

CARING FOR OUR COMMUNITY LIKE FAMILY

Primary Care Quality Update

Long Nguyen, DO

Agenda







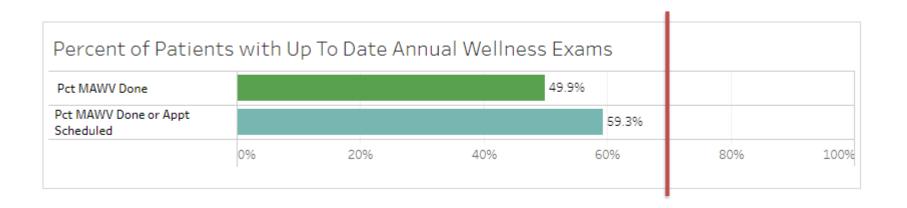
Quality Metrics

Care Pathways

Awards!



Medicare Annual Wellness Visits (AWV)



Goal: 70% by end of 2023



Patients Are First- Panel Based Measures

Disease Management (5 measures)

- Diabetes A1c control
- Diabetes BP control
- Diabetes Retinal Exam
- Diabetes Kidney Health
- HTN BP control
- Depression-PHQ9 utilization

Preventive Management (6 measures)

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Chlamydia Screening
- Childhood Immunization Status



Diabetes Care- A1c of less than 9.0

+11,800 patients with diabetes in our clinic network

September 2023: 75.7% (Goal 74.7%)

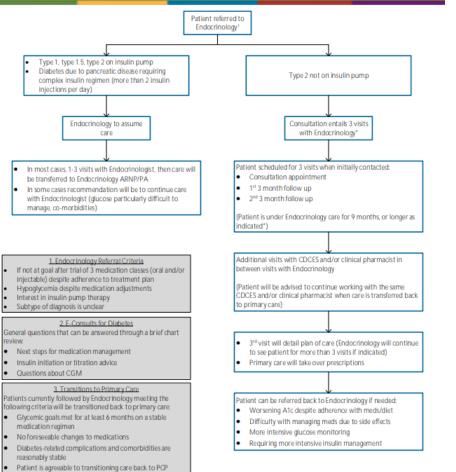


Diabetes Care Pathways

UW Medicine | VALLEY MEDICAL CENTER Ambulatory Care Pathway: Newly Diagnosed Diabetes 1. Provider/RN Follow Up Visit Newly diagnosed patients should have a Diabetes visit with an RN Care Manager as soon as possible (Recommended within 2 weeks of notifying patient). Newly diagnosed patients should have a visit with a provider Provider adds diabete Within 2 weeks if A1c is ≥ 7 to problem list In 3 months if A1c is <7 RN or Health Facilitator will screen patient for social determinant of health Result forwarded to RN Care Manager 2. Orders to be pended by RN Glucometer, test strips, lancets Complete referral to Care Injection supplies (if needed) Management Referral to Clinical Pharmacist and/or Lifestyle Medicine for Diabetes Education Referral to Ophthalmology RN notifies patient of new RN associates diagnosis with pended diagnosis Schedule follow up visits *Newly Diagnosed DM* Smartset under with the RN and the construction Provider¹ RN pends orders per DM Diagnosis Order Set² RN Follow Up Visit Provider Follow Up Visit Support and education Refer to Medications for Glucometer use Diabetes Ambulatory Care Discuss medications as needed Follow up with provider after 3 months, sooner if indicated Refer to Chronic Diabetes Management Ambulatory

