Summer 2011

Clinic Connection: Summer 2012

CentraCare Clinic

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President’s Message

Are you different or am I?

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

Cultural diversity has increased dramatically throughout Central Minnesota during the last decade as unprecedented numbers of foreign-born immigrants make our communities their home. These population changes have resulted in patients presenting to providers with a wider range of religious, cultural and linguistic diversity than we had been accustomed to. Unfortunately, few practicing physicians in the U.S. have any training in cross-cultural medical care. Many providers struggle with providing appropriate care for new immigrants and refugees, for patients whose cultural or religious beliefs are at odds with Western medicine and for those patients who speak a language other than English. These challenges have clearly resulted in racial and ethnic disparities which negatively impact the quality of the care and service we provide to our patients and our communities.

To ensure that the highest quality of care is provided to every patient and family, we need to improve the cultural competency of our organizations by focusing on and increasing the cultural competence of the behaviors, attitudes and policies within our organizations so that we are enabled to work effectively in cross-cultural situations. However, no organization can impose or bestow cultural competence on its constituency. Rather, as members of the organization, each of us must embark on our own personal journey to cultural competence by purposefully becoming aware of our personal assumptions,

continued on inside
Medical issues are more than adherence and affordability

By David Tilstra, MD, Medical Director, CentraCare Clinic

Most patients with chronic health conditions are on medications. Common medication problems include issues with adherence, effectiveness and safety. When medication doesn’t appear to be effective, it can be difficult to identify the source of the problem. Because more than 50 percent of patients have low health literacy, lack of adherence may be caused by the patient not fully understanding instructions, but it appears that adherence is only part of the problem.

A recent study published in Health Affairs (Smith, et al, April 2011) looked at drug therapy problems identified by a systematic review of medications used by Medicaid patients. The problems they identified provide a framework for thinking about issues patients have with medications. There were four broad categories of problems: indication, effectiveness, safety and adherence.

Indication for the drug was the most common issue in nearly 30 percent of the problems with 23 percent needing a second drug and 7 percent on an unnecessary drug. Drug effectiveness was a problem for about 23 percent; 16 percent needed a higher dose and 7 percent needed a different drug. Patient safety issues were identified for 23 percent; nearly 16 percent of the problems were adverse drug events and 5 percent of the problems were a dose that was identified to be unsafe.

Patient adherence problems were identified in only 26 percent of the patients, which surprised the authors as this was a population of Medicaid patients. They were confident of their results, however, because of their interview process. The breakdown of the problems indicated that about 11 percent were due to the patient not understanding how to take the medication. About 7 percent of the patients preferred not to take the medication, but didn’t tell their provider of their preference; 5 percent simply forgot to take the medications; and 4 percent didn’t take the medication because they couldn’t afford the medication or it wasn’t available through the payer’s formulary.

The study highlights that medication issues are more than adherence and affordability. On the other hand, it is sometimes difficult to ascertain the problem source. Use of pharmacists to review medication usage would be helpful, but pharmacists are not always available. The framework provided in this study does help us begin to understand some of the sources of medication problems.

Preparing for the transition from ICD-9 to ICD-10

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

With the implementation date for International Classification of Diseases, 10th revision (ICD-10) just more than two years away, the health care industry is hard at work preparing for the transition from ICD-9 with approximately 13,000 codes to ICD-10 with 68,000+ codes. The switch to ICD-10 will lead to more accurate and precise clinical information which leads to more appropriate reimbursement and lower overall costs of health care. While the importance of proper documentation won’t change with the transition to ICD-10, many elements that support the codes will change, resulting in more detailed documentation.

Changes that will need to be in the medical record documentation:

**Laterality:** Many providers already document which side of the body the disease or injury occurred, but it is now a required data element. Approximately 5,000 codes have a right and left distinction.

**Combination codes:** A single code is used to classify two diagnoses with an associated secondary process or complication. This relationship cannot be assumed or inferred; the documentation must clearly state the relationship. For example, degenerative changes of the spine (spondylosis) documentation should state the exact level (i.e. cervical, thoracic, lumbar, etc.).

**Episode of care:** Many injuries, particularly fractures, must have documentation indicating what stage of the patient’s fracture care the physician rendered so your coders can add the appropriate seventh character (one of A–S).

**Greater specificity:** Identifying diseases, conditions and the documentation will need to reflect the exact diagnosis to take advantage of the improved level of detail.

