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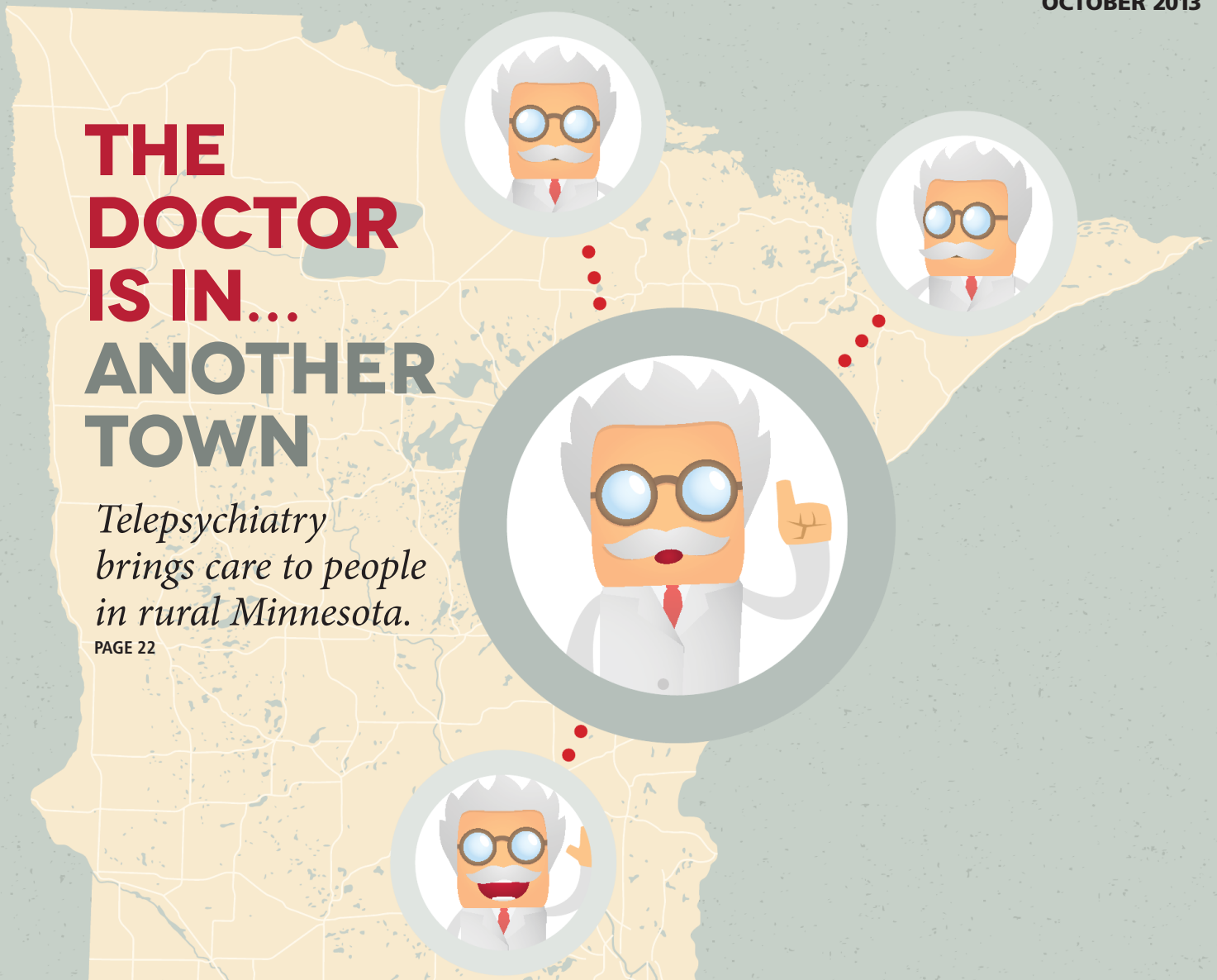

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*Victoza® 1.2 mg and 1.8 mg when used alone or in combination with OADs.

†**Victoza® is not indicated for the management of obesity, and weight change was a secondary end point in clinical trials.**

VICTOZA®
liraglutide (rDNA origin) injection

Indications and Usage

Victoza® (liraglutide [rDNA origin] injection) is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Because of the uncertain relevance of the rodent thyroid C-cell tumor findings to humans, prescribe Victoza® only to patients for whom the potential benefits are considered to outweigh the potential risk. Victoza® is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise.

Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis has been observed in patients treated with Victoza®. Victoza® has not been studied in patients with a history of pancreatitis. It is unknown whether patients with a history of pancreatitis are at increased risk for pancreatitis while using Victoza®. Other antidiabetic therapies should be considered in patients with a history of pancreatitis.

Victoza® is not a substitute for insulin. Victoza® should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings.

Victoza® has not been studied in combination with prandial insulin.

Important Safety Information

Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Victoza® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be ruled out by clinical or nonclinical studies. Victoza® is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Based on the findings in rodents, monitoring with serum calcitonin or thyroid ultrasound was performed during clinical trials, but this may have increased the number of unnecessary thyroid surgeries. It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate human risk of thyroid C-cell tumors. Patients should be counseled regarding the risk and symptoms of thyroid tumors.

Do not use in patients with a prior serious hypersensitivity reaction to Victoza® (liraglutide [rDNA origin] injection) or to any of the product components.

Postmarketing reports, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis. Discontinue promptly if pancreatitis is suspected. Do not restart if pancreatitis is confirmed. Consider other antidiabetic therapies in patients with a history of pancreatitis.

When Victoza® is used with an insulin secretagogue (e.g. a sulfonylurea) or insulin serious hypoglycemia can occur. Consider lowering the dose of the insulin secretagogue or insulin to reduce the risk of hypoglycemia.

Renal impairment has been reported postmarketing, usually in association with nausea, vomiting, diarrhea, or dehydration which may sometimes require hemodialysis. Use caution when initiating or escalating doses of Victoza® in patients with renal impairment.

Serious hypersensitivity reactions (e.g. anaphylaxis and angioedema) have been reported during postmarketing use of Victoza®. If symptoms of hypersensitivity reactions occur, patients must stop taking Victoza® and seek medical advice promptly.

There have been no studies establishing conclusive evidence of macrovascular risk reduction with Victoza® or any other antidiabetic drug.

The most common adverse reactions, reported in ≥5% of patients treated with Victoza® and more commonly than in patients treated with placebo, are headache, nausea, diarrhea, dyspepsia, constipation and anti-liraglutide antibody formation. Immunogenicity-related events, including urticaria, were more common among Victoza®-treated patients (0.8%) than among comparator-treated patients (0.4%) in clinical trials.

Victoza® has not been studied in type 2 diabetes patients below 18 years of age and is not recommended for use in pediatric patients.

There is limited data in patients with renal or hepatic impairment.

Please see brief summary of Prescribing Information on adjacent page.

0513-00015590-1 June 2013

Victoza® (liraglutide [rDNA origin] injection)
Rx Only
BRIEF SUMMARY. Please consult package insert for full prescribing information.

WARNING: RISK OF THYROID C-CELL TUMORS: Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Victoza® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be ruled out by clinical or nonclinical studies. Victoza® is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Based on the findings in rodents, monitoring with serum calcitonin or thyroid ultrasound was performed during clinical trials, but this may have increased the number of unnecessary thyroid surgeries. It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate human risk of thyroid C-cell tumors. Patients should be counseled regarding the risk and symptoms of thyroid tumors *[see Contraindications and Warnings and Precautions]*.

INDICATIONS AND USAGE: Victoza® is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. **Important Limitations of Use:** Because of the uncertain relevance of the rodent thyroid C-cell tumor findings to humans, prescribe Victoza® only to patients for whom the potential benefits are considered to outweigh the potential risk. Victoza® is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise. Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis has been observed in patients treated with Victoza®. Victoza® has not been studied in patients with a history of pancreatitis. It is unknown whether patients with a history of pancreatitis are at increased risk for pancreatitis while using Victoza®. Other antidiabetic therapies should be considered in patients with a history of pancreatitis. Victoza® is not a substitute for insulin. Victoza® should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings. The concurrent use of Victoza® and prandial insulin has not been studied.

CONTRAINDICATIONS: Do not use in patients with a personal or family history of medullary thyroid carcinoma (MTC) or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Do not use in patients with a prior serious hypersensitivity reaction to Victoza® or to any of the product components.

WARNINGS AND PRECAUTIONS: Risk of Thyroid C-cell Tumors: Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors (adenomas and/or carcinomas) at clinically relevant exposures in both genders of rats and mice. Malignant thyroid C-cell carcinomas were detected in rats and mice. A statistically significant increase in cancer was observed in rats receiving liraglutide at 8-times clinical exposure compared to controls. It is unknown whether Victoza® will cause thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors could not be determined by clinical or nonclinical studies. In the clinical trials, there have been 6 reported cases of thyroid C-cell hyperplasia among Victoza®-treated patients and 2 cases in comparator-treated patients (1.3 vs. 1.0 cases per 1000 patient-years). One comparator-treated patient with MTC had pre-treatment serum calcitonin concentrations >1000 ng/L suggesting pre-existing disease. All of these cases were diagnosed after thyroidectomy, which was prompted by abnormal results on routine, protocol-specified measurements of serum calcitonin. Five of the six Victoza®-treated patients had elevated calcitonin concentrations at baseline and throughout the trial. One Victoza® and one non-Victoza®-treated patient developed elevated calcitonin concentrations while on treatment. Calcitonin, a biological marker of MTC, was measured throughout the clinical development program. The serum calcitonin assay used in the Victoza® clinical trials had a lower limit of quantification (LLOQ) of 0.7 ng/L and the upper limit of the reference range was 5.0 ng/L for women and 8.4 ng/L for men. At Weeks 26 and 52 in the clinical trials, adjusted mean serum calcitonin concentrations were higher in Victoza®-treated patients compared to placebo-treated patients but not compared to patients receiving active comparator. At these timepoints, the adjusted mean serum calcitonin values (~1.0 ng/L) were just above the LLOQ with between-group differences in adjusted mean serum calcitonin values of approximately 0.1 ng/L or less. Among patients with pre-treatment serum calcitonin below the upper limit of the reference range, shifts to above the upper limit of the reference range which persisted in subsequent measurements occurred most frequently among patients treated with Victoza® 1.8 mg/day. In trials with on-treatment serum calcitonin measurements out to 5-6 months, 1.9% of patients treated with Victoza® 1.8 mg/day developed new and persistent calcitonin elevations above the upper limit of the reference range compared to 0.8-1.1% of patients treated with control medication or the 0.6 and 1.2 mg doses of Victoza®. In trials with on-treatment serum calcitonin measurements out to 12 months, 1.3% of patients treated with Victoza® 1.8 mg/day had new and persistent elevations of calcitonin from below or within the reference range to above the upper limit of the reference range, compared to 0.6%, 0% and 1.0% of patients treated with Victoza® 1.2 mg, placebo and active control, respectively. Otherwise, Victoza® did not produce consistent dose-dependent or time-dependent increases in serum calcitonin. Patients with MTC usually have calcitonin values >50 ng/L. In Victoza® clinical trials, among patients with pre-treatment serum calcitonin <50 ng/L, one Victoza®-treated patient and no comparator-treated patients developed serum calcitonin >50 ng/L. The Victoza®-treated patient who developed serum calcitonin >50 ng/L had an elevated pre-treatment serum calcitonin of 10.7 ng/L that increased to 30.7 ng/L at Week 12 and 53.5 ng/L at the end of the 6-month trial. Follow-up serum calcitonin was 22.3 ng/L more than 2.5 years after the last dose of Victoza®. The largest increase in serum calcitonin in a comparator-treated patient was seen with glimepiride in a patient whose serum calcitonin increased from 19.3 ng/L at baseline to 44.8 ng/L at Week 65 and 38.1 ng/L at Week 104. Among patients who began with serum calcitonin <20 ng/L, calcitonin elevations to >20 ng/L occurred in 0.7% of Victoza®-treated patients, 0.3% of placebo-treated patients, and 0.5% of active-comparator-treated patients, with an incidence of 1.1% among patients treated with 1.8 mg/day of Victoza®. The clinical significance of these findings is unknown. Counsel patients regarding the risk for MTC and the symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea or persistent hoarseness). It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate the potential risk of MTC, and such monitoring may increase the risk of unnecessary procedures, due to low test specificity for serum calcitonin and a high background incidence of thyroid disease. Patients with thyroid nodules noted on physical examination or neck imaging obtained for other reasons should be referred to an endocrinologist for further evaluation. Although routine monitoring of serum calcitonin is of uncertain value in patients treated with Victoza®, if serum calcitonin is measured and found to be elevated, the patient should be referred to an endocrinologist for further evaluation. **Pancreatitis: Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis, has been observed in patients treated with Victoza®. After initiation of Victoza®, observe patients carefully for signs and symptoms of pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back and which may or may not be accompanied by vomiting). If pancreatitis is suspected, Victoza® should promptly be discontinued and appropriate management should be initiated. If pancreatitis is confirmed, Victoza® should not be restarted. Consider antidiabetic therapies other than Victoza® in patients with a history of pancreatitis.** In clinical trials of Victoza®, there have been 13 cases of pancreatitis among Victoza®-treated patients and 1 case in a comparator (glimepiride) treated patient (2.7 vs. 0.5 cases per 1000 patient-years). Nine of the 13 cases with Victoza® were reported as acute pancreatitis and four were reported as chronic pancreatitis. In one case in a Victoza®-treated patient, pancreatitis, with necrosis, was observed and led to death; however clinical causality could not be established. Some patients had other risk factors for pancreatitis, such as a history of cholelithiasis or alcohol abuse. **Use with Medications Known to Cause Hypoglycemia:** Patients receiving Victoza® in combination with an insulin secretagogue (e.g., sulfonylurea) or insulin may have an increased risk of hypoglycemia. The risk of hypoglycemia may be lowered by a reduction in the dose of sulfonylurea (or other concomitantly administered insulin secretagogues) or insulin **Renal Impairment:** Victoza® has not been found to be directly nephrotoxic in animal studies or clinical trials. There have been postmarketing reports of acute renal failure and worsening of chronic renal failure, which may sometimes require hemodialysis in Victoza®-treated patients. Some of these events were reported in patients without known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration. Some of the reported events occurred in patients receiving one or more medications known to affect renal function or hydration status. Altered renal function has been reversed in many of the reported cases with supportive treatment and discontinuation of potentially causative agents, including Victoza®. Use caution when initiating or escalating doses of Victoza® in patients with renal impairment. **Hypersensitivity Reactions:** There have been postmarketing reports of serious hypersensitivity reactions (e.g., anaphylactic reactions and angioedema) in patients treated with Victoza®. If a hypersensitivity reaction occurs, the patient should discontinue Victoza® and other suspect medications and promptly seek medical advice. Angioedema has also been reported with other GLP-1 receptor agonists. Use caution in a patient with a history of angioedema with another GLP-1 receptor agonist because it is unknown whether such patients will be predisposed to angioedema with Victoza®. **Macrovascular Outcomes:** There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with Victoza® or any other antidiabetic drug.

