**SCOPE OF WORK**

Care + Community + Equity

**Self-Measurement of Blood Pressure**

June 30th, 2022 – September 29th, 2023

This scope of work has been designed to:

* Align with the recent UDS emphasis on strengthening data infrastructure to capture, use, and share patient-generated health data
* Help practices implement or optimize an existing self-measurement of blood pressure (SMBP) program

**Aims**

Through Care + Community + Equity (CCE), the Diabetes, Heart Disease and Stroke Program (DHDS) at the Rhode Island Department of Health (RIDOH) is seeking to improve clinical care of patients with hypertension. This program uses out-of-office blood pressure measurement to assist in diagnosing and managing hypertension and increase patient participation in their own care and is provided in conjunction with team-based care, telehealth counseling, and other clinical interventions.

DHDS envisions a health care system where providers are connected to the communities they serve, and communities are connected to the providers within their neighborhood.

Within this scope of work, DHDS aims to:

1. Identify patients with hypertension (diagnosed and undiagnosed)
2. Improve blood pressure control through the integration of out-of-office blood pressure measurement, or SMBP, into the standard of care for hypertension

**Scope of Work**

To effectively participate in this work, each practice must have the ability to:

* Generate reports from their electronic health records (EHRs) of
	+ the number of patients with undiagnosed hypertension
	+ the percentage of patients with hypertension in control (CMS 165v10)
* Develop and implement workflows that support data collection and management, screening, and referrals to SMBP
* Track the distribution of at-home blood pressure monitors, purchased in Year 1 of CCE

The following deliverables outline in greater detail the responsibility of the practices.

Year 4 of CCE is designed to lead to improvements in SMBP programs. Deliverables in CCE’s implementation phase are categorized as “core” or “incentive.” Core deliverables comprise up to 80% of the funding available to a practice or agency.

*Core Deliverables for Year 4 of Care+Community+Equity*

1. Meet with your CTC-RI practice facilitator quarterly or more based on meeting performance and scope of work requirements to review progress, address barriers, and obtain support for self-measurement of blood pressure activities.
2. Identify members of the CCE project team. Include clinical staff and, if applicable, a CHW, who will be involved in the QI project/PDSA and can participate in these meetings.
3. Submit the following data quarterly by the 15th of October, January, April, and July to the CCE Portal (link and measure specifications to be provided). The final data submission will be due September 29, 2023 (data through September 15, 2023).
	* **Adult Patient Panel**: Number of adult patients who are active (seen by a primary care provider for at least one medical visit) in the practice in the last 12 months
	* **Hypertension in Control (**CMS 165v10): Percent of patients whose blood pressure was adequately controlled during the measurement period (<140/90mmHg)
	* **Elevated Blood Pressure without Hypertension Diagnosis**: Number of patients during the past 12 months who do not have a diagnosis of hypertension but who have had two or more blood pressure readings > 140 mmHg SBP and/or >90 mmHg DBP, including the most recent visit.
	* **Patient Submission of Blood Pressure Readings**: Percent of patients with a diagnosis of hypertension who were advised by their provider participating in the SMBP program who have submitted their blood pressure readings to their provider at least once during the measurement period.
4. Attend and participate at quarterly CCE best practice sharing meetings (dates TBD in September 2022, December 2022, March 2023, June 2023, and September 2023). Please come prepared to discuss best practices and progress on your PDSA; this discussion will be incorporated into each meeting. Invite members of the care teams to participate in these meetings.
5. Meet with your CTC practice facilitator to draft and finalize your Year 4 QI projects/PDSA and aim statements. Your PDSA and aim statements must address improving your SMBP program. We strongly suggest using the PDSA template that will be provided by your practice facilitator.

While the completed QI project/PDSA will be submitted in June 2023, reporting on its components will take place throughout the year.

