March is National Colorectal Cancer Awareness Month

80% by 2018 Communications Guidebook: Effective Messaging to Reach the Unscreened

Over the last ten years, colorectal cancer incidence rates have dropped 30% in the U.S. among adults 50 and older, almost entirely thanks to screening. Yet, despite the good news, colorectal cancer remains the second-leading cause of cancer death in the United States when men and women are combined. 23 million Americans between the ages of 50 and 75 are not being regularly screened, even though general awareness of colorectal cancer screening is high. The challenge is that those who are still unscreened will be the most difficult to reach. We now need a final push to the finish line to substantially reduce colorectal cancer screening as a major public health problem and make sure that all Americans are benefitting equally from this life-saving technology.

So, how can we reach the unscreened in a more strategic way? The American Cancer Society, the Centers for Disease Control and Prevention and the members of the National Colorectal Cancer Roundtable have been working to answer that question.

With these messages, we intend to help educate, empower and mobilize three key unscreened audiences:

• The Newly Insured  • The Insured, Procrastinator/Rationalizer  • The Financially Challenged

To access the full Guidebook click here.

REGISTRATION CLOSES MARCH 5TH!

March 9th - 11th - The Hilton Polaris

Don't miss OACHC's biggest event of the year! The 2015 Annual conference will be located at the Hilton Polaris which is near many restaurants, shopping and more! It will feature tracks and sessions applicable for all Community Health Center staffing levels including: Finance, Clinical, Workforce, Outreach & Enrollment, Dental, Administration, Board and Advanced 202 sessions!
Preconception Health and Health Care

Preconception health refers to the health of women and men during their reproductive years. It focuses on steps that women, men, and health professionals can take to reduce risks, promote healthy lifestyles, and increase readiness for pregnancy. Although preconception health care emphasizes preparing for pregnancy, all women and men of reproductive age can benefit, whether or not they plan to have a baby one day.

Evidence-Based Effectiveness

There is evidence that many preconception interventions reduce the risks of adverse pregnancy outcomes that include birth defects, fetal loss, low birth weight, and preterm delivery. The challenge for health professionals is to reach women and men with these interventions at the time they will be most effective in reducing risks. Such interventions include:

- Managing medical conditions (such as diabetes, obesity, phenylketonuria, sexually transmitted infections, hypothyroidism, seizure disorders, and HIV).
- Counseling women to avoid certain risks (such as alcohol consumption, smoking, prescription and over-the-counter teratogenic drug use, excess vitamin intake, under nutrition, and exposure to toxic substances).
- Counseling women to engage in healthy behaviors (such as reproductive life planning, folic acid consumption, and proper nutrition).
- Counseling women about the availability of vaccines to protect their infants from the consequences of infections that affect the mother (such as rubella, varicella, and hepatitis B).
- Counseling men to avoid certain risks (such as tobacco use and exposure to toxic substances).
- Counseling men to engage in healthy behaviors (such as reproductive life planning, proper nutrition, and healthy weight maintenance).

Preconception Care: Timing is Key

The fetus is vulnerable to developing certain problems 17-56 days after conception. Prenatal health care, which usually begins in weeks 11 or 12 of pregnancy, may be too late to prevent these problems. This is particularly true in the case of certain prescription drugs that are known to cause birth defects and hazardous substances in the workplace and home.

What You Can Do

As a health professional, you have an important role in preconception health and health care. Health professionals can support the three goals of preconception care by:

- Screening for risks.
- Recommending interventions to address identified risks.
- Promoting health and providing education.

To learn more about preconception care and how you can make it part of your medical practice. Source: cdc.gov

Good news! The 2014 Infant Mortality Summit is now on the web. Plenary session videos with accompanying slide shows plus audio recordings of the breakout sessions are here. Increase your knowledge on Infant Mortality in Ohio and spread the word. The collaborative website’s main page is http://bit.ly/everybabymatters.
New Report Highlights Savings Achieved by Medical Homes

Between 2009 and 2013, PCMHs supported by payment incentives had increased in number (from 26 to 114), patients served (5 million to 21 million), and number of states embracing medical home transformation (18 to 44), according to the PCPCC report, which reviewed PCMH initiatives in several states. In all, the report combined findings from seven state reports, seven insurance reports and 14 peer-reviewed studies.

