

# CLINICAL OPERATIONS

## AT THE DECKPLATE



VOLUME 3, ISSUE 2

SPRING 2010

### NAVY MEDICINE RESPONDS TO HAITI WITH DISASTER RELIEF



Within hours of the 7.0 magnitude earthquake that struck Haiti on 12 January 2010, Navy Medicine took action to provide Humanitarian Assistance/Disaster Relief (HA/DR), as part of the international mission, Operation Unified Response. Three days after the earthquake, Navy Hospital Ship USNS COMFORT was underway with 550 personnel onboard. Not far behind was the Casualty Receiving and Treatment Ship (CRTS) surgical team on the USS BATAAN. An additional 350 augmentees to the Comfort arrived on January 20.

The Comfort began receiving patients in transit via airlift prior to anchoring off the coast of Port-au-Prince January 20. Once anchored, the Comfort immediately began receiving injured patients from the local hospitals and international medical facilities. The relief effort engaged nearly 1,288 medical personnel from the U.S. military, who were embarked and treating earthquake survivors.

Medical personnel on the Comfort treated 871 patients, and performed over 843 surgeries. According to the ship's Director of Surgery, CDR Tim Donahue, the Comfort received patients every six to nine minutes during its first four days and had more than 540 critically-injured patients on board within the first 10 days.

This was the first deployment where the ship reached full operational capacity, using all operating rooms and beds since it was delivered to the Navy in 1987. Navy Medicine deployed approximately 1,500 medical and non-medical personnel both afloat and ashore units, with continuing support from TRICARE, Army and Air Force Medicine, and Navy reservists.

The Military wasn't the only entity to quickly respond. More than 244 nongovernmental organizations (NGO's), including Johns Hopkins, Project HOPE, Operation Smile, and the American Red Cross, provided an average of 109 medical personnel onboard the Comfort from 27 January - 13 February.

In addition to the Navy medical personnel who operate the hospital, the Comfort is crewed by over 70 federally employed civilian mariners who operate and navigate while military and civilian medical personnel operate the shipboard hospital. Their responsibilities included delivery of cargo, ranging from blood supplies and medications to jet fuel, and transportation of over 450 patients to the ship and back to shore following their treatment.

After 58 days of deployment, the Comfort safely returned to Baltimore on March 19th. "I am incredible proud of the professionals who came together on short notice to make the deployment happen...Medicine is a common language that all people understand, it is a way to bridge differences." VADM Adam Robinson Jr. He continued, "I am equally proud of our team that remained at home and ensured this large response from Navy Medicine did not affect our ability to continue to provide quality care to our beneficiaries at our hospitals and clinics nationwide."

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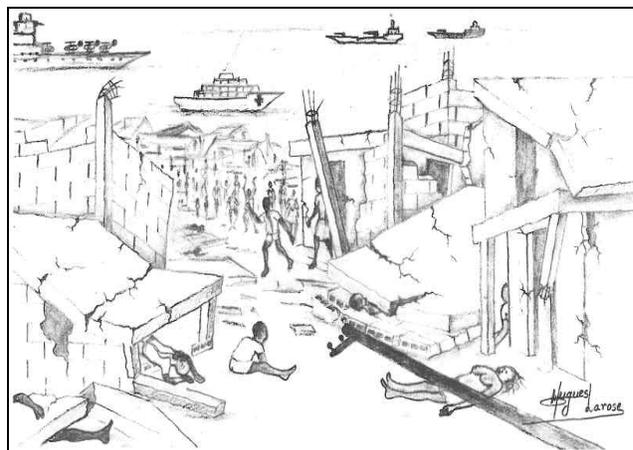


Fig 1 Patient Drawing of Haiti Given to Medical Provider Aboard USNS Comfort



**49<sup>TH</sup> NAVY AND MARINE CORPS  
PUBLIC HEALTH CONFERENCE!**  
*Access for Key Presentations*

**MEDICAL MANAGEMENT TRAINING**

NMCPHC Annual Public Health Conference shared great information for deckplate staff. NMCPHC is working to upload the dozens of presentations provided at this conference to their Website. Until they do, please utilize the SharePoint sites below to access Medical Management Curriculum.

**Evidence-Based Health Care: From Prevention to Chronic Care**

- ❖ **Topics include (not limited to):**
  - ✓ Admiral's Welcome: Medical Management: Attaining Population Health
  - ✓ NCQA Key Note Address: Measurement + Transparency + Accountability = Healthy America
  - ✓ Patient-Centered Medical Home Model in Military MTF's
- ❖ **SharePoint Access:** EBHAB SharePoint Site  
<https://esportal.med.navy.mil/SiteDirectory/PHAMO/ebhab>

**Asthma Breakout**

- ❖ **Topics include (not limited to):**
  - ✓ Rolling out the DoD/Asthma Clinical Practice Guideline
  - ✓ Asthma PBB Metrics
  - ✓ Healthcare Outcomes Research
- ❖ **SharePoint Access:** AAT SharePoint Site  
<https://esportal.med.navy.mil/SiteDirectory/PHAMO/aat>

**Diabetes Breakout**

- ❖ **Topics include (not limited to):**
  - ✓ Air Force Best Practices in Diabetes Care
  - ✓ Navy Best Practices in Diabetes Care
  - ✓ Obesity Preventable Risk
- ❖ **SharePoint Access:** DAT SharePoint Site  
<https://esportal.med.navy.mil/SiteDirectory/PHAMO/dat>

