April marks National Minority Health Month to raise awareness surrounding health disparities that continue to affect racial and ethnic minorities. The African American’s guide to Health Living is a wonderful resource, free of charge, that can be provided throughout the state to interested parties as a means of supplementing outreach efforts. African Americans experience illness and disease at higher rates and more intensely than many other racial or ethnic groups. Some of the factors that lead to racial health disparities include lack of health coverage, health providers that do not understand diverse cultural needs, patients who feel unable to trust the health care system, and doctors who do not have enough time to spend with patients. The healthcare system may not change overnight, but there are steps that can be taken to help people get the care that they need.

The African American’s Guide to Healthy Living was created to help African Americans take control of their health by making the most of doctor visits and by knowing the facts about health problems that most frequently affect African Americans.

This guide provides tips on how to interact with the world of healthcare, how to live a healthy lifestyle, where to find additional information about healthcare topics, and what health conditions may put you at risk. This health guide provides basic information on nutrition, exercise, sexually transmitted infections, HIV/AIDS, chronic health conditions like diabetes, and substance use and abuse.

This guide is available statewide for distribution by request at no cost through AIDS Resource Center locations. For more information, or to request copies of the guide, please call (614) 340-6707 or email us at info@ohioaidscoalition.org.

Source: Ohio Aids Coalition

Are You a Culturally Competent Clinician?

Cultural competency is one of the main ingredients in closing the disparities gap in health care. It’s the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice (The Blueprint) is an implementation guide to help you advance and sustain culturally and linguistically appropriate services within your organization. The Blueprint dedicates one chapter to each of the 15 Standards, with a review of the Standard’s purpose, components, and strategies for implementation. In addition, each chapter provides a list of resources that offer additional information and guidance on that Standard.

Find more information through the Office of Minority Health by clicking here.

Source: Office of Minority Health
The Future of Patient-Centered Medical Homes

*Foundation for a Better Health Care System*

Patient-Centered Medical Homes (PCMHs) are transforming primary care practices into what patients want, focusing on patients themselves and all of their healthcare needs. They also are foundations for a healthcare system that gives more value by achieving the ‘triple aim’ of better quality, experience and cost. This white paper lays out our vision for achieving that goal by chronicling PCMH evolution to date, challenges before us, potential solutions underway and those yet to be developed.

More than 10 percent of U.S. primary care practices, approaching 7000 altogether, are recognized as PCMHs by the National Committee for Quality Assurance (NCQA), which has the nation’s largest PCMH program. To earn NCQA recognition, practices must meet rigorous standards for addressing patient needs. That means offering access afterhours and online so patients get care where and when they need it. PCMHs get to know patients in long-term partnerships, rather than hurried, sporadic visits. They make treatment decisions together with patients based on individual preferences. They help patients become better engaged in their own healthy behaviors and healthcare. Everyone in the practice - from clinicians to front desk staff - works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly-trained clinicians are not doing tasks lower level staff can do. They also avoid costly and preventable complications and emergencies by focusing on prevention and managing chronic conditions.

A growing body of evidence documents PCMHs’ many benefits, including better quality, patient experience, continuity, prevention and disease management. Studies also show lower costs from reduced emergency department visits and hospital admissions. Other studies show reduced income-based disparities in care and provider burnout. Yet some have equivocal results.

PCMHs’ power in improving the quality, cost and experience of primary care, however, only begins the broad change our health care system needs. Other providers and facilities must build on PCMH foundations to establish patient-centered care throughout all of healthcare. This is beginning in Patient-Centered Specialty Practices (PCSPs), which help specialists become part of medical neighborhoods to improve quality and access. Adoption of patient-centered strategies also is underway in many emerging Accountable Care Organizations (ACOs). ACOs build on a solid PCMH foundation to coordinate doctors, hospitals, pharmacies, other providers and community resources and make sure people get all the care they need. They share savings from reduced waste and inefficiency if they also improve quality.

But this still is only a start. Most providers today are not yet in PCMHs, PCSPs or ACOs. Those who are may be on steep learning curves, or lack the capabilities, commitment and resources to sustain transformation. PCMH transformation is not easy and requires a long-term commitment from every team member and a significant financial investment. Practices may face technological or legal challenges with electronic access privacy and liability. Coordination with community services, public health, dental, post-acute and other settings is minimal. Linking with behavioral care is particularly challenging yet critical because many with chronic illness also have behavioral co-morbidities. Payments and other supports vary widely among insurers and may not be sufficient, especially for non-face-to-face and team-based services not traditionally covered. Also, most patients are unaware of PCMHs. Focus groups with PCMH patients show they are aware of better access and coordination, but not the PCMH name. Those not in PCMHs often doubt such care is even possible.

