Improving Preventive Care

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Objectives

- Recall preventive care services
- Describe ways in which EHR optimization can improve preventive health screenings
- Describe the team based care model to patient care
- Explain the role of the Community Health Worker
- Compare and contrast health equity vs health equality
Who is MPRO?

MPRO is an independent nonprofit organization and a national leader in health care quality improvement and medical review.
The IHI Triple Aim

Population Health

Experience of Care

Per Capita Cost
Risk Stratification

- **High-Cost Patients**
  - 1% Catastrophic illness
  - 4% 5+ chronic conditions

- **Rising-Risk Patients**
  - 20% 2-4 chronic conditions

- **At-Risk Patients**
  - 25% One chronic condition
  - 15% At risk for developing a chronic condition

- **Healthy Patients**
  - 35% No ongoing physical health needs

Clinical Risk | Social Risk | Behavioral Risk
Preventive Care

• United States Preventive Service Task Force (USPSTF)
  – Created in 1984
  – National experts in prevention and evidence-based medicine
  – Evidenced based recommendations on screenings, counseling services and preventive medications
Preventive Care

- Screen for diseases
- Alcohol and tobacco use
- Encourage a healthy lifestyle
- Vaccinations
- Medications and supplements
- Patient/provider relationship
Improving Preventive Care

• Policies and procedures
• EHR optimization
• Workflow redesign - staff empowerment
• Patient engagement
• Provider recommendation
• Health Equity
Policies and Procedures

- Consistency and efficiency
- Utilized for staff training
- “Human aspect”
Electronic Health Record (EHR) Optimization

• Standardization in documentation
• Gaps in care report
• CDS alerts/Health maintenance
• Patient portals/reminders
Documentation

• The first step to improving preventive care is making sure everyone in the office is documenting properly/accurately in the EHR
Gaps in Care

• Garbage in = garbage out
• Develop a policy
• Non-compliant vs. uninformed
Clinical Decision Support/Health Maintenance

- More than one type of alert
- Watch out for alert (pop-up) fatigue
- Utilize alerts with your patient population in mind
- Develop policy to satisfy alerts
- Review health maintenance on every visit not just yearly physical
Patient Portals & Reminders

• Secure
• Easy to navigate
• Engaging
• Utilizing gaps in care: Patient reminders can be sent
Workflow

- Develop a team
- Physician/staff champion
- Utilize Plan Do Study Act PDSA model
- Staff empowerment
Patient Engagement

• Who?
• What?
• Why?
• How?
Provider Recommendation

“Nothing influences people more than a recommendation from a trusted friend.”

- Mark Zuckerberg
Health Equity

“Of all forms of inequality, injustice in health care is the most shocking and inhumane.”

- Dr. Martin Luther King
Questions?

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Resources

• USPSTF
  http://www.uspreventiveservicestaskforce.org/Page/Name/about-the-uspstf

• Electronic preventive service selector:
  http://epss.ahrq.gov/PDA/index.jsp

• Make it your own:
  http://www.miyoworks.org/login/auth;jsessionid=9BB51E863BE5FC10B3F58B44D9011124
Integrated Care

WHAT “ADDRESSING THE WHOLE PERSON” REALLY MEANS
Integrated Care

- Uses evidence-based models of care to develop plans to treat the patient head-to-toe
- Prioritizes focus areas of treatment based on patient engagement, severity of conditions and risk factors
- Incorporates goals and self-care that is achievable
- Addresses barriers
- Supports the patient
- Is about the patient!
A Case Study

Victor is a 62 year old male in a rural community setting. He hasn’t had his “own place” for the past 3 years, and has been sleeping on his mother’s couch. Over the years, he has been diagnosed with Major Depressive Disorder, Asthma, and COPD. He has visited the emergency department three times in 2016, so far, for acute illness. He reported that he struggles with depression, has difficulty getting out of bed, lacks energy, has back pain, feels hopeless. When asked about suicidal ideation, he declines to answer and changes the subject. He reports having no primary care physician, and mainly “deals with depression” on his own. He does not adhere to regular medication; he has a history of only getting prescriptions at the ER, which have been muscle relaxers for pain, and corticosteroid for asthma attacks.
The Mission

