Obesity Interventions Cost-Effective

According to a review published online Jan. 17 in Obesity Reviews, The majority of obesity prevention interventions are cost-effective in the long-term, with the most favorable interventions being those which modify a target population's environment.

Researchers from University Medical Center Hamburg-Eppendorf in Germany used nine decision-analytic simulation models to evaluate the long-term (40 years or more) cost-effectiveness of 41 obesity prevention interventions in 18 analyses. They found the majority of 31 preventive interventions for obesity to be cost-effective, costing less than $20,000 per quality-adjusted life year gained per disability-adjusted life year averted, and seven interventions were cost saving. The most favorable cost-effectiveness was seen for interventions which modified a target population's environment.

"The majority of studies included in this review considered future health care costs for obesity-related diseases only. Yet individuals may generate expenditures for the treatment of diseases unrelated to obesity or its comorbidities, e.g., falls in old age, in the life-years gained as a consequence of preventive measures. There is an ongoing debate if, and as to how, future health care cost of unrelated diseases should be included in cost-effectiveness analysis," the authors write.

For the full article go to www.physiciansbriefing.com.

Obesity, Inactivity and Arthritis

Not getting enough physical activity is a problem for many of us – and, a study finds, especially for obese people with arthritis. Researchers at the Centers for Disease Control and Prevention saw the effect of arthritis in data from national health surveys in 2007 and 2009. From the CDC’s Kamil Barbour: Adults with obesity and arthritis were 44 percent more likely to be physically inactive, compared to adults with only obesity. Listen here for more.

The study also found that almost 36 percent of obese adults had arthritis. But people who have arthritis and who do physical activity right can help to control their weight and manage their arthritis.

Scientific studies have shown that participation in moderate-intensity, low-impact physical activity improves pain, function, mood, and quality of life without worsening symptoms or disease severity. Being physically active can also delay the onset of disability if you have arthritis. Tips for starting and maintaining a physical activity program for arthritis patients include the SMART choices.

Start low, and go slow.

Modify activity as needed.

Activities should be "joint friendly."

Recognize safe places and ways to be active.

Talk to a health professional.
March is Colorectal Cancer Awareness Month

The Blue Star; A symbol of hope and survival

The Blue Star symbolizes the fight against colorectal cancer. The star represents the memory of those whose lives have been lost to the disease and the shining hope for a future free of colorectal cancer. Colorectal cancer is preventable, treatable and beatable!

Spread the word. Share a star. Save a life!

To learn more, visit ASGE’s site dedicated to colorectal cancer screening, www.screen4coloncancer.org

Improve your Colorectal Cancer Screening Rates

Colorectal Cancer Screening in a new UDS measure for CHCs as well as HEDIS and a Healthy People 2020 Leading Health Indicator. Here is a great resource for your practice on Screening! Implement changes NOW to achieve the FOUR ESSENTIALs and increase cancer screening and improve the care of patients.

**Essential #1: Make a Recommendation**
- Determine the screening messages you and your staff will share with patients
- Explore how your practice will assess a patient’s risk status and receptivity to screening, taking into account any insurance coverage and the patient preferences

**Essential #2: Develop a Screening Policy**
- Create a standard course of action for screenings, document it and share it with everyone in your practice
- Compile a list of screening resources and determine the screening capacity available in your community

**Essential #3: Be Persistent with Reminders**
- Determine how your practice will notify patients and physician when screening and follow up is due
- Endure that your system tracks test results and uses reminder prompts for patients, providers and follow up all positives

**Essential #4: Measure Practice Progress**
- Discuss how your screening system is working during regular staff meetings and make adjustments as needed
- Have staff conduct a screening audit to see how you are doing all year long

For the complete PCP Tool kit see: [http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf](http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf)
For more info see: [http://www.cancer.org/Healthy/InformationforHealthCareProfessionals/ColonMDClinicansInformationSource/ForYourClinicalPractice/index](http://www.cancer.org/Healthy/InformationforHealthCareProfessionals/ColonMDClinicansInformationSource/ForYourClinicalPractice/index)
OIG Recommendations on Health Center QA Programs