We are making steady progress in addressing many of these challenges. For example, Medicare is moving to support PCMHs with both performance-based and non-face-to-face chronic care management payments. Interest in PCSPs and ACOs is growing, and patients, providers and payers with PCMH experience agree this is the future we all want. This journey to get better healthcare value by focusing on patients will succeed.

To read the complete article, click [here](#).

*Source: NCQA*
PCMH Recognized Health Centers in Ohio

March/April 2014

Congratulations to all of the teams who have worked so hard to transform into Patient Centered Medical Homes! Is your Health Center missing from the list? If so, please contact Heather Porter or Ashley Ballard at OACHC and let us know.

New NCQA PCMH Standards for 2014 Recognition

Medical homes use teamwork and technology to improve quality and patients’ experience of care, and reduce costs. NCQA’s PCMH Recognition program is the most widely adopted medical home model in the country.

Key changes affecting the advantages and requirements of NCQA PCMH Recognition include:

⇒ Alignment with Meaningful Use Stage 2 (MU2) - NCQA’s requirements continue to position clinicians to qualify for federal Meaningful Use rewards for adoption of health information technology, and raise the bar to include expectations for MU2.

⇒ Enhanced emphasis on team-based care - Revised standards emphasize collaboration with patients as part of the care team and establish team-based care as a “must-pass” criterion for NCQA Recognition.

⇒ Care management focus on high-need populations - Practices must address socioeconomic drivers of health and poorly controlled or complex conditions. Practices also focus on the special needs of patients referred from the “medical neighborhood” of practices that surround and inform the medical home.

⇒ Alignment of quality improvement with the triple aim - Practices must show that they are working to improve across all three domains of the triple aim: patient experience, cost and clinical quality.

⇒ Sustained Transformation - In keeping with the goal of continuous improvement, practices show that they comply with NCQA standards over long periods.

Integration of behavioral health - Expectations rise, as they did in previous NCQA standards, that a practice support patients’ behavioral health. This includes disclosing to patients a practice’s behavioral health care capabilities and collaborating with behavioral health care providers.

Source: NCQA
Two state senators -- Charlotta Tavares, a Democrat from Columbus, and Shannon Jones, a Republican from Springboro, teamed up this summer and fall to research infant mortality statewide. Those trips could save lives from largely rural Adams to heavily urban Cuyahoga counties. Jones and Tavares introduced five bipartisan bills earlier this month that are desperately needed to curb Ohio’s appallingly high infant mortality rates. Unsafe sleeping practices and prematurity are all-too-common killers of babies under one in Ohio. Ohio lost 1,045 babies before their first birthdays in 2012, according to the Ohio Department of Health. That earns Ohio a ranking of 48th out of 50 states for total infant deaths, according to the National Center for Health Statistics. Ohio ranks 37th in infant deaths for white babies and an unspeakable 49th for African-American babies.

Jones and Tavares deserve praise for trying to change those dreadful statistics, starting with this optimistic note: “At the end of the day, Ohio is better than 48th,” says Jones. It is, but it has to start acting like it by taking this issue seriously. These bills focus on the need to support pregnant women and to create a cultural shift in sleeping practices. Many deaths could be prevented if babies were put on their backs to sleep and without bedding in a crib, says Tavares.

Three of the bills are no-brainers, offering low-cost ways to help curb infant mortality by distributing information on safe sleeping practices (Senate Bill 276), establishing an infant mortality commission (Senate Bill 277) and mandating uniform reporting standards for infant sleeping deaths (Senate Bill 278).

Two others would cost more money but would be worth it if they reduce costly pregnancy complications and premature births: Senate Bill 280 requires postpartum care that would help women with non-Medicaid-eligible expenses, such as transportation to get to pediatrician visits, while Senate 279 would establish four pilot “Centering Pregnancy” programs.

CP has had success in reducing infant mortality by bringing several pregnant women together to talk to each other and a medical provider. Tavares and Jones want to earmark $25 million for the postpartum program and $500,000 each in 2015 and 2016 for the pilot programs so they could take in many more women than they do now.

The money would come from savings from Medicaid as the federal Affordable Care Act picks up the health insurance tab for the poor, say Jones and Tavares.

It’s a wise and humane investment in Ohio’s youngest citizens.

