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*The voice of public health physicians, guardians of the public's health*

***Preventive Services ToolKit Project***

***Instructor's Manual and Supplemental Materials***

***Module 3 - Planning***

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**Slide 1: Title Slide**

AAPHP  
Preventive Services Toolkit

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**Planning**

- selecting problems to address
- selecting interventions

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Feb 12, 2006      AAPHP PSTK Planning      Module 3, Slide 1

In this module we will build on the material from the Introductory and Evidence modules, and discuss policy issues, locally available data sets, coding and reimbursement, and setting up data systems in the planning stage for ongoing program evaluation.

The tasks to be addressed are selecting the problems to address, and the interventions to address those problems.

As with the Evidence Module, supplemental reference material is available in the Instructor's Manual on the AAPHP web site,

Under "Preventive Services ToolKit

**Slide 2: Teaching Objectives**

**Teaching Objectives**

1. Address preventive services from a policy perspective
2. Understand how best to select problems to address and select packages of interventions
3. Understand coding and reimbursement for clinical preventive services
4. List and locate software and other tools for planning and evaluation
5. Understand how statistical approaches to planning and evaluation differ from research

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Feb 12, 2006      AAPHP PSTK Planning      Module 3, Slide 2

Properly considering the "policy" perspective takes us back to the discussion of mindsets in the introductory module. If a new program is to be adopted, and if it is to enjoy the kinds of support that will enable it to thrive, it needs sign-off from the policy/political people, the fiscal and other administrators, and support from the medical and nursing staff. This need for policy and administrative support can tremendously distort how we approach program planning, advocacy, and the steps needed to assure it does not get eliminated with the next budget cut.

(read rest of slide)

**Slide 3: Policy and Management Issues from a Healthcare Perspective - 1**

Policy and Management Issues  
from a Healthcare Perspective - 1

- Many preventive services are considered social or educational – not medical services
- Counseling services are often seen as "soft" and ineffective
- Some preventive services not reimbursed as clinical services
- Most are unrelated to current chief complaints

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Feb 12, 2006      AAPHP PSTK Planning      Module 3, Slide 3

Those advocating new or expanded preventive services carry a heavier burden of proof than those advocating for new clinical services or other ancillary services. This is true in both healthcare and public health settings.

Since so much of public health is dominated by people with clinical mindsets, we will approach these issues primarily from a healthcare perspective.

**▪The principal underlying reason why insurance administrators are reluctant to pay for preventive services**

**is that many of them are easily identified as "social" or "educational."** While such counseling and education is verbally encouraged – this encouragement is not matched by recognition of the time required to provide these services.

- The second most prominent reason for such non-support is that counseling and health education are seen as “soft” and therefore ineffective.
- There is tremendous variation from reimbursement system to reimbursement system relative to what preventive services are and are not reimbursed. Major reasons for this variability are the result of emphasis by third party reimbursement systems on activities that result from “laying on of hands” or prescribing drugs rather than counseling
- Almost by definition, preventive services are unrelated to the patient’s chief complaint. Since demand for these services are “pulled” by physicians rather than “pushed” by patient demand, some insurance companies are reluctant to pay for them.

#### **Slide 4: Policy and Management Issues from a Healthcare Perspective – 2**

##### **Policy and Management Issues from a Healthcare Perspective -2**

- ❑ Some are best provided on a community, rather than clinical, basis
- ❑ Benefits may be indirect and therefore difficult to quantify
- ❑ Benefits may only accrue to a percentage of recipients, and therefore be difficult for staff to recognize
- ❑ Return on investment (both health-related and fiscal) are often delayed

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Module 3, Slide 4

Since some preventive services are better provided on a community, rather than clinical basis – clinicians advocating for such services need to keep this option in mind. The means by which clinicians pursue community based preventive services is the topic of our Partnering module.

Impact and benefits may not be direct enough to be detected and attributed to the preventive services through the billing records. For example, counseling related to arthritis and other disorders that

seldom result in hospitalization may substantially improve patient outcomes, but might not reduce healthcare costs.

- “Return on Investment” as most commonly estimated in health insurance settings require reductions in healthcare costs within the same fiscal year of the preventive service. Benefits in terms of offsetting healthcare costs are not always captured within that first year. To further complicate matters, such year to year reductions in cost will cease to occur once the service has been fully in place for several years because of saturation of benefit – a topic to be discussed further in the upcoming Epidemiology module.