ADVERSE REACTIONS: Clinical Trials Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. The safety of Victoza® has been evaluated in 8 clinical trials: A double-blind 52-week monotherapy trial compared Victoza® 1.2 mg daily, Victoza® 1.8 mg daily, and glimepiride 8 mg daily; A double-blind 26 week add-on to metformin trial compared Victoza® 0.6 mg once-daily, Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, placebo, and glimepiride 4 mg once-daily; A double-blind 26 week add-on to glimepiride trial compared Victoza® 0.6 mg daily, Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, placebo, and rosiglitazone 4 mg once-daily; A 26 week add-on to metformin + glimepiride trial, compared double-blind Victoza® 1.8 mg once-daily, double-blind placebo, and open-label insulin glargine once-daily; A double-blind 26-week add-on to metformin + rosiglitazone trial compared Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily and placebo; An open-label 26-week add-on to metformin and/or sulfonylurea trial compared Victoza® 1.8 mg once-daily and exenatide 10 mcg twice-daily; An open-label 26-week add-on to metformin trial compared Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, and sitagliptin 100 mg once-daily; An open-label 26-week trial compared insulin detemir as add-on to Victoza® 1.8 mg + metformin to continued treatment with Victoza® + metformin alone. *Withdrawals:* The incidence of withdrawal due to adverse events was 7.8% for Victoza®-treated patients and 3.4% for comparator-treated patients in the five double-blind controlled trials of 26 weeks duration or longer. This difference was driven by withdrawals due to gastrointestinal adverse reactions, which occurred in 5.0% of Victoza®-treated patients and 0.5% of comparator-treated patients. In these five trials, the most common adverse reactions leading to withdrawal for Victoza®-treated patients were nausea (2.8% versus 0% for comparator) and vomiting (1.5% versus 0.1% for comparator). Withdrawal due to gastrointestinal adverse events mainly occurred during the first 2-3 months of the trials. *Common adverse reactions:* Tables 1, 2, 3 and 4 summarize common adverse reactions (hypoglycemia is discussed separately) reported in seven of the eight controlled trials of 26 weeks duration or longer. Most of these adverse reactions were gastrointestinal in nature. In the five double-blind clinical trials of 26 weeks duration or longer, gastrointestinal adverse reactions were reported in 41% of Victoza®-treated patients and were dose-related. Gastrointestinal adverse reactions occurred in 17% of comparator-treated patients. Common adverse reactions that occurred at a higher incidence among Victoza®-treated patients included nausea, vomiting, diarrhea, dyspepsia and constipation. In the five double-blind and three open-label clinical trials of 26 weeks duration or longer, the percentage of patients who reported nausea declined over time. In the five double-blind trials approximately 13% of Victoza®-treated patients and 2% of comparator-treated patients reported nausea during the first 2 weeks of treatment. In the 26-week open-label trial comparing Victoza® to exenatide, both in combination with metformin and/or sulfonylurea, gastrointestinal adverse reactions were reported at a similar incidence in the Victoza® and exenatide treatment groups (Table 3). In the 26-week open-label trial comparing Victoza® 1.2 mg, Victoza® 1.8 mg and sitagliptin 100 mg, all in combination with metformin, gastrointestinal adverse reactions were reported at a higher incidence with Victoza® than sitagliptin (Table 4). In the remaining 26-week trial, all patients received Victoza® 1.8 mg + metformin during a 12-week run-in period. During the run-in period, 167 patients (17% of enrolled total) withdrew from the trial: 76 (46% of withdrawals) of these patients doing so because of gastrointestinal adverse reactions and 15 (9% of withdrawals) doing so due to other adverse events. Only those patients who completed the run-in period with inadequate glycemic control were randomized to 26 weeks of add-on therapy with insulin detemir or continued, unchanged treatment with Victoza® 1.8 mg + metformin. During this randomized 26-week period, diarrhea was the only adverse reaction reported in ≥5% of patients treated with Victoza® 1.8 mg + metformin + insulin detemir (11.7%) and greater than in patients treated with Victoza® 1.8 mg and metformin alone (6.9%).

Table 1: Adverse reactions reported in ≥5% of Victoza®-treated patients in a 52-week monotherapy trial

	All Victoza® N = 497	Glimepiride N = 248
Adverse Reaction	(%)	(%)
Nausea	28.4	8.5
Diarrhea	17.1	8.9
Vomiting	10.9	3.6
Constipation	9.9	4.8
Headache	9.1	9.3

Table 2: Adverse reactions reported in ≥5% of Victoza®-treated patients and occurring more frequently with Victoza® compared to placebo: 26-week combination therapy trials

Add-on to Metformin Trial			
	All Victoza® + Metformin N = 724	Placebo + Metformin N = 121	Glimepiride + Metformin N = 242
Adverse Reaction	(%)	(%)	(%)
Nausea	15.2	4.1	3.3
Diarrhea	10.9	4.1	3.7
Headache	9.0	6.6	9.5
Vomiting	6.5	0.8	0.4
Add-on to Glimepiride Trial			
	All Victoza® + Glimepiride N = 695	Placebo + Glimepiride N = 114	Rosiglitazone + Glimepiride N = 231
Adverse Reaction	(%)	(%)	(%)
Nausea	7.5	1.8	2.6
Diarrhea	7.2	1.8	2.2

Constipation	5.3	0.9	1.7
Dyspepsia	5.2	0.9	2.6
Add-on to Metformin + Glimepiride			
	Victoza® 1.8 + Metformin + Glimepiride N = 230	Placebo + Metformin + Glimepiride N = 114	Glargine + Metformin + Glimepiride N = 232
Adverse Reaction	(%)	(%)	(%)
Nausea	13.9	3.5	1.3
Diarrhea	10.0	5.3	1.3
Headache	9.6	7.9	5.6
Dyspepsia	6.5	0.9	1.7
Vomiting	6.5	3.5	0.4
Add-on to Metformin + Rosiglitazone			
	All Victoza® + Metformin + Rosiglitazone N = 355	Placebo + Metformin + Rosiglitazone N = 175	
Adverse Reaction	(%)	(%)	
Nausea	34.6	8.6	
Diarrhea	14.1	6.3	
Vomiting	12.4	2.9	
Headache	8.2	4.6	
Constipation	5.1	1.1	

Table 3: Adverse Reactions reported in ≥5% of Victoza®-treated patients in a 26-Week Open-Label Trial versus Exenatide

	Victoza® 1.8 mg once daily + metformin and/or sulfonylurea N = 235	**Exenatide 10 mcg twice daily + metformin and/or sulfonylurea** N = 232
Adverse Reaction	(%)	(%)
Nausea	25.5	28.0
Diarrhea	12.3	12.1
Headache	8.9	10.3
Dyspepsia	8.9	4.7
Vomiting	6.0	9.9
Constipation	5.1	2.6

Table 4: Adverse Reactions in ≥5% of Victoza®-treated patients in a 26-Week Open-Label Trial versus Sitagliptin

	All Victoza® + metformin N = 439	**Sitagliptin 100 mg/day + metformin** N = 219
Adverse Reaction	(%)	(%)
Nausea	23.9	4.6
Headache	10.3	10.0
Diarrhea	9.3	4.6
Vomiting	8.7	4.1

Immunogenicity: Consistent with the potentially immunogenic properties of protein and peptide pharmaceuticals, patients treated with Victoza® may develop anti-liraglutide antibodies. Approximately 50-70% of Victoza®-treated patients in the five double-blind clinical trials of 26 weeks duration or longer were tested for the presence of anti-liraglutide antibodies at the end of treatment. Low titers (concentrations not requiring dilution of serum) of anti-liraglutide antibodies were detected in 8.6% of these Victoza®-treated patients. Sampling was not performed uniformly across all patients in the clinical trials, and this may have resulted in an underestimate of the actual percentage of patients who developed antibodies. Cross-reacting anti-liraglutide antibodies to native glucagon-like peptide-1 (GLP-1) occurred in 6.9% of the Victoza®-treated patients in the double-blind 52-week monotherapy trial and in 4.8% of the Victoza®-treated patients in the double-blind 26-week add-on combination therapy trials. These cross-reacting antibodies were not tested for neutralizing effect against native GLP-1, and thus the potential for clinically significant neutralization of native GLP-1 was not assessed. Antibodies that had a neutralizing effect on liraglutide in an *in vitro* assay occurred in 2.3% of the Victoza®-treated patients in the double-blind 52-week monotherapy trial and in 1.0% of the Victoza®-treated patients in the double-blind 26-week add-on combination therapy trials. Among Victoza®-treated patients who developed anti-liraglutide antibodies, the most common category of adverse events was that of infections, which occurred among 40% of these patients compared to 36%, 34% and 35% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. The specific infections which occurred with greater frequency among Victoza®-treated antibody-positive patients were primarily nonserious upper respiratory tract infections, which occurred among 11% of Victoza®-treated antibody-positive patients; and among 7%, 7% and 5% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. Among Victoza®-treated antibody-negative patients, the most common category of adverse events was that of gastrointestinal events, which occurred in 43%, 18% and 19% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. Antibody formation was not associated with reduced efficacy of Victoza® when comparing mean HbA_{1c} of all antibody-positive and all antibody-negative patients. However, the 3 patients with the highest titers of anti-liraglutide antibodies had no reduction in HbA_{1c} with Victoza® treatment. In the five double-blind clinical trials of Victoza®, events from a composite of adverse events potentially related to immunogenicity (e.g. urticaria, angioedema) occurred among 0.8% of Victoza®-treated patients and among 0.4% of comparator-treated patients. Urticaria accounted for approximately one-half of the events in this composite for Victoza®-treated patients. Patients who developed anti-liraglutide antibodies were not more likely to develop events from the immunogenicity events composite than were patients who did not develop anti-liraglutide antibodies. *Injection site reactions:* Injection site reactions (e.g., injection site rash, erythema) were reported in approximately 2% of Victoza®-treated patients in the five double-blind clinical trials of at least 26 weeks duration. Less than 0.2% of Victoza®-treated patients discontinued due to injection site reactions. *Papillary thyroid carcinoma:* In clinical trials of Victoza®, there were 7 reported cases of papillary thyroid carcinoma in patients treated with Victoza® and 1 case in a comparator-treated patient (1.5 vs. 0.5 cases per 1000 patient-years). Most of these papillary thyroid carcinomas were <1 cm in greatest diameter and were diagnosed in surgical pathology specimens after thyroidectomy prompted by findings on protocol-specified screening with serum calcitonin or thyroid ultrasound. *Hypoglycemia:* In the eight clinical trials of at least 26 weeks duration, hypoglycemia requiring the assistance of another person for treatment occurred in 11 Victoza®-treated patients (2.3 cases per 1000 patient-years) and in two exenatide-treated patients. Of these 11 Victoza®-treated patients, six patients were concomitantly using metformin and a sulfonylurea, one was concomitantly using a sulfonylurea, two were concomitantly using metformin (blood glucose values were 65 and 94 mg/dL) and two were using Victoza® as monotherapy (one of these patients was undergoing an intravenous glucose tolerance test and the other was receiving insulin as treatment during a hospital stay). For these two patients on Victoza® monotherapy, the insulin treatment was the likely explanation for the hypoglycemia. In the 26-week open-label trial comparing Victoza® to sitagliptin, the incidence of hypoglycemic events defined as symptoms accompanied by a fingerstick glucose <56 mg/dL was comparable among the treatment groups (approximately 5%).