Source: www.cleveland.com
Buying Children’s Dental Coverage through the Marketplace

Of all of the provisions in the Affordable Care Act, the children’s dental benefit can be among the most confusing to families. A new guide co-produced by the Children’s Dental Health Project and Families USA helps parents understand how this benefit works. The guide is called “Buying Children’s Dental Coverage through the Marketplace” and uses 8 frequently asked questions to explain or clarify how the dental benefit works.

1. How do I buy children’s dental coverage through my state’s marketplace?
2. How long will my kids be able to get children’s dental coverage?
3. Which dental services will plans cover?
4. What’s the difference between dental coverage that is sold as part of a health plan and dental coverage that is sold as a separate dental plan?
5. How do I figure out which children’s dental coverage option is most affordable?
6. Can I get financial assistance to help pay for children’s dental coverage?
7. Do I have to buy dental coverage for my children?
8. Can I buy dental coverage for myself or other adults in my family through the marketplace?

Click here for the guide. 

Dental Setting Useful in Early Detection of Diabetes

There is a lot of supportive literature on screening dental patients for conditions such as hypertension and cholesterol, and now a new field trial has found that the dental setting can play an important role in identifying patients who may have diabetes or prediabetes.

A significant percentage of Americans with diabetes remain undiagnosed, and a large number of them, both children and adults, will see their dentist every year, so it is important to determine the feasibility of screening for diabetes at the dental office, said study author Robert Genco, DDS, a distinguished professor of oral biology and microbiology at the State University of New York at Buffalo, in an interview with DrBicuspid.com.

Early diagnosis of diabetes provides an opportunity to reduce smoking, hypertension, dyslipidemia and other risk factors for cardiovascular disease and other complications of diabetes. Also, dentists need to be aware of whether their patients have diabetes, because uncontrolled diabetes is associated with an increased progression of periodontal disease.

Dr. Genco and colleagues assessed whether point-of-care measurement of hemoglobin (Hb) A₁c from a finger-prick blood sample combined with use of the American Diabetes Association Diabetes Risk Test, demographic and health data, and periodontal evaluation would be useful in establishing a feasible method of screening for undiagnosed diabetes and prediabetes in dental practices (Journal of the American Dental Association, January 2014, Vol. 145:1, pp. 57-64).

They collected data from 11 general and periodontal specialty dental offices and a dental clinic within a community health center. They included 1,022 participants 45 years or older with no history of diabetes. The study results show that screening for prediabetes and diabetes is feasible in a dental office, with acceptance by the dentists and dental office staff members, patients’ physicians, and patients, the study authors noted.

“Screening for diabetes and prediabetes in the dental office may provide an important benefit to patients and encourage interprofessional collaboration to achieve a chronic care model in which healthcare professionals work together to care for a panel of patients,” the authors concluded.
Immunizing Adult Patients: New Standards for Practice

Your patients have probably not received all the vaccines they need.

Even though most insurance plans cover the cost of recommended vaccines, adult vaccination rates in the U.S. are unacceptably low. Each year, tens of thousands of adults needlessly suffer, are hospitalized, and even die as a result of diseases that could be prevented by vaccines.

Your patients may not even realize that they need vaccines.

A recent national survey showed that most adults are not aware that they need vaccines throughout their lives to protect against diseases like shingles, pertussis, and hepatitis. Many also report not receiving vaccine recommendations from their healthcare professional.

You can make a difference.

Healthcare professionals are the most valued and trusted source of health information for adults. Research shows that most adults believe vaccines are important and that a recommendation from their healthcare professional is a key predictor of patients getting needed vaccines.

Make Immunization a Standard of Patient Care In Your Practice:

ASSESS the immunization status of all your patients at every clinical encounter. Stay informed about the latest CDC recommendations for immunization of adults.

Implement protocols in your office to ensure that patients’ vaccine needs are routinely reviewed and patients get reminders about vaccines they need.

SHARE a strong recommendation with your patients for vaccines they need. Address patient questions and concerns in clear and understandable language.

Highlight your positive experiences with vaccination (personal or in your practice).

ADMINISTER needed vaccines or REFER your patients to a vaccination provider. For vaccines that you stock, make vaccination services as convenient as possible for your patients.

For vaccines that you don’t stock, refer patients to providers in the area that offer vaccination services.

DOCUMENT vaccines received by your patients. Participate in your state’s immunization registry to help your office, your patients, and your patients’ other providers know which vaccines your patients have had.

Follow up to confirm that patients received recommended vaccines that you referred them to get from other immunization providers.

Coverage of Adult Vaccines

Most private health insurance plans cover the cost of recommended vaccines. If your patients do not currently have health insurance, refer them to www.HealthCare.gov to learn more about health coverage options.

