

February 2007 HepTalk Listserv

One of the focuses of the HepTalk training is on the **use of efficient questions and prompts on clinic charts and forms to help incorporate risk assessment for communicable diseases, including hepatitis, into your clinic system.** Preliminary observations from the HepTalk project visits indicate that risk questions are most often asked when they are included in a chart form. We'll devote the February issue of the listserv to information about the use of charts and forms, including the use of Electronic Medical Records (EMR). We're aware of two clinics in the project who are currently using EMRs, and several others who are moving in that direction. If you are switching to EMRs, remember that you have the power to insert the risk questions you want into your medical history records! Use these guidelines to guide you as you customize your new system.

1. Charting Handout. A guide compiled by the HepTalk team to help you assess the risk assessment portion of your clinic's forms.
2. Three articles regarding the effectiveness of charts, checklists, and other tools to increase preventive care
3. Two articles regarding the use of EMR (electronic medical records).

1. The HepTalk Charting Handout You can access this handout through the MCN website at www.migrantclinician.org. Go to Clinical Excellence, then to Hepatitis, then to Resources. Print out this guide and use it to look at your medical history forms to see if you have covered hepatitis risk factors (which are also factors for many other communicable diseases). Key areas to cover are listed, and sample questions (suggested wording—there are other ways to phrase each one). Think about what you need to ask and what you don't need to ask—if it does not get you useful and useable information, take the question off.

2.a Increasing the screening and counseling of adolescents for risky health behaviors: a primary care intervention. Ozer EM , Adams SH , Gee S , Garber AK , Gardner LR , Rehbein M , Addison L , Irwin CE Jr
<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dop> Pediatrics. 2005 Apr;115(4):960-8. Division of Adolescent Medicine, Department of Pediatrics, and Research and Policy Center for Childhood and Adolescence, University of California, San Francisco, California 94143, USA. eozer@itsa.ucsf.edu

OBJECTIVE: To determine whether a systems intervention for primary care providers resulted in increased preventive screening and counseling of adolescent patients, compared with the usual standard of care. **METHODS:** The intervention was conducted in 2 outpatient pediatric clinics; 2 other pediatric clinics in the same health maintenance organization served as comparison sites. The intervention was implemented in 2 phases: first, pediatric primary care providers attended a training workshop (N = 37) to increase screening and counseling of adolescents in the areas of tobacco, alcohol, drugs, sexual behavior, and safety (seatbelt and helmet use). Second, screening and charting tools were integrated into the intervention clinics. Providers in the comparison sites

(N = 39) continued to provide the usual standard of care to their adolescent patients. Adolescent reports were used to assess changes in provider behavior. After a well visit, 13- to 17-year olds (N = 2628) completed surveys reporting on whether their provider screened and counseled them for risky behavior. RESULTS: Screening and counseling rates increased significantly in each of the 6 areas in the intervention sites, compared with rates of delivery using the usual standard of care. Across the 6 areas combined, the average screening rate increased from 58% to 83%; counseling rates increased from 52% to 78%. There were no significant increases in the comparison sites during the same period. The training component seems to account for most of this increase, with the tools sustaining the effects of the training. CONCLUSIONS: The study offers strong support for an intervention to increase clinicians' delivery of preventive services to a wide age range of adolescent patients.

PMID: 15805371 [PubMed - indexed for MEDLINE]

2b. Effect of medical records' checklists on implementation of periodic health measures. Cheney C, Ramsdell JW. <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=pubmed> Am J Med. 1987 Jul;83(1):129-36.

Recent re-evaluation of preventive health care has resulted in more limited and directed guidelines; nonetheless, physician compliance has remained poor. This study assessed whether an inexpensive reminder system of preventive care checklists would improve physician implementation of periodic health measures. Residents in internal medicine were randomly placed into two groups: one received a copy of the appropriate checklist with each patient's medical record; the other did not. After one year, 200 randomly selected records were audited to determine the proportion of recommendations implemented for each patient. Residents who received checklists performed appropriate preventive health measures at a significantly higher rate than those who did not (0.56 +/- 0.26 versus 0.39 +/- 0.22, p less than 0.002). The actual use of the checklist to record the results was associated with an even higher rate of compliance compared with instances in which the checklists were provided but not used and instances in which checklists were not received (0.70 +/- 0.21 versus 0.44 +/- 0.24 and 0.39 +/- 0.22, respectively, p less than 0.002). These data suggest that a physician's use of simple checklists can provide an inexpensive and effective means of improving implementation of periodic health maintenance.

PMID: 3605164 [PubMed - indexed for MEDLINE]

3c. Office system interventions supporting primary care-based health behavior change counseling.

Dickey LL, Gemson DH, Carney P.

