Clinical Learning Day 2017
Primary Care Clinical Program

Mark R. Greenwood, M.D.
Medical Director
Leadership

“A process of social influence in which a person can enlist the aide and support of others in the accomplishment of a common task”
Our Common Task:
Helping People Live the Healthiest Lives Possible

It's not that diabetes, heart disease and obesity runs in your family. It's that no one runs in your family.
Intermountain Leader: Dr. Marc Harrison

Our Future:
- “Helping People Live the Healthiest Lives Possible”
- *Population Health*

Marc’s Compass:
- Safety
- *Quality*
- Patient Satisfaction
- Access
- Stewardship
Change in Healthcare Delivery

Old paradigm: Individual Health
- Fee for service
- Individual practitioner
- Apprentice based

New paradigm: *Population Health*
- Fee for value
- Care teams
- Identified best practice (Evidence based)
- Data and reports
How can the Primary Care Clinical Program help lead you through this change, and facilitate improved care delivery?

(Or can it?)
“We’re here to help!”

"Hi — I’m from the Government, and I’m here to help you!"
Overview

Clinical Programs in general
Primary Care Clinical Program specifically
Clinical Learning Day Purpose
How can PCCP help? (tools/tricks)
  o iCentra
  o Reports
  o CPM’s
  o Flash Cards
  o Care Pathways
  o Advisories
  o Alerts
Clinical Programs Purpose

Identify Best Practices
Decrease Variation
Improve Outcomes
Reduce Cost

Take home message: Quality Improvement arm of Intermountain
Primary Care Clinical Program Leadership

Medical Director: Mark R. Greenwood, M.D.
Operations Director: Sharon Hamilton, MS, APRN
Clinical Program Manager: Tonya Schaffer, RN, MBA
Quality Improvement Manager: Laurel Price, RN
Data Manager: Stephen Smith
Analysts: Jonathan Anderson, Dane Stewart, Denney Edgel, Matt Anderson
Medical Informaticist: Naveen Maram, M.D.
Administrative Assistant: Gary Garbett
Primary Care Clinical Program
Development Teams

Anticoagulation: Scott Woller, M.D.
Asthma: Rich Hendershot, M.D.
High Blood Pressure: Greg Parkin, M.D.
CV Risk/Statins: Mark R. Greenwood, M.D. & Don Lappe M.D.
Pediatric Preventive Care: Sylvie Backman, M.D.
Preventive Care: Tamara Sheffield, M.D.
Choosing Wisely: Mark R. Greenwood, M.D. & Sharon Hamilton
CKD: Paula Haberman, M.D.
Diabetes: Chris Jones, M.D.
Diabetes Prevention: Sharon Hamilton, MS, APRN & Liz Joy, M.D.
Collaborating Development Teams

Opioids
iCentra
Wellness/Prevention
MHI
Antibiotic Stewardship
Development Team Topic Selection Factors

Board Goals
Medical Group initiatives (i.e. VRP)
Financial incentives
SelectHealth priorities
STARS Measures
HEDIS Measures
Internal priorities (Senior Leadership)
National initiatives (i.e. Measure Up/Pressure Down®)
Disease specific factors (prevalence, cost, morbidity/mortality, etc.)
Geographic committee/population health priorities
PCCP Guidance Council feedback
Individual provider issues
Clinical Learning Day Purpose

Facilitate improvement in care delivery (*change* physician behavior!)

- Close care gaps
- Message best practice
- Improve patient outcomes
- Facilitate meeting goals/measure
PCCP 2017 Goals: High Blood Pressure

Improve the percentage of patients age 18-85 with HBP with a primary care clinician in the Intermountain Medical Group whose blood pressure is in control (HEDIS, STARS, VRP)
PCCP 2017 Goals: Diabetes Prevention

Pilot and evaluate a new program for diabetes prevention. Additionally we will evaluate and propose next steps for reaching the maximum number of patients with pre-diabetes to further this aim (Stewardship).
PCCP 2017 Goals: Lipids

Improve the percentage of patients on SelectHealth Medicare Advantage who have diabetes and have never had ASCVD who have filled a prescription for a statin in the past 12 months (STARS).
PCCP 2017 Goals: Choosing Wisely