Table 5: Incidence (%) and Rate (episodes/patient year) of Hypoglycemia in the 52-Week Monotherapy Trial and in the 26-Week Combination Therapy Trials

	Victoza® Treatment	**Active Comparator**	**Placebo Comparator**
Monotherapy	**Victoza®** (N = 497)	**Glimepiride** (N = 248)	**None**
Patient not able to self–treat	0	0	—
Patient able to self–treat	9.7 (0.24)	25.0 (1.66)	—
Not classified	1.2 (0.03)	2.4 (0.04)	—
Add-on to Metformin	**Victoza® + Metformin** (N = 724)	**Glimepiride + Metformin** (N = 242)	**Placebo + Metformin** (N = 121)
Patient not able to self–treat	0.1 (0.001)	0	0
Patient able to self–treat	3.6 (0.05)	22.3 (0.87)	2.5 (0.06)
Add-on to Victoza® + Metformin	**Insulin detemir + Victoza® + Metformin** (N = 163)	**Continued Victoza® + Metformin alone** (N = 158*)	**None**
Patient not able to self–treat	0	0	—
Patient able to self–treat	9.2 (0.29)	1.3 (0.03)	—
Add-on to Glimepiride	**Victoza® + Glimepiride** (N = 695)	**Rosiglitazone + Glimepiride** (N = 231)	**Placebo + Glimepiride** (N = 114)
Patient not able to self–treat	0.1 (0.003)	0	0
Patient able to self–treat	7.5 (0.38)	4.3 (0.12)	2.6 (0.17)
Not classified	0.9 (0.05)	0.9 (0.02)	0
Add-on to Metformin + Rosiglitazone	**Victoza® + Metformin + Rosiglitazone** (N = 355)	**None**	**Placebo + Metformin + Rosiglitazone** (N = 175)
Patient not able to self–treat	0	—	0
Patient able to self–treat	7.9 (0.49)	—	4.6 (0.15)
Not classified	0.6 (0.01)	—	1.1 (0.03)
Add-on to Metformin + Glimepiride	**Victoza® + Metformin + Glimepiride** (N = 230)	**Insulin glargine + Metformin + Glimepiride** (N = 232)	**Placebo + Metformin + Glimepiride** (N = 114)
Patient not able to self–treat	2.2 (0.06)	0	0
Patient able to self–treat	27.4 (1.16)	28.9 (1.29)	16.7 (0.95)
Not classified	0	1.7 (0.04)	0

*One patient is an outlier and was excluded due to 25 hypoglycemic episodes that the patient was able to self-treat. This patient had a history of frequent hypoglycemia prior to the study.

In a pooled analysis of clinical trials, the incidence rate (per 1,000 patient-years) for malignant neoplasms (based on investigator-reported events, medical history, pathology reports, and surgical reports from both blinded and open-label study periods) was 10.9 for Victoza®, 6.3 for placebo, and 7.2 for active comparator. After excluding papillary thyroid carcinoma events *[see Adverse Reactions]*, no particular cancer cell type predominated. Seven malignant neoplasm events were reported beyond 1 year of exposure to study medication, six events among Victoza®-treated patients (4 colon, 1 prostate and 1 nasopharyngeal), no events with placebo and one event with active comparator (colon). Causality has not been established. **Laboratory Tests:** In the five clinical trials of at least 26 weeks duration, mildly elevated serum bilirubin concentrations (elevations to no more than twice the upper limit of the reference range) occurred in 4.0% of Victoza®-treated patients, 2.1% of placebo-treated patients and 3.5% of active-comparator-treated patients. This finding was not accompanied by abnormalities in other liver tests. The significance of this isolated finding is unknown. **Vital signs:** Victoza® did not have adverse effects on blood pressure. Mean increases from baseline in heart rate of 2 to 3 beats per minute have been observed with Victoza® compared to placebo. The long-term clinical effects of the increase in pulse rate have not been established. **Post-Marketing Experience:** The following additional adverse reactions have been reported during post-approval use of Victoza®. Because these events are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure: Dehydration resulting from nausea, vomiting and diarrhea; Increased serum creatinine, acute renal failure or worsening of chronic renal failure, sometimes requiring hemodialysis; Angioedema and anaphylactic reactions; Allergic reactions: rash and pruritus; Acute pancreatitis, hemorrhagic and necrotizing pancreatitis sometimes resulting in death.

OVERDOSAGE: Overdoses have been reported in clinical trials and post-marketing use of Victoza®. Effects have included severe nausea and severe vomiting. In the event of overdosage, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms.

More detailed information is available upon request.

For information about Victoza® contact: Novo Nordisk Inc., 800 Scudders Mill Road, Plainsboro, NJ 08536, 1–877-484-2869

Date of Issue: April 16, 2013

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VICTOZA®
liraglutide (rDNA origin) injection

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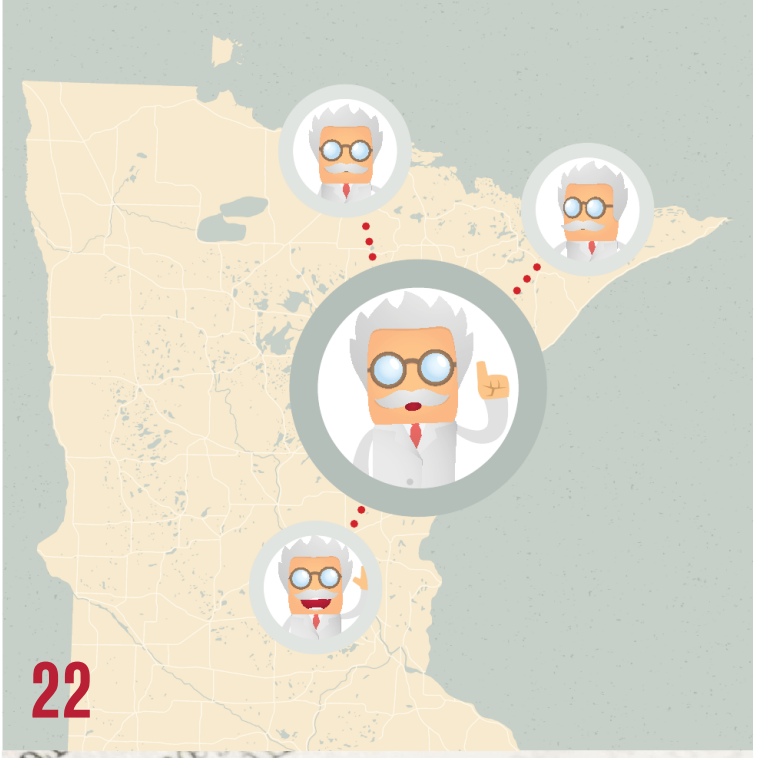

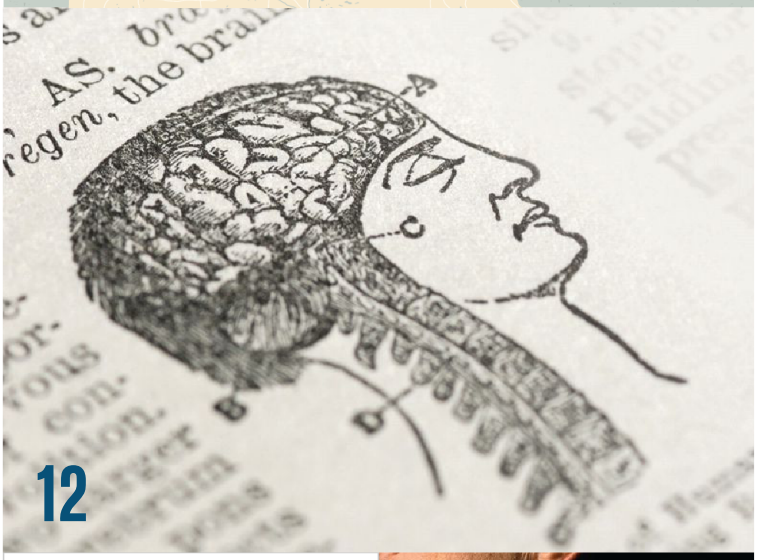

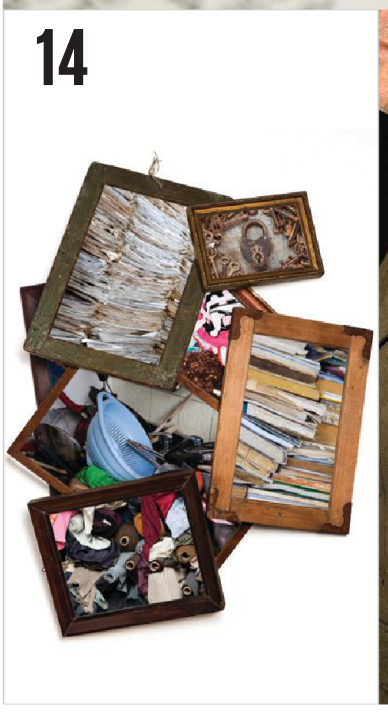

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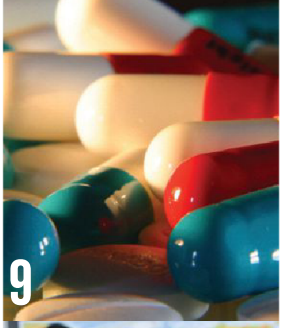
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To submit an article
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PHOTO BY SCOTT WALKER

Charles R. Meyer, M.D., Editor in Chief

Cracking the capsule

Recently, a friend struggling through her unsuccessful battle with uterine cancer said after months of pain, bleeding, chemotherapy and radiation therapy, "It is so isolating to be sick." Despite having a caring, attentive husband, a supportive family and a plethora of friends, she still felt that, in the end, the pain and deterioration were her own—and the experience an intensely personal one that only she had to withstand even as everybody tried to help.

From the mundane cold to the life-threatening cancer, illness isolates its victims, encapsulating them in a swirl of symptoms that pulls them away from normal human interaction. Perhaps no disease is more isolating than mental illness. Like other illnesses, mental illness can devastate its victims with debilitating symptoms. Unlike other illnesses, mental illness and its thought disturbances can distance a patient even further from others. And as is the case with any illness, the physician's job is to breach that capsule, meeting the patient wherever they can to treat and to comfort.

It seems like mental health treatment approaches go through more changes than the public school curriculum.

Whether they are diagnosed with mild anxiety or seemingly refractory schizophrenia, people with mental illness encounter barriers when relating to the daily world and to the medical world. Depression and anxiety can skew perception and fog concentration. Delusions and hallucinations frequently hamper all communication. So letting doctors know what it's like inside their capsule is a problem for the mentally ill and for their doctors.

The problem physicians face in treating mentally ill patients is echoed across the health care system. It seems like mental health treatment approaches go through more changes than the public school curriculum. Yesteryear's institutional incarceration of the seriously mentally ill gave way to the push to get them out into the community, a strategy currently being questioned by some. As revelations of the chemical basis of many mental illnesses surfaced and drugs that altered those chemicals emerged, psychiatry moved from the talk of psychotherapy to the pills of psychotropic medications—a trend now being challenged by those who have realized the limitations of "pill pushing." And psychiatry's coding system, the DSM, has just undergone a radical revision that will change what psychiatrists diagnose and, perhaps, the way they think. Even the definition of recovery from mental illness is being debated.

Perhaps that is why it is so difficult to get anybody to pay for the care of psychiatric problems. Insurance companies construct elaborate controls and restricted capitation structures to limit their coverage of mental illness's admittedly costly treatments. In part because of the inadequate reimbursement of psychiatric services, psychiatry as a professional choice for medical school graduates has experienced a steady decline until this year's 3.4 percent uptick in the residency match statistics.

Despite the promises of neuroscience, psychiatric disease is not going to get simpler and the debates will not likely evaporate. Yet mental health professionals agree that early identification is crucial. To identify those who are afflicted, the medical community needs to challenge the stigma, mention the unmentionable and bring up the topic.

So physicians of all stripes need to be capsule crackers, reaching into the silent world of patients suffering from illness—physical or mental—and trying to understand so they can treat. **MM**

Charles Meyer can be reached at meyer073@umn.edu.

Minnesota Medical Association

Tuesday, November 12, 2013

Primary Care Physician Workforce Summit

Minnesota is in the middle of a crisis. As the Affordable Care Act kicks into high gear in January thousands of Minnesotans will gain access to health care coverage. In addition, an increasing number of primary care physicians are retiring and our population continues to get older.

How are we going to meet this growing need for care and how will it affect your practice?

Help the MMA tackle one of Minnesota's largest challenges by taking part in "Finding Solutions: the Primary Care Physician Workforce Summit." Examine trends with national experts, learn how groups across Minnesota are responding, take away strategies that will help you meet the challenge, and share your ideas and concerns.

Together, we can find the answer.

Event details

Tuesday, November 12, 2013
4 – 8 pm

Ramada Plaza Minneapolis
1330 Industrial Blvd NE
Minneapolis, MN 55413

COST: (includes dinner) $50 for MMA members, $75 for nonmembers, $10 for students

Keynote Speaker

Scott Shipman, M.D., M.P.H.

Director of Primary Care Affairs and Workforce Analysis
Association of American Medical Colleges
National trends in primary care medical education

Closing Speaker

Paul Rockey, M.D., M.P.H.