**Tobacco Cessation Breakout**

- ❖ **Topics include (not limited to):**
  - ✓ Going Tobacco-Free
  - ✓ Tobacco Cessation and Fleet Community
  - ✓ Tobacco Cessation and Pharmacotherapy
- ❖ **SharePoint Access:** TCAT SharePoint Site  
<https://esportal.med.navy.mil/SiteDirectory/PHAMO/tobaccocessation>

**IMPORTANT EVENTS**

- **PERINATAL ADVISORY BOARD**  
APRIL 21<sup>ST</sup>-23<sup>RD</sup> @ SAN DIEGO, CA
- **PRIMARY CARE ADVISORY BOARD**  
APRIL 28<sup>TH</sup>-30<sup>TH</sup> @ BREMERTON, WA
- **MUSCULOSKELETAL CONTINUUM OF CARE ADVISORY BOARD**  
APRIL 29<sup>TH</sup>-30<sup>TH</sup> @ SAN DIEGO, CA
- **EVIDENCE-BASED HEALTHCARE ADVISORY BOARD**  
MAY 24<sup>TH</sup>-25<sup>TH</sup> @ JACKSONVILLE, FL
- **ORAL HEALTH ADVISORY BOARD**  
JUNE 9<sup>TH</sup> @ BETHESDA, MD
- **BEHAVIORAL HEALTH ADVISORY BOARD**  
JUNE 14<sup>TH</sup>-15<sup>TH</sup> @ QUANTICO, VA
- **TRAUMA CARE ADVISORY BOARD**  
JUNE 15<sup>TH</sup>-16<sup>TH</sup> @ PENSACOLA, FL
- **DIABETES ACTION TEAM**  
JULY 21<sup>ND</sup>-22<sup>ND</sup> @ BREMERTON, WA
- **ASTHMA ACTION TEAM**  
SUMMER, 2010 NHC HAWAII
- **TOBACCO CESSATION ACTION TEAM**  
SUMMER, 2010 NHC HAWAII

**“DID YA KNOW?”**

**Perinatal Education Opportunity!**

**S.T.A.B.L.E. INSTRUCTOR COURSE:**

WHEN	WHERE
7-8 June 2010	NMC San Diego
23-23 June 2010	NNMC Bethesda
POCs	WHO?
<b>ALSO: Instructor</b>	CDR Jeff Quinlan
<b>S.T.A.B.L.E.: Instructor</b>	CDR Con Yee Ling
	LCDR Cindy Schultz
<b>NM MPT&amp;E</b>	LCDR Rhonda Hinds 301.295.5591 <a href="mailto:rhonda.hinds@med.navy.mil">rhonda.hinds@med.navy.mil</a>

- **Want education on Patient Safety & Risk Management?**
  - Free CEUs recorded and available at [www.npic.org](http://www.npic.org)

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# BUMED'S CORNER

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## TRANSPARENCY IN MILITARY HEALTH SYSTEM (MHS) CAPT Linda Grant, NC, BUMED

In August 2006, Executive Order (EO) 13410 was signed by the President. The purpose of the order was to “ensure that health care programs administered or sponsored by the Federal Government promote quality and efficient delivery of health care through the use of health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers.” The intent is also to “make relevant information available to these beneficiaries, enrollees, and providers in a readily useable manner and in collaboration with similar initiatives in the private sector and non-Federal public sector.”

Transparency is an initiative providing patients the ability to compare the quality of healthcare services, so they can make informed choices among doctors and hospitals. When patients have information about quality, they take an active role in their health care and can make better decisions.

For MHS direct (military) and purchased care facilities, quality information has been available to the public on *The Joint Commission Quality Check* site at [www.jointcommission.org](http://www.jointcommission.org). The TJC Website details information on accreditation, National Patient Safety Goals, and National Quality Improvement Goals (ORYX) with comparisons to national and state statistics. For purchased care, *Hospital Compare* is a public tool to find information on the quality of hospitals care for patients with certain [medical conditions or surgical procedures](#). It also includes results from a patient survey about the quality of care received during a recent hospital stay. Hospital Compare was created by Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services, and other members of the [Hospital Quality Alliance](#). Hospitals agree to submit quality information to *Hospital Compare*, knowing that it will be posted for the public on the Website: [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov).

TRICARE Management Activity (TMA) has been actively pursuing increased transparency of MHS quality information over the past two years. The designated transparency Website for the public, [www.mhs-cqm.info](http://www.mhs-cqm.info), currently has ORYX data available by facility. HEDIS measures will be available in the next few weeks. Patients will be able to compare multiple organizations data. TMA is also in discussion with the CMS to include the military treatment facilities data on the *Hospital Compare* Website.

All information made available to the public is released by DoD *only* and is in accordance with 10 USC 1102 and HIPAA requirements. Per DoD policy, aggregate statistical quality information regarding DoD programs may be released. Aggregate statistical information are numerical data (i.e. numbers, percentages, and ratios; there is a strict set of definitions). This ensures that adequate precautions are taken to protect the identity and privacy of individuals. Individual MTFs are *not authorized* to release quality data to the public. TMA will continue to explore options to improve transparency of our data/information. Navy Medicine leadership fully supports this initiative for our beneficiaries.

