Hypertension

Document Title: Hypertension		
Index #: HLN.P.016	Created by: Adult PCP Leader Committee	Approved by: HLN QCCC
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Supporting Documents:		Next Review Date: 10/01/2025

Hypertension is a major preventable risk factor for heart disease and stroke, which are the first and fifth leading causes of death in the U.S. Our population includes patients 18-85 years of age with a diagnosis of Hypertension. The most recent national guidelines also include additional categories of blood pressure thresholds:

Systolic Blood Pressure, mmHg		Diastolic Blood Pressure, mmHg	Classification 2017 ACC/AHA
<120	And	<80	Normal BP
120-129	And	<80	Elevated BP
130-139	Or	80-89	Stage 1 Hypertension
140-159	Or	90-99	Stage 2 Hypertension
≥160	Or	≥100	Stage 2 Hypertension

Diagnosing Hypertension:

HLN recognizes that making a diagnosis of hypertension requires the integration of multiple blood pressure readings, use of appropriate technique in measuring blood pressures, and utilizing measurements made outside of the clinical setting (home BP monitoring). The diagnosis of hypertension should be made based on the average of at least two blood pressure readings taken on two or more occasions. In accordance with guidelines from USPTF, ACC/AHA, and ESC/ESH, HLN supports recommendations that all individuals 18 years or older should be evaluated, with appropriate technique, at a minimum:

- Adults with normal blood pressure should have reassessment of their blood pressure yearly.
- Adults with elevated blood pressure should be evaluated at least twice yearly, especially with risk factors for hypertension or if their previously measured systolic blood pressure was 120 to 129.

The approach to diagnosing hypertension can also be made, without further confirmatory readings in the following uncommon scenarios:

- Patients presenting with hypertensive urgency or emergency (patients with blood pressure ≥180 mmHg systolic or ≥120 mmHg diastolic)
- Patient who presents with an initial blood pressure of ≥160 mmHg systolic or ≥100 mmHg diastolic and has known target end-organ damage

Hypertension Strategies and Goals:

- Increase hypertension awareness, encourage lifestyle modifications, and focus antihypertensive medication initiation on the adult population with high CVD risk.
- Blood Pressure targets should be individualized based on patient's overall cardiovascular risk.
- Patients with a current diagnosis of hypertension will achieve a blood pressure goal of less than 140/90 by utilizing a standardized, clinical approach through ambulatory management.
- Patients with a diagnosis of CKD, early BP management is recommended with a blood pressure goal of less than 130/80.

Non-pharmacologic therapy, lifestyle changes:

Recommended reinforcement at each visit:

- Weight loss, healthy diet, reduced intake of dietary sodium, enhanced intake of dietary potassium, physical activity, and moderation in alcohol intake, and smoking cessation.

Medication Management:

Recommended Approach:

- Refer to "Epic" physician sidebar for HLN antihypertensive formulary and clinical points.
- Communicate most common side effect (i.e., dizziness, fatigue, peripheral edema, etc.).
- Address medication adherence issues promptly.
- Prescribe antihypertensive medication(s) for 6 months or less, 90-day supply with 1 refill recommended.
- Require follow-up visit for refill.
- If lack of follow-up, offer refills at a reduced quantity.

Follow-Up Visits:

With initiation or change of an antihypertensive medication for BP ≥ 140/90, follow-up is recommended in 2 weeks with provider or for a nurse visit.

- 2-week follow-up schedule is recommended until BP is at defined goal and stable.
- All patients should be seen a minimum of two times a year once BP goal met.
- Engage patients in blood pressure self-measurement with yearly documentation of "BP Cuff Validation" in Epic Storyboard to ensure home BP readings are accurate.

Measurement Plan:

Process Measures:	Outcome Measures:
% Of patients seen twice yearly	Blood pressure control 140/90 Blood pressure control 130/80 (CKD/DM Population)
RAS Antagonist Medication Adherence	PDC 90%

Advanced Illness and Frailty Exclusions for Hypertension:

- Patients will be excluded if there is evidence of frailty for example pressure ulcers, durable medical equipment (DME) usage or home health/skilled nursing services; advanced illness due to chronic conditions; and palliative care.
- Patients 66-80 years old with frailty and advanced illness, or 81 years old and older with frailty only may be excluded for Controlling High Blood Pressure (CBP).