#### **Slide 5: Benefits of Preventive Services**

##### **Benefits of Preventive Services**

- ❑ Improve health outcomes
- ❑ **Improve compliance with regulatory and accreditation guidelines**
- ❑ Reduce healthcare costs
- ❑ Reduce absenteeism
- ❑ Improve job performance (of patients)
- ❑ Increase satisfaction by all stakeholders
- ❑ Improve the community’s perception of the local healthcare system

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Module 3, Slide 5

Given the mindsets of most of the people who must approve new programming, claiming improved health outcomes is necessary, but never sufficient to sell the program.

The most powerful argument you can put forth is that the program is needed to comply with regulatory and accreditation guidelines.

Failing that, the next most powerful is that it will reduce healthcare costs. Pursuing this argument, however, might

impose a burden on you to develop a data system that will track costs, process and both health and fiscal outcomes, and develop verifiable projections as to the dollars to be saved. This can be very tricky, and is discussed in greater detail in the Epi module.

- Reducing absenteeism and improving employee on-the-job productivity is very important to employers, but of little concern to most health insurers and healthcare providers. The “big three” in this regard, in terms of services that can improve health outcomes, reduce absenteeism and increase employee productivity, without reducing healthcare costs are mental health (with primary focus on substance abuse and depression), low back pain and arthritis. Some companies contract directly for these services, totally bypassing their health insurers and healthcare providers.
- These improvements in satisfaction can be of substantial value when marketing these healthcare plans to yet other employers

### Slide 6: Initiating a Preventive Services Plan

Initiating a Preventive Services Plan

- Acceptance of bright ideas, innovations, local preference or opportunity
- Analysis of practice diagnosis-specific treatment data
- Regulatory and accreditation guidelines
- Community Diagnosis per outcome of COPC process

Feb 12, 2006      AAPHP PSTK Planning      Module 3, Slide 5

The first, and the most difficult step is deciding that you wish to step beyond the usual boundaries of the healthcare setting or the current programmatic limitations of your local health department to do something new.

- The better understanding you have of your patient population or public health jurisdiction, the better the job you can do in selecting problems to be addressed. More often than not, both healthcare and public health people have no knowledge of problems unrelated to the services they are currently providing,

or the needs of potential patients who never come to the door.

- This is more difficult that it may seem. (*give examples 1) Obesity with lack of access to attractive and reasonably priced produce and 2) Asthma due to mold and cockroach antigen in the home.*)

Individuals may have sudden bright ideas which lead to prevention. An excellent example is that of a group of community physicians who identified exposure to vinyl chloride and intervened to reduced liver cancer.

- Analysis of data from within your own practice may suggest ways to limit disease, save time and effort and enhance the practice’s reputation and income. When Dr. Buttery (one of our workshop faculty) started practice in 1956 one of his tools was a set of Royal McBee punch cards on which he punched holes corresponding with major common diseases. Semiannual analysis (20 years before computers were introduced to medical practices) let him identify areas to study, to improve his skills, and make him more competitive with his peers.

- We have already discussed the value of knowing the elements of your practice by incidents and effort, not only to comply with accreditation guides but to enhance your skills and your practice outcomes.

- You will also find the planning process is an important part of the COPC process to be discussed in the Partnering module.

### Slide 7: Implementing Preventive Services

Implementing Preventive Services

- Select the problem and/or the intervention
- Select population(s) to be served
- Consider the Evidence
- Define the
  - Package of interventions
  - Baselines and benchmarks
- Secure authorization and resources
- Advocate, Implement, Evaluate

Feb 12, 2006      AAPHP PSTK Planning      Module 3, Slide 6

- Select one or more problems and evaluate how this preventive intervention might affect the populations/subpopulations you serve such a women between 18 and 40, seniors with hypertension, obese patients with potential type 2 diabetes.

- Consider the evidence of the USTFPS and determine the strength of the evidence and the likelihood its use will make a difference. How much time are you spending screening for prostate cancer (NOT advised by the task force)? The reasons are found in the task force reports.
- Develop strategies to introduce the prevention modality and consider how you can sell it to a sub population you are convinced will benefit from its availability (pneumonia shots for the elderly).
- Be sure you have identified all potential sub-groups in your community who could benefit, then develop ways to let them know what you can do for them.
- Plan on gathering data to measure the impact of your efforts, numbers, results, costs, time etc.