Scholar in Residence
The Accreditation Council for Graduate Medical Education
National trends in primary care residency training

General Session

The Economics and Business Side of Primary Care

Breakout Session Topics (attendees will choose one):

1. The Current State of Medical Education in Minnesota
2. Primary Care Practice Transformation

To register, visit

www.mnmed.org/PCPSummit

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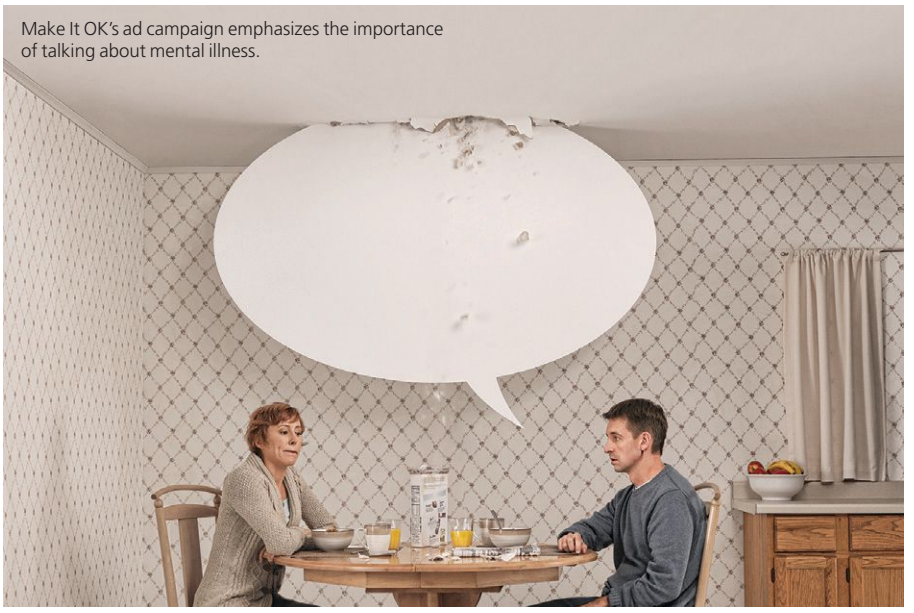


Make It OK's ad campaign emphasizes the importance of talking about mental illness.

Stopping the stigma

BY KIM KISER

The ads are clever: Each one features two people uncomfortably turned toward each other. A giant empty cartoon speech bubble hovers above them. The message, however, is serious: Silence makes the stigma of mental illness worse.

COURTESY OF MAKE IT OK

Getting people to talk about mental illness—and ending the stigma—is the goal of Make It OK, a recent collaboration involving a number of Minnesota health care and mental health organizations. They launched the ads last spring along with a website (www.makeitok.org) that offers suggestions about what to say when a person opens up about his or her mental illness.

"For a person with cancer, you'd think, 'This is so simple.' But the fact that we have to call out what to say and what not to say shows how uncomfortable it is to talk about mental illness," says Donna Zimmerman, senior vice president of government and community relations for HealthPartners, which is taking the lead on the initiative along with Regions Hospital Foundation and NAMI Minnesota. Guild Inc., Park Nicollet Foundation, PrairieCare Hospital and Clinics and Twin Cities Public Television (TPT) are also involved.

Zimmerman says the idea for Make It OK emerged during discussions with families and patients while planning for the new mental health center at Regions Hospital. "We kept hearing that a better model of care is needed in the community and that we need to address the ongoing issue of the stigma people face," she says. Representatives from several sponsoring organizations worked with Preston Kelly, a Minneapolis agency, to create the ad campaign and website.

"One in four people will be affected by mental illness," Zimmerman says. "We want to make sure the community understands how common it is and that there are many good treatments available." This month, the partners will rerun the ads. In addition, they will introduce a four-part series on TPT that will feature the stories of people who have had a mental illness and have experienced the associated stigma.

This isn't the only Minnesota-made series aimed at raising awareness about mental illness. Another one that aired on TPT and KSTP-TV in 2012, "Understanding Depression, Hope Through Treatment," is now available on YouTube (you can find a link at www.understandingdepression.org).

That five-part series was produced by psychiatrist James Jordan, M.D., and social worker and cable television host Mary Hanson. It features the stories of four individuals who have lived with depression, including Patricia Lindholm, M.D., a family physician in Fergus Falls, Minnesota, and former MMA president.

What to say when a person tells you they have a mental illness:

"Thanks for opening up to me."
"How can I help?"
"Thanks for sharing."
"I'm sorry to hear that. It must be tough."
"I'm here for you when you need me."
"I can't imagine what you're going through."
"People do get better."
"Can I drive you to an appointment?"
"How are you feeling today?"
"I love you."

Source: Make It OK

Minnesota's suicide trend ticks upward

Minnesota has seen an increase in suicides over the last 10 years, especially among middle-aged men.

According to the Minnesota Department of Health, which in August released its annual report on suicide, 684 deaths by suicide were reported in 2011. The number of suicides has been steadily rising since 1999, when 437 were reported. Health officials noted that the biggest increase in recent years has been among men ages 55 to 59 years.

Minnesotans ages 25 to 64 years of age had the highest suicide rate (17 per 100,000 population). The rate among adults age 65 and older held steady between 2005 and 2010, but rose dramatically from 10.2 per 100,000 to 13.8 per 100,000 between 2010 and 2011. The rate for persons younger than 25 years of age has hovered at around 5 per 100,000.

The health department also found the suicide rate was higher in greater Minnesota (14.3 per 100,000) than in the seven-county metro area (10.9 per 100,000). Males in greater Minnesota had the highest rate (23.0 per 100,000).

The trend prompted representatives from the Department of Health, Department of Human Services, other state agencies and advocacy groups to form a task force that will update the state's suicide prevention plan and encourage prevention activities that target middle-aged adults and other populations at higher risk.

"We must do more to connect with those who are suffering and contemplating suicide," Minnesota's health commissioner Ed Ehlinger, M.D., said in a statement. "This is especially important because we know suicides are preventable."

Twenty percent of children in the United States say they have been bullied in the last year.

A bullying pulpit

Bullying is a health issue, according to a new report from Children's Hospitals and Clinics of Minnesota. "Understanding the Threat of Bullying" is the fourth in Children's "Check-Up" series, which focuses on a different aspect of Minnesota children's health each year.

The report points out that children who have health problems are among those who are most likely to be bullied. Kids who are obese or have eating disorders, have unusual physical characteristics or deformities, who are weak because of illness, and who behave differently than others are among those likely to be targeted. For example, 46 percent of adolescents with an autism spectrum disorder and 94 percent of students with disabilities report being bullied.

It also notes that bullying makes kids sicker. It can exacerbate conditions such as Tourette syndrome, put kids at a higher risk for depression and suicide, and lead to psychosomatic manifestations such as headaches and stomachaches.

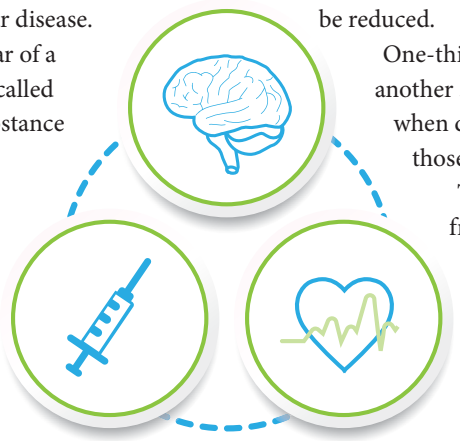
The report states that "bullying persists in every school district," with 13 percent of youths in grades 6, 9 and 12 being bullied regularly at school; across the United States, 20 percent of kids report having been bullied in the last year. It calls for educators, parents, the legal system and physicians to respond. Clinicians are urged to ask children and parents about emotional functioning and peer experiences in an effort to uncover bullying.

The report is available at www.childrensmn.org/images/Advocacy/Bullying/childrens%20of%20minnesota%20-%20understanding%20the%20threat%20of%20bullying_web.pdf.

ICSI leads trial of new treatment approach

The Minnesota-based Institute for Clinical Systems Improvement (ICSI) is leading an effort, involving 10 organizations from seven states, to better treat Medicare and Medicaid patients who have depression and diabetes and/or cardiovascular disease. The organizations are entering the second year of a three-year trial of a collaborative care model called COMPASS (Care of Mental, Physical and Substance Use Syndromes).

COMPASS is a team-based approach intended for use in primary care settings. It includes the following elements: evaluation of the patient to identify the conditions and measure their severity; use of a patient registry; a care team that includes a care manager, a consulting psychiatrist and a physician with expertise in treating diabetes and/or cardiovascular disease; and a focused effort to prevent relapse and exacerbation. The hope is that patients will do better with the approach and the costs associated with their care will be reduced.



One-third of Medicare patients have diabetes and another 30 percent have coronary artery disease; when depression is present, health care costs for those patients are 65 percent higher.

The work is funded by an $18 million grant from the Center for Medicare and Medicaid Innovation.

Source: ICSI. "The COMPASS Model for Improving the Care of Patients with Chronic Mental and Physical Diseases." November 2012.

Public health's mental health agenda

BY CARMEN PEOTA

This month sees the release of a report on mental health from Minnesota's public health community. The report is the work of a group convened by the State Community Health Services Advisory Committee that included representatives from local public health agencies, county commissioners, mental health advocates, consumers, payers, Indian tribal leaders and providers.

"Over the years, it's been clear that mental health is a high priority [for communities]," says Ellen Benavides, assistant commissioner of health. What was less clear was how to address it.

The report acknowledges the "clear links" between mental and physical health and asserts that there are "compelling reasons for public health, health care, human services and other systems to work better together to address mental health." The report calls for a state framework on mental health and recommends that the state and its local partners do better with data collection and dissemination; promoting positive mental health; and encouraging social connectedness and physical exercise to help prevent mental illness.

What will the state of the state look like if those recommendations are implemented? "We'd have local public health organizations working in partnership with other players—health care systems, communities and citizens—to really change the conversation about mental health, to send different messages," Benavides says.

Information about the workgroup and its charge as well as the report itself are available on the Department of Health website. Go to www.health.state.mn.us/divs/opi/pm/schsac/wkgp/2012/mentalhealth/.

Help for the nonpsychiatrist

Resources for those on the frontline

BY CARMEN PEOTA

In recent years, much has been made of the fact that primary care physicians and other nonpsychiatrists are on the frontline when it comes to diagnosing and treating people with mental illnesses. An ob/gyn might see a woman experiencing postpartum depression. A pediatrician may find him or herself sifting through the possibilities explaining the behavior of a disruptive child. There's been concern that these physicians don't necessarily know all they need to in order to accurately diagnose, treat or appropriately refer patients. Several efforts to support them have sprung up in recent years.

Calls for kids

One is the Minnesota Collaborative Psychiatric Consultation Service. In response to national concern that too many children were taking psychotropic medications, the Legislature in 2010 authorized the Department of Human Services (DHS) to help guide pediatricians, family physicians and others who treat children with mental health problems. Data showed that a high percentage of those kids were only getting prescriptions. "That was a concern for us because we know a lot about what the research says works for kids with certain disorders," says Pat Nygaard, M.P.H., head of children's mental health division at DHS.

With experts from across the state, DHS developed a series of protocols for primary care physicians to use with children with a suspected or known mental health problem. They also set dosage thresholds for particular antipsychotic drugs as well as for those used to treat attention deficit disorder and attention deficit hyperactivity disorder. Physicians who prescribe dosages above those thresholds are required to call for a psychiatric consultation.

In addition, DHS began offering training and established a telephone consultation service staffed by psychiatrists. Physicians with questions about a patient may contact the service voluntarily.

The call center operates Monday through Friday from 7 a.m. to 7 p.m.; calls are returned within four hours. The physician making the call can be reimbursed for the time spent on the consultation. Calls about children on fee-for-service Medicaid are given priority. But physicians may call about any patient of any age.

Since the service launched, the majority of calls have been from physicians mandated to make them. Nygaard says she and others would be pleased if more physicians voluntarily sought help. And she'd like to see more physicians trained to use the protocols. "We want to get kids who need medications to get on them immediately. But there's tons of research about anxiety, depression and disruptive behavior that says there are psychosocial treatments that work without medication," she says. "We have to give primary care physicians some other tools to work with."

Help for moms (and moms-to-be)

For a number of years, Hennepin County Medical Center (HCMC) ran the Provider Education Service, which supported physicians and others who care for women suffering from mental illnesses during and after a pregnancy.

In April, that service morphed into the Mother-Baby HopeLine. The HopeLine is one facet of HCMC's new Mother-Baby

Minnesota Collaborative Psychiatric Consultation Service
Telephone consultations and training related to diagnosing or treating children with mental illnesses.
855-431-6468 (toll-free) www.mnpsychconsult.com

Hennepin County Medical Center's Mother-Baby HopeLine
A free information service for pregnant women, mothers of young children or their doctors. 612-873-HOPE (4673)

Fast-Tracker
Online help in tracking down available mental health providers
www.fast-trackermn.org

Program, which offers inpatient and outpatient treatment and other services for women suffering from mental health problems during pregnancy and after giving birth. One in eight women experience significant depression and anxiety during that period, according to Helen Kim, M.D., director of the program.

Kim says physicians, pharmacists and the women themselves don't always know the latest about the safety of medications, and thus women often are encouraged to stop or avoid taking them. "This leads to needless suffering, delayed treatment for highly treatable conditions such as depression and anxiety, and in some cases, it increases the risk for self-harm or suicide," she says.

Physicians, other providers and family members themselves can call the HopeLine and ask questions about a condition or where to find help. They will be asked to leave a message, and a member of HCMC's mental health staff will call back within two business days. Since the HopeLine launched, HCMC has received more than 100 calls from women and 40 from health care providers.

Access to appointments

About a year ago, the Minnesota Psychiatric Society (MPS) launched Fast-Trackermn.org, a website where physicians and patients can search for psychiatrists and other mental health care providers who not only have certain expertise but who also might have openings in their schedules.

Those who post on the site can list their availability as "under a week," "two to four weeks," "over a month" or "closed." And they can update their availability if they have a cancellation. Says MPS executive director Linda Vukelich, "We're trying to catch last-minute cancellations and make them available so that they don't go to waste."

Physicians and patients searching for available providers and programs do not have to register to use the site. Those posting their services do. The site also has information about research, advocacy groups and other resources. **MM**

Carmen Peota is an editor of *Minnesota Medicine*.