Chris Koller, president of the Milbank Memorial Fund, said one of the barriers to wider adoption of medical homes is the number of insurers in a given market. The Milbank fund supports initiatives that join multiple insurers such as Medicaid, public employees and private insurance companies. Seventeen states now have a multi-payer medical home program.

When medical homes and new payment models are being introduced, it can be difficult to convince insurance companies of their value, Koller explained. Despite the resistance, he emphasized that it constitutes a relatively small investment for insurers to increase spending on primary care.

“It’s kind of like Kabuki theater,” Koller said. “(Primary care) physicians say, ‘We’re doing the Lord’s work so give us the money.’ The plans say, ‘Show us the savings.’ Then physicians say, ‘You don’t ask that of emergency room doctors when they order all of those tests.’"

Three elements are essential for the medical home to be effective, said Rajkumar.
- The physician should receive incentives such as shared savings in the second or third year of the initiative.
- The care team needs training to handle multiple tasks to preserve the physician’s time.
- All participating institutions need access to patient information at a specified point.

Typically, studies have shown, evaluations of medical homes put too much emphasis on costs savings, often ahead of other important considerations such as access to care.

"You are most likely to see changes in utilization rates first before you see changes in cost," said PCPCC CEO Marci Nielsen, Ph.D., M.P.H.

Keys to Success
Each initiative that researchers studied was measured based on savings in cost and utilization, preventive health service offerings, primary care access and patient satisfaction.

Oregon has been one of the early success stories in terms of expanded access and increase in primary care received. The Oregon Coordinated Care Organizations reported a 19 percent reduction in emergency department spending and a 17 percent reduction in emergency room visits during 2013.

One Oklahoma initiative, the Sooner Care Choice Program, reported that it avoided 61,000 ER visits from 2009 to 2013, for a cost savings of $21 million. More than 90 percent of children and adolescents in the plan had access to a primary care physician in 20013.

However, some medical home initiatives that have been evaluated by research journals, such as the Department of Veterans Affairs Patient Aligned Care Team program and the Pennsylvania Chronic Care Initiative, were found not to have achieved savings.

“Despite early and sometimes mixed findings, the evidence here suggests that trends continue to be positive for practices that are able to fully implement the PCMH model of care,” the report’s authors wrote. “As highlighted previously, the longer a PCMH practice has implemented the model, the more impressive the results.”

The report calls for increased spending on primary care and a restructuring of payments to support enhanced primary care efforts, including coordinated care.

“Out of all the dollars we spend on health care, only 4 to 7 percent is spent on primary care, and yet 55 percent of all visits are to primary care,” Nielsen said. “Something is out of kilter here.”

Source: AAFP
The elimination of measles in the United States in 2000 is one of public health’s most celebrated success stories.

Before the measles vaccination program started in 1963, about 3 to 4 million people got measles each year in the United States. Of those, 400 to 500 died, 48,000 were hospitalized, and 4,000 developed brain swelling (encephalitis).

With a highly effective measles vaccine, along with a strong vaccination program that achieves high vaccine coverage in children, and a strong public health system for detecting and responding to measles cases and outbreaks, we were able to eliminate measles.

But as recent outbreaks have revealed, there is still reason to be concerned about measles. Last year we saw 644 measles cases in the United States—more cases than we had seen in 20 years. In 2015, there are already more than 100 cases; most are related to a large, ongoing outbreak linked to an amusement park in California.

Measles is still common in other parts of the world and can be brought into the United States anytime by a person who gets infected in another country. In recent years, many measles cases have been brought into the United States from common U.S. travel destinations, such as England, France, Germany, India, and, during 2014, from the Philippines and Vietnam. Measles spreads easily through the air when an infected person coughs or sneezes. It is so contagious that if one person has it, 9 out of 10 of the people around him or her will also become infected if they are not protected. Pockets of unvaccinated communities are especially at risk for large outbreaks.

