As one strategy for responding to health care reform, the concept of aligning incentives has received a lot of discussion and serious evaluation in many health care organizations. Some organizations already have shifted some physician compensation away from strict productivity, typically measured with wRVUs, to a compensation model with greater emphasis on quality, patient satisfaction and cost of care. There undoubtedly will be significant changes in physician compensation models as payment models from Medicare, Medicaid and other payers increasingly base some payments on quality, service and value.

However, simply throwing money at providers will not be effective in leading to the changes that will be required by the coming perfect storm of health care reform, the economic environment, state and federal deficits and an aging population. In an uncertain future, we all have a choice to make. We simply can react as victims and complain about everything we perceive is being done to us, or we can utilize the immense talents of each other and our staff to collaboratively work together to learn how to do more for our patients with less: provide more quality, more service and more value, while being paid less.

Financial incentives can help reward the work needed to meet these challenges. But, regardless of the money, we still will need to learn how to better address the fear and anxiety of patients and how to better motivate patients to actively participate in taking care of their health. We still need to learn how to refocus on purpose and the meaningful work we do, how to best appeal to the professional pride of providers and how to motivate them to truly be patient-centered — to overcome power struggles, turf battles, conflicting values and social mores — so that together we can do more with less.
Noncompliant medication use is a significant health care problem

By David Tilstra, MD, Medical Director, CentraCare Clinic

Many patients fail to take their medications as directed, and 33 percent of patients never fill their prescriptions — including up to 50-60 percent of patients with chronic conditions. Improper medication use is one of the leading causes of hospitalizations and up to 125,000 patient deaths are linked to drug noncompliance. Improper use of warfarin, other anticoagulants, insulin and other diabetic drugs is a leading cause of hospital readmissions. Simply stated, noncompliance medication use is one of the most significant problems in health care today. Often patients are blamed for this noncompliance, but there are things that providers can do to help their patients.

• Assess the likelihood that the patient will be noncompliant. There are validated tools to explore this such as the Morisky medication adherence questionnaire, an eight-item questionnaire that explores patient’s beliefs about taking medications. (Available at http://www.acpinternist.org/archives/2009/02/adherence.pdf)

• When a new drug is prescribed, always explain the medication’s purpose, probable side effects, as well as frequency and dosing. Ask the patient to “teach back,” that is, tell you how they think they are supposed to take the medication. At follow-up visits, ask how the patient takes the medication, especially if the drug does not appear to have the expected effect.

• Stress the effects of failing to take the medication, and especially try to find out what drives the patient. Point out how failure to take the medication may interfere with some of their life plans, such as being around to see their grandchildren.

• Try to minimize any financial barriers for the patients, especially co-pays and other out-of-pocket costs, through the use of generic medications. Studies have shown that each $10 increase in co-pays is associated with a 10 percent decrease in compliance.

• Use reminder systems, from simple pill boxes to more sophisticated automated reminder systems. Patients can sign up for a daily text reminder to take their medications at scriptyourfuture.org, a collaboration of the National Consumers League and the AMA.

• Use other professionals, such as diabetes educators or asthma educators, to teach patients about their conditions and medication use.

(Adapted from AMA news Oct 10, 2011)

ICD-10 new documentation requirements

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

The ICD-9 documentation guidelines today are very specific, but they are not specific enough for changing documentation requirements. ICD-10 is a clinical classification system that is sophisticated enough, and specific enough, to keep up with the changes in medical regulations.

The “buzz” word for ICD-10 documentation is DETAIL. Complete and detailed documentation helps physicians organize observations and examinations, justify their treatment plan, support the diagnosis and document patients’ progress and outcomes. It establishes medical necessity.

Increased clinical documentation may be required for ICD-10 to support the specificity needed for encounters. Additional documentation will depend on the type of patient encounters. You will not have to write a two-page patient visit note for each patient encounter.

For example, if your patient comes into the office with a sore throat and you do a simple exam, palpate the throat, have the nursing staff perform a strep swab, which turns out positive, and diagnose the patient with strep throat, your regular documentation will suffice. This is because there are not many more specific details needed in order to determine that the patient actually has strep throat.

Documentation variables may include:

• Type of encounter (initial or subsequent)
• Applied specificity (did the patient lose consciousness?)
• Acute versus chronic
• Relief or non-relief (intractable versus non-intractable)
• External cause (what caused the accident?)
• Activity (what was the patient doing when she was injured?)
• Location (where was the patient when she was injured?)

In conclusion, complete, accurate and detailed documentation will be necessary to assign the appropriate ICD-10 code, just as it is for ICD-9.
Improving asthma care in Central Minnesota

By Mary Keating, MD, Pediatric Allergist, CentraCare Clinic

More than 22 million Americans have asthma with nearly 4,000 people dying each year from complications. In Minnesota, almost 8 percent of adults and 7 percent of children are living with asthma. The MN Community Measurement (MNCM) for asthma has been implemented in Central Minnesota for our asthmatic patients with the goal of improving asthma and achieving optimal asthma care. Optimal asthma care for patients is defined as:

- patient has a current asthma action plan (AAP);
- asthma is well controlled as measured by the asthma control test (ACT); and
- patient is not at increased risk of exacerbations.

The asthma action plan outlines in writing what steps to take in the event of an asthma exacerbation. It includes the patient’s triggers and symptoms and information about asthma medications. The National Asthma Education and Prevention Program strongly recommends that all asthmatics develop their own specific action plan in partnership with their physician. We believe the action plan promotes asthma education.

