

eCQM Title	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	eCQM Version Number	13.0 0000
eCQM Identifier (Measure Authoring Tool)	22	GLID	9a023a64-3a9b-11e1-963a-00273b2f6174
CBE Number	Not Applicable	eCQM GUID	
Measurement Period	January 1, 2020X through December 31, 20XX		
Measure Steward	Centers for Medicare & Medicaid Services (CMS)		
Measure Developer	Mathematica		
Endorsement description	None		
Disclaimer	Interpretation of patient visits for patients aged 18 years and older during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is elevated or hypertensive. Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary copyrights from the owners of these code sets. CPT(R) contained in the Measure specifications is copyright 2004-2023 American Medical Association. LOINC(R) is copyright 2004-2023 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2023 World Health Organization. All Rights Reserved.		
Disclaimer	These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for appropriateness or safety. THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.		
Measure Scoring	Proportion		
Measurement	Proxies		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Hypertension is a prevalent condition that affects approximately 66.9 million people in the United States. It is estimated that about 20-40 percent of the adult population has hypertension; the majority of people over age 65 have a hypertension diagnosis (Apostel et al., 2013 and Luehr et al., 2012). Winter (2012) noted that 1 in 3 American adults have hypertension and the lifetime risk of developing hypertension is 80 percent. The African-American population or non-Hispanic Blacks, the elderly, diabetics and those with chronic kidney disease are at increased risk of stroke, myocardial infarction and renal disease. Non-Hispanic Blacks have the highest prevalence of hypertension (at 70 percent) (Vines et al., 2013). Hypertension is a major risk factor for ischemic heart disease, left ventricular hypertrophy, left ventricular failure, stroke and dementia (Luehr et al., 2012). Prevention of hypertension and the treatment of established hypertension are complementary approaches to reducing cardiovascular disease risk in the population, but prevention of hypertension provides the optimal means of reducing risk and avoiding harmful consequences. Periodic blood pressure (BP) screening can identify individuals who develop elevated BP over time. More frequent BP screening may be particularly important for individuals with elevated atherosclerotic cardiovascular disease (ASCVD) risk (Whelton et al., 2019). Hypertension is the most common reason for an adult office visits other than pregnancy. Garrison (2013) stated that in 2007, 47 million Americans were attributed to hypertension (Garrison & Oberhelman, 2013). It also has the highest utilization of prescription drugs. Numerous resources and treatment options are available, yet only about 40-50 percent of the hypertensive patients have their blood pressure under control (<140/90) (Apostel et al., 2013 and Luehr et al., 2012). In addition to medication non-compliance, poor outcomes are also attributed to poor adherence to lifestyle changes such as a low-sodium diet, weight loss, increased exercise and limiting alcohol intake. Many adults find it difficult to continue medications and lifestyle changes when they are asymptomatic. Elevated blood pressure is a common condition that affects approximately 66.9 million people in the United States. It is estimated that about 20-40 percent of the adult population has hypertension; the majority of people over age 65 have a hypertension diagnosis (Apostel et al., 2013 and Luehr et al., 2012). Winter (2012) noted that 1 in 3 American adults have hypertension and the lifetime risk of developing hypertension is 80 percent. The African-American population or non-Hispanic Blacks, the elderly, diabetics and those with chronic kidney disease are at increased risk of stroke, myocardial infarction and renal insufficiency) (Luehr et al., 2012). Appropriate follow-up after blood pressure measurement is a pivotal component in preventing the progression of hypertension and the development of heart disease. Detection of marginally or fully elevated blood pressure by a specialty clinician warrants referral to a provider familiar with the management of hypertension and prehypertension. The American College of Cardiology/American Heart Association (ACC/AHA) 2017 Guidelines provide updated recommendations for ASCVD risk. For additional information please refer to the 2017 ACC/AHA guidelines: https://www.ahajournals.org/doi/full/10.1161/HYP.0000000000000065. Lifestyle modifications have demonstrated effectiveness in lowering blood pressure (U.S. Department of Health and Human Services, 2020). The effect of several lifestyle modifications results in greater benefits than a single modification alone. Baseline diagnostic/laboratory testing establishes if a co-existing underlying condition is the etiology of hypertension and evaluates if end organ damage is present and if BP reading is elevated. Landmark trials such as the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) have repeatedly proven the efficacy of pharmacologic therapy to control blood pressure and reduce the complications of hypertension. A review of 35 studies found that the pharmacologic interventions involved medication lowered the optimal means of reducing risk and avoiding harmful consequences. Periodic blood pressure (BP) screening can identify individuals who develop elevated BP over time. More frequent BP screening may be particularly important for individuals with