VIM Journal – For Physicians/Dentists/Clinical Providers

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All contributions in this issue are original articles written by physicians at VIM on Hilton Head Island.

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As always, this issue will be incorporated (in a few weeks) with the earlier installments in our "VIM Journal – For Physicians/Dentists/Clinical Providers." An icon leading to this guide can be found on the computer's desktop in the examining rooms. It can also be accessed by copying and pasting bit.ly/VIM-Journal (soon to be bit.ly/VIM-Jounral3) in any browser {N.B. this link is a change}. This is a standard bit.ly type of link to my personal Dropbox site and completely safe to click on.

Steven P. Siegelbaum, MD, FACG
Chairman of the Medical Executive Committee
Journal Editor

❖ Letter from VIM Executive Director

Message from Raymond L. Cox, MD, MBA

"It was a Very Good Year"
- Sinatra

As our 25th anniversary year draws to a close, I think we can safely say we made Dr. Jack proud. We started the year by eliminating patient fees which had been implemented during the economic downturn. The process went very smoothly and patient donations have been higher than expected. On February 6, Dr. Jack passed away shortly after his 93rd birthday. The services he planned and the memorials by his family and friends were a testament to a life well-lived and the love he inspired through his compassion, foresight and determination.

The Board determined a commitment to improving the security of our environment to ensure privacy of patient information and provide a safer environment for our volunteers and staff. In June, we received a memorial gift from the Heberton family in honor of Board member Bill Heberton. In August we received a 4-star Charity Navigator rating for the 5th year in a row, a feat achieved by fewer than 10% of all non-profits. We have given over 70 clinic tours, including a group of 22 Cypress residents, Bill Miles from the Chamber of

Commerce and Dr. Al Panu, Chancellor of USCB. For the ninth year, Latinos Unidos sponsored a Community Festival which was a great success. We received numerous local grants in support of our various programs, including an Impact grant from Wexford Foundation to pay for radiology and dental equipment. In addition, Drs. Strayer, Wayne, Mootz and Mikita made significant donations to assist in paying for some of the radiology equipment. Sadly, Dr. Strayer passed away in late December after a brief illness. Also, Dr. Ross McKay and Dr. Joe Sanker were lost over the past year. All three made significant contributions to the clinic over several years and will be missed.

We were awarded the Best Nonprofit on the island by the Hilton Head Monthly for a 2nd year in a row. The highlight of the year was the annual VIM Gala held at the Sonesta on November 17th. The 460 festive guests and sponsors helped to raise over $200K for clinic operations.

In June, Demetra Ladson was hired as a full-time medical records support manager. Her position is funded by a 3-yr limited endowment from a private foundation. Demetra has already begun improving use rates of the electronic record by actively training physicians and by implementing the Dragon dictation system. We need your help to improve how we document our work so that we can improve the quality of our work and make it easier to win grant funding. Also, please save March 6 from 11:30-2:00 p.m. for the Annual Clinician Luncheon (place to be determined). We want to ensure our dentists, nurse practitioners and PA's feel welcome at this meeting.

As you can see, it has been a "fun-filled, action-packed" and highly productive year. The Board leadership team of Jim Collett, Joe Scodari, Andi Argast and the committee chairs have been highly effective in promoting Board member engagement and enthusiasm. I am excited by the commitment to purpose, learning, caring and teamwork demonstrated by our staff. The volunteers, especially our clinicians, remain the foundation of our Circle of Caring. We will be focused on the implementation of the key action items from our new 5-yr Strategic Plan, a 5 month process led capably by Joe Scodari. Our newly formed Marketing Committee will help us tell our story to the local community and beyond. I have no doubt that we will continue to exceed our goals and look forward to an even more successful 2019. Thank you so much for all you do every single day to advance the mission and vision of our Circle of Caring.

Sincerely,

Raymond L. Cox, MD, MBA
Executive Director
Volunteers in Medicine HHI

❖ Chart Audits

Submitted by Dr. Ray Cox and Lynn Jennings Taylor

Dear Colleague:

We have been performing chart audits to determine a baseline of the content of substantive clinical visits (not visits in which a patient only requires renewed medication). These audits have been conducted by physicians and nurses.

We are looking for documentation of such basic things as: personal information (nursing), drug allergies (nursing), the patient's history (self-report form), legibility (clinician), logical order (clinician), symptoms and findings (clinician), final diagnosis (clinician), treatment/management plan (clinician), medications/dosages (clinician), discussion of plan with the patient (clinician), and if an interpreter was used (clinician).