For patients 65 years or older enrolled in Medicare, Medicare Part B covers the cost of influenza and pneumococcal vaccines as well as HepB vaccine for persons at increased risk of hepatitis. Those with a Medicare Prescription Drug Plan (Part D) or enrolled in a Medicare Advantage Plan (Part C) that offers Medicare prescription drug coverage may also have coverage for additional vaccines like zoster, MMR, and Tdap. Visit www.Medicare.gov for more information.

Vaccine coverage for Medicaid beneficiaries varies by state. Contact your State Medicaid Agency for more information.

Source: CDC

Adult Vaccination Rates for 2012:

Only 14% of adults 19 years or older received Tdap vaccine.

Only 20% of adults 60 years or older received zoster vaccine.

Only 20% of adults 19 to 64 years at high risk received pneumococcal vaccine.

One & Only Campaign

A public health campaign, led by the Centers for Disease Control and Prevention (CDC) and the Safe Injection Practices Coalition (SIPC), to raise awareness among patients and healthcare providers about safe injection practices.

http://www.oneandonlycampaign.org/
All women should be screened for gestational diabetes at 24 weeks of pregnancy, even if they have no symptoms, according to new federal recommendations.

The B-level recommendation from the U.S. Preventive Services Task Force (USPSTF), published in the Annals of Internal Medicine, aligns with that of several other medical organizations, including the American Association of Clinical Endocrinologists, the American Diabetes Association (ADA), and the American College of Obstetricians and Gynecologists (ACOG).

“It’s good to see that the task force has finally changed the recommendation from an ‘I’ [for insufficient evidence] one, [since gestational diabetes] screening is the norm/standard of care in the U.S.,” Sue Kirkman, MD, of the University of North Carolina in Chapel Hill, told MedPage Today.

“The recommendation for universal screening has been that of the American Diabetes Association for several years now,” she added. Kirkman spent many years as an official at the ADA.

When the draft guidance was released last May, ACOG called the updated recommendation “an important step forward in harmonizing the many recommendations that currently exist among many healthcare organizations.”

Estimates of the prevalence of gestational diabetes in the U.S. range from 1% to 25%, and associated risks include preeclampsia, fetal macrosomia, and neonatal hypoglycemia.

The task force recommends testing with a 2-hour, 50-g oral glucose challenge test (OGCT) between 24 and 28 weeks. If patients hit or exceed a threshold of 130 mg/dL, they should follow-up with the 2-hour, 100-g oral glucose tolerance test (OGTT).

Other options for screening include a fasting plasma glucose or screening based on other risk factors, but the task force said there’s limited evidence on these alternative screening approaches. Kirkman noted this is an area of ongoing controversy.

 Roxana Mehran, MD, of Icahn School of Medicine at Mount Sinai in New York City, said in an interview with MedPage Today that the 2-hour glucose challenge test is the gold standard.

“You can do a fasting glucose, but, to be frank, what needs to be done is the 2-hour tolerance test, even though it’s a burden to have to take on a large volume of high sugar content,” said Mehran, who is a professor of cardiology and health evidence and policy. She said she sees the screening as a way to make women more aware of their cardiovascular health.

She added that it’s important to follow women who’ve had complications during pregnancy for future cardiovascular risk.

“It’s a fantastic time to engage women” in cardiovascular health,” Mehran said. “When we become mothers, that is when we begin to care about ourselves and think about a heart-healthy life.”

If screening does indicate that a woman has gestational diabetes, she should be treated with moderate physical activity, dietary changes, support from diabetes educators and nutritionists, and glucose monitoring, according to the recommendation.

The task force concluded that there is insufficient evidence to assess risk and benefits of screening before 24 weeks’ gestation.

Kirkman added that while several studies -- including the ACHOIS study -- have strengthened the recommendations for gestational diabetes screening, the evidence base for treating type 2 diabetes in general earlier is even stronger.

“Evidence that waiting to make a diagnosis until the disease manifests itself clinically means that a significant proportion of patients have signs of diabetes complications already at the time of diagnosis,” Kirkman said. “I certainly hope this means that the USPSTF will finally reverse its ‘I’ recommendation for screening for type 2 diabetes in high-risk adults.”

Source: MedPage Today
Join OACHC’s Quality Committee

OACHC is looking for participants for its broadened Quality Committee and we want to hear from you! This will be a great opportunity to provide your experiences and expertise as well as to learn from peers, network, and help shape the clinical initiatives of OACHC. Did you know that we also have a clinical listserv where you can communicate via e-mail to others across the state within the Health Center family and ask questions? If you’d like to join either please contact Ashley Ballard at aballard@ohiochc.org.