Advanced Illness Exclusions:

Based on any of the following claim(s) with an advanced illness code during the current or prior year for:

- Two outpatient, emergency department (ED), observation or nonacute inpatient visits, when in person, telephone or online, on different dates of service
- One acute inpatient stay
- One dispensed dementia medication

Frailty Exclusion:
For measurement year 2023, frailty exclusion will require at least 2 indications of frailty on different dates of service during the measurement year.

Palliative Care Exclusions:
Based on any single claim with a palliative care code during the current year.
*Review guidelines for Advanced Illness and Frailty Value Set for further information.

Ongoing Program Evaluation and Enhancement:
In accordance with the HLN Ongoing Quality Management process, the HLN Adult Primary Care Leader Committee with support of the HLN Quality & Care Coordination Committee will:

- Monitor performance of the Hypertensive Disease clinical program
- Evaluate the effectiveness of the clinical program recommended best practices
- Recommend changes to further improve the clinical program

*Disclaimer: Home blood pressure monitoring is not a substitute for office visits. Always make sure patients know what to do should they have a blood pressure measurement that is outside the pre-determined acceptable range or if they experience any symptoms with a high or low blood pressure measurement.

Supporting Evidence:

- Guidelines Made Simple 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults CITATION: J Am Coll Cardiol. Sep 2017, 23976; DOI: 10.1016/j.jacc.2017.07.745
- New Aspects of the Risk Assessment Guidelines: Practical Highlights, Scientific Evidence and Future Goals CITATION: ACC, Nov 2018
- Improving Care for those with Advanced Illness and Frailty: NCQA, July 2018

This document has been developed with input from clinicians and administrative leaders within HLN. It is intended to provide recommendations and guidance for a Population Health program. Clinical care decisions related to the care of individual patients are determined by the patient's providers

Health Leaders Network

Best Practice Recommendations from HLN Providers:

Lifestyle	Educational Materials: MyChart Health Library (Healthwise) Information (includes videos) about hypertension, lifestyle changes & management strategies: ▪ DASH Diet video, sample menu, heart healthy eating, etc. ▪ High Blood Pressure, Sodium and High Blood Pressure, ▪ Lifestyle changes, Medications for High Blood Pressure, etc.
Rx Mgmt.	Prescribe antihypertensive medication(s) for 6 months or less, requiring follow-up visit for refill. If lack of follow-up, offer refills at a reduced quantity. 10/25/2019 – Rx Refill Workflow Example: Dr. Ashley Guy's Clinic
Follow-up	Epic BPA (GEN BPA HYPERTENSION) triggers in the Quality Activity & Plan for patients with a diagnosis of HTN and BP ≥ 140/90: ▪ 1 week for nurse visit or 1 week for provider visit ▪ 2 weeks for nurse visit or 2 weeks for provider visit ▪ 4 weeks for nurse visit or 4 weeks for provider visit At the 2-week visit instruct the patient to bring their home monitoring device for correlation and verification. Reported Home BP is available in the Vital Signs section, allowing nursing staff to document the home BP reading for trending purposes.
Home BP Monitoring*	Annually, at a minimum, have the patient bring their home device to an appointment so the provider/care team can verify: ▪ the at-home blood pressure cuff is properly fitted ▪ accuracy of measurement by comparing the readings with the clinic's blood pressure device and confirmation that it is within the accepted range of variability ▪ patient performance ▪ Epic documentation: ▪ Yearly documentation of BP Cuff Validation in Storyboard (Epic) Documentation of blood pressure measurements in Epic: ▪ Patient is signed up for MyChart ▪ Provider places order for MyChart questionnaire – BP flowsheet ▪ Patient uses MyChart to enter Self-Measured Home Blood Pressure ▪ New site location of Home Blood Pressure is in the Vital Sign section Communicating blood pressure measurements to the physician or care team: ▪ MyChart message to provider ▪ Note: Home BP will display differently on the Vital Signs Flowsheet
Patient outreach	Identify patients for f/u through the following EPIC reports located on the HLN Metric Dashboard. ▪ My HLN members meeting the measure ▪ My HLN members NOT meeting the measure ▪ MyChart: Appointments and Reminders

