CLINICAL OPERATIONS

AT THE DECKPLATE

VOLUME 3, ISSUE 1 WINTER 2010

NAVY MEDICINE REDESIGNS PRIMARY CARE

BUMED Primary Care Model Working Group (PCMWG)

A strong Patient-Provider relationship is key to assuring optimal patient satisfaction and treatment outcomes for Navy Medicine beneficiaries. In 2008, MHS Senior Leadership requested action plans to address continued access concerns and satisfaction gaps between direct and purchase care sectors. Months of policy development led to the establishment of Seven Core Principles to guide MHS primary care delivery. As Navy Medicine was forging ahead with priorities set by the Surgeon General's Strategic Goals, specifically Patient and Family Centered Care and Quality of Care, the Assistant Secretary of Defense (Health Affairs) released the policy memorandum (Sept 2009) for Implementation of the 'Patient-Centered Medical Home' Model of Primary Care in MTFs. TMA/Health Affairs defined the Patient-Centered Medical Home (PCMH) as a model of primary care that improves continuity of care and enhances access through patient-centered care and effective patient-provider communication. This policy memo was based on input from representatives from all three Services through the TMA Patient-Centered Medical Home Tiger Team.

INSIDE THIS ISSUE

1	Navy Redesigns Primary Care
2	NMC Public Health Center
3	BUMED Corner and Calendar of Events
4	TriService
5	Primary Care
6-8	Disease Management
9	Perinatal
10	Ancillary Services: Pharmacy

Navy and Marine Corps Primary Care Definition

Moving forward with the commitment to provide patient and family-centered care, the DSG sponsored the Primary Care Model Working Group (PCMWG) in December, 2009. The PCMWG attendees were comprised of Subject Matter Experts (SMEs) of PCMH in Primary Care, as well as SMEs from IM/IT, Training, and Co-Chairs from the Primary Care Advisory Board (PCAB). The group was tasked to develop a policy and supporting business rules to standardize Navy Medicine's approach to primary care, using key concepts of the PCMH. The deliverables included provider and support staffing to empanelment ratios (including development of a Primary Care Team; Business Rules for Clinic Management, After Hours Care, and Emergency Department Protocols; recommendations on IM/IT initiatives to support Clinic Management and Patient to Primary Care Team Communication; and metrics for measuring clinic and team performance. The PCWG established the following definition for Navy Primary Care:

Navy Medicine Primary Care is an integrated, comprehensive, continuous approach to the care of the Navy and Marine Corps active duty members and our other beneficiaries. This care includes, but is not limited to readiness, prevention wellness, behavioral health, and disease management. All aspects of care are coordinated by a personal provider supported by a closely aligned healthcare delivery team led by a physician. Quality, safety, and readiness are hallmarks of Navy Medicine Primary Care. Measures of success in the primary care environment include quality of care, continuity, enhanced access, and satisfaction of patients and

Navy Medicine Leadership is very excited about the new model of Navy Primary Care and is committed to support its success at the deckplate.

(continued in Primary Care on page 5)

49TH NAVY AND MARINE CORPS PUBLIC HEALTH CONFERENCE!

Offered 19-25 MARCH 2010 at Convention Center in Hampton, VA

MEDICAL MANAGEMENT TRAINING

In support of DODI 6025.20 (Medical Management), BUMED 6300.17 (Case Management), Navy Medicine Policy 06-011 (Disease Management)** and the Tri-Service Business Plan.

- **Intent**: Assist with the advancement of Disease Management programs already established and to provide training for newly appointed personnel.
- **Curricula**: BUMED Evidence-Based Healthcare Advisory Board (EBHAB) and Action Teams for Asthma (AAT), Diabetes (DAT), Tobacco Cessation (TCAT) created 13 half-day sessions
  - ✓ General Medical Management topics include Patient-Centered Medical Home, new Medical Management guidance, leveraging evidence, becoming effective clinical champions, and will feature Peggy O'Kane, NCQA President, delivering the Key Note address.
  - ✓ Tracks for Asthma (including education competencies and spirometry programs), Diabetes, Tobacco Cessation
  - ✓ Tracks for Quality Management, Case Management, Evidence-Based Practice, and Medical Informatics (with lab!), Deployment Health, Immunizations (4 days plus lab!), and Infection Prevention (**NEW!**)
- **Suggested participants**: Clinical champions; program coordinators; staff in the fields of disease/case management, health promotion, occupational/preventive health, patient education, performance improvement, and population health; and staff managing diabetes, asthma, tobacco cessation, or providing clinical preventive services to beneficiaries

Full participation by MTFs is expected, with attendance at the command's expense. There are no registration fees and continuing education (CME/CEs) will be offered. **REGISTRATION OPENS JANUARY 20TH!** This year, we're expecting representation from all 3 services at this venue, **so register early!** Registration and conference information are available at the Navy and Marine Corps Public Health Center (NMCPHC) website: http://www-nmcphc.med.navy.mil/Public_Health_Conference/Conference10/index.htm
HINT: Searching by "Interdisciplinary" Specialty will assist in quickly locating course offerings. For more information contact:

- ✓ Ms. Jessica Williams at #757-953-0734 (jessica.williams2@med.navy.mil)
- ✓ Mr. Nick Sicignano at #757-953-2440 or (nick.sicignano@med.navy.mil).

