OKPRN News

Oklahoma Physicans Resource/Research Network Fall 2010

Board of Directors

Poison Ivy and Spider Bites: Two Great Projects in Search of Clinicians/Participants

– Jim Mold

Some of our best research projects take place during the summer when we have medical students to help us. This summer we are studying poison ivy. The protocol is easy, and patients can earn $20 by completing a symptom diary. We need more clinicians. If you are interested, contact Brad Long (Bradley-long@ouhsc.edu) or Cara Vaught (cara-vaught@ouhsc.edu).

After several quiet years, we are now moving forward again on the spider bite problem. This summer we are helping researchers at SW Missouri State University develop a clinical test for brown recluse spider bites. The protocol is a little more difficult than other studies we have done, but it pays you $180 per bite and the patient $20.

Here are the steps required:

1. Hand patient a brief summary of the project. If interested, they must call us and we consent them by phone.
2. Complete(s) a data collection form (5 minutes).
3. Take a picture of the bite close up and farther away with a digital camera (your camera) and a picture of the data collection form.
4. Swab(s) the bite site with NS on a cotton swab for 30 seconds and then a spot on the opposite side of the patient's body with another NS swab as a control. Swabs are put in tubes that we will provide and frozen.
5. If the patient brings the spider, put it in formalin, label and save.
6. E-mail the pictures to the principle investigator.
7. We will come around periodically and pick up the specimens and data collection forms.

If you are interested in this study, contact me (james-mold@ouhsc.edu) or Joel Kardokus (joel-kardokus@ouhsc.edu).

What is a Health Access Network? - *Jim Mold*

In 2009, the Oklahoma Health Care Authority decided to abandon its managed care approach in favor of a modified fee-for-service system. Fee-for-service reimbursement is now supplemented by a monthly care management payment determined by level of provision of certain services characteristic of the patient-centered medical home (PCMH) model. In addition, a special waiver was obtained from the Centers for Medicare and Medicaid Services to permit the establishment of up to four health access networks (HANs) covering up to 55,000 patients. The HANs are to be paid $5 per member per month to coordinate quality improvement activities, provide care management services for high risk patients, and promote the adoption of electronic health records, electronic data exchange, and telehealth services.

Three HANs have been approved to date, Canadian County, OU-Tulsa, and OSU-COM. The first two of these began to receive funding July 1, 2010. The third will begin to receive funding on January 1, 2011. The HANs are somewhat similar to the Community Care networks in North Carolina.▲

Should OKPRN Charge Dues? - *Jim Mold*

Membership in OKPRN has always been free. Dues have been proposed periodically but never enacted. There are several reasons to consider dues:

1. OKPRN is poor. In order to move the organization out of poverty, we need to be able to afford a real Executive Director.
2. Dues paying members might be more motivated to make sure the organization is providing them with what they want/need.
3. Some OKPRN members rarely participate. Thinning the membership list to those who are truly interested could save some time and money on database management, postage, and time spent tracking folks down to complete surveys, etc.

A proposal has been made to the Board that we begin charging a membership fee of $120 per year ($10 per month). Those present at the OKPRN Business Meeting thought that was reasonable. What do you think? Let a Board member know how you feel about this. ▲

Can Health Risk Appraisals (HRAs) Improve Primary Care?

– *Zsolt Nagykaldi*

HRAs have been used widely as health education tools for promoting individual behavior change, but mostly in worksite programs, universities, community wellness initiatives and health fairs. HRA feedback was appealing to individual users, employers, and payers, because its quantification of personal risk status was new and interesting. Despite the popularity of HRAs, reviews of the literature have found limited evidence that HRA instruments alone change individual behavior.

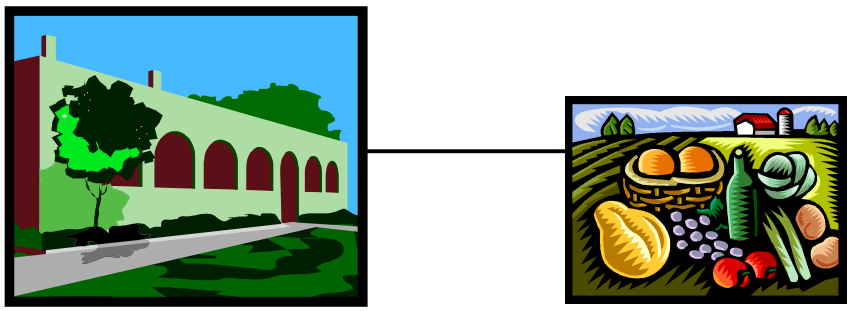
First, it is not enough to provide feedback on the individual's health status. Tailored, effective, and simple ways of achieving personal goals must also be determined and communicated. Second, primary care clinicians should be key participants in assisting a person to carry out his or her wellness plan. HRA instruments should ideally be integrated into comprehensive primary care –driven wellness programs that provide ongoing personal support and access to community resources. More recent studies also emphasized the importance of visualizing risk scores and linking particular risks to recommendations for health-behavior modifications within the HRA. [Continued on Page 3]