Our reviews demonstrate a high degree of compliance with most clinical notes receiving 9-10 points out of the 12 possible. We will continue to perform these audits and will share the overall results with the medical staff leadership.

Sincerely,

Raymond L. Cox, MD, MBA
Lynn Jennings Taylor, RN, JD

Chart Audit Criteria

1. Is the patient's personal information recorded? (nursing)
2. Are the drug allergies recorded in the Medical Record? (nursing)
3. Is the patient's medical/family/social history recorded? (self-report form)
4. Is the handwriting legible or computer generated? (clinician)
5. Do the notes follow a logical order? (clinician)
6. Are the symptoms/complaints recorded? (clinician)
7. Are the Physical Examination findings recorded? (clinician)
8. Is the final diagnosis clearly and visibly recorded? (clinician)
9. Is the treatment/management plan clearly recorded? (clinician)
10. Are ALL medications/dosages recorded? (clinician)
11. Is the discussion of the management plan with the patient recorded? (clinician)
12. If yes, was an interpreter used? (clinician)

❖ New Medical Records Department

Submitted by Demetra Ladson, MBA

Who?
My name is Demetra Ladson and I am the new Medical Records/e-MDs Support Manager at Volunteers in Medicine.

What?
I was hired to reform the medical records department and train our staff on how to use our electronic medical records system.

Why?
Our current donors and future donors want to see how well the clinic is doing. We also want to boast about our amazing staff and physicians and how well they are treating our patients. The only way are able to create these results is through electronic records reports. We need more concrete data pulled from our physician notes.

How?
On-going training in e-MDs and all-day support so you all feel comfortable with using the system. We will also be converting to ICD-10 coding so we have more precise diagnoses. We have also implemented a more accurate dictation system, Dragon. This system works directly into e-MDs, which has already proven to decrease charting times.

WE NEED YOUR HELP!

We have compiled a list of five items, we feel are necessary and non-negotiable, to complete a note:

1. **Chief Complaint**
2. **Findings**
3. **Assessment**
4. **Plan**
5. **Updated list of prescriptions**

"We need to know that we make a positive difference through the work we do." - Mike Anderson

❖ Prediabetes

Submitted by Rick Sunderlin, MD

Prediabetes, as defined by the American Diabetes Association (ADL), exists when an individual's plasma glucose is higher than normal but not yet high enough to be diagnostic of diabetes. This includes patients with fasting plasma glucose between 100 and 125mg / dL or a hemoglobin A1C between 5.7% and 6.4% (any abnormality needs to be confirmed on a different day from the original test).

Prediabetes represents an important risk factor for future diabetes and cardiovascular and renal disease, as well as, hypertension and peripheral vascular disease. The scope of the problem is enormous. The Center for Disease Control (CDC) estimates that as of 2014, 37% of US adults ages 20 or older had prediabetes but only 11% were aware of the diagnosis. Between 1999 - 2008, in overweight adolescents aged 12-19, the prevalence of prediabetes increased from 9% to 23%. Therefore, it is important to identify patients early and begin intervention early. It is recommended that criteria for screening include those with first-degree relatives with diabetes, a prior history of gestational diabetes, hypertension, low HDL cholesterol, high triglycerides, severe obesity, or polycystic ovarian syndrome (PCOS). The American Diabetes Association (ADA) also recommends screening children at age 10 and then every three years if they are overweight and have two of the following risk factors: family history of type 2 diabetes, African-American or Latino ethnicity, hypertension, dyslipidemia, PCOS, or a maternal history of gestational diabetes during the child's gestation.

Once identified, patients need lifestyle counseling with a healthy diet, moderate levels of exercise, and weight reduction. This can afford up to a 58% risk reduction of progression to diabetes. Metformin is the only pharmacologic therapy currently recommended by the ADA to help prevent progression of prediabetes to diabetes (18%-31% risk reduction). Most research has revealed that the risk of the classic microvascular and macrovascular complications can begin during the prediabetes period. Therefore, the VIM Diabetes Clinic monitors and treats blood pressure on every visit, performs annual urine microalbumins and intervenes with ACE inhibitors or ARBs (angiotensin receptor blockers) as necessary, and performs annual lipid profiles with statin intervention as needed.