What is SBIRT?

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

SAMHSA published a white paper in 2011 on SBIRT that discusses the evidence supporting the effectiveness of screening, brief intervention, and referral to treatment (SBIRT) as a comprehensive approach, as well as for the implementation and effectiveness of the individual components of SBIRT for different behavioral health conditions. The report describes briefly the underlying research that has been conducted in the prevention and early intervention of risky alcohol, substance abuse and tobacco consumption, as well as commonly reported mental health problems, and describes existing studies/models for specific populations and settings. SAMHSA defines a comprehensive SBIRT model to include the following characteristics:

- It is brief (e.g., typically about 5-10 minutes for brief interventions; about 5 to 12 sessions for brief treatments).
- The screening is universal.
- One or more specific behaviors related to risky alcohol and drug use are targeted.
- The services occur in a public health non-substance abuse treatment setting.
- It is comprehensive (comprised of screening, brief intervention/treatment, and referral to treatment).
- Strong research or experiential evidence supports the model’s effectiveness.

To learn more and to access the white paper, please click here.  

Source: SAMHSA
Upcoming Training Opportunities

**Great Lakes Medical/Dental Summit 2014**

Friday, May 09, 2014 - Saturday, May 10, 2014

The Primary Care Associations from Illinois, Michigan and Ohio have collaborated with the DentaQuest Foundation to arrange a Medical/Dental Integration Summit. Through our extensive participation in the DentaQuest initiative to “Strengthen the Oral Health Safety Net”, we aspire to continue the strong tradition of Public Health professionals sharing best practices and spreading new and innovative models of learning with each other. The focus of this Summit is to collaborate and promote interprofessional relationships among healthcare providers responsible for overall patient health. Contact Susan Lawson.

It’s not too late to have your FREE Health Center Accessibility Assessment completed!

To learn more about Ohio Disability and Health Program (ODHP) or how your health center can participate in a free accessibility assessment, please contact Yiping Yang at Yiping.Yang@osumc.edu or (614) 688-2928.

**Healthy Lifestyles Train-the-Trainer Workshop**

March 24-25, Columbus, OH at OSU

The Healthy Lifestyles curriculum was designed by and for people with disabilities to help people develop confidence and skills to stay on a journey toward a healthy and happy life. This 2-day workshop is free, fun, and educational for people who will commit to teaching people with disabilities about Healthy Lifestyles. The training will feature Master Trainers, Angela Weaver, from the Oregon Office on Disability and Health, and Joe Basey, from the City of Eugene Adaptive Recreation. Contact info: Erica.Coleman@cchmc.org or call 513-803-4399.

**SAMHSA’s Opioid Overdose Toolkit**

The Toolkit is designed to educate community members, first responders, and overdose survivors on ways to prevent and intervene in an opioid overdose situation. Click here for toolkit.

**SAVE THE DATES for OACHC’s newest Quality Program focused on Leadership Development**

The Leadership Development Series aims to meet healthcare challenges head on and build the skills and competency necessary for sustainable success. The training series enlists a two-track approach that tailors curriculum to the unique interests of staff in key leadership roles, specifically in the areas of Operations and Quality Improvement. More information to come but this 6 month webinar series will start in April and go through September, 2014 and will also offer in-person, virtual, collaborative and individual learning opportunities.

**Midwest Clinicians Network**

MWCN is a nonprofit corporation consisting of ten states in the Midwest: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio and Wisconsin. The Network, house at the Michigan Primary Care Association, is open to all clinical providers within Region V & Region VII. MWCN provides research opportunities, mentoring programs and education opportunities for all its members. MWCN also hosts a robust listserv where you can interact with other health center staff in the region. For more information please click here.

**ICD-10 Training, in-person, hosted by OACHC**

April 29 - Achieving ICD-10 Implementation Success

ICD-10 is the most significant change to how medical organizations conduct business in over 25 years. Contrary to popular belief, the transition to ICD-10 is not just a coding or IT challenge. Its impact cuts across the entire continuum of the healthcare practice. This training focuses on what physicians and their staff REALLY need to know to get engaged and motivated for this significant change. Info & Registration here.

July 11 - ICD-10 Documentation for Providers and Coders

In this workshop, attendees will learn ICD-10 is not the ‘monster in the closet’ that they have been led to believe. This workshop was developed through physician and coder collaboration demonstrating critical documentation elements required for accurate documentation to allow for coding to the highest level of specificity. Info here.