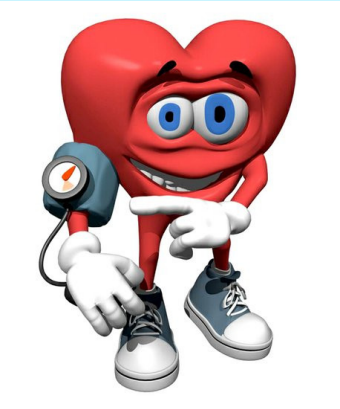


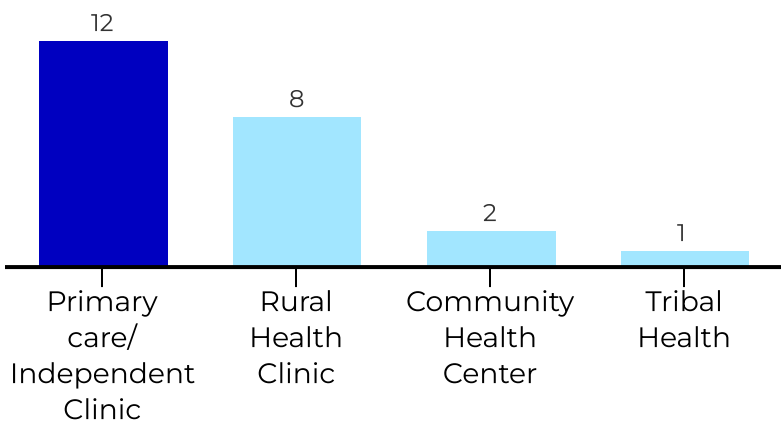
Conducting Blood Pressure Quality Improvement, Years 1-5

Project Goal: Use the Plan-Do-Study-Act (PDSA) quality improvement process to improve a blood pressure-related health outcome for clinic patients.

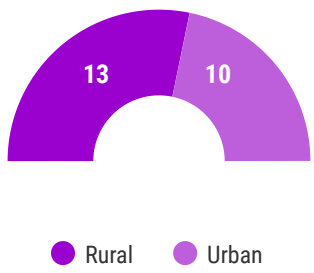
PublicHealth IN THE 406 | MONTANA CARDIOVASCULAR HEALTH PROGRAM

Clinic Characteristics Among 23 Participating Facilities

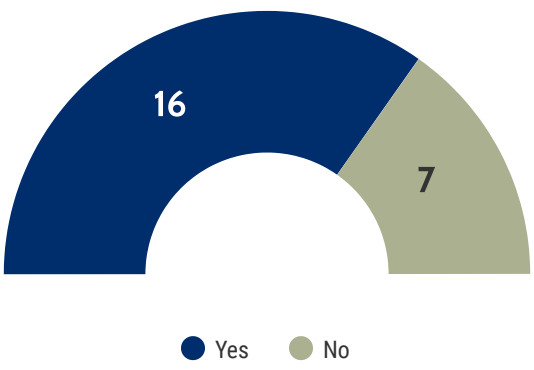
Type of Healthcare Clinic



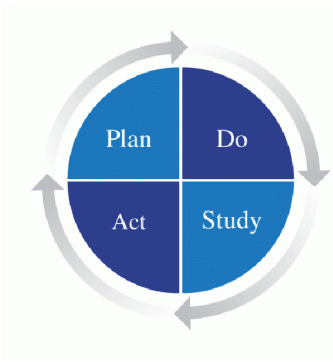
Location of Healthcare System



Previously Conducted Blood Pressure (BP)-related QI



91% were familiar with PDSA for Quality Improvement at start of project



Type of QI Strategies

- Develop standardized protocols/practices
  - Hypertension protocol
  - Blood pressure (BP) re-checks
- Implement self-measured blood pressure (SMBP) monitoring
- Implement Care Management
- Use Electronic Health Record (EHR) data and data analytics
  - Patient identification
  - Add BP control to dashboard
  - Clinical decision support (e.g., reminder system)
- Improve follow-up with elevated BPs
- Utilize American Heart Association MAP* Framework
- Increase pharmacist referrals
- Enhance standardize workflow
  - Schedule patient follow-up visits
  - Referrals (e.g., pharmacist, care management, etc.)
  - Establish goals
- Offer staff training/education
  - Accurate BP measurement
- Offer patient training/education
  - Life style
  - Accurate home BP measurement
  - Medication management
  - Physical activity

*MAP - Measure accurately, Act rapidly, and Partner with Patients

Facilitators

- Physician Champion
- Dedicated staff
- Management/provider/staff buy-in and engagement
- Standardized protocols and training
- Leadership support
- Hypertension as a priority
- Use of data and data analytics (e.g., Dashboard, code to bill BP education and SMBP)
- Communication
- Being proactive
- Resources and templates
- Willingness/Desire of staff to identify/overcome IT limitations

MONTANA DPHHS DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

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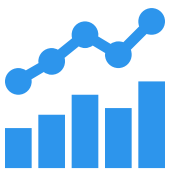
Conducting Healthcare Quality Improvement, Years 1-5, continued

