Planned Care for your Patient Population

Rebecca Jaffe, MD, MPH, FAAFP, FACSM

ACTIVITY DISCLAIMER

The material presented here is being made available by the American Academy of Family Physicians for educational purposes only. Please note that medical information is constantly changing; the information contained in this activity was accurate at the time of publication. This material is not intended to represent the only, nor necessarily best, methods or procedures appropriate for the medical situations discussed. Rather, it is intended to present an approach, view, statement, or opinion of the faculty, which may be helpful to others who face similar situations.

The AAFP disclaims any and all liability for injury or other damages resulting to any individual using this material and for all claims that might arise out of the use of the techniques demonstrated therein by such individuals, whether these claims shall be asserted by a physician or any other person. Physicians may care to check specific details such as drug doses and contraindications, etc., in standard sources prior to clinical application. This material might contain recommendations/guidelines developed by other organizations. Please note that although these guidelines might be included, this does not necessarily imply the endorsement by the AAFP.
DISCLOSURE

It is the policy of the AAFP that all individuals in a position to control content disclose any relationships with commercial interests upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflict of interest (COI), and if identified, conflicts are resolved prior to confirmation of participation. Only those participants who had no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this CME activity.

All individuals in a position to control content for this session have indicated they have no relevant financial relationships to disclose.

The content of my material/presentation in this CME activity will not include discussion of unapproved or investigational uses of products or devices.

Rebecca Jaffe, MD, MPH, FAAFP, FACSM

Regional Medical Director, Aledade ACO, Bethesda, Maryland; Private practice, Wilmington, Delaware

Dr. Jaffe graduated from the Medical College of Pennsylvania, Philadelphia, and completed her residency in family medicine at the Medical Center of Delaware (now Christiana Care), Wilmington. She has spent her entire career in the Wilmington, Delaware area, working at a federally qualified health center (FQHC) and in private practice. Dr. Jaffe is board certified in family medicine and primary care sports medicine. While serving in full-time private practice, she earned a Master of Public Health (MPH) degree from Drexel University, Philadelphia, Pennsylvania. After 35 years of patient care, she now sees far fewer patients and is working full time as regional medical director for Aledade ACO. Dr. Jaffe has held many respected national volunteer roles, such as serving on the United States Olympic Committee and the AAFP Board of Directors. Currently, she is vice president for the American Academy of Family Physicians Foundation. In her local area, she has served on the board of her hospital and other organizations, and she volunteers in her community at sporting and educational events. She has authored more than two dozen publications in the medical field.
Learning Objectives

1. Understand the basics of population health management.
2. Assess health disparities of the practice’s patient population.
3. Describe the value of team-based care for the practice and the patient.
4. Develop knowledge and skills to apply a population health approach to delivery of primary care services.

Audience Engagement System

Step 1
Step 2
Step 3
Leading change

• Many on the team act as change agents, not just “the usual few”
• Want-to, get-to, not just have-to mindset.
• Leaders engage the head and the heart, not just the head.
• Leadership and coach, not more management

Poll Question 1

**Why** is planned care so important? (check all that apply)

A. Improves health outcomes of your patient population
B. Standardization assists in capturing the entire patient population
C. Medical care has gotten fairly complex and this allows for improved office functioning.
D. Allows every member in the office to assist with the best care possible for each patient.
E. Shares in the responsibilities for the best possible care to all the patients in the practice.
F. Fosters a team approach to healthcare
Evolution of the record systems - we have come a long way

Original medical record

Original registry

Record and registry

Transport aircraft cockpit
**standardization** = fewer accidents

Checklist Manifesto = better safety

Suitable applications in our offices = quadruple aim
A team is not a group of people who work together. A team is a group of people who trust each other. - Simon Sinek

**Successful offices:**
where team members work to the top of their license

- **Goals** that are defined and patient centered
- Strong leadership with **support and coaching** as tools for staff
- **Resources** for the needs of the work
- **Communication** that is clear and concise
- **Culture** that supports **quality improvement**
- **Empanelment** to make the necessary practice team changes
- **Rewards** that are tangible to staff and to the patient
Evolution of the health care team- a necessary improvement

Value in team based care- collaborate to foster knowledge translation

• Practices maximize the use of the full skillset of key staff such as MAs and RNs to enhance patient care and increase efficiency and effectiveness.

• Teams now manage complex, multi-problem patients with behavioral health issues and complex drug regimens. This requires taking on new functions that improve clinical quality, patient experience, and job satisfaction.

