



Winter 2016 Quarterly Newsletter

<http://www.familymedicine.vcu.edu/research/fmresearch/acorn/>

Virginia ACORN - your partner in practice based primary care research. Helping you and your practice stay informed on the latest happenings in primary care.

Featured articles in this edition

- **An Update on Blood Pressure Goals**
- **Dr. Elizabeth Wolf, MD earns APA Young Investigator Award**
- **Fairfax Family Practice Centers' partner with Privia Medical Group**
- **MacColl Center on Health Care Innovation: Primary Care Team Guide and 2016 webinar series**
- **VCU Nelson Clinic adopts Integrated Care Model**
- **ABFM helping Family Physicians navigate practice and payment changes**
- **Connecting the Dots between Primary Care and Community Development**

Get Involved & Save the Date

- **PBRN & NAPCRG Conferences – check out the scholarship opportunity**
- **ACORN Partner Board**

Our mission is to improve health and transform care delivery through primary care research and implementation.

Latest Preventive Service Guidelines: Blood Pressure Goals



If you are like me, you welcomed the new JNC 8 blood pressure guidelines in December 2013. The new goal blood pressure of less than 140/90 for everyone under the age of 60 (even patients with diabetes and kidney disease) and less than 150/90 for all patients over age 60 made sense. It was easier to get patients to goal, it minimized side effects, and it was supported by evidence – the ACCORD trial. ACCORD showed no benefit and increased harm trying to get high risk diabetic patients to a goal systolic blood pressure of <140 versus <120.

Then on November 2015, the SPRINT trial results were released. It showed the opposite of the ACCORD trial. In fact, aiming for a systolic blood pressure of <120 versus <140 now resulted in lower all-cause mortality (155 versus 365). But the trials excluded diabetics and only included patients with cardiovascular disease, chronic kidney disease, a ACC-AHA cardiovascular risk score more than 15%, or age over 75 years.

So what blood pressure should we aim for now? The guidelines have not actually changed, so we could stick with the JNC 8 recommendations. Or we could embrace the SPRINT trial findings. If so, it is important to recognize some caveats – SPRINT doesn't apply to diabetics, it only includes high risk patients, most patients did not achieve a systolic BP of 120 (the average BP for the intervention group was 121), and blood pressure was defined as an average of three readings taken after sitting quiet for 5 minutes.

Like many preventive services, the best course of action may be to tailor care to each patient. Patients at highest risk for cardiovascular disease, low risk for medication side effects, who want more aggressive treatment may be good candidates for more aggressive BP control. Conversely, it may be best to stick with the guideline goal for patients at average or low risk for cardiovascular disease, at risk for medication side effects, or who don't want to closely monitor their medications.

Submission provided by Dr. Alex Krist, MD MPH



Dr. Elizabeth Wolf, MD is awarded APA Young Investigator Award

Project Title: Identifying Gaps in Well-Child Care Attendance among Primary Care Clinics Serving Low-Income Families

Award Title: Maternal and Child Health Bureau Bright Futures Young Investigator Award

Description of Project: It is estimated that children 0-6 years of age miss about ¼ of their recommended well child-care visits. Children from low-income families miss an even greater proportion. Deficient well-child care is associated with increased emergency department utilization and hospitalizations. This study aims to determine what age's well-child visits are most likely to be missed and what preventive services are lacking in these children. We will also explore patient- and provider- reported causes for gaps in well-child care to help inform the development of future interventions to improve receipt of preventive services in children.