Hoarding

The subject of reality television **now has a place in the DSM-5.**

BY SARAH T. WILLIAMS

Charles E. Nightingale's loved ones and neighbors want him to be remembered as an artist and gardener and not as a hoarder. But that is why the St. Paul man ended up in the headlines on July 10, 2013. During a fire in his densely packed home, Nightingale was unable to get out, and firefighters were unable to get in. Tragically, the former Marine first-responder was just a few feet from his front door, trapped by a mountain of stuff, when the smoke and flames overtook him.

Reality TV, aggressive media coverage and even an E.L. Doctorow novel about the fabled Collyer brothers have brought the issue of hoarding to light, such that most people now at least have a name for the behavior. But beyond fueling a type of voyeurism, what has the attention done?

"I appreciate that reality TV shows gave us a language for hoarding," says Janet Yeats, a family therapist and co-founder (with therapist Jennifer Sampson) of the Hoarding Project in Minnesota. "What I don't appreciate is that they show only extreme situations of hoarding. And they set people up so that they can't do anything but scream, yell, cry and freak out."

There is a kinder, gentler, more effective way of working with people who hoard, she says—one that does not involve threats, ultimatums, forced cleanings and broken relationships.

A redefinition of hoarding

Many assume that hoarding is a consequence of the modern material age or a result of extreme deprivation, such as living through the Great Depression. But it has been with us for a long time in some form or another, wrote Gail Steketee and Randy Frost in their 2011 book *Stuff: Compulsive Hoarding and the Meaning of Things*. Dante's fourth circle of hell is reserved for hoarders, they point out. And Dickens, Balzac, Conan Doyle and Gogol all created characters who hoarded. "Garbage houses" have been identified in Japan, Australia, Russia and Canada.

It's estimated that between 2 percent and 5 percent of Americans (6 million to 15 million people) hoard. "That's just the tip of the iceberg," says Yeats, who argues that a real calculation of the size of the problem would include every single family member of a person who hoards.

For a long time, the American Psychiatric Association considered hoarding a subset of obsessive-compulsive personality disorder and defined it as a preoccupation with orderliness and an inability "to discard worn-out or worthless objects even when they have no sentimental value." As Steketee and Frost point out: "Objects in a hoard may appear to be without value to an observer, but someone with a hoarding problem would hardly describe them as worthless."

Their pioneering work (and the work of many psychiatrists, neuroscientists and therapists like Yeats) has led to a new definition of hoarding. In the recently issued DSM-5, hoarding is now its own distinct disorder characterized by "persistent difficulty discarding or parting with possessions, regardless of their actual value." Eventually, hoarding causes significant distress, posing health and safety risks and casting those who hoard and all who love them into a particular ring of hell.

Challenging assumptions

From the outside, a person who hoards might appear to be merely eccentric, slovenly or recalcitrant. Yeats and others have a more nuanced understanding of those individuals. They have observed, for example, that some have unusually detailing, intelligent minds, which can perceive the exquisite beauty and importance of everything from the contents of the daily newspaper to the warp and weave of an imported tweed. Some worry about wasting and can't bear to casually toss out a flawed garment, a nonfunctioning toaster, a yogurt container or a used paper plate. And some view objects not merely as keepsakes or mementoes but as gateways to significant emotional experiences. A great many people with hoarding problems have also experienced trauma of some kind (child abuse, parental abandonment, loss of a spouse, sexual violence). To these individuals, objects are safer, more reliable alternatives to people, even their own children and spouses.

Yeats says unresolved grief or trauma affects the majority of people who seek her help. "Hoarding fills a hole," she says. "Perhaps someone died, perhaps there's a divorce—in some way the person was *left*, and they're going to fill that hole with things that won't leave."

What not to do

No one can blame estranged and wounded family members for declaring war on the squalor and hiring a biohazard team. But the least-effective strategy is to force a cleanout, Yeats and other mental health professionals say. Without the consent of the person, the condition will only worsen. "If you fill up your hole with things that won't leave, and then someone comes along and just rips those things away, you risk being re-traumatized," she says. Yeats notes that it might initially take 10 years for someone to fill up a house but only three to six months to get it back to worse than what it was.

Desperate family members often resort to ultimatums: "Clean this up or I'm not coming back." They may register their disgust or dismay verbally or with body language, or clean up or touch things without permission. This is also ineffective, Yeats says, and the consequence is almost always a permanently shattered relationship.

In extreme cases and emergencies, when the hoarding poses personal and public safety hazards, the courts or public safety officials can order a cleanout. But, once again, the rebound effect can leave everyone worse off than before.

What to do

Yeats says she and her colleague almost always encourage family members to "go the route of relationship." They need to stop policing their loved ones who are hoarding; resume their roles as daughters, sons, siblings or spouses; and find creative ways to protect the family ties. "If it's no longer possible to go inside Grandma's house, then bring her to your house to bake cookies with the grandkids," she says.

"If there's a relationship, then there can be trust," she says. Only then is it possible to approach the loved one and suggest that they seek help. Yeats imagines the conversation might sound something like this: "I love you. I'm concerned that your home is not safe or healthy. I'm concerned that it's getting in the way of the life you want to live. Can we work at making a change?"

If the person is willing, she says, the first priority would be to identify and treat the underlying causes of hoarding, particularly unresolved grief and trauma.

"When we're able to help them process or grieve—deal with the trauma, get through the loss—then we can deal with the behaviors. And when there's no more hole, there's no more need to fill up the hole." (The person who is hoarding isn't the only one who needs help, she says. Family members do as well. "They've lost the relationships that they wanted to have. Those losses need to be recognized.")

After therapy, it's time to engage in a one-step-at-a-time exercise to help the person get organized. Yeats describes the process this way: "When the client is ready, we'll have them bring a box of their things. The idea is to help get them used to the idea of sorting. So we will have three boxes or bags in the office: one for things to be kept, one for things to be donated and one for things to be recycled. Maybe we have a fourth—one that's for garbage. And we ask the client to go through that box. Let's say they pull out some baby food jars. We might ask, 'What are you keeping those for?' They might say, 'Well this could be used and, you know, there's a bunch of reasons.' We might ask, 'Could you get those at another time if you needed them?' They might say, 'I probably could do that. I'll put that in recycle.'"

Eventually, the person who is hoarding comes to trust that the process of sorting, discarding and recycling might not cause the kind of pain they once anticipated or dreaded.

Yeats says family members might need to adjust their idea of success at the same time. "For some people, success may be a cleaned-out house. Success could also be measured by bringing the home to safety, so that the person living in the home may still have a hoarded home, but entrances and exits are cleared, there are working smoke alarms, three-foot pathways to let a gurney through and no flammable materials. If we can get a client's home to safety, and that client commits to keeping the house that way, that's success."

The work can be slow and painstaking, "and there are no guarantees," Yeats says. "But there are no guarantees anyway. At least this way, you still have the relationship." **MM**

Sarah T. Williams is a longtime Twin Cities journalist.

What can a physician do?

Primary care physicians can be on the lookout for signs of hoarding such as respiratory problems, the strong smell of ammonia from animal urine and a lack of attention to hygiene.

Says expert Janet Yeats: "I'd love it if we could get every primary care physician, physician assistant and nurse to ask: 'Are the rooms in your home able to be used for their intended purpose? Can you cook in your kitchen? Can you sleep in your bedroom? Can you use your bathroom?' Those simple, nonjudgmental questions would help get to a lot of hoarding situations." If hoarding is suspected, then physicians can steer their patients to appropriate resources.–S.T.W.

For more information

To learn more about hoarding and how to help someone who may be hoarding, go to:

The Hoarding Project (http://thehoardingproject.org/home/)

The International OCD Foundation (www.ocfoundation.org/hoarding/)

Children of Hoarders (www.childrenofhoarders.com)

Warriors' hidden wounds

*The VA tries to stem the **rising suicide rate** among veterans.*

BY J. TROUT LOWEN

Nearly a decade after he completed active duty in Iraq, Daniel Somers took his own life. The former Army intelligence officer who suffered from traumatic brain injury and PTSD was just 30 years old when he committed suicide on June 10. In a lengthy letter to his family that has since been widely published in the media, Somers poured out his feelings of desperation and hopelessness.

"My body has become nothing but a cage, a source of pain and constant problems ... that not even the strongest medicines could dull. ... My mind is a wasteland, filled with visions of incredible horror, unceasing depression and crippling anxiety ... not only am I better off dead, but the world is better without me in it," he wrote.

Somers' letter has given voice to the thousands of veterans who have suffered and taken their own lives. Suicide is now recognized as a growing epidemic among this population, as rates have been rising steadily since 2005.

In an annual survey of 4,000 active-duty military personnel and veterans from the Iraq and Afghanistan conflicts, suicide ranked as the most important issue. Conducted earlier this year by Iraq and Afghanistan Veterans of America (IAVA), it found nearly one-third of respondents said they have thought about taking their own lives; 37 percent said they know a veteran of Iraq or Afghanistan who has committed suicide. Of that 37 percent, more than half know more than one veteran who has died by suicide.

The problem isn't limited to veterans of the current wars. Suicides by veterans from all conflicts have been increasing, and they now account for 22 percent of all suicide deaths in the United States. Veterans make up only about 10 percent of the U.S. adult population. According to one recent estimate, some 49,000 veter-

Guidance for physicians

Suicide risk is "a compilation of our ability to cope or not cope with stress and things that happen to us," says Lindy Fortin, suicide prevention coordinator at the Minneapolis Veterans Affairs Medical Center.

Military service adds an additional layer of stress. Fortin suggests physicians ask specific questions to assess patients for suicide risk, starting with, "Are you a veteran?" If they are, physicians should follow up with these questions:

- When and where did you serve?
- Did you experience trauma?
- Did you experience combat?
- Did you receive care (in cases where the patient had experienced trauma)?
- Did you get counseling while in service?
- Were you on a lengthy deployment?

Physicians also should be attuned to physical complaints such as backache and stomachache, as they may be symptoms of a mental health issue.

If a physician feels a veteran may be at acute risk of suicide, he or she should have that individual evaluated by a mental health professional and/or considered for hospitalization.

If there is a concern that the risk is ongoing rather than acute, the physician should refer the individual to mental health services. Together, the physician and patient and his or her family should develop a "safety plan." The plan will help the veteran remember that there are resources out there to help them cope with suicidal thinking or behavior. –J.T.L.

ans died by suicide between 2005 and 2011.

In an attempt to address the problem, the U.S. Department of Veterans Affairs (VA) in 2007 launched a broad suicide-prevention initiative, establishing a national crisis hotline and suicide-prevention programs in each of its 156 facilities. Through the hotline, VA staff try to identify and track vets at high risk of suicide and provide them with enhanced prevention and treatment services. As part of the initiative, the VA has also trained all of its staff, both clinical and nonclinical, to talk with veterans about suicide and to recognize the warning signs. In addition, the VA is working to educate physicians in the community about suicide assessment, awareness and prevention.

Helping civilian medical providers better screen veterans for suicide risk is especially important, says Lindy Fortin, coordinator of the Suicide Prevention Program at the Minneapolis VA. Most veterans, including the more than 350,000 living in Minnesota, get their health care in community-based settings. And like many Americans, they get their mental health care from their primary care physician.

Yet many primary care physicians never inquire about their patients' veteran status or ask about suicide or depression, Fortin says. "It seems pretty basic, but sometimes some places out in the community don't even ask if they're dealing with a veteran or a spouse of a veteran. That in and of itself does provide information, and a reason to find out more," she says. "I want to make sure providers incorporate asking if the person is a veteran into their practice, and incorporate a risk assessment or at least asking depression screening questions or post-traumatic stress-related questions to give them a better idea of who they are dealing with."

Who is at risk?

Until recently, service in a combat area was considered the major factor for determining which veterans are at highest risk of suicide; but a longitudinal study of active and veteran military service personnel identified other causes. The Millennium Cohort Study, the results of which were

published in the August 7 issue of *JAMA*, followed 151,560 armed forces personnel who served between 2001 and 2008. Researchers identified 646 deaths during the study period, 83 (12.8 percent) of which were confirmed suicides. The investigators found that military personnel deployed to current operations (both combat and noncombat) were no more likely to die from suicide than those who did not deploy.

The main risk factors identified in the study were underlying and untreated mental illness (specifically manic-depressive disorder and depression), being male, engaging in heavy or binge drinking and having alcohol-related disorders. Other signs that physicians should watch for include relationship challenges, impulsivity, and gambling or other risk-taking behaviors, says Dan Reidenberg, Psy. D., executive director of SAVE (Suicide Awareness Voices of Education), a nonprofit agency based in Minnesota that works to raise awareness and aid suicide survivors and their families.

Reidenberg notes that soldiers returning from Iraq and Afghanistan have already had more experience with trauma than most people ever will. They may have served in combat areas for prolonged periods without a break. Many were on duty for 12 hours a day, he notes, and they often faced an unidentified enemy—one who could appear as a police officer or even a child. Because of that, they often are unable to relax and return to a normal mental state. "They experience such a heightened state of arousal for such a period of time that we know it's changing their endocrine system, and that's a bad thing," he says. "It's affecting the roots of their functioning."

Many are reluctant to seek help for mental health issues. In the IAVA survey, 63 percent of respondents said they have a friend in need of mental health care, and half reported they had been advised to seek mental health care by a friend or family member. The reasons most frequently cited for not seeking help were concern about how they would be viewed by others and how it would affect their careers. More than three-quarters of the respondents also said the Department of Defense and the VA are not providing adequate mental health care and support.