• Everyone on the team works together to partner with the patient for the best possible outcome.
Value proposition

Contact me first for Comprehensive Continuous Coordinated Care

What is Population Health?

The health of a population as measured by health status indicators and as influenced by social economic and physical environments, personal health practices individual capacity and coping skills, human biology, early childhood development, and health services.

Conceptual framework for thinking about why some populations are healthier than others as well as the policy development, research agenda and resource allocation that flow from this framework.

Includes health outcomes, patterns of health determinants, and policies and interventions that link these two

Dunn and Hayes 1999
Young 1998

Kindig and Stoddart 2003
Population Health Management

- Analysis and action
- Patient outcomes
- Identifying gaps in care and filling those gaps
- Manage care and engage patients
- Institute for Healthcare Improvement (IHI): the work by healthcare organizations to improve outcomes for individual patients to maximize the health of the population.
- And so much more

True Population Health Management

Requires a collaborative strategy between leaders in healthcare, politics, charity, education and business (RWJF, 2014)
Most health care is not acute

- Risk stratification of patients to assist with current priorities.
- Be proactive and organized.
- Patient centered
- Team oriented
- **Start with an easy achievable workflow change to assess the team and courage for the work**
- Build on successes

---

**Focus** initially on a few important things first

- 81 Quality Measures  Value-Based Contracts
  - **Control** High Blood Pressure (LDL) Use of Aspirin or Another Antiplagial Platelet Therapy for Patients with CVD or Persistence of a Beta Blocker Treatment After a Heart Attack
  - Persistent Use with lab monitoring: Digoxin, ACE-I/ARB or Diuretic
  - Medical Attention for Nephropathy HbA1C Good Control (=9%) HbA1C Testing
  - Foot Exam Statin Therapy for Patients with Diabetes Urate Protein
  - Screening Colorectal Cancer Screening Breast Cancer Screening
  - Cervical Cancer Screening Chlamydia Screening Adult
  - Assessment of BMI Tobacco Screening and Cessation
  - Chronic Care Visits Well-Child Visits (0-15 mo) Well-Child Visits (3-6 yrs) Well Child Visits (12-21) Adolescent Well Care Visits
  - Appropriate Treatment of Children with URI
  - Typanostomy Tube insertion Pediatric Hearing
  - Test Pharyngitis Pediatric Appropriate Treatment Avoidance of Antibiotic Treatment in Adults Monitoring Physical Activity
  - Improving or Maintaining Physical Health
  - Improving or Maintaining Mental Health PCP Visit Qualified Physician Visit Discharge Follow-Up Potentially Preventable Admissions (Risk-Adjusted) Hospitalizations for Potentially Preventable Complications (HPC) ER Visits All-Cause Readmission Readmissions (Risk-Adjusted) All Cause Unplanned Readmission Acute Composite Adolescent Immunization Childhood Immunization
  - Childhood Immunization Asthma High Risk Medications Brand Formulary Compliance Rate Generic Fill Rate Osteoporosis Management in Women Who Have Had a Fracture Rheumatoid Arthritis Management Imaging Studies Annual Dental Visit Medication Reconciliation Depression Management Member Satisfaction 30-Day Post PCP Written Prescription for Kids 6-12 yo on ADHD Medication % of Beneficiaries >18 yo prescribed Xanax Use of Certified EHR Technology Falls Risk Screening Special Needs Plan Care Management Care for Older Adults (Functional Status Adjustment) Care for Older Adults (Pain Assessment) CAHPS Access to Medical Records Complaints about the Health Plan Members Choosing to Leave the Plan Beneficiary Access and Performance Problems Health Plan Quality Improvement % of Optional Radiology Performed at Free Standing Facilities % of Optional Lab Services Performed at Independent Labs % of Optional Surgeries Performed in ASC Non-Trauma Admits Per 1,000 Call Center Foreign Language Interpreter and TTY Availability Plan Makes Timely Appeals Decisions Reviewing Appeals
Creating standardized workflows:
Focus on making it easy to do the right thing

• Standing orders
• Data retrieval for chronic conditions (labs and specialist notes and tests), gaps in care (USPSTF, insurance driven), previsit preparation (labs, tests, specialists notes), post hospitalization (medication lists, discharge summary, all tests, consultants notes, OR notes), post ED visit (notes, labs, tests, consults).
• Registries of diseases: hypertension, diabetes.
  • A list of patients- their condition- their key measures
• Standard screenings
• Ask the question of why to frame the visit

Be proactive, not reactive whenever possible

DO SOMETHING TODAY THAT YOUR FUTURE SELF WILL THANK YOU FOR.

