Prevention Management

Objectives

- Review the critical statistics important to wellness and prevention
- Identification of the population appropriate for wellness and prevention screening
- Review of wellness and prevention screening criteria
- Review measures used to monitor the delivery of wellness and preventive care

Risk Factor Definition

A behavior (life-style), condition or characteristic that increases a person's chances of developing a disease.

- Example: smoking, high blood pressure, and positive family history are risk factors for heart disease.

Healthy Behaviors to prevent chronic disease

- Avoid tobacco use
- Exercise regularly
- Maintain a healthy weight
- Avoid alcohol or use in moderation
- Eat a healthy diet

CDC Guidelines

Physical Activity

- In 2011, more than half of adults aged 18 years or older did not meet recommendations for aerobic exercise or physical activity
  - In addition, 76% did not meet recommendations for muscle-strengthening physical activity

Diet

- In 2011, more than one-third of adolescents and adults said they ate fruit less than once a day
- 38% of adolescents and 23% of adults said they ate vegetables less than once a day

Fast Facts (Center for Disease Control)

- 7 of the top 10 leading causes of death in the United States are due to chronic diseases
- Not eating a healthy diet or getting enough physical activity increases a person's chance of having a chronic disease
- The United States spends $147 billion on obesity-related health care costs each year.
- The country spends $117 billion on health care costs associated with inadequate physical activity each year

Risk for Heart Disease or Stroke

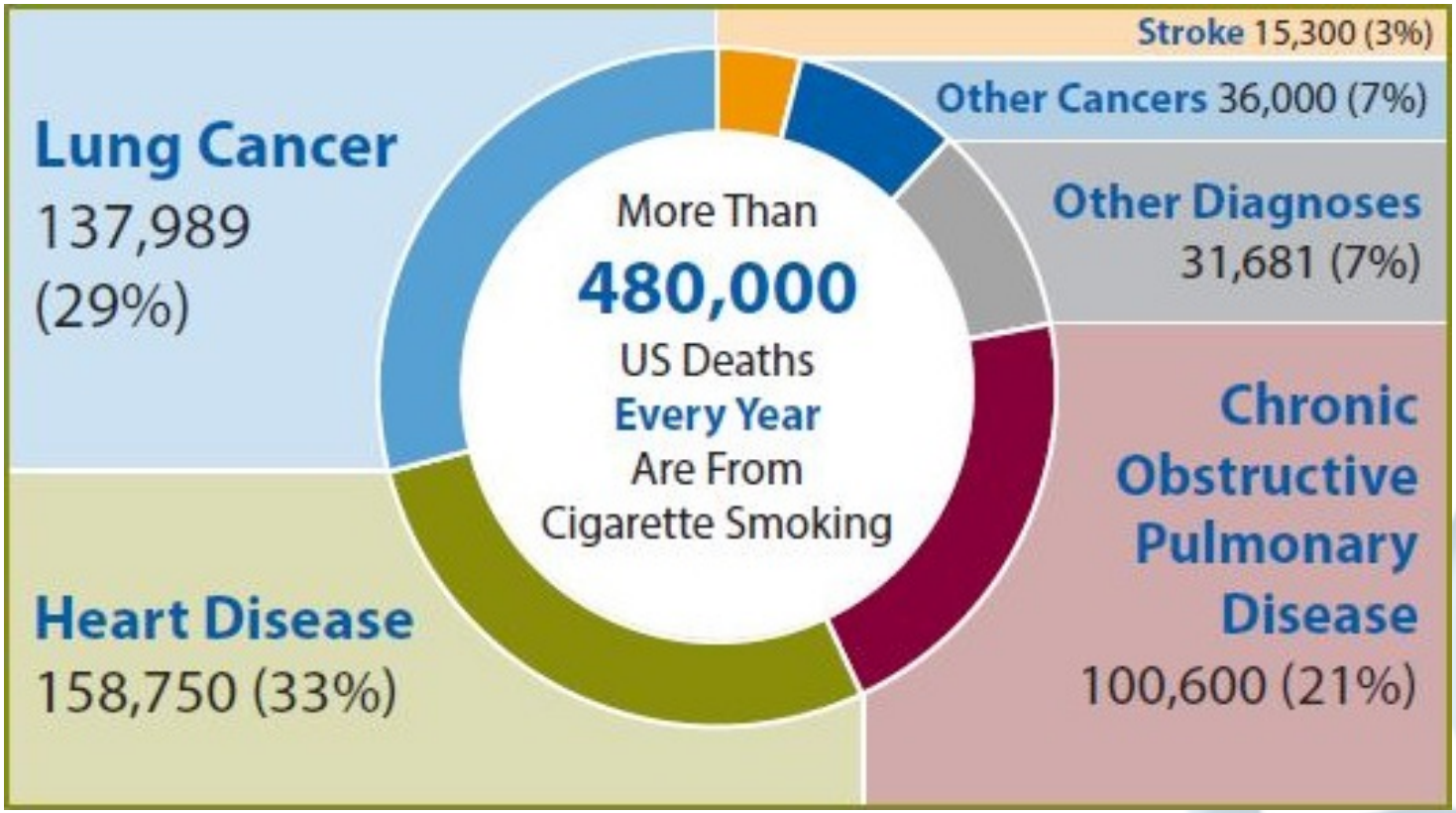
- About half of US adults have at least one of the following major risk factors for heart disease or stroke:
  - Uncontrolled high blood pressure
  - Uncontrolled high LDL cholesterol
  - Are current smokers

- Ninety percent of Americans consume too much sodium, increasing their risk of high blood pressure