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?CMD=search&DB=pubmed>

Am J Prev Med. 1999 Nov;17(4):299-308. Links

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CONTENT: This article reviews the literature on the effectiveness of office system interventions to improve behavior-change counseling in primary care. These instructions consist of two principle components: tools and teamwork. Tools have been developed to assist providers with health risk assessment (questionnaires, health risk appraisals), prompting and reminding (chart

stickers, checklists, flow charts, reminder letters), and education (manuals and handbooks). Teamwork entails the coordination and delegation of tasks between providers and staff.

CONCLUSIONS: A number of clinical trials, particularly in the area of smoking cessation, have demonstrated the effectiveness of tools and teamwork for increasing counseling rates and counseling effectiveness. Although no one type of tool or method of teamwork is consistently more effective than another—with effectiveness varying according to practice, provider, and patient characteristics—the use of different tools and teamwork approaches leads to additive improvements in counseling and patient behavior-change rates. More high-quality research is needed, particularly in the areas of health risk assessment and electronic reminder systems, to develop effective office interventions that can be readily implemented into a wide variety of primary care practices.

PMID: 10606199 [PubMed - indexed for MEDLINE]

3a. A Proposal for Electronic Medical Records in U.S. Primary Care

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<http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=12509352>

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Delivery of excellent primary care—central to overall medical care—demands that providers have the necessary information when they give care. This paper, developed by the National Alliance for Primary Care Informatics, a collaborative group sponsored by a number of primary care societies, argues that providers' and patients' information and decision support needs can be satisfied only if primary care providers use electronic medical records (EMRs). Although robust EMRs are now available, only about 5% of U.S. primary care providers use them. Recently, with only modest investments, Australia, New Zealand, and England have achieved major breakthroughs in implementing EMRs in primary care. Substantial benefits realizable through routine use of electronic medical records include improved quality, safety, and efficiency, along with increased ability to conduct education and research. Nevertheless, barriers to adoption exist and must be overcome. Implementing specific policies can accelerate utilization of EMRs in the U.S.

3b. Use of an Electronic Medical Record Improves the Quality of Urban Pediatric Primary Care

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<http://pediatrics.aappublications.org/cgi/content/abstract/111/3/626> PEDIATRICS Vol. 111 No. 3 March 2003, pp. 626-632

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Objective. To evaluate the quality of pediatric primary care, including preventive services, before and after the introduction of an electronic medical record (EMR) developed for use in an urban pediatric primary care center.

Methods. A pre-postintervention analysis was used in the study. The intervention was a pediatric EMR. Routine health care maintenance visits for children <5 years old were reviewed, and documentation during preintervention (paper-based, 1998) and postintervention visits (computer-based, 2000) was compared.

Results. A total of 235 paper-based visits and 986 computer-based visits met study criteria. Twelve clinicians (all attendings or nurse practitioners) contributed an average of 19.4 paper-based visits (range: 5–39) and 7 of these clinicians contributed an average of 141 computer-based visits each (range: 61–213). Computer-based clinicians were significantly more likely to address a variety of routine health care maintenance topics including: diet (relative risk [RR]: 1.09), sleep (RR: 1.46), at least 1 psychosocial issue (RR: 1.42), smoking in the home (RR: 15.68), lead risk assessment (RR: 106.54), exposure to domestic or community violence (RR: 35.19), guns in the home (RR: 58.11), behavioral or social developmental milestones (RR: 2.49), infant sleep position (RR: 9.29), breastfeeding (RR: 1.99), poison control (RR: 3.82), and child safety (RR: 1.29). Trends toward improved lead exposure, vision, and hearing screening were seen; however, differences were not significant. Users of the system reported that its use had improved the overall quality of care delivered, was well-accepted by families, and improved guidance quality; however, 5 of 7 users reported that eye-to-eye contact with patients was reduced, and 4 of 7 reported that use of the system increased the duration of visits (mean: 9.3 minutes longer). All users recommended continued use of the system.

Conclusion. Use of the EMR in this study was associated with improved quality of care. This experience suggests that EMRs can be successfully used in busy urban pediatric primary care centers and, as recommended by the Institute of Medicine, must play a central role in the redesign of the US health care system.

HepTalk is a project of the Migrant Clinicians Network and Community Health Education Concepts. HepTalk is funded by the Centers for Disease Control and Prevention. The goal of HepTalk is to help clinicians serving migrants and recent immigrants engage in productive discussions about hepatitis risks with their clients and help them make prevention plans. The HepTalk listserv is a support service for clinics participating in the project. This is a post-only listserv and postings will come from HepTalk staff about once a month. If others at your clinic would like to be on the listserv, or if you have questions about the listserv or resources listed here, or if you would like to add something to the posts, please contact Kathryn Anderson, HepTalk training and education coordinator and listserv administrator, at dempander@earthlink.net. You can also contact the listserv administrator if you would like to unsubscribe from the list.