Premier Pulse

News for Premier Health Physicians

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Implicit Bias – Is it Real?

By Marc Belcastro, DO, chief medical officer, Premier Health Southern Region

Implicit, or unconscious, bias is an unconsciously held set of associations about a social group. The word "unconscious" implies that we are not aware of these patterns. A more academic description is often noted as implicit social cognition. These attitudes or stereotypes affect our actions and decisions in an unconscious manner. Thus, implicit biases are not accessible through introspection. These associations develop over the course of a lifetime, beginning at a very early age, through exposure to direct and indirect messages. These unconscious beliefs can exist for race, religion, gender, weight, generations, socioeconomic status, and a variety of other groups. While less common, it is even possible to have an implicit bias toward a group to which one belongs.

My exposure to this area of cognitive research came while studying infant mortality and birth outcomes improvement. Shockingly, black infants have approximately twice the rate of preterm birth and infant mortality compared with non-black infants – the current theory being that the chronic stress of maternal exposure to societal and health care workers' implicit biases can predispose the maternal physiology to preterm labor.

A greater awareness of this topic can improve communication and your relationships with your patients and ultimately a compassion they will more likely experience. The following is a personal story that helped me explore my own attitudes and deeply held associations: The NICU team was preparing for the discharge of a preterm infant to a socially and economically challenged family, when a nurse stated that the mother had not visited her baby in the past two weeks. Parental participation is critical for the safe discharge of a preterm infant. As the care team discussed the mother's lack of involvement, imagine the variety of stories verbalized by the rounding team. Fortunately, our astute social worker said, "She is a single mother, working two jobs, with two children in school, and her car recently broke down. She has not been able to visit due to lack of transportation and time."

This moment was pivotal for me. My beliefs and conversations with families shifted to assuming the best, even when the information or situation appeared to indicate otherwise. My connections with families became stronger and my compassion was deepened. While much of this research has been challenged, and the implicit bias tests viewed with skepticism by some, I would encourage you to remain open to exploring this topic.

If you have any interest in testing and self-improvement work, two popular links are: **https://implicit.harvard.edu/implicit/takeatest.html** and **https://diversity.ucsf.edu/resources/strategies-address-unconscious-bias.**

SERVICE LINE UPDATE: NEURO

Specialized Care for Epilepsy

By Jason Merritt, vice president of Premier Physician Network specialty services, service line vice president for neurosciences

The Comprehensive Epilepsy Center of Dayton at Premier Health is the only National Association of Epilepsy Centers-accredited adult care facility in Dayton. As a Level 3 Adult Epilepsy Center, we provide specialized comprehensive care for patients with epilepsy. A multidisciplinary group of fellowship trained epileptologists, functional neurosurgeons, neuropsychologists, neuroradiologists, advanced practice providers, and electroneurodiagnostic technologists collaborate to provide specialized care for patients with epilepsy.

Our fellowship trained epileptologists specialize in the care of patients with refractory epilepsy, including those who may need surgery for epilepsy as well as special populations such as women with epilepsy and seizure patients with traumatic brain injury. Individualized treatment options can include medication management, nutrition therapies, and referrals to additional support services. For some patients, surgical treatment options might be considered. Advanced diagnostics with admission to the Epilepsy Monitoring Unit (EMU) at Miami Valley Hospital can be utilized to assist in making an accurate diagnosis and determining the best treatment options for individual patients. Additionally, Miami Valley Hospital hosts a monthly epilepsy support group, and weekly art therapy services are being offered at Upper Valley Medical Center from Oct. 7 through Nov. 11.

In patients who are being evaluated for consideration of surgery, a thorough diagnostic evaluation is performed – including advanced neuroimaging, EMU evaluation, and brain mapping/neurocognitive assessment at the Brain Mapping Center. All patients being considered for surgical intervention are discussed in a multidisciplinary case conference to review results of testing and provide individualized recommendations. Surgical treatment options offered include:

- Placement of a vagus nerve stimulator (VNS) that can be used as a tool to prevent or decrease seizures by sending pulses of electric energy to the vagus nerve
- Minimally invasive laser ablation using the MRI guided technology Visualase™
- Open surgery to remove the seizure focus
- Surgical placement of short-term intracranial EEG leads to identify precise seizure focus and assist with additional surgical planning

To refer a patient for an epilepsy evaluation and treatment, call **(937) 208-4200** or search for the Clinical Neuroscience Institute in Epic and include “direct referral to epilepsy” in the comment section. Non-Epic practices can use the Clinical Neuroscience Institute referral form. Epilepsy patients are seen at all Premier Health Clinical Neuroscience Institute locations – Centerville, Dayton, Englewood, Middletown, and Troy. Additionally, we welcome referrals from neurologists who would like consultation or advanced treatment options for complex epilepsy patients.

