

# ***MINUTES***

**COMMITTEE ON PUBLIC HEALTH & PREVENTIVE MEDICINE  
MINNESOTA MEDICAL ASSOCIATION  
BROADWAY PLACE WEST  
1300 GODWARD STREET NORTHEAST  
SUITE 2500  
MINNEAPOLIS, MN 55413**

**TUESDAY, APRIL 20, 2010  
6:00 p.m.**

Members Present

Amy Gilbert, M.D., Chair  
Craig Anderson, M.D. (via conf. call)  
John Balfanz, M.D.  
Laurel Hansen, M.D.  
Thomas Kottke, M.D.  
Mark Liebow, M.D. (via conf. call)  
Doug Pryce, M.D.  
Maureen Murphy-Ryan, Med. Student Section  
Rahul Suresh, Med. Student Alternate

Members Absent

Ed Ehlinger, M.D.  
Vince Garry, M.D.  
Michael Garvis, M.D.  
Rahel Ghebre, M.D.  
Donald Hagler, M.D.  
David Hutchinson, M.D.  
Luciano Kolodny, M.D.  
Kathryn Lombardo, M.D.  
Warren Warwick, M.D.  
Tushar Dabade, M.D., Resident Fellow Section

Guests Present

Michelle Barclay, MN-ND Alzheimer's Assoc.  
Jim Hart, M.D., MN Public Health Assoc.  
Alexander Levitan, M.D.  
George Schoepfoerster, M.D., Geriatric Services of MN  
John Selstad, MN Board on Aging  
Michael Trangle, M.D., HealthPartners

Staff Present

Britta Orr

**I. Call to Order & Introductions**

The MMA Public Health & Preventive Medicine Committee was called to order at 6:05 p.m. by Amy Gilbert, M.D., committee chair. Introductions were held and guests were welcomed.

**II. Approval of Minutes of January 21, 2010**

With no objections noted, the minutes of the January 21, 2010 meeting were **APPROVED**. Dr. Gilbert reminded Britta Orr, MMA staff, that she still needed to circulate information on health impact assessments (HIAs) as requested at the last meeting.

### **III. Alzheimer's and Cognitive Screening**

Three guests – George Schoephoerster, M.D., Geriatric Services of Minnesota; Michelle Barclay, MN-ND Alzheimer's Association; and John Selstad, Minnesota Board on Aging – joined the committee to discuss the role of physicians in dementia screening. Dr. Schoephoerster described the 2009 Minnesota Legislature Alzheimer's Disease Working Group which is composed of experts examining issues such as quality, early identification and support, and patient-centered medical care for dementia and related cognitive disorders. He explained that the workgroup wants to enable “practice transformation” and help physicians understand the impact of undiagnosed or untreated dementia as it relates to chronic disease management.

Dr. Schoephoerster shared that 13% of U.S. residents over age 65 and 37.4% over age 90 have dementia. Currently, around 94,000 Minnesotans live with dementia. This is projected to increase to 110,000 by 2025. Alzheimer's is a growing cause of death and 95% of those with a dementia diagnosis suffer from at least one other diagnosis. These comorbidities can exacerbate cognitive dysfunction, increase disability, and complicate treatment protocols. Dementia can make it difficult to assess a patient's decision-making capacity, limit the patient's ability to engage in self care or medication management, and change the field of reasonable goals. In addition, the average healthcare costs per person are more than three times higher for those with dementia than those without. This does not account for the vast amount of unpaid assistance provided by family and other informal caregivers.

Dr. Schoephoerster asked committee members to consider promotion of dementia screening by using cognitive status as a 6<sup>th</sup> vital sign. Dr. Gilbert asked what tools are available to engage in proper early screening techniques and what meaningful information can be provided to patients at that stage. Al Levitan, M.D., expressed concern that a fruitful cognitive screen would be tedious and time-consuming. Dr. Schoephoerster clarified that screening does not necessarily need to be done by physicians, but they could explain the typical course of dementia (including variations from mild to moderate to severe) and make appropriate referrals. Ms. Barclay added that caregiver education is a major resource and that simply “having a plan” as a caregiver can result in significantly better outcomes for the patient. Mr. Selstad said that many such resources are available through the Alzheimer's Association or local area aging services organizations.

The committee felt there was potential for further discussion of this topic by the 2010 House of Delegates. Likely components of a resolution would be 1) general awareness and promotion of the Legislative Working Group recommendations, 2) provision of web materials and links to valuable referral resources, particularly for caregivers, and 3) direct education and/or an article in Minnesota Medicine on the importance of making an early diagnosis. Mark Liebow, M.D., and others felt promoting cognitive status as a 6<sup>th</sup> vital sign only makes sense in practices with high numbers of elderly patients (similar to autism screening in pediatrics). At the suggestion of Jim Hart, M.D., Dr. Liebow also agreed to ask the Institute for Clinical Systems Improvement (ICSI) evidence-based medicine committee to consider cognition as part of its routine screening guidelines. Tom Kottke, M.D., thought a resolution should encourage ICSI (or another source) to look at the science behind cognitive screening recommendations. Dr. Schoephoerster agreed to work with Ms. Orr to craft an appropriate draft resolution for consideration at the June 21 committee meeting.