- Relationships between the patient, the family, and provider must be fostered and supported.
- Emphasis on wellness of the whole person, family, and community including physical, mental, and emotional wellness.
- Locations that are convenient for the patient (minimal stops for service)
- Access is optimized and waiting times are limited
- Working together with the patient as an active partner
- Intentional whole system design to maximize coordination and minimize duplication
- Outcome and process measures to continuously evaluate and improve
- Not complicated but simple and easy to use
- Services are financially sustainable and viable
- Encourage understanding
- Listen with an open mind
- Notice the dignity and value of ourselves and others
- Engage others with compassion
- Share our stories
- Strive to honor and respect ourselves and others
Using Care Teams in Evidence-Based Practice

- Primary Care Provider
- Behavioral Health Provider
- Nurse Care Manager
- Community Health Worker

- Examples of successful models: Nuka, IMPACT, COMPASS and others...
Team Structured Care

- **As a team:**
  - Define specific and measurable outcomes and objectives
  - Ensure that all systems support defined work; data assesses progress and performance (Electronic Health Record)
  - Shared communication process is defined, schedule team huddles daily and hold members accountable for participation
  - Patient Engagement strategies, making patient the “hub” of the care team
• Defined: *verb* - **Care coordination** is the organization of activities between participants responsible for different aspects of a patient’s care designed to facilitate delivery of appropriate services across all elements of the broader health care system. It includes management of integrated primary and specialty medical services, behavioral health services, and social, educational, vocational, and community services and supports to attain the goals of holistic, high quality, cost-effective care and improved patient outcomes. Components of care coordination include knowledge of and respect for the patient’s needs and preferences, information sharing/communication between providers, patient, and family members, resource management and advocacy.

**All care team members are held responsible for this activity!**
Focusing on the PATIENT

- Monitor progress – everyone plays a role – when in doubt, document

- Update care plans/track results – critical to engage patient w/ regular contact

- Implement new training where necessary

- Strengthen partnerships
Community Health Workers: Addressing Barriers

- Patient Fears
- Unknown Partners
- No model established
- Follow-up questions
Motivational Interviewing

“Goal-oriented, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence”
What is it, really?

- Patient-centered “counseling” approach meant to elicit behavior change, and explore and resolve ambivalence
- Meeting the patient “where they are”
- Addressing barriers
Using Motivational Interviewing to Address Barriers

- Do I listen more than I talk? Or am I talking more than I listen?
- Do I keep myself sensitive and open to this person’s issues, whatever they may be? Or am I talking about what I think the problem is?
- Do I invite this person to talk about and explore his/her own ideas for change? Or am I jumping to conclusions and possible solutions?
- Do I encourage this person to talk about his/her reasons for not changing? Or am I forcing him/her to talk only about change?
- Do I ask permission to give my feedback? Or am I presuming that my ideas are what he/she really needs to hear?
- Do I reassure this person that ambivalence to change is normal? Or am I telling him/her to take action and push ahead for a solution?
- Do I help this person identify successes and challenges from his/her past and relate them to present change efforts? Or am I encouraging him/her to ignore or get stuck on old stories?
- Do I seek to understand this person? Or am I spending a lot of time trying to convince him/her to understand me and my ideas?
- Do I summarize for this person what I am hearing? Or am I just summarizing what I think?

- Do I value this person’s opinion more than my own? Or am I giving more value to my viewpoint? Do I remind myself that this person is capable of making his/her own choices? Or am I assuming that he/she is not capable of making good choices?
Addressing Health Equity

Adapted from [http://indianfunnypicture.com/search/equality+doesn%27t+mean+justice](http://indianfunnypicture.com/search/equality+doesn%27t+mean+justice)
Health Equity vs. Inequity

- “A state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity”
- “All persons have access to the resources and power they need to attain their full health potential”
- “Systemic, avoidable, unfair, and unjust differences in health status and mortality rates, as well as in the distribution of disease and illness across population groups”
Values and Assumptions

- **Racism**
  - Functions to maintain structural inequities that are to the disadvantage to people of color

- **Cultural Humility**
  - Vital to the identification and elimination of social injustice

- **Policy Change to internal and external organizations**
  - Address inequities at the community level and within organization
  - Promote equity within the Health Department to strengthen efforts in the community
CHWs and Social Determinants of Health

- CHWs are ideal members of the care team to collect Social Determinants of Health (SDOH)
- Health Centers are screening, more regularly, on SDOH
- The data is useless unless we make it actionable
- Develop a PDSA – and use it!
Personal Information

Street address __________________________ City __________________________ State _______ ZIP code _______

Household annual income $________________________ Number of people in your household ______________________

Please provide the names and dates of birth of the children living in your household:

What is your preferred language for health discussion/information:

☐ English  ☐ Spanish  ☐ Vietnamese  ☐ Serbian/Bosnian  ☐ Other: __________________________

Do you have any special needs (for example hearing or vision impairment, wheelchair/walker dependent)?