elevated atherosclerotic cardiovascular disease (ASCVD) risk (Whelton et al., 2019). The types of recommended nonpharmacologic interventions, such as lifestyle modifications, are listed following the section on Recommended Follow-Up Interventions based on BP Classification. Recommended Blood Pressure Follow-Up Interventions: -Normal BP: No follow-up required for SBP < 120 mmHg AND DBP < 80 mmHg -Elevated BP: Patients with SBP 120-129 mmHg AND DBP < 80 mmHg -Referral to Alternate/Primary Care Health Care Professional OR -Follow-up with rescreen within 6 months AND recommend nonpharmacologic interventions -First Hypertensive BP Reading: Patients with one elevated reading of SBP >= 130 mmHg OR DBP >= 80 mmHg -Referral to Alternate/Primary Care Health Care Professional OR -Follow-up with rescreen within 4 weeks AND recommend nonpharmacologic interventions -Second Hypertensive BP Reading: -Second Hypertensive BP Reading: Patients with second elevated reading of SBP of 130-139 mmHg OR DBP of 80-89 mmHg (and not SBP >= 140 OR DBP >= 90): -Referral to Alternate/Primary Care Health Care Professional OR -Pharmacologic intervention AND BP-lowering medication AND assessment within 4 weeks AND an order for a laboratory test or ECG for hypertension The 2017 Guideline outlines nonpharmacologic interventions (lifestyle modifications) which must include one or more of the following as indicated: -A "heart healthy diet," such as Dietary Approaches to Stop Hypertension (DASH) Eating Plan -Dietary Sodium Restriction -Increased Physical Activity -Moderation in alcohol consumption This eCQM is an episode-based measure. An episode is defined as each eligible encounter for patients aged 18 years and older during the measurement period (and 90 days prior) in which a blood pressure measurement was reported for every visit. The measure requires that blood pressure measurements (i.e., diastolic and systolic) be obtained during each visit in order to determine the blood pressure reading used to evaluate an intervention is needed. Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple blood pressures obtained during a patient visit, the most recent, recent, pressure measurement will be used to evaluate the measure requirement. The intent of this measure is to screen patients for high blood pressure and provide recommended follow-up as indicated. This document is intended for use by clinicians and other healthcare providers who are responsible for the blood pressure reading as indicated. "Patient referred to primary care provider for BP management." Telehealth encounters are not eligible for this measure because the measure requires a clinical action that cannot be conducted via telehealth. This version of the eCQM uses QDM version 5.6. Please refer to the eCQM resource center (https://ecqm.health.gov/qdm) for more information on this update.		
Clinical Recommendation Statement	The U.S. Preventive Services Task Force (USPSTF, 2021) recommends screening for high blood pressure in adults aged 18 years and older. This is a grade A recommendation.		
Improvement Notation	Higher scores indicate better quality		
Reference	Reference Text: "Apostel, S. L., Neo, C., Hill, C. A., Douglas, K. A., Adams, R. J. (2013). Untreated hypertension: prevalence and patient factors and beliefs associated with under-treatment in a population sample. Journal of Human Hypertension, 27, 453-462. https://doi.org/10.1097/HJT.0b013e3182901202." Reference Type: CITATION		
Reference	Reference Text: "Garrison, G. M., & Oberhelman, S. (2013). Screening for hypertension annually compared with current practice. Annals of Family Medicine, 15 (3), 119-121. doi:10.1136/afm.2012.001197." Reference Type: CITATION		
Reference	Reference Text: "Luehr, D., Woodley, T., Brunk, B., Dolmen, F., Harris, R., Johnson, M., Schoenleber, M., 2012). Hypertension diagnosis and treatment: Institute for Clinical Systems Improvement health care guideline. Updated November, 2012." Reference Type: CITATION		
Reference	Reference Text: "Reeves, L., Robinson, K., McChesland, T., Ardroyin, C., Broesecke, A., and Adunlin, C. (2020). Pharmacist Interventions in the Management of Blood Pressure Control and Adherence to Antihypertensive Medication: A Systematic Review of Randomized Controlled Trials. Journal of Clinical Pharmacy and Therapeutics, 45, 115-125. Available at https://doi.org/10.1111/jcph.12593. Accessed 05/05/2021." Reference Type: CITATION		
Reference	Reference Text: "U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute & National High Blood Pressure Education Program (2003). The Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (The JNC-7). NIH Publication No. 03-5225" Reference Type: CITATION		
Reference	Reference Text: "U.S. Preventive Services Task Force (USPSTF) (2021). Screening for hypertension in adults. US Preventive Services Task Force Evidence Report: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Hypertension, 71(6), e16-e115. doi.org/10.1161/HYP.0000000000000065" Reference Type: CITATION		
Reference	Reference Text: "Witter, K. H., Tuttle, L. A. & Vera, A.J. (2013). Hypertension. Primary Care Clinics in Office Practice, 40, 179-194. doi:10.1016/j.pop.2012.11.008" Reference Type: CITATION		