### **IV. Serious Mental Illness**

Michael Trangle, M.D., HealthPartners attended the meeting to discuss serious mental illness (SMI) and the “MN 10 by 10 Initiative.” Dr. Trangle explained that there is increased morbidity and mortality associated with serious mental illness, largely due to preventable medical

conditions. In fact, compared to the general population, persons with major mental illness typically lose more than 25 years of normal life span. This holds true in Minnesota where an analysis of Minnesota Department of Health death statistics found that adults with Bipolar Disorder or Schizophrenia are dying, on average, 24 years earlier than the general public – from basic physical ailments like heart disease, diabetes, and cancer. A major reason is that very few in this population routinely see their primary care physician for an annual check-up. To address this issue, a group of public and private professionals and payers (the SMI Lifespan Workgroup) is launching an initiative to increase the average lifespan of Minnesotans with SMI by 10 years within 10 years.

Dr. Trangle's goal in speaking to the committee was to advocate a strong primary care role in decreasing this lifespan gap and to encourage dissemination of the "Lifespan Tool." The tool explains that people with SMI need to work with their primary care physicians and other care providers to make sure that five basic health issues are addressed (maintain a healthy weight, avoid smoking, minimize alcohol intake, maintain a healthy heart, and avoid or manage diabetes). The tool also includes encouraging the use of a Best Practice Bundle at least once per year among primary care physicians that serve this population. The bundle tracks six modifiable risk factors for patients including BMI, tobacco use, alcohol use, blood pressure, LDL, and blood sugar.

Dr. Kottke asked whether this initiative simply involves a changed job description for care managers. Dr. Trangle agreed that this is certainly an important part of the effort, but that the support and compliance of primary care doctors is critical. Dr. Liebow echoed that case manager training would be most useful to address this problem (similar to diabetes educators or smoking cessation counselors). He also asked whether it would make sense to narrow the field of indicators to the two or three that have the biggest impact on loss of life. Dr. Trangle replied that all six are important and, collectively, encourage cardiac health above all else. Dr. Hart said he agreed with the goal of the initiative, but argued that a greater impact could be achieved by making strides toward coordinated mental health care rather than improved primary care for those with mental health diagnoses. He asked if quality of life wasn't more important than longevity in these populations. Doug Pryce, M.D., felt similarly that good psychiatric care is more important than adding to the primary care agenda. Dr. Trangle responded that the shortage of psychiatrists poses a real problem and means that many SMI patients are *only* seen in primary care.

While the committee was generally supportive of Dr. Trangle's goals, it was somewhat resistant to endorse the bundle which gives physicians one more administrative task and forces an added layer of patient processing. It was determined that Dr. Trangle would work with Ms. Orr to craft a resolution for the 2010 House of Delegates. It would include: 1) general endorsement and an effort to raise awareness of the MN 10 by 10 Initiative, 2) a commitment to post information on the MMA website, 3) an acknowledgement that psychiatric and primary care communities must share responsibility and partner to address this problem, and 4) support for the provision of regular and reliable psychiatric care in addition to annual primary care assessments for patients with SMI.

#### **V. Worksite Health Promotion**

Ms. Orr reminded committee members that worksite health promotion (WHP) was a strategic planning interest identified by the group to address the behavioral causes of chronic disease. Filling in for Nico Pronk, M.D., HealthPartners Research Foundation, committee member Dr. Kottke graciously presented on the topic of WHP. He explained that "WHP represents the combined efforts of employees, families, employers, communities, and society to optimize worker health and wellbeing and overall business performance." The case for WHP is strong

given that employers are intimately linked to the provision of health insurance, 65% of American adults may be reached through a worksite, they constitute a relatively captive audience for frequent and sustained messaging, and the potential to influence behavior and provide incentives is high. Dr. Kottke stressed that at least four components should be a part of any worksite wellness program: assessment, advice, behavior change, and environmental intervention. If these elements are present, WHP can achieve dramatic cost savings – both direct and indirect. Studies have found that for every dollar invested, there is a return of \$3.27 on medical costs and \$2.73 on costs linked to absenteeism.

Dr. Gilbert asked whether the WHP data and experience has just been with larger employers. Dr. Kottke said both large and small employers can benefit, but that larger corporations may have greater success due to their ability to hire FTEs to design and manage programs. Ms. Orr shared that she is staying loosely connected to the Alliance for a Healthier Minnesota, an organization dedicated to making Minnesota healthier by harnessing the power and influence of employers statewide. Major Twin Cities businesses have signed on to support the effort and many others are expected to follow suit. Ms. Orr said she would keep the committee updated if a clear role for physician involvement emerged or if there was anything interesting to report.

## **VI. Updates & New Business**

### **A. Vitamin D Deficiency**

Ms. Orr met recently with Mary Manning and others at MDH in Health Promotion & Chronic Disease to discuss their current work and future interest in addressing vitamin D deficiency statewide (as directed by HOD-09 Resolution 302). MDH staff acknowledged limited involvement in this area and few resources to expand their efforts; however, they agreed that after updated recommendations are released by the Institute of Medicine in the next few months, they would be willing to consider a more formal partnership aimed at disseminating the best information available for both physicians and patients.

### **B. CHB Medical Consultants**

Ms. Orr reported that she is partnering to arrange a conference call focus group to engage MMA and MDH staff in a conversation to discuss the role and support of the Community Health Services Medical Consultants. The call will involve representatives from approximately six out-state counties and is likely to happen in mid-May.

### **C. HOD-09 Resolution 104: The Financial and Health Benefits of Paid Parental Leave**

Resolution 104 resolved “that the Minnesota Medical Association study potential fiscal and societal impacts of paid parental leave for the birth or adoption of children with report back to the Minnesota Medical Association House of Delegates in 2010.” Ms. Orr said she would be researching this topic over the next month and would seek input from the public health committee prior to and during the June 21 meeting.

## **VII. Adjourn**

There being no additional business, the meeting was adjourned at 8:08 p.m.