PREMIER HEALTH EPILEPSY TEAM

Barbara Phillips, MD, epileptologist, Miami Valley Hospital

Cassandra Milling, MD, epileptologist, Miami Valley Hospital

Michael Kentris, DO, epileptologist, Miami Valley Hospital

Arshi Naz, MD, epileptologist, Atrium Medical Center

Charles Hall, MD, epileptologist, Miami Valley Hospital North and Upper Valley Medical Center

Daniel Gaudin, MD, neurosurgeon, Clinical Neuroscience Institute

Fadi Tayim, PhD, Brain Mapping Center

Stephanie Fliehman, NP, epilepsy

Anne Flynn, CNP, neurosurgery

Blood Drive Success, NICU Wins, and Breaking Ground

Atrium Medical Center

The fifth annual Highway to Help charity motorcycle ride, organized by hospital employees, saw a record 250 participants in its mission to raise funds for Adopt-A-Family for the upcoming holiday season. Activities for children, including the Middletown Fire Department's Smoke House and a Bicycle Rodeo, were added to this year's event.

Representatives from Atrium's Level III Trauma Center, Senior Emergency Center, and Cardiology Department promoted hospital services at National Night Out events in Middletown, Monroe, Franklin, and Lebanon. These family-friendly events attract hundreds, and in some cases thousands, of people in each community. New marketing displays promoting Atrium's emergency services were utilized at this year's events.

Other recent community relations activities include: Atrium was the main sponsor of the Franklin Area Chamber of Commerce's annual golf outing, which included a foursome led by Josh Ordway, MD, of Franklin Family Practice; the Lebanon Blues Festival held Aug. 2-3 in downtown Lebanon was sponsored in part by Premier Health and Atrium Medical Center; Atrium staff donated 122 bookbags filled with school supplies in a highly successful drive for co-workers and local families needing assistance; Atrium was represented at community health fairs in Lebanon and Butler County; Atrium Medical Center's Level III Trauma Center, Ohio State Highway Patrol, and other members of Warren County Safe Communities Coalition promoted steps to prevent drunk driving ahead of the Labor Day weekend as part of the National Drive Sober or Get Pulled Over campaign; and a Community Blood Center blood drive at the hospital collected 39 donations to meet 126 percent of its goal.

Miami Valley Hospital

Miami Valley Hospital has become the first treatment facility in greater Dayton to utilize the Visualase™ MRI-Guided Laser Ablation system for epilepsy patients. The hospital is one of only 110 locations throughout the United States to gain access to this advanced technology, which enables specialists to use a less invasive option to ablate seizure-causing tissue in epilepsy patients while monitoring the procedure's progress in real time. Miami Valley Hospital is a Level 3 Epilepsy Center accredited by the National Association of Epilepsy Centers. The center's team works together to determine if patients are a good candidate for the Visualase™ system.

In early August, the community was met with a mass shooting incident in the Oregon District that left nine people dead and many others injured. The dedicated clinical team at our Miami Valley Hospital campuses treated 23 patients. A Code Yellow was called to handle not only the patients, but to manage the onslaught of media calls and teams on our campus from all over the country. This was followed by a visit by the president and first lady of the United States; the logistics of navigating a presidential visit that was orchestrated by the White House was monumental. Two weeks later, the Oregon District hosted a benefit event that drew more than 20,000 people; Premier Health provided first aid, and 50 of the 200 volunteers working the event were Premier Health employees.

Premier Health hosted a free joint pain seminar on hip and knee pain at the Miami Valley Hospital North Education Center. These popular joint pain seminars include information on a variety of joint health topics, such as innovative surgical and non-surgical treatment options to help restore mobility and reduce pain caused by arthritis and other conditions. The evening consisted of a presentation, open forum panel discussion, and Q&A session with specialists John Powell, MD, orthopedic surgeon, and Frank (Trey) Dossman III, PT, DPT, physical therapist.

Miami Valley Hospital's Clinical Research Center is conducting a clinical trial using augmented reality during surgery to stabilize broken ribs. Augmented reality is a technology that superimposes a computer-generated image on a user's view of the real world, providing a composite view that enhances the natural environment or situation. Using the Microsoft HoloLens headset, a 3-dimensional hologram of the patient is projected to the surgeon to serve as a roadmap. The holograms are centered into the field of view, leaving both the center and peripheral vision unobstructed. The images are interactive in real-time and controlled by the surgeon using simple hand gestures. The study will help to determine if an augmented reality headset can be

used in real-time in the operating room to fix broken ribs. Patients admitted to Miami Valley Hospital who meet the criteria for the procedure will be enrolled in the study with their consent. About 12 local patients will be invited to take part in the research.

