Fall 2011

Clinic Connection: Fall 2011

CentraCare Clinic

Follow this and additional works at: https://digitalcommons.centracare.com/clinic-connection

Part of the Organizational Communication Commons

Recommended Citation
CentraCare Clinic, "Clinic Connection: Fall 2011" (2011). Clinic Connection. 4.
https://digitalcommons.centracare.com/clinic-connection/4

This Article is brought to you for free and open access by the CentraCare Health Publications (Newsletters, Annual Reports, Etc.) at DigitalCommons@CentraCare Health. It has been accepted for inclusion in Clinic Connection by an authorized administrator of DigitalCommons@CentraCare Health. For more information, please contact schlepers@centracare.com.
Nearly half of all American adults (90 million people) have trouble understanding and using basic health information according to the Institute of Medicine report, “Health Literacy: A Prescription to End Confusion”. For most of the population, anything above the 8th grade level is difficult to read, especially when it includes medical jargon. In fact, surveys show that on average, U.S. adults read 3-5 levels below their years of education. The 5th - 6th grade level can be understood by the majority of those using the health care system. Unfortunately, most health care information provided to patients is written at the 12th grade level or higher, creating a significant gap of understanding for most patients.

The inability to read, understand and make use of health information affects people from all backgrounds. It is particularly problematic for individuals with multiple chronic diseases, those older than age 65, Medicaid enrollees, low income or unemployed, those without a high school diploma, Hispanic Americans and African Americans. Although some groups are at high risk for low health literacy, it remains a hidden problem as physicians typically cannot easily tell which patients are challenged with low health literacy.

Low health literacy is a significant barrier to quality health care and has been linked to medication errors, decreased patient satisfaction, non-compliance, poor outcomes, increased hospitalizations and higher health care costs. If we are to achieve our vision of being the best in Minnesota, we will need to bring a renewed focus to ensure our patients hear and understand what we say.
Computer-based testing can help with evaluation and management of concussions

By George Morris, MD, Sport Medicine Physician, CentraCare Clinic

Concussions in youth sports are being identified more often and the goal of the medical team should be to support the accurate diagnosis, appropriate treatment and return-to-play recommendations. Youth sports have long been a part of growing up and fortunately, injuries are fairly uncommon. Head injuries can happen in many different activities and are more common in sports with collisions (i.e. football, hockey), higher speeds (i.e. downhill skiing, motocross) or higher heights (i.e. cheerleading stunts).

Identification of serious head or neck injuries should be the initial concern of any health care professional covering a sports event or when asked to help in an emergency. Concussion management should include the realization that it is not just a “ding.” An injury to the brain often is not as obvious as a broken bone or laceration. It is important to keep the athlete from risk of further harm by not allowing them to return to play on the same day of any suspected concussion.

Once the concussion is diagnosed, it is important to allow a period of cognitive and physical rest before the athlete returns to the sport. School performance can be affected and academic modifications may need to be initiated.

Concussion symptoms can be vague and hard to describe. They include headaches, balance problems and a feeling of fogginess. Computer-based testing is a tool to help evaluate and manage concussions and mild traumatic brain injuries. We use ImPACT computer-based testing within the Sports Medicine Department at CentraCare Clinic. It also is used in many schools, youth sports leagues, colleges and professional teams. These tests can give an objective evaluation of the concussed athlete and help with management decisions. A gradual and monitored stepwise return-to-play program may be initiated once the athlete’s signs and symptoms have resolved at rest and with exertion.

The diagnosis and management of concussions is becoming a high-profile concern. Physical and cognitive rest is an important part of the recovery process. Computer-based testing, such as ImPACT, can be an additional tool to aid in the appropriate treatment of the young athlete.

For more information about ImPACT or concussion management, please contact our Sports Medicine physicians at (320) 229-4917.

Small bowel capsule endoscopy helps to detect gastrointestinal bleeding

By Peter Nelson, MD, Gastroenterologist, CentraCare Clinic

Video capsule endoscopy is a novel technology that allows for direct imaging of the entire small intestine. Its primary indication is the investigation of patients with obscure GI bleeding. The indications for capsule endoscopy are expanding, and its value has been shown in the evaluation of patients with known or suspected nonstricturing Crohn’s disease. Capsule endoscopy also may be of value in assessing the small bowel in polyposis syndromes.

The video capsule is 11 x 26 mm in size and acquires images at a rate of two frames per second for approximately eight hours. Capsule images are wirelessly transmitted to a portable receiver worn by the patient, and the resultant video is subsequently downloaded and reviewed.