A continuum of care

As part of its suicide prevention efforts, the VA has developed "wrap-around" services for at-risk veterans, Fortin says. Those at high-risk are eligible for enhanced care in both the VA's mental health and primary care clinics. A veteran can receive inpatient care, if needed, until he or she is stabilized, followed by three weeks of treatment in an outpatient day program that includes group and individual therapy, safety planning, cognitive behavior therapy and coping exercises. This is followed by continued outpatient care that may include sessions with a therapist, treatment by a psychiatrist or both. Treatment steps down gradually over two or three months, as the patient improves, Fortin says.

The VA is also working to increase awareness in the community. Fortin and her staff offer suicide awareness training for families, veterans organizations and others, and suicide assessment training for clinicians. The clinical training covers risk factors and warning signs and teaches physicians how to incorporate those into a risk assessment and plan appropriate treatment. It also helps physicians become more comfortable asking patients about suicide and talking about psychological pain and what to do if they feel a veteran is at risk.

That is especially important because primary care physicians are often the last line of defense, Fortin says. Nearly half of the veterans who received care at the Minneapolis VA and died by suicide had only received care from a physician; they were never seen by a mental health specialist. Other studies have shown that about 80 percent of adults who died by suicide saw a physician of some type within a month of their death, 40 percent within week of their death and 20 percent on the day of their death.

Resources

For veterans

The 24-hour Veterans Crisis Line offers free confidential support to veterans in crisis and their families. Veterans can call 800-273-8255 and press 1 to speak with someone immediately, chat online at www.veteranscrisisline.net/chat*now, or send a text message to 838255.

For providers

The Minneapolis VA offers training for clinicians on how to identify and care for a veteran who may be suicidal. Physicians learn to recognize warning signs and risk factors and how to translate those into a clinical risk assessment and basic intervention steps. For more information or to schedule training, contact Lindy Fortin, the VA's suicide prevention coordinator, at lindy.fortin@va.gov or 612-467-3620.

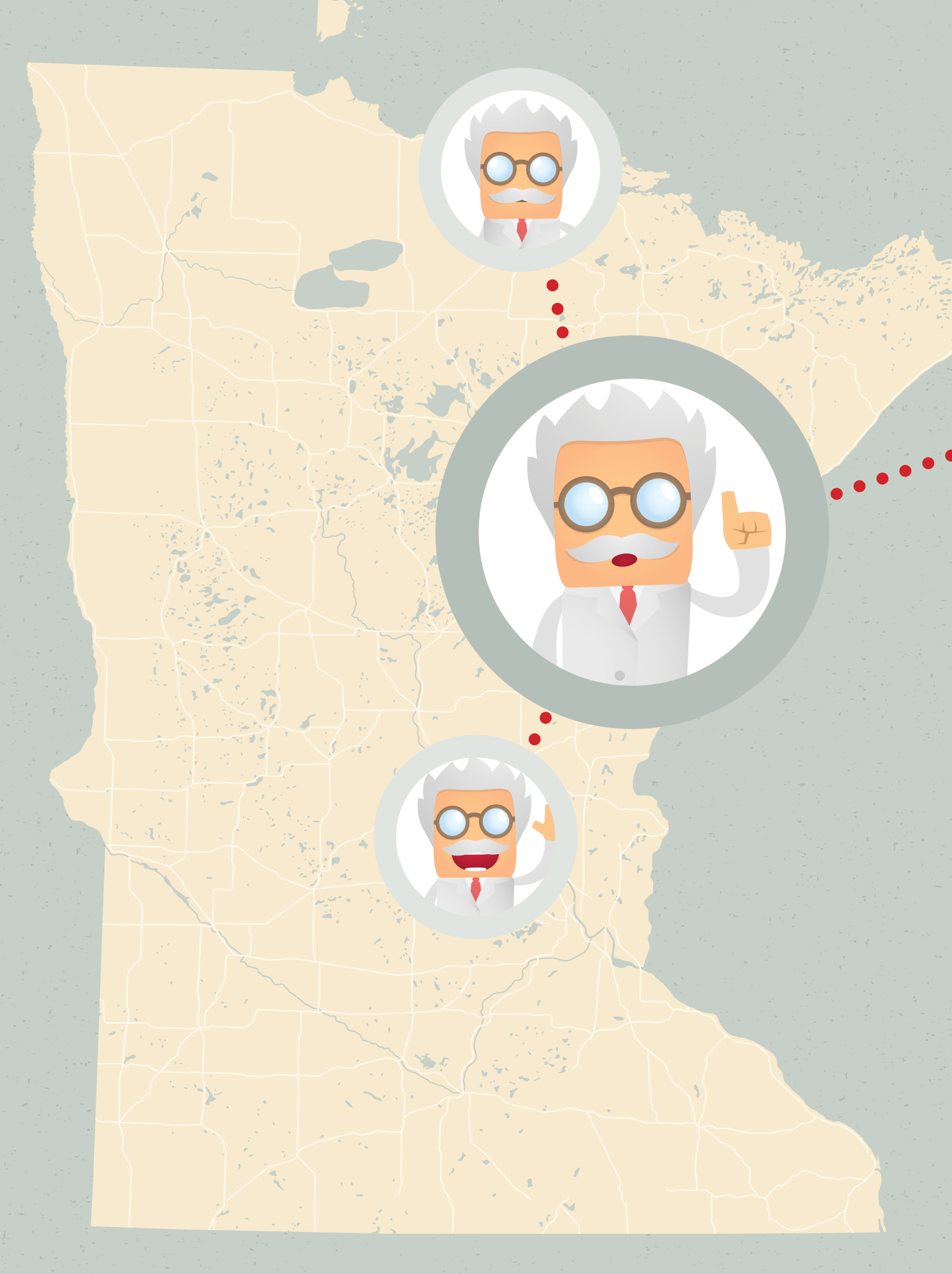
You can learn more at www.mentalhealth.va.gov or www.veteranscrisisline.net/Resources/Default.aspx.

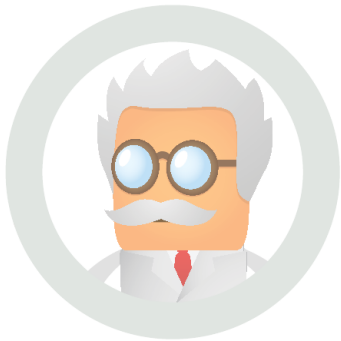
"We know that they're going to their primary care office; they are really, truly the front line," Reidenberg says. "Everybody needs to be aware of it. Physicians, physician assistants, nurses, even dentists need to be aware of it."

In addition to asking veterans the right questions, physicians need to look beyond their immediate physical complaints. "They may talk about backaches, headaches, neck aches, stomachaches. That's what they say hurts," Reidenberg says. "Physicians pick up on that as a medical issue. They miss the fact that this is about a mental health issue."

It's also important to ask patients not just how they're feeling today but how they felt last week or last month, and to have that conversation over weeks or months. People thinking about suicide often pull away from family, friends and their community, Reidenberg says. "Often, their last hope is somebody outside of their normal group of people, and it's a doctor. Those doctors have the greatest opportunity to help save somebody." **MM**

J. Trout Lowen is a Minneapolis freelance writer and editor.





THE DOCTOR IS IN... ANOTHER TOWN

Telepsychiatry brings care to people in rural Minnesota.

BY JEANNE METTNER

Ten years ago, psychiatrist Steve Bauer, M.D., was spending a little too much time looking through a windshield. Every two weeks, he would drive four hours round trip between the Duluth-based Human Development Center, which he directs, and its outpost clinic in Grand Marais to see a handful of patients who lived in the area.

Then in 2004, the Center received a grant to purchase equipment for "telemental health" visits—consultations conducted remotely using video teleconferencing technology. Since then, Bauer has been able to log on to the system, connect with patients in a Grand Marais community health clinic, and do an assessment or check to see how they are doing and whether their medications need to be adjusted. Today, he sees those patients in Grand Marais face-to-face only about once every other month.

The system has worked so well that he and another psychiatrist, John Glick, M.D., are now also conducting telemental health visits in Two Harbors as well as in clinics in Lake, Carlton, St. Louis, Cook and Douglas (Wisconsin) counties. In total, the two psychiatrists spend roughly 20 hours a month doing televisits from their Duluth office. "The decreased in-person time with patients at those outposts is justified by the increase in the number of people I can now see with the several hours of provider time I've gained by not driving," Bauer explains.

Telemental health care seems an obvious response to a big problem. The mental health needs in rural Minnesota are great. In 2005, the Minnesota Department of Health found that as many as 40 percent of women in rural areas suffered from depression, compared with 13 to 20 percent in urban areas—and people in rural communities who were treated for depression were three times as likely as their urban counterparts to be hospitalized. Compounding the issue is the fact that rural Minnesota has a paucity of psychiatrists, psychologists, and therapists and clinical social workers who can manage the needs of mentally ill individuals. The Health

Care Services Administration reported in September of this year that Minnesota was short the equivalent of 171 full-time mental health practitioners and that 76 of the state's 87 counties are considered Health Professions Shortage Areas for mental health.

Primary care physicians meet some of the needs of these patients, says Gary Davis, Ph.D., regional campus dean of the University of Minnesota Medical School Duluth and associate director of its Center for Rural Mental Health Studies. "But just like with many health problems, there will be patients who need to be referred for consultation because of the complexity of their case." Although telemedicine technology can't increase the number of mental health providers in the state, it is making care accessible to patients who need their services.

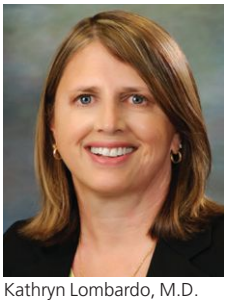
A good fit

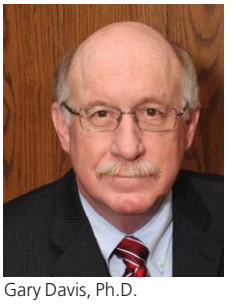
The way telemental health visits work is quite simple: Patients living in rural areas check in at a primary care clinic close to home that is equipped with videoconferencing capabilities. A nurse or medical assistant takes their height, weight and vital signs (a requirement for reimbursement), then a staff member brings them into the exam room with the telehealth equipment. Meanwhile, a mental health practitioner in a distant "base" location logs into the system and connects with the patient. Psychotherapists can use the technology to conduct counseling sessions. Psychiatrists use it to discuss medication effectiveness and adjust prescriptions or to assess a patient and make a diagnosis.

Telemedicine is a good fit with psychiatry, according to Kathryn Lombardo, M.D., a psychiatrist and president of Olmsted Medical Center (OMC) in Rochester. "It isn't that we don't do an exam; it's that those exams center around conversations more than physical contact with a patient," she explains. As part of a multimillion-dollar Beacon grant awarded to southeast Minnesota in 2010, OMC and four other institutions were charged with finding ways to use technology to improve care. In 2012, they began using telemedicine to provide psychiatric services. Lombardo did her first telemental health visit in December 2012; two other psychiatrists and one social worker from OMC soon followed suit. To date, Lombardo, who is based in Rochester, has done about 30 telemental health visits with patients in nursing homes in Spring Valley, Chatfield and Pine Island and in OMC clinics in Preston and Spring Valley.

Just how widespread telepsychiatry has become is hard to assess. The U.S. Department of Veterans Affairs has had telemental health capabilities for two decades. By 2011, more than 380,000 VA patients were receiving care remotely. Other mental health providers have been slowly adopting the approach. According to data compiled by the American Psychological Association's Center for Workforce Studies, the percentage of practitioners using videoconferencing for mental health visits increased from 2 percent to 10 percent between 2000 and 2008.


Steve Bauer, M.D.


Kathryn Lombardo, M.D.


Gary Davis, Ph.D.

The positives

Psychologists and psychiatrists from the University of Minnesota Duluth's Rural Telemental Health Network, which provides services in a dozen clinics throughout the state, have seen thousands of patients since the initiative launched in 2003. Participants on both sides of the camera are positive about it: A continuous quality-improvement initiative found 86 percent of patients served were "very satisfied," and 91 percent of physicians, therapists and other providers considered the system "definitely useful."

Davis surmises that the majority of their patients either would not have received care or would have had to travel long distances to get it had it not been for the network's efforts. Patients tell him that they like the system not only because it's convenient but also because it eliminates stigma. Says Davis: "They get to go to their doctor's office like everyone else and are put in an exam room like everyone else, only their room happens to have a telecommunications system that allows for a mental health visit. It makes it easier for them because they don't have to go to a psychiatrist's office. This can be especially important for someone residing in a rural community, and it actually increases the likelihood that they will follow the referral from the physician to the mental health provider."

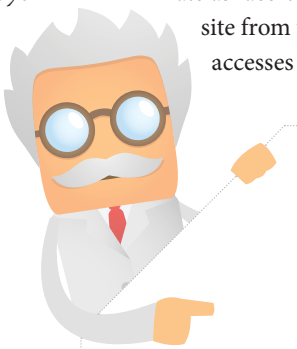
Psychiatrists and other mental health providers like the variety that telehealth provides them. "Seeing patients I would have not otherwise been able to see has made it a valuable and fulfilling addition to my practice," Lombardo says.

Many of the technology issues that plagued telemedicine programs a decade ago—such as frozen or pixilated screens—have all but disappeared. Cost has also come down. Expenses used to hover around $5,000 per set, whereas today, they typically run $2,500 or less. "We've gone from using sophisticated equipment—a big-screen TV and separately controlled camera with a highly sensitive microphone—to essentially a commercialized, encrypted Skype-type system, which I use through my laptop," the Human Development Center's Bauer says. "While you lose a lot of the sensitivity and have some decreased quality of sound, the equipment doesn't break down nearly as much."

