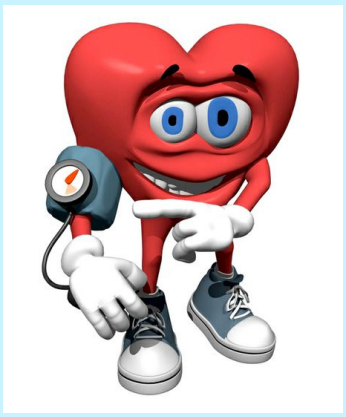
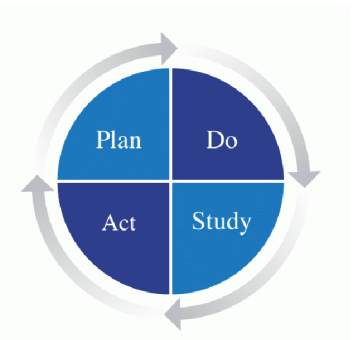


Conducting Healthcare Quality Improvement, Years 1-4

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



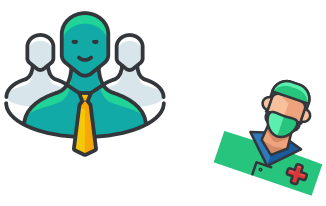
Clinic Characteristics

	Year 1	Year 2	Year 3	Year 4
Clinic type	3 - Primary Care 2 - RHC 1 - Tribal Health	6 - RHC 1 - Primary Care	2 -Primary Care	4 - Primary Care 1 - CHC
Location	3 - Rural 3 - Urban	6 - Rural 1 - Urban	2 - Urban	3 - Rural 2 - Urban

RHC - Rural Health Clinic, **CHC -** Community Health Center, Location is county

Type of QI Strategies

- Develop standardized protocols/practices
  - Hypertension protocol
  - Blood pressure (BP) re-checks
- Implement self-measured blood pressure monitoring (SMBP)
- 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
- 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

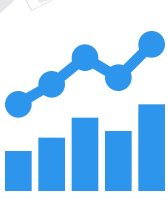


Facilitators

- Physician Champion
- Dedicated staff
- 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

Barriers

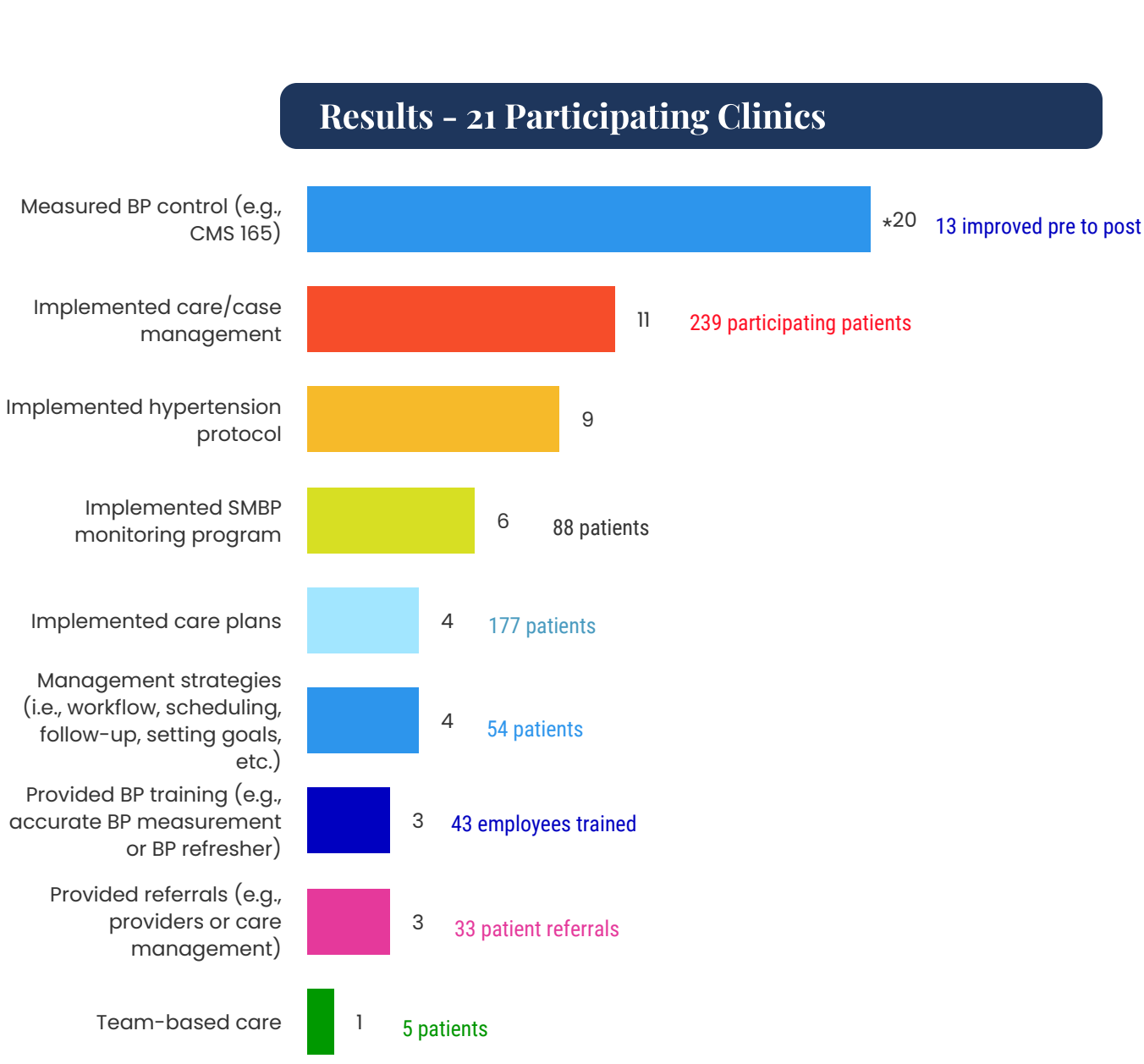
- COVID-19 (e.g., staffing shortage)
- Provider buy-in
- Consensus of BP targets and protocols
- Competing priorities
- Provider/staff unfamiliar with all available programs (e.g., SMBP, Chronic Care Model, etc.)
- EHR technical issues - abstracting data/reports
- Poor attendance at patient follow-up appointments
- Inconsistent scheduling of follow-up appointments
- Medication stops/changes not communicated on discharge



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
- 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

Results - 21 Participating Clinics



*20 of 21 clinics were able to obtain pre-/post-data.