There is a considerable potential for a new generation of "enhanced" HRAs that combine successful HRA tools with an implementation approach that puts a particular emphasis on improved presentation of personal risks, tailored and prioritized care recommendations, linked strategies for lifestyle modification, and continuing involvement of the individual's primary care team (e.g. health coaching). We are currently developing and testing such a tool in OKPRN practices.▲

Linking primary care practices and community-based nutrition education programs – *Toney Welborn*

An application for funding was submitted in June to link primary care practices (PCPs) throughout Oklahoma with county-based nutrition education programs (NEPs) offered by the Oklahoma Cooperative Extension Service Family and Consumer Sciences (OCES-FCS) Division. The OCES-FCS NEPs, available at no cost to low income clients and families, have been shown to effect healthy behavior changes. We propose to use our well-tested quality improvement strategies to help PCPs improve recognition and referrals of overweight and obese patients and to help OCES-FCS learn to respond to these referrals. If funded, this two year project would include 24 clinicians in the first year and 24 clinicians in the second year of the project.

We believe that forming this PCP/OCES linkage will serve as a model for additional PCP/community resource referral linkages, particularly those involving Cooperative Extension. Cooperative Extension offers many programs that would pair well with the needs of PCPs including for example co-parenting through divorce classes, home and community education, healthy living with diabetes programs, and gerontology and aging programs. ▲



RESEARCH PROJECTS

What Should We Be Doing About OSA? – *Jim Mold*

Primary care practices attract patients with obstructive sleep apnea (OSA). Our patients are heavier (median BMI is 31) than the general population and have more health problems like hypertension, diabetes, and both right and left-sided heart failure, all of which are associated with OSA. As a result, almost 50% of adult patients in our waiting rooms are at high risk for OSA and between 12% and 25% actually have it based upon data collected in OKPRN and 4 other networks across the country. However, few of us routinely screen patients for OSA risk factors and symptoms or use validated tools to assess severity of symptoms, and we are only diagnosing the problem in only about 16% of those at high risk. Eighty-five percent of patients who we send for testing have OSA. In Oklahoma, most of us prescribe the CPAP, counting heavily upon the DME Company to educate and fit the patient properly. Many of us are unsure about who is supposed to report usage patterns and how we are supposed to determine effectiveness. [Continued on page 4]

As many as 50% of our patients quit using the equipment within the first 6 months. We are interested in your ideas on how to improve this process. Send me an e-mail at **james-mold@ouhsc.edu**.▲

Obesity Management by eMass – *Toney Welborn*

Overweight and obesity are epidemic. We performed a study that examined the attitudes and actions of Oklahoma clinicians in obesity treatment, and the characteristics and perceptions of a subset of patients who had lost at least 10% of their body weight and kept it off for more than a year or more. Through in-person interviews, we explored how Oklahoma clinicians could more effectively help their patients lose weight. The comments of individuals who were successful at losing weight helped us develop a 5-step approach to obesity management, called S-MASS, which can be efficiently implemented in a primary care clinician's office. *]*

S **1) Screen everybody using BMI. Consider also measuring waist circumference and asking about number of fruits and veggie servings per day.**

M **2) Help patients find Motivation/Reasons to lose weight. Link weight to functional limitations or functional goals.**

A **3) Achieve Commitment from the individual to lose weight. This is a key step. It represents a life changing decision.**

S **4) Help the individual design a Strategy that includes calorie reduction, exercise, and relevant lifestyle changes to lose weight.**

S **5) Support Weight Loss Maintenance**

a) Assist patient in developing a maintenance strategy.
b) Establish a target weight range.
c) Negotiate a follow up interval.
d) At each follow-up visit:
   i. Assess progress toward goal
   ii. Negotiate modification of plan and/or goal with patient
   iii. Use positive reinforcement and/or rewards
   iv. Address motivation, both barriers and re-enforcers

Why We Should Follow the NAEP Asthma Guidelines – *Jim Mold*

When practices implement the National Asthma Education Program's (NAEP) guidelines, numbers of unplanned asthma visits to the office are reduced by 50% and visits to the Emergency Department go down by 90% according to a well-designed clinical trial.