**Navy Medicine Policy 06-011 mandates the establishment of Disease and Condition Management Programs, for asthma, diabetes and breast health and the appointment of clinical champions and program coordinators for each of these programs. The policy's Clinical Quality metrics are also integrated into the Tri-Service Business Plan under Advancing Evidence-Based Health Care (EBHC), which have been incorporated into the MHS' Pay for Performance (P4P) plan. This training enables MTFs to enhance current disease management programs to successfully meet P4P objectives.

HEALTH PROMOTIONS TRACK

Brings Training, Skill Building, and Information Updates to Navy and Marine Corps Health Promotion Community

HEALTH PROMOTION COURSES

- ✓ Navy Health Promotion and Wellness Course Choose Healthy Options for Wellness (CHOW)
- ✓ Introduction to Patient-Centered Prevention Counseling Course
- ✓ Tobacco Cessation Facilitator Training 101 ShipShape Facilitator Training
- ✓ Innovative Strategies for Navy Physical Conditioning
- ✓ Navy Health Promotion Basics Course, Level II
- ✓ Introduction to Wellness Coaching
- ✓ *Fundamentals of HPV Prevention Counseling
- ✓ *HIV-STI Prevention: Sexual Partner Services
- ✓ *Promoting Sexual Health

*Listed under PMT Track of Conference Agenda

GENERAL SESSIONS

- ✓ Health Promotion Track Opening Session (includes presentation of Navy Surgeon General's Blue H Health Promotion & Wellness Awards, Roundtable Discussions of Hot Topics in Navy Health Promotion)
- ✓ Ms. Shelley Maniscalco, USDA, 2010 Dietary Guidelines for Americans: An Insider's Look
- ✓ Dr. John Kugler, MD, MPH, OSD, DoD (HA), Update of the DoD Healthy Lifestyle Initiatives and Summary of the 2008 DoD Health Behavior Survey Among Military Personnel

BREAKOUT SESSIONS (including, but not limited to)

- ✓ Capturing Productivity for Health Promotion Visits
- ✓ Prevention First Self-help CD
- ✓ Navy Operational Fueling Series
- ✓ Serving Those Who Serve: Exploring Military and Civilian Tobacco Control Partnerships
- ✓ Delivering the Health Promotion Message for Oral Health
- ✓ Fleet Forces Suicide Prevention Policies and Initiatives

VIEW FULL CURRICULUM AND SCHEDULE FOR THE 2010 HEALTH PROMOTIONS TRACK: http://www-nmcphc.med.navy.mil/Public_Health_Conference/Conference10/index.htm

BUMED'S CORNER

NAVAL OPERATIONAL MEDICAL LESSONS LEARNED CENTER

Ann Yoshihashi, *NOMI Pensacola*

Mission: To collect, analyze, manage, and disseminate relevant medical observations, insights, and lessons learned in support of Navy and Marine Corps operations.

Register on the NOMLLC website with your CAC card to have access to Navy Medicine's central repository of operational medicine relevant information, share your insights, and receive the quarterly NOMLLC newsletter.

Clinical Reasons to Register on the NOMLL Website:

1. Learn from those who have gone before.
   a. Read observations and recommendations from previous deployments to CENTCOM area of responsibility (e.g. Iraq, Afghanistan, Kuwait), to Central and South America and Pacific Regions by Navy Medicine personnel.
   b. View presentations from operational relevant conferences and courses (e.g. annual Aeromedical Conference, Humanitarian Assistance Course, Tactical Combat Casualty Course)
2. Learn what teleconsultation support is available by email for all deployed providers with patient care questions. Typical turnaround time of less than 5 hours with frequently more than one consultant providing inputs.
3. Familiarize yourself with what medical conditions in general are considered disqualifying for deployments to Iraq and Afghanistan. Stable medical conditions stateside can worsen in extreme temperatures and/or austere deployment environments.
4. Understand the culture and language. Familiarity with the culture and language is invaluable for deployments on humanitarian assistance and host nation capacity building assignments. Downloadable resources and important websites available.
5. Familiarize yourself with the Joint Theater Trauma Systems CPGs and other online medical resources before deploying to Iraq or Afghanistan.

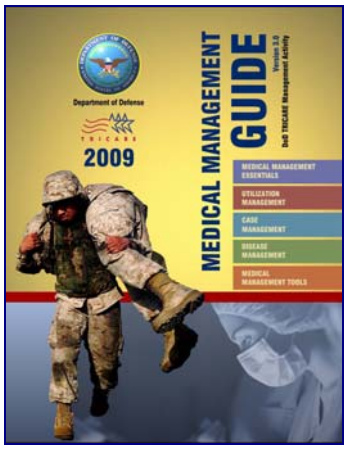
Above are just some of the valuable resources available on the NOMLLC website. If you have any questions or problems, please contact the NOMLLC staff at 850-452-7706 or email us at mllstaff@med.navy.mil .