Our actions and decisions today will shape the way we will be living in the future.
Poll Question 2

How many are using standing orders? For what kind of care mostly?

A. Immunizations
B. Standard testing in chronic diseases
C. Orders for health maintenance tests
D. Disease diagnosis
E. Disease treatment.
F. Not using standing orders.
G. Most of the above situations.

Standing orders
a special case of written physician’s orders

• A standing order is an order conditioned upon the occurrence of certain clinical events.
  • all the patients who meet the criteria for the order receive the same treatment.

• A common use of standing orders is in public health clinics that treat specific diseases.
  • A venereal disease control program will use the Centers for Disease Control (CDC) protocols for antibiotic dosages. Once the specific venereal disease is identified, the nurse administers the antibiotics as specified by the CDC protocol and authorized by the physician directing the clinic. In this situation, the CDC protocol is a standing order from the medical director, and the conditional event is the diagnosis of a specific venereal disease.

Standing orders: vaccinations:
www.immunize.org/standing-orders/

Standing orders: a great place to start
www.standingorders.org to improve vaccination rates
Office Example for Vaccinations

• Initially Run a report in your EHR
  • People aged 65 and no Prevnar or Pneumovax.

• Call all patients with neither vaccine in for an Annual Wellness visit.
• Flag rest of the charts with the reminder.
• Let your standing orders for pneumonia vaccination happen.

Run report on regular cycle to catch opportunities that slip through.

Standing orders: other office situations

• Dysuria
  https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Standing%20Order%20-%20UTI.pdf
• Medication refills
• Ordering Mammograms
• Ordering Colon Cancer Screening
• Ordering routine care including A1c, microalbumin in diabetics

• RN led AWV in Primary setting
  https://scholarworks.gvsu.edu/cgi/viewcontent.cgi?article=1019&context=kcon_doctoralprojects
Are Standing Orders Effective? Yes they are!

- Based on a review of 29 studies (1997 – 2009) that examined standing orders either alone or combined with other activities, the Community Prevention Services Task Force found:
  - Standing orders were effective in increasing vaccination rates when implemented in a range of clinical settings, among various providers and patient populations
  - Standing orders were effective for vaccine delivery to children (universally recommended vaccinations) and adults (influenza and pneumococcal)

- [www.thecommunityguide.org/vaccines/standingorders.html](http://www.thecommunityguide.org/vaccines/standingorders.html)

---

**Preventive services**

- HEDIS
- MSSP Quality
- Commercial contract metrics for bonus

<table>
<thead>
<tr>
<th>PREVENTIVE SERVICES</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last AHW (All)</td>
<td>N/A</td>
</tr>
<tr>
<td>Advance Care Planning (All)</td>
<td>No data found</td>
</tr>
<tr>
<td>CRC Screening (50-75)</td>
<td></td>
</tr>
<tr>
<td>DEIA (65+)</td>
<td>Singh, Mihesh</td>
</tr>
<tr>
<td>Flu Shot (All)</td>
<td>Funk, William</td>
</tr>
<tr>
<td>Mammogram (50-74)</td>
<td>Nguyen, Thanh</td>
</tr>
<tr>
<td>Pneumovax (65+)</td>
<td>Funk, William</td>
</tr>
<tr>
<td>Prevnar (65+)</td>
<td></td>
</tr>
<tr>
<td>Retinal Eye Exam (18-75)</td>
<td>Kaplan, Jason</td>
</tr>
<tr>
<td>Shingles Vaccine (50+)</td>
<td></td>
</tr>
</tbody>
</table>

Leverage the data and the lists to your advantage

Blood sugar
Mammogram
Immunizations
Well child care
Colon cancer screening

Demo, no PHI included
Registries: allows you to build evidence within the practice

- Lists of your patients with a clinical issue that has potential long lasting consequences. (patient with diabetes, pt. with CHF)
- Proactive management of your entire patient panel by reviewing data and results on a regular basis (immunizations by age)
- When new medication or recommendation available, able to call in and deploy for patient (Hodgkin's post radiation patients for thyroid and breast issues)


Previsit preparation as part of planned care

- Remind and retrieve all labs and test results prior to appointment.
- Retrieve all consultation communication prior to appt.
- Review immunizations against the standard, especially for well child, to ensure you have in stock and available.
Real life wins

• 68 year old male comes in for Transition of Care visit.
• Post lumbar laminectomy
• MRI of back done just prior to procedure, retrieved by staff for review per protocol.
• In reviewing the study prior to seeing the patient, there is note of a 5.6 cm abdominal aortic aneurysm.
• Reviewed with patient if this had been shared, consult done?
  • Answer was no.
• Called vascular surgeon who saw patient next day and operated later that week.

