From the American Academy of Family Physicians

Increasing Pneumococcal Immunization Rates

WORKING WITH AAFP STATE CHAPTERS

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

The American Academy of Family Physicians (AAFP) and Pfizer Independent Grants for Learning & Change (IGLC) collaborated to offer a new immunization opportunity to AAFP state chapters. The goals of this grant opportunity were to support quality improvement (QI) initiatives that increase adult pneumococcal vaccination rates, as well as support state-level projects that increase pneumococcal vaccination rates in adults, with a specific focus on patients 65 years and older and populations living in medically underserved areas.

State chapters developed QI projects and outcomes that had an impact on direct patient care and system changes. Education and/or QI projects included team-based approaches and behavioral change resources for health care clinicians and their practice teams. As part of their QI initiative, the selected state chapters were required to implement evidence-based interventions. Evidence-based interventions, strategies (e.g., recommend, assess status, document), and system changes that are proven to increase adult immunization rates include:

- Providing strong recommendations
- Documenting and tracking immunizations
- Identifying missed opportunities for vaccination
- Utilizing a team-based approach to improve immunization rates
- Disseminating outcomes and findings
- Sustaining outcomes and findings

Selected AAFP State Chapters and Projects

Kansas Academy of Family Physicians (kafponline.org)

The Kansas Academy of Family Physicians (KAFP) and Kansas Foundation for Medical Care (KFMC) provided training and coaching sessions to inform teams about the evidence-based standards for adult immunization, benefits of team care, and how to make system changes to support pneumococcal and other adult immunization screening improvements. KFMC assisted participating clinics in conducting a root-cause analysis to learn of any barriers in their practice, and define and implement system changes to ensure that pneumococcal immunization is systematically assessed and treated at every clinical encounter utilizing the National Vaccine Advisory Committee's (NVAC's) Standards for Adult Immunization Practice. In this initiative, the KAFP partnered with family physicians to implement evidence-based practices to promote effective immunizations of Medicare patients. Practices used their electronic health records (EHRs) to track and improve their pneumococcal and other immunization rates for patients 65 years and older. The aggregate rate increase for the seven practices was 38.4%, which far exceeded their goal of 10%. Data showed that practices with lower baselines would have no problem achieving the absolute rate of 90% if the project continued beyond the 12-month baseline period. They believe the same interventions and processes used in this project could identify other gaps in care and improve health status and compliance rates for any targeted condition or patient population.

Illinois Academy of Family Physicians (www.iafp.com)

The Illinois Academy of Family Physicians (IAFP) worked with participating practice sites to harness the power of family medicine leadership to increase immunization rates. A team was created at each site with one individual health center champion. The champion provided technical assistance to increase immunization rates at each site, with the aid of a regional QI consultant, subject matter experts, and physician leadership. Through interactive learning and action sessions in a team-based setting, strategies were identified, including standing orders protocol. Engagement and delivery were chosen to best fit the individual needs of each site, while allowing for a tailored approach at each site. The four health systems showed 3-6% increases in pneumococcal immunization rates for 6-7 months. The practices with lower rate improvements were in locations with stronger anti-vaccine cultures. A main takeaway for success was getting pneumococcal vaccinations on EHR dashboards for three of the major health systems. A clinical champion (especially individuals in leadership positions) at each practice helped bring this issue to the forefront of care. A QI coordinator in practices allowed for consistent and sustainable changes to increase the pneumococcal immunization rate in patients 65 and older, as well as patients with chronic disease and diabetes, and patients who smoke.

New Jersey Academy of Family Physicians (www.njafp.org)

Using a collaborative and consultative model, the New Jersey Academy of Family Physicians (NJAFP) engaged primary care practices in a series of virtual learning and consultative visits with one live, face-to-face event midway through the project to review progress, share challenges, and celebrate successes. This model engaged practices in rapid-cycle changes, and provided opportunities to make improvements, learning from topic experts, in addition to learning from one another. The consultative model supplements educational activities through on-site,

hands-on guidance and support from NJAFP practice coaches to foster activities that reduced gaps identified in the needs assessment. Performance data collected were national consensus quality measures for benchmarking and minimizing barriers to collection. The 14 practices had an aggregate vaccination rate of 69%, which was an increase of 1% from the baseline. There was an 8% increase in Medicare annual wellness visits (AWVs) in the practices. There were six educational webinars throughout the program that received good evaluation reviews. The practices worked with practice coaches to identify change ideas, as learned through the webinars. These resulted in about 40 Plan-Do-Study-Act (PDSA) cycles throughout the year, with 11 of the changes adopted or spread throughout the project. Practices were able to increase AWVs, increasing preventive care patient visits.

Project Impacts

A total of 55 practices participated. Each state had a different approach, and different populations were targeted. In Kansas, rural and/or small primary care providers were included. In Illinois, family physicians and other primary care clinicians (internal medicine, pediatrics, and other specialty clinics, such as geriatrics) participated. Illinois also utilized mid-level providers, such as physician assistants, advanced practice nurses, and registered nurses. New Jersey focused on 15 primary care practices that included privately owned practices, system-based residency program practices, and accountable care organization (ACO) practices. These included family or internal medicine physicians, resident physicians, physician assistants, and nurse practitioners. Educational materials were developed and provided to all staff, including nurses, medical assistants, front desk staff, and administrators.