IMPORTANT EVENTS

- **PRIMARY CARE ADVISORY BOARD**
  JANUARY 11TH -13TH @ PENSACOLA, FL
- **ELECTRONIC HEALTH RECORD ADVISORY BOARD**
  JANUARY 12TH-13TH @ BETHESDA, MD
- **MUSCULOSKELETAL CONTINUUM OF CARE ADVISORY BOARD**
  JANUARY 14TH – 15TH @ FT. SAM HOUSTON, TX
- **PERINATAL ADVISORY BOARD**
  FEBRUARY 17TH-19TH @ SAN DIEGO, CA
- **EVIDENCE-BASED HEALTHCARE ADVISORY BOARD** FEBRUARY 25TH-26TH @ BETHESDA, MD
- **ORAL HEALTH ADVISORY BOARD**
  MARCH 3RD @ BETHESDA, MD
- **TRAUMA CARE ADVISORY BOARD**
  MARCH 2ND-3RD @ SAN DIEGO, CA
- **DIABETES ACTION TEAM**
  MARCH 10TH-11TH @ SAN DIEGO, CA
- **ASTHMA ACTION TEAM**
  TBD
- **BEHAVIORAL HEALTH ADVISORY BOARD**
  MARCH 18TH 19TH @ ANNAPOLIS, MD
- **TOBACCO CESSATION ACTION TEAM**
  MARCH 25TH-26TH @ HAMPTON, VA

ECOMS TRAINING SYMPOSIUM AT NH JAX IN APRIL 20-22, 2010

1. **DATES**: Tuesday 20 April at 0730 through Thursday 22 April at 1200.
2. **LOCATION**: Navy Gateway Inns and Suites at Naval Air Station (NAS) Jacksonville, FL
   Phone number: (904) 542-3138/3139 or 1-877-NavyBed (628-9233) ext JAX (522).
3. **CONFERENCE ROOM**: Located to the left of the NGI&S Registration Desk. Group Registration Number is: 802850
4. **ITEMIZED EXPENSES**: Forward your Estimated Expenses Georgi Irvine (Georgi.Irvine@med.navy.mil)
5. **REGISTRATION**: Visit http://nmsc.med.navy.mil; click "Privileging/CCPD" in the left blue banner; click green-button Navy ECOMS Chair page; Click on "ECOMS Chair Training Symposium Event Registration."
6. **BUMED FUNDING** ECOMS Chair (or substitute) only. Others, e.g., Credentials Chair/Dept Heads are welcome to attend, if parent command funds TAD expenses.
7. **REIMBURSEMENT:** NMSC will only fund if you have DTS and a government travel card. If you do not have a government travel card, please get one. Exceptions: personnel with no access to DTS (e.g. someone on a ship who is potentially an ECOMS traveler). Please Contact Georgi Irvine (Georgi.Irvine@med.navy.mil) with any questions.



DOD MEDICAL MANAGEMENT GUIDE, 2009

TMA Medical Management Guides have been revised for 2009 through the TMA Office of the Chief Medical Officer (OCMO)/Population Health and Medical Management Division (PHMMD). The new guides are being sent to BUMED for distribution to MTFs and other Navy sites staffed with medical management personnel.

The guide is available in hard copy, DVD and also can be accessed on the TMA website in searchable .pdf format at http://www.tricare.mil/OCMO/download/MMG_v3_2009.pdf.

The guide is accompanied by training modules available on MHS Learn; CHE/CME is available for physicians and nurses https://mhslearn.csd.disa.mil/ilearn/en/learner/mhs/portal/home.jsp.

There are four modules; the Medical Management module is a prerequisite for the Case, Disease, and Utilization Management modules.

If you have any questions, please contact TMA/OMCO/PHMMD:

- LtCol Regina Julian at regina.julian@tma.osd.mil or
- MAJ William Amsink at william.amsink@tma.osd.mil

"DID YA KNOW?"

NMCPHC HAS A NEW CLINICAL QUALITY MEASURES WEBSITE!

Clinical Quality Measures play a vital role in measuring progress of an MTF's disease management programs, population health programs, and business plans.

The link below provides information regarding:

- Clinical Quality Policies (DOD, NavMed)
- Clinical Quality Resources (MHS, NCQA, TJC, PHN)
- Performance-Based Budget (PBB) Resources
- NMCPHC Webpages
- Other Navy, MHS, Clinical Quality Resources

Visit the Website today: http://www-nmcphc.med.navy.mil/Preventive_Medicine/Clinical_Quality.aspx

HIGHLIGHTS FROM THE MHS CQM NEWSLETTER!

