Clinic Connection: Fall 2013

CentraCare Clinic

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President’s Message
Value is based on the patient experience
By David Tilstra, MD
President, CentraCare Clinic

I recently heard two speakers talk about health care reform. Each had very different perspectives on the federal approach to health care reform known as Obamacare or Affordable Care Act. Interestingly, both believed that health care reform was needed, and each was convinced if their version didn’t move forward, the country likely would see major turmoil in the coming years.

While their versions differed, what was clear is that delivery of health care will need to change from the traditional method of fee per service to a “value approach.” Understanding what value is and delivering on it will be necessary regardless of the rhetoric coming out of Washington.

What is value? First, patients perceive value as the interaction and service they get from their health care provider. To many patients, quality is defined by their patient experience. If we don’t deliver on the experience, there is no value to the patients. Second, rapid communication of clinical patient information is critical for improving the overall quality of care. While most providers do react appropriately if they have all the information, we all have experienced the frustration of trying to manage a patient while not knowing what a specialist prescribed the day before or the MRI result completed in another institution a few days ago. That information needs to be available instantaneously, just like credit card purchases that show up online a few minutes after we purchase something. We, as a profession, need to have the attitude that our work isn’t done until we appropriately communicate what we did during a patient visit. Third, we need to understand what clinical activities provide value and what is unnecessary or frankly, unhelpful.

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Seasonal flu and our role as health care providers

By George Morris, MD, Medical Director, CentraCare Clinic

Influenza (flu) is poised and ready to reemerge to affect our patients and us. We know there are only a few things we can do to decrease the spread. Good hand hygiene and immunization are two of the most effective measures.

The Centers for Disease Control and Prevention (CDC) estimates that 5 to 20 percent of Americans come down with the flu during each flu season. Children are two to three times more likely than adults to get sick with the flu, and children frequently spread the virus to others. Although most people recover from the illness, the CDC estimates that in the United States more than 200,000 people are hospitalized and about 36,000 people die from the flu and its complications every year.

We know that flu can be passed even before a person knows they are sick, and most people are sick for at least a week. To avoid spreading the flu, the CDC recommends that ill people stay home for at least 24 hours after a fever is gone.

We encourage all of our providers and staff to receive the influenza immunization each season. Most companies now produce quadrivalent vaccines to improve coverage of multiple strains. Last year’s vaccine effectiveness was about 56 percent when measured as a percentage of individuals who saw a provider within seven days of becoming ill.

We realize this is not a great success rate, but immunization has shown effectiveness in decreasing time lost from work, hospitalizations, serious illness and death. One study showed one life saved per 4,000 immunizations. CentraCare Health’s goal is to obtain close to 100 percent immunization rate of our providers and staff. We cannot completely prevent our patients from becoming ill, but vaccination is one thing we can do to protect our patients and us.

If not for YOU, get the flu vaccine for THEM.

Rheumatology update

Our Rheumatology department has temporarily closed its practice to any new consultations or new visits until further notice. This is because three of our five rheumatologists have departed for essentially unrelated reasons in the past six months.

Rheumatologists Aaron Holmgren, MD, and Bharath Akkara Veetil, MBBS, are committed to the challenging task of managing our established patients, many who are taking immuno-modulating drugs requiring rheumatologic management.

This closure will impact patients who have been seen in the past, but have not required active follow-up. Similarly, we are unable to accommodate new patients who have been seen at St. Cloud Hospital, even if seen by rheumatology within the hospital. These patients will be asked to follow-up with their primary care provider.

We understand and apologize for the burden this restriction places on our local and regional medical communities, especially given the relative scarcity of rheumatology services. Please know we are fully engaged in an effort to recruit new providers to our practice and to extend our services by other means.

In the interim, rheumatology services are available in Brainerd, Maple Grove, the Twin Cities, Duluth, Fargo, N.D. and Sioux Falls, S.D. Our staff can help answer questions that you or your patients may have.

It is our sincere hope to reopen our practice as soon as possible so we again can provide new patient consultations in the St. Cloud area. Until that time, we thank you for your understanding and support.

President’s Message

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It’s more than just cutting back on what we do or looking for the cheapest drugs, tests or materials. If cutting back on regular HgbA1cs results in a hospitalization for uncontrolled diabetes, we haven’t saved any money. We need to continue to evaluate what we do to better understand what provides value to the patient.

This list can go on, and I am sure many of you could name more ways to provide value to the patient. As a profession that is under pressure to change our mode of health care delivery, we need to focus now more than ever on putting the patient first.
While all of us are aware of the transluminal intervention within the arterial system, the potential and spectrum of transvenous interventional neurological techniques is less well understood. Transvenous interventional procedures are performed via catheters that are introduced through the femoral vein and advanced through the iliac vein, inferior vena cava, right atrium, superior vena cava, brachiocephalic vein and subsequently the internal jugular vein. Microcatheters, angioplasty balloons, and stents can be further introduced into the cerebral dural venous sinuses including sigmoid, transverse, superior sagittal, and other sinuses. Several procedures can be performed as outlined below:

1. **Evaluation of pituitary tumors and Cushing’s disease:** Venous blood sampling via catheterization of petrosal veins bilaterally can allow measurement of various hormones secreted by both lobes of pituitary glands at baseline and after injection of dexamethasone. The functional activity assessment allows determination of concentration and laterality of hormone secretions. The test is the gold-standard method for diagnosing Cushing’s disease.