From ECRI: A March 2, 2012, report from the U.S. Department of Health and Human Services’ Office of Inspector General (OIG) found that almost all health centers and clinics funded by the Health Resources and Services Administration (HRSA) had quality assurance programs and that preventive services provided were generally appropriate for health center patients. The report contains data collected about the quality assurance programs of 147 health center grantees and the medical records for 448 patients from those grantees who had at least two patient encounters between January 1, 2006, and December 31, 2007. In reviewing the aggregated data, OIG makes four recommendations to HRSA: (1) specify what elements should be included in quality assurance programs, and provide more guidance about how grantees conduct their periodic assessments of services; (2) provide more specific guidance concerning what information is required in patient records at health centers; (3) provide more specificity about patients’ receipt of required primary health services; and (4) establish procedures to independently assess patients’ receipt of primary health services and the adequacy of patients’ records. In its response, HRSA said it concurred with the recommendations and said OIG’s report “provides an opportunity to highlight the extensive ongoing quality improvement/quality assurance activities HRSA has undertaken with health centers in the last 5 years.”

Conference Recap - OPIATES

Dr. Gary LeRoy, MD, FAAFP presented “Prescription Opiates: Addressing the Problem at a Community Level”. Dr. LeRoy wanted those that were in attendance to have some additional information on the basics that all providers and health centers should be doing to help address this ever-growing problem. The slides from the presentation along with some additional ones are posted on the website at www.ohiochc.org. A great thank you to Dr. LeRoy for providing such great information to share with the group!

Specifics Measures to Decrease Drug Seeking Behaviors in your Health Centers
1. Check an OARRS report on new patients (HB 93 allows a designated staff member to be a proxy for the physician) who present with c/o anxiety, depression, or pain related disorders. Any new patient presenting with a history of using controlled substances should have an OARRS screen. No new patient should be given controlled substances on the first visit without first giving permission to run an OARRS report or communication with their previous physician.
2. Do not make it convenient for drug seekers. They need to be seen by the CHC professional at least every 2 months. Do not call in after hour refills or fax refills of controlled substances. A semi-annual OARRS report should be run on any patient who is chronically using controlled substances.
3. Have the patient review, check off specific agreements, and sign an agreement regarding the use of controlled substances. Violators should be dismissed.
4. Patients who sign out of the hospital AMA after a drug related OD should be dismissed from the CHC.
5. Flag charts of patients who have demonstrated a history of drug seeking behavior, as an alert to all members of the CHC.
6. DO NOT give large quantities or extended refills of controlled substances.
7. If you do not have one already develop a CHC policy (and guidelines) on dispensing of controlled substances by licensed health care professionals.
8. Trust but verify.

FY12 Tobacco UDS Measures

% of patients age 18 years and older who were queried about tobacco use one or more times within 24 months

% of patients age 18 years and older who are users of tobacco and who received (charted) advice to quit smoking or tobacco use

U.S. surgeon general report finds 1 in 4 high school seniors smoke. According to the report, about 80 percent of youth smokers will continue to smoke as adults, and 9 in 10 current adult smokers started before the age of 18.
Healthy Lifestyle Tips

- Get outside and spend your time in the open air daily, if possible. Exposing yourself to fresh air and sunshine on a daily basis is beneficial to your health.

- Maintain a balanced lifestyle. There should be a balance between your work time and your leisure time. Remind yourself, “All work and no play make Jack a dull boy.”

- Spending 5 to 10 minutes per day to practice deep breathing can improve your overall health. Deep breathing reduces stress, relaxes your muscles, improves your oxygen intake and delivery to all your organs and stimulates your lymphatic system.

Supporting Appropriate Immunizations Across the Age Spectrum

PROTECTcme.org (SupPorting AppROPriate Immunizations Across the AgE SpeCTrum) is a collaborative educational curriculum with the mission of improving clinician performance and patient health associated with immunizations across the age spectrum. Through this collaboration, NCQA offers three new FREE Performance Improvement online educational activities for clinicians. Using a HIPAA-compliant, confidential platform, clinicians can evaluate how well their practice manages patient immunizations and be guided to resources that help to overcome barriers and initiate systems-based solutions. Providers may choose which patient population they would like to select for their performance improvement effort - early childhood, adolescent or high-risk adult. Click here to go to the program’s welcome page for more information, to register and earn CMEs!
Beers Criteria Revisions Released

A wide range of medications—some relatively new and others long available—can cause serious side effects and other adverse events in people 65 and older if not prescribed with care, according to the new American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. The criteria, last revised in 2003, will appear in the early online edition of the Journal of the American Geriatrics Society on March 1, and will be available, with additional professional and public education materials, at www.americangeriatrics.org.