Miami Valley Hospital South served as a gold sponsor for the 71st Washington Township Firefighters Association Ice Cream Social Sunday event. Our Emergency Medical Services team manned a table with giveaways and allowed guests to tour a Premier Health Mobile Intensive Care Unit. Miami Valley Hospital South President Joann Ringer was one our representatives who also served as a celebrity ice cream server.

Miami Valley Hospital North was a gold sponsor for the Trotwood Chamber of Commerce Business Expo. This event provided an opportunity for businesses in the Trotwood area to showcase products and services to the broader community. Miami Valley Hospital North hosted a booth with giveaways and information about the campus.

The Neonatal Intensive Care Unit at Miami Valley Hospital had much to celebrate in August. The NICU team celebrated one year without a central line-associated bloodstream infection (CLABSI) or necrotizing enterocolotis (NEC), and four years without a ventilator-associated pneumonia (VAP).

The Palliative Care team officially began weekend coverage at Miami Valley Hospital. A Palliative Care advanced practice provider is on-site on Saturday and Sunday to assist with new consults and current patients receiving palliative care, focusing on medical decision making/goals of care, withdrawal of life-sustaining treatment and symptom management. Consultations will be provided by the on-site nurse practitioner and by a physician as deemed necessary. Funded through the Miami Valley Hospital Foundation, extending on-site coverage to weekends will better serve the needs of patients and their families and reduce additional days spent in the hospital setting.

Promise to Hope has teamed up with Joshua Recovery Ministries and Montgomery County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) to provide the only sober living option for pregnant and newly parenting women in Montgomery County for mothers in the Promise to Hope program. Joshua Recovery Ministries is a faith-based organization that provides recovery support and counseling services for patients with substance use disorders. They provide on-site management of the sober living complex, overseeing structured, daily requirements for the participating moms. Residents of the sober living program must agree to a specific treatment plan, including counseling, Medication Assisted Treatment, prenatal care, and support group attendance. Daily, on-site peer monitors – two of whom are Promise to Hope graduates – support the moms as they progress in their recovery journey.

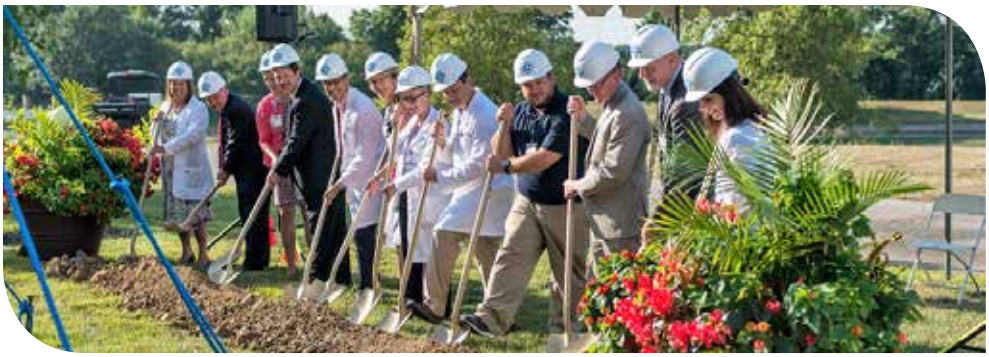
Upper Valley Medical Center

On Aug. 7, Upper Valley Medical Center broke ground for an addition on the south side of the hospital to provide for expansion of the cardiopulmonary rehabilitation program. The 7,600-square-foot addition will more than double the size of the existing cardiopulmonary rehab department and provide a separate entrance for participants in the program. It also will include an employee wellness area for exercise and wellness activities for hospital staff. Along with the cardiopulmonary rehab expansion, UVMC will make additional enhancements to the hospital over the next year including reconfiguration and updates to the main lobby and registration areas to provide improved comfort, convenience, ease of access, safety, and confidentiality for patients and visitors. The retail pharmacy and hospital gift shop will be moved closer to the front entrance of the hospital, and the coffee bar will be relocated to help lessen congestion and noise in the main lobby area. First and second floor wayfinding signage will be enhanced as part of the project, and waiting areas will be enhanced and refreshed for a more comfortable, healing environment.

The UVMC Level II Interventional Cardiac Catheterization Lab had a successful Ohio Department of Health survey the week of Aug. 19. Reviewers expressed appreciation for the quality of work performed. Only one citation was issued related to volume not meeting the annual goal of 300 cardiac catheterizations in 2018, which was expected due to the lab just opening in July.