**Slide 8: Accreditation**

**Accreditation**

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- Immunization – child, adolescent, adult
- Cancer screening – breast and colon
- Chlamydia screening
- Smoking cessation
- Prenatal and postnatal care

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- Examples on this slide are some you might pursue.
- These are based on HEDIS 2006 guidelines.

**Slide 9: Evidence Based Interventions**

**Evidence Based Interventions**

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- High Priority Health Conditions
  - Diabetes
  - Obesity
  - Heart Disease and Stroke
  - Asthma
  - Cancer
  - Physical Inactivity and Poor Nutrition
  - Tobacco Use\Youth Risk Taking

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Each of the diseases on this list have a high priority at the CDC’s Center for Chronic Disease Prevention and Health Promotion,(for URLs see Supplemental Information handout for this module) (these are the STEPP interventions).

**Slide 10: Planning Datasets**

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Translating these national recommendations and guidelines into local practice will, sooner or later, require data to address baselines (where you are starting from), benchmarks (best practices by others) and objectives (where you want the program to take you in terms of outcome data). This slide lists a number of common sources of such data. Please keep in mind that, in the absence of local baseline data, you can always start with the national average and what you feel to be reasonable adjustments of that average to estimate your current local baseline. Lay policymakers are much more tolerant of this approach than are health professionals.

**Slide 11: Establish Baselines:**

**Establish Baselines, Benchmarks and Objectives By Sub-Population**

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- Define sub-populations
- Determine baselines from local data
- Identify benchmarks from reference documents
- Determine health outcome goals and objectives

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- When looking at the sub populations within your practice and the community an important resource is the Healthy People

2010 hand book and site (See Supplemental Information handout) which provides goals and objectives in 17 domains and more than 200 potential interventions. The objectives are linked to data from AHRQ and the CDC to provide risk profiles, morbidity and mortality rates that you can compare with your practice/institution so you can set reasonable objectives for improving the health of your patients. You should supplement the recommendations and baselines within the Healthy People manual with state and local data, and data from local/state disease registries to determine the objectives when applying preventive interventions in your practice.

- Introduce use of 2010 objectives and other resources –
- One practical approach to setting health outcome goals is to determine the risk profiles, morbidity and utilization rates for your most favored sub-population, then set your goals in terms of reducing the gap between each of the higher risk groups and that most favored subpopulation.
- For any health condition, there is likely to be just a small group of individuals in any given year that account for most of the illness, death and healthcare costs. For preventive programming – the greatest cost-efficiency can be secured if you can identify the groups at highest risk and concentrate your outreach and interventions on those groups. Often, but not always, even in private sector settings, they will reflect social and economic variables like income, education and race/ethnicity.

**Slide 12: Coding and Reimbursement -1**

- **Error! Objects cannot be created from** When planning preventive interventions you should consider how you code your clinical interventions to ensure that where it is appropriate you can obtain reimbursement. Some third parties do not pay for is
- Some health plans pay for all immunizat cover particular patients unless your grou model. Other plans pay for group educati cost effective. You may need to prompt use, which is particularly important for pæ pay for group teaching if you use a health educator or nurse practitioner/coordinator.
- Currently available CPT codes are prese

**Slide 13: Coding and Reimbursement – 2**

- **Error! Objects cannot be created fro**
- Another bit of bad news reflects the ar preventive counseling. With many clin in length – counseling of this intensity r something is done to address this issue
- This slide presents the first of two sets of CPT codes. This set is for individual preventive counseling presented to the patient as a separate procedure. The code and reimbursement rate depends not on the topic of the counseling, but on the duration of the counseling.

**Slide 14: C**

- **Error! Objects cannot be created fro**
- The good news is that these codes are available for use
- The bad news, however, is that not all carriers recognize
- This is the second of the two sets of CPT codes to be presented in this workshop.

**Slide 15: Trackir**

Tracking – Evaluation and Data Systems - 1

- Quarterly and annual tracking
- Software
  - Agency data warehouse
  - Excel
  - Access
  - Epi Info
  - GIS for health and hospital systems

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- These codes address comprehensive preventive evaluations – both initial and follow-up, by age group. As with the previous set of codes – the availability of a code does not assure that the carrier will recognize these services for reimbursement.

as to satisfaction and other comments by both medical staff and patients, can greatly increase your ability to institute mid-course corrections and assure favorable results at annual report. By conducting pilot studies in the subgroups considered most at risk you can compare their changes with the groups not benefiting from the interventions. Even better, if you have a large enough patient population you might randomly select half a group of patients at high risk for an intervention and compare their progress with those not selected.

