GE-NMF PRIMARY CARE LEADERSHIP PROGRAM PCLP

Integration of Standing Orders into the Patient-Centered Medical Home Approach:

A Community Health Center Provider Perspective

Delphine Colar

Adelante Healthcare

Phoenix, AZ

GE Foundation

NATIONAL MEDICAL FELLOWSHIPS

changing the face of medicine

Introduction

- Standing Orders
  - Pre-determined set of procedures established by physicians
  - Carried out by support staff (MAs or nurses)
  - Does not require physician supervision or approval at every visit
  - Ex: Immunizations for children

Background - PCMH

- **Patient-Centered** Medical Home
  - Team-based approach to healthcare
  - Designed by primary care professionals
  - Established by the Joint Principles of PCMH in 2007
    - AAFP
    - AAP
    - ACP
    - AOA
- Key Characteristics
  - Personal physician
  - Physician directed medical practice
  - Whole person orientation
  - Coordinated care
- Updated in 2014

Methodology

- Standing Orders Research
  - Chronic Conditions
    - Diabetes
    - Hypertension
  - Preventative Health
    - Adults
    - Children
- Provider Survey
  - Assess provider attitude toward the idea of standing orders and its place in PCMH.
  - Standing Orders as a means of
    - increasing patient compliance
    - enhancing overall quality of healthcare
    - Affecting workload and productivity

GE-NMF PRIMARY CARE LEADERSHIP PROGRAM

PCLP

Results

Hypertension

1. **Confirm diagnosis of hypertension**
   a. If first reading is elevated, repeat measurement and document both readings
2. **Assess patient for cardiovascular risks**
   a. Non-modifiable risks
      i. Genetic predisposition
      ii. Age
      iii. Gender
   b. Modifiable risks
      i. Smoking
      ii. Exercise
      iii. Sodium intake
   c. Target Blood pressures

Low Risk	BP 140/90 mm Hg over 3 visits within 1 month
High Risk	BP 140/80 mm Hg over 3 visits within 1 month

	Hypertensive Patients BP Goals*	w/ DM or nondiabetic CKD *
Age >60	<150/90	
Age 30-59	<140/90 Diastolic <90	<140/90
Age <30	<140/90	<140/90

3. **Determine if any end organ damage has occurred**

Test	Frequency
Dipstick urine test: hematuria and proteinuria	Every year
ACR (albumin:creatinine)	Every year
CMP/CBC: Measure eGFR, electrolytes, HbA1c, lipid panel, urate	Every year
Ophthalmic exam	Every year
EGC	Every year

4. **Detect causes of secondary hypertension**
   a. Excessive alcohol intake
   b. Obstructive sleep apnea
   c. Medicines
      i. Ex: oral contraceptives, NSAIDs
   d. Drug abuse
      i. Ex: cocaine or methamphetamine
   e. Renal disease
   f. Renal artery stenosis
   g. Primary hyperaldosteronism
   h. Cushing's syndrome
   i. pheochromocytoma

* Guidelines taken from JNC 8: Evidenced Based Guideline for the Management of High Blood Pressure in Adults JAMA. 2014;311(5):507-520. doi:10.1001/jama.2013.284427.

Preventative Health – Adults

	Age: 18-39	Age: 40-64	Age: 65+
Cholesterol Screen	Every 5 years at age 35	Every 5 years	Every 5 years
Blood Pressure	Every visit	Every visit	Every visit
Diabetes	If at risk *	If at risk *	If at risk *
Tetanus-diphtheria booster	Every 10 years	Every 10 years	Every 10 years
Influenza vaccine	Every year	Every year	Every year
Pneumococcal vaccine	Once if at high risk	Once if at high risk	Once at age 65
Clinical breast exam	Women: Every 3 years beginning at age 20	*Women*: Every year	*Women*: Every year to age 75
Cervical cancer (pap) screenings	Women: Do not screen younger than age 21. Every 3 years with cytology or every 5 years with co-testing (cytology/HPV testing)	*Women*: Every 3 years with cytology or every 5 years with co-testing (cytology/HPV testing)	*Women*: Do not screen if patient has had adequate prior screening and are not at high risk
Mammogram	---	*Women*: Every 2 years	*Women*: Every 2 years to age 75
Osteoporosis	---	---	Women: Every 2 years
Colon cancer screenings**	---	Begin at age 50; see below **	** until age 85
Prostate exam	---	*Men*: Every year at age 50	*Men*: Every year