## “CASE IN POINT” PLATINUM AWARD Rose M. Gingery, BUMED

Navy Case Management won the first annual *Case In Point* Platinum Award for overall Military Case Management Program. *Case In Point* is the official magazine of the Case Management Society of America.

The *Case In Point* Platinum Awards were created to recognize the most successful and innovative case management programs working to improve health care across the care continuum. This award sought to honor those programs that best educate and empower patients, improve adherence and wellness, manage quality care, and contain health care costs. The award program was open to any case management program in the United States that fit within the specified 25 categories including Behavior Health Case Management, Disability Case Management, Disease Management/ Population Health, Long Term Care, Military Case Management, Pediatric Case Management, Social Work, Utilization Management, Workers Compensation Case Management, among others. All three services as well as a VA Hospital applied for the Military Case Management category.

The application included a brief description of our Navy Case Management (CM) Program and a synopsis of the reasons why our program deserved to win in the category of our choice. Our synopsis included our program description and achievements over the past year. Select achievements include:

- ❖ Ensure 100% of Navy and Marine Corps service members evacuated from theater for medical reasons evaluated for case management; this includes over 2,000 service members since Jan 08.
- ❖ Streamline and augment many processes to support all Wounded Ill and Injured Service members; starting from point of injury on battlefield, until they return to full duty or medically retire.
- ❖ Navy CM works addresses issues including body image and loss, impact on family relations; extensive rehabilitation, and financial problems to coordinate resources and communicate the treatment plan.

Awardees were honored at a luncheon on 20 April 2010 at the National Press Club in Washington, DC. Four members from BUMED's Case Management Department and five Case Managers from National Naval Medical Center in Bethesda were in attendance at the luncheon. CDR Moise Willis accepted the award on behalf of Navy Case Management.

# TRISERVICE

OCMO

Office of the Chief Medical Officer



## TMA MEDICAL MANAGEMENT COURSE COMING TO AN MTF NEAR YOU!

- ❖ **LOCATION:** Naval Hospital Pensacola
- ❖ **DATES:** 2-5 November 2010
- ❖ **SPONSOR:** TMA Population Health and Medical Management Division offers 4-day onsite classroom-based training
- ❖ **PURPOSE:** Provide military treatment facility healthcare personnel a comprehensive, educational program, which demonstrates the link between business planning and clinical decision-making under a Medical Management program.
- ❖ **AUDIENCE:** Nurses, providers, administrators, case managers, disease managers and utilization managers, etc. involved in Medical Management
- ❖ **DETAILS:** Staff from the Office of the Chief Medical Officer, along with contract personnel, provide information related to medical management concepts, tools, and processes. Personnel from the TRICARE Regional Offices and the Managed Care Support Contractors provide region-specific presentations.

**Registration** and additional information can be found at:  
[http://www.neweditions.net/phmmd/mm\\_locations.asp](http://www.neweditions.net/phmmd/mm_locations.asp).

## Free Online CME!

**NEW** Online Educational Activity with **FREE** Continuing Education Credit (CMEs/CNEs)

- **"Increasing Tobacco Cessation Among MHS Beneficiaries"**. This activity includes findings from the 2008 DoD Survey of Health Related Behaviors Among Active Duty Military Personnel, highlights key cessation strategies, the VA/DoD CPG for the Management of Tobacco Use and presents a number of websites that offer tools and resources to support tobacco cessation efforts.

8 online activities are available on the **MHS-CQM** website. All provide free CME/CNE continuing education credits through the Uniformed Services University of the Health Sciences.

## TMA NEWS

### Pneumonia and Influenza Added to ALL Core Measure Populations

In February 2010, the Clinical Measures Steering Panel (CMSP) added the pneumonia and influenza immunization measures (previously associated with only the Pneumonia Core Measure set) to ALL Core Measures. This change will include: AMI, HF, HBIPS, SCIP, STK and VTE. The decision to emphasize these measures is based on evidence that the administration of these vaccinations can save lives and avoid costly hospitalizations.

A CDC study of data on pneumonia among the Medicare population concluded that hospitalization was a vaccination "opportunity" not to be missed. "... because two-thirds or more of patients with serious pneumococcal disease have been hospitalized at least once within 5 years before their pneumococcal illness, the offering of pneumococcal vaccine in hospitals at the time of patient discharge, should contribute substantially to preventing the disease." Accordingly, the Infectious Disease Society of America (IDSA) panel endorses current CDC guidelines for pneumococcal vaccine. Unvaccinated patients with risk factors for pneumococcal disease and influenza should consequently be vaccinated during hospitalization whenever possible. Source: [www.ama-assn.org/amednews/2009/01/26/hlsc0127.htm](http://www.ama-assn.org/amednews/2009/01/26/hlsc0127.htm)

Note: Deaths associated with pneumonia and influenza combined are the sixth leading cause of mortality in the U.S. for adults over 65. Although pneumonia and influenza are largely preventable by vaccination, only 67 percent of Medicare beneficiaries receive an annual influenza vaccination. Source: <http://www.cms.hhs.gov/adultimmunizations/>

## "DID YA KNOW?"

### SHARING EACH OTHER'S SUCCESS

Have you been part of a team that has made a significant improvement in your quality metrics? Are you proud of the changes your clinic or hospital has made in improving patient care? Do you have a success story to share? Please let us know and we'll share your story with other MHS healthcare professionals. Contact Karla Herres at [karla.herres@lmco.com](mailto:karla.herres@lmco.com)

### SAVE THE DATE: MHS Clinical Quality Summit!

The second annual MHS Clinical Quality Summit is scheduled for August 24-26 at the National Conference Center outside Washington, DC. More information to come.