Visit preparation- to augment the previsit prep

Form with specifics filled out by patient and given to MA when called back.

“This form is to help organize and direct your encounter today and will be shredded next week.”

1. Any new health/life issues that have occurred since your last visit
   • Hospitalizations, ED visits, Deaths in family, Changes in status
2. 3 most important health issues you wish provider to review/discuss today.
3. Medications which require refills today or in next 3 months.
4. Providers or new specialists who you have seen since your last visit
5. Any other important pertinent information.
Visit Execution
prior to clinician and planned care

• Confirm reason for visit and other priorities: document
• Vital signs (wt (BMI), bp, pulse, each visit; height yearly.
• If BP is higher than 140/90, then a repeat BP will be performed prior to clinician visit (or by physician)
• Immunizations by standing order.
• Tests that are due or late, by standing order.
• Call for any labs or tests still not received from previsit prep

Poll Question 3

Does your office call patients who do not call you?

• Yes
• No
• I do not know
• Why should we?
Outreach to patients who do not reach into your office

• Immediately post hospitalization, especially if you get notifications
• Post emergency room visit
• When office receives abnormal lab and/or test results
• When insurance companies identify health maintenance gaps in patient’s care
• On attributed list but not seen
• Not seen in 2 years

Outreach to patients who do not call you proactively

• Receive refill request and patient not seen in office in last 6 or 12 months, depending on their medical issues.
• Registry review:
  • Patient with diabetes, but no A1C in over 9 months.
  • Patients on statin medications.
  • Patient whose last BP over your “normal” and not returned in x months.
Leverage resources to support patient needs and education

- Do not be limited by your four walls.
- Consider care management, if not already doing.
  - Support patient with regular touchpoints, especially high risk patients
- Use resources from your local community or The EveryOne Project
- Provide information on the patient’s reading level, in the patient’s language of choice to assist in their understanding and self management of their chronic health issues.

Health disparities - The Everyone Project -
**Patient handouts for education and to help with your planned care action plan**

- Wide range of topics
- [www.familydoctor.org](http://www.familydoctor.org) has Spanish and English at a 5th grade reading level.
- Prepared stock in Electronic record
- Customized to your office’s protocols and “standards”

**AWV- annual wellness visit:**
planned care for your patient population
100% coverage by insurance

- Outreach to your patients with the highest acuity of need
- Use standing orders to get immunizations and care gaps filled.
- Create a personalized care plan to inform and engage patient in their own care
- Depression, falls, alcohol screenings.
- Chronic disease gaps filled such as A1c, diabetic eye exams
- Assess for social determinants of health
Practice Recommendations - AWV in 11 easy steps

- 1. Perform Health Risk Assessment (HRA) including falls risk
- 2. Review history (Past Medical Hx, Family Hx, Social Hx, Meds/Allergies)
- 3. Update Care Team
- 4. Exam (HT, WT, BMI, BP, vision, hearing)
- 5. Dementia Screen if appropriate and necessary
- 6. Depression/mood disorder screen (PHQ2, PHQ9)
- 7. Safety/functional abilities screening
- 8. Review preventive services, provide beneficiary with referrals and written plan
- 9. Review risk factors and treatment plan (written plan)
- 10. Initiate appropriate referrals
- 11. End of life care (IPPE- info/discussion only) (AWV -Advanced Care Planning add-on)
Proactive questions/care/education

How many of these factors do you ask about?
How many do you screen for?
Do you specifically ask and document around social and economic factors?
Do you have local community resources readily available?

Standardization=Planned Care

Summary

1. No quick fixes- start small
2. Workflows matter!
   Standing orders and use EHR for lists
   Pneumococcal vaccination optimization
3. Team optimization- all work
4. Let technology help support
5. Concentrate on the most vulnerable
   Stress resilience enhancer- so you will not miss care, quality

Demo: no PHI included
Contact Information

Planned care: Your patients will thank you and so do I. 
bjaffe@aledade.com

Thank you!


Questions