Decrease the percentage of patients who have a preventive care visit who have a chemistry panel ordered at that visit using a preventive care ICD 10 code (Stewardship)
Affiliated Provider Disclaimer:

* Terms subject to change without notification. Those who choose to raise expectations do so at their own risk. We reserve the right to delay, postpone, or cancel election pledges in which we deem unattainable due to circumstances beyond our control. We cannot guarantee that we and/or any content, including promises provided during our campaign is accurate or complete and we expressly disclaim all warranties and conditions, including implied warranties and conditions of satisfactory quality and fitness for a particular purpose.
### Primary Care Clinical Program High Blood Pressure Patient Management List

#### Employment Status:

- Affiliated

#### Clinic:

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Pediatrics</td>
<td>Aardema, Crit (37777)</td>
</tr>
<tr>
<td>Alpine Family Medicine</td>
<td>Albarca, Sergio (29991)</td>
</tr>
<tr>
<td>Alpine Pediatrics - Lehi</td>
<td>Adams, Les (56099)</td>
</tr>
<tr>
<td>Alpine Pediatrics - Orem</td>
<td>Adams, R. Mitchell (2530)</td>
</tr>
<tr>
<td>Alpine Pediatrics - Pleasant Grove</td>
<td>Alba, Jesse (42378)</td>
</tr>
<tr>
<td>Alpine Pediatrics - Saratoga Springs</td>
<td>Allen, Brandon (29359)</td>
</tr>
<tr>
<td>Alta Internal Medicine</td>
<td>Allen, D. Wain (3389)</td>
</tr>
<tr>
<td>American Fork Pediatrics</td>
<td>Allen, Juanta (32427)</td>
</tr>
<tr>
<td>Basin Medical Clinic</td>
<td>Allison, Camille (45891)</td>
</tr>
<tr>
<td>Bear River Medical Arts</td>
<td>Allred, Don (5695)</td>
</tr>
<tr>
<td>Bigelow Internal Medicine</td>
<td>Allred, John (30253)</td>
</tr>
<tr>
<td>Brigham Medical Clinic</td>
<td>Allred, Michael (28114)</td>
</tr>
<tr>
<td>Brigham Pediatrics</td>
<td>Allred, Nathan (34248)</td>
</tr>
<tr>
<td>Busy Bee Pediatrics</td>
<td>Amann, Kelly (26594)</td>
</tr>
<tr>
<td>Cache Valley Women's Center</td>
<td>Andersen, Dana (5050)</td>
</tr>
<tr>
<td>Callahan Clinic</td>
<td>Anderson, Bradley (27751)</td>
</tr>
<tr>
<td>Canyon View Pediatrics - Payson</td>
<td>Anderson, David (39993)</td>
</tr>
</tbody>
</table>

#### Group/Disease Cohort:

- Choose Cohort

#### Sort:

- Date of Last Contact

#### Filter on BP value:

- None

---

This patient list is designed to assist in the management of patients with high blood pressure based on recommendations from high blood pressure guidelines. The data used to populate this report are updated daily.
How PCCP can help: iCentra

A tool for “at the elbow” care process improvement

But, how invasive/aggressive?

• Advisories (Joel Porter)
• Alerts (Sharon Hamilton)
How PCCP can help: Reports

Disease specific reports (HTN, DM, etc.)

PCCP 1 Report (combines these reports into “1 Report”)
PCCP 1 Report
PCCP 1 Report
# PCCP 1 Report

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Provider Name</th>
<th>Measures Met</th>
<th>Patient ID</th>
<th>Birth Date</th>
<th>Phone</th>
<th>Payor</th>
<th>Measure Name</th>
<th>Measure Value</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>71-72%</td>
<td>1234567890</td>
<td>MEDICARE</td>
<td>Most Recent BP</td>
<td>154/91</td>
<td>✗</td>
</tr>
<tr>
<td>CKD</td>
<td>12/15/2016</td>
<td>Most Recent BP</td>
<td>140/90</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>12/15/2016</td>
<td>Most Recent BP</td>
<td>140/90</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Diabetes Bundle 4** includes:
- Blood Pressure
- Eye Exam
- HbA1c
- Nephropathy
How PCCP can help: CPMs
CPMs

Care Process Models (CPMs)

CPMs are developed by multidisciplinary clinical experts from Intermountain Healthcare and based on national and other guidelines. They are part of our comprehensive care management system. All CPMs may be ordered from iPrintstore.org.