While most people in this country are protected against measles through vaccination, the current outbreak highlights the importance of vaccination, as the majority of the adults and children in the outbreak reportedly either did not get vaccinated or did not know whether they had been vaccinated. One thing we are most certain of, the measles vaccine is safe and very effective. Two doses of measles vaccine are 97% effective, and even one dose is 93% effective.

Source: US Dept. of Health & Human Services

Measles Cases and Outbreaks

January 1 to February 20, 2015*

154 Cases

3 Outbreaks representing 90% of reported cases this year

U.S. Measles Cases by Year

*Provisional data reported to CDC’s National Center for Immunization and Respiratory Diseases
Incorporating SBIRT into your FQHC Practice

Including Screening, Brief Intervention, and Referral to Treatment (SBIRT) into the daily medical office routine has become a major national effort that many FQHCs have enthusiastically embraced. In Ohio, we are wrestling with multiple behavioral and physical health challenges that currently are not being adequately addressed. Whether we point to the rising incidence of abuse of opiates, the rise in unintentional drug overdoses, the suicide rate in our youth, or other behavioral challenges, we in the traditionally clinical healthcare delivery setting must embrace new methods of involvement if we want real change to happen in the communities we serve.

One Health Ohio, one of our Ohio FQHCs, was recently featured in an article in the Youngtown Vindicator as an organization that is successfully integrating SBIRT into its clinical practice. Excerpts from the article are included in this issue of Clinician’s Corner to both highlight their efforts and to encourage other clinicians to include this very practical screening tool into their practice. This is an excellent illustration of how Behavioral and Clinical Medicine can more effectively collaborate at the practice level to achieve our goal of whole patient care - the primary care biopsychosocial perspective that America so needs!

Involves using SBIRT, a behavioral health screening process

When One Health Ohio medical doctors ask their patients how they are doing physically, they also take a few minutes to screen them for emotional and behavioral health problems.

One Health mental-health professionals reverse the process to determine if their patients need to see a medical doctor. This process, called Screening, Behavioral Intervention and Referral to Treatment, is referred to as the “fifth vital sign” by Dr. Ronald Dwinnells, chief executive officer of One Health Ohio, a federally qualified health center.

“When people visit their medical providers, four vital signs — temperature, pulse, breathing rate and blood pressure — are usually the first things checked to ensure that the basic vital portions of our health are intact,” said Dr. Dwinnells.

SBIRT is an integrated health care philosophy or mechanism to screen and help people who have behavioral-health issues and get them help and treatment as quickly as possible, said Dr. Dwinnells, whose organization is considered a pioneer of the concept and has received federal and state funding for additional research.

Headquarters for One Health Ohio is at Youngstown Community Health Center at 726 Wick Ave., Youngstown.

“Our clinical research project on SBIRT has gained considerable attention in the health care world,” said Dr. Dwinnells.

Recently, one of his research articles on SBIRT was accepted for publication in The Annals of Family Medicine, a national medical journal; and locally, OHO received an award from Youngstown’s Neil Kennedy Recovery Center recognizing OHO’s efforts to integrate and support behavioral health and medical care.

By incorporating a screening process for behavioral-health issues, Dr. Dwinnells said OHO identified 70 percent of its patients as having some type of behavioral health problem, such as alcoholism, drug abuse or depression.

This is significant because most people do not go to the medical doctors because they have a drinking, drug or depression problem; they usually go because of some tangible physical problem such as a headache or sore throat, he said.

Also, in general, doctors do not ask patients if they are depressed or abusing anything. As a result, patients often suffer in silence until it is too late, he said.

A pre-screening questionnaire consisting of five questions is given with every medical visit, to make sure their well-being check is complete.

If the questionnaire garners any positive answers, there are more detailed tests: Drug Abuse Screening Test, Alcohol Use Disorders Identification Test, and Patient Health Questionnaire for Depression.