Learn more about Dr. Elizabeth Wolf at <http://www.chrichmond.org/Provider-Directory/Wolf.Elizabeth.htm>. *Please join me in welcoming Dr. Wolf to the network of primary care researchers working in collaboration with ACORN & VCU Family Medicine & Population Health.*

Practice News

Fairfax Family Practice Centers' 133 Providers partner with Privia Medical Group

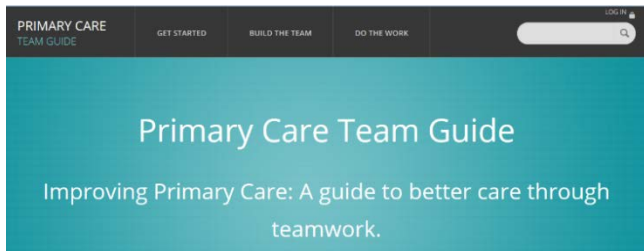


ARLINGTON, VIRGINIA (October 1, 2015) Privia Health, LLC ("Privia"), a national physician practice management and population health technology company announced today that Fairfax Family Practice Centers is partnering with [Privia Medical Group](#) ("PMG") in its Mid-Atlantic market. Privia's integrated delivery network is now one of the largest in the country, with over 1,000 providers in the Mid-Atlantic region alone, with additional operations in 6 states and currently serving over 2 million patients.

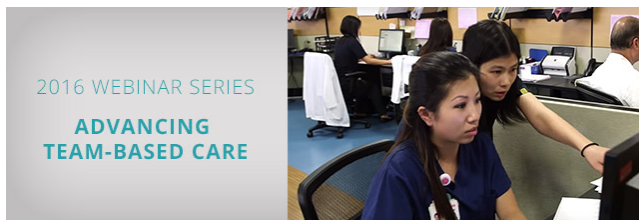
[Fairfax Family Practice Centers](#) ("FFPC") is one of the largest and most well respected independent physician practices in the Mid-Atlantic, with over 130 providers practicing across 14 locations in the Northern Virginia area, including Centreville, Fairfax, Gainesville, Loudoun, Lorton, Manassas, Reston, South Riding and Vienna. These locations specialize in Family Medicine and are recognized by the National Committee for Quality Assurance as Level III Patient-Centered Medical Homes, serving over half a million patients annually. (Continue reading press release at http://www.priviahealth.com/releases/10012015-fairfax_family_practice_providers_partnering_with_pmg.html)

The Quarterly Feature as recommended by Dr. Rebecca Etz, PhD

MacColl Center for Health Care Innovation



The [Primary Care Team Guide](#) is a free online tool that helps primary care practices build high functioning teams. This leads to better care, and healthier and happier patients and staff. Read more <http://www.improvingprimarycare.org/>



New webinar series teaches staffing innovations in primary care

Find out more about the webinars <http://weitzmaninstitute.org/sites/default/files/pdf/NCAWebinarTopics.pdf>



VCU Nelson Clinic adopts Integrated Care Model

In the past year, the scope of behavioral services provided in Family Medicine at Nelson Clinic at VCU has greatly expanded due to the addition of a psychiatrist (.1 FTE), psychologist (.2 FTE), and social worker (1 FTE) to our team of providers. It is estimated that PCP's provide the majority of treatment for depression and anxiety. Furthermore, behavioral health can have a significant impact in the management of many health concerns. Within our clinic the providers, nurses, and patients have welcomed the additional support and collaboration with these new specialties.

With the addition of these services we are able to provide mental health treatment, health behavior change, and social support for our patients. The psychologist provides brief individual counseling (4-6 sessions), initial neuropsychology screening for dementia and learning disorders, and triage and bridge care for patients requiring more intensive therapy. The psychiatrist provides medication management for patients with more severe mental health symptoms. The social worker helps patients to access needed social services, including financial services, transportation, and insurance needs.

Having behavioral health providers collocated in the clinic allows for increased access to services. In addition to seeing patients for scheduled appointments, the social worker and psychologist often work with patients via warm hand-offs. Warm hand-offs is a process where the patient comes into see their PCP and behavioral health or social needs are identified and the psychologist or social worker meet with the patient during that visit. Through warm hand-offs, we are able to provide services when a concern first arises. By offering these services in a primary care setting where the patient already has a relationship with the doctor and nurses we are decreasing stigma related to mental health treatment.