Sustainability

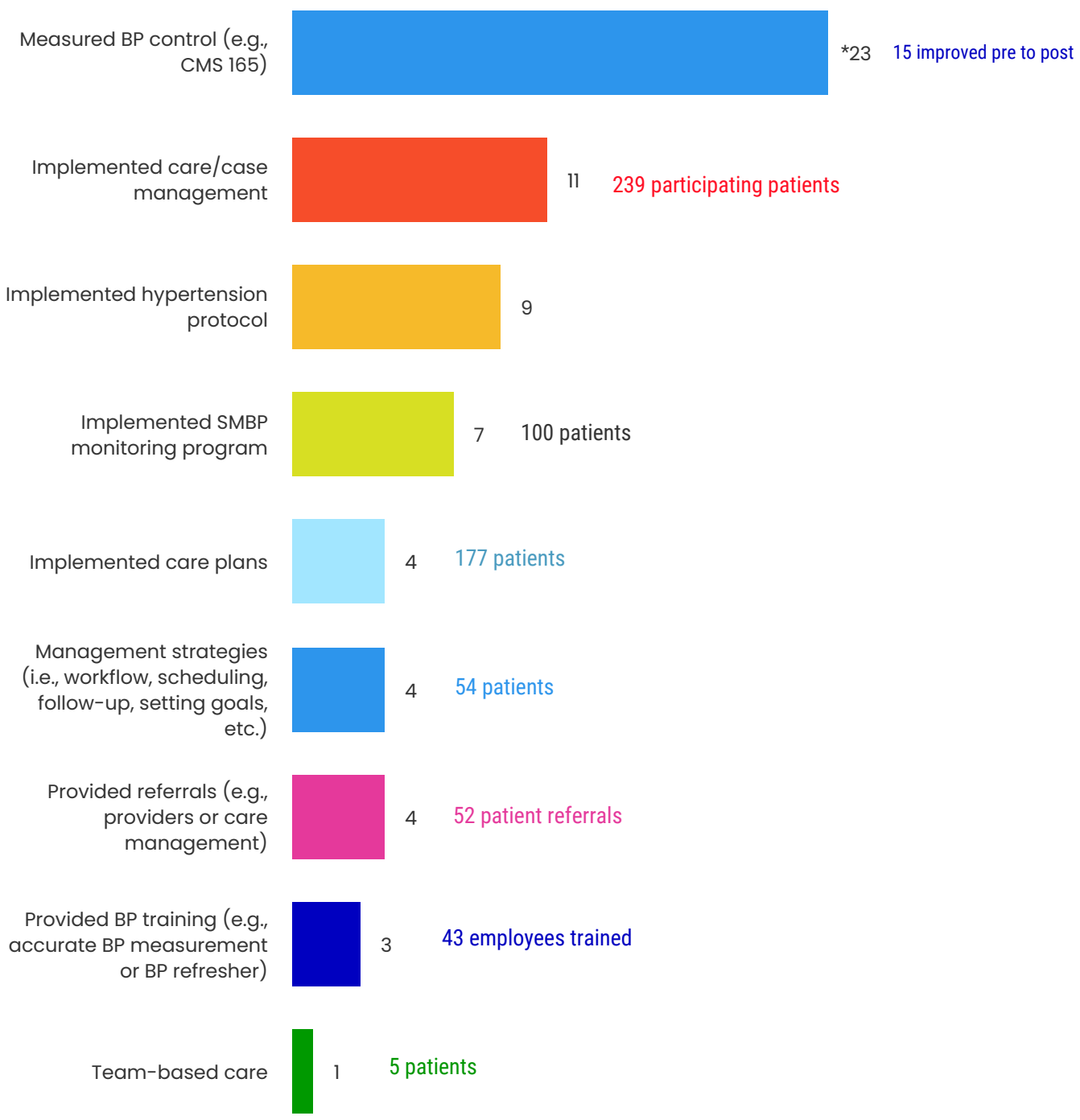


- Make SMBP a standard of care
- Implement population health model to identify care gaps
- Keep hypertension a priority
- Include hypertension on quality measure dashboard
- Offer BP re-checks an continue messaging staff about BP re-checks
- Increase referrals (e.g., pharmacist, care management, etc.)
- Offer BP walk-in clinic
- Implement and continue Care Management
- Use reimbursable services
- Combine efforts with community partners
- Continue to monitor quality measures
- Incentivize higher performing care teams

Barriers

- COVID-19 (e.g., staffing shortage)
- Provider buy-in
- Consensus of blood pressure (BP) targets and protocols
- Competing priorities
- Provider/staff unfamiliar with all available programs (e.g., SMBP, Chronic Care Model, etc.)
- Electronic health record (EHR) technical issues - abstracting data/reports
- Poor attendance and inconsistent scheduling of patient follow-up appointments
- Medication stops/changes not communicated on discharge
- Steadily increasing referrals/enrollment in SMBP program as facility scales up project
- Staff non-compliance with BP re-checks.

Results - 23 Participating Clinics



*22 of 23 clinics were able to obtain pre-/post-data.