President’s Message

Team-based medicine and the use of clinical guidelines and protocols

By Allen Horn, MD, MBA, FACPE
President, CentraCare Clinic

Clinical autonomy remains one of the most valued characteristics of our profession. Most physicians remain fiercely attached to clinical autonomy and believe it is vital to practicing the science and the art of medicine. Although advances in medical science and the effectiveness of medical practice have long served to earn us this autonomy, the combined forces of payer and governmental regulation, changing expectations of patients and our clinical performance have altered how society views our profession. This changing view has resulted in an erosion of autonomy over the past few decades. Society has learned that the basis for this autonomy, our scientific knowledge and extensive training, has not been consistently applied for their benefit.

There certainly are many important examples of the appropriate and consistent application of science to which we can all point. Within CentraCare, we have seen significant impact from using evidence-based medicine, standardization and a multidisciplinary approach to the delivery of health care. Our cardiologists, through the STEMI program, have achieved remarkably low, 3 percent overall in-hospital mortality for patients with an acute myocardial infarction. Our Intensivists have created an ICU recognized nationally for providing clinical innovation and improved outcomes while reducing cost. Nevertheless, countless national studies continue to demonstrate unexplained practice variation.
Updated growth charts now available

By David Tilstra, MD,
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The Centers for Disease Control and Prevention (CDC), with the support of the World Health Organization (WHO) and the American Academy of Pediatrics (AAP) have recommended that growth charts for infants and children 0-2 years of age be updated. The previous growth charts were created by the CDC based on a large, but unselected, cross-section of American children between the 1970s and 1990s. They officially should be referred to as a “growth reference.” The recommended WHO charts are based on 882 children who were closely followed to be certain that children with chronic illness and/or malnutrition were excluded from the data set. The children were breast fed, came from a variety of ethnic groups and from a high socioeconomic status (to eliminate economic concerns affecting nutrition status).

The WHO charts are similar, but not exactly the same as the CDC charts. The CDC charts tended to inappropriately identify as many as 7-11 percent of children as underweight, causing significant parental worry, inappropriate testing and referrals and unnecessary expense. The WHO charts in a typical practice will show about three percent of children as underweight, as might be expected from using a definition of two standard deviations below the mean. This should result in many more “true positives,” with children with real disease conditions being referred for further evaluation.

There will be some downsides to using the WHO charts because the charts don’t match the CDC 2-20 year growth charts so some children will shift height and weight percentiles when switching to the older age charts. The WHO growth charts for older children have not been endorsed for the United States by the CDC or the AAP.

The WHO charts can be obtained online at www.cdc.gov/growthcharts/who_charts.htm.

A practical tip for hairy lacerations

Lacerations of the scalp or other hairy areas of the body can be made more challenging by the fact that hair around a laceration always seems to get in the way when you are trying to close the wound. As an alternative to trimming the hair around a laceration on the scalp or on a hairy leg, try using antibiotic ointment to mat the hair down and direct it away from the wound.

Another practical ‘Q’ tip

Cotton swabs dipped in water and frozen in individual plastic bags can provide quick relief for a burned tongue or lip or a tooth that is almost out. They also can help stop bleeding in the mouth or nose.
My father, the Internist, calls me “The Externist”; a dermatologist and “photophobe” whose mission is to prevent and treat skin cancers. He also ribs me about my children becoming Vitamin D-deficient since they are covered head-to-toe with hats, rashguards, board shorts, and sunscreen when visiting beautiful Green Lake in the summer. I tell him the American Academy of Dermatology (AAD) is proud of my efforts to limit ultraviolet exposure in my family and patients and instead recommend an adequate amount of Vitamin D be obtained from a healthy diet and oral supplementation with Vitamin D when needed (see aad.org for the AAD’s response to how much Vitamin D is necessary).

Basal cell carcinoma (bcc) and squamous cell carcinoma (scc) are the most common forms of skin cancer affecting one in five Americans during their lifetimes. They arise on sun-exposed areas of the body and may present as non-healing or easily-bleeding growths. Bcc can present as a pearly pink telangiectatic papule with or without ulceration and scale, and scc, as a non-healing hyperkeratotic papule. Superficial basal cell carcinoma can masquerade as the “eczema” that doesn’t respond to topical steroids and never goes away.