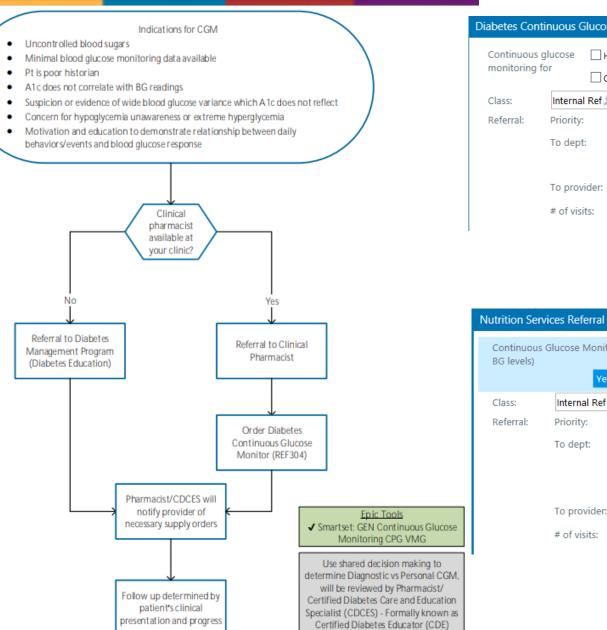
Care Pathway

UW Medicine | VALLEY MEDICAL CENTER Ambulatory Care Pathway: Transitions to Endocrinology





Ambulatory Care Pathway: Continuous Glucose Monitoring (CGM)



Diabetes Conti	Diabetes Continuous Glucose Monitoring ✓ Accept X Cance								
Continuous g monitoring fo	or _	HbA1c not at target □Therapy change □ Recurrent hypoglycemia □ Pregnancy Other							
Class:	Internal Ref								
Referral:	Priority:	Routine Propert STAT							
	To dept:	VMC LIFESTYLE MEDICINE LIFESTYLE MEDICINE RENTON HIGH	ILANDS						
LIFESTYLE MEDICINE TIME SQUARE									
	# of visits:	4							

						·
Continuous (BG levels)	_			used within the pro	ogram to educate non-compliar	nt patients abou
Classe	Yes					
Class:	Internal Ref	30				
Referral:	Priority:	Routine ,	Routine Urgent	STAT		
	To dept:	VMC LIFESTYLE N	VMC LIFESTYLE M	EDICINE	LE MEDICINE COVINGTON	
			LIFESTYLE MEDICI	NE MAPLE VALLEY	LIFESTYLE MEDICINE RENTO	N HIGHLANDS
			LIFESTYLE MEDICI	NE TIME SQUARE	VMC RADIATION ONCOLOGY	Y
	To provider:		00			
	# of visits:	6				

✓ Accept X Cancel

Diabetes Smartset

GEN Diabetes Mellitus Type 2 CPG VMG≈	
- Chronic Diabetes Management Care Pathway	
▼ Orders	
▶ Labs	Click for more
▶ Labs - Future 3 Months	Click for more
Labs - Future 6 Months	Click for more
▶ MyChart —	Click for more
▶ Referrals	Click for more
▼ Supplies	
▶ Supplies	Click for more
CGM Supplies	Click for more
▼ Medications	
▶ Metformin	Click for more
▶ GLP-1RA	Click for more
▶ DPP-4i	Click for more
▶ SGLT2i	Click for more
▶ TZD —	Click for more
▶ SU ──	Click for more
Insulins - Basal Analog	Click for more
Insulins - Intermediate Acting	Click for more
Insulins - Prandial	Click for more
Insulins - Premixed	Click for more
▶ Hypoglycemic Therapy	Click for more
• Other Medications	Click for more
▶ Immunizations	
▼ Level of Service	
New Patient	Click for more
Established Patient	Click for more
▼ Patient Instructions	
Patient Instructions	Click for more