By identifying medications that are potentially dangerous for older adults, the 2012 AGS Beers Criteria can help clinicians more safely prescribe for older patients. More than 40% of people aged 65 and older take five or more medications according to a 2008 study published in the Journal of the American Medical Association and each year more than a third of them will suffer a drug side effect or other adverse drug event (ADE). Estimates from studies published in JAMA (2003) and the American Journal of Medicine (2005) conclude that 27% of ADEs in primary care settings and 42% in long-term care facilities are preventable. A 2000-2001 Medical Expenditure Panel Survey estimates healthcare expenditures related to the use of potentially inappropriate medications at approximately $7.2 billion.

The Beers Criteria also influence research, the training of healthcare professionals, quality measures, and healthcare policy. The National Committee on Quality Assurance (NCQA) and the Pharmacy Quality Alliance have used the Beers Criteria when developing key quality measures regarding pharmacotherapy and the Centers for Medicare and Medicaid Services (CMS) has incorporated the criteria into its evaluation of nursing home compliance with medication-related regulations. ♦

Source: American Geriatric Society

HP 2020 Leading Health Indicators

Environmental Quality
The environment directly affects health status and plays a major role in quality of life, years of healthy life lived, and health disparities. Poor air quality is linked to premature death, cancer, and long-term damage to respiratory and cardiovascular systems. Secondhand smoke containing toxic and cancer-causing chemicals contributes to heart disease and lung cancer in nonsmoking adults. Globally, nearly 25% of all deaths and the total disease burden can be attributed to environmental factors. Poor environmental quality has its greatest impact on people whose health status is already at risk.

The Environmental Quality Leading Health Indicators are:
• Air Quality Index (AQI) exceeding 100
• Children aged 3 to 11 years exposed to secondhand smoke

Poor air quality contributes to cancers, cardiovascular disease, asthma, and other illnesses. Poor water quality can lead to gastrointestinal illness and a range of other conditions, including neurological problems and cancer.

Injury and Violence
Motor vehicle crashes, homicide, domestic and school violence, child abuse and neglect, suicide, and unintentional drug overdoses have become widespread occurrences in the United States. In addition to their immediate health impact, the effects of injuries and violence extend well beyond the injured person or victim of violence, affecting family members, friends, coworkers, employers, and communities. Witnessing or being a victim of violence is linked to lifelong negative physical, emotional, and social consequences.

The Injury and Violence Leading Health Indicators are:
• Fatal injuries
• Homicides

Unintentional injuries and violence-related injuries can be caused by a number of events, from motor vehicle accidents to physical assault, and can occur virtually anywhere. No matter what the circumstances of the event are, injuries can have serious, painful, and debilitating physical and emotional health consequences, many of which are long term or permanent, including: Hospitalization; Brain injury; Poor mental health; Disability; Premature death

While their extent, severity, and impact may vary, injuries from any cause can significantly influence the physical, mental, and economic well-being of individuals, families, and communities nationwide.

Source: American Geriatric Society

According to a Merritt Hawkins 2011 Survey of final-year medical residents they found that lifestyle and location trumped compensation for ideal placement.

By location, residents aren’t referring to climate preferences. According to the survey, they often want to practice within 50 miles of where they were trained, where they grew up or where their spouses/significant others grew up. Another factor is population – 94 percent would prefer to practice in population centers of 50,000 or more.

Source: MGMA e-source
PCDC Guide to Clinical Quality Improvement

PCDC has recently released a publication that uses health center case study for improving disease management through advanced use of health IT titled Translating Evidence into Practice: A How-To Manual for Implementing Clinical Decision Support.

The manual provides step-by-step guidance for medical directors and senior leaders at primary care organizations to implement quality improvement initiatives, with a special focus on using electronic health records to advance chronic disease management. The manual was developed following a two year project with Open Door Family Medical Centers (Open Door), a federally qualified health center (FQHC) with four practice sites in Westchester county, NY serving over 40,000 underserved patients.