When we don't follow the guidelines, we tend to make the following mistakes:

1. We both over- and under-diagnose asthma because we don't routinely perform spirometry before and after bronchodilator as part of the diagnostic evaluation.
2. We underestimate asthma severity because we don't do spirometry at the time of diagnosis and because we don't ask enough questions.
3. We fail to pick up exacerbations early because we don't provide adequate education, give patients action plans, or recommend planned asthma visits every six months for those with persistent asthma. [continued on page 5]

4. We under treat with inhaled corticosteroids because we underestimate level of control because we don't ask enough questions and because our expectations are too low. (We expect that patients with asthma will occasionally wheeze, when, in fact, well-controlled asthmatics should rarely wheeze.)

OKPRN is currently helping 24 practices throughout Oklahoma to implement the asthma guidelines. Let us know if you are interested in receiving similar help. We may not be able to provide it right away, but we will try our best to get to you as soon as possible (james-mold@ouhsc.edu). ▲

Best of ClinIQ 2009-2010 – *Toney Welborn*

Question: *Is consumption of green tea associated with reduced mortality due to cardiovascular disease?*
Answer: Yes, based on two prospective cohort studies.
Resident: Oxana V. Douglas, MD (PGY-3)
Faculty: Dan F. Criswell, MD, and Toney L. Welborn, MD
Program Name: Southwest Oklahoma Family Medicine Residency Program, Lawton, Oklahoma
Evidence Based Answer: There is an inverse correlation between green tea consumption and cardiovascular disease-related mortality, especially stroke-related mortality. An adult person would need to drink between 2 to 7 cups of green tea, made of dry leaves, daily to have the positive effect, but studies are somewhat contradicting in regards to the exact number of cups of tea. ▲

Question: *Does sunscreen use cause vitamin D deficiency?*
Answer: Not in the general population, based on two prospective cohort studies, a randomized control trial and review article.
Resident: Misty Bogle, MD (PGY2)
Faculty: Jeffery Hodgden, MD
Program Name: St. Anthony Family Medicine Residency, Oklahoma City, OK
Evidence Based Answer: Sunscreen does decrease vitamin D conversion in a technical sense, however; there is no decrease in vitamin D levels in sunscreen users compared to the general population. This has been attributed to improper use of sunscreen as well as small areas of uncovered, unprotected skin that is exposed to sunlight on a daily basis. All these factors contribute to the possible reasons that all the good randomized studies have not shown clinical significance of sunscreens affect on vitamin D production. There is still some concern for vitamin D deficiencies especially in the elderly and those with co-morbidities that affect the chemical pathways to formation of active vitamin D. For this reason it is reasonable to test and supplement those at risk for vitamin D deficiencies. Sunscreen does have an affect on vitamin D production but it does not appear to be clinically significant in the general population. ▲

Question: *Are adults with nocturia more likely to have obstructive sleep apnea?*
Answer: Yes, based on two prospective cohorts and one retrospective chart review.
Residents: Shyama Gandhi, MD (PGY-3) and Vikas Jain, MD (PGY-2)
Faculty: Toney Welborn MD, MS, Cheryl Aspy PhD
Program Name: University of Oklahoma Health Sciences Center, Family Medicine Residency Program, Oklahoma City, OK
Evidence Based Answer: Little research has been done on patients with nocturia to diagnose whether they have a sleep disorder. However, given the physiology of nocturia and obstructive sleep apnea (OSA) and some evidence for an association between sleep disordered breathing, nocturia, and nocturic frequency, it may be reasonable to consider the diagnosis of OSA in patients who have symptoms of nocturia and increased nocturic frequency and who also present with other signs or symptoms suggestive of OSA (i.e. snoring, increased neck size, etc). The articles reviewed suggest a possible relationship between sleep disordered breathing and nocturia. However, these studies were mainly based on subjects who already had been diagnosed with sleep apnea. More research needs to be directed towards patients who first present with nocturic symptoms and the prevalence with which they are then diagnosed with OSA. ▲

