Concluding Remarks

(What are the take home points?)

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Action Items: PCCP

Population Health is here to stay
Use Your Teams
Use Reports and Advisories to close care gaps
Action Items: HBP

Identify patients not in control via reports (HBP or 1 Report)
Repeat blood pressure after 5 minutes if initial BP is elevated
Enter the repeat BP in the EMR!
If BP is still elevated at 5 minutes
  • Add another medication in accordance with the CPM
  • Bring them back within 2-4 weeks for another visit (nurse, pharmacy, or doc)
**Action Items: Diabetes Prevention**

Screen patients every 3 years with FSB or A1c

When ordering labs, look at prior results. If Glucose elevated, add A1c

When patients identified as having Pre Diabetes:

- Enter in problem list
- Refer to the patient appropriate venue (WTH, 101, etc.)
Action Items: CKD

Order urine ACR and eGFR with lab order for:
- DM
- HTN
- CKD
- CAD

Identify the stage on the chart using eGFR and ACR (Flash Card or App)
Enter correct diagnosis on the EMR problem list
CKD=ACE/ARB
Identify a point in clinic process to increase rates of testing (ACR/eGFR)
Action Items: CV Risks/Statins

Diabetes=statin, regardless of LDL (STARS)
ASCVD=Statin, preferably high dose (STARS)
Use the Lipid Report (or 1 Report) to identify patients not on statin
Add to problem list (not allergy list) if “statin intolerant”: myalgia, myositis, myopathy, rhabdo
Actions Items: Choosing Wisely

Order indicated diagnostic and screening labs
Avoid ordering non-indicated screening labs
Associate the correct diagnosis with any test ordered
Take Home Points: MHI

Have nurse perform PHQ 2 on intake
Have nurse perform PHQ 9 if PHQ 2 is positive
Perform PHQ9 twice yearly for patient with diagnosis of depression
Current Performance: HBP
Current Performance: Others
Case Study

39 yo male
• BMI=29 (weight 207)
• Sedentary
• Poor diet
• Acid reflux—taking Prilosec daily
• Elevated cholesterol—on a statin
• Snoring—likely early sleep apnea
• Easily fatigued
• Out of shape, lifestyle impaired
Case Study

Intervention

• Joined Weight Watchers
• Started eating better and eating less
• Started exercising regularly
Case Study

Results 1 year later

• BMI=22 (down 55 pounds)
• Eating a healthy and balanced diet
• Exercising regularly
• Acid reflux: gone
• Hypercholesterol: gone
• PPI: gone
• Statin: gone
• Snoring: gone
• Fatigue: gone
• Wellbeing: restored
My Vision for the future of the Primary Care Clinical Program

High quality, evidence based treatment of chronic diseases
Effective treatment of mental health conditions
Team based care in a population health environment (Reports)
Continued use of iCentra to deliver evidence based care
Increased emphasis on wellness and prevention (get upstream)
My Wish: Lifestyle Bundle

Non Smoker
Normal BMI
Healthy Diet
Regular Exercise

NEJM 2016: “within any genetic risk category, adherence to a healthy lifestyle was associated with a significantly decreased risk of both clinical coronary events and subclinical burden of coronary artery disease.”