In terms of information gathering and the effectiveness of the interventions, "we've determined there is not much of a difference [between in-person visits and videoconferencing]," Davis says. One meta-analysis of 10 randomized clinical trials involving more than 1,000 patients found no significant differences between

face-to-face and telemental health consultations with regard to outcomes on symptoms, quality of life and patient satisfaction. The article was published in a 2010 issue of the *Journal of Clinical Psychiatry's* primary care companion.

Bauer says they also use the system to consult with their patients' primary care providers. "It allows us to ask questions, give updates and share ideas and information for many more clients in a shorter period of time," he says.



The drawbacks

Although technology is bringing services to people in remote areas, users face challenges that are not insignificant. Bauer says he has difficulty getting medical records transferred back and forth between the "originating site," where the patient is accessing the telehealth system, and the "distant site," where the mental health practitioner is located, particularly because the Human Development Center is still using paper records. "Typically, they will fax me notes from the patient's last two psychiatric visits [provided either remotely or in person]. But I don't get the notes from the provider doing therapy on-site at the clinic, I don't get the social worker's notes and I don't get the laboratory notes, so I am at a bit of a disadvantage, because when you are on site, you usually have all that information," he explains. Bauer hopes some of those challenges will be ameliorated when the Human Development Center moves to an electronic medical record system later this year.

Another problem is that some patients shy away from the technology itself. "People who are paranoid and/or psychotic, which primary care providers prefer to have psychiatrists see, aren't always happy using this technology," Bauer says. "Some have delusions about being spied on, being wire-tapped, so trying to get them to use it is hard."

Reimbursement realities

Those using videoconferencing technologies to see patients far away face the same challenges with reimbursement that other mental health care providers face. In most cases, telemental health visits are reimbursed at the same or nearly the same rate as face-to-face visits. (The site from which the patient accesses the videoconferencing technology also receives a "facility fee" for use of the exam room.) That's the good news. The bad news is that mental health services—virtual or not—are historically under-reimbursed, particularly if the patient seeking services is enrolled in Medicare or Medicaid. "That's the real rub on where psychiatry is today. The estimate is that Medicare or Medicaid pays just 20 percent of what the actual cost is on the dollar to have a mental health provider in a practice," Bauer says.

PATIENTS LIKE THE SYSTEM NOT ONLY BECAUSE IT'S CONVENIENT BUT ALSO BECAUSE IT ELIMINATES STIGMA. "IT MAKES IT EASIER FOR THEM BECAUSE THEY DON'T HAVE TO GO TO A PSYCHIATRIST'S OFFICE." –GARY DAVIS, PH.D.

That puts a financial strain on places such as the Human Development Center in Duluth, which has more than 30 therapists and 11 physicians and nurses, and where 60 to 70 percent of all patients are on Medicare or Medicaid. "In order for the clinic to pay for that provider, that provider would theoretically have to see 10 to 12 patients per hour," Bauer says. "You can see how a practice could get ridiculously busy in a way that does not afford good patient care."

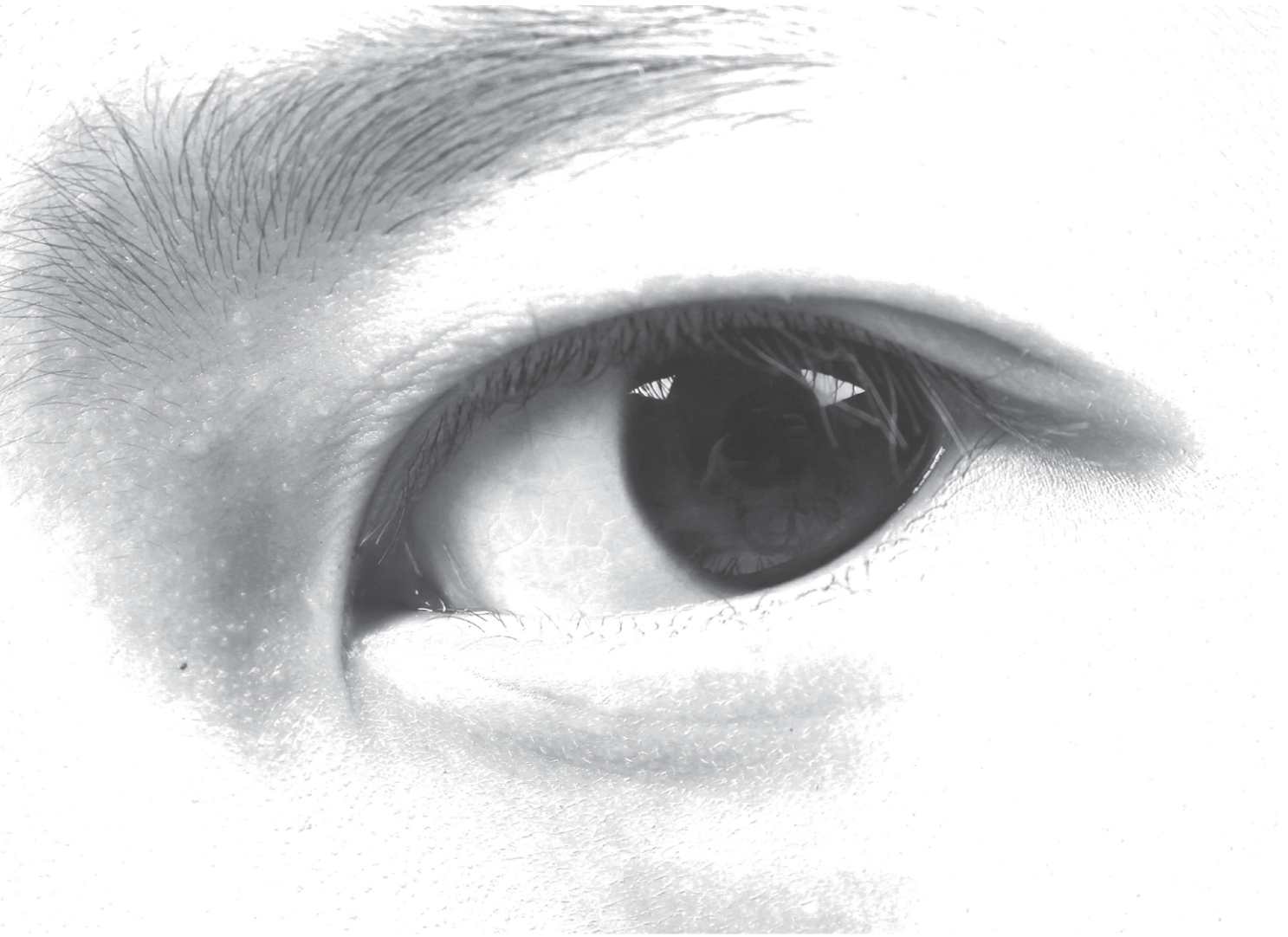
The center's providers must follow certain protocols in order to ensure that a visit with a Medicare or Medicaid patient is reimbursable. In Minnesota, for example, Medicaid does not differentiate between rural and urban settings for reimbursement of telemental health visits, which means that the patient can be located at a rural or urban facility, but coverage is limited to those services provided by a psychiatrist, psychologist or pharmacist. Medicare's rules for reimbursement are even more stringent. A beneficiary can only use telehealth services in facilities that are located in certain federally designated rural areas—namely, those designated as Health Professional Shortage Areas or located outside a Metropolitan Statistical Area. And providers must be licensed in the state in which their patients are located. "That can sometimes pose challenges for providers," Lombardo says.

Still, a shortage

Even those who are enthusiastic about telepsychiatry believe it is only a partial solution to the access problem in rural areas. "The central hurdle still remains: finding enough providers to provide the services," Davis says, explaining that the schedules of psychiatrists across the state are already full. "If you have a full practice, why would you extend your practice to a different service population?"

Adds Lombardo: "We can't expect telehealth to solve all of our problems because those problems are great. And it will take more than technology to fix them." **MM**

Jeanne Mettner is a Minneapolis writer and frequent contributor to *Minnesota Medicine*.



The 20-minute clinic visit

It's sometimes easier for physicians to bring up what families cannot.

BY JENNIFER LE

I walked into an exam room and was greeted by a small middle-aged Hmong woman and her interpreter. Her chief complaints were facial acne, shoulder pain and wrist pain. It was her first visit to the clinic. It was also the first week of my family medicine clerkship, so I was still grappling with how I was going to fit this visit into 20 minutes.

When the allotted time was up, we had only covered her acne and seemingly straightforward musculoskeletal pain. As I began gathering the rest of her history, it became apparent that there was a much larger issue looming beneath her concerns. Her husband had passed away five years ago, and she was unemployed and raising a 14-year-old son on her own. Without income, she could not provide for her son, who was living with her brother while she bounced from home to home every night searching for a place to stay.

"Have you been feeling depressed? Or anxious recently?" I asked.

"Yes," she replied.

"Have you considered suicide?"

"Yes," she again replied.

As I asked more about depression, it became increasingly clear that her wrist and shoulder pain were not the primary reason for her clinic visit. Both her PHQ-9 and GAD-7 scores were above 20.

My grandfather had struggled with depression during the end stages of congestive heart failure and had threatened to hang himself. Although he was the picture of depression with suicidal ideation, my fam-

ily had been unwilling to talk about it, even with one another. When I asked my mother how we could help him, she just said, "That's normal; all families have their own secrets behind closed doors."

I marvel at how easy it was for me, as a medical student, to have that conversation with my patient. I felt I could ask her about her depression and get an honest answer. Perhaps it is the expectation that I can help find solutions to patients' problems that makes me feel this way.

Physicians can ask questions that no one else can, whether it's about depression or sexual health or drug use or other issues.

So that got me thinking: If it isn't OK for family and friends to ask about depression, yet it is socially acceptable for me—a complete stranger and medical professional—to ask about it, then where else would a patient go for help if not to me?

I realize that not everybody has the same difficulty breaking through the social stigma associated with depression, and that it is somewhat related to culture, environment and other factors, but I feel it is my responsibility, as a health care professional, to spend the necessary time to recognize a patient's hidden condition and ask the right questions.

This experience made me realize how physicians can ask questions that no one else can, whether it's about depression or sexual health or drug use or other issues. And as health professionals, we have a responsibility to ask those questions—to address all aspects of our patients' well-being.

The visit with my Hmong patient ended with me recommending that she see a therapist for her depression and my attending prescribing her some medication. Although I never saw her again, her story still resonates with me. **MM**

Jennifer Le is a fourth-year medical student at the University of Minnesota.

GOVERNANCE CHANGES:

House of Delegates suspended until 2016

PHOTO BY KATHRYN FORSS

After a lengthy and spirited debate, the MMA House of Delegates voted on September 21 to suspend activity until 2016 so that the MMA can focus on developing new ways to engage members.

For the past four years, the MMA and its House have debated how the organization will govern itself. It will now take a break from the House format for the next two.

This decision came as a compromise after testimony was heard in a lengthy reference committee on September 20 and then further debated on the House floor. "In the end, we came to a decision as a team," said MMA Board Chair Dave Thorson, M.D. "We worked as a group to reach a compromise that will help the association move forward."

The Board of Trustees had recommended eliminating the House altogether. Going into the Annual Meeting, which was held at the Minneapolis Marriott Northwest, a strong contingent of longtime members opposed this recommendation. After several hours of testimony on Day 1, a governance reference committee came back on Day 2 with a recommendation to suspend House activity until 2017 while the MMA tries new models to engage more members.

Much of the debate during the House session on Day 2 revolved around this recommendation. Delegate Lyle Swenson, M.D., offered an amendment that would have removed the "suspension" language from the overall amendment and have kept the House in place even as the MMA moved forward with its new plans for engaging physicians. "If the House of Delegates is suspended, our membership will suffer," Swenson said.

The House debated Swenson's proposed amendment for an hour. However, it eventually was voted down 59-47.

Edwin Bogonko, M.D., president of the Twin Cities Medical Society, then offered an amendment that would shorten the length of the suspension by a year, suggesting that suspending the House in 2014 and 2015 would provide enough time to "test" the new governance model, which was approved by the delegates.

In 2016, when the House returns, it will meet solely to discuss whether the new governance structure is working and has been "successful in increasing member engagement in policy decision-making."

House approves formation of Policy Council

With suspension of the House, the MMA will focus on developing additional ways to engage physicians including a new 40-member policy council, listening sessions and policy forums.

The council will meet at least twice a year—once at the Annual Meeting—to "discuss and recommend positions to the Board of Trustees on critical policy issues." The council will select two members to serve as trustees with full voting privileges. Its chair will be appointed by the council itself.

To ensure that members and CMSs can continue to submit new ideas for policy, the House voted to allow resolutions to be submitted to the council directly from CMSs. This will be just one way for idea development.

PHOTO BY KATHRYN FORSS

Twin Cities Medical Society President Edwin Bogonko, M.D., reacts during the governance debate at the House of Delegates.

Electronic voting will be open to all MMA members

Additionally, the House approved establishment of member-wide electronic elections to select the MMA president-elect, trustees, and AMA delegates. This will allow all members the opportunity to vote, with nominations from component medical societies, specialty societies and individuals submitted to and reviewed by the MMA Nominating Committee prior to the election.

Electronic elections will begin in 2014.

MMA awards presented to five members

Each year, the MMA and its members recognize special individuals with awards. At this year's Annual Meeting, the MMA honored five members for going above and beyond the call of duty.