Smoking

- More than 42 million adults—close to 1 of every 5—said they currently smoked cigarettes in 2012
  - Cigarette smoking accounts for more than 480,000 deaths each year
  - Each day, more than 3,200 youth younger than 18 years smoke their first cigarette, and another 2,100 youth and young adults who smoke every now and then become daily smokers

CDC Fast Facts



Alcohol Use

- Drinking too much alcohol is responsible for 88,000 deaths each year, more than half of which are due to binge drinking
  - About 38 million US adults report binge drinking an average of 4 times a month, and have an average of 8 drinks per binge, yet most binge drinkers are not alcohol dependent

CDC Fast Facts – Alcohol Use

The Dangers of Drinking Too Much - Excessive alcohol use places drinkers, their families, and their communities at risk for many harmful health effects, including:

- **Chronic conditions**
  - High blood pressure, various cancers, heart disease, stroke, and liver disease
- **Sexual risk behaviors**
  - Unintended pregnancy, HIV infection, and other sexually transmitted diseases
- **Violence and injuries**
  - falls, drowning, homicide, suicide, intimate partner violence, and sexual assault
- **Fetal alcohol spectrum disorders**
  - resulting in physical, behavioral, and learning problems later in life
- **Motor vehicle crashes**

Registry Use and Tracking

Registry Definition

National Institute for Health defines the registry as:

- A collection of information about individuals, usually focused around a specific diagnosis or condition
- Registries can be sponsored by a government agency, nonprofit organization, health care facility, or private company

McCall Institute Improving Health Care defines the registry as:

- A list of patients and their relevant clinical data that can be sorted by a condition or set of conditions in order to improve and monitor the care of the population

Value of a Registry

- Registries can provide health care professionals and researchers with first-hand information about people with certain conditions, both individually and as a group, and over time, to increase our understanding of that condition
- Some registries collect information that can be used to track trends about the number of people with diseases, treatments, and more (population management)

Key preventive quality measures

Key Preventive Quality Metrics
Controlling High Blood Pressure
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Preventive Care and Screening: Influenza Immunization
Pneumonia Vaccination Status for Older Adults
Diabetes: Eye Exam
Diabetes: Hemoglobin A1c Poor Control
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Falls: Screening for Fall Risk
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
Documentation of Current Medications in the Medical Record
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
Breast Cancer Screening
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

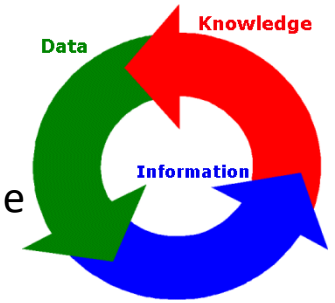
Preventive Screening – General Population

- Tobacco Use: Screening and Cessation Intervention
- Influenza Immunization
- Screening for Clinical Depression and Follow-Up Plan
- Documentation of Medication Reconciliation to include current medications in the medical record
- Body Mass Index (BMI) Screening and Follow-Up Plan

Preventive Screening – Specialized Population

- Controlling High Blood Pressure
- Pneumonia Vaccination Status for Older Adults
- Diabetes: Eye Exam
- Diabetes: Hemoglobin A1c Poor Control
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Falls: Screening for Fall Risk
- Breast Cancer Screening
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Key Actions



- Ensure data is:
  - Complete (all patients within the described measure are included in the database)
  - Accurate (all data fields are accurately entered into the EHR/registry database)
- Regularly monitor the measures:
  - At the time of appointments
  - Between appointments with a defined process, to include frequency intervals
- When gaps of care are identified (overdue for a measure or the measure is not meeting the defined value):
  - Notify the care team (provider, care manager, behavioral specialist, others)
  - Based on the teams input and providers recommendation, determine next steps and actions and make sure all team members are informed
    - When appropriate for your role, complete the next steps and actions

Registry Use and Population Management

Goal of Population Health Management:

- Keep a patient population as healthy as possible
- Minimize the need for expensive interventions
  - Emergency department visits
  - Hospitalizations
  - Imaging tests and procedures
- Focus on
  - High risk patients who generate the majority of health costs
  - Systematically addressing the preventive and chronic care needs of every patient

Health Coaching and Quality Measures

Examples of follow-up actions based on the registry gaps:

- Call a patient that is overdue for a colonoscopy. Explain this is the primary way for early detection of colon cancer
  - If standing orders are in place, initiate the order
  - If there are no standing orders, inform the provider and obtain an order
- Call a patient that is overdue for an influenza vaccination. Review the benefits of immunizations and the importance for their age group
  - If standing orders are in place, provide the vaccination
  - If there are no orders, inform the provider and be prepared to administer the vaccination after approval

Tools and resources to assist patients with Healthy Eating:

- Obtain an accurate height and weight at health care visits
- Record the patients Body Mass Index (BMI)
- If the BMI indicates obesity, bring this to the providers attention
- Review local, state and national resources available
  - https://healthfinder.gov/HealthTopics/Category/nutrition-and-physical-activity

Tools and resources to assist patients with quitting smoking and the use of alcohol:

- Track tobacco and alcohol use at health care visits
  - Use the registry/EHR to identify patients with gaps in care for screening for tobacco and alcohol use
  - Record answers in the EHR and notify the provider
- Provide quite smoking materials and resources available through government and state programs
  - https://betobaccofree.hhs.gov/quit-now/index.html#professionals

All Patients

- Insure preventive care is accurately measured and documented in the patients record
- When preventive care screenings are not being met, work with the team to identify process improvement opportunities
- When applicable, partner with the patient to create a self-management plan
- When a self-management action plan is created, build in accountability processes such as enlisting a family member or a member of the health care team to follow-up with the patient
- Be encouraging and empathetic to patients challenges in leading a healthy lifestyle. Acknowledge challenges and successes.

https://www.youtube.com/watch?v=uRQ853sRt0o

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