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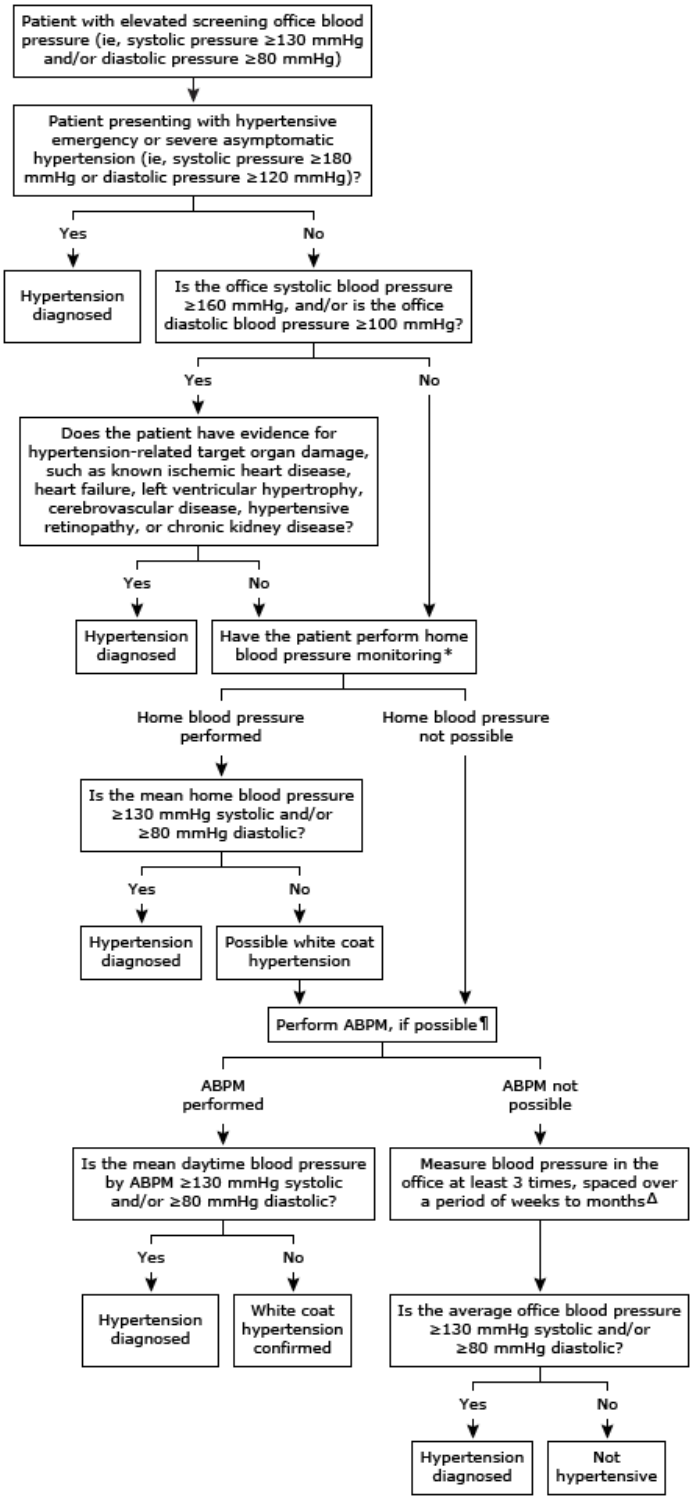
Appendix: Diagnosis of Hypertension in Adults



ABPM is performed by having the patient wear, typically for 24 hours, an electronic blood pressure device that automatically measures the blood pressure, usually every half-hour during the day and hourly at night. Use the mean daytime value to determine the presence of hypertension. ABPM is possible if it is available in the clinic or via an external vendor and if it can be paid for by the patient's insurance or by the patient.

Risk Adjusted HCC Documentation Tips

Essential (primary) hypertension (I10) is not an HCC code, meaning this diagnosis does not contribute to a patient's risk score if reported. The ICD-10-CM classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term "with" in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For hypertension and conditions not specifically linked by relational terms such as "with" or "due to" in the classification, provider documentation must link the conditions in order to code them as related.