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# DISEASE MANAGEMENT – ASTHMA AND DIABETES

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## **PRIMARY CARE TEAM & UNCONTROLLED ASTHMA: THE SERIES**

### **Chapter 3: Why Is My Patient's Asthma Uncontrolled?**

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.

- Active and/or passive exposure to tobacco smoke
- Undiagnosed or under treated co morbidity ( Rhinitis)
- Non adherence to asthma treatment plan

#### **Exposure to Tobacco Smoke**

There is clear evidence now that concurrent smoking, and or exposure to environmental tobacco smoke adversely impacts asthma control. The prevalence of current smoking among patients with asthma varies from 15% to 25%. In a retrospective cohort study of a large general practice database, current smokers were almost 3 times more likely than non-smokers to be hospitalized for their asthma over a 12-month period. Suboptimally controlled asthma in smokers may be the result of concomitant COPD or asthma misdiagnosed as COPD. An alternative explanation is that ICS therapy fails more often in smokers. Studies of smokers with asthma indicate that these patients respond differently to corticosteroids than do non-smokers. These findings highlight the importance of identifying current smoking habits of patients with asthma, as well as, ETS exposure of children with asthma, particularly those whose symptoms are poorly controlled. While an oral history may not elicit this fact, patients and parents may admit to smoking when asked via a written self-completed questionnaire, as they may feel less threatened. The ideal therapy for patients with asthma who smoke and the smoking caregivers of children with asthma is smoking cessation.

Asthma and rhinitis, both allergic and non-allergic, are linked in many ways: they share a similar epidemiology (most patients with asthma have rhinitis), and they have common triggers. The pattern of inflammation is similar, involving T helper type 2 cells, mast cells, and eosinophils. Moreover, nasal challenge results in asthmatic inflammation and vice versa. Finally, the presence of rhinitis predicts the development of asthma. Asthma patients with rhinitis use more health-care resources than those without rhinitis, indicating that their asthma is less well-controlled.

#### **Undiagnosed or under treated co morbidity**

In a retrospective cohort study of 27,000 adult patients with asthma included in a large general practice database, patients with concomitant rhinitis were 50% more likely to be hospitalized for their asthma, and significantly more likely to visit their primary care provider, over a 12-month period than those without

rhinitis. The presence of concomitant rhinitis was associated with significantly higher drug use and costs among these patients with asthma. For children in a similar study, the presence of concomitant asthma and rhinitis more than doubled the likelihood of being hospitalized and significantly increased the likelihood of a physician visit for asthma. All levels of rhinitis can impact on asthma control: the percentage of adult patients with poor asthma control is greater even among those with mild rhinitis, as compared with patients with asthma alone.

The question thus arises whether treatment for rhinitis will improve asthma control. While this question requires further study, preliminary data would suggest that it does. While a good history and examination of the nose will aid in the diagnosis of rhinitis, the patient's answer to a single, practical question, adapted from that used by the International Study of Asthma and Allergies in Childhood (ISAAC), may be all that is needed to diagnose rhinitis. "Do you have an itchy, sneezy, runny, or blocked nose when you don't have a cold?" The inflammation of both upper and lower airways should be treated to obtain optimal asthma control.

#### **Non adherence to asthma treatment plan**

Prescribed treatments are effective only if taken. Patient non adherence to treatment is an important problem across chronic illnesses, with as much as 30-50% of prescribed medications not taken as directed. This level of non adherence represents a loss to health-care systems, because of wasted resources and costs of inadequate treatment, and to patients, because of the missed opportunity for improving health. In asthma, non adherence to controller therapy, especially ICS, is common and is a factor in poor asthma control. However, non adherence is often a hidden problem because it is not commonly assessed at routine asthma visits. Patients may be reluctant to admit non adherence to avoid disappointing their provider, and providers may be reluctant to query about adherence because they lack a clear and easy method to improve it. Formal interventions to improve adherence have not been successful, perhaps because of lack of complete understanding about the causes of non adherence.

Causes of non adherence can be broken down into two categories: unintentional and intentional non adherence. Unintentional non adherence results from practical barriers to treatment, such as language barriers, forgetfulness, and inadequate understanding of the instructions. Poor inhaler technique falls under this category. Intentional non adherence results from patient choice to take less medication than prescribed (or none), or to take it differently than prescribed. The term concordance describes the degree to which the patient and health-care provider agree about the nature of the patient's

illness and chosen treatment path. As such, concordance (1) recognizes that patients and healthcare providers bring to the visit two sets of (potentially opposing) beliefs about the illness and treatment, and (2) incorporates a presumption of adequate communication between patient and health-care provider. When beliefs differ, and the patient and provider fail to reach an understanding during the visit, no concordance is the result, and patient non adherence to treatment is more likely.

Patients often doubt the necessity of taking a daily medication for asthma, when they experience symptoms episodically. People commonly underestimated the seriousness of their symptoms (and overestimated control of their asthma) and patients often have concerns about potential side effects from taking ICS. In a recent study, patients' beliefs about ICS were shown to correlate with their adherence, as measured both by self-report as well as by pharmacy prescribing records

Interventions to facilitate optimal adherence are likely to be more effective if they identify adherence behavior, identify the mix of perceptual and practical barriers for the individual, and tailor the intervention and support according to specific barriers and patient preferences. Non adherence is relevant, of course, only if asthma symptoms are poorly controlled.