Timeliness of Oryx® Data

One of the most frequently voiced frustrations related to ORYX(r) is, "the data are old by the time we see it." In the upcoming months, Lockheed Martin (LM) will initiate a pilot program with 2-3 volunteer MTFs to abstract records earlier. The MTFs will work with LM to determine the processes needed to ensure more timely abstraction. The data will then be immediately available for analysis and appropriate action. Service Representatives are currently determining which MTFs will be able to participate in this pilot program. Contact CAPT Linda Grant Linda.Grant@med.navy.mil for more information.

FREE On-Site ORYX(r) Consultations!

Consultations are tailored to your MTF's needs and can cover topics such as MHS-CQM overview, analysis and use of your MTF's data associated with TJC ORYX(r) and other PI initiatives, prioritization of processes, consultation on an organization's PI plan/processes, etc. Consultations are especially beneficial for new PI Directors, new measures champions, and when there is substantial turnover of leadership staff. Consultations can be schedule up to one year in advance!! Again, there is NO COST to the MTF!!! Learn more about these visits:

1. https://www.mhs-cqm.info (under the Measures tab)
2. Contact Karla Herres at karla.herres@lmco.com or 830-229-5228 to discuss or schedule a visit.

NEW Online Educational Activity

FREE Continuing Education Credit (CMEs/CEs) for online activity entitled, *"Improving Influenza Immunization Rates"* was released on October 15.

This activity is based on the 2008 MHS-CQM study that examined influenza immunization rates among TRICARE enrolled beneficiaries diagnosed with asthma, congestive heart failure, and/or acute myocardial infarction. The activity explores CDC guidelines on preventing the spread of influenza and presents strategies for improving immunization rates for seasonal flu, novel H1N1 virus and pneumonia.

In addition to this, the MHS-CQM Website offers seven other topics. All provide free CME/CE continuing education credits through the Uniformed Services University of the Health Sciences. All of the activities focus on military healthcare issues.

PRIMARY CARE

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

THE USPSTF RELEASED NEW EVIDENCE-BASED GUIDELINES AFFECTING PRIMARY CARE!

The U.S. Preventive Services Task Force (USPSTF) recently released new recommendations for clinical preventive services. Please see some highlights from these recommendations below. For the full list of USPSTF recommendations, as well as other helpful materials and tools, please visit the USPSTF Website at http://www.ahrq.gov/clinic/uspstfix.htm

1. USPSTF recommendations for **Breast Cancer Screening** (November, 2009):
   - ✓ Recommend against teaching breast self-examination (BSE).
   - ✓ Recommend biennial screening mammography for women aged 50 to 74 years.
   - ✓ The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms as well as risk factors that may increase the patient's chance to develop breast cancer.
   - ✓ Conclude that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older.
   - ✓ Conclude that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older.
   - ✓ Conclude that the current evidence is insufficient to assess the additional benefits and harms of either digital mammography or magnetic resonance imaging (MRI) instead of film mammography as screening modalities for breast cancer.
2. The USPSTF recommendations for **Depression in Adults** (December, 2009) include:
   - ✓ Recommend screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
   - ✓ Recommend against routinely screening adults for depression when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient.
3. The USPSTF recommendations for **Screening for Obesity in Adults and Adolescents** (January, 2010):
   - ✓ Recommend that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.

The United States Preventive Services Task Force (USPSTF) is sponsored by the Agency for Healthcare Research and Quality (AHRQ) and is the leading independent panel of private-sector experts in prevention and primary care. The USPSTF conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. Per **SECNAVINST 6120.3**, Navy Medicine follows USPSTF screening recommendations.

"Navy Medicine Redesigns Primary Care" continued from page 1

Navy and Marine Corps Primary Care Execution

The Navy and Marine Corps Primary Care policy is being finalized and will be forwarded to MTFs when available. BUMED and Regional leadership visited MTF leadership in January, 2010 to describe the necessary steps for successful deployment of this new primary care model. The first MTFs to implement this new model include NNMC Bethesda, NMC Portsmouth, NMC San Diego, and the five Family Medicine Teaching Hospitals. Each MTF will relay the details of this roll-out, once the policy is signed by the Surgeon General. The remainder of Navy Primary Care Providers will implement these new operating principles by June, 2011.

Navy Medicine recognizes each MTF has a unique patient population and distinct resources tied to their primary care operations. These differences between MTFs will in some cases require adjustments to the model, but the desired end state remains the same. Navy Medicine will provide quality, patient-centered, highly accessible primary care delivered in a familiar and continuous manner. Please look for further communications and information to follow over the coming months as Navy Medicine takes this exciting step forward to better serve all our beneficiary populations and our own healthcare personnel!

PRIMARY CARE TEAM & UNCONTROLLED ASTHMA: THE SERIES

Chapter 2: Asthma Patients Need Correct Diagnosis and Inhaler

CAPT Henry Wojtczak, MC, *NMC San Diego*

As a provider seeing a patient with uncontrolled asthma, the tendency is to blame the lack of control on "not enough medicine". However, I can assure you there are many more common reasons to consider. Listed below are those reasons, followed by a brief discussion for each.