* Asymptomatic adults with sustained blood pressure greater than 135/80mm Hg should be screened for type 2 diabetes mellitus

** Annual screenings with high-sensitivity fecal occult blood testing (FOBT)
Sigmoidoscopy every 5 years, with high sensitivity fecal occult blood testing every 3 years
Screening colonoscopy every 10 years

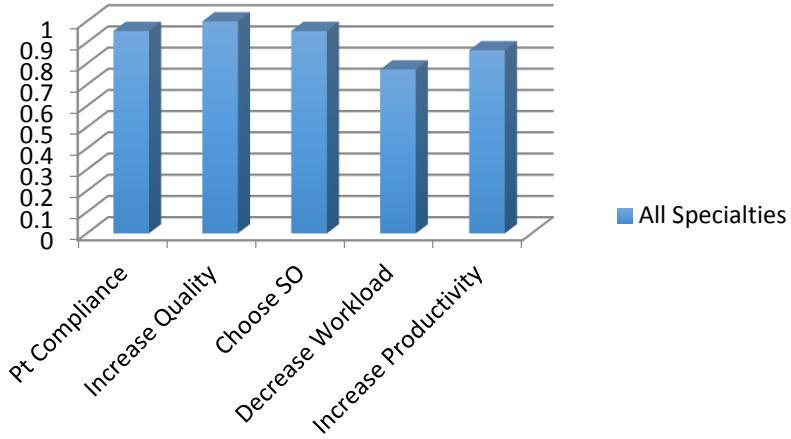
Preventative health – Children

	Infancy (Newborn – 9mo)	Early Childhood (12mo- 4 yrs)	Middle Childhood (5 yrs – 10yrs)	Adolescence (11 yrs-18yrs)
Length/Height & Weight	Every visit	Every visit	Every visit	Every visit
Head Circumference	Every visit	Every visit up to 24 mo	--	--
Weight for length	Every visit	Every visit up to 18 mo	--	--
BMI	--	Every visit at 24 mo	Every visit	Every visit
Blood pressure		Every visit at 3y	Every visit	Every visit
Vision	--	Every 2-3y at age 4	As needed	As needed
Hearing	At Newborn	Every 2-3y at age 4	Every 2-3 years	As needed
Autism screening	--	At age 18 mo At age 24 mo	--	--
Developmental surveillance	Every visit	Every visit	Every visit	Every visit
Psychosocial/Behavioral Assessment	Every visit	Every visit	Every visit	Every visit
Alcohol and Drug Use	--	--	--	Every visit
Depression screening	--	--	--	Every visit
Newborn Blood screen	Once	--	--	--
Critical Congenital Heart Defect screening	At newborn	--	--	--
Hematocrit or Hemoglobin		At 15 and 30 mo	--	--
Immunization	Every visit	Every visit	Every visit	Every visit
Dyslipidemia screening	--	--	Around age 10	--
STI/HIV screening	--	--	--	Between 16-18yrs
Cervical dysplasia screening	--	--	--	Age 21
Oral Health	--	Beginning at age 12 mo		