- Behavioral Health CPMs and Related Tools
- Cardiovascular CPMs and Related Tools
- Collaborative Pharmacy Models
- Imaging Services CPMs and Related Tools
- Intensive Medicine CPMs and Related Tools
- Musculoskeletal CPMs and Related Tools
- Neurosciences CPMs and Related Tools
- Pain Services CPMs and Related Tools
- Pediatric Specialty CPMs and Related Tools
- Primary Care CPMs and Related Tools
- Surgical Services CPMs and Related Tools
CPMs

Case Process Model
MAY 2015

MANAGEMENT OF High Blood Pressure
May 2015 Update

The High Blood Pressure Management Development Team, under the guidance of Intermountain Primary Care and Consultative Clinical Programs, developed this care process model (CPM) to guide the effective, consistent management of high blood pressure for patients across the Intermountain system. This CPM is based on the JNC-8 guidelines with recent updates from the American Heart Association and the American College of Cardiology. It is intended to guide primary care providers in the management of high blood pressure.

What's New in this Update?

- New updated blood pressure classifications. The hypertension guidelines will be updated to reflect the latest recommendations from the American Heart Association (AHA) and the American College of Cardiology (ACC).
- New treatment algorithm that reflects the latest evidence.

What's Inside

- AHA guidelines for high blood pressure
- Updated scientific evidence
- Intermountain Healthcare Internal Medicine Performance Improvement data
- CPMs for other CPGs

Case Process Model
APRIL 2015

OUTPATIENT MANAGEMENT OF Adult Diabetes Mellitus
2015 Update

Intermountain Healthcare

This care process model (CPM) was created by the Diabetes Prevention and Management Development Team, a committee of the Primary Care Clinical Programs at Intermountain Healthcare. It incorporates the most current medical literature and, with clear evidence in mind, provides comprehensive guidelines for diagnosing and treating diabetes. It provides direction with treatment goals and interventions that are known to be effective for outcomes in adult patients with diabetes.

What's New in this Update?

- New updated blood pressure classifications. The hypertension guidelines will be updated to reflect the latest recommendations from the American Heart Association (AHA) and the American College of Cardiology (ACC).
- New treatment algorithm that reflects the latest evidence.

What's Inside

- American Diabetes Association guidelines
- AHA guidelines for high blood pressure
- Updated scientific evidence
- Intermountain Healthcare Internal Medicine Performance Improvement data
- CPMs for other CPGs
Flash Cards

**Cervical Cancer Screening**

**SCREENING**

<table>
<thead>
<tr>
<th>Patient age</th>
<th>Test</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 (regardless of sexual history)</td>
<td>Do not screen</td>
<td></td>
</tr>
<tr>
<td>21 to 29</td>
<td>Cytology (Pap smear)</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>30 to 65</td>
<td>Co-testing: Cytology and HPV testing (recommended)</td>
<td>Every 5 years</td>
</tr>
</tbody>
</table>

**Patient identifiers**

- Age 65 who have had adequate prior screening and are not high risk
- After hysterectomy with removal of cervix and with no history of high-grade pre-cancer or cervical cancer
- HPV-vaccinated
- Immunocompromised or HIV (+)
- Any age with (+) cytology or HPV

**Screening notes**

- "See back of card"

**MANAGEMENT**

- Age ≥30 with (-) Cytology and (+) HPV
  - REPEAT co-testing in 1 year
  - OR
  - HPV DNA typing immediately

- ASC-US* on cytology
  - IF ASC-US cannot exclude HSIL, GO DIRECTLY to colposcopy
  - Otherwise choose an option below

- HPV testing (recommended)
  - HPV (-)
  - HPV (+)**
  - ASC-US* or more severe
    - REPEAT cytology in 1 year (acceptable)
  - Cytoplasmology (-)

- REPEAT co-testing in 3 years
  - Endocervical sampling preferred in women with no lesions and those with inadequate colposcopy; it is acceptable for others.

- Colposcopy
  - Routine screening
    - Endocervical sampling preferred in women with no lesions and those with inadequate colposcopy; it is acceptable for others.