Also, because these providers are a part of our clinic team it facilitates coordination of care through face-to-face consultations, as well as email and shared appointment notes. Physicians report a high level of satisfaction with the additions. It allows for a higher level of care for the patient. It allows for improved communication and coordination in

caring for the whole patient. It also promotes improved chronic care outcomes for these patients who often have significant barriers to optimizing their health.

By integrating behavioral health into our clinic we are better able to provide the best care possible for our patients, ensuring that we are addressing the multitude of factors that impact a patient's health and well-being. The leadership team is eager to conduct further analysis of this financial viability of this newly implemented program along with lessons learned for those interested in doing something similar.

Submission provided by Carolyn Peel, MD and Rebecca Aycock, PhD

ABFM helping Family Physicians navigate practice and payment changes



The ABFM and AAFP are partnered on the Family Medicine Support and Alignment Network (SAN) to help family physicians take advantage of the Transforming Clinical Practice Initiative. This initiative is designed to give you resources to facilitate change so that your practice is prepared for Medicare and Medicaid payment changes, but more importantly, to help make your practice even more effective for your patients. Family physicians who join a Practice Transformation Network (PTN), under this initiative, will be eligible for MC-FP Part IV credit, CME courses under development by the AAFP, and will receive services to help improve their practices. PTNs are looking to enroll family physicians.

You can find out more about this on the AAFP website here: <http://www.aafp.org/practice-management/transformation/tcpi.html>; the ABFM website here: <https://www.theabfm.org/primeregistry/>; or the HealthCare Communities website: <http://www.healthcarecommunities.org/CommunityNews/TCPI.aspx>

The ABFM is tripling the value of the grant from the Centers for Medicare & Medicaid Services, committing \$6 million to supporting board certified family physicians who join a PTN by enrolling them in the PRIME Registry free for 3 years. The registry is designed to:

- Extract data from your EHR
- Assess and manage quality for patients and populations
- Participate in Maintenance of Certification
- Report for PQRS and Meaningful Use (available 2016)

To get the registry support for free, enroll in a PTN and be sure to sign up for the Family Medicine Support and Alignment Network (SAN) Community.

If you are an ABFM board certified family physician, this will put you in the queue to be enrolled in the PRIME Registry for free. We plan to start enrolling practices in the PRIME Registry Spring, 2016, and you'll be securing your place in the first 6,000 who get it for free. If you work with other primary care clinicians, they can join the registry for \$33/month. The PRIME Registry will work with 85 different EHRs.

Join our Family Medicine SAN Community on Healthcare Communities

at: <http://www.healthcarecommunities.org/Communities/TCPIAvailableCommunities.aspx> to learn more or email Dr. Elizabeth Bishop at ebishop@theabfm.org

Featured Faculty Member



Connecting the Dots between Primary Care and Community Development

Steven Woolf, MD MPH
Laurel Case Guest Lecturer
Oregon Health Sciences University
November 12, 2015

Catch the lecture now!

<https://echo360ess.ohsu.edu:8443/ess/echo/presentation/89239165-9aa3-4056-8811-4420d64804c5>

Get Involved and Save the Date



NAPCRG PBRN Conference, July 11-12, 2016, Bethesda, MD. Proposal submissions due: April, 1, 2016. <http://www.napcrg.org/Conferences/2016PBRNConference>

Check out the scholarship opportunity for community stakeholders

<http://www.napcrg.org/Conferences/Practice-basedResearchNetworkConference/TravelScholarships>

NAPCRG Annual Meeting, November 12-16, Colorado Springs, CO. Proposal submissions due: April, 18, 2016. <http://www.napcrg.org/NA16>

ACORN Partner Advisory Board:

March 7, 2016 at 7pm-8pm or March 10, 2016 at 12pm-1pm. If you're interested in participating, please contact us at ACORN@vcu.edu for more information.

Virginia Ambulatory Care Outcomes Research Network (ACORN)

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