

Using Team-Based Care to Increase the Use of Home Blood Pressure Monitoring (HBPM)

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How can clinical teams increase the use of home blood pressure monitoring (HBPM)?

The benefits of HBPM are **well-established**, including improved blood pressure control, diagnosis of white coat hypertension, and enhanced prediction of cardiovascular risk. HBPM is less costly than 24-hour ambulatory blood pressure monitoring and is generally well-received by patients when accompanied by a prescription and counseling from their provider.

All of **Ohio's Medicaid managed care organizations (MCOs)** cover the cost of HBPM for their members.

However, HBPM prescription and education is often underutilized, due in part to time constraints on provider visits. Clinical team members, such as nurses and medical assistants, can collaborate to increase the use of HBPM.

Tips to leverage team-based care in improving the use of HBPM:

<p>Face-to-Face</p> 	<p>Before visit</p> <ul style="list-style-type: none"> Rooming staff identify and flag patients with hypertension as candidates for HBPM during screening. Clinic staff 'pend' initial prescriptions for HBPM for the prescribing clinician to review and sign, if appropriate. 	<p>During or after visit</p> <ul style="list-style-type: none"> Providers include a customized "smart phrase" (or standardized language) in patients' home-going instructions to educate on correct HBPM use for accurate readings. Support staff routinely schedule 2-4 week follow-up for all patients with hypertension who are not yet at blood pressure goal.
<p>Telehealth</p> 	<p>Before visit</p> <ul style="list-style-type: none"> Clinic staff flag scheduled patients with hypertension as candidates for HBPM in advance of each clinic day or week. Clinic staff 'pend' initial prescriptions for HBPM for the prescribing provider to review and sign, if appropriate. 	<p>During or after visit</p> <ul style="list-style-type: none"> Providers or clinic staff give these instructions via secure patient email portals, or clinic staff print and send them by mail, if available at the clinic site. Support staff routinely schedule 2-4 week follow-up for all hypertensive patients who are not yet at blood pressure goal.

Blood Pressure Measurement Devices

The **blood pressure Validated Device Listing (VDL)** became available online in 2020. These blood pressure measurement devices are preferred because they have been validated for accuracy. Additional automated devices are added as they are submitted for evaluation. Consider providing a **validated device list** to clinical teams, particularly while in-person device checks are less readily available.

For more information, access Cardi-OH's expanded resource on **HBPM**.

References

- George J, MacDonald T. Home blood pressure monitoring. Eur Cardiol. 2015;10(2):95-101. doi:10.15420/ecr.2015.10.2.95.
- Carter EJ, Moise N, Alcántara C, et al. Patient barriers and facilitators to ambulatory and home blood pressure monitoring: a qualitative study. Am J Hypertens. 2018;31(8):919-927. doi:10.1093/ajh/hpy062.
- Kario K. Home blood pressure monitoring: current status and new developments. Am J Hypertens. 2021;34(8):783-794. doi:10.1093/ajh/hpab017.

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