Definition	Blood Pressure (BP) Classification: -Normal BP: Systolic BP (SBP) < 120 mmHg AND Diastolic BP (DBP) < 80 mmHg -Elevated BP: SBP 120-129 mmHg AND DBP < 80 mmHg -First Hypertensive Reading: SBP of >= 130 mmHg OR DBP >= 80 mmHg without a previous SBP of >= 130 mmHg OR DBP of >= 80 mmHg during the 12 months prior to the encounter -Second Hypertensive Reading: Requires a SBP >= 130 mmHg OR DBP >= 80 mmHg during the current encounter AND a most recent BP reading within the last 12 months SBP >= 130 mmHg OR DBP >= 80 mmHg Recommended BP Follow-Up: -The 2017 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults from the American College of Cardiology and American Heart Association recommends BP screening thresholds as defined under Blood Pressure Classifications and recommends interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow-Up Interventions" section of this measure. -The time periods for follow-up actions specified for the elevated and the second hypertension (130-139 DBP OR 80-89 SBP) BP classifications slightly differ from time periods given in the 2017 Guideline. This allows for clinician discretion due to patient condition and stability of the measure specification over time. -The types of recommended nonpharmacologic interventions, such as lifestyle modifications, are listed following the section on Recommended Follow-Up Interventions based on BP Classification. Recommended Blood Pressure Follow-Up Interventions: -Normal BP: No follow-up required for SBP < 120 mmHg AND DBP < 80 mmHg -Elevated BP: Patients with SBP 120-129 mmHg AND DBP < 80 mmHg -Referral to Alternate/Primary Care Health Care Professional OR -Follow-up with rescreen within 6 months AND recommend nonpharmacologic interventions -First Hypertensive BP Reading: Patients with one elevated reading of SBP >= 130 mmHg OR DBP >= 80 mmHg -Referral to Alternate/Primary Care Health Care Professional OR -Follow-up with rescreen within 4 weeks AND recommend nonpharmacologic interventions -Second Hypertensive BP Reading: -Second Hypertensive BP Reading: Patients with second elevated reading of SBP of 130-139 mmHg OR DBP of 80-89 mmHg (and not SBP >= 140 OR DBP >= 90): -Referral to Alternate/Primary Care Health Care Professional OR -Pharmacologic intervention AND BP-lowering medication AND assessment within 4 weeks AND an order for a laboratory test or ECG for hypertension The 2017 Guideline outlines nonpharmacologic interventions (lifestyle modifications) which must include one or more of the following as indicated: -A "heart healthy diet," such as Dietary Approaches to Stop Hypertension (DASH) Eating Plan -Dietary Sodium Restriction -Increased Physical Activity -Moderation in alcohol consumption This eCQM is an episode-based measure. An episode is defined as each eligible encounter for patients aged 18 years and older during the measurement period (and 90 days prior) in which a blood pressure measurement was reported for every visit. The measure requires that blood pressure measurements (i.e., diastolic and systolic) be obtained during each visit in order to determine the blood pressure reading used to evaluate an intervention is needed. Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple blood pressures obtained during a patient visit, the most recent, recent, pressure measurement will be used to evaluate the measure requirement. The intent of this measure is to screen patients for high blood pressure and provide recommended follow-up as indicated. This document is intended for use by clinicians and other healthcare providers who are responsible for the blood pressure reading as indicated. "Patient referred to primary care provider for BP management." Telehealth encounters are not eligible for this measure because the measure requires a clinical action that cannot be conducted via telehealth. This version of the eCQM uses QDM version 5.6. Please refer to the eCQM resource center (https://ecqm.health.gov/qdm) for more information on this update.		
Transmission Format	TBC		
Initial Population	All patient visits for patients aged 18 years and older at the beginning of the measurement period		
Denominator	Eligible Initial Population		
Denominator Exclusions	Patient has an active diagnosis of hypertension.		
Numerator	Patient visits where patients were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is elevated or hypertensive		
Numerator Exclusions	Not Applicable		
Denominator Exceptions	Documentation of medical reason(s) for not screening for high blood pressure (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status).		
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex		
Table of Contents	<ul style="list-style-type: none"> <li>Population Criteria</li> <li>Definitions</li> <li>Terminology</li> <li>Supplemental Data Elements</li> <li>Risk Adjustment Variables</li> </ul>		
Population Criteria	<ul style="list-style-type: none"> <li>Initial Population</li> <li>Denominator</li> <li>Denominator Exclusions</li> <li>Numerator</li> <li>Numerator Exclusions</li> <li>Denominator Exceptions</li> <li>Stratification</li> </ul>		
Definitions	<ul style="list-style-type: none"> <li>Denominator</li> <li>Denominator Exclusions</li> <li>Denominator Exceptions</li> <li>Numerator</li> <li>Numerator Exclusions</li> <li>Denominator Exceptions</li> <li>Stratification</li> </ul>		
Terminology	<ul style="list-style-type: none"> <li>Initial Population</li> <li>Denominator</li> <li>Denominator Exclusions</li> <li>Numerator</li> <li>Numerator Exclusions</li> <li>Denominator Exceptions</li> <li>Stratification</li> </ul>		
Supplemental Data Elements	<ul style="list-style-type: none"> <li>Initial Population</li> <li>Denominator</li> <li>Denominator Exclusions</li> <li>Numerator</li> <li>Numerator Exclusions</li> <li>Denominator Exceptions</li> <li>Stratification</li> </ul>		
Risk Adjustment Variables	<ul style="list-style-type: none"> <li>Initial Population</li> <li>Denominator</li> <li>Denominator Exclusions</li> <li>Numerator</li> <li>Numerator Exclusions</li> <li>Denominator Exceptions</li> <li>Stratification</li> </ul>		