In other cardiac cath news, a celebration of the one-year anniversary of the lab's opening was held Aug. 28 in the UVMC cafeteria. The event for the entire UVMC family featured a heart healthy cookout, music, a team selfie station, and a door prize drawing. Special guests included local EMS providers and a number of heart attack survivors who were patients in the lab. Tom Parker, UVMC president, spoke of his personal experiences as a patient in the lab last year and praised the entire cardiac cath team for their dedication and hard work.

The 19th Annual Bill and Ruth McGraw Cancer Awareness Symposium was hosted Aug. 26 at the Crystal Room in Troy. The program featured keynote speaker Kelly Corrigan, New York Times best selling author of "The Middle Place." The symposium, presented by the UVMC Foundation and the UVMC Cancer Care Center, is made possible by grants from the McGraw Family Fund of the Troy Foundation and the UVMC Foundation.



CompuNet Lab Orders Affected by New Anthem Filing Deadline

Anthem recently informed CompuNet Clinical Laboratories that it is reducing its filing deadline from 180 days to 90 days beginning Oct. 1, 2019. This is effective for all commercial and Medicare Advantage claims submitted on or after Oct. 1, and will also affect other professional and ancillary providers.

Because the decreased filing deadline will affect the lab's billing processes, physician offices might experience an increase in the number of calls from CompuNet Billing to obtain missing lab order information.

The following information is required with each lab order so CompuNet can properly bill insurance:

- Patient name (must match patient's insurance card)
- Patient address
- Patient date of birth
- Patient gender
- Insured ID number
- Ordering physician
- Diagnosis code

By providing the required information at the time of the lab order, CompuNet can successfully bill payers. Additionally, the number of phone calls to providers' offices will be reduced, thus minimizing disruption to offices' workflow.

CompuNet Revises Fasting Requirement for Lipid Panels

Effective Sept. 16, CompuNet will no longer require patients to fast for lipid panels and the associated analytes, cholesterol, LDL, HDL, and Triglycerides.

Current guidelines now recommend non-fasting for routine testing of lipid levels based on comparisons of non-fasting and fasting populations. A study published in JAMA, "Association of Nonfasting vs. Fasting Lipid Levels With Risk of Major Coronary Events in the ASCOT-LLA"[1], found that measurement of non-fasting and fasting lipid levels yields similar results in the same individuals for association with incident coronary and atherosclerotic cardiovascular disease (ASCVD) events.

The JAMA study did note, however, that non-fasting triglycerides were modestly higher. If a patient is non-fasting for a lipid panel or its associated analytes, the following comment will be added to the results report: "Non-fasting specimens may have modest increases in Triglyceride levels." (JAMA Intern Med, 2019).

The removal of the fasting requirement will provide patients with greater flexibility when they utilize a CompuNet Patient Service Center. Fasting patients typically arrive at a Patient Service Center early in the morning; without the lipid fasting requirement, patients can now choose to arrive at a later time.

For questions regarding the lipid fasting requirement change, please contact your CompuNet account representative or call CompuNet Client Services at **(937) 297-8260**.

[1] Mora, Lan Chang, Moorthy, Sever. (2019). Association of Nonfasting vs Fasting Lipid Levels With Risk of Major Coronary Events in the ASCOT-LLA. JAMA Intern. Med., Volume 179(7), 898-905. doi:10.1001/jamainternmed.2019.0392

Premier Health Regional Referral Center Now Open

Referring hospitals, nursing homes, and physicians who need to transfer or directly admit a patient to a Premier Health facility can now contact our new regional referral center. The center, which opened Sept. 4, is housed inside the Dayton Media Center at 1611 S. Main St. in Dayton.

The center's rapid referral process will help ensure patients receive the care they need as soon as possible. With the high-tech bank of computer screens that track aircraft and mobile intensive care units, more than 60 staff members will access real-time information to rapidly find the optimal spot to care for incoming patients among the more than 1,600 licensed beds across the Premier Health system. More staff could be added over time.

In a first for Dayton, the regional referral center will house communications for CareFlight Air and Mobile Services' medical helicopter services, which cover a 17-county area. The referral center also handles other transportation needs, including the movement of six mobile intensive care units. Additionally, staff will arrange for an admitting physician to be in place when a patient arrives at a facility, and thousands of pages will be sent to physicians who provide care in Premier Health hospital emergency departments. The center will coordinate a patient's entire care journey, as well as coordinate follow-up care when the patient is discharged.

Previously, Premier Health's access and transfer center, the CareFlight communications center, and bed access were handled from separate locations and primarily served Miami Valley Hospital. The new regional referral center takes a more holistic approach in coordinating care systemwide.