Overall, a total of 185 primary care providers were impacted by the project, with 37 physicians in Kansas; 106 physicians in Illinois; and 42 physicians, nurse practitioners, and physician assistants in New Jersey. By the end of the AAFP's initiative, there were a total of 27,843 patients in the targeted population that were directly impacted by the projects in all three states. AAFP staff will work with the physician consultants, and all three state chapters to develop patient education materials to be posted on the AAFP's familydoctor.org website. The materials will include a fact sheet/handout for patients about the different pneumococcal vaccines, combating vaccine hesitancy, and shared decision making in patient care.

Barriers

Different barriers were identified during the various phases for each state chapter project. There were common themes demonstrated by all practices who participated in the state chapters projects, including:

- Proper onboarding and staff buy-in were important. Practices would utilize webinars and planning meetings to help educate and train staff, but it was difficult when staff changed. Training new staff to understand the processes and stay proactive was difficult. This seemed to be especially true when the office champion was replaced.
- Development and creation of standing orders for vaccines, as well as getting into the habit of using them, took adjusting for the practices.
- Patients getting vaccinated at the pharmacy was a challenge with no way to document that information in the patient medical chart or follow up with the pharmacy to see if the patient received the vaccine.
- Medicare denying reimbursement for the vaccine was another challenge, with the payer stating that the patient may have already received the vaccine. To address this barrier, some practices started making patients sign an Advance Beneficiary Notice of Noncoverage (ABN), and they noticed a decrease in the number of patients who would still opt for the vaccine, most likely due to fear of having to pay.
- All EHRs are not the same. Many EHRs do not have the same functions or capabilities, so additional steps may need to be implemented to achieve some of the same functions. Not all practices have information technology (IT) resources to navigate and overcome this barrier. Several practices undertook massive changes to their EHRs during the project, which affected their ability to record and pull necessary information.
- Family physicians working in various settings, from rural to urban areas, as well as solo practices to large health systems, presented different challenges. For example, large health systems have administrative support, but there are more channels to navigate for approval of changes. Smaller practices have fewer channels for approval, but limited staff and other resources with a small number of administrative staff covering a wide scope of work.
- Navigating the COVID-19 pandemic proved to be an unexpected challenge. Changes in some practices limited in-person practice visits, postponed wellness

visits, increased telehealth visits, closed some clinics for safety or COVID-19 response, and furloughed workers. All of these impacted the project during spring 2020, and may have affected the sustainability of the project.

Tools and Resources for Physicians/Practices

Overall, tools and resources were utilized to overcome barriers identified during the project, including:

- Practices' abilities to assess their workflow and identify roles and responsibilities during a well-patient visit ensured that each step of the process had a specific person assigned. Discussing vaccines in a workflow strategy allowed each practice to have a customized approach that works for their clinic and ensures that no steps are missed during a visit.
- Standing orders were made readily available to practices, and staff were trained to utilize them.
- Practice staff created a "prescription task" in their EHR system, and worked with pharmacy staff to ensure that after the patient received the vaccine, the task was marked as checked or completed, so that clinic staff could note it in the patient's EHR. Ideally, all vaccine providers would input patients' vaccinations in the state/national immunization registry. However, until that becomes a consistent practice, finding tools to navigate this particular gap was helpful.

During the COVID-19 pandemic, practices utilized telehealth resources, including:

- Leveraging patient-facing mobile apps or having patient screening/health wellness checklists sent through patient portals for patients to complete prior to telehealth visits proved effective. Allowing patients to self-assess their risk for specific vaccine-preventable illnesses may increase adherence in the same manner that motivational interviewing aids in patient-centered learning.
- Leveraging telehealth to educate patients on the benefits of immunization allowed for easier dissemination of information. The AAFP is currently creating more patient-facing education materials for the familydoctor.org website to engage, educate, and inform patients with consistent messaging similar to what messages they receive from their family physician.

Positive Feedback

Overall, practices were incredibly positive about the changes they saw in their immunization rates and lessons from PDSA cycles. Participating practices provided other positive feedback about the project and its outcomes, including:

- Patients felt they were getting "special treatment" with extra time and a customized approach to their health care needs.
- Practices implemented AWV slots in their schedule, which provided a means to offer preventive care.
- Practices implemented pre-visit planning, and utilized tools from the project, which led to improved practice workflows and increased preventive health measures.
- Practices appreciated having real-time data, which helped keep the focus on pneumococcal vaccines, and kept their project on track.
- Practices felt empowered to set program/QI goals, and achieve them.

For more information, tools, and resources to increase immunization rates in your practice, please visit https://www.aafp.org/patient-care/public-health/immunizations/pneumococcal-grant.html.

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