Dermatologists are trained in cutaneous surgery and histopathology and evaluate and manage cutaneous malignancies. When detected early, full lesional biopsy may be accomplished with either a punch or full scoop-shave; at times an incisional or excisional specimen removal.

Various treatment options in a dermatologist’s armamentarium include chemotherapeutic topicals such as 5-fluorouracil, diclofenac gel, imiquimod cream; also cryotherapy; eletrodessication and curettage, excision, and Mohs micrographically-controlled surgery (MMS).

MMS is a method of removing skin cancers with margin control while sparing normal tissue. It is used for skin cancer recurrences (primarily bcc and scc) and for cutaneous malignancies on areas where tissue-sparing is required, such as the face, head, neck, hands.

Typically, the patient’s skin cancer is delineated with a Gentian violet pen. The area is locally anesthetized and the skin cancer is removed with a scalpel encompassing the whole tumor (and some, sparingly, 1-2 mm of normal skin). A drawing (map) is made of the tumor with dye placement and strategic hatch marks for orientation.

Next, the specimen is processed in our Mohs laboratory; it is frozen and cut by a trained histotechnician, such that all margins and the deepest margin can be fully evaluated. Think of the tumor as a Jell-o mold placed upside down on a plate that is cut from the plate-side first. The slides are then stained and microscopic examination by the Mohs dermatologic surgeon proceeds. The surgeon acts as both pathologist and dermatologic surgeon in this method. Areas of tumor involvement are marked on the drawing/map or in the case of being clear of tumor on all margins, declared negative for further malignancy. Only areas of tumor involvement are removed in subsequent stages until tumor-free or until Mohs can no longer proceed.

The patient’s resultant defect following tumor removal is then repaired. The whole process may take 30 minutes to several hours. The recurrence rates after Mohs are as low as 1-3 percent. Patients appreciate the convenience of having their skin cancer treated and cleared in typically one visit.

For more about Mohs surgery, visit The American Society of Mohs Surgery Web site at www.mohssurgery.org or to make a referral, please call the CentraCare Clinic Dermatology Department at (320) 229-4924.

Determining barriers to patient compliance

By Allen Horn, MD

Poor adherence is a problem we all confront regularly. When prescribing a long-term medication, such as lisinopril for hypertension, I initially write the prescription for a one-month supply, plus refills, and schedule a follow-up visit two months later. If at this visit the patient is not doing as well as expected, I ask the patient to tell me how she is taking the medication. The answer is usually “You told me to take one pill a day” or “The bottle says take one a day.” I then ask how many bottles she has finished. Too often, the patient admits she is still on the first bottle. Having confirmed in a non-threatening manner that the patient is not taking the prescription as instructed, it is important to determine what barriers are preventing the patient from taking her medication as prescribed. Therefore, without any need for lecturing or scolding, the patient’s problem with compliance can be discovered and, in a subtle way, the patient can be helped to realize that the medication can’t be expected to work when it remains in the bottle.
Attempts at peering into body cavities without making large incisions began in the 1800s with tubes and magnifying lenses using candlelight. The modern era of minimally invasive surgery began in the late 1990s with the availability of laparoscopes using attached video cameras and fiberoptic light sources. The report of 1989 describing removal of the gallbladder through “band-aid” incisions forever changed the nature of surgery, and led to attempts to incorporate this technology into other areas. Very quickly, this instrumentation was introduced into chest surgery and had the same revolutionary effect on this field as it had on abdominal surgery.

Traditional open chest surgery (thoracotomy) remains significantly traumatic to the patient and results in prolonged disability. This is especially concerning for patients with respiratory compromise. Major chest wall muscles are cut and the ribs have to be spread apart. But for most of a century, this was the only approach available for working in the chest.

With thoracoscopy, typically three small incisions are made and the surgeon works with instruments introduced between the ribs. The thoracoscope is identical to the laparoscope. A special bifurcated endotracheal tube is placed by anesthesia (as is done in traditional chest surgery) so the lung on the operated side collapses.

Uses for thoracoscopy include lung biopsy, lung nodule resection for diagnosis, treatment of pneumothorax, treatment of empyema and hemothorax, resection or biopsy of mediastinal masses, and now lung cancer surgery.

A stapling device (the diameter of a finger) is used to transect lung tissue or major vessels. Using the stapler, a generous wedge of lung tissue can be removed for diagnostic purposes, a lung nodule can be resected, or lung tissue with blebs causing pneumothorax can be removed. Other instrumentation allows complete clearing of empyema loculations, old blood clots from trauma and removal of any rind which might be trapping the lung. In select patients, lobectomy for cancer can be performed.