### In conclusion...

To summarize the learning points:1) reviewing the diagnosis of asthma is the first step in assessing poor symptom control, 2) identify patients with concomitant rhinitis, a common reason for sub-optimal asthma control, 3) Smoking is another factor that is now a well-established cause of poor asthma control, 4) eliciting patients' views about therapy could help guide discussion to address perceptual barriers to taking maintenance therapy (doubts about personal necessity and concerns about potential adverse effects) and practical barriers such as poor inhaler technique.

Strategies to develop open, communicative, non-judgmental relationships with patients and to let patients take an active part in the planning process should be stressed. In this way the caregiver can adopt a partnership approach to asthma management. There is increasing evidence that patient-focused strategies, including shared decision making and individualized verbal and written information, can improve the patient's experience. One area that remains challenging is poor inhaler technique. The development of videos demonstrating proper technique and care for each inhaler type could be useful in this regard. Ultimately, we hope this information can be incorporated into tools to help clinicians to optimize asthma therapy and to greater enable each patient to have full quality of life with minimal or no impediment from their asthma.

## AAT Webcast Training

### Asthma and the Active Duty Population

The BUMED Asthma Action Team (AAT) disease management training lecture series announces the next in its series of webcasts to be presented **June 8th, 2010: "Asthma and Active Duty Population"** presented by: CDR Nations, MC, NNMC. 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:

- ❖ August 3rd, 2010: **Role of Respiratory Therapists**  
Presented by: HM1 Ragland, NMC San Diego

## DAT Webcast Training

### Best Practices Guidebook

The BUMED Diabetes Action Team (DAT) disease management training lecture series announces the next in its series to be presented on **July 13th, 2010: "DAT Best Practices Guidebook"** presented by **CDR Alan Douglass, MC, NMC San Diego**. 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.

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

#### Future Webcast Training Schedule:

- ❖ September 7th, 2010: **Diabetes & Surgical Weight Loss**  
Presented by: LCDR David You, NHC Great Lakes

## Webcast Phone Bridges for AAT

PT	ET	Eur	Asia	Bridge: (210) 249-4234 /DSN (312) 421-3272
6am	9am	3pm	(10pm)	(Passcode: TBD)
9am	1pm	6pm	(1am)	(Passcode: TBD)
12pm	3pm	(9pm)	(4am)	(Passcode: TBD)
3pm	6pm	(12mid)	~7am	(Passcode: TBD)

## Webcast Phone Bridges for DAT

PT	ET	Eur	Asia	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—ASTHMA & TOBACCO CESSATION

## BEING AN ASTHMA EDUCATOR

CAPT John Manning, NC, NH *Camp Lejeune*

Controlling asthma can be complicated. It includes recognizing and avoiding triggers; taking medications as prescribed; knowing when to change medications depending on symptoms; using medication delivery devices correctly; and knowing when to make an appointment and when to call 911. Patient education is so important that the National Asthma Education and Prevention Program (NAEPP) list education as an essential component of asthma management.

In most primary care clinics, the diagnosis of asthma is made on a daily basis in both adult and pediatric patients. Patients often present with a recurrent cough, during the day and at night; intermittent complaining of feeling short of breath and wheezing; and absences from work or school. The medical history may reveal numerous emergency department visits, clinic appointments, and multiple medications, including bronchodilators and bursts of oral steroids, in addition to an array of allergy medications. When asked about previous diagnoses, the patient often reports frequent bronchitis and if a child, reactive airway disease. Asthma has never been discussed with the patient, but is high on your differential diagnosis list. Today you will explain asthma physiology; spirometry and peak flow monitoring; controller versus rescue medications; medication delivery devices; and “step up” and “step down” therapy. All in the 15 or 20 minute appointment - a daunting task!

Enter the asthma educator. Most patient diagnosed with asthma are cared for and managed by primary care providers, although certain asthmatic patients require referral to specialty care. An asthma educator complements the provider. They are an expert in teaching, educating, and counseling individuals with asthma and their families. They impart the knowledge and skills necessary to minimize the impact of asthma on their quality of life. The educator possesses knowledge of asthma pathophysiology, management, and instructs individuals with asthma on the use of medication delivery devices. The educator also works with an individual with asthma, their family, and other healthcare professionals to develop, implement, monitor, and revise an asthma action plan customized to the individual's need. Key teaching points and essential content areas include: basic asthma facts, trigger avoidance and control strategies, necessary device skills and self-management skills to include asthma action plans and recognizing deteriorating control. The focus of the asthma educator should always be on how to help patients gain and maintain control over their asthma.

Members of the healthcare team providing asthma education must be qualified using one of the following options:

1. Completion of NEHC-approved asthma educators and spirometry course.
2. Completion of National Asthma Educator Certification Board (NAECB) course
3. Individuals who provide asthma education, counseling or coordination of services with a minimum of 1000 hours of experience.

CPT codes can be used to monitor patient and family asthma education. The following CPT codes have been approved for non-physician healthcare professionals:

1. 98960 – face to face with the patient (could include caregiver/ family) each 30 minutes, individual patient.
2. 98961 2-4 patients
3. 98962 5-8 patients.