The Open Door experience, described throughout the manual, demonstrates that hypertensive patients treated using a clinical decision support intervention were 1.5 times more likely to have controlled blood pressure than pre-intervention. Using this success as an on-the-ground model, the manual provides a systematic approach for designing, planning, implementing and evaluating a quality improvement initiative with a clinical focus. Specific goals of the manual include defining the project, setting quality improvement goals, assessing and understanding current data and technology capabilities, implementing change, and using data to evaluate and sustain improvements. To be directed directly to the free manual please click here http://www.pcdc.org/resources/quality-improvement/translating-evidence-into-practice.html?utm_source=Copy%20of%20CDS%20Manual%20Press%20Release&utm_campaign=cdsmanual&utm_medium=email.

Track Patient Hospitalizations and Emergency Department Visits

Tracking hospital and emergency department (ED) visits in a timely manner facilitates appropriate medical follow-up, improves monitoring, and can help prevent readmissions. Providers should be aware of all hospitalizations and changes in a patient’s medical history in order to provide quality care.

Clinicians and staff in health centers and free clinics can use this checklist to help track patient hospital and ED visits:

- Educate patients and families to notify the health center of any hospital or ED visits, and explain why this notification is important. Provide educational materials to patients during regular visits or post reminders on the health center’s website.
- Ask patients at the beginning of each visit whether they have been to a hospital or ED since their last health center visit. Document the patient’s response in the medical record.
- Follow-up with the patient, provider, or outside facility to request pertinent medical information (e.g., diagnostic studies, discharge summary) related to a hospital or ED visit.
- Educate staff on the process to follow when they are notified of a hospital admission or ED visit from a patient, family member, provider, or hospital contact, including during weekends or evening hours. Identify any and all internal health center staff who may receive this communication.
- Set up a voicemail box in the health center for hospital admission and ED notifications. Identify a staff member who is responsible for monitoring the voicemail box and taking appropriate action.
- Keep a log of all patient hospital and emergency room visits by using a computer tracking system or Hospital Admission and Emergency Visit Log.
- Ensure that all local hospitals and urgent care clinics have contact information for the health center, including telephone and fax numbers.
- Maintain communication with hospitals in the community and identify the key people (e.g., ED management, case managers) who may serve as the health center’s point of contact for admission or ED activity. However, keep in mind that health center policies cannot dictate or depend on the actions of hospital staff.

Source: ECRI
The patient-centered medical home (PCMH, or medical home) aims to reinvigorate primary care and achieve the triple aim of better quality, lower costs, and improved experience of care. This study systematically reviews the early evidence on effectiveness of the PCMH. Against this backdrop, decisionmakers consider whether the evidence supporting the model is strong enough to proceed with widespread adoption, or whether gathering additional evidence is warranted. Given that interest in the model is recent, the expectation was that only precursors to the PCMH would have been evaluated so far. At the same time, these early evaluations present a valuable opportunity to inform stakeholders about the current state of the evidence on PCMH effectiveness on quality, cost, and patient and professional experience.

Out of 498 studies published or disseminated from January 2000 through September 2010 on U.S.-based interventions, 14 evaluations of 12 interventions met our inclusion criteria: the evaluation (1) tested a primary-care, practice-based intervention with three or more of five key PCMH principles and (2) used quantitative methods to examine effects on either (a) a triple aim outcome (quality of care, costs (or hospital use or emergency department use, two major cost drivers), and patient and caregiver experience) or (b) health care professional experience. We use a formal rating system to identify interventions that were evaluated using rigorous methods and synthesize the evidence from these evaluations. We also provide guidance to inform current efforts and structure future evaluations to maximize learning.

The results indicate the need for more evaluations of the medical home to assess and refine the model. While the interventions varied, most essentially tested the addition of a care manager operating from within the primary care practice rather than a fundamentally transformed practice. Turning to the evaluations, less than half assessed all triple aim outcomes. Evaluations of 6/12 interventions provide rigorous evidence on one or more outcomes. This evidence indicates some favorable effects on all three triple aim outcomes, a few unfavorable effects on costs, and mostly inconclusive results. Improving primary care is the linchpin of achieving the triple aim outcomes. The PCMH is a promising innovation, and the model is rapidly evolving. Stronger evaluations are needed to provide guidance on how to refine and target the model to ensure that the substantial efforts of practices and payers needed to adopt the model are most effective.

To be directed to the full publication click here http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_evidence_evaluation_v2.

Source: AHRQ

Guiding Transformation to a Medical Home

A growing consensus supports the patient-centered medical home as a model for strengthening primary care, the foundation of an effective and efficient health care system. In a new Commonwealth Fund report, researchers from the MacColl Institute for Healthcare Innovation and Qualis Health lay out the changes that most medical practices will need to make to become patient-centered medical homes.

