Greater Hazleton Health Alliance Medical Staff Link

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Northeast Continence Center

The Northeast Continence Center has opened and is accepting patients. The clinic is owned and operated by Hazleton Saint Joseph Medical Center of the Greater Hazleton Health Alliance. It is located on the ground floor of the Medical Arts Building across the street from Hazleton Saint Joseph Medical Center. The clinic is open Monday through Friday from 8 a.m. - 4:30 p.m. Clinic staff includes:
Ki Bum Lee, M.D., Medical Director; Maria Miscavige, MSN,CS,CRNP, nurse practitioner; Tina Caputo, receptionist/clerk; and Judy Callavini, medical office assistant. The clinic is also under the direction of Mary Ann Kolcun, Director of Outpatient/Short Procedure Departments and Margo McGilvrey, Vice President, Ambulatory Services/Outreach.

The goal is to diagnosis the specific type of urinary incontinence affecting the patient and develop a treatment plan to help the person manage the incontinence, thereby improving his/her quality of life. On the initial visit a complete history and physical exam is performed and medications reviewed. Dr. Lee does the initial visit and return visits are completed by Maria Miscavige, CRNP. Special procedures such as urodynamic testing, biofeedback, electrical stimulation, and bladder ultrasound are available. The clinic also works in conjunction with the area urologists if specialized testing or referrals are needed. Most insurances are accepted. Patients can refer themselves unless they have a managed care health plan and then a referral from the primary care physician is required. If you or your patients have any questions regarding the clinic, please feel free to call 501-6868.

ACLS RECERTIFICATION COURSE FOR PHYSICIANS

ACLS Recertification Course for physicians will be held on:

Date: Tuesday, July 31
Tuesday, August 7

Time: 6:00 P.M. to 10:00 P.M.

Place: HSJMC - Board Room
Need current BLS card (CPR/Basic Life Support) prior to attending recertification.
To register call Paula Triano, Director of Education at 501-6222.

INSIDE THIS ISSUE

INTERPRETATION OF TUBERCULIN REACTIONS IN PERSONS WITH A HISTORY OF BCG VACCINATION

Many foreign countries will use BCG as part of their TB control programs, especially in infants. Tuberculin skin testing is NOT contraindicated for persons who have been vaccinated with BCG, and the skin-test results of such persons are used to support or exclude the diagnosis of *M. tuberculosis* infection.

The presence or size of a postvaccination tuberculin skin-test reaction does not predict whether BCG will provide any protection against TB disease. Furthermore, the size of a tuberculin skin-test reaction in a BCG-vaccinated person is not a factor in determining whether the reaction is caused by *M. tuberculosis* infection or by the prior BCG vaccination.

The CDC states that tuberculin skin testing is not contraindicated for BCG-vaccinated persons. Latent TB infection (LTBI) diagnosis and treatment should be considered for any BCG-vaccinated person whose skin test reaction is $\geq$ **10 MM**, if any of these circumstances are present.

- Was contact of another person with infectious TB
- Was born or has resided in a high TB prevalence country
- Is continually exposed to populations where TB prevalence is high

Treatment for infection should be considered for BCG-vaccinated persons who are infected with HIV and who are at risk for *M. tuberculosis* infection if they have a tuberculin skin-test reaction of $\geq$ **5 mm.**

Core Curriculum on Tuberculosis: What the Clinician Should Know

Centers for Disease Control and Prevention, Division of Tuberculosis

Elimination, Fourth edition, 2000, pp. 99-100.

MENINGITIS

When sporadic cases of bacterial meningitis occur in the hospital setting or households, antimicrobial chemoprophylaxis of intimate contacts remains the primary preventive measure for eradicating nasopharyngeal carriage of the organism. Significant exposure is defined as at least 30 minutes face to face contact with the index case. It has become clear through clinical studies that two specific bacterial exposures require attention:

First, H. influenzae type b can be transmitted from patients with meningitis to household contacts and healthcare providers. The risk is highest in those under age two and decreases with age. Most secondary cases will occur within one week of exposure but the risk remains for about one month. About 5% of those exposed will develop disease if not treated with chemoprophylaxis. Rifampin, 20 mg/kg daily for 4 days is recommended. Pregnant women need individual consideration for prophylaxis and should not receive Rifampin.

Neisseria meningitidis meningitis can also be transmitted to contacts and the risk is also greatest in the age group less than 5 and declines with age. About 1% of those exposed will develop disease, usually within the first 5 days. The CDC recommends Rifampin 10 mg/kg twice daily for two days, 4 total doses. Ciprofloxacin and Ceftriaxone also have been used but should be reserved for specific situations.