If assistance with setting up an asthma education program is required, contact CDR John Manning, Pediatric Nurse Practitioner, Camp Lejeune, NC.

## “DID YA KNOW?”

### DoD/VA Asthma Clinical Practice Guideline is Available!

Access the new Asthma CPG

<https://www.qmo.amedd.army.mil/asthma/Asthfr.htm>

Visit AMEDD QMO Website for other DoD/VA CPGs at:

<https://www.qmo.amedd.army.mil/pguide.htm>



**U.S. ARMY MEDICAL DEPARTMENT**  
**Office Of Quality Management**

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

# DISEASE MANAGEMENT – TOBACCO CESSATION

## UTILIZING TOBACCO CESSATION RESOURCES IN YOUR COMMUNITY: A Win/Win Situation Colleen Haydon, MSW, MPH, Project UNIFORM

In the battle against tobacco use, military and civilian public health professionals are on the same team. We all want people to stop using tobacco and have access to the most effective and appropriate cessation services available. In the real world, however, we sometimes forget the support and resources we gain from collaborating with each other. This unique collaboration is the focus of Project UNIFORM (Undoing Nicotine Influence From Our Respected Military). Our goal is to build bridges between military and civilian tobacco prevention/cessation resources so that we can assist those within military communities to educate on and stop the use of tobacco. While we have made many inroads into solidifying these collaborations, in the end it is often the medical provider that is critical in assisting service members and their families to quit using tobacco products.

With so many demands put on providers and the belief that tobacco interventions take an enormous amount of time, tobacco cessation may take a back seat to other concerns. But what if providers could give a tobacco intervention in less than 2 minutes and feel confident that it would be successful? What if providers had access to national networks of services? What if providers could offer web-based tools that a patient would want to use? What if all of these things were free and available to anyone, anywhere within the United States and beyond?

The wait for all of these options is over! In collaboration with national resources, and by utilizing a simple 2-minute approach, every provider can give their patients access to tobacco cessation services regardless of what is offered within an installation, MTF, and/or community. First, every provider can use the **AAR** approach. It is as simple as **Asking** all service members and beneficiaries if they or anyone in their household uses tobacco; **Advising** them that it is in the best interest of their overall mental and physical health to quit using tobacco; and **Referring** them to appropriate quit resources. These resources could include hospital-based programs or on-installation resources, but those aren't the only options. Anyone can call **1-800-QUIT-NOW** from any US state or territory and receive tobacco cessation help and resources for FREE. These quit lines offer counselors who are well trained and usually available late into the evening. If telephone help isn't appealing to the patient, anyone can go to the DoD-sponsored website [ucanquit2.org](http://ucanquit2.org) and access live tobacco cessation chat, calculate how much they spend on tobacco products, and/or use tools to help them to quit tobacco.

Most tobacco users want to quit, but they don't know how. By utilizing all of the resources you have on your installation as well as collaborating with civilian tobacco control efforts, you as a provider can offer a variety of tobacco cessation options to

your patients. In the end, military and civilian public health providers are on the same team in the battle against tobacco use. Through collaborative efforts we all benefit. For information on the creating military-civilian partnerships, tobacco cessation resources, and/or Project UNIFORM, please contact Colleen Haydon at [colleen@projectuniform.org](mailto:colleen@projectuniform.org) or 916-339-3424 ext. 26.

## Subs Going Smoke-Free!



The Commander of the Navy Submarine Forces, Vice Admiral Donnelly, issued a message that all smoking will be phased out banned effective 31 December 2010 for the entire submarine community!

This decision was based upon the harmful effects of secondhand smoke exposure to the crew, and the results of a study that showed the negative effects of environmental tobacco smoke.

The Navy Marine Corps Public Health Center and the MTFs have been working with the sub community to train two Tobacco Cessation Facilitators per boat to provide cessation at the deckplate, and to provide ongoing training and treatment at each of the bases. The Submarine community are including Nicotine Replacement Therapy - patches and gum, as part of their pharmacy and AMAL.

## BZ Submarine Community!

### TOBACCO CESSATION FOR FLEET!

The BUMED Tobacco Cessation Action Team has developed a accessible product for the fleet medical community! The Tobacco Cessation Resources for the Operational Forces CD is designed to have ready-to-use handouts, treatment guides, clinical practice guidelines, posters, and training materials to help patients quit using tobacco! There is a Web-based version of the CD at <http://www.nmcpbc.med.navy.mil/bumed/tcat/CD/Index.htm>

To order the CD, which includes the training video's, please send your mailing address to [sst@nehc.mar.med.navy.mil](mailto:sst@nehc.mar.med.navy.mil)

# PERINATAL CARE

## NEW PERINATAL METRICS

The National Perinatal Information Center (NPIC) contracts with BUMED and the Perinatal Advisory Board (PAB) and reports metrics to MTFs.

### ❖ Focusing on Deliveries

- ◆ **Current Metric:** Elective Deliveries < 37 weeks w/o medical indication
- ◆ **Transitional Metric:** Current Inductions and Cesarean deliveries < 37 weeks w/o medical indication (**Tracking Now**)
- ◆ **Future Metric** (Joint Commission): Elective deliveries 37 to 38 6/7 weeks without medical indication

### ❖ Adverse Outcome Index

Last year, BUMED asked to NPIC to add the analysis of Adverse Outcome Index (AOI) for MTFs. The AOI is the number of deliveries with one or more of the identified adverse events as a percentage of total deliveries. Each event has a severity weight associated with it.