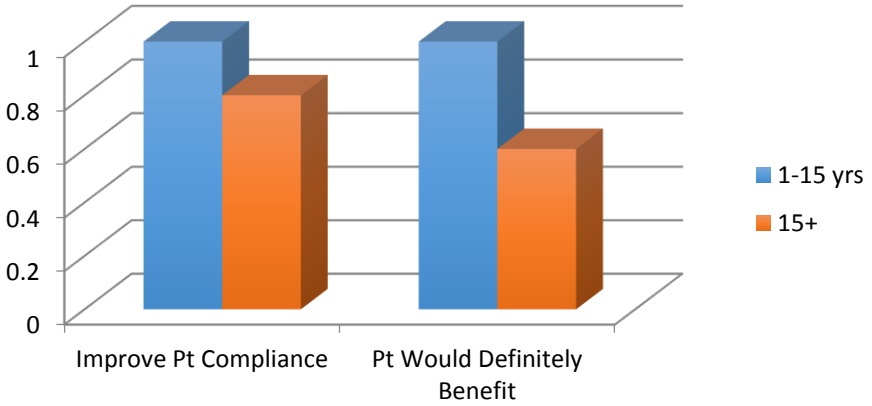
Results

GE-NMF PRIMARY CARE LEADERSHIP PROGRAM
PCLP

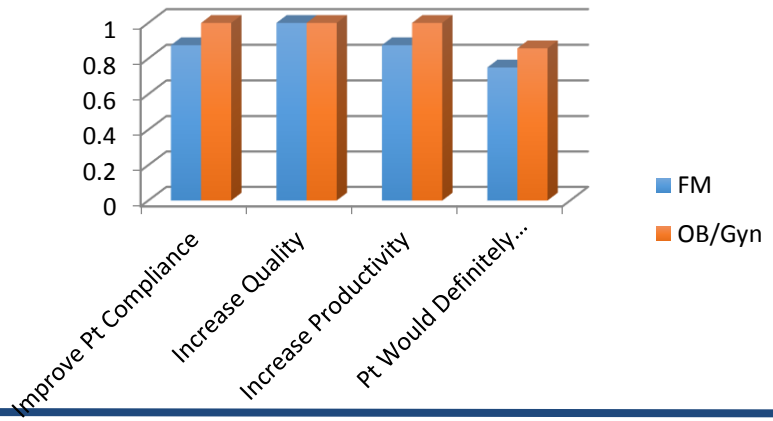
Use of Standing Orders in PCMH



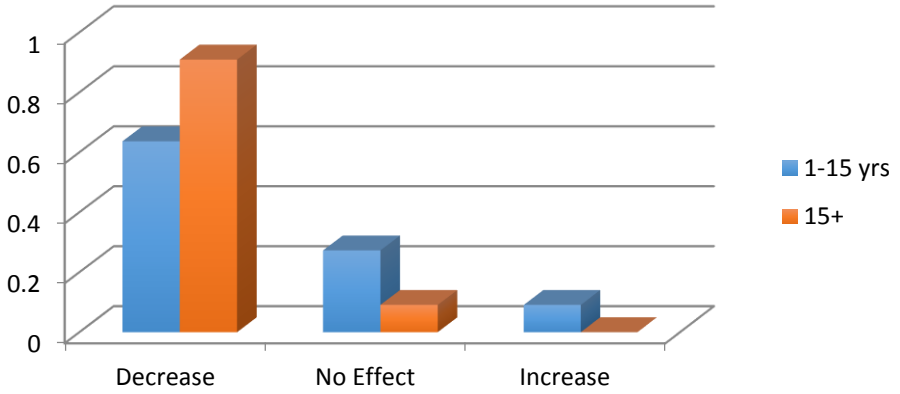
Family Medicine



Use of Standing Orders in PCMH



Effect of Standing Orders on Workload Across All Specialties



Discussion

- Overall view of standing orders in PCMH among primary care providers is positive
- Questions Raised:
  - Is there a significant difference in perspective among newer and older providers?
  - Are standing orders really effective in improving patient compliance?
- Further Research
  - Larger sampling of physicians
  - More extensive study into patient compliance
  - Taking support staff opinion into consideration – surveying MAs and nurses

Recommendations

- Implement the use of standing orders into PCMH
- Obtain the perspective of MA/nurses
- Standing orders will likely improve the overall quality of healthcare
- PCMH will likely improve the overall quality of healthcare

Conclusion

- All physicians should want to provide the highest quality of healthcare for all their patients
- Standing orders is a way to standardize healthcare so that it is more accessible for all, despite patient's ability to pay
- Use of standing orders will enhance primary healthcare quality and delivery
- Standing orders will decrease workload and increase productivity
- Use of standing orders will hopefully improve patient compliance

GE-NMF PRIMARY CARE LEADERSHIP PROGRAM
PCLP

Acknowledgements

- GE-NMF PCLP Program & Staff
- Audrey Bohanan
- Lisa Blue
- Dr. Avein Tafoya
- Dr. Doug Campos-Outcalt
- Adelante Healthcare Team
- Dr. Pavel Petkov
- Ebenezer Kureshi, PA-C
- Dr. Shary Borhan
- Dr. Gary Cloud
- Fellow PCLP participants