

Community Transformation Grant

Clinical Interventions

In 2009, the prevalence rates of high blood pressure and high cholesterol in Montana were 28% and 36%, respectively with higher rates for both in the Eastern and North Central regions of the state. Over 60% of the adult population live in one of the seven most populated counties, and, according to HealthShare Montana, 60% of the primary care physicians are also located in these counties. Most primary care providers in these counties work in group practice settings in close cooperation with community hospitals. These primary care providers are the gate keepers for blood pressure and cholesterol management. Many rely heavily on the use of Physician Assistants and Nurse Practitioners to deliver healthcare to residents. The Communication Transformation Grant clinical project will establish practice-specific systems to improve the quality of care for patients with high blood pressure or high cholesterol in a primary care setting.

Project Aims	<ul style="list-style-type: none"> • Increase the number of Montana adults with increased access to systems or opportunities that support high blood pressure and/or high cholesterol control in healthcare settings.
Project Description	<ul style="list-style-type: none"> • Through a competitive process, the Community Transformation Grant clinical project will select practices with appropriate information technology and quality improvement infrastructure to participate in activities such as developing registries and improving office systems to improve outcomes for patients with high blood pressure and high cholesterol. Certain practices will be encouraged to collect relevant Physician Quality Reporting System (PQRS) cardiovascular measures. PQRS is a voluntary reporting system providing incentive payments to eligible health professionals. Prompt periodic feedback will be given to practices including local benchmarks. Practices will be required to complete at least one blood pressure and one cholesterol quality improvement project. In Year 1, five Montana hospitals were selected.
Current Stakeholders (Year 1 Subaward Recipients)	<p>Billings Clinic Will develop a report from the freestanding dyslipidemia registry identifying patients who have no documented visit with their primary care provider within the last year. This list will be distributed to five locations and they will compare the success rate of getting these patients in for a visit before Sept.14, 2012. Will compare the success rates of chronic disease management between primary care sites with and without nurse navigators.</p> <p>The hypertension intervention will develop a combination report from the freestanding hypertension registry and electronic health record (EHR) identifying patients with uncontrolled hypertension who have upcoming appointments. Clinical staff will incorporate this into their pre-appointment chart preparation. Will measure % of patients with uncontrolled hypertension who have a documented intervention during the visit.</p> <p>Bozeman Deaconess Will establish a lipid management clinic staffed with pharmacists who actively manage their patients with hyperlipidemia in a collaborative protocol-based fashion on referral from the provider. The EHR will be used to identify diabetic patients with elevated low-density lipoprotein (LDL); these patients will be invited to participate in the lipid management clinic. Will compare the LDL achieved of those patients seen in the lipid management clinic to those who were not seen.</p> <p>The hypertension intervention will focus on patients with coincident diabetes and hyperlipidemia. Will include blood pressure measurement at the lipid management clinic visits. The primary care provider will be notified via EHR of an elevated blood pressure so action can be taken. At the end of the period, the last recorded blood pressure of these patients will be compared to those with diabetes and hyperlipidemia</p>

	<p>who did not have additional blood pressure measurement management via the lipid management clinic. In addition, they will report on the blood pressure control for all patients with hypertension.</p> <p>Community Medical Center Will develop a registry within their EHR to identify patients with hypertension and dyslipidemia. Will identify patients not at goal through an EHR report. Pharmacy students and residents will use the report to contact each patient not at goal to review barriers to compliance and schedule a visit with a provider. The pharmacy student or resident will document the encounter on a specified electronic form, and the provider will review and acknowledge agreement. A summary report will show outreach and the percent of patients at goal initially and at the end of the intervention.</p> <p>Madison Valley Medical Center Will optimize EHR records and reporting data. Physicians will receive reports which identify patients with uncontrolled hypertension and dyslipidemia, test dates/results, and current med lists. Outreach will be conducted with patients who are not controlled.</p> <p>St. Peter's Hospital Medical Group Will expand and enhance data management functions and information systems within the EHR. Patients with hypertension and dyslipidemia will be identified through the EHR. Approximately half of the primary care provider care teams and their associated target patients will be enrolled in an exposure group with the remaining practices continuing usual practice. Will compare outcomes between the exposure and control population with % improvement in blood pressure and cholesterol measured between groups.</p>
Measuring Success	In the first year of the project, hospitals will collect PQRS measures, and 4 sites will submit data to the Centers for Medicare & Medicaid Services (CMS). Enhanced EHR capabilities will result in increased blood pressure and cholesterol control in patients.
Accomplishments	<ul style="list-style-type: none"> • First quarter deliverables have been submitted, and all sites have started their quality improvement projects.
Challenges	<ul style="list-style-type: none"> • The short timeframe the first year of this project was challenging for the Cardiovascular Health Program as well as for the participating sites.
Next Steps	<ul style="list-style-type: none"> • In Years 2-5, the clinical project will expand to additional hospitals/physicians groups, Rural Health Clinics and Community Health Centers which use ambulatory EHRs.

For more information, contact:

Marilyn McLaury, Montana Cardiovascular Health Program, Montana Department of Public Health
Cogswell Building, 1400 Broadway P.O. Box 202951 Helena, MT 59620-2951, Phone, (406) 444-6968 mclaury@mt.gov