- Wrong diagnosis
- Poor inhaler technique and/or wrong device for patient

Wrong Diagnosis

Patients may be given a diagnosis of asthma on the basis of a compatible history and a successful trial of therapy. If asthma symptoms do not respond as expected to treatment, an important step before increasing doses or adding medications should be to review and attempt to confirm the diagnosis of asthma. Other conditions share common features with asthma, and other confounding illness, such as allergic rhinitis, can worsen asthma symptoms. Returning to the basics of making a diagnosis is essential, including a thorough history, physical examination, and appropriate diagnostic testing. Ideally, a diagnosis of asthma should be based on objective evidence of reversible airflow obstruction. Because asthma is a variable disease, challenge testing may be required. Normal spirometry results do not exclude the diagnosis. Spirometry, it seems, is not always performed, even when the equipment is available. Moreover, many primary care providers may not have the equipment or sufficient time or experience to perform accurate and reliable spirometry. Measures of inflammation, when they become available, may also become useful.

The differential diagnoses for adults include respiratory and non-respiratory causes. Eliciting a thorough medical history is essential. Patients may not readily admit to smoking, occupational exposures, or exposure to other triggers such as having pets. In addition, co-morbidities, such as gastro-esophageal reflux disease, allergic rhinitis, chronic obstructive pulmonary disease (COPD), infection, and cardiac disorders. The youngest patients, those under 5 or 6 years of age, usually cannot perform the maneuvers necessary for accurate spirometry, and the diagnosis thus rests on history, physical examination, and ancillary testing. In this age group, differential diagnoses also include respiratory (upper and lower) as well as non-respiratory causes. Young children commonly wheeze with colds. A clinical index of asthma risk (Asthma Predictive Index) aids in identifying children with recurrent wheeze >2 years of age who are more likely to develop persistent asthma: For children who have had four or more wheezing episodes, the likelihood of asthma is greater if they have one of three major risk factors (parental history of asthma, personal history of physician diagnosed eczema, or allergic sensitization to >1 aeroallergen)or two of three minor risk factors (allergic sensitization to milk, egg, or peanuts, wheezing apart from colds, and eosinophilia of >4%).

Poor inhaler technique and/or wrong device for patient

Poor inhaler technique is a common problem among patients with asthma, and asthma control worsens as the number of mistakes in technique increases. Asthma guidelines stress the importance of patient training in inhaler use. Moreover, trainers should be competent, and inhaler technique should be rechecked at every routine asthma encounter with patients demonstrating their inhalation technique. When inhaler devices are used correctly, there is no clinical difference between devices. However, each inhaler type requires a different pattern of inhalation for optimal drug delivery to the lungs. Each patient must be able to use their device correctly to obtain optimal benefit. If possible, device types should not be mixed for any individual patient.

Currently available inhalers include (1) pressurized metered-dose inhalers (MDIs), (2) breath-actuated MDIs (BAIs), and (3) dry powder inhalers (DPIs). Lung deposition of drug varies according to fine particle dose (particles <5 mm) and characteristics of the particle size range. The use of a valved holding chamber (spacer) with an MDI, approximately doubles lung deposition, and significantly reduces systemic absorption.

MDIs are often used incorrectly; therefore, it is important that patients be trained to use them correctly. MDIs require a slow and deep inhalation over 5 s with coordination between dose release and the start of the inhalation. However, only 8% of patients inhale slowly and deeply with good coordination during routine use with their MDI. Therefore, MDIs should be used with spacers, in all patients with asthma. The most common mistake patients make with these devices is to inhale too fast. Other common problems include poor coordination of actuation and inhalation and inhaling through the nose (solved through training). However, despite training, patients will revert back to their bad habits.

DPIs require a rapid acceleration rate during the initial part of the inhalation maneuver to transform the metered dose into a quality dose that has the greatest potential for lung deposition. Failure to inhale deeply and forcibly at the start of the inhalation maneuver means that the drug particles generated are too big to enter the lungs and are simply deposited in the mouth and oropharynx where they have no clinical efficacy. Moreover, if the patient does not inhale fast enough or long enough, not all the dose is emitted. Young children have trouble achieving the minimum rate of inspiratory flow and thus DPIs should be prescribed to children <5 years old only after assuring technique. Sensitive to moisture, DPIs should be stored in a dry place, and patients should take care not to blow into the inhaler, as this will affect dose delivery.

When choosing an inhaler device, it is important to consider each patient's preferences and views, as well as to simplify the regimen and not mix inhaler types. Patients should be trained to use their inhaler devices properly, and their technique should be rechecked on each revisit. Observation of technique by a health professional or by patients themselves, perhaps on video in some settings, can be useful to detect problems.

Asthma Hot Topics!

DoD/VA Asthma CPG Has Arrived!