Since there are considerable changes needed to move to ICD-10, diagnosis coding should be as specific as possible. This is accomplished by understanding the relationship between specificity and reimbursement and creating a complementary partnership between the coder and physician.
Introducing our new CentraCare Clinic Specialists

**Pediatrics**

**Jill Amsberry, DO**

**Medical School:** Midwestern University, Glendale, AZ  
**Residency:** University of Iowa, Children’s Hospital, Iowa City, IA  
**Board Eligible:** Pediatrics  
**Clinical Interest:** General Pediatrics

**Partners:** Jon Dennis, MD, MPH  
Kelly Fandel, MD  
Weining Hu, MD, PhD  
Janelle Johnson, MD  
Wendi Johnson, MD  
Kathleen Kulus, MD  
Denise Lenarz, MD  
Cindy Melloy, MD

**Geri Ignace, MD**

**Medical School:** University of Minnesota, Minneapolis  
**Residency:** Medical College of Wisconsin, Milwaukee  
**Board Certified:** Pediatrics  
**Clinical Interests:** Well baby care

**Partners:** Dale Minnerath, MD  
Marilyn Peitso, MD  
Jennifer Rogan, MD  
Thomas Schrup, MD  
Sylvia Sundberg, MD  
Dove Watkin, MD

**Cardiovascular & Thoracic Surgery**

**John Castro, MD**

**Medical School:** University of the Philippines College of Medicine, Manila, Philippines  
**Residency:** General Surgery, SUNY, Syracuse, NY  
**Fellowship:** Cardiothoracic Surgery, University of Minnesota, Minneapolis  
**Clinical Interests:** Vascular Surgery, Thoracic Surgery and Cardiac Surgery

**Partners:** Edgar Pineda, MD  
John Teskey, MD

**Hospitalist**

**Rebecca Campbell, MD**

**Medical School:** University of Minnesota, Minneapolis  
**Residency:** Indiana University, Indianapolis  
**Board Eligible:** Internal Medicine  
**Clinical Interests:** Hospital Medicine and quality improvement

**Ghassan H. Elkadi, MD**

**Medical School:** Cairo University School of Medicine, Cairo, Egypt  
**Residency:** Roger Williams Medical Center/BU, Providence, RI  
**Fellowship:** Vascular Medicine, Ochsner Clinic, Ochsner Clinic, New Orleans, LA  
**Board Certified:** Internal Medicine  
**Clinical Interest:** Vascular Medicine/EVLT

**Partners:** Olayiwola Adetunji, MD  
Hanadee Alameldin, MBBS  
Christopher Aronson, MD  
Sarah Carter, MD  
Darren Chihos, MD  
Arihant Dalal, MD  
Sheri Haroldson, MD  
Khadir Kakal, MD  
Paul Marek, MD  
Eric McFarling, MD  
Joseph Mercuri, MD

**Gemma C. Lim, MD**

**Medical School:** University of the East, Quezon City, Philippines  
**Residency:** SUNY Upstate Medical University Hospital, Syracuse, NY  
**Fellowship:** Endocrinology, Metabolism & Nutrition, SUNY Upstate Medical University Hospital, Syracuse, NY  
**Board Certified:** Internal Medicine  
**Clinical Interest:** Internal Medicine, Hospitalist and Endocrinology

**Partners:**  
Ravikanth Nathani, MBBS  
Brian Nelson, MD  
John Oyakhire, MD  
Holly Peterson, MD  
Todd Severnak, DO  
Shweta Sharma, MD  
Mary Joy Sia Su, MD  
Walter Sia Su, MD  
Jeremy Skramsted, MD  
Peter Waldusky, MD  
Darin Willardsen, MD

Access all CentraCare Clinic physician bios online at www.centracare.com
Ramadan is considered a month of community because religious practices such as prayers, fasting, charity and self-accountability are often practiced within a community setting. Ramadan is a month where believers learn to exercise self-control. A major facet of this is the abstinence from food, drink and smoking that is prescribed to all healthy Muslims during the hours of sunrise to sunset. In the evenings, Muslims gather as family and community to break their fast, pray and read the Quran.

Ramadan is believed to be the most blessed and spiritually beneficial month of the Islamic year. Based on the Quran, those who are sick, elderly or on a journey, and women who are pregnant or nursing are permitted to break the fast and make up an equal number of days later in the year. Although the sick are exempt, many continue to fast and abstain not only from eating and drinking water, but also from consuming oral medications and taking intravenous fluids.

An article providing pertinent advice for fasting Muslims in good health and those on medication can be found at www.ethnomed.org.

Balancing religious beliefs with health needs

By Rosemond Sarpong Owens, Health Literacy/Cultural Competency Specialist, CentraCare Health System

Ramadan in 2011 will start August 1 and continue through August 31

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attitudes, beliefs, biases and behaviors that might influence, consciously or unconsciously, our care of patients and families and our interactions with colleagues and staff from diverse racial, ethnic and socio-cultural backgrounds.