2. **Treatment of idiopathic intracranial hypertension:** A prominent proportion of patients who present with headaches and papilledema secondary to idiopathic intracranial hypertension have impaired venous outflow due to stenosis or occlusion of transverse or sigmoid sinuses. Treatment of outflow obstruction improves venous drainage and pressure with subsequent improvement in intracranial pressure (see Figure 1).

3. **Treatment of tinnitus:** Tinnitus can be secondary to enlargement of veins that connect sigmoid sinus to external jugular veins. These veins are located behind the ear and increased flow creates refractory tinnitus (see Figure 2 on next page). The external carotid artery branches can anastomose with sigmoid or transverse sinuses creating refractory tinnitus through flow via these anatomic channels. Obliteration of these abnormal channels through coils or liquid embolic agents can result in complete cure of symptoms.

4. **Treatment of intracerebral hemorrhage:** Increase in venous pressure due to thrombosis of the cerebral veins or sinuses can result in intracerebral hemorrhages. Lysis of thrombus using transvenous thrombolitics or mechanical thrombectomy can prevent further intraparenchymal hemorrhages and intracranial hypertension. Intracerebral hemorrhage also can occur because of increase in venous pressure secondary to arteriovenous fistulas derived from external or internal carotid artery branches pathologically anastomosing with sigmoid or transverse sinuses. Obliteration of these abnormal channels through coils or liquid embolic agents can result in further progression of symptoms or new intracerebral hemorrhages.

5. **Treatment of multiple sclerosis:** Recent studies have documented that venous engorgement and perivenular inflammation can be seen in patients with multiple sclerosis. Impairment of venous outflow due to stenosis or occlusion of transverse or sigmoid sinuses can be seen in these patients. Most patients with multiple sclerosis are not candidates for transvenous treatment of venous outflow impairment. Selection of appropriate candidates requires demonstration of stenosis or occlusion of transverse or sigmoid sinuses and increased blood volumes in cerebral veins. Transvenous approach is not a cure, but may result in improvement of symptoms in a highly select group of patients.

6. **Electroencephalographic monitoring for difficult to diagnose seizures:** This technique is in early phase of evolution. Microwires placed in transverse or straight sinus can conduct electrical impulses from brain tissue located in the vicinity of the sinuses. Such areas are not assessed appropriately by surface electrodes and transvenous approach may provide an alternate method for electroencephalographic monitoring.
7. **Treatment of pediatric venous malformations:**
   Dilation and ectasias of cerebral venous sinuses can occur in conditions such as Vein of Galen malformation and result in hydrocephalus, cephalomegaly, and congestive heart failure. Early recognition and treatment by transvenous obliteration of malformation can be life-saving and prevent long-term disability.

   The applications of transvenous approach and treatment success rates are increasing with new technology. As medical professionals, we must be aware of the indications of transvenous approaches so we can provide the best options for our patients.

   We recently saw a 21-year-old female with a three-year history of idiopathic intracranial hypertension whose headaches have been refractory to medical therapy. Previous vision loss responded to lumbar puncture. In an 18-month period, she had 19 lumbar punctures with opening pressures as high as 65 cm H2O. We performed cerebral angiography and venography and she was noted to have severe left transverse-sigmoid venous sinus stenosis. Pressure measurements were obtained within the transverse sinus and subsequently in the sigmoid sinus and a gradient of 12 mm Hg was demonstrated. At that point, primary angioplasty was performed with excellent venographic results. The previously demonstrated pressure gradient also normalized. The patient’s headache resolved at 24 hours and her vision was back to normal.

For more information or a referral to CentraCare Clinic’s Interventional Neurologists, call 320-240-2829.

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**Should E-cigarettes be used to help smokers quit?**

**By Nabeel Ailabouni, DO, Family Medicine, CentraCare Clinic – Big Lake**

Since the recent cigarette cost increase, a common topic for patients has been the role of e-cigarettes in smoking cessation. The electronic cigarette, or e-cigarette, is a simple, battery-operated device that heats up liquid nicotine to create a vapor that a person inhales and then exhales. This mimics the action of smoking and nicotine is delivered to the user’s lungs and into the blood stream. E-cigarettes were first developed in China in the early 2000s and have been in the United States since about 2007. Many see e-cigarette use as a “healthier” alternative to cigarettes since there is no smoke and just nicotine vapor. But is this true?

There are several concerning issues with e-cigarette use. The FDA is trying to ban e-cigarettes for use until adequate research can be conducted to assess safety. Granted, the main chemicals in the devices — nicotine, glycol (which makes the smoke appearance) and flavoring — have minimal to no health effects when compared to cigarettes, but without adequate testing the facts remain unknown. Also, lack of federal or legal regulations on product manufacturing creates concern about what additives may be included in the device without consumer knowledge, as well as what health effects could arise. The most recent FDA investigation did show traces of carcinogenic (cancer-causing) chemicals in the e-cigarette, but the level was nowhere near the amount of cancer-causing chemicals in cigarettes. The FDA is pushing for more research on these devices before suggesting use due to the lack of evidence to support safe usage.