▼ Supplies —	-
☐ Blood Glucose Test Kit Panel	
insulin syringe,safetyneedle 1 mL 31 gauge x 15/64" Syringe Normal, R-0, Please provide brand as covered by insurance, Diagnosis code E11.9	
insulin syringe-needle U-100 1 mL 31 gauge x 15/64" Syringe Normal, R-0, Please provide brand as covered by insurance, Diagnosis code E11.9	
pen needle, diabetic 32 gauge x 5/32" Needle Normal, R-0, Please provide brand as covered by insurance, Diagnosis code E11.9	
▼ CGM Supplies	_
✓ Dexcom G6 CGM Panel	
✓ blood-glucose meter,continuous (DEXCOM G6 RECEIVER) Misc Use to check glucose using Dexcom G6 sensors daily. Normal, Disp-1 each, R-0	
✓ blood-glucose sensor (DEXCOM G6 SENSOR) Device Use to check glucose daily. Change every 10 days. Normal, Disp-9 each, R-3	
✓ blood-glucose transmitter (DEXCOM G6 TRANSMITTER) Device Use to check glucose with Dexcom G6 sensor daily. Change every 90 days. Normal, Disp-1 each, R-3	
✓ FreeStyle Libre CGM Panel	
✓ flash glucose scanning reader (FREESTYLE LIBRE 2 READER) Use as directed for continuous glucose monitoring Normal, Disp-1 each, R-0	
✓ flash glucose sensor (FREESTYLE LIBRE 2 SENSOR) Use as directed for continuous glucose monitoring Normal, Disp-6 kit, R-3	
✓ blood sugar diagnostic (FREESTYLE PRECISION NEO STRIPS) Strip 1 strip by NOT APPLICABLE route daily as needed Use to check blood glucose using Freestyle libre 2 READER daily as needed. Normal, Disp-100 strip, R-3	

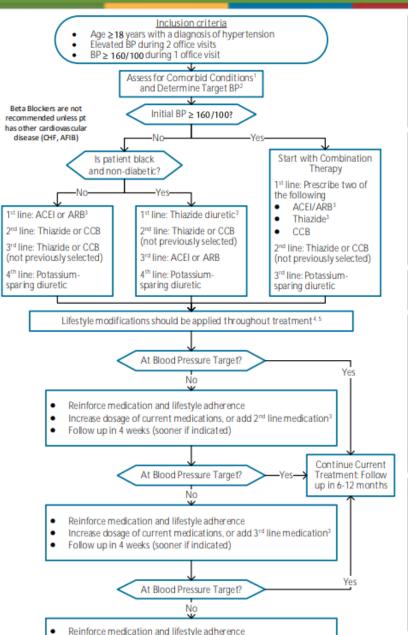
Hypertension: Goal BP < 140/90

Hypertension Blood Pressure Control - Panel	Numerator Denominator Pct of Total	14,662 21,847 67.1%	14,908 21,983 67.8%	14,888 21,940 67.9%	0	0	0	0	0	0	0	0	0	14,888 21,940 67.9%	67.9%	×	68.4%
						,											
Diabetes Blood Pressure Control - Panel	Numerator	8,559	8,700	8,706	0	0	0	0	0	0	0	0	0	8,706			72.1%
	Denominator	11,672	11,802	11,844	0	0	0	0	0	0	0	0	0	11,844	73.5%	~	
		73.3%		73.5%										73.596			

Hypertension

- Recheck BP if 1st BP is high
- Close follow up for patients with uncontrolled HTN or starting new medication (1-2 months)
- Refer to lifestyle medicine or specialist when necessary
- Consider health coach program

UW Medicine | VALLEY MEDICAL CENTER Ambulatory Care Pathway: Hypertension



Assess for Comorbid Conditions

- Hypercholesterolemia
- Tobacco Use
- Diabetes Mellitus
- Obesity

Initial Lab Work/Testing

- CMP
- CBCLipid Panel
- TSHUrinalysis

• EKG

2. Determine Target BP						
Age < 80 years old ASCVD risk < 10%	Target BP < 140/90					
Age < 80 years old ASCVD risk ≥ 10%	Target BP < 130/80					
Age ≥ 80 years old	Target BP < 150/90					

Individualized BP targets for patients with multiple comorbidities, high fall risk, fraility, dementia or short life expectancy

3. Monitoring

Before and within 4 weeks of starting ACEI/ARB or Diuretics, order a Basic Metabolic Profile