* ASC-US: atypical squamous cells of undetermined significance
** Managed the same as women with low-grade squamous intraepithelial lesion (LSIL)
How PCCP can help: Care Pathways
### Vital Signs & Assessments

<table>
<thead>
<tr>
<th></th>
<th>Latest</th>
<th>Previous</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>154 / 84</td>
<td>138 / 76</td>
</tr>
<tr>
<td></td>
<td>12/12/16</td>
<td>11/10/16</td>
</tr>
<tr>
<td>Body Mass Index Measured</td>
<td>27.59</td>
<td>27.48</td>
</tr>
<tr>
<td></td>
<td>12/12/16</td>
<td>11/19/16</td>
</tr>
<tr>
<td>Weight Measured</td>
<td>99.6</td>
<td>99.2</td>
</tr>
<tr>
<td></td>
<td>12/12/16</td>
<td>11/19/16</td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>11/18/16</td>
<td>10/14/16</td>
</tr>
</tbody>
</table>

### Labs

<table>
<thead>
<tr>
<th>Date</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCT 14, 2016</td>
<td>10/12/16</td>
</tr>
<tr>
<td>SEP 12, 2016</td>
<td>10/12/16</td>
</tr>
<tr>
<td>SEP 11, 2016</td>
<td>10/12/16</td>
</tr>
</tbody>
</table>
# Care Pathways

## Ambulatory Workflow

### Labs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine Level</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>0.89</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>0.93</td>
<td>--</td>
</tr>
<tr>
<td>Hemoglobin A1c</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>11.5</td>
<td>--</td>
</tr>
<tr>
<td>Potassium Level</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>4.1</td>
<td>--</td>
<td>4.5</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>6.6</td>
<td>--</td>
</tr>
<tr>
<td>Sodium Level</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>133</td>
<td>--</td>
<td>131</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>126</td>
<td>--</td>
</tr>
<tr>
<td>WBC</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>9.3</td>
<td>--</td>
</tr>
<tr>
<td>Platelets</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>368</td>
<td>--</td>
</tr>
<tr>
<td>Glucose Level</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>279</td>
<td>--</td>
<td>364</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>590</td>
<td>--</td>
</tr>
<tr>
<td>BUN</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>27</td>
<td>--</td>
<td>27</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>28</td>
<td>--</td>
</tr>
<tr>
<td>Chloride Level</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>101</td>
<td>--</td>
<td>101</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>92</td>
<td>--</td>
</tr>
</tbody>
</table>
# Care Pathways

## Ambulatory Workflow

### Treatment Assessment Component

<table>
<thead>
<tr>
<th>Component</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is Pregnant:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has Heart Failure:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has 3+ comorbidities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has Diabetes Mellitus:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has CAD (ACS/MI or revascularization with angina):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has African ethnicity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has CKD:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient is 80 years and older:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Care Pathways Treatment Options

- **Ambulatory - In Office (Meds in Office)**
- **Ambulatory (Meds as Rx)**

**Options**

- Please enter target BP by going to 'Vital Signs & Assessments->Target BP'.

The suggested target BP for patients with Chronic Kidney Disease and Diabetes and Hypertension with ACR > 300 is -130/80 (OR 125/75 on home BP).

The suggested escalation of treatment for patients with Chronic Kidney Disease and Diabetes and Hypertension with ACR > 300, whose BP is not within target is -

1. Start Therapeutic Lifestyle Changes (TLC) concurrently with Medications
2. Start an ACEI/ARB - Lisinopril 10mg (or for a minimum 2 weeks)
Care Pathways

1. Start Therapeutic Lifestyle Changes (TLC) concurrently with Medications.
2. Start an ACEI / ARB - *Lisinopril 10mg* (for a minimum 2 weeks duration).
3. If BP above target, increase ACEI / ARB - *Lisinopril 20mg* (for a minimum 2 weeks duration).
4. If BP above target, add Ca Channel Blocking agent - *Amlodipine 5mg* (for a minimum 2 weeks duration).
5. If BP above target, increase Ca Channel Blocking agent - *Amlodipine 10mg* (for a minimum 2 weeks duration).
6. If BP above target, replace ACEI / ARB with Hydrochlorothiazide combo drug - *Lisinopril-HCTZ 20mg-12.5mg* (for a minimum 2 weeks duration).
7. If BP above target, increase ACEI / ARB with Hydrochlorothiazide combo drug - *Lisinopril-HCTZ 40mg-25mg* (for a minimum 2 weeks duration).
8. If BP still above target, consult HBP specialist.