Lead with yes.

As Premier Health strives to enhance patient access to our care, as called for in our current three-year strategic plan, we are pleased to announce a new patient access campaign: "Lead With Yes."

Across our health system, both clinical and nonclinical employees have a role to play in ensuring the success of this new initiative, which includes but is not limited to the launch of our new regional referral center that will coordinate medical transportation between facilities, as well as into and out of our health system.

"Lead With Yes" seeks to build a solution-oriented culture that ensures seamless experiences and handoffs for referring facilities, providers, and patients. It encompasses an overhaul of our health system's procedures for:

- Accepting patients at all Premier Health facilities
- Discharging patients from Premier Health facilities
- Providing access to patient beds
- Opening beds at alternative facilities if certain facilities are at capacity
- Taking calls at the regional referral center
- Streamlining the bed flow process and turning over beds more quickly

To help transform these processes used in managing acute-care access, the Lead With Yes campaign focuses on the following:

- Immediacy: Whether it involves an EMS agency or a direct admission from another hospital, employees who control access to inpatient beds should always use a solution-oriented approach that leads with an attitude of "Yes, we can help you" and affirms that every effort will be made to admit the patient to a Premier Health facility as expeditiously as possible.
- Engagement: We recognize that all employees and physicians play a key role in improving our processes. Your ideas, problem-solving skills, expertise, leadership and ownership of our processes are key in driving that improvement.

We ask that leaders take steps to recognize employees who "lead with yes" and will be evaluating additional ways to encourage "peer-to-peer" recognition in the future.

Your "Yes" might help break down a barrier, streamline a process, improve a family's experience, or positively affect a patient's care. Your "Yes" might change everything.

PHYSICIAN ADVISOR'S CORNER

Surviving the Sepsis-3 Conundrum

By Andrew Maigur, MD, system director, Physician Advisor Program

Disclaimer: "The accurate diagnosis of Sepsis is not for Diagnosis Related Group (DRG) assignment, increased reimbursement, or improved quality metrics. The prompt diagnosis and treatment of Sepsis is first to improve medical care and outcomes of patients."

Before we jump into the Sepsis-3 definition, let's start with what we know so far about Sepsis: the all-too-familiar Sepsis 1 and 2 definitions and systemic inflammatory response syndrome (SIRS) criteria (SIRS plus source of infection equals Sepsis; and Sepsis plus acute organ dysfunction equals severe Sepsis). As of today, the Centers for Medicare and Medicaid Services (CMS) continues to follow the antiquated Sepsis 1 definition for the Sepsis core measure bundle. What resulted was a misinterpretation; what was meant to be a screening tool for SIRS became a diagnostic criterion. Clinicians and Clinical Documentation Improvement (CDI) specialists forgot that Sepsis mandates that the patient is sick with a capital "S."

Sepsis-3 defines Sepsis as a life-threatening organ dysfunction caused by a dysregulated host response to infection. In other words, sicker than the average patient with the localized infection. Integral to this definition of Sepsis is acute sepsis-related organ dysfunction.

Enter the Third International Definition for Sepsis and Septic Shock in February 2016. It was only in 2017 that the Surviving Sepsis Campaign (SSC) adopted the definition of Sepsis-3 and effectively removed all references to SIRS from their literature. Needless to say, the Sepsis-3 definition has been wrapped in controversy with a lot of debate and has ultimately been endorsed by the Centers for Disease Control and Prevention (CDC), American College of Emergency Physicians, and the Society of Critical Care Medicine (SCCM).

What about Sequential Organ Failure Assessment (SOFA)? SOFA and qSOFA are tools designed to prognosticate mortality in the ICU patient, but they are not intended to be the definitive clinical criteria for diagnosis.

A few comments on the SOFA score; the bar is pretty low for a positive SOFA score greater than 2. The score is based on a change from baseline (acute sepsis-related organ dysfunction). The presumption is that the score is 0 if there is no previously known organ dysfunction. If the patient has organ dysfunction at baseline, the score is determined by the change in strata. There are organ dysfunctions that are not found in SOFA but could be supportive of sepsis. These include (acute sepsis-related) ileus; Type 2 myocardial infarction (MI); critical illness neuropathy or myopathy; toxic epidermal necrolysis (from infection, not from medication); and liver dysfunction such as transaminitis (without hyperbilirubinemia).