4. Lifestyle Modifications

- Smoking cessation, limit alcohol intake
- · Control blood glucose and lipids
- Diet

Eat healthy (DASH diet) Reduce sodium intake to <2400mg/day

Physical activity
 Moderate activity at least 150 mins per week

For low risk patients lifestyle modifications can be implemented for 3 months prior to starting medications

averaging 30mins most days of the week

5. Referral Criteria

- Clinical Pharmacist: If not at goal after 3 meds, or significant drug interactions and/or allergies
- Cardiology: If not at goal after 3 meds, and HTN associated with severe CHF or Cardiomyopathy
- Nephrology: If not at goal after 3 meds, has ≥ CKD Stage 3, or abnormal secondary hypertension renal workup
- Health Coach Program: Consider Health Coach Program Referral for patients who request additional support with working toward healthrelated goals and lifestyle changes to improve self-management of chronic condition(s).

Breast and Colon Cancer Screening

Progress:

- **Breast Cancer screening**
 - July 70.6% → September 70.1% (Goal 77.4%)



- Colon Cancer screening
 - July 70.0% → September 70.4% (Goal 72.6%)





American Heart Association Awards



Check. Change. Control. Cholesterol.

- > Cardiology Clinic
- > Cascade Primary Care Clinic
- > Covington Primary Care
- > Diabetes-Thyroid Clinic
- > Fairwood Primary Care Clinic
- > Kent Primary Care Clinic
- > Kent Station Primary Care Clinic
- > Lake Sawyer Primary Care Clinic
- > Maple Valley Primary Care Clinic
- > Newcastle Primary Care Clinic
- > Renton Highlands Primary Care Clinic
- > Senior Care & Internal Medicine Primary Care Clinic
- > Valley Family Medicine
- > Valley Medical Center





Target: BP

Gold+

- > Covington Primary Care Clinic
- > Fairwood Primary Care Clinic
- > Kent Station Primary Care Clinic
- > Lake Sawyer Primary Care Clinic



Silver

- > Cardiology Clinic
- > Cascade Primary Care Clinic
- > Diabetes/Thyroid Clinic
- > Kent Primary Care Clinic
- > Maple Valley Primary Care Clinic
- > Newcastle Primary Care Clinic
- > Renton Highlands Primary Care Clinic
- > Renton Landing Primary Care Clinic
- > Senior Care, Internal Medicine Primary Care Clinic
- > Valley Family Medicine
- > Valley Medical Center





Target: Type 2 Diabetes

- > Cascade Primary Care Clinic
- > Covington Primary Care
- > Diabetes-Thyroid Clinic
- > Fairwood Primary Care Clinic
- > Kent Primary Care Clinic
- > Kent Station Primary Care Clinic
- > Lake Sawyer Primary Care Clinic
- > Maple Valley Primary Care Clinic
- > Newcastle Primary Care Clinic
- > Renton Highlands Primary Care Clinic
- > Senior Care, Internal Medicine Primary Care Clinic
- > Valley Family Medicine
- > Valley Medical Center





Patient-Centered Medical Home Recognition Congratulations to all 11 Primary Care Clinics!

- > Cascade Primary Care Clinic
- > Covington Primary Care
- > Fairwood Primary Care Clinic
- > Kent Primary Care Clinic
- > Kent Station Primary Care Clinic
- > Lake Sawyer Primary Care Clinic
- > Maple Valley Primary Care Clinic
- > Newcastle Primary Care Clinic
- > Renton Highlands Primary Care Clinic
- > Senior Care, Internal Medicine Primary Care Clinic
- > Valley Family Medicine





FY2024 Ambulatory Quality Overview



Quality Improvement:

Time Out Breast cancer screening Colon cancer screening Depression/suicide screening



Care Pathways:

Stroke update Osteoporosis (new) Depression/Suicide update



PCMH



Strategic Incentive Planning



THANK YOU!