The other major issue with the e-cigarette is more on a social level and has to deal with the fact that e-cigarettes contain no tobacco. One might say that no tobacco is a good thing, but this means that e-cigarettes are not subject to tobacco laws so a minor can purchase the product without an ID. Although nicotine may not have “adverse” health risks, it is a very highly addictive drug minors can obtain easily.

While most consumers may be unaware about the lack of safety evidence, Canada, Australia, Mexico and Israel have banned e-cigarettes from sale or usage. Also, Hennepin County recently banned e-cigarette use on any Hennepin County-owned property. In addition, Metro Transit also is in the process of banning these products on trains and buses until further research is conducted to assess not only its safety to the user, but also with second-hand exposure.

From a medical standpoint, it is very difficult for providers to make an informed judgment on the safety of this product due to the lack of evidence. With that said, it seems reasonable that use of these products for smoking cessation may be beneficial, but it also must be understood they have not been studied to even show any effectiveness in smoking cessation.

In my opinion, there are other proven and safe alternatives to smoking cessation, such as the FDA-approved nicotrol inhaler, and until further evidence is available, providers should not recommend e-cigarette use as an alternative to smoking.
Introducing our new CentraCare Clinic Specialists

**Cardiology**  
CentraCare Heart & Vascular Center at Willmar, 320-656-7020

*Anthony Annese, MD*

Medical School: Boston University  
Residency: Boston University Medical School  
Fellowship: Cardiovascular Disease, Cleveland Clinic, Weston, Florida  
Certification: Cardiac CT, Johns Hopkins University, Baltimore, MD  
Board Certified: Echocardiography and Nuclear Cardiology  
Clinical Interests: Heart Failure

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**General Surgery**  
CentraCare Clinic – River Campus, 320-252-3342

*Andrea Kales, MD*

Medical School: Creighton University, Omaha, Neb.  
Residency: TriHealth and Affiliate Hospitals, Cincinnati, Ohio  
Board Eligible: General Surgery  
Clinical Interests: Breast cancer, thyroid and laparoscopic surgery

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**Maternal & Fetal Medicine**  
St. Cloud Hospital, 320-656-7024

*Jessica Swartout, MD*

Medical School: University of Minnesota, Minneapolis  
Residency: University of Texas Southwestern/Parkland Memorial Hospital, Dallas  
Fellowship: University of Minnesota, Minneapolis  
Board Certified: Maternal & Fetal Medicine and Obstetrics/Gynecology

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**Neonatal-Perinatal Medicine**  
St. Cloud Hospital, 320-255-5781

*Timothy Vedder, MD*

Medical School: University of Minnesota, Minneapolis  
Residency: Tripler Army Medical Center, Honolulu, Hawaii  
Fellowship: Tripler Army Medical Center, Honolulu, Hawaii  
Board Certified: Neonatal-Perinatal Medicine and Pediatrics

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**Pediatrics**  
CentraCare Clinic – Women & Children, 320-654-3610

*Andrew Maloney, MD*

Medical School: University of Nebraska, Omaha  
Residency: Creighton-Nebraska-Children’s Health Foundation Joint Pediatric Program, Omaha  
Board Eligible: Pediatrics  
Clinical Interests: Asthma and Sports Medicine

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Assigning codes based on underlying conditions is not a new concept of ICD-10, but providers need to better understand how their documentation of the patients’ illnesses affects coding. Through education of the coding staff and the medical staff, we can improve documentation practices by:

- clearly stating manifestations of chronic conditions;
- differentiating between specific conditions (i.e. Diabetes Mellitus Type I and Diabetes Mellitus Type II. If the latter condition requires insulin, it should be noted as Diabetes Mellitus, Type II, insulin requiring) (as opposed to insulin dependent);
- showing any existing relationships between hypertensive disease, congestive heart failure and renal failure;
- fully documenting exacerbations of COPD;
- identifying the vessel affected as either native or grafted, autologous or non-autologous, and/or vein or artery graft material used, when a diagnosis of coronary atherosclerosis is made;
- indicating the side affected — dominant or non-dominant — when hemiplegia occurs following a stroke;
- clearly distinguishing between traumatic and pathological fractures when diagnosing fractures, along with laterality and visit encounter (i.e. initial, subsequent or sequel) in addition to if routine healing, delayed healing, non-union or malunion or open/closed; and
- clearly documenting complications of medical and surgical care.

Consider these two patients. Patient A is a type 2 diabetic with well-controlled diabetes. Patient B is a type 2 diabetic with uncontrolled diabetes who also suffers from diabetes-related chronic kidney disease.

If the provider documents “diabetes mellitus” for both patients, coders would report the same code, even though the patients have very different conditions. The provider loses reimbursement on Patient B, who is sicker and requires more care.

In today’s busy health care environment, it is important to remember that submitted codes will affect future payment schedules, research databases and public reporting of disease incidence to name a few. It is very important to document to the highest specificity of known condition or disease.