



AVERA ST. BENEDICT HEALTH CENTER IMPROVES THE MANAGEMENT OF HYPERTENSION



QI TOOLKIT CASE STUDY:

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Thank you to Melissa Gale and Heather Bowar of Avera St. Benedict Health Center for sharing this case study.

[About Avera St. Benedict Health Center](#)

Avera St. Benedict Health Center is a 25-bed Critical Access Hospital with surgical and obstetrics capabilities. Under one roof are the attached Parkston Certified Rural Health Clinic; a 47-bed long term care facility that provides skilled nursing services; a 27-bed assisted living facility; and a physical therapy wing with wellness center. Avera St. Benedict also owns and operates a licensed daycare off site as well as the Certified Rural Health Clinics in Tripp and Lake Andes, SD. Outreach to area nursing homes, Hutterite colonies, and consultations at other healthcare facilities are also a part of Avera St. Benedict's medical staff duties.

This project is from the team at the Avera St. Benedict Health Center's Parkston Certified Rural Health Clinic site.

[About the Interviewees – Melissa Gale and Heather Bowar](#)

Our role for this project was clinic quality. In clinic quality, we review data, implement change based on Plan-Do-Study-Act cycles, and track changes and adjust processes over time with each project or area for improvement. The physicians, advanced practice providers (APPs), clinic nurses, and other clinic ancillary staff are all considered our team.

[What is the focus of this QI initiative?](#)

Hypertension management at the Avera St. Benedict Health Center's Parkston Certified Rural Health Clinic site.

What challenge or problem does this QI initiative address? How did you know this problem existed?

Our challenge was improving hypertension control rates among adults served by the Parkston clinic. We discovered this was a problem when we were able to start using clinical informatics to look at the numbers of the population.

Why was this a priority for your facility/organization?

- This was made a priority when the numbers were taken to the physicians. We basically thought that we did very well with hypertension management until we were able to look at the entire population.
- A move to value based arrangements, Merit-based Incentive Payment Systems (MIPS), Medicare Access and CHIP Reauthorization Act (MACRA), and shifts to population health models also influenced the priority level. Since these changes meant payment to Avera was based on quality measures performance, it became a bigger priority for the organization as a whole.

What was the role of leadership in supporting this work?

- The facility CEO was very supportive of the focus on this area.
- The decision to address it came from a provider led approach, so then all nurses, ancillary clinic staff, and clinic quality staff were on the same page. This was then introduced at clinic nurses' meetings and clinic staff meetings.
- We were transparent with the data to help promote change with "friendly competition." Everyone involved wanted to do their best for their patients.

How did you implement this QI initiative?

- We used the Plan, Do, Study, Act (PDSA) format for the process.
- We focused on each nurse being consistent with how they were taking blood pressures, charting blood pressures, and taking a second set of vitals manually.
- We also integrated blood pressure magnets on the clinic door frames for those patients that needed additional blood pressure readings taken. By doing all of these things, we were able to take the variables that we could control out of the equation.

When implementing this approach, what went well?

- Training and education went well. Everyone was on board with the project.
- Staff learning the PDSA process also went well.

What were some of the challenges?

- It does take extra time in a busy clinic day to take extra blood pressure readings and to make sure the standards of taking the blood pressures are followed.
- Utilizing data and being able to pull reports from the electronic medical record (EMR) was an ongoing challenge, including validating the data.

What did you learn along the way? What changes, if any, did you have to make to your approach?

- We learned how to take change one small step at a time, implement the change process consistently, and allow for deviation as needed as the EXCEPTION, not the rule.
- We also learned that taking blood pressures on vital machines were inconsistent and that we had to validate them and order some new cuffs for the best readings.

What were the outcomes of this QI initiative? Is this process still in place? If so, how did you make that happen?

- Blood pressure control was tracked for over a year with percentages of blood pressure control improving by 20-30%.
- The process is not just hard wired into clinic operations. We review the blood pressure data each month with chart audits and trouble shoot problems if there is a lot of variability.
- Training and retraining takes place often. All quality numbers, which blood pressure control is a part of, are reviewed at nurse's meetings, quality meetings, and medical staff meetings.

How did QI help you and your team make your changes?

We learned we have created a framework for quality and change management with this first project that we were then able to use with other clinical quality measures, such as hemoglobin A1C control, flu shots, pneumonia vaccination, cancer preventative measures, etc.

What advice do you have for others who are considering starting the QI process?

- Start with one measure or process.
- Communicate with the staff about the why and how of the process.
- Train and retrain as needed.
- Keep the data in front of staff in a variety of ways all the time (verbal, written, experiential, etc.).