Although the major primary care professional associations have advanced principles to guide the transformation to a medical home, the new report details specific practice modifications that likely are essential to the change process. For example, the authors discuss the key role of empanelment—the linking of each patient or family with a specific provider—in facilitating continuity in care and enabling clinicians to more easily monitor their patients and identify those requiring a higher level of attention and services. They also emphasize the importance of patient registries and other information systems in identifying gaps in care for patients before they visit, and decision support systems in helping clinicians make evidence-based choices. To read the full report to learn more about the keys to becoming a patient-centered medical home click here http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Feb/Guiding-Transformation.aspx?omnid=20.

Source: The Commonwealth Fund
Training Opportunities

From “The Beaver” to “The Bieber”: Wellness for the Ages w/ Michael Samuelson
March 16, 2012 – 12pm
This particular talk outlines the importance of avoiding cookie cutter approaches to wellbeing programming and for management to recognize the impact of both generational and cultural differences at the worksite. When designing wellbeing programs and policies it helps if you have a basic grasp of what rings real for each generation. What occurred on the world stage that helped form each generation's world view? What are their values and how are they motivated? According to audience reviews, this presentation is interesting, insightful, amusing and very practical ... lots of "AH HA!" moments. To register please go to http://healthpromotionlive.com/2012/02/mar-16-generational-coming-of-age-with-michael-samuelson/.

The Guideline Advantage: Use of Evidence-Based Medicine in the Outpatient Setting
March 23, 2012 – 12-1:15pm
This teleconference will explain how The Guideline Advantage™ program can help you use clinical practice guidelines to improve care in the outpatient (ambulatory care) setting. Attendees will learn how to apply proven strategies in the development of organizational action plans for better practice performance in clinical measures. CME and CEU's will be available. To register please go to http://www.surveymonkey.com/s/GuidelineAdvantage.

Training for New Medical Directors
Saturday, March 24, 2012 (during P&I), Washington, DC
NACHC is pleased to offer Training for New Medical Directors as a foundational and essential building block in your career development as a health center Medical Director. This full-day in-person training provides the core knowledge and competencies that all health center Medical Directors need to function as effective managers, leaders, and advocates for their centers and communities. In addition to providing contextual knowledge regarding the history, political evolution, regulatory expectations, and terminology of the health center movement, course content focuses on developing competency in evolving health care issues such as the patient centered medical home, electronic health records, and meaningful use. The course format includes didactic learning, presentation and discussion of case studies, and networking opportunities. http://www.nachc.com/newmeddirstraining.cfm.

340B Peer-to-Peer webinars
Upcoming HRSA 340B Peer-to-Peer webinars will be held on the following Wednesdays from 2-3pm
March 28, 2012 - Medicaid Billing and Avoiding Duplicate Discounts
April 25, 2012 - Audits: Understanding the Process and Preparing Your Pharmacy
To register for any or all of these Peer-to-Peer webinars and to view past archived webinars, please go to http://healthpromotionlive.com/2012/02/mar-25-340b-peer-peer-webinars. Just What the Doctor Ordered….Improving Patient Adherence through Engagement
April 26, 2012 – 8–3pm at The Ohio Union Senate Chamber at OSU
Hear about Motivational Interviewing/Patient Activation: What strategies activate and engage people in their own care; Culture and Patient Adherence: What adherence means to different cultures; Panel of Experts: Panel discussion of medication adherence, telehealth coaching for wellness, adherence strategies used in case management of CHF. For more information contact Barbara Sweeney at sweeney.132@osu.edu or call 614.292.4450.

AHRQ Releases Web-based Modules To Help Pharmacy Faculty and Pharmacists Implement Health Literacy Concepts
AHRQ has released a set of Web-based modules to help pharmacy faculty integrate health literacy quality improvement into courses, experiential education, and for PharmD thesis or pharmacy residency projects. Advancing Pharmacy Health Literacy Practices through Quality Improvement: Curricular Modules for Faculty includes four PowerPoint slide sets, more than a dozen guides to encourage active learning and resources to provide faculty and students with background and references for topics covered in the modules. For more information please go to http://www.ahrq.gov/pharmhealthlit/index.html#pharmltqi.