The asthma control test is used to identify patients with poorly controlled asthma. It also is useful for predicting an asthma exacerbation and changes in treatment decisions.

The last MNCM measurement is determining asthma risk. This involves asking the patient if there have been any asthma-related hospitalizations or emergency room visits.

The following data from September 2010 to November 2011 demonstrates the change CentraCare Clinic has documented for patients with asthma.

<table>
<thead>
<tr>
<th></th>
<th>Sept. 2010</th>
<th>Nov. 2011</th>
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</thead>
<tbody>
<tr>
<td>Patients with AAPs</td>
<td>32%</td>
<td>72%</td>
</tr>
<tr>
<td>Patients ACT done</td>
<td>34%</td>
<td>84%</td>
</tr>
<tr>
<td>Risk documented</td>
<td>28%</td>
<td>77%</td>
</tr>
<tr>
<td>Optimal asthma care</td>
<td>16%</td>
<td>52%</td>
</tr>
</tbody>
</table>

CentraCare Clinic has been working hard to improve asthma care and is making progress with our asthma patients. We anticipate our improvements in asthma care will reduce emergency room visits, hospitalizations and medical costs. If you would like to learn more about our efforts to improve asthma care or if you have challenges with an asthma patient, please call our Allergy Clinic at (320) 654-3650.

Education is key to reducing carbon monoxide poisoning in children

By Marla Moore, MD, Pediatric Critical Care, CentraCare Clinic

Epidemiology: Accidental carbon monoxide (CO) poisoning causes an estimated 500 deaths per year in the U.S. Most poisonings from this odorless, tasteless gas are secondary to exposure to engine, furnace or heater exhaust.

Pathophysiology: Following inhalation, CO binds to hemoglobin to form carboxyhemoglobin at a rate 200-300 times that of adult hemoglobin. As the hemoglobin tetramer structure changes, oxygen release becomes more difficult, shifting the oxygen dissociation curve to the left. CO also interferes with cytochrome oxidase and the electron transport chain, reducing ATP production and slowing or shutting down cellular metabolism. Tachypnea, tachycardia, neurologic changes, metabolic acidosis and eventual cerebral edema and death ensue.

CO has an even greater affinity for fetal hemoglobin than adult hemoglobin. In utero, exposure to CO can be quickly lethal. Infants and children have higher metabolic rates than adults, using oxygen faster and making them more vulnerable to carbon monoxide’s toxic effects.

Testing: Blood levels greater than 20 percent are considered mild intoxication. Levels greater than 60 percent represent severe intoxication. Death is likely without prompt intervention. Blood levels may not correlate with clinical findings. Pulse oximetry values are falsely elevated and misleading. Every exposure should be treated promptly.

Treatment requires prompt removal from the CO source and administration of 100 percent oxygen. If neurologic findings warrant, endotracheal intubation may be required. High concentrations of oxygen shorten the half life of CO and hasten its removal from cytochrome oxidase. Hyperbaric oxygen produces dramatic changes, shortening the half life to as little as 30 minutes. Hyperbaric oxygen consultation is recommended for children with persistent neurological changes after oxygen administration.

Preventive measures: State law requires at least one CO detector in every home. Cost is $20-$60. Remind your patients, family and friends about this important safety measure.
Minimally invasive surgery for lung cancer

By Scott Houghton, MD, and Matthew Maunu, MD, General Surgeons
CentraCare Clinic – River Campus

Video Assisted Thoracic Surgery (VATS) or thoracoscopy is a minimally invasive approach to chest surgery. It is similar to laparoscopic surgery using many of the same instruments and techniques. Thoracoscopy has been used for simple procedures throughout the years including wedge biopsies and procedures for the pleural space, but now can be used to perform more complex anatomic resections, specifically those for lung cancer.

Lobectomy is considered the standard of care for those patients with peripheral lung cancers that can medically tolerate a major resection. Lobectomy for lung cancer now can be performed thoracoscopically using three to seven ports placed at various points in the chest. A small access incision is used to remove the specimen and also can be used to facilitate lung dissection.

Thoracoscopic (VATS) lobectomy has been shown to have all of the benefits of open lobectomy for lung cancer but avoids some of the complications. Importantly, thoracoscopic lobectomy has been shown in prospective randomized trials to be oncologically equivalent to open lobectomy, providing equivalent rates of long-term survival and locoregional recurrence. In single institution series comparing thoracoscopic lobectomy versus thoracotomy and lobectomy, mortality rates tend to be lower for thoracoscopic lobectomy, but these are not statistically significant. Blood loss also has been shown to be similar. Length of hospital stay, days with a chest tube and the rate of major postoperative complications are all lower for thoracoscopic lobectomy.

Thoracoscopic lobectomy results in decreased postoperative pain both acutely and chronically. Patients have fewer pulmonary complications and are earlier to ambulate. In our experience, many patients go home without narcotics and those who do have stopped them before scheduled follow-up.

Operative times are longer for thoracoscopic lobectomy, but the benefits justify the time. Reported conversion rates are between 2.5 and 17 percent. At our hospital, operative times are 1.5 times longer with a conversion rate of 10 percent.

For more information or to make a referral, contact the CentraCare Clinic Surgery Department at (320) 240-7822.