- Prior to program initiation – you should decide what data you will be tracking, and the software and hardware to be used for this purpose. In some cases this will require extracting data from one or more agency data warehouses, then manipulating these patient-specific and encounter-specific data on your desktop computer. You may be able to manipulate the data with simple software tools such as Access and Excel, or may need to use SPSS or SAS depending on the amount of data in your organization.
- Another two software programs that some clinicians will find useful, particularly those not used to performing data analyses are first CDC's Epi-info (see the URL list) used to analyze community level disease occurrence. The CDC web site contains the instruction for use and provides tutorials.
- A second piece of software is that for showing the distribution of disease as a map. The best software of this type is found at the ESRI site (see URL list) and gives example of health related mapping. Such maps are excellent for displaying needs and results to organization managers. They are clear and easily understood. The organization that can map its patient distribution and the results of disease intervention has a significant business advantage over competitors without the capability.

### Slide 16: Tracking – Evaluation and Data Systems – 2

Tracking – Evaluation and Data Systems - 2

- Guides for community health agencies
  - NACCHO guidance documents
    - Model Practices Program.
    - APEXPH program
    - Strategic decisions about Partnerships.
    - MAPP
    - National Public Health Performance Standards Toolkit
  - Map-It
  - BMJ -- Socio-Economic Determinants of Health

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Further guides for development of disease planning interventions at the community level can be found at the web site of the National Association of City and County Health Directors in its Model Practices Program, also in its APEXPH program. Then site also has considerable discussion about partnerships to develop strategic decisions will should assist you as you work through the COPC module using the MAPP program.

- MAPP is Mobilizing for Action through Planning and

Partnerships

- The toolkit for implementing the National Public Health Performance Standards are increasingly consistent with developing prevention goals in clinical practice and may be useful to many of you. ,
- MAP-It is a primer from the Healthy People USA manual on developing a Healthy Community Consortium
- The British Medical Journal has produced an excellent set of references on the socio-economic determinants of health which are particularly applicable to organizations that provide primary care and are in the process of planning and working with community partnerships.

Statistical Data

- Baselines and trends
- $p < 0.2$  is "statistically meaningful" for planning and evaluation
- (statistical significance at  $p < 0.05$  impossible to achieve and maintain for most state, local and healthcare facility preventive services)

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### Slide 17: Statistical Data

Establishing a statistical guideline that differences at  $p < 0.2$  are to be considered "statistically meaningful" for purposes of

program evaluation will be accepted by administrators, and fiscal officers and greatly enhance your ability to take advantage of what many of these software packages have to offer.

▪ All too often, rather than use this alternative p-value, consultants and academicians will advise policy makers that since statistically significant differences cannot be demonstrated – that the program is either ineffective, or the decision-making should be entirely based on political and perceptual grounds rather than science.

### **Slide 18: Final Comments and Q and A**

**Error! Objects cannot be created from editing field codes.**

(at this point, remind participants of Supplemental Materials available on line at [www.aaphp.org](http://www.aaphp.org), as part of the Module 3 Instructor's Manual.

## **Supplemental Materials**

### Slide 6 Initiating a Plan – 1

Additional evidence-based list of health issues amenable to preventive services

1. JCAHO – Sentinel Events and ambulatory care issues:  
<http://www.jcaho.org/accredited+organizations/sentinel+event/sentinel+event+statistics.htm>  
<http://www.jcaho.org/accredited+organizations/ambulatory+care/specialized+programs/index.htm>
2. Regulatory and accreditation guidelines
3. Community Diagnosis per outcome of COPC process: Ref:  
<http://www.nap.edu/books/POD202/html/1.html>  
<http://www.pitt.edu/~super1/lecture/lec13971/index.htm>

### Slide 10 Planning Datasets

Reference re: demographics: vital data books, Census Bureau data, NCHS The Virginia Atlas  
<http://67.92.69.86/>

Reference re Medical records data: NCHS Advance Data, Number 365, October 4, 2005, Table 13. (.pdf copy on [www.aaphp.org](http://www.aaphp.org) web site)

### Slide 11 Selecting Interventions – 1

ref **Health Disparities — Less Talk, More Action**, Nicole Lurie, M.D., M.S.P.H. NEJM 353;7 [www.nejm.org](http://www.nejm.org) august 18 2005

