Creating a Protocol for Patient Outreach at a Primary Care Clinic

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Abstract

Purpose. The way that patient care is being delivered is evolving. One way in which this is happening is through patient centered medical homes (PCMH). PCMH represent a model of care that is accountable for meeting a patient's care needs, including prevention and wellness, acute care and chronic care. To obtain status as a recognized PCMH, practices must fulfill specific quality care initiatives including patient outreach. Another way in which patient care is changing is through MACRA. This government initiative changes the way that practices are reimbursed for their services from fee-for-service to outcomes based measurements. Practices are now responsible for reporting on 4 different measures, with this project focusing on the quality improvement and meaningful use. This protocol is meant to fulfill these requirements. This project outlines specific guidelines for 12 different patient outreach topics including: pap smears, hypertension, colorectal cancer screening, pneumonia vaccinations, depression screening, smoking cessation in patients with COPD, hepatitis vaccination, Tdap vaccination, INR in patients on coumadin, mammograms, HgA1C, and influenza vaccination. These guidelines determine the criteria for creating lists of patients via the electronic health record (EHR), that need to be contacted for each of the 12 topics.

Methods. It was planned to use reporting tools and data mining capabilities from the EHR in use at the clinic to develop lists of patients who met specific criteria pertaining to each topic and its associated guideline and to contact patients electronically via MyHealthOnline (a profile used to securely communicate from provider to patient and vice versa). The goal was to encourage them to contact the office to make an appointment to address that specific health maintenance topic. Outcome measures were determined to be the number of patients who needed to perform each of these activities at the beginning of implementation, versus those who have them completed after patient outreach within a 4-month period.

Results. Electronic communication was not feasible as many of the patients at the practice were not signed up for MyHealthOnline. Instead, a smaller sample size of 64 patients was contacted across 4 selected health maintenance topics: colonoscopies, pneumococcal vaccines, Hemoglobin A1C's >8%, and hypertension. Twenty patients were contacted about colonoscopies, 6 for pneumococcal vaccines, 18 for HgbA1C >8% and 20 for hypertension. Of those contacted, 34 answered their phone and 30 were left voicemails – 2 of whom immediately called back. Average time spent per phone call was 2 minutes, with outliers of 17 seconds and 20 minutes. Currently, 2 months have passed since the intervention was implemented. Outcomes will be calculated once 4 months have passed since implementation.

Conclusion. Reliable methods of communication between care providers and patients are vital to patient outreach. Organization of clinical data and protocols for doing such activities are vital for ease of submission of required data for clinics wishing to maintain their status as a patient centered medical home and to achieve maximum reimbursement from Medicare/Medicaid. Patient outreach has other benefits including presenting a unique opportunity for education and motivation.

Rationale and Specific Aims

Rationale:

a) Utilizing a specific protocol for patient outreach will help to meet PCMH requirements
b) Patient outreach will help to improve patient outcomes
c) Creating a protocol will put into place a replicable process that can be used year after year.
d) Data mining tools to help the practice see specific data sets that will be useful for patient outreach

Specific Aims:

a) Creation of a standardized protocol for patient outreach on a different topic each month. Protocol should be easily repeatable to improve longevity and usefulness of protocol. Schedule is as follows:
    a) Jan – Pap smears
    b) Feb – HTN (prescriptions filled?/uncontrolled HTN)
    c) March - Colorectal cancer screening
    d) April – Pneumococcal vaccinations
    e) May – Depression (PHQ – 2)
    f) June – Smoking Cessation and COPD
    g) July – Hepatitis (screen/vaccine)
    h) August – Immunizations (TDAP)
    i) September – A-fib/coumadin
    j) October – Breast cancer / mammograms
    k) November – Diabetes: HgbA1C: 8%
    l) December – Influenza vaccine
b) Analysis of data will be looking at the size of the population preintervention versus post-intervention
c) Higher immunization rates for influenza and pneumonia
d) Increased adherence to medication regimens
e) Understanding of efficacy of different communication modalities
f) Continued accreditation as a patient centered medical home

Conclusions

Usefulness of work:

a) Provides mostly qualitative data at this point
    a) 3 specific cases, 2 about diabetic follow up and one about vaccination follow-up
a) Quantitative data would provide concrete evidence about how effective intervention was
b) Objectives of patient outreach were met
c) Time to generate lists and send out mass communication is minimal - 20 minutes
d) This intervention is in compliance with PCMH requirements and MACRA requirements for patient outreach and meaningful use

Sustainability

a) Difficult to sustain if this exact intervention is performed (calling patients individually)
b) Original plan was to contact patients via mass communication – much more sustainable as it does not require more of the providers time
c) Cost is minimal – essentially just the time it takes to create the lists of patients for each health maintenance topic

a) Potential for spread to other contexts
    a) Understanding of the effects of follow-up conversations with patients
    b) Role of a care coordinator
    c) Contacting patients can be the push they need to pursue their goals for their health
b) Further study:
    a) What patients retain from their appointments with their PCP?
    b) How do regular phone calls from a health care professional affect patient health outcome?
    c) Do patients already have goals in place? Are they more successful with or without phone call intervention?
c) Suggested next steps:
    a) Study the usefulness of protocol with health care provider staff within Appletree Bay Primary care
    b) Implement any suggestions in second version of protocol
    c) Implement a long-term study on the effect of regular patient contact via phone calls on chronic disease outcomes

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Acknowledgements and Contacts

I would like to thank both Ellen Watson, MSN and Dr. Janine Carr for their assistance with this project.

I declare that there were no conflicts of interest in the creation of this project..

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