When BP is at target, maintain current therapy and evaluate BP every 6 months. Maintain TLC throughout course of treatment.
Care Pathways

Maintain TLC throughout course of treatment

- amlodipine 10 mg oral tablet
  - Last Ordered: 12/12/16
  - 1 tabs, Oral, Daily, ≠ 30 tabs

- amlodipine 5 mg oral tablet
  - 1 tabs, Oral, Daily, ≠ 30 tabs

- lisinopril 10 mg oral tablet
  - 1 tabs, Oral, Daily, ≠ 30 tabs

- lisinopril 20 mg oral tablet
  - 1 tabs, Oral, Daily, ≠ 30 tabs

- lisinopril-hydrochlorothiazide 20 mg-12.5 mg oral tablet
  - 1 tabs, Oral, Daily, ≠ 30 tabs

- lisinopril-hydrochlorothiazide 20 mg-12.5 mg oral tablet
  - 2 tabs, Oral, Daily, ≠ 60 tabs

- Referral to Cardiology

[Order buttons for each medication]
Care Pathways

Care Pathways Patient Education

Content Domain: Krames InPatient
Language: English

- Proprinted Booklet Given: BP Basics (IH)
- Proprinted Item Given: BP Tracker
- High Blood Pressure and the DASH Diet (IH)
- How to Monitor Your Blood Pressure (IH)
- High Blood Pressure Treatment: A Decision Guide (IH)
- Borderline High Blood Pressure: Act Now to Protect Your Health (IH)

Added Patient Education

HEADACHE, Migraine (Classical)
Advisories

**Patient Advisories**

Unable to retrieve HealthRegistries data. Contact your system administrator.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Favorites</th>
<th>Last Action</th>
<th>Priority</th>
<th>Frequency</th>
<th>Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care: Influenza Vaccine, Give Yearly To Patients 9 Ye...</td>
<td>★</td>
<td>1.000000 unknown unit (9...</td>
<td>High</td>
<td>Seasonal</td>
<td>AUG 31, 2016</td>
</tr>
<tr>
<td>Preventive Care: Patient Is Due For A Medicare Annual Wellness...</td>
<td>★</td>
<td>--</td>
<td>High</td>
<td>Q 1years</td>
<td>DEC 19, 2016</td>
</tr>
<tr>
<td>Preventive Care: Prevent 13. Give One Time To Patients 65 Year...</td>
<td>★</td>
<td>--</td>
<td>High</td>
<td>One-time only</td>
<td>DEC 19, 2016</td>
</tr>
<tr>
<td>Diabetes: Foot Exam Every Year</td>
<td>★</td>
<td>--</td>
<td>Medium</td>
<td>Q 1years</td>
<td>DEC 19, 2016</td>
</tr>
<tr>
<td>Diabetes: Professional Eye Exam Every 2 Years</td>
<td>★</td>
<td>--</td>
<td>Medium</td>
<td>Q 2years</td>
<td>DEC 19, 2016</td>
</tr>
<tr>
<td>Diabetes: Statin. Prescribe Statin To Diabetics Between Age 40 a...</td>
<td>★</td>
<td>--</td>
<td>Medium</td>
<td>One-time only</td>
<td>DEC 19, 2016</td>
</tr>
<tr>
<td>Preventive Care: Activity Level. Minutes And Frequency Of Physic...</td>
<td>★</td>
<td>--</td>
<td>Medium</td>
<td>Q 1years</td>
<td>DEC 19, 2016</td>
</tr>
<tr>
<td>Preventive Care: BMI &gt;= 30. Counsel Patient About Risks Of Ob...</td>
<td>★</td>
<td>--</td>
<td>Medium</td>
<td>Q 1years</td>
<td>DEC 19, 2016</td>
</tr>
</tbody>
</table>
Connect with Social Media

[Image of a Facebook page for the Primary Care Clinical Program]
“Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests.”

Questions???