Quick SOFA (qSOFA) was meant to be an easily-obtained-at-the-bedside surrogate for the SOFA score, which requires blood work results. The criteria are:

- Respiratory rate ≥ 22/minute (so nurses who guestimate 18 or 20 won't trigger qSOFA)
- Altered mentation (think ENCEPHALOPATHY!)
- Systolic blood pressure ≤ 100 mm Hg

(see SOFA chart on next page)

There are six things that the provider should consider regarding a sepsis diagnosis:

1. Is there a presumed or confirmed infection? Is it documented in a codable format?
2. Is the patient sicker than the average patient with the localized infection?
3. Is there organ dysfunction due to the sepsis?
   - Linkage must be to sepsis and not to the alternate diagnosis, e.g., "AKI due to dehydration."
   - The SOFA score can be supportive if ≥ 2. If not, the provider should acknowledge and document thought process.
4. Can the coder pick up the code for "severe sepsis"?
   - All sepsis is the condition formerly known as Severe Sepsis.
   - The combination of "sepsis" and acute sepsis-related organ dysfunction is adequate support for Severe Sepsis.
5. Are the core measures being attended to?
   - Core measure bundle should be performed on all patients with "sepsis" (formerly known as Severe Sepsis).
6. SIRS can prompt you to consider Sepsis and assess for organ dysfunction but is not singular grounds for making the diagnosis.

What are some of the tools for your tool belt to assist in documenting Sepsis accurately in the medical record?

- The Sepsis dot phrase – .Sepsis3 – created by EPIC programmers makes documenting easy with drop down menus. Example: Sepsis due to [infection] with acute sepsis-related organ dysfunction as evidenced by [specify organ dysfunctions].
- A SOFA score calculator is currently being built into the Scoring tools in EPIC.
- Make sure the diagnosis carries through the record from the time of diagnosis to the discharge summary with consistent documentation by all providers.
- Use uncertain diagnosis (possible sepsis) – It's better to entertain early and make an uncertain diagnosis and rule out, than to miss the diagnosis.
- The patient either has Sepsis (life-threatening organ dysfunction caused by dysregulated host response to infection) or they do not; there is no code for "early," "impending," or "aborted" sepsis.
- Avoid "multiple system organ failure." That can't be coded. List the organ dysfunctions.
- Avoid sepsis-adjacent phrases like "urosepsis," "early sepsis-like pattern," meets "sepsis criteria," and "sepsis syndrome."
- Providers should tell the story longitudinally and avoid contradictory, conflicting, or flip-flopping documentation.

In today's payer denial environment, Sepsis is nationally a diagnosis most prone to audits and denials. Payers can deny a diagnosis up to five years after discharge, which leads to a DRG downgrade and reimbursement recoupment from hospitals. So far, UnitedHealthcare is the only payer that has officially announced they have adopted the Sepsis-3 definition. Most other payers are citing Sepsis-3 definition criteria in their denial letters, hence the importance of defensive documentation in the medical record.

Providers, without a doubt you take excellent care of patients, but you need to document well to get credit for having done so. You want the patient to look as sick and complex in the medical record as they appear in real life. Happy Documentation!!

SOFA (SEQUENTIAL ORGAN FAILURE ASSESSMENT)

	SCORE				
SYSTEM	**0**	**1**	**2**	**3**	**4**
Respiration PaO_2/FIO_2, mm Hg	≥400	300-399	200-299	100-199 w/ respiratory support	<100 w/respiratory support
Coagulation Platelets, X 10^3 /µL	≥150	100-149	50-99	20-49	<20
Liver Bilirubin, mg/dL	<1.2	1.2-1.9	2.0-5.9	6.0-11.9	>12.0
Cardiovascular	MAP ≥ 70 mm Hg	MAP < 70 mm Hg	Dopamine ≤ 5 or dobutamine (any dose)	Dopamine 5.1-15 or epinephrine ≤ 0.1 or norepinephrine ≤ 0.1	Dopamine >15 or epinephrine > 0.1 or norepinephrine > 0.1
Central nervous system Glasgow Coma Scale score	15	13-14	10-12	6-9	<6
Renal Creatinine, mg/dL	<1.2	1.2-1.9	2.0-3.4	3.5-4.9	>5.0
Urine output, mL/d				200-499	<200

SPOTLIGHT

Dayton's First and Only Comprehensive Head and Neck Cancer Program

Premier Health's newly formed Head and Neck Cancer Program provides a full spectrum of collaborative care, offering patients diagnosis, treatment and support services close to home. Through this skilled and highly coordinated program, patients benefit from conveniently located comprehensive services typically found only at large academic medical centers.

Our experienced multidisciplinary team can diagnose and treat a wide range of benign and malignant head and neck tumors, including those of the eye, oral cavity, salivary glands, oropharynx, larynx, thyroid/parathyroid glands, esophagus, sinonasal tract, temporal bone, and skull base. We also treat the full gamut of skin cancer in the head and neck region.

