The "UW Medicine Way" means delivering predictably excellent care for the population we serve. Supporting that requires a transformation in the way we turn data into information, and information into action. In this newsletter, I want to highlight some great examples of this. Building on the work of empanelment, added analytic functions and changes in the EPIC dashboard enable our primary care teams to see how their panel -- their "slice of the population pie"-- is faring for key measures of health and well-being. With these insights, we can better help patients when they see us in clinic or reach out to them at home to help with preventive care, manage their chronic conditions and improve their health. With this approach and led by great primary care clinic chiefs, we have seen remarkable progress in key measures of patient health. As an example, in less than a year, Federal Way Clinic Chief Vicky Fang, MD has led her team in a panel management project that has resulted in a 10% improvement in blood pressure control and 11% increase in retinal screening among patients with diabetes. The Federal Way clinic is also using the Annual Wellness Visits (AWV) as a way to make sure all people get the preventive care they need and nearly 75% of Medicare Advantage patients have had such visits. This has helped close 78% of patient care gaps! That's amazing progress and according to Vicky, it is highly reproducible. "It's all about getting team members involved, educating about the importance of the work and using our new Epic population health tools to forecast and plan pre-visit activities to manage our panels." What's emerging is a set of best practices for panel management that includes reaching out to those who have not come in to see us in the clinic, taking advantage of centralized disease management services (see this month's updates) and using the AWV wellness as an opportunity to increase preventive care. Thanks Vicky for all you and your colleagues are doing! Great tips for all to use as we move to predictably excellent care!

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# Care Transformation Updates

## Depression PATH (Population Approach to Health)

At UW Medicine, nearly 15% of our primary care patients –nearly 40,000 people– are diagnosed with depression. Though effective treatments exist, reaching out and engaging patients in treatment can be a challenge. Over the last few years we have employed a systematic, stepped-care approach to screening, diagnosing, and treating our patients with depression. One component of this is integrated depression treatment, now available in most UW Medicine primary care clinics. However, even with the best efforts, patients with depression can "fall through the cracks." For those patients our new Depression Population Approach to Health (PATH) group, provides outreach and support for patients and teams. Led by physician champions Marc Avery, MD and Denise Chang, MD, launched in January 2017, with an initial focus on test populations as we learn how to scale it up to all patients . The Depression-PATH team monitors patient files and clinic reports of newly diagnosed patients to identify opportunities for improving care. In these pilot populations, more than 536 people with depression have been identified. PHQ-9 surveys (depression assessment questionnaires) are being monitored for response to treatment and to determine if medication adjustments are needed. The results are encouraging – with almost half of newly diagnosed patients having a 50% reduction in depressive symptoms (defined as a treatment response), and 30% showing full remission in 12 months of follow up. This is genuine population health in action and as the program scales up I'm confident it will accomplish predictably excellent care- the UW Medicine Way-for all those who struggle with depression in our system.

## Hypertension Pathway

Hypertension is another common, chronic disease where the traditional approach to care-episodic treatment dependent on the patient coming into the clinic-may need to be transformed if we want to prevent more cardiovascular complications and death. Valley Medical Center has developed a hypertension pathway, under the guidance of Travis Dalton, ARNP and Kimberley Herner, MD, and saw improvement in blood pressure control rates from 73% to 83%. Key learnings from their process included translating the clinical practice guidelines into operational processes, clarifying team roles, and having transparent reporting. These learnings helped inform a rapid performance improvement workshop and a pilot program across the rest of UW Medicine. D.C. Dugdale, MD and Pamela Mei Yung, MD are leading this effort, collaborating with physician leaders and practitioners across our system. It includes encouraging adherence to the pathway, giving clinical teams daily updating information on patients with hypertension that need to be contacted and encouraging out of system blood pressure testing to optimize medication management. One unique feature of hypertension management measurement is that it is based on people diagnosed in the first half of the year, so DC is providing a central monitoring role for the patients we know need better management and is reaching out to all clinic chiefs. With pathways and PATH programs we are looking forward to really moving the needle-and delivering predictably excellent care to all UW Medicine patients with hypertension.