Like laparoscopy, thoracoscopy has been a welcome addition to the surgeon’s armamentarium allowing us to help patients in a minimally invasive, less traumatic way.

For more information or to make a referral, please call CentraCare Clinic Surgery Department at (320) 252-3342.
Affordable Care Act brings Medicare changes

By Paula Lijewski, CPC; Connie Goulet, CPC; Sue Stein, CPC, Compliance Specialists, CentraCare Clinic

As a result of the Affordable Care Act (ACA), Medicare now allows an annual wellness visit (AWV), including personal prevention plan services (PPPS).

Eligibility

AWV: Medicare will pay for an AWV for a beneficiary who is 12 months past the effective date of his/her first Medicare Part B coverage period, and who has not received either an IPPE or an AWV providing PPPS within the past 12 months.

Medicare pays for one first AWV (HCPCS G0438) per beneficiary per lifetime. All wellness visits after that must be billed as a subsequent AWV (HCPCS G0439).

IPPE (i.e. Welcome To Medicare): Beneficiaries in their first 12 months of Part B coverage will continue to be eligible for only the IPPE. Medicare continues to pay for only one IPPE per beneficiary per lifetime.

Deductible and Coinsurance

AWV: As a result of the ACA, the Medicare deductible and coinsurance for the AWV (HCPCS G0438 and G0439) are waived.

IPPE: As a result of the ACA, the Medicare deductible and coinsurance (for HCPCS code G0402 only) are waived for the IPPE provided on or after Jan. 1, 2011.

HCPCS codes used to bill the AWV

For the first AWV provided on or after Jan. 1, 2011, the health professional shall bill HCPCS G0438 (Annual wellness visit, including PPPS, first visit). This is a once per lifetime allowable Medicare benefit.

All subsequent AWVs shall be billed with HCPCS G0439 (Annual Wellness Visit, including PPPS, subsequent visit). If a beneficiary selects a new health professional to complete a subsequent AWV, the new health professional must bill the subsequent AWV with HCPCS G0439.

First AWV services providing PPPS (HCPCS G0438) are a ‘one-time’ Medicare benefit and include the following elements furnished to an eligible beneficiary by a health professional:

- Establishment of the individual’s medical/family history;

- Establishment of a list of current providers and suppliers who are regularly involved in providing medical care to the individual;

- Measurement of the individual’s height, weight, body mass index (or waist circumference, if appropriate), blood pressure (BP), and other routine measurements as deemed appropriate, based on the individual’s medical and family history;

- Detection of any cognitive impairment the individual may have;

- Review of an individual’s risk factors for depression, including current or past experiences with depression or other mood disorders. This is based on an appropriate screening instrument for persons without a current diagnosis of depression. The health professional may use standardized screening tests designed for this purpose and recognized by national professional medical organizations;

- Review of the individual’s functional ability and level of safety, based on direct observation of the individual, or the use of appropriate screening questions or a screening questionnaire. The health professional may use standardized screening tests designed for this purpose and recognized by national professional medical organizations;

- Establishment of a written screening schedule for the individual, such as a checklist for the next five to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and Advisory Committee of Immunizations Practices (ACIP), as well as the individual’s health status, screening history and age-appropriate preventive services covered by Medicare;

- Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions identified through an IPPE, and a list of treatment options and their associated risks and benefits;

- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention and nutrition;

- Voluntary advance-care planning upon agreement with the individual;

- Any other element(s) determined appropriate by the Secretary through the National Coverage Determination (NCD) process.

continued on back page
Subsequent AWV services providing PPPS (HCPCS G0439) include the following elements furnished to an eligible beneficiary by a health professional:

- Update to the individual’s medical/family history;
- Update of the list of current medical providers and suppliers who are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing PPPS;
- Measurements of an individual’s weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual’s medical and family history;
- Detection of any cognitive impairment the individual may have;
- Update to the individual’s written screening schedule developed at the first AWV providing PPPS;
- Update to the individual’s list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, as developed at the first AWV providing PPPS;
- Furnishing of appropriate personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs;
- Voluntary advance-care planning upon agreement with the individual, and;
- Any other element determined appropriate by the Secretary through the NCD process.

References: