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Joshua D. Streeter

University of Vermont

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Creating a Protocol for Patient Outreach at a Primary Care Clinic

Joshua Streeter, RN
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Advisors: Jeanine Carr, PhD, RN and Ellen Watson, MS, APRN

There are no relationships, conditions, or circumstances that present a conflict of interest relevant to the content of this presentation.
Introduction — Problem

- Appletree Bay Primary Care is a Patient Centered Medical Home (PCMH)
- PCMH requirement: patient outreach
- Currently, there is no standardized patient outreach protocol at Appletree Bay
Available Knowledge

• $3.2 trillion was spent on healthcare, 86% of which is spent on those with chronic medical conditions

• $10.4 billion was spent on direct costs for hospitalizations and outpatient visits related to the flu alone
Available Knowledge

• Studies:
  – Community health team was utilized, led to improvements in HbA1C, LDL cholesterol, and total cholesterol
  – Meta-analysis of 106 studies on ways to increase influenza and pneumonia vaccinations showed patient outreach was most effective
  – Estimated that 20%-50% of patients are nonadherent to prescribed medications; text message reminders were shown to increase adherence
Available Knowledge

• We know that certain forms of patient outreach are effective
• Will this method be effective?
Rationale

- Utilizing a specific protocol for patient outreach will help to meet PCMH requirements
- Patient outreach will help to improve patient outcomes
- Creating a protocol will put into place a replicable process that can be used year after year
- Data mining tools to help the practice use specific data sets that will be useful for patient outreach
Purpose & Aims

• Create a standardized protocol for patient outreach on a different topic each month. Protocol should be easily repeatable to improve longevity and usefulness of protocol.

• Continued accreditation as a patient centered medical home
Purpose & Aims (cont.)

- Increased adherence to medication regimens
- Understanding of efficacy of this communication modality
Purpose & Aims (cont.)

– Schedule:

• Jan – Pap smears
• Feb – HTN (prescriptions filled/?/uncontrolled HTN)
• March - Colorectal cancer screening
• April – Pneumococcal vaccinations
• May – Depression (PHQ – 2)
• June – Smoking Cessation and COPD
• July – Hepatitis (screen/vaccine)
• August – Immunizations (TDAP)
• September – A-fib/coumadin
• October – Breast cancer / mammograms
• November – Diabetes: HgbA1C: 8%
• December – Influenza vaccine
Methods — Context

There is no protocol for patient outreach currently at Appletree Bay Primary Care. Data mining capabilities are available, but are underutilized.
Intervention(s)

• Create a standardized protocol for patient outreach
• Apply standardized patient outreach protocol to monthly topics
• Collect data from electronic health record to determine populations requiring outreach; Data collection dependent on monthly topic
• Patient outreach
Study of the Intervention(s)

• Improvements in patient outcomes as measured in accordance with monthly topic
  • For example: monthly topic is influenza vaccination; improved outcome would be higher influenza vaccination rate
Measures

- Success will be measured by looking at the size of the population pre-intervention versus post-intervention. Protocol will be in place for the 2018 year.
- First set of measurements taken 4 months post-implementation
Analysis

• Size of the population pre-intervention versus post-intervention
• Evaluate objectives met
• Evaluate effectiveness of outreach on specific topics
• Discuss qualitative findings and their impact
• Discuss quantitative findings
Ethical Considerations

• Patient confidentiality
• Adherence to HIPPA
• Patient’s will not be coerced into action
• Beneficence and non-maleficence
  • Refrain from causing harm (i.e. over recommendation of screenings in breast cancer)
• This project was submitted, reviewed, and approved by the University of Vermont IRB
Results

• **Initial Steps:**
  - Research of available guidelines for specific month’s topics – June 2017
  - Compilation of chosen guidelines – July 2017
  - Creation of final document containing guidelines and email message – August 2017
  - Creation of report lists for each month’s required documentation – September 2017
  - List of steps required for report lists – October 2017
  - Contact with patients via phone – January 2018 - February 2018 (modified from contacting patients via email/patient portal)
Results

- **Phone calls** – 64 patients were contacted across 4 selected health maintenance topics: colonoscopies, pneumococcal vaccines, those with a hemoglobin A1C >8%, and those diagnosed with hypertension with recorded blood pressures >150/90
Results

• Specific script used for each call concerning each health maintenance topic
• Average time spent per call was 2 minutes with outliers of 17 seconds and 20 minutes
• Of those called 34 answered their phone and 30 were left voicemails – 2 of whom immediately called back
• Patient outreach was recorded in each patient’s health record
• Phone calls were made versus contacting via patient portal
Results

• Process measures will be recorded from February 1, 2018 to June 1, 2018 – effect on patient’s health maintenance adherence

• Success of the project will be dictated by:
  • Intervention successful in increasing numbers of patients performing various health maintenance measures
  • Successful use of protocol
Results

- **Unintended consequences**
  - Need for increased numbers of patients to be signed up for patient portal for ease of communication
  - Difficultly with cost effective/time effective communication method
  - Compliance with MACRA requirements
  - **Opened lines of communication**
Discussion

• Qualitative Findings
  – 60 year old male, HbA1C >10%, retired RN
  – 65 year old female, smoker
  – 45 year old male, HbA1C >9%
Interpretation

• Compliance with PCMH and MACRA requirements were directly fulfilled as a result of this project

• Protocol for creating lists for each health maintenance topic was created
Interpretation

• Comparison of results with findings from other studies
  • Arretz - utilizing a community health worker to follow-up with patients on their diabetes mellitus type II had a positive impact on their self-management skills and clinical outcomes
    • Similar themes in contacting patients about health maintenance topics can lead to improved clinical outcomes (expected result from this project)
  • Lau - patient outreach was more effective if personal contact was involved in vaccinating patients for influenza
    • Personal contact via phone calls will lead to increased adherence to vaccination guidelines
  • Foreman et al. – contacting patients via text message led to better medication regimen adherence in patients who take medications daily
    • Reinforcing the concept that contacting patients to assist them can lead to increased adherence to recommended treatment
Interpretation

• Impact of the project on people and systems
  • Impact on patients is still being measured- only qualitative data available at this point
  • Future study- impact of list generation and outreach on healthcare outcomes from all list topics
• Reasons for differences between observed and anticipated outcomes
  • Project evolved from list generation and automated outreach to list generation and phone call intervention
  • Patients did not utilize MyHealthOnline communication method
Limitations

- Small Caucasian population from one primary care clinic
- Only applicable to practices using EPIC EHR system
- Lack of uniformity in patients using MyHealthOnline
- Only patients with a preferred method of contact as via phone were contacted
- Time constraints of project limited comprehensive pre- and post-intervention analysis
Conclusions

• Provides mostly qualitative data at this point
  – 3 specific cases, 2 about diabetic follow up and one about vaccination follow-up

• Quantitative data would provide concrete evidence about how effective intervention was

• Objectives:
  – Creation of a standardized protocol for patient outreach (met)
  – Increased adherence to medication regimens (in progress)
  – Understanding of efficacy of communication modalities (in progress)

• This intervention is in compliance with PCMH requirements and MACRA requirements for patient outreach and meaningful use
Conclusions

• Sustainability
  • Difficult to determine sustainability using this exact intervention (calling patients individually)
  • Original plan was to contact patients via mass communication – much more sustainable as it does not require more of the providers time
  • Cost is minimal – essentially just the time it takes to create the lists of patients for each health maintenance topic
Conclusions

• Suggested next steps:
  • Study the usefulness of protocol with staff within Appletree Bay Primary care
    • Include use of the “mass communication” function
    • Implement any suggestions in second version of protocol
  • Implement a long-term study on the effect of patient outreach via the mass communication function
  • Implement a new long-term study on the effect of regular patient contact via phone calls on chronic disease outcomes
References


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