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Spring 2015

Clinic Connection: Spring 2015

CentraCare Clinic

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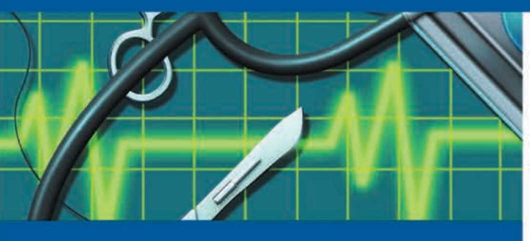

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Clinic connection

A publication from CentraCare Clinic
for health care providers in Central Minnesota

St. Cloud Hospital Patient Transfer Line
888-387-2862

Acute Myocardial Infarction
877-STEMI-SC or 877-783-6472

Adult Critical Care Intensivists
320-309-8132

Behavioral Health Access Nurse
320-255-5774

Behavioral Health (adult)
320-229-4977

Behavioral Health (pediatrics)
320-229-4945

Hospitalists 320-250-2678

Pediatric Hospitalists 320-255-5742

CentraCare Clinic Specialties

Allergy 320-654-3650
Bariatric Medicine 320-240-2828
Cardiology & Cardiac Surgery 320-656-7020
Dermatology 320-229-4924
Endocrinology 320-229-5000
Gastroenterology 320-229-4916
Genetics 320-654-3654
Infectious Disease 320-240-2204
Internal Medicine 320-240-2203 or 320-229-4928
Interventional Neurology 320-240-2829
Maternal & Fetal Medicine 320-656-7024
Neonatology 320-255-5781
Nephrology 320-240-2206
Neurology 320-240-2829
Neurosurgery 320-240-2836
Obstetrics & Gynecology 320-654-3630
Oncology/Hematology 320-229-4907
Pediatric Critical Care 320-255-5781
Pediatrics 320-654-3610
Pulmonology 320-240-2207
Radiation Oncology 320-229-4901
Rheumatology 320-240-2208
Sleep Medicine 320-251-0726
Sports Medicine 320-229-4917
Surgery 320-252-3342
Urology 320-259-1411
Wound Care 320-656-7100

Physician Referral Line
320-240-2201
800-458-7272

President's Message

Formation of Clinically Integrated Network underway

By David Tilstra, MD, CPE
President, CentraCare Clinic

More and more, we realize that "our" patients are not just patients of CentraCare, but that "our" patients receive care from many Central Minnesota providers.

As our payment systems move toward total cost of care and value reimbursement, CentraCare Health has begun to explore partnerships with health care providers outside of CentraCare Health to form a Clinically Integrated Network (CIN). This CIN will permit providers within the network to share patient information and ultimately contract together with the payers to demonstrate better outcomes and lower cost. Development is underway for a CentraCare CIN which will include our Epic Connect partners in Willmar, Alexandria and Wadena, as well as St. Cloud Medical Group, Buffalo and Monticello Clinic and HealthPartners. In the future, we hope to expand this network throughout the region.

The CIN will be a separate non-profit company under CentraCare Health and will be governed by a board of physician members in the network. The goal is to have the organization and initial membership operational by this summer. The members will develop quality initiatives based on work CentraCare already has underway like diabetes, depression and heart failure.

For more information on the CentraCare Clinically Integrated Network, contact Joe Hellie, CentraCare Health Vice President of Strategy and Network Development: **helliej@centracare.com** or **320-255-5699**.