WIDESPREAD CHEMOPROPHYLAXIS TO LOW RISK CONTACTS SHOULD BE DISCOURAGED BECAUSE OF THE CONCERNS OF THE EMERGENCE OF RESISTANT ORGANISMS AND THE POSSIBLE FUTURE LIMITATIONS ON THIS APPROACH.

REFERENCES

Mandell et al, Principles and Practice of Infectious Diseases, 1998.

5 KEYS TO GOOD DOCUMENTATION

1 - HISTORY

- Chief Compaint: the symptoms for which hospitalizationhas been ordered.
- Histoty of Chief Complaint: record the duration of symptoms, and any outpatient treatments that have been tried.
- Past Medical Treatment: past surgeries and relevant medical history.
- Allegies: if there is an allergy or several allergies, record both the causative agent and the manifestation. Patients may not understand the difference between a reaction and an allergy.
- Current Meds: list all known medicaitons and ask specifically about over the counter meds. Is there a corresponding disease listed in past medical history?
- Social/Family History: occupation; use of alcohol, tobacco, etc.; patient's home status; Is there a family or partner able to assist with post-hospital care? Is the patient a caretaker?

2 - PHYSICAL

- Record current status: vitals, mentation, physical findings for each body system (do not routinely defer), reflexes, ambulation capability and range of motion.
- Conclude with a provisional diagnosis(es) and a treatment plan: diagnostics, therapeutic, palliative.

If the patient has a statement of advance directives, record it here and in the progress notes at a minimum.

3 - PROGRESS NOTES

- Date and time each note.
- Record both subjective and objective findings.
- Note changes in treatment and status, including improvements, adverse events, and plans for follow-up after discharge.

4 - ORDERS

- Write legibly or type accurately when using computerized order entry systems.
- Be sure of the spelling of any medication you are ordering and of the appropriateness of the dose you have ordered.
- Date and time each order.

Telephone/verbal orders must be signed within 24 hours.

5 - DISCHARGE SUMMARY

- Provide a brief description of the hospital course, including reason for admission, treatments and administered, and relevant test findings.
- Record all relevant diagnoses and procedures as specifically as possible. (If you are not specific, persons reviewing the record later may try to interpret diagnostic test results on their own.)
- Record discharge meds and patient disposition.

Extra! Extra!

Physicians can now bill and receive payment for their time and expertise in certification and re-certification of home health patients who receive Medicare coverage. The change stems from the addition of two HCPCS (G) codes: G0180 for initial certification on Medicare home health care and G0179 for re-certification.

Also, HCFA dropped CPT codes 99375 (home health) and 99378 (hospice), which were used for Care Plan Oversight. In their place are the HCPCS codes G0181 (home health) and G0182 (hospice), which have the same rules as last year's CPT 2000 code 99375.

Under the new certification/re-certification policy:

Physicians should use G0180 for initial certification of Medicare home health care.

- This is billable only when a patient is admitted to home care.
- There should "rarely be more than one bill for a particular patient during any 60-day interval" under this code.
- Only physicians can bill on this code.
- Signing orders for Medicaid services, durable medical equipment and outpatient physical therapy cannot be billed under this code.

Physicians should use G0179 when billing for re-certification of Medicare home health

- Billing under this code should occur only once every 60-day episode-of-care for patients who have prolonged home care needs
- Billing may occur more than once for patients who require a *complete renewal of orders midway through an episode of care due to a significant change in condition*
- This code does not apply to change/interim orders or other documents you receive for signature throughout the care process
- Only physicians can bill on this code
- Signing orders for Medicaid services, durable medical equipment and outpatient physical therapy cannot be billed under this code

Generally, physicians cannot bill for both certification/re-certification and Care Plan Oversight. In most cases this would be double billing. A physician can bill for certification/re-certification and Care Plan Oversight only if:

- The physician has a very complex case that requires more extensive oversight, i.e. frequent or prolonged interaction with other health care professionals
- The physician provides and documents 30 minutes per month in additional, countable CPO work during the certified interval.

Improved Nutrition Evaluation

In order to provide better health for our hospitalized patient population and residents in the community, we will incorporate prealbumin into our hospitals nutritional screening process. Both medical staffs of the Greater Hazleton Health Alliance have approved this as a screen for malnutrition. This screening program is scheduled to begin July 2001 on all patients admitted to both the Church and Broad Street Campuses.

GHHA New Card Access System

On June 22, 2001 at 9:00 P.M., the GHHA's New Card Access System was offically activated. This system, designed to ensure the safety of our patients, physicians, and employees, will be used to gain access to HGH or HSJ between the hours of 9:00 PM and 5:00 AM daily. All physicians without a photo in the 2001 Directory should contact the Medical Staff Office at 501-6198 to have a photo taken as soon as possible.