“The reason SBIRT and the integration of behavioral and primary health care is so big in the health world is that it has never been done on this large of a scale,” said Dr. Dwinnells.

Also, he had a very personal reason for wanting to see screening for behavioral problems instituted through SBIRT: His father’s depression that led to his eventual suicide was not identified by a medical doctor.

“Perhaps if a health clinician had intervened to address my father’s depression before it was too late, he might have lived. That is an unrealized possibility that he said has guided his efforts to integrate behavioral health into primary-care settings in his own work.”

Source: The Vindicator

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

A public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders.

Learn more here.
Managing the Emergency Walk-in Patient

Daniel Brody, DMD, Chief of Oral Health, Valley Health Systems, Inc. and Member, NNO- HA Board of Directors

The emergency walk-in dental patient, aka “the schedule buster,” can strike fear in the hearts of the dental team. Nothing is more stressful and lowers staff morale more than falling behind on the schedule and having to leave late. I would like to share some strategies for managing walk-in patients efficiently, using the common situation of an emergency dental patient that requires a tooth extraction.

1) Deal with the problem once: Treatment is always the best option. In this case, the best way to get rid of an infection is to get rid of the source of the infection. Delaying treatment through the use of antibiotics and analgesics simply creates a second incident of chaos because an appointment time has to be found the following week, which is usually double booked. You are also inviting the patient to become a “no-show” only to present again somewhere down the line with the same problem and have the cycle repeat itself until they end up in a hospital emergency room.

2) Know the answer before asking the question: There are key determinants that can impact your treatment plan. Your dental assistants can help you and save significant time by triaging the patient, which will assist you in determining a course of action and feasibility of immediate treatment. Medical history responses including blood thinners; prosthesis, diabetes, heart conditions, and allergies require follow-up. Ideally, the pertinent medical information can be accessed through a shared EHR. If not, you should develop a plan for emergency consultation with your medical department. Also, consider having a standing order for radiographs for emergency patients. This allows diagnostic information to be available and waiting for you when you enter the operatory allowing you to make a timely diagnosis and treatment plan.

3) Be prepared: Instrumentation to anesthetize should be ready and waiting when you enter the operatory. Utilize your team members to the top of their license capabilities. If licensed to do so in your state, dental hygienists can provide local anesthesia. I also order the necessary instruments I will need to complete the extraction when anesthetizing and then proceed to my regularly scheduled patient. In my absence, the assistant prepares the instruments, completes the necessary consents and reviews post-op instructions.

4) Expect the best but prepare for the worst: Have all the necessary instrumentation and medicaments at your immediate disposal. Package your instruments in a fashion that groups the instruments into level of need progressing from routine to surgical and have them at your immediate disposal. Nothing wastes valuable chair time and detracts from other team members completing their duties more than someone constantly calling out to staff to bring additional instruments.

5) Failure to plan is planning to fail: Study the radiograph and develop your plan of attack based on the tooth root morphology. In Photo 1, know you are dealing with a three rooted lower molar before you begin. 6) Be aggressive: Lay a flap and section a tooth from the start, not after 30 minutes of trying to remove the tooth intact, and finally fracturing the root which will then will take another 30 minutes to retrieve. If a root fracture occurs, make your flap large enough to have good access to retrieve the root. In Photo 3, the radiograph shows the need to immediately remove the crown of the tooth and section the tooth.

SAA Grant Application Available Now

The Smiles Across America® Capacity Building Project Grant application is now available on OHA’s website. Grants ranging from $5,000-$20,000 will be awarded for the 2015-2016 school year to support community-based oral health preventative services programs that provide care to children in school-based or school-linked settings. Grant applications are due by March 13—learn more and download the application on OHA’s grants webpage.
Medication Therapy Management:

What is it and what does it mean to me?

You may have heard this phrase, “Medication Therapy Management” or “MTM” and wondered what this means. Isn’t this what happens in usual care? Is this medication reconciliation? How does this relate to what I am doing in caring for my patients?