ADVERSE EVENT	POINTS
✓ Maternal Death	750
✓ Intrapartum and Neonatal Death	400
✓ Uterine Rupture	100
✓ Maternal Admission to ICU	65
✓ Birth Trauma	60
✓ Return to OR/L&D	40
✓ Admission to NICU	35
✓ Blood Transfusion	20
✓ 3 <sup>rd</sup> and 4 <sup>th</sup> Perineal Lacerations	5

## THE JOINT COMMISSION PERINATAL ORYX METRICS

### ❖ 5 New Proposed Metrics:

1. Elective Delivery 37 to 38 6/7 weeks EGA
  2. Exclusive breastfeeding at discharge
  3. Nosocomial infections for inborns
  4. Appropriate use of antenatal steroids
  5. Cesarean deliveries (primary) rate low risk
- ❖ Data Source: Discharges starting April 2010
- ❖ Data Collection: July 2010
- ✓ TMA funds ORYX data collection
- ❖ Data Report: October 2010

# COMING SOON...

## MEASURING NEWBORN HEARING SCREENING

The BUMED Perinatal Advisory Board is working to perform an initial analysis of newborn hearing screening services to determine DOD/Navy performance baseline. Look for this assessment to be coming soon to an MTF near you!

**PURPOSE:** Collect data on the current practices and procedures for NHS and EHDI at DOD Military Treatment Facilities (MTFs).

It is believed that most large military birthing facilities have Newborn Hearing Screening (NHS) programs with standard operating procedures. DoD has not collected this data; therefore, there is unknown compliance with national standards of care, as outlined by

- ✓ Joint Committee on Infant Hearing  
<http://www.jcih.org/posstatemts.htm>
- ✓ CDC's National Goals for the Early Hearing Detection and Intervention (EHDI) Program  
<http://www.cdc.gov/ncbddd/ehdi/nationalgoals.htm>

## ANEUPLOIDY SCREENING UPDATES

To comply with ACOG's standard on aneuploidy screening, each MTF must offer some type of screen. We are all in compliance by offering the Maternal Quad Screen. The "gold standard" of first trimester screening only picks up an additional 2%; therefore, this is an excellent choice for our purposes.

1. **First trimester:** Nuchal translucency screening NT measurement plus 1<sup>st</sup> trimester analytes PAPP-A, free  $\beta$  hCG)
2. **Second trimester:** Quad screen (hCG, UE3, inhibin A, AFP)
3. **Serum integrated screening**
  - ✓ 1<sup>st</sup> plus 2<sup>nd</sup> trimester analytes
  - ✓ Offers approx. 86% detection of aneuploidy
  - ✓ 5% False Positive

# ANCILLARY SERVICES: DENTAL

## **TOBACCO IS TOBACCO IS TOBACCO**

CAPT Larry Williams, DC, *NHC Great Lakes*



No matter how you cut it, sell it, or package it, tobacco is a harmful substance. The basic adverse health effects of tobacco use involve all body systems. Of particular note is the simple fact that tobacco first impacts the oral cavity. Whether halitosis, stained teeth, periodontal disease, caries, or cancer, tobacco impacts the mouth first before the heart, lungs, and vessels are harmed.

Recent press has generated questions about the “less harmful” forms of tobacco such as snus. Just because a tobacco product is not smoked does not make it less harmful. The chewed and dipped forms of tobacco have been shown to contain the same types of carcinogens and toxins associated with smoked tobacco. Of course the lungs are being spared but the poisons are still circulated throughout the body.

The newer products such as “snus” are indeed tobacco. It is supposed to be a “powdered” product that is made to dissolve in the mouth. There is supposed to be no spitting involved. Snus has been found to have a variety of toxins and carcinogens based on the manufacturing process. Snus available in the United States is so varied that there is very little data which can be generalized for the many forms. A letter sent recently to the FDA from Congress asked that the FDA closely study this product. Of note is the

fact that “dissolvable tobacco products (snus) contain between 60-300 percent of the nicotine found in a single cigarette, and experts estimate that ingesting 10 to 17 Camel Orbs (a newer marketed snus product) could kill an infant. In addition to the potential for immediate serious adverse health consequences or death, these products also have the potential to hook a new generation of teenagers to tobacco by facilitating the ingestion of nicotine with a delivery device that is identical to candy.”

More recently, the issue of the electronic cigarette (e-cig) is making the news. No matter what the adverse health outcomes, there is always a new tobacco product that will fill a gap. The e-cig is banned for import into the United States and is noted as an “unapproved drug delivery device”. The e-cigs tested thus far by the FDA have been shown to contain antifreeze and other harmful products. The chemical being volatilized is a tobacco liquid and has not been proven to be safe or effective.

The bottom line is simple- there is no safe form of tobacco. The best way to quit is to make up your mind to quit, find a program that works for you, and stay tobacco free. The Navy offers numerous opportunities for cessation support. The DoD offers the UCANQUIT2 website to support your efforts to quit. Additionally, each state has a quitline which will be available for support.