Following self-evaluation, it is important to develop some understanding of patients’ diverse cultures in order to eliminate health care disparities and provide excellent service and quality to every patient. Only by establishing a foundation securely anchored in genuine acceptance and understanding of other cultures will we be able to consistently provide high-quality care and excellent service for every patient.
Parents who refuse shots for their children are a prickly problem in the office, frustrating providers who see the obvious benefits of immunizations and requiring extra time to repeatedly review information and correct misconceptions. There have been increasing problems with refusal of immunization over the past decade, going nationally in 1991 from a rate of approximately 1 percent of school children exempted from shots to 1.5 percent in 2004. As high as 11.5 percent of parents had refused a shot in 2009.

Family who refused immunizations have appeared to have varied concerns:

- the vaccines don’t work;
- they might cause autism or brain damage;
- there is a lack of trust in the government;
- there is a belief that their child is not at risk or that the disease is not dangerous;
- it is better to have the child naturally infected;
- it is harmful to give multiple vaccines together; or
- the cost is too high.

In our office, we have tried a few things that seem to help. Many of our pediatricians see that parents will eventually come around if you stick with them, keep talking and maintain your respect for their opinions and appreciation for the confusion created by widespread false information and scare tactics. As a last resort, extended schedules might be an option, but these place increased risk of the child acquiring the diseases, infecting other children, reinforcing the hysteria and missing some shots.

For the Somali families and other families who refuse MMR because of presumed problems with autism, we usually try to point out that there has been an outbreak of measles with a few children hospitalized in St. Paul, and scientific evidence shows that there is no association with autism. Sometimes the parents will agree to let their child get the MMR vaccine by age 2 as a last resort.

I usually keep some CDC news articles next to the vaccine information sheets in each room. These sheets describe some of these outbreaks or cases of meningitis or whooping cough. Parents seem to pay attention to the news articles.

There also are concerns about mercury in immunizations, but of course, there has not been any thimerosal in any of the regular childhood shots except some of the flu vaccine over the last eight years. In addition, there has not been any evidence or scientific studies that there was any neurologic damage before this time and certainly there has not been any decrease in autism once the thimerosal was removed.

Some families will never agree to have any immunizations. We have debated the idea of excluding these families from our practice, primarily based on the possible risk of infecting other children in our waiting room. To date, we have not done so, but it might be a last resort if the parent does not seem to have any inclination or intention to listen to us for any other advice.

The Centers for Disease Control, in partnership with the American Academy of Family Physicians and the American Academy of Pediatrics, have developed fact sheets to learn new strategies for having successful conversations with parents about vaccines. For more information, visit www.cdc.gov/vaccines/spec-grps/hcp/conv-materials.htm.

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**Immunization refusal brings challenges to physicians**

By Jon Dennis, MD, Pediatrician, CentraCare Clinic

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**Doc...When I kick off my shoes, everyone leaves the room. What can I do?**

Foot odor is a common problem that often can be treated with some simple “home remedies.”

Consider the following suggestions for your patients:

- Wash feet daily with deodorant soap and dry them well;
- Change socks as frequently as possible - even three or four times a day;
- Alternate shoes on a daily basis so you don’t wear the same pair two days in a row;
- Sprinkle the fragrant herb sage into your shoes to control odor;
- Use your underarm antiperspirant or deodorant on your feet;
- Sprinkle the inside of your shoes with cornstarch to help absorb moisture and keep your feet drier; and
- Shake on deodorizing foot powder that contains aluminum chloride hexahydrate.
Some newborns who require admission to a neonatal intensive care unit (NICU) may be at risk for long-term growth and development effects. At the time of discharge from our NICU, selected infants are scheduled to be seen in our Infant & Child Development Clinic. Criteria for follow-up include birth at or before 32-weeks gestation, birth weight at 1500 grams or less, a number of intrauterine or postnatal conditions or complications or social concerns.

A team, including a neonatologist, a dietitian and a developmental specialist evaluate and follow these infants, as well as referred at-risk graduates of other NICUs. Children under age 4 who have developmental concerns also can be referred. Our routine follow-up schedule is at 6 months, then 1, 2 and 4 years of age, though many children are seen more frequently if problems are identified that require closer monitoring. If there are areas of concern, the team and the family work together to develop a plan to further assess and treat the child, such as a referral to a specialist or agency.

The parents are provided with nutritional and developmental information, any pertinent specific information regarding their child and support as needed. A report of each visit is sent to the family and all who provide care and services for the child. Our team is committed to patient and family centered care, and works with the parents, primary care providers, medical specialists, school and community resource persons and physical, occupational and speech therapists to maximize each child’s potential.

For referrals, information or to schedule an appointment, call (320) 255-5781 or (800) 835-6652, ext. 55781.