The updated DoD/VA Asthma Clinical Practice Guidelines have been released and posted on the BUMED Asthma Action Team SharePoint site at https://esportal.med.navy.mil/SiteDirectory/PHAMO/AAT/AAPP/default.aspx.

- Find the updated CPG under the "Documents" section
- SharePoint has additional Asthma resources
  - ✓ Links and presentations of all Asthma Disease Management Webcasts;
  - ✓ Instructions for uploading Asthma AIM form into AHLTA templates;
  - ✓ Information on upcoming Asthma Educator and Spirometry Courses (spring/summer 2010).
- Problems accessing CPG on SharePoint? Updated DoD/VA Asthma CPG is also available at http://www.healthquality.va.gov/Management_of_Asthma_Adult_and_Pediatric.asp.

Asthma Webcast Now Has CME Credit!

There is now one hour of CME credit is available for AAT Webcast participants.

- ✓ Evaluations are required prior to granting CME certifications, which will be attached to the AAT Webcast advertisement circulated the week before the Webcast.
- ✓ You will complete the appropriate evaluation form and return it to Ms. Ellyn Seestedt via email (ellyn.seestedt@med.navy.mil) or fax (703-738-1627). Upon receipt, you will receive your CME certificate promptly via email.

Coming Soon….CE Credit for AAT Webcast!

AAT Webcast Training

Role of Respiratory Therapists

The BUMED Asthma Action Team (AAT) disease management training lecture series alternate with the Diabetes Action Team Webcasts currently being offered on the 1st Tuesday of the month. The BUMED AAT announces the next in its series of webcasts to be presented on **April 6th: "Role of Respiratory Therapists"** by HM1 Charles Ragland, NMC San Diego. We are pleased to announce you can now earn CME credits by participating in the asthma Webcasts! (CE credit should be forthcoming.)

Sessions will be offered several times throughout the day to allow maximal participation (see phone bridges below). The Webcast will be available at https://connect.dco.dod.mil/aatwebcast. Mark your calendars now for these exciting training opportunities!

Future Webcast Training Schedule:

- June 1st, 2010: **Asthma and Active Duty Population**
  Presented by: CDR Nations, MC, NNMC Bethesda

Webcast Phone Bridges for AAT

PT	ET	Eur	Asia	Phone Bridge (210) 249-4234/ DSN (312) 421-3272
6am	9am	3pm	(10pm)	**(Passcode: 26307#)**
9am	1pm	6pm	(1am)	**(Passcode: 58665#)**
12pm	3pm	(9pm)	(4am)	**(Passcode: 97289#)**
3pm	6pm	(12mid)	~7am	**(Passcode: 40583#)**

DAT Webcast Training

ADA Dietary Guidelines

The Diabetes Action Team (DAT) announces the next in its series of webcasts to be presented on **May 4th, 2010: "New ADA Dietary Guidelines"**. Sessions will be offered several times throughout the day to allow maximal participation (see phone bridges above), archived for future access, and will provide CME/CEU credit. The Webcast will be at https://connect.dco.dod.mil/datwebcast. Mark your calendars now for these exciting training opportunities!

Webcast Phone Bridges for DAT

PT	ET	Eur	Asia	Phone Bridge (210) 249-4234/ DSN (312) 421-3272
6am	9am	3pm	(10pm)	**(Passcode: 85964#)**
9am	1pm	6pm	(1am)	**(Passcode: 37847#)**
12pm	3pm	(9pm)	(4am)	**(Passcode: 32558 #))**
3pm	6pm	(12mid)	~7am	**(Passcode: 55252#)**

DISEASE MANAGEMENT - TOBACCO CESSATION

LEVERAGING IT SUPPORT FOR TOBACCO CESSATION: LET'S GO DIGITAL!

CAPT Joseph McQuade, MC, *NH Jacksonville*

Effective use of health information technology has been cited as "number two" of the top ten medical advances of the first decade of the 21st century. The Internet and information technology has arrived with AHLTA. A number of tools I harness here at NH Jacksonville help make life easier for providers to do better for their patients trying to quit tobacco use. Most all these tools are available at your MTFs as well.

AHLTA

First off, let's use the technology AHLTA has to offer. I created a consult in AHLTA for tobacco cessation, which is unique for every branch clinic. This allows them to closely track the numbers of patients sent from each site and enable local nursing support to download the consults and provide follow-up for these patients. The electronic consult provides a patient registry, which gives a denominator to measure the quit rates. It also includes a metric to show the effectiveness or lack of effectiveness of providers sending me patients for quit therapy. I call the consult **SMOKE Tobacco Cessation** to make it easy for the providers to remember.

CHCS

I use CHCS 1 for the raw data that I want to count every month. In CHCS 1, the ^ rvo key enables me to count any order a provider has written. I count numbers of consults for SMOKE Tobacco Cessation. I, then, compare the number of consults divided by patient encounters for the residents and staff, which provides a benchmark for providers.

I use a facet of our command intranet clinical portal called "**Print Patient Letters**" to communicate with all patients, who are trying to quit. At initiation of the consult, as well as at 1, 3, 6, 9, and 12 months, we send compute-generated, pre-written letters to the potential quitters encouraging them and reminding them to follow up with us should they relapse. Every Fall, we send the High Risk Flu letter to the homes of those who have relapsed. We encourage them to follow up for their Flu vaccine and offer the opportunity for follow-up, if they want to try to quit again.

Email

I send "At-a-glance" emails to our medical staff, monthly. This keeps them appraised of the latest tobacco cessation data showing number of consults submitted, where the consults were written, and the quit rates, as they are available. The monthly email serves as a clinical reminder. It offers provider education about our program and spurs inter-clinic rivalries regarding who can send the most patients into therapy.

CDM

The Clinical Data Mart (CDM) is the latest tool we have used to help track our data. We generate automated quit rates on a monthly basis by mining the data from the "Vital Signs" section of the AHLTA Notes, for patients referred into the SMOKE Tobacco Cessation consult. With this data we stand on solid ground measuring the cost effectiveness of our tobacco cessation program.

Audiocare

Audiocare is a method many MTF's use to remind patients of upcoming clinic appointments. We tie it to the pharmacy orders for any medication from the SMOKE order set or Varenicline. Therefore, when patients pick up the medications, a telephone message to their home is made with my voice giving them a 2 minute pep talk, which congratulates them on their attempt at tobacco cessation. I am regularly stopped in the Commissary by patients apologizing for missing my phone call. Audiocare can also be crafted to send monthly updates to patients on the registry, or as we plan, to deliver a New Year's greeting and welcome back to the relapsed tobacco users.

Patient Registry

At NH Jacksonville we have created a secure link to a tobacco cessation patient registry, which can be searched to identify patients who succeeded or relapsed on a provider by provider basis or as a clinic. The data is shown graphically including total number of consults made; which drugs have been used; and the percentage of patients from the registry who have abstained. This enables solid feedback to providers showing the quit rates of referred patients and enabling disease management staff to deploy resources based on the data.

Tobacco use is a chronic, relapsing medical condition which requires a process at every command to address and measure efforts at cessation. The IT services we use help to keep our staff interested in the program and help to create the illusion we have our arm out and around the shoulder of the tobacco user guiding them to success at quitting. Email me to help you get started going digital for your tobacco users!

How Do I Receive the Clinical Operations Newsletter? To receive the quarterly Clinical Operations Newsletter, please email Sarah.Clarke@med.navy.mil to be included on the distribution list. Thank you!

PERINATAL CARE

NHCP OBGYN EXCELS IN BOARD CERTIFICATION!

LCDR Kelly Elmore, MC, *NH Camp Pendleton*

The Department of OBGYN at Naval Hospital Camp Pendleton (NHCP) is proud to announce a 100% pass rate. Four OBGYNs successfully sat and passed the oral boards! LCDR Kenny Choi, LCDR Shannon Hart, LCDR Kelly Elmore, and LCDR Janel Takahashi are all graduates of prestigious medical schools and the highly acclaimed military residency programs at Naval Medical Center San Diego and Naval Medical Center Portsmouth.

How Did They Succeed?

- The residency programs at the NMCs, as well as the well-rounded experience of caring for patients at NHCP, fully prepared each physician for these examinations.
- The providers and ancillary staff in the NHCP Department of OBGYN fully supported each physician over the past year, as they prepared for these oral boards. The physician's colleagues took extra call, reviewed case lists, and performed mock orals for each other. The ancillary staff helped gather information and verbally supported the physicians.
- During December and January, each person flew to Dallas, Texas, where the boards are held, to defend their case list for 3 hours. This defense occurred in front of a panel of eight board-certified OBGYNs from across the U.S.

These four officers represented not only themselves, but their fellow military colleagues, as they each wore their uniforms proudly. Each physician would like to thank everyone in their circle for their support and encouragement this past year.

The Joint Commission

TJC: IMPORTANT SENTINEL ALERT AFFECTING THE PERINATAL COMMUNITY!

The Joint Commission (TJC) publishes **Sentinel Event Alerts**, which identifies specific sentinel events, describes their common underlying causes, and suggests steps to prevent occurrences in the future. TJC released a Sentinel Event Alert January 26, 2010, Issue 44: *Preventing Maternal Death*.

Preventing Maternal Death addresses the tragic loss of mothers. Unfortunately, current trends and evidence suggest that maternal mortality rates may be increasing in the U.S., despite the rarity of the incidence of maternal death – deaths that occur within 42 days of birth or termination of pregnancy. The Alert includes an overview of the leading causes and prevention of maternal death; Existing Joint Commission requirements; Joint Commission suggested actions; as well as references and additional resources.

Please review the full *Sentinel Event Alert* at http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_44.htm

HELP! The Perinatal Advisory Board (PAB) has been tasked with development of Perinatal Teams for Humanitarian Assistance Unit Type Codes. They have worked closely with Dr. Yoshihashi at NOMI (Medical Lessons Learned) creating a survey to reach out to the perinatal communities. PAB needs additional input from our PNP, FNP, and any other Nurse Corps colleagues that have participated in these missions specifically focused on Perinatal Care. Please complete using this link: https://www.surveymonkey.com/s.aspx?sm=QWam9_2fKaOXh6bvIYm2e4UQ_3d_3d

"DID YA KNOW?"

SELF HELP DVD AVAILABLE!

The PRxEVENTION FIRxST self help DVD leads each individual through the self-assessment and health behavior planning processes, using evidence based approaches to make health behavior changes. Through tailoring, which is any combination of strategies and information intended to reach **one specific person**, based on characteristics that are unique to that person, related to the **outcome of interest, and derived from an individual self-assessment**, the appropriate actions are chosen.

PURPOSE:

- To keep low cost beneficiaries low cost
- Reduce or prevent cardiometabolic associated risks and conditions such as inactivity, obesity, diabetes, hyperlidemia, and hypertension

PROVIDES:

- Easy access to **tailored** exercise, nutrition, and behavioral interventions to all at-risk adults
- An evidence based tool that facilitates a standardized approach with high dissemination capability
- A greater continuity of preventive care

The self help CD should be given to individuals who express an interest during medical visits, health fairs, Periodic Health Assessments, Fitness Enhancement Programs, ShipShape Programs, and registered Dietician visits.

Questions? Contact the Health Promotion & Wellness Division, Navy Marine Corps Public Health Center at: nutrition@nehc.mar.med.navy.mil

ANCILLARY SERVICES: PHARMACY

ASTHMA CONTROL TEST (ACT) AT NH CAMP PENDLETON PHARMACY

Can asthma control be assessed at pharmacy point of care?

Nahed Bahlawan, PharmD, *NH Camp Pendleton*

Asthma affects more than 20 million individuals in the United States, more than 7.5% of the world's population and nearly 3600 Americans die from it each year. The most recent NHLBI asthma guidelines have introduced impairment and risk assessments into the management of asthma. Impairment assessment is based on symptom frequency and pulmonary function and is the focus of Asthma Control Test (ACT), which will be discussed in this article, whereas risk assessment is based on exacerbation frequency and severity. Recent study results suggest that asthma patients continue to be undertreated. The treatment guidelines, alone, are not enough for optimum asthma control; which points to the need for a simple tool to assess asthma control with or without the use of lung function test. The Asthma Control Test (ACT) is a tool that has been found reliable, responsive, efficacious, and valid in identifying patients with uncontrolled asthma in outpatient settings.

The adult ACT is a simple and brief self-assessment, a five-item questionnaire; whereas the ACT for children ages 4-11 years is a seven-item questionnaire, which includes four questions for the child to complete and three questions for parents or caregivers. The total score range from 0 to 27. Higher scores indicate better control and a score of 19 or less indicates that asthma may be uncontrolled. The ACT questionnaire assesses asthma control by assessing asthma symptoms, use of rescue medications, and the impact of asthma on everyday functions.

The BUMED Asthma Action Team (AAT) developed a small pilot study at Naval Hospital Camp Pendleton Pharmacy Department earlier this year. The objective of the study was to assess the benefit of using the ACT test in our asthma population presenting at the pharmacy. The ACT questionnaire was given randomly to patients picking up inhalers used for asthma at the pharmacy window. The ACT questionnaires also included the patient name, date, primary care provider's name, and contact phone numbers. Pharmacy staffs to include technicians, pharmacists and pharmacy interns were involved in the process of explaining to patients and caregivers on how to complete the form and answered any questions patients might have.

During a 12-week time period, a total of 53 patients returned the completed questionnaires to the pharmacy and data was collected into an excel spreadsheet. Out of a total of 53 patients, 62.3% had a score ≤19 who were contacted by pharmacy interns for follow-up by the end of the pilot study. A total of 19 (57.6%) out of 33 patients were reached, 15 (78.9%) made appointments with their healthcare provider, and 11 (73.3%) had an intervention and medication adjustment due to the low score on their ACT questionnaire.

The pilot study at NHCP with all its limitations has shown some benefit and promising results in targeting patients with uncontrolled asthma in a busy setting. The BUMED Asthma Action Team is currently in the process of recruiting and selecting three Navy MTF pharmacy sites in order to initiate an expanded pharmacy based ACT study that could potentially benefit asthma control in the military healthcare system.

PORT-AU-PRINCE, Haiti (Jan. 20, 2010) The Military Sealift Command hospital ship USNS Comfort (T-AH 20) anchored off the coast of Haiti, while helicopters bring on medical evacuated patients. Comfort is conducting humanitarian and disaster relief operations as part of Operation Unified Response after a 7.0 magnitude earthquake caused severe damage in Haiti on Jan. 12, 2010.