## **IMPLEMENTING TOBACCO CESSATION IN THE DENTAL PRACTICE**

CAPT Larry Williams, DC, *NHC Great Lakes*

The use of any form of tobacco in the oral cavity has the potential to cause numerous problems. These problems can range from simple tooth staining to gingival recession, periodontal disease, and cancer. The dental patient who uses tobacco should have this issue addressed as with any other oral health problem. The “Treating Tobacco Use and Dependence: 2008 Update-Clinical Practice Guideline (CPG)” clearly states that healthcare providers (to include dentists) should assess tobacco use, implement cessation support, and prescribe medications for tobacco cessation.

Questions sometimes arise as to the qualifications of dentists for prescribing medications in support of tobacco cessation. The first-line medications listed in the 2008 CPG update are well within the scope of care of any licensed dentist. Just as with any medication prescribed, any healthcare provider must be familiar with the risks, benefits, precautions, and limitations of the medications being prescribed.

Evidenced-based tobacco cessation medications will greatly increase the success of patients wanting to quit their tobacco use. As with any medication being used, oral health providers should be aware of the proper use of these medications. Currently, Medscape offers a free CE online course which fully explains the 2008 CPG and associated medications. The title is “Treating Tobacco Use and Dependence” and it can be found at: <http://cme.medscape.com/viewprogram/17710>

Since tobacco is the leading preventable cause of death in the United States, it is imperative that all levels of healthcare support the cessation effort for our patients. The ADA and the AGD both clearly support the efforts of general and specialty oral health providers in the goal of helping patients become tobacco free. Our patients expect and deserve a very clear message that tobacco use causes harm to the oral cavity. The provision of tobacco cessation should be included in every dental practice in order to truly optimize the oral health of our patients.

# ANCILLARY SERVICES: DENTAL

## PREVENTIVE DENTISTRY UPDATE

CDR Jonathan Stahl, DC, *NMC San Diego*  
CAPT Jeffery Nordin, DC, *NNMC Bethesda*

Dental caries constitutes the most prevalent chronic childhood disease outpacing even asthma by a 5 to 1 ratio. Caries can lead to a diminished quality of life in children and adults (World Health Organization, 2003) and has also recently been linked to many non-dental conditions: 1.) slowed somatic growth in children (Nicolau et al, 2005), 2.) a variety of acute and chronic medical conditions (Loesche, 2007), 3.) and through inflammatory mediators, to the development of cardiovascular disease, the leading cause of adult mortality (Ford et al, 2007; Joshipura et al, 2006).

Dental caries is an infectious, communicable, chronic disease resulting in the destruction of tooth structure by acid-forming bacteria. These bacteria are found in dental plaque and in the presence of sugar, produce organic acids, such as lactic acid. These acids can then initiate demineralization of the tooth structure by acting to dissolve calcium and phosphate ions that are present in dentin and enamel. However, there can be a substantial amount of mineral loss from the tooth structure without the complete loss of the enamel structural integrity. The first visual clinical presentation of dental caries, often referred to as the white spot lesion or early lesion, is actually visualized at a relatively late stage in the caries process. Under conditions of high cariogenic challenge, there can be a rapid softening and loss of the enamel surface of the tooth resulting in a clinical cavitation or “hole” in the tooth. This defect is non-reversible and will necessitate a dental restoration or filling.

By stopping the demineralization process (net loss of calcium and phosphate ions) prior to the tooth becoming cavitated, the surgical treatment (“drilling and filling”) of the tooth can often be avoided. In most cases, prior the tooth becoming cavitated, the decay process can be stopped, and in fact reversed, resulting in the remineralization of tooth structure. Caries progression can be arrested or reversed by modifying multiple etiologic factors and initiating some tried

and true preventive measures. Some of the most common etiologic factors leading to an increased caries rate would include: 1.) a diet with a high frequency of sugar intake, 2.) poor oral hygiene, and 3.) systemic factors such as reduced salivary flow. Reduced salivary flow is often a side effect from a number of prescription medications. Remineralization therapies include high dose fluoride regimens both in-office and at home; the use of antimicrobial mouthrinses such as chlorhexidene; and increasing salivary flow via sugar-free chewing gums. Many of these gums contain anti-cariogenic agents such as Xylitol (a sugar alcohol) or amorphous calcium phosphates (Recaldent).

Caries risk management strategies have been developed to address the disease process and move us away from the “drill and fill” mentality of the past. The primary goal of the modern restorative dentist is to reduce disease activity. Restorations should be looked at as a last resort when all other preventive-type treatment options have been exhausted. All health care providers can play an important role in the caries/disease management by recognizing those patients who are at high risk for dental caries and taking steps aimed at modifying any high risk behaviors. The role of any medical care provider, not just oral health professionals, in caries prevention should be a very active one. This is especially true where no direct dental support is available. The Navy Oral Disease Risk Management (ODRM) Instruction BUMED 6600.16 provides guidance on proper risk classification for caries, periodontal disease, and oral cancer. Treatment protocols for high caries risk patients as well as remineralization therapies are also provided. An increased emphasis on caries risk assessment and prevention will potentially lead to significant reductions in the high cost of the disease both individually and enterprise wide.



The Military Sealift Command hospital ship USNS Comfort (T-AH 20) arrives at Naval Station Norfolk following deployment to provide medical care in Haiti.



Helicopters transfer ammunition between the multipurpose amphibious assault ship USS Bataan (LHD 5) and the Military Sealift Command dry cargo and ammunition ship USNS Lewis and Clark (T-AKE 1).