Health Information Technology (HIT) Acronyms In Your Future - *Zsolt Nagykaldi*

ASP: Application Service Provider (health IT services, e.g. an entire electronic medical record system, provided over the Internet, usually by a commercial entity)
CCD: Continuity of Care Document (a compromise between the competing HL7 and CCR health information exchange standards that integrates the two in one standard)
CCR: Continuity of Care Record (one of the national health information exchange standards, created to hold an entire patient chart and thus support the continuity of care)
CDA: Clinical Document Architecture (an overarching XML-based standard that describes the semantics of documents for health information exchange, but not how documents are transported)
CDS: Clinical Decision Support (automated and preferably sophisticated clinical decision support content delivered real time at the point of care to care providers or patients)
CPOE: Computerized Physician Order Entry (an electronic system for initiating and tracking clinical orders in a particular organization or health network)
EHR: Electronic Health Record (goes beyond a classic clinical record and includes information about the patient's overall health and wellness also)
EMR: Electronic Medical Record (the clinician's electronic record of patient "charts")
GUI: Graphical User Interface (the screen one sees when a computerized system is used)
HIE: Health Information Exchange (meaningful exchange of health related information across traditional boundaries and silos of care)
HITRCs: Health Information Technology Resource Centers (national and regional centers to strategically assist health care providers in technology adoption and utilization)
HITSP: Health Information Technology Standards Panel (a national cooperation between public and private entities that is responsible for the harmonization and integration of health IT standards)
HL7: Health Level Seven (one of the comprehensive health information exchange standards, originally created for single-instance point-to-point exchanges, e.g. transmission of lab results)
MU: Meaningful Use (use and type of implementation of an EMR/EHR system that meets the Office of National Coordinator for Health IT criteria, including financial incentives or penalties)
NEDSS: National Electronic Disease Surveillance System (a CDC initiative to advance the development of surveillance systems)
NHIN: National Health Information Network (an expanding nationwide medical information backbone)
ODBC: Open Data Base Connectivity (a technology standard to connect various disparate databases)
ONC: Office of the National Coordinator for Health IT (Instituted by the Bush administration to enhance the adoption and use of electronic systems in health care)
PHI: Personal Health Information (HIPAA –regulated sensitive health or personal data)
PHR: Personal Health Record (the patient's own electronic medical and health record – qualitatively different from the clinician's record)
RHIO: Regional Health Information Organization (a former term for a local or regional health information exchange network)
SDO: Standards Development Organization (regional, national, or international organizations for standards development, including ISO, ANSI, or ASTM that developed the CCR)
SOA: Service Oriented Architecture (electronic functionality is provided as a utility-type web service by various entities to enhance clinical processes at the point of care)
SQL: Structured Query Language (a computer language to program and manage relational databases)
SSL: Secure Sockets Layer (a communications protocol used widely on the Internet to secure the transmission of sensitive data)
SSO: Single Sing-On (one set of credentials logs the user on to several distinct, but connected systems)
URL: Uniform Resource Locator (this is the line that describes the address of a web site or other electronic information)

OKPRN Membership Summary

Zsolt Nagykaldi

Current Number of OKPRN Members: 244	By Discipline:	By Specialty:
By membership status:	MDs: 144	Family & General Medicine: 207
Full member: 176	DOs: 56	Internal Medicine: 10
Affiliate: 57	NPs: 17	Pediatrics: 13
Inactive: 11	PAs: 22	Other: 4
	Other: 5	Unknown: 10
Current Number of OKPRN Practices: 141	By Quadrant of the State:	By Ownership:
By location:	SW: 31	Hospital: 13
Urban: 37	SE: 33	Physician or group: 42
Sub-urban: 35	NE: 43	Other corporate: 10
Rural: 69	NW: 33	Other: 19
		Unknown: 57

OKPRN Website Activity Report

Zsolt Nagykaldi

Our website (www.okprn.org) continues to draw a number of visitors each month. In the course of June, for example, we received over 6,000 hits that represent almost 2,000 page views and 1,669 individual visits. After the week of our Convocation, page views increased to over 700 per week for a period. Our most frequently browsed resources include "Best Practices" pages, the OKPRN presentation library, publications, and more recently, Convocation 2010 resources. Besides Oklahoma, we registered visits from Texas (47), Pennsylvania (47), Washington (54) and many other states, in addition to international inquires from the UK (32), China (55), Sweden (32), and India (30).▲

Month	Page Views	Visits	Hits
June, 2010	1,989	1,669	6,168