CentraCare Clinic

Introducing our new CentraCare Clinic Specialists

Endocrinology

CentraCare Clinic – Health Plaza, 320-229-5000

Abel Alfonso, DO

Medical School: Michigan State University – College of Osteopathic Medicine, Lansing, Mich.
Residency: Brooke Army Medical Center, San Antonio, Texas
Fellowship: Walter Reed Army Medical Center, Washington, DC
Board Certified: Internal Medicine, Endocrinology

Perinatology

St. Cloud Hospital Perinatology Clinic, 320-656-7024

Kathleen Pfleghaar, MD

Medical School: Baylor College of Medicine, Houston, Texas
Residency: University of Minnesota, Minneapolis
Fellowship: Thomas Jefferson University Hospital, Philadelphia, Penn.
Board Certified: Obstetrics/Gynecology and Maternal & Fetal Medicine

Physical Medicine & Rehabilitation

CentraCare Health Plaza 320-229-4944

Jun Herrera, MD

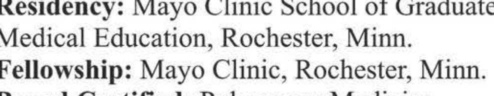
Medical School: Saint Louis University Baguio City, Philippines
Residency: University of Minnesota, Minneapolis
Board Certified: Physical Medicine & Rehabilitation, Brain Injury Medicine

Pulmonary Medicine

CentraCare Clinic – River Campus, 320-240-2207

Timothy Ehle, MD

Medical School: Michigan State University, East Lansing



Residency: Mayo Clinic School of Graduate Medical Education, Rochester, Minn.
Fellowship: Mayo Clinic, Rochester, Minn.
Board Certified: Pulmonary Medicine, Critical Care, Internal Medicine
Clinical Interests: Asthma, COPD, Interstitial lung diseases, lung cancer, pleural diseases

Access all CentraCare Clinic physician bios online at centracare.com

A brief overview of Venous Stasis Ulcers

By Marc A. Young, MD, FACS, Wound Center Medical Director, CentraCare Health

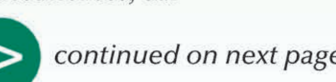
Venous stasis ulcers are a common problem in the Upper Midwest. They limit how much a patient can work, can cause a significant amount of morbidity and place the patient at a much higher risk for lower extremity amputation.

Venous stasis ulcers are believed to form secondary to pressure from venous hypertension within the superficial venous system, eventually leading to tissue injury and ulceration. Studies also have shown a relationship between obesity and chronic venous disease, which may explain the increasing incidence of venous stasis ulcers as our population continues to become more obese.

Most venous stasis ulcers occur medially in the lower leg near the ankle, although they can be found circumferentially from the mid-calf area to just below the malleoli. They usually are shallow, have an irregular border and the base is usually granulation tissue. Some patients report mild achy pain that often is relieved by elevation.

All patients with a suspected venous ulcer should be assessed for arterial disease at a minimum using an Ankle-Brachial Index (ABI). ABI values can be falsely elevated in patients with diabetes and calcified non-compressible arteries. These patients should be referred for a formal arterial duplex study. A venous ultrasound competency exam also may be helpful to verify the diagnosis and obtain detailed anatomic information of their venous insufficiency.

Multilayer compression therapy is the mainstay of treatment for venous stasis ulcers. Patients with an ABI of greater than 0.7 may undergo compression therapy. These dressings usually are placed on the affected limb and changed on a weekly basis. This type of dressing has good results, with studies showing 73 percent healing without other intervention. Larger ulcers often require weeks and sometimes months to heal. A large percentage of these patients will benefit from a referral to vascular surgery. Venous ablation procedures have been shown to greatly reduce the recurrence of venous stasis ulcers, which is the natural history of this condition. Compression stockings also reduce recurrences, but long-term compliance with wearing them is a problem.



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Accurate documentation required for ICD-10 and good patient care

By Connie Goulet, CPC; Sue Stein, CPC; Jessica Timmer, CPC; and Lindsey Theisen, RHIT, Compliance Specialists, CentraCare Clinic

REMINDER: ICD-10 is effective Oct. 1, 2015. See below for examples of documentation specificity.

- Clinical documentation is not just about coding, and coding is not just about payment.
- Accurate coding is a requirement for good health care data.
- Good health care data is critical to improving the quality of care, effectiveness of care and ensuring our patients' safety.
- Complete and accurate documentation of important clinical concepts condition is a required for good patient care.