### Slide 17; NAMCS

NAMCS <http://www.cdc.gov/nchs/about/major/ahcd/adata.htm> Advance data 2003 -(Page 26)



## Slide 18 : Tracking – Evaluation and Data Systems – 1

Epi Info <http://www.cdc.gov/epiinfo/>

<http://www.cdc.gov/epiinfo/communityhealth.htm>

GIS for health and hospital systems

<http://www.esri.com/industries/health/index.html>

<http://www.esri.com/industries/health/business/hospitals.html>

## Slide 19: Tracking – Evaluation and Data Systems - 2

NACCHO Model Practices Program. <http://archive.naccho.org/modelPractices/>

NACCHO APEXPH program <http://www.naccho.org/topics/infrastructure/APEXPH.cfm>

Strategic decisions about

Partnerships. <http://www.naccho.org/topics/infrastructure/strategicdecisions.cfm>

Healthy People 2010, <http://www.healthypeople.gov/>

Health USA, 2005 <http://www.cdc.gov/nchs/hus.htm>

Health Protection Goals <http://www.cdc.gov/about/goals/>

AHRQ, <http://www.ahrq.gov/>

NCQA, <http://www.ncqa.org/index.htm>

JCAHO, <http://www.jcaho.org/index.htm>

URAC, with special attention to Disease Management Accreditation.

[http://www.urac.org/prog\\_accred\\_DM\\_po.asp?navid=accreditation&pagename=prog\\_accred\\_DM](http://www.urac.org/prog_accred_DM_po.asp?navid=accreditation&pagename=prog_accred_DM)

Examples of Planning Tools usable by participants:

NACCHO

PACE EH

Demonstration Sites:

Polk County Health Department/Bartow, FL;

Multnomah County Health Department/Portland, OR

Mahoning County District Board of Health/ Youngstown, OH

San Juan Basin Health Department /Durango, CO

(plus other demonstration sites and Advanced Practice Centers )

Community-based Environmental Health Assessment (CEHA)

**CDC supports a variety of programs to improve the nation's health by preventing chronic diseases and their risk factors.** These programs provide national leadership by offering guidelines and recommendations and by helping state health and education agencies promote healthy behaviors. These major programs are listed here.

Arthritis, Cancer Control, Diabetes, Genomics, Global Health, Healthy Aging, Healthy Youth, Heart Disease and Stroke, Nutrition and Physical Activity, Oral Health, PHHS Block Grant, Prevention Research Centers, REACH, Safe Motherhood, Steps to a HealthierUS Cooperative Agreement, Tobacco, WISEWOMAN

Behavioral Risk Factor Surveillance System

The BRFSS is a state-based system of health surveys that make up the world's largest telephone

survey. The survey tracks health risks in the United States and uses this information to improve the health of the American people. Available resources include the following:

- **Prevalence Data:** State-level estimates can be compared to other states and grouped by selected demographics.
- **Trends Data:** Observe state-level trends in the prevalence of certain health risk behaviors.
- **SMART Data:** View local area estimates and statewide “Quick View” charts.
- **BRFSS Maps:** Generate maps displaying state- and local-level estimates.
- **Annual Survey Data:** Download the data and documentation for all completed survey years.
- **Youth Risk Behavior Surveillance System**

The YRBSS was developed to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. These behaviors are often established during childhood and early adolescence.

▪ **Cancer Registries**

CDC’s goal is for all states to maintain registries that provide high-quality data on cancer and cancer care. Data collected by state cancer registries enable public health professionals to better understand and address the cancer burden.

▪ **CDC Data Warehouse.**

[CDC Recommends](#) is a searchable storehouse of documents containing CDC recommendations on a variety of health, prevention, and public health practice issues. Use the Search option below to select documents from the system, or use the links at left to browse several program-specific sites at CDC that have compiled CDC recommendations and guidelines. Learn more about this system or obtain information describing the new features that differ from the former Prevention Guidelines Database in the CDC WONDER system.

Resources on setting Prevention guidelines are found in two documents:

- **The Guide to Clinical Preventive Services, 3rd Edition**
- **The recommendation of the “United States Preventive Services Task Force’ within AHRQ.**
- **Software for Analysis include simple programs such as MS Excel and ACCESS, as well as more sophisticated programs such as SAS and SPSS. (The length of the module will not allow an explanation of use of most of these models which are listed for your further use and study)**