Do you have an Advanced Directive for medical or behavioral health care?  Y  N  -- If yes, copy needed

Do you have a legally appointed guardian?  Y  N  If yes, please have your guardian sign all documents and provide the court documents at your first appointment.

Do you have a legally appointed payee?  Y  N  If yes, please provide name, phone number, address and date of birth of payee.

Who is your emergency contact?

Name __________________________ Relationship __________________________ Phone number __________________________

Race: Please check the box next to one of the following that best describes your race:

☐ American Indian/Alaskan Native  ☐ Asian  ☐ Black/African American

☐ More Than One Group  ☐ Native Hawaiian  ☐ Other Pacific Islander

☐ White  ☐ Decline to specify  ☐ Unknown

Ethnicity: Please check the box next to one of the following that best describes your ethnicity:

☐ Latino or Hispanic  ☐ Not Latino or Hispanic  ☐ Decline to specify

Housing Situation: Please check any box that describes your current housing situation:

☐ Doubling Up (living with extended family, friends, or acquaintances)

☐ Not Homeless (legally occupied, single family, owned or rented)

☐ Other

☐ Street (on the street, in cars, abandoned buildings, under bridge)

☐ Transitional (treatment program, hospital, jail, motel)

☐ Unknown/Unreported

Migrant/Agriculture History: Please circle Y or N based on you or your family’s primary source of income:

1. In the last 24 months have you worked on a farm/orchard planting or harvesting crops?  Y  N

If you answered no, you may skip the next 3 questions.

1. In order to work in agriculture, have you moved during the past 2 years?  Y  N

2. Due to the seasonal nature of your work in agriculture, have you had to change jobs, reduce the number of hours you work, or been temporarily laid off during the past 2 years?  Y  N

3. Have you or family you live with stopped working in agriculture due to disability or old age?  Y  N

Patient/Parent/Legal Guardian Signature __________________________ Date __________________________

9/24/15 Form #690Fsp

All slides in this presentation are the property of the presenter. Please do not duplicate slides without the written permission of the presenter.
1. In the past 12 months, have you tried to lose weight by taking diet pills or laxatives, making yourself vomit (throw up) after eating, or starving yourself?

2. Do you eat some fruits and vegetables every day?

3. Are you active after school or on weekends (walking, running, dancing, swimming, biking, playing sports) for at least 1 hour, on at least 3 or more days each week?

4. Do you always wear a lap/seat belt when you are driving or riding in a car, truck, or van?

5. Do you always wear a helmet when you are biking, rollerblading, skateboarding, motorcycling, snowmobiling, skiing or snowboarding?

6. During the past month, have you been threatened, teased, or hurt by someone (on the internet, by text, or in person) or has anyone made you feel sad, unsafe, or afraid?

7. Has anyone ever abused you physically (hit, slapped, kicked), emotionally (threatened or made you feel afraid) or forced you to have sex or be involved in sexual activities when you didn’t want to?

8. Have you ever carried a weapon (gun, knife, club, other) to protect yourself?

9. In the past 3 months, have you smoked cigarettes or any other form of tobacco (cigars, black and mild, hookah, e-cigarettes, other) or chewed/used smokeless tobacco?

10. In the past 12 months, have you driven a car drunk, high, or while texting or ridden in a car with a driver who was?

11. In the past 3 months, have you drunk more than a few sips of alcohol (beer, wine coolers, liquor,
Use your data collected to prioritize challenges with patient, set goals and timeline, and get ready for change.
Priority 1: Victor’s Housing – looking into permanent supportive housing solutions – WHY?
Priority 2: Victor’s Depression – let’s help Victor feel better about himself, so that he can focus on his chronic physical conditions – who should be involved? What might happen with Victor’s pain?
Priority 3: Monitor Victor’s medication adherence.
Priority 4: Link Victor to social environment (support group, faith-based organization, book club, physical activity, etc) and maintain contact through check-ins.
If you do not change direction, you may end up where you are heading.

Lao Tzu
Resources

- Nuka Model of Care
  - www.southcentralfoundation.com/nuka
- IMPACT Model of Care
  - www.impact-uw.com
- Compass Model of Care
  - www.miccsi.org/COMPASS.html
- SAMHSA
  - www.samhsa.gov
- World Health Organization
Questions or Feedback?

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