Medication therapy management (MTM) is a service or group of services that optimizes therapeutic outcomes for individual patients. Pharmacists do this by identifying, preventing, and resolving medication therapy problems. Examples of the types of MTM services provided include pharmacotherapy consults, medication therapy reviews, anticoagulation services, immunizations, and many other clinical pharmacy services including smoking cessation or diabetes education. Pharmacists are the medication experts in health care and as such, are the best equipped to offer MTM services.

In Ohio, an MTM Consortium has developed through a partnership among the Ohio Department of Health, OACHC, the Ohio Pharmacists Association, and Colleges of Pharmacy in Ohio focusing on improving chronic disease outcomes with MTM. There are three FQHCs currently involved that are integrating pharmacists into their patients’ care and showing improvements in achieving blood pressure and A1C goals. This effort is expanding and hoping to engage more pharmacists and primary care clinics across the state. If you are interested in learning more about the project, contact Jen Rodis at The Ohio State University College of Pharmacy. Are you interested in offering this valuable service to your patients and working with us to show improvements in patient outcomes? Please complete the online form and you will be contacted about this opportunity.
How Primary Care Providers Can Help Patients with HIV

For those diagnosed with HIV in 2015, life expectancy is similar to someone who does not have the virus. The medical profession now considers HIV a chronic disease much like Type 2 diabetes. Adherence to a treatment regime, avoidance of risky behavior and careful health monitoring can extend life expectancy considerably, while neglect almost always leads to additional health problems and a reduction of life expectancy.

As with all chronic conditions, the primary care provider plays an important role in helping the patient with HIV manage their condition effectively. Primary care providers are the experts in chronic care management and are able to apply these skills and expertise to HIV treatment. Particularly when primary care providers are delivering care within a patient centered medical home, patients with chronic conditions receive comprehensive services that address barriers to treatment and support their care management goals. When primary care providers incorporate HIV into their chronic care management services, people living with HIV/AIDS benefit.

Moreover, as people living with HIV/AIDS are living longer lives, primary care providers can ensure that their patients with HIV are receiving appropriate preventive care for the conditions that affect everyone as they age. “In many HIV practices now, 80 percent of patients with HIV infection have the virus under control and live long, full lives. Doctors need to tell their HIV-infected patients, ‘Your HIV disease is controlled and we need to think about the rest of you.’ As with primary care in general, it’s about prevention.” said Judith A. Aberg, MD, director of the Division of Infectious Diseases and Immunology at the New York University School of Medicine. Dr. Aberg is the lead author of recently updated guidelines from the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA). These updated guidelines reflect the fact that people with HIV are now living normal life spans, and their physicians need to focus on preventive care, including screening for high cholesterol, diabetes and osteoporosis.

For primary care providers who are moving to integrate HIV treatment as part of their chronic care management, free training and technical assistance is now available, funded by the Centers for Disease Control and Prevention (CDC).

For more information click here.

Cigarettes Linked to More Deaths Than Previously Thought

The U.S. surgeon general estimates that cigarette smoking kills about 480,000 people in the United States each year. But a new study led by American Cancer Society researchers found smoking may kill tens of thousands more from diseases that are not currently included in that official estimate.

Published online Feb. 12 in the New England Journal of Medicine, the study (www.nejm.org) found that about 17 percent of excess deaths in smokers were caused by diseases that at least doubled the risk of death from renal failure, intestinal ischemia, hypertensive heart disease, infections and various respiratory diseases other than chronic obstructive pulmonary disease.

“The number of additional deaths potentially linked to cigarette smoking is substantial,” said Eric Jacobs, Ph.D., co-author of the study, in a news release (pressroom.cancer.org) “We believe there is strong evidence that many of these deaths may have been caused by smoking. If the same is true nationwide, then cigarette smoking may be killing about 60,000 more Americans each year than previously estimated, a number greater than the total number who die each year of influenza or liver disease.”

