Montana Cardiovascular Health Program
Chronic Disease Prevention & Health Promotion Bureau

SUCCESS STORY

Quality Improvement Project Successes

Public Health Issue

Managing chronic disease is challenging. To reduce the risks of chronic disease, health systems need to identify and engage patients.

Electronic health records (EHRs) have been adopted by many health systems in Montana and can be used to help manage chronic disease. However, challenges continue in effectively using EHRs to identify patients with chronic disease, collect patient data, and measure outcomes.

Program Action

The Montana Department of Public Health (DPHHS) partnered with the Commissioner of Securities and Insurance and contracted with Health Technology Services (HTS) [formerly the Regional Extension Center] to provide assistance to Patient Centered Medical Home (PCMH) clinics. To support primary care clinics, HTS staff provided technical assistance on electronic quality measure collection and submission to 28 clinics.

Several of the participating clinics chose to advance their QI initiatives further. They continued working with HTS and DPHHS using the eCQI process, which uses the functionality of the EHR along with clinical best practices to advance quality improvement initiatives. Key actions included:

- Selecting a QI Project
- Determining clinical quality measure(s)
- Using the EHR to obtain baseline data
- Validating data, confirming electronic and physical workflow, and training staff on workflows
- Using Plan Do Study Act (PDSA) cycles to move QI projects forward
- Providing project management assistance
- Giving clinics mini-grants for completion of a QI project

Impact

- *Kalispell Regional Healthcare Woodland Clinic* focused its QI efforts on diabetes care. First, the clinic selected the percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam. Initially, the electronic workflow was assessed so an accurate report could be run. In addition, physical workflows such as removing a patient's shoes and socks at all visits to remind the provider of the need for a foot exam were implemented. These changes resulted in the measure increasing from 5% at baseline to 57%. Woodland Clinic is now working on measures including diabetic eye exams (increased from 1% at baseline to 14%), diabetes urine/protein screening (increased from 1% to79%), closing the referral loop (increased from 1% to 49%), and clinical depression screenings (increased from 0 to 19%).
- *Kalispell Regional Healthcare Big Fork Clinic* implemented a similar project, and its documented foot exams increased from 3% at baseline to 41%. They plan to focus on cancer screenings next.

- *Northern Montana HealthCare* focused on hypertension management, starting with staff training on accurate blood pressure measurement. They also implemented a Blood Pressure (BP) Cuff Loaner Program so patients could "check out" automated BP monitors to use for a specific time period to help improve their BP control. Use of the program has increased greatly since its implementation. A majority of providers are using the program with 66% of participating patients seeing their BP return to normal range.
- *Great Falls Clinic Northwest* assessed their patient BP education process and focused on increasing the number of patients receiving education and returning for follow-up appointments. Providers reached consensus on which educational materials to use and modified the visit design to ensure patients received educational materials before leaving the office. They educated staff on the electronic and physical workflow. Patients receiving BP education increased from 40% at baseline to 67%, and follow-up increased from 6% at baseline to 16%.
- *The Children's Clinic of Billings* worked on QI related to clinical depression screening and documentation of a follow-up plan, if needed. They looked at the physical workflow of the office visit to ensure patients were completing the screening when checking in, determined the electronic workflow and educated staff on documentation in the EHR. The efforts resulted in an increase of documented screening from 0 at baseline to 99%.
- *Helena Indian Alliance (Leo Pocha Clinic)* determined hypertension management was a priority for them. They implemented a Hypertension Protocol to ensure clinical best practices for hypertension management. They initiated an undiagnosed hypertension project to look at patients with and without diabetes who did not have a hypertension diagnosis but had BP measures above the normal range at 2 visits. This prompted them to assess and change their front office procedure to ensure they had current contact information so they could reach patients to schedule follow-up visits. So far, they have had follow up appointments and reassessed 63% of their previously undiagnosed patient panel, diagnosing 50% of those with hypertension.

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