Improving Prevention Measures through HIT – Looking Forward

Presenters: Jerri Hiniker, Program Manager
Jane McGrath, Program Manager

Date: Wednesday, July 16, 2014

Objectives

- Learn successful methods to improve prevention quality measures
- Hear actual clinic stories and examples of how to improve quality measures from participating clinics
- Discover upcoming opportunities to participate in future collaboratives related to quality improvement, Meaningful Use and PQRS reporting

(Source: http://www.mountcarmelhealth.com/medical-education/physician-planning/faculty-resources/how-to-write-cme-objectives.html, 10/5/10)
Learn successful methods to improve prevention quality measures

How?

- Stratis Health, Medicare Quality Improvement Organization for Minnesota
- North Dakota Health Care Review Inc. (NDHCI), Medicare Quality Improvement Organization for North Dakota
- REACH, Regional Extension and Assistance Center for HIT for Minnesota and North Dakota
- Prevention Learning and Action Network (LAN)
Collaboration

- NDHCRI, Stratis Health, REACH
- Wisconsin (METASTAR), South Dakota (SDFMC), and Iowa (Telligen) all Medicare Quality Improvement Organizations
- Minnesota Community Measurement, Aligning Forces for Quality, American Cancer Society
- Medicare & Medicare Incentive Programs
- Providers & Practices

Using Health Information Technology to Improve Quality
Topics

• Clinical Decision Support
• Shared Decision Making
• Patient Engagement Series
• Quality Measures and Reporting
• Cardiac, Colon Cancer, Million Hearts

Topics (cont.)

• ACOs, PCMH
• Stage 1 & 2 Meaningful Use requirements
• Health Information Exchange
Hear actual clinic stories and examples of how to improve quality measures from participating clinics

ESSENTIA HEALTH-DEER RIVER
Hypertension initiative through ASTHO Grant
Home blood Pressure Monitoring Program

- Deer River Protocol for Home Blood Pressure Monitoring Program-Patient instructions on Home Blood Pressure Monitoring
- Deer River Protocol for Home Blood Pressure Monitoring Program-Checklist for patients newly enrolled in the program
- EHR-We have incorporated our Home Blood Pressure Monitoring Program into our EHR in several ways, including:
  1. Upon set-up, identifying the patient as a home blood pressure monitor user.
  2. Entering the home blood pressures into the EHR after completion of the program.
  3. Using the home blood pressures to identify if a treatment regimen needs to be changed/adjusted and creating an easy access point for anyone needing the results by utilizing EHR.

Success Stories

- A provider saw a 71 year old female, who had never taken any prescription medication in her life. During the visit she was diagnosed with hypertension. She told the provider that she was not going to take any medication, because she didn’t trust medication. The patient was educated on the damage high blood pressure could do to her body. I offered her to try the clinic’s new home blood pressure monitoring program that would allow her to take her blood pressure at home. Once completing more education with the patient, she finally agreed to take the blood pressure machine home. After a few days of taking her blood pressure at home 3 times a day and observing her elevated blood pressures, she brought back the monitor and wanted to start a blood pressure medication. After taking her medication for a week and tracking her blood pressure at home, she is taking her medication every day.

- A 45 year old female that has been treated in the clinic for hypertension, but her BP readings were erratic. We sent her home with a BP monitor kit. The first 2 weeks her results showed, out of 34 BP readings, 33 of them were hypertensive, ranging from 128-171 over 73-125. There was a medication adjustment and monitored her BP at home for another 2 weeks. This time, out of 42 readings, there were 31 that were hypertensive, ranging from 116-150 over 69-144. There was another medication adjustment and monitored her BP at home for another 2 weeks. Now her readings showed, out of 52 readings, 19 were hypertensive ranging from 116-150 over 66-100. One more medication adjustment and monitored it at home for 2 more weeks. Out of 38 readings there were 0 that were hypertensive. Success!

- We originally had approximately 5 home blood pressure machines. We now have about 25 machines, with machines located in each of our locations (Remer, Grand Rapids, Deer River). Many providers are on board with the process, with the Deer River clinic not having enough machines many times. We have a waiting list! Also, we have incorporated teaching at the initiation of the program, to include healthy lifestyle changes. We are looking at taking this Essentia Health Wide in the future, with the process for this being completed currently.
CONTACT INFORMATION

- Adam Thayer, RN Clinic Nurse Supervisor
  Adam.thayer@Essentiahealth.org or 218-246-4089.

- Tammy Bartch, LPN
  Tammy.bartch@essentiaHealth.org or 218-246-7348.

Riverwood HEALTHCARE CENTER
Together we will.
Referral Process

- Add template into EHR
- Keep it brief

Create workflow
Update sent prior to 30 day f/u visit. Prepares PCP for visit.

HTN Outreach/Patient Support

- Were you able to fill your prescription?
  - Yes
  - No, due to...
- If so, have you been able to take your medication as directed by your provider?
  - Yes
  - No, due to...
- What other lifestyle changes have you began to make to improve your blood pressure?
  - Decreased sodium intake
  - Eating more fruits and vegetables
  - Increased level of exercise
  - Decrease or D/c caffeine
  - Decreasing stress
  - Drinking less alcohol
  - Tobacco cessation or considering quitting
  - None
  - Other...
- How often do you monitor your blood pressure? (Coach will document BP given by patient)
  - Daily
  - 1-2x per week
  - 3-4x per week
  - Monthly
  - I don’t
- On a scale of 0-10, how important is it you to make healthy lifestyle changes to improve your blood pressure?
Health Coaching Outcomes

To Date:
- Lost nearly 40 lbs.
- BP well controlled
Dan F. Schletty  
Health and Wellness Coach  
DSchletty@riverwoodhealthcare.org

Riverwood Healthcare Center  
Together we will

Discover upcoming opportunities to participate in future collaboratives related to quality improvement, Meaningful Use and PQRS reporting
Coming Soon…

• Collaboratives and Learning and Action Network (LAN) opportunities
  – Chronic Disease Prevention
    • Cardiac
    • Diabetes
  – Health Information Technology
  – Meaningful Use
  – PQRS reporting

Future Topics?
Topic – Format – Speakers

- Reporting Quality Measures?
- Transitions of Care?
- Stage 3 MU?
- Learning from Peers?
- Conference Call/In Person?

Q&A
Contacts

• Judy Beck
  jbeck@ndhcrl.org
  Phone: 701-852-4231

• Jerri Hiniker, BSN, RN, CPEHR
  jhiniker@stratishealth.org
  Phone: 952-853-8540