Asthma	Heart Failure
Document classification: • Intermittent • Mild persistent • Moderate persistent • Severe persistent • Cough variant • Exercise-induced bronchospasm **Document complication type:** • Uncomplicated • (Acute) exacerbation • Status asthmaticus	**Document (if known):** • Diastolic vs. systolic vs. combined • Left side/right side • Acute or chronic vs. acute on chronic **Document Specialized Heart Failure:** • Heart failure following surgery • Heart failure due to hypertension (benign or malignant) • Heart failure due to (benign or malignant) hypertension with CKD • Heart failure, rheumatic
Diabetes	**Depression**
Document types: • Type 1 • Type 2 – Due to drug or chemical – Due to underlying condition – Document underlying condition (i.e. Malignant condition) **Document associated complications** • Diabetic peripheral angiopathy • Diabetic autonomic neuropathy • Diabetic foot ulcer **If blood glucose control is not maintained, document insulin control status as:** • Inadequately controlled • Poorly controlled • Uncontrolled	**Document type as:** • Mild • Moderate • Severe **Document occurrence:** • Single event • Recurrent event • In partial remission • In full remission **Document any comorbidities/disorders:** • With psychotic features • With anxious distress • With mood disorder

A brief overview of Venous Stasis Ulcers *continued from previous page*

Venous stasis ulcers continue to be a major health care issue, and their incidence may be rising with the obesity epidemic. Through correct identification and treatment with compression therapy, most of these ulcers will heal over several weeks. Recurrence can be reduced with surgical intervention and regular use of compression stockings.

Patients with chronic wounds and conditions, such as pressure and diabetic ulcers, non-healing surgical wounds and minor burns, can improve with wound care. The CentraCare Wound Center also provides hyperbaric oxygen therapy (HBOT) for patients to facilitate healing.

CentraCare Health provides wound care in St. Cloud and Monticello. Early this summer, we will provide wound care in Sauk Centre.

For more information or a referral to the CentraCare Wound Center, call 320-656-7100.

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Clinic Connection is published quarterly by CentraCare Clinic, 1200 Sixth Ave. N., St. Cloud, MN 56303. CentraCare Clinic is part of CentraCare Health.

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Reconstructive Urology addresses complex issues

By Andrew Windsperger, MD, CentraCare Clinic – Adult & Pediatric Urology

- **Transvaginal mesh complications** have garnered recent attention as some patients have complications following mesh procedures, such as erosion of mesh and perforation of mesh into adjacent organs. I have extensive training in treating these complications and have performed numerous mesh removal procedures. At the same time, it is possible to perform biological reconstruction to correct both incontinence and/or prolapse using the patient's native tissue, cadaveric donor tissue, or tissue transfer using the patient's own tissue obtained from alternate sites.
- **Urethral stricture disease** includes the development of scar tissue that occludes the urinary outlet. Meticulous reconstructive techniques, such as tissue-based flaps and the use of tissue transfer grafts, can treat strictures in a procedure called urethroplasty. I use these techniques to address strictures that often are refractory to prior intervention such as dilation.
- **Genitourinary fistulas** are an abnormal connection between urinary structures and adjacent organs. I manage fistulas through perineal, transvaginal and open abdominal approaches and minimally invasive surgical techniques. Adjunctive procedures, such as muscle flaps or tissue flaps, also may improve the success of the repair.
- **Urologic prosthetics** may be used to treat urinary incontinence and erectile dysfunction. I have advanced training in placement of penile prostheses, including revision surgery, and prosthetics for urinary incontinence. I also perform advanced repair and revision for artificial urinary sphincter failures, complications and device replacement.
- **Bladder reconstruction** may be performed for patients with a history of neurogenic bladder, complications from prior urinary diversion or complications from treatment of prior malignancy. Treatment includes revision of urinary diversion, as well as creation of alternative options for catheterization and urine storage.
- **Ureteral and renal reconstruction** may be performed for congenital issues, trauma or injury from previous procedures. Advanced open surgical techniques, as well as minimally invasive techniques, may be employed in restoring patency to the ureters to allow for proper renal drainage.

For more information or a referral to Dr. Windsperger, call 320-259-1411.