Without an aggressive approach to the diagnosis and management of prediabetes, the projected doubling of patients with type 2 diabetes and their comorbidities over the next 30-40 years seems inevitable.

❖ H. pylori Basics and Update

Submitted by Peter Leff, MD, FACG
(continued on next page)

Helicobacter pylori (H. pylori) is felt to be the most common chronic bacterial infection in humans (>50% of the world's population is infected and 70-80% of the population in developing nations). Multiple studies point to childhood socioeconomic status as the major risk factor. In the United States, the incidence of infection is approximately 27% in Caucasians, 51% in African-Americans, and 58% in Hispanics, with second-generation immigrants less likely to become infected.

Gastric cancer is a leading cause of mortality worldwide and H. pylori is the leading infection associated with this cancer. A recent article in Gastroenterology **preliminarily** suggests that treatment of H. pylori is associated with a lower risk of gastric cancer, particularly in older subjects.

Conditions associated with H. Pylori infection

1. Chronic active gastritis
2. Peptic ulcer disease
3. Gastric adenocarcinoma
4. Gastric lymphoma (MALToma)

Who should be tested?

1. Patients with a history of gastroduodenal ulcers
2. Patients with uninvestigated dyspepsia
3. Patients with functional dyspepsia (symptomatic with negative endoscopy)
4. First-generation immigrants from regions where H. pylori is highly prevalent or who belong to an ethnic group (such as Latinos) associated with an elevated infection risk
5. Other groups warranting strong consideration for testing (although supporting evidence is somewhat weaker) include the following:
    a) Patients with symptomatic GERD
    b) Patients with gastric MALT lymphoma (gastric B-cell lymphoma)
    c) Patients with a family history of gastric cancer
    d) First-degree relatives in infected patients (H. pylori is typically acquired in childhood and spreads within families)

*It is not indicated to test asymptomatic patients for prevention of gastric cancer at this time except those with a family history of gastric cancer and possibly first generation immigrants from high incidence regions, such as Latin America. Also, it is not the standard in the United States today to test for H. pylori before NSAID treatment. Lack of a history of symptoms of acid peptic disease is of no value in predicting future complications from H. pylori infection, and therefore, it is advised that all patients with active H. pylori receive treatment.

Laboratory tests

1. IGG serologic test (H. pylori antibody) - This is widely available and relatively inexpensive but **not useful after treatment to check for eradication, as it generally stays positive for prolonged periods after treatment.**
2. Urea breath test (available by referral through Nena at VIM) - This test is useful to identify active infection and can be used both before and after treatment but is more expensive and can be affected by concurrent use of antibiotics and proton pump inhibitors. (see #5 below)
3. Stool antigen test (same indications and limitations as urea breath test)
4. Histology (endoscopy with biopsy/same usage indications and limitations as urea breath test but most expensive).
5. **In addition to not relying on the IGG serologic test for active infection in previously treated patients, it is advised that treatment with bismuth, antibiotics or proton pump inhibitors be stopped at least 4 weeks before testing. (ie; testing with breath test, stool antigen etc.)**

Treatment

Regimens generally include 2 or 3 antibiotics and a proton pump inhibitor for 14 days. There are multiple regimens with 70-90% eradication rates. The pharmacy at VIM stocks a pre-packaged regimen felt to be highly effective as follows:

1. Amoxicillin, 1 gm twice a day (omit if penicillin allergic)
2. Clarithromycin, 500 mg twice a day
3. Metronidazole, 500 mg twice a day
4. Omeprazole, 20 mg twice a day

Alternate 14-day treatment for penicillin allergic patients includes Clarithromycin, Metronidazole and Omeprazole, as above (without Amoxicillin) or the following:

1. Metronidazole, 500 mg twice a day
2. Tetracycline, 500 mg four times a daily
3. Omeprazole, 20 mg twice a day
4. Bismuth subsalicylate, 525 mg four times daily

Resistance to clarithromycin, metronidazole and the fluoroquinolones has increased in the United States, and in some areas these drugs are no longer being used as empiric therapies. However, this has not been an issue among our population to date.

If two attempts to eradicate H. pylori are unsuccessful (based on breath testing or stool antigen), the patient will need further testing, such as gastric biopsy or stool testing, to assess antimicrobial susceptibility.

Despite many claims about natural treatment and cures for H. pylori, none have been scientifically proven to be of any benefit.