EMR Athena Health that can be uploaded to the patient portal for their reference. We will also make referrals to the nutritionist for the patient to follow up.

A: Kathleen: Our teams utilize the My Plate method when speaking with patients. We utilize AHA literature in Spanish and English to discuss the role of diet in blood pressure. We also include diet on our Self-Management Care plan and we have a dietician available on-site to address dietary concerns.

Q: How do the speakers intend on connecting with their community partners for SMBP?

A: Kate: we are actively connected with our department of health and through them have access to community resources for SNAP-ED, pharmacy, Giant Foods nutritionist, and others.

A Kathleen: We have an active community outreach team who are already involved in reaching out to our special populations. We have made contacts with religious communities in the area and we do blood pressure teaching and monitoring at various outreach events.

Q: Are these reimbursement amounts for FQHC only.

A: No - they are for CMS; private payers vary, as does Medicaid. Medicare – yes.

Q: Do you know what insurance coverage is like on these CPT codes? Does Medicare generally cover them?

A: Medicare does cover both of these codes, YES.

Q: How are groups submitting these codes when they are outside a provider visit?

A: Kate: After the visit, the provider enters the billing portion of the EMR (Athena) and the codes are programmed there for them to select.

Q: Are these codes being used for Medicaid patients? If yes, are there instances of them being "bill-above" for FQHCs?

A: SMBP codes 99373 and 99374 are covered by Medicare patients based on the CMS coverage determination final rule for 2020. Because these codes are new this year it is unknown at this time whether private payers will reimburse them. Typically, private plans do follow CMS coverage determinations.

Medicaid plans vary from State to State. Please check with Medicaid in your state to confirm whether 99473 and 99474 are covered.

Q: We purchased monitors before the US list came out. If we are performing the device accuracy check on each monitor, but our device is not on the list yet, can we submit the CPT codes?

A: Yes, if the blood pressure monitors have been validated for clinical accuracy. As mentioned on the webinar, all devices on validatebp.org are validated for clinical accuracy, but not all devices that are validated have been submitted to be listed on the site. Until that occurs, it is necessary to look up whether a device has been validated. This can be done either on the FDA website, through a literature search of peer-reviewed publications, or by looking up the device on a validated device list from another country that may include the device you are using (such as Hypertension Canada's or STRIDEBP in Europe. The webinar slides have these additional validation website URLs.

Q: If the patient brings in their electronic monitor, and the provider retrieves their last 12 readings off that, can that count as "digitally stored and transmitted to the provider."

A: For now, unfortunately, the answer is unknown. Based on previous questions to NCQA (the measure steward for the UDS measure) their answer has been "no" in the past. However, clarification from NCQA has been requested. Currently, bringing a device does not meet the numerator guidance of a BP being "transmitted". It is unclear, however, based on the existing language for the UDS measure if that language will be applied to the UDS measure. It is assumed based on other quality measures that NCQA has created, but for now the question remains unanswered.

Q: Does the patient education/training need to be completed in-person to bill for 99473?

A: Prior to the COVID-19 Public Health Emergency, the answer was "yes" because of device calibration, which can only happen in person. This requirement has been waived temporarily due to the public health emergency. While that is in effect, the requirement to perform calibration has been temporarily waived and the education/training can be performed remotely through a telephone or video visits with healthcare staff.

Q: Are there ways to use a remote monitoring device that doesn't automatically transmit? For example, could the patient take a photo of the display and send that?

A: This is unclear for the UDS measure. For the HEDIS measure, which for which NCQA is also the measure steward, the use of video in real-time while a patient scrolls through device measurements has been confirmed by NCQA as being acceptable for use. However, photos of the device screen have not been confirmed for HEDIS. At this time, video has not been approved for UDS, but that does not mean

that using video is not acceptable for UDS. We just don't know and are awaiting clarification.

Q: If a single SMBP reading can be used for the quality measure, why would one have the patient go to the trouble of doing multiple measurements over a week, and the healthcare provider averaging it?

A: The organization that creates the quality measure to calculate provider performance uses a single BP (in or out of the office) to calculate a performance measure score. That score, however, is not reflective of medical evidence to manage a patient. We diagnose and manage patients with conditions like hypertension based on medical evidence, such as those in clinical practice guidelines and scientific statements, not performance measure specifications designed to evaluate a group of providers in an organization to see how well they are performing in that measure.

The reason that multiple measurements over 3-7 days (min 12 readings) are used in clinical practice guidelines around the world both to diagnose hypertension and assess BP to determine treatment effectiveness is that the average of 3-7 days of readings has been shown to be a better predictor of future cardiovascular risk, independent of office BPs.

There is no evidence we are aware of to support using 1-2 home BPs to assess BP control in a patient.

Home BP measurements are taken as a vital sign for a virtual visit (ideally, per clinical guidelines, two BPs averaged) can be used as a vital sign in an office visit for screening to assess BP if a patient is not already diagnosed with hypertension. If these virtual vital BPs are high, then a week of SMBP should be used to determine whether to diagnose a patient with hypertension. For patients already diagnosed with hypertension, a week of SMBP should be used to assess control, regardless of whether a BP/BP average obtained in a virtual visit is elevated or not.

Q: Do vitals taken by the patient at a virtual visit count towards compliance for eCQM 165 Controlling High BP?

A: If the blood pressure(s) is taken using a remote monitoring device, then yes, based on the wording in the performance measure, this would count. There is no clinical guidance, however, to suggest that using 1-2 BPs from home during a virtual encounter is acceptable to use to make clinical decisions about a patient's blood pressure. A minimum of 12 readings over a 3 to 7 day period, averaged, is recommended for clinical decision making. Remember also, 135/85 mmHg at home is equivalent to 140/90 mmHg in the office. Thus, if possible, it's best to distinguish documentation of home vs. office readings in the EMR.

Q: I haven't seen any notice about allowing remote monitoring BPs counting towards UDS measure. Can you provide a link or details on where that was found?

A: The HRSA Program Assistance Letter dated Feb 12, 2020, stated that the UDS Quality of Care measure Controlling High Blood Pressure measure would now be aligned with CMS 165v8. The specifications explained for CMS165V8 are the current guidance for UDS High Blood Pressure Control measure for 2020.