Essential (primary) hypertension		CMS-HCC	RAF
I10	Essential (primary) hypertension (includes high blood pressure in addition to benign, arterial, malignant, and systemic hypertension)	--	0.000
If coding hypertensive heart disease with heart failure (I11.0), use an additional code to identify the type of heart failure (I50.1-I50.9)		CMS-HCC	RAF
I11.0	Hypertensive heart disease with heart failure	85	0.331
Heart Failure (I50.1-I50.9)		CMS-HCC	RAF
I50.1	Left ventricular failure, unspecified	85	0.331
I50.2-	Systolic (congestive) heart failure - Add 5th character: (1) acute, (2) chronic, (3) acute on chronic, (0) unspecified	85	0.331
I50.3-	Diastolic (congestive) heart failure - Add 5th character: (1) acute, (2) chronic, (3) acute on chronic, (0) unspecified	85	0.331
I50.4-	Combined systolic (congestive) and diastolic (congestive) heart failure - Add 5th character: (1) acute, (2) chronic, (3) acute on chronic, (0) unspecified	85	0.331
I50.81 -	Right heart failure - Add 6th character: (1) acute, (2) chronic, (3) acute on chronic, (4) due to left heart failure, (0) unspecified	85	0.331
I50.82	Biventricular heart failure	85	0.331
I50.83	High output heart failure	85	0.331
I50.84	End stage heart failure	85	0.331
I50.89	Other heart failure	85	0.331
I50.9	Heart failure, unspecified congestive heart \disease; congestive heart failure NOS [CHF])	85	0.331
• For I50.2-, I50.3- and I50.4-, code also end stage heart failure, if applicable (I50.84). • For I50.814, I50.82 and I50.84, code also the type of heart failure, if known (I50.2- – I50.43).			
If coding hypertension with chronic kidney disease, use an additional code to identify the stage of CKD (N18.1-N18.6)		CMS-HCC	RAF
I12.0	Hypertensive CKD with stage 5 CKD or end stage renal disease	136	0.289
Chronic kidney disease (N18.1-N18.6)		CMS-HCC	RAF

Health Leaders Network

N18.1	CKD, Stage 1	--	0.000
N18.2	CKD, Stage 2 (mild)	--	0.000
N18.3	CKD, Stage 3 (moderate)	138	0.069
N18.4	CKD, Stage 4 (severe)	137	0.289
N18.5	CKD, Stage 5 (requiring chronic dialysis use N18.6)	136	0.289
N18.6	End Stage Renal Disease (ESRD)	136	0.289
N18.9	CKD, unspecified		0.000
*Use an additional code to specify: "Dialysis status" (Z99.2) "Noncompliance with dialysis" (Z91.15) "Kidney transplant status" (Z94.0)			
If coding hypertensive heart disease with heart failure and chronic kidney disease (I13.0, I13.2), use an additional code to identify the type of heart failure (I50.1-I50.9) and the stage of CKD (N18.1-N18.6)		CMS-HCC	RAF
I13.0	Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD, or unspecified CKD	85	0.331
I13.11	Hypertensive heart and CKD without heart failure, with stage 5 CKD, or end stage renal disease	136	0.289
I13.2	Hypertensive heart and CKD with heart failure and with stage 5 CKD, or end stage renal disease	136	0.331

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MODIFICATION HISTORY

Type	Revised By	Revised Date	Approval Date *(If Applicable)*	Notes
Creation		4/1/2018		
Revision		8/1/2018		Figure 1 adjusted to 2-week follow; HLN.P.016.1 – HTN Supplement: 2-week f/u recs added; HLN.P.016.2 – HTN Supplement: Home BP supplement added; HTN document is now a 5 page document when combined; Revision date changed to 2Q19;
Revision		8/20/2018		HLN.P.016.1 – HTN Supplement: Follow-up Verbiage change: Previous: Medication Management: No refills, if not seen within last 6 months Current: Medication Management: Prescribe antihypertensive medication for 6 months or less, requiring follow-up visit for refill. If lack of follow-up, offer refills at a reduced quantity due to lack of follow-up.
Revision		3/29/2019	4/9/2019	Retired HLN.P.016.1 & HLN.P.016.2 Modified HLN.P.016 removed flow, modified language. Combined the three documents into one. Clinical points and Meds will be on the EPIC Side bar. Approved by Adult Leader CPC; Approved by QCCC with physician names added to header as recommended.
Revision		2/28/2020	3/10/2020	Adult PCP Committee approved new document format and the addition of Dr. Ashley Guy's workflow to "best practices." The standard/expectation was approved; Document reviewed and approved by QCCC
Revision	Megan Rainey	1/20/2023	2/10/2023	Included CDC HTN Control graphic on BP targets; updated measurement plan to include Medication Adherence targets; added Advanced Illness and Frailty info; Approved by Adult Leaders Committee
Revision	Kallia Bouton	3/6/2023		Added Addendum for Risk Adjusted Coding Tips section; Approved by QCCC
Revision	Megan Rainey	3/14/2023		Incorporated diagnosis criteria to align with hypertension targets as requested by QCCC, added section "Diagnosing Hypertension" and Appendix: Diagnosis of Hypertension in Adults algorithm
Approval	QCCC		4/4/2023	