During July and August, develop a timeline and due dates for each component of the QI project/PDSA

* + Submit the Plan section of the PDSA and the aim statement(s) to RIDOH in September. Plans will be shared during the September best practice sharing meeting
	+ Summarize and present your test of change during the December and March best practice sharing meetings
	+ Present a final report during the June best practice sharing meeting

The use and incorporation of the American Heart Association’s (AHA) SMBP resources are encouraged during this time:

[HTN Control Practice Assessment](https://targetbp.org/practice-assessment-tool/%20%5Btargetbp.org%5D)

[Getting Prepared](https://targetbp.org/patient-measured-bp/implementing/)

[Loaning Devices](https://targetbp.org/patient-measured-bp/implementing/smbp-device-loaner-program/)

[Training Patients](https://targetbp.org/patient-measured-bp/implementing/smbp-training-patients/)

[Collecting Data](https://targetbp.org/patient-measured-bp/implementing/smbp-data-collection-review/)

[Managing your Devices](https://targetbp.org/patient-measured-bp/implementing/smbp-device-inventory-management/)

1. If needed/desired, identify appropriate staff to attend a training on proper blood pressure measurement techniques and a review of SMBP concepts. Trainer and training date(s) TBD.

The use and incorporation of AHA’s [Technique Quick Check](https://targetbp.org/tools_downloads/technique-quick-check/) and [other resources](https://targetbp.org/tools-downloads/?sort=topic&) is encouraged.

Note: If applicable, as it relates to your SMBP policy, describe how WISEWOMAN eligible patients are identified and referred to SMBP within your organization. WISEWOMAN patient navigators can assist in referring these patients to SMBP.

1. Complete a final evaluation survey, due September 29, 2023.

If deliverables cannot be completed by the due dates referenced in the CCE Year 4 project plan, practices must notify RIDOH’s Quality Improvement Consultant (Jayne Daylor) via email, preferably in advance. A plan of corrective action may need to be completed and submitted.

*Incentive Deliverables for Year 4 of Care+Community+Equity*

Incentive payments will be distributed annually if *three* of the following deliverables are met (up to 20% of funds allocated within each CCE Implementation Phase). Incentive payments will be prorated for 1­–3 deliverables achieved and will be dispersed as a lump sum at the end of the contract year.

By end of the Year 4 contract:

1. Complete a practice-designed incentive:

With members of your care team, craft a project with target(s) consistent with the goals of this scope of work. Establish benchmarks to demonstrate achievement of the target by June 29th, 2023. Review and discuss with your practice facilitator and RIDOH for approval by September 15th, 2022.

Options:

1. Craft a target that aligns with your PDSA; establish and monitor progress so that achievement of the agreed upon target could be demonstrated by June 2023.
2. Participate in the Rhode to Equity (July 1,2022 to June 30, 2023) for hypertension
3. Participate in CTC’s Pharmacy Quality Improvement Initiative for ambulatory measurement of blood pressure, which is scheduled to begin in June 2022 or September 2022.
4. Demonstrate that the percentage of patients with HTN in Control is at or above the goal of 65%. Target must be met and sustained each quarter.
5. Participate in the American Heart Association’s Quality Improvement Initiatives

Apply and earn Participant, Silver or Gold Status recognition for AHA’s Target:BP® initiative

*and/or*

Apply and earn Participant, Silver or Gold Achievement recognition for AHA’s Check. Change. Control. *Cholesterol™* initiative

1. During quarterly site visits, demonstrate how SMBP patients are managed and at-home blood pressure reading results are interpreted. Demonstrate that at least 10% of patients enrolled in the SMBP program achieved HTN Control.
2. Invite members of the clinical care team to a CCE Best Practice Sharing meeting scheduled for September, December, or March and present a practice or patient story that demonstrates successes and/or challenges in implementing a self-measurement of blood pressure program.
3. Utilize the road map tool from the Center for Disease Control - Improve Blood Pressure Control in African Americans. The tool organizes groups of intervention and activities to help practices develop a deliberate strategy or approach to your practice’s hypertension management efforts.

The following deliverables outline in greater detail the responsibility of RIDHDS.

RIDHDS will:

* Provide practice facilitation and EHR technical assistance through existing contracts with CTC-RI and AHP
* In collaboration with the Rhode Island Health Center Association, provide training and technical assistance opportunities to FQHCs and free clinics serving vulnerable populations
* Provide technical assistance on RIDOH’s Community Health Network (CHN)
* Assist with evaluation of process measures and other analytical/data support (i.e., analyzing de-identified data, pre-post evaluations, etc.)
* Report quarterly on the number of CHN referrals made by each site
* Facilitate and strengthen connections between each health center and RIDOH programs (i.e., HEZ, CHN, DPP, WISEWOMAN)
* Distribute funds
* Alert practices to new resources and continuing education opportunities through regular programmatic updates