Contraindications include patients who are pregnant, those with swallowing disorders and patients with known or suspected small bowel obstruction or strictures. Patients with gastroparesis may require endoscopic placement of the capsule into the duodenum. The procedure also is contraindicated in those with implanted electromechanical devices, such as pacemakers or defibrillators. However, these patients can be safely studied in a monitored hospital setting for the day of the study.

The major complication of capsule endoscopy is capsule retention. Capsule retention may require surgery or endoscopy to retrieve the capsule. In healthy individuals this risk is minimal, but in patients with known Crohn’s disease the risk is approximately 5 percent. In patients who are at risk for capsule retention, a capsule patency study may be done to help assess the risk for capsule retention.

For more information about small bowel capsule endoscopy, contact the CentraCare Digestive Center at (320) 229-4916.
Patient-physician interaction in the EMR era

By Bryan Rolph, MD, Nephrologist and EMR Physician Champion, CentraCare Clinic

During any typical clinic visit in the past, there was a minimum of three participants: the patient, the physician and the chart. Recently, the chart has been replaced by the electronic medical record (EMR). The chart was a prominent focus for a physician’s attention, but had the advantage of being more mobile and could be placed between the physician and the patient to allow for better eye contact during a visit. A significant disadvantage of the paper chart was that information was more difficult to find. Also, physicians could be distracted from the patient as they paged through information.

Computers, on the other hand, are typically in desktop form and in a fixed position. This arrangement affects a physician’s ability to maintain eye contact during the visit as screen gazing and keyboarding demand more of a provider’s attention and often require the physician be turned away from the patient. In addition, as more information becomes available in the EMR, the patient is at risk of becoming a less active participant in providing history. On the other hand, an EMR makes information easier to find, potentially leaving more time for direct interaction with the patient.

To better enhance interaction with the actual patient instead of the “iPatient,” some common-sense adjustments can be used. These include:

• Try to review the bulk of data in the EMR before initiating contact with the patient. Past studies demonstrate that doctors who sat down and faced the patient were rated by patients as having spent more time with them, even when, for the purposes of the study, they had spent only half as much time (in minutes) in the room with the patient compared with another group of doctors who were studying the chart during an interaction with a patient. Therefore, it makes sense to potentially trade time used in the room reviewing information for time outside of the room reviewing information. The face-to-face time with the patient may end up being the same, but may be perceived as being longer by the patient.

• Review EMR data collaboratively with the patient (i.e. labs, graphs, radiographic images).

• If an extended amount of time is spent gazing at the monitor or keyboarding, try to maintain conversation with the patient about what is being reviewed, documented or ordered.

• Try to re-establish eye contact with the patient when not interacting with the computer.

• Use of a tablet PC in the room as a source of EMR information could be considered.

• Consider performing heavy amounts of ordering after the appointment if possible.

• Share positive comments about EMR use with the patient. For example, how much easier it is to find information.

While the transition to electronic medical records has not been without its challenges, the ultimate goal is to provide the best possible care for patients, and I believe the electronic medical record has enhanced our ability to do so.
Patient’s race, ethnicity and language are important for routine medical care

By David Tilstra, MD, Medical Director, CentraCare Clinic

Patient-specific data on race, ethnicity, language (REL) and country of origin data now are required for collection by several state and national agencies. Some very practical reasons for collecting and using REL data in routine medical care include:

**Language:** Do we need an interpreter to see the patient? It’s a very practical question that can save time if we know a communication barrier exists.

**Country of origin:** We know some countries have endemic diseases that need to be recognized quickly to prevent spread in the U.S. Nearly 12.5 percent of people in the U.S. were foreign-born, making this a more common risk factor than other questions.

**Race and ethnicity:** Many of the quality assurance groups require reports using the U.S. government definitions. Race can be thought of as the big groups of shared genetic background, i.e. African American. This might be useful for determining disease risk. A good example is the recommendation to start colonoscopies in African American males at age 45 rather than at the standard 50 years of age.

Ethnicity is a more specific cultural group, such as Hmong or Kurdish. West Africans have different cultural values and approaches to health care than East Africans, but both could be classified as African American for racial purposes. Providers could use ethnicity data to determine specific approaches to a patient’s beliefs and help them to seek appropriate care.

Racial and ethnic data could be used in reports to determine discrepancies in intended care. Some cultural and racial groups do not have the shared understanding of health care that many of us have. Preventive services are foreign to those who have spent most of their life focusing on survival. Recognizing which groups are not receiving specific care can help us tailor a message to provide the best long-term care.

As with other data, REL data can be used for good or bad. Using REL data to improve our patients’ health is a valid reason to collect data. Patients always have the right to refuse to answer the questions. If used properly, health care providers should gain patient trust as the patients would benefit from having their health care providers know these details. For more information, visit www.ahrq.gov.