Patients referred to the program have their care directed by head and neck cancer reconstructive surgeon Sameep Kadakia, MD. Here, Dr. Kadakia explains the program in greater detail:

What services does Premier Health's newly formed Head and Neck Cancer Program provide?

This is a unique program that is the first of its kind in the greater Dayton area. Our comprehensive head and neck cancer program offers multidisciplinary collaborative care for all head and neck cancer patients, with the goal of providing excellent care to treat all aspects of their challenging diagnoses. The program is able to diagnose, work-up, and treat these patients whether they need surgery, chemotherapy, or radiation treatment.

Our team includes providers that can perform advanced head and neck cancer surgery; plastic and reconstructive surgery; general surgical oncology; dedicated head and neck medical and radiation oncology; wound care along with hyperbaric oxygen treatment; a full suite of radiographic imaging; speech and swallow therapy; feeding tube placements; nutritional support; medical and cardiopulmonary management; oncology nurse navigators; social support; and more.

We seek to partner together with our patients and community as a team to keep all cancer care local and convenient for the patient so they can undergo this challenging treatment in the comfort of their community. We highly value the engagement of patients' families in their treatment process as well. Any need that a cancer patient has can be easily met by our team from the moment a patient walks into

our practice to when they are treated and rehabilitated.

How does having this program benefit patients?

Previously, patients with advanced head and neck cancers were being sent to outside facilities for treatment. While the treatment was certainly adequate, the challenge of having patients go to outside facilities lies in the great inconvenience and difficulty for them to make multiple trips to destinations that are several hours away. Cancer patients require the assistance of multiple providers, resulting in many appointments for consultations, treatment, imaging, etc. This poses a great burden to them and their families due to the time and expense required to make these trips.

This program provides comprehensive cancer support with the advantage of remaining close to home. Patients no longer have to travel several hours to go to their appointments; they can simply remain in the Dayton area and be treated in the comfort of their community. Having the convenience of being close to home is a source of great comfort for these patients. We believe in individualized patient care and give special attention to these patients.

Why is it important for our physicians to know about these services?

It is important for physicians to know of these services so they can refer these patients locally. It is always valuable and appreciated by patients when they are aware of a local treatment option that provides outstanding care. Physicians should be aware of these services so they can have a place to send patients for care of these challenging problems.

Importantly, when physicians know the team providing care for their patients locally, they can easily be involved in the care as a part of the team. Often when patients are referred to places farther away, the referring doctors are left out of the treatment team and there can be a gap in communication. With local cancer care, referring doctors can partner with us and be an integral part of treatment efforts while maintaining seamless communication.

Additionally, Premier Health is a certified member of MD Anderson Cancer Network®, a program of MD Anderson Cancer Center. Our membership means that we can connect local patients to the expertise of one of the nation's leading cancer centers. This includes peer-to-peer consults as well as evidence-based guidelines and treatment plans.

Tell us about your training and medical experience:

I went to medical school at Drexel University in Philadelphia, at which point I became interested in otolaryngology-head and neck surgery. I then went to do my residency in New York City, graduating from the Mount Sinai program.

I became interested in head and neck cancer along with reconstructive plastic surgery, so I went to Texas to pursue fellowship training with Dr. Yadro Ducic. In my fellowship, I learned special techniques in the surgical management of advanced head and neck cancer patients. I learned how to operate on patients with all types of head and neck cancer, including thyroid cancer, tongue and mandible cancer, laryngeal cancer, sinus cancer, skin cancer, and more. I also performed many procedures in conjunction with neurosurgery dealing with cancers at the skull base. Being a large referral center for refractory cases, I was trained in managing cancers that recurred after treatment and also cancers that recurred/persisted after radiation treatment. I was also trained in the full gamut of head and neck reconstruction, including local and regional flaps; along with expertise in microvascular free tissue reconstruction, whereby I can reconstruct any head and neck defect using various muscle, skin, and bone grafts from different parts of the body to restore function to the operated area.

What are some examples of head and neck cancer?

Tongue cancer, mandible cancer, laryngeal cancer, sinonasal cancer, skull base cancer, skin cancer, pharyngeal cancer, esophageal cancer, temporal bone cancer, thyroid cancer

What are the symptoms, warning signs, and risk factors that physicians should look out for in their patients?

Specifically for head and neck cancers, many of the symptoms are quite vague and nonspecific. Symptoms to watch out for include: weight loss, unexplained fevers or night sweats, lumps or bumps in the neck or face region, vision changes, persistent nasal congestion, persistent nasal bleeding, headaches, throat pain, dysphagia, voice changes, and pain.