Researchers also linked smoking to smaller increases in risk of death from other cancers not formally recognized as being caused by smoking, including breast cancer, prostate cancer and cancers of unknown site.

The team analyzed data from more than 950,000 men and women in the United States who were 55 or older and enrolled in one of five cohort studies (American Cancer Society's Cancer Prevention Study II, Health Professionals Follow-up Study, NIH-AARP Diet and Health Study, Nurses' Health Study and Women's Health Initiative).

During the approximately 10 years the cohorts were followed, more than 180,000 deaths occurred, according to the news release. Researchers also found that current smokers, as expected, had death rates nearly three times higher than nonsmokers.

Read more here.
OACHC Annual Conference—Helping All Communities Live Healthier Lives
March 9-11, 2015 Hilton Polaris · Columbus, OH
The conference will kick off on Monday afternoon with the OACHC Meeting of the Board of Directors. Bright and early on Tuesday, all of the attendees will come together for our opening plenary Legislative Update, highlighting the latest news that is or will be affecting your health center. Educational breakout sessions will follow and we will close the day with our Welcome Reception (Sponsored by Cardinal). Wednesday morning will open with a CMO Networking breakfast followed by additional educational sessions and close with Dr. Ben Miller speaking on Behavior Health Integration (Sponsored by CareSource).

Colorectal Cancer Screening 80% by 2018 Call
Monday, March 9, 2015, 2:00 pm—Register Here
A live broadcast event featuring Dr. Richard Wender, Chair of the National Colorectal Cancer Roundtable and Chief Cancer Control Officer of the American Cancer Society, Dr. Lisa C. Richardson, Director of the Division of Cancer Prevention and Control at the Centers for Disease Control and Prevention and other leaders for a look at the first year of the 80% by 2018 effort and the year ahead.

Cradle Cincinnati, Every Baby, Every Day
Thursday, March 12, 2015 10:00 AM–12:00 PM, Community Action Agency, Cincinnati, OH
Join Cradle Cincinnati and other local leaders on March 12th at our annual open meeting From Grief to Action as we announce our 2014 Infant Mortality Rate, learn about new initiatives designed to drive change and discuss practical action steps you can take to improve our numbers. Everyone has a role to play in reversing infant mortality; only by working together can we positively impact the health of moms and babies now and in the future. Register here.

Oral Health Workshops: Prenatal Oral Healthcare and Treating Children Under Age Three
Friday, March 20, 2015, 9:00 AM–3:00 PM, Mercy Medical Center, Canton, OH
Friday, April 17, 2015, 9:00 AM–3:00 PM, Athens Community Center, Athens, OH
Hosted by COHAT, the purpose of this training is to educate oral health providers and stakeholders about the importance of prenatal and postnatal oral health care and its benefits in the prevention of Early Childhood Caries (ECC). Attendees will learn effective techniques to educate parents and caregivers about the importance of oral health care for infants and young children. To register for the event click here.

OACHC Legislative Day at the Statehouse
Wednesday, April 15, 2015, 9:00 AM–5:00 PM, Vern Riffe Center, Columbus, OH—Register Here
Join us for a brand new approach! April 15th marks the first ever OACHC Legislative Day at the Statehouse, replacing our Legislative Reception typically held in conjunction with the Annual Conference. Meetings will be scheduled with your legislators by the staff of OACHC. We will be meeting in the morning to arm you with talking points, information and answer any questions you may have.

ICD-10 Roadmap Webinar Series: The Physician’s Path to ICD-10 Preparedness
Thursday, April 20, 2015, 3:00 PM–3:30 PM, Webinar by NextGen
We should all be working towards the new deadline of October 1, 2015 for the ICD-10 transition. If your practice isn’t on the right track for ICD-10, or even if it is, join our panel of experts each month to help you prepare and implement your ICD-10 transition. In this month’s Webinar, we’ll look at the ICD-10 transition from the physicians perspective. How do you get medical professionals to focus on this critical change? Join Gary Wietecha, MD as he provides insight into how to engage doctors about ICD-10 without affecting their focus on patient care.