Thyroid cancer has been identified as the fastest growing cancer for women in the United States. What guidelines do you suggest physicians follow to watch out for the disease?

Routine examination for all patients as part of their physical. Also, any new thyroid mass/lump/change in size should be evaluated with ultrasound.

At what point should a physician refer a patient to you for evaluation?

Any patient with a biopsy-proven head and neck malignancy; any patient with a prior history of head and neck malignancy needing follow up; any patient with prior head and neck surgery needing reconstruction or further treatment; any patient with a new head and neck mass or concerning findings on symptoms/exams; any patient with persistent symptoms as mentioned above that would benefit from full head and neck oncologic exam, including fiberoptic scope exam; and any patient with abnormal imaging findings, even if incidentally found

Referrals

To refer to Dr. Kadakia, please contact his office directly, or refer through EPIC.

OFFICE
(513) 420-4678
(513) 420-4705 FAX

EPIC
In the Order Search box, choose either "Premier ENT Associates" or "Kadakia."

Provider Praise

Premier Health patients submit thousands of comments each year acknowledging physicians across our health system for providing excellent care. Here is a random sampling of appreciation received in recent months:

Can't say enough about **Dr. Barney** and her team. Compassionate care and great communication.

I had total knee replacement and I am doing quite well with recovery. The staff was great, and I can't say enough great things and praise for surgeon **Dr. Dennis Brown**. His rapport is outstanding!!!

Love my surgeon, **Dr. Davis**.

Very pleased with **Dr. Fishbein**, his staff, and the hospital staff. Thank you.

Dr. Guy and the nurses were amazing, and I would recommend this facility to others!

Dr. Hadaway did an excellent job in surgery.

Dr. Hammock was extremely helpful. 1. Ordered echocardiogram 2. Ordered GI consult 3. Helped clarify blood results needed for approval for surgery.

Dr. Khattak is wonderful! Very pleasant and smiled. He knew my health history.

Dr. Lowry and team, thank you all. You were very nice to me. God bless all.

Excellent hospital! **Dr. Ludwig** is outstanding! Very patient friendly. Very courteous. Very professional. Very knowledgeable. Outstanding surgeon!

ER **Dr. Medapali** and hospitalist Dr. Patel showed excellent attention to care.

Everyone in the labor and delivery/ maternity unit is amazing, and **Dr. Morales** is the best!

Dr. Raab and his staff did a wonderful job. Your hospital is immaculate, and your staff were great.

I was impressed with **Dr. Shuck** and **Dr. Rolan**.

Dr. Tim and **Dr. Terry** were very kind and helpful. Very satisfied with my treatment.

Utmost praise for **Dr. Alan Thurman**.

Atrium Medical Center Receives Award from American Heart Association

Atrium Medical Center has received the Mission: Lifeline® Gold Receiving Plus Quality Achievement Award for continuing to implement the highest level of quality improvement measures outlined by the American Heart Association for the treatment of patients who suffer severe heart attacks.

"Atrium Medical Center has an established record of providing the highest level of care for heart attack patients in our community who come in directly or by transfer from another facility," said Mouhamad Abdallah, MD, medical director of Atrium's Chest Pain Center and medical director of Atrium's cardiac catheterization lab. "We take pride in our commitment to save lives through cardiac care and are honored that our dedication has again been recognized at the highest level by the American Heart Association through Mission: Lifeline."

Atrium is one of two hospitals in the Cincinnati market – and one of only three in the state of Ohio – to receive the Gold Plus Quality Achievement Award. Gold Plus is the association's highest honor for facilities that receive severe heart attack patients. Nationwide, only 66 hospitals received the Gold Plus Award, according to the heart association.

This award recognizes Atrium for meeting specific criteria and performance standards outlined by the American Heart Association for quick and appropriate treatment of ST elevation myocardial infarction (STEMI) – the deadliest type of heart attack, caused by a blockage of blood flow to the heart. To prevent death, Atrium staff work diligently to perform timely emergency procedures that re-establish blood flow as quickly as possible, either by mechanically opening the blocked vessel or by providing clot-busting medication.

"We commend Atrium Medical Center for this award in recognition for following evidence-based guidelines for timely heart attack treatment," said Tim Henry, MD, chair of the Mission: Lifeline Acute Coronary Syndrome Subcommittee. "We applaud the significant institutional commitment to their critical role in the system of care for quickly and appropriately treating heart attack patients."

The American Heart Association's Mission: Lifeline program's goal is to reduce system barriers to prompt treatment for heart attacks, beginning with the 9-1-1 call, to EMS transport and continuing through hospital treatment and discharge. The initiative provides tools, training, and other resources to support heart attack care following protocols from the most recent evidence-based treatment guidelines.

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