Distinguished Service Award

The MMA's highest honor goes to a physician who has made outstanding contributions to medicine and the MMA during his or her career. This year, the MMA's Distinguished Service Award went to **Macaran Baird**, M.D., who has been head of the department of the Family Medicine and Community Health at the University of Minnesota since 2002. Baird began his career as a family physician 35 years ago in rural Minnesota. He has been active with the MMA since 1986, attending Day at the Capitol regularly and serving on a number of committees. One colleague noted that Baird "is a special leader who works to help the underserved and disadvantaged and is someone who is always willing to help with no strings attached."

President's Award

The MMA's President's Award went to two individuals this year:

Erick Reeber, M.D., a 53-year veteran of the MMA who practiced family medicine out of his home in Bagley for more than 40 years. During his tenure with the MMA, he has been a board member, treasurer and an active committee member. He has served on a number of MMA committees including ethics and medical-legal affairs; quality; and health care access, financing and delivery. He currently serves on the Committee on Administration and Finance.

Fred Nobrega, M.D., was recognized for his long-standing service to medicine as executive director of the Zumbro Valley Medical Society. He will step down from the post in October after serving for 13 years. In addition to his work with Zumbro Valley, he served as chair of Citizens for a Smoke-Free Rochester and as a member of the Olmsted County Community Health Advisory Committee. He opposed construction of a tire-burning facility in Preston and helped pass Olmsted County's ban on smoking in the workplace. Nobrega is retired from the Mayo Clinic, where he specialized in preventive medicine.

Community Service Award

Similar to the President's Award, two individuals were honored with this year's Community Service Award:

Patrick Zook, M.D., who is leading the fight against pertussis in central Minnesota. In his role as Stearns Benton Medical Society president, Zook has built a coalition of community partners to combat the rise of the disease. The St. Cloud area Circle of Health includes representatives from public health, area pharmacies, nursing, schools, as well as civic and business leaders. The Circle of Health, under his leadership, received a grant from the CentraCare Foundation to provide free Tdap immunizations to the community.

Brian Sick, M.D., who since 2007, has volunteered as medical director for the Phillips Neighborhood Clinic in Minneapolis. In this capacity, he oversees medical students, who run the clinic. The clinic's mission is to provide free health care to underserved patients and to educate

MMA's 2013-2014 officers


Cindy Firkins Smith, M.D.


Donald Jacobs, M.D.

PHOTOS BY STEVE WEWERKA

PRESIDENT: **Cindy Firkins Smith**, M.D., a dermatologist at Affiliated Community Medical Centers in Willmar

PRESIDENT-ELECT: **Donald Jacobs**, M.D., chief of clinical operations with Hennepin County Medical Center in Minneapolis

AMA DELEGATES: **Raymond Christensen**, M.D., assistant dean at the University of Minnesota-Duluth Medical School; **Sally Trippel**, M.D., an internist at Mayo Clinic in Rochester and **Paul Matson**, M.D., an orthopedic surgeon at The Orthopaedic and Fracture Clinic in Mankato.

AMA ALTERNATE DELEGATES: **John Abenstein**, M.D., an anesthesiologist at Mayo Clinic in Rochester; **Stephen Darrow**, M.D., a resident at the University of Minnesota School of Medicine in Minneapolis; and **David Estrin**, M.D., a pediatrician with South Lake Pediatrics in Plymouth.

MMA BOARD OF TRUSTEES: **Robert Koshnick**, M.D., a family physician with Essentia Health in Detroit Lakes; **Fatima Jiwa**, M.B.Ch.B., a pediatrician with Partners in Pediatrics in Rogers; and **Michael Tedford**, M.D., an otolaryngologist at The Ear, Nose and Throat Clinic and Hearing Center in Edina.

students on helping the population in an inter-professional environment. Each year, the clinic serves more than 1,100 patients.

House of Delegates passes additional non-governance-related resolutions

Aside from debating MMA governance, the House approved resolutions that will result in the following:

- The Park Region and the East Central Minnesota medical societies will be dissolved. Their members will continue membership in the MMA consistent with MMA bylaws.
- The Mid-Minnesota, Camp Release, Lyon-Lincoln, Southwestern, Blue Earth County and Blue Earth Valley medical societies will merge. The Brown County Medical Society will become part of this merged organization if they so choose at a later time.
- The Mower County Medical Society dissolved; any future members will assume at-large membership in the MMA consistent with MMA bylaws.
- The MMA will draft medical apology legislation in Minnesota to prohibit apologies from being admissible in court. The MMA will also draft legislation that protects statements made by physicians and health care administrators in efforts made at early disclosure and offers to settle health care disputes.
- All regular and ad hoc MMA committee or task force meetings will remain open to all members. All committee meeting schedules, agendas and minutes will be made available as soon as possible to the membership. Final actions and reports will be available to the membership. The only open meeting exceptions will be those involving staff personnel issues. The MMA should continue to explore additional options for member engagement in committee and task force activities.

Immediate Past President Dan Maddox, M.D., President Cindy Firkins Smith, M.D., and Board Chair Dave Thorson, M.D. share a laugh during the House of Delegates.

PHOTO BY KATHRYN FORSS

- The MMA will explore the development of evidence-based policies that would reduce harm caused by illicit drug use and illicit use of prescription drugs. The MMA will also support increasing evidence-based treatment services for users of illicit drugs such as methadone, buprenorphine and heroin substitution programs.
- The MMA will continue to pursue efforts to quantify and assess (perhaps through self-reporting by clinics) the administrative and financial burden associated with quality measurement reporting, especially on family medicine and other primary care clinics. The MMA will also continue to advocate for adequate payment to clinics for costs associated with Minnesota's statewide quality reporting and measurement requirements.
- The MMA will urge Minnesota Community Measurement to be more transparent about and improve documentation on the evidence base associated with its measures. The MMA will advocate that Minnesota Community Measurement develop criteria for and a process to limit the number of measures that a clinic is required to report in a given year, based on factors such as strength of evidence and value for clinical improvement.
- The MMA will provide access to information about MNsure and continue to keep membership informed as it evolves.
- The MMA will convene members in discussions about Medicaid-funded and state-controlled first-dollar family medical accounts coupled with Medicaid-funded major medical insurance plans for Medicaid populations.
- **T**he MMA will work with other stakeholders to examine the impact and, as appropriate, address the consequences of the 2009 moratorium on adult and child corporate foster care licenses.
- The MMA will work to advance efforts to make using the Minnesota Prescription Monitoring Program easier for physicians.

The House also asked the MMA Board of Trustees to further discuss and take action on resolutions related to:

- Credentialing for telemedicine
- Obstetric liability in rural hospitals
- Allowing counties to pursue guardianship in appropriate cases.

VIEWPOINT

Becoming one again

PHOTO BY STEVE WEWERKA

Dave Thorson, M.D.

In the end, we came to a decision as a team.

At this year's Annual Meeting, our House of Delegates (HOD) voted to suspend its activities until 2016. This will allow the MMA to focus on developing new ways to engage all of our members and provide more opportunities for them to come forward with ideas for health care policy.

The debate wasn't without controversy. As we entered the weekend, some were proposing to dissolve the House of Delegates completely. Others wanted to preserve it. Supporters of each idea presented logical arguments on why their belief was the best for the association. Passions ran deep.

After the dust settled, we reached a compromise that will help us move forward. After all, we are all part of the same profession. We may have differing opinions, but we do respect each other's points of view.

I left the meeting with this one overriding takeaway—we are all passionate about the MMA. And that's a good thing. We want what is best for the organization. We agree that the way we need to govern our group needs some tweaking, and we are putting into place elements that will get that done.

Minnesota is known as the Land of 10,000 Lakes. I'd like us to be known as the Association of 10,000 Voices. We may not always agree, but we should always be heard. We have debated governance for four years. Now it is time to put it in the rearview mirror. Onward to more listening sessions, policy forums and the approved twice-a-year policy councils, each of which will draw in a variety of voices from across the state.

Input from all segments of our diverse membership will make us stronger as we tackle the big issues that threaten our profession and our patients—administrative burdens, the shrinking primary care physician workforce, access to care, prescription opioid misuse, escalating health care costs, the patient experience, and on and on.

Now that the House of Delegates has voted to suspend itself until 2016, the MMA must follow through with its promise to engage more of its members. Work needs to begin immediately on forming the policy council and creating a format that attracts even more members.

I know we will be successful. With a membership as passionate as I witnessed this past Annual Meeting, I am confident we are prepared to take on whatever challenges we will face in the future.

"Input from all segments of our diverse membership will make us stronger as we tackle the big issues that threaten our profession and our patients."

SCENES FROM THE

2013 Annual Meeting

ALL PHOTOS ON THIS PAGE BY STEVE WEWERKA

1 Edwin Bogonko, M.D.

2 Joseph Hwang, M.D.

3 Michael Ainslie, M.D.

4 Medical student Rahul Suresh.

5 Medical students Blake Fechtel, Mark Bergstrand and Sagar Chawla.

6 Patrick Zook, M.D., accepts his Community Service Award while Immediate Past President Dan Maddox, M.D., looks on.

ALL PHOTOS ON THIS PAGE BY KATHRYN FORSS

7 Stefan Pomrenke, M.D.

8 Lisa Mattson, M.D. and Paul Takahashi, M.D., joined 70 other physicians at the policy forum on the future of the Health Care Access Fund and provider tax.

9 A participant clicks in her vote at the policy forum.

10 Lindsey Thomas, M.D.

11 Kevin N. Brown, M.D.

12 Fatima Jiwa, M.B., Ch.B., urges her fellow delegates to vote for her nomination to the Board of Trustees. She prevailed.

13 Phillip Stoltenberg, M.D.


Guthrie actors Raye Birk and Candace Barrett


Cafe Accordion's Robert Bell and Dan Newton

PHOTOS BY KATHRYN FORSS

Hippocrates Cafe features *Minnesota Medicine* writing contest winners

Physicians, medical students, and their friends and family members gathered September 19 to celebrate 10 years of *Minnesota Medicine's* Medical Musings writing contest at a Hippocrates Cafe event at the Mill City Clinic in Minneapolis.

Editor-in-chief Charles Meyer, M.D., welcomed the audience of about 75 attendees including the authors of some of the winning works. Hippocrates Cafe founder and MMA member Jon Hallberg, M.D., introduced the evening's performers, Guthrie Theater actors Candace Barrett and Raye Birk, who read the entries. Musicians Dan Newton and Robert Bell from the Café Accordion Orchestra performed in between readings.

The following is a list of poems and essays that were included in the program and the year in which they were published in *Minnesota Medicine's* July arts issues.

"Seed" by Elizabeth Reid, M.D. (2004)

"The Ones that Undid Me" by Catherine Ehlen (2005)

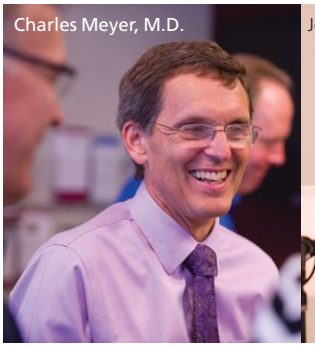
"Baby's Breath" by Marilyn Aschoff Mellor, M.D. (2006)

"Queen" by Alice Swenson, M.D. (2006)

"Homonymous Hemianopsia" by Kathy Ogle, M.D. (2007)

"Anticoagulation Complication" by Marilyn Aschoff Mellor, M.D. (2008)


Audience members enjoy the show.


Charles Meyer, M.D.


Jon Hallberg, M.D.

"On the Navajo Reservation" by Therese Zink, M.D. (2009)

"In Memory" by Nancy Baker, M.D. (2010)

"Hospice" by William Shores, M.D. (2011)

"Better than This" by Dave Dvorak, M.D. (2012)

"Raising of Lazarus" by Elizabeth Raskin, M.D. (2012)

"Blind" by Michael Shreve, M.D. (2013)

News briefs

Meeting planned to address primary care physician workforce shortage

Work continues on finalizing details for the MMA's Primary Care Physician Workforce Expansion Summit that will be held November 12 from 4 to 8 p.m. at the Ramada Plaza Minneapolis.

"The summit is aimed at identifying and sharing strategies for increasing Minnesota's primary care physician workforce," says Juliana Milhofer, an MMA policy analyst. The MMA formed a task force to examine this issue earlier this year.

Scott Shipman, M.D., M.P.H., director of Primary Care Affairs and Workforce Analysis at the Association of American Medical Colleges, will serve as the keynote speaker. Paul Rockey, M.D., with the Accreditation Council for Graduate Medical Education, will close out the event.

In addition, the summit will include a general session on the economics and business side of primary care and two concurrent breakout sessions on:

- The current state of medical education in Minnesota
- Primary care practice transformation.

Audience members will be able to provide input that will guide the MMA's efforts to address the state's primary care physician workforce shortage.

Visit www.mmned.org to register for the event.

Rise in e-cigarette use concerns Minnesota physicians

In early September, the Centers for Disease Control and Prevention (CDC) reported that the percentage of U.S. middle and high school students who use e-cigarettes more than doubled between 2011 and 2012.

E-cigarettes contain nicotine, which is vaporized and ingested by the user. Although they resemble cigarettes, they do not contain tobacco and many states are still wrestling with how to treat them. Currently, they are available in a variety of kid-friendly flavors.

Proponents of e-cigarettes say they are beneficial because smokers use them to wean themselves off tobacco. Opponents see them as another entry-point to nicotine addiction.

"Clinicians are understandably being cautious about e-cigarettes," says Terry Clark, M.D., FCCP, an adjunct professor at the University of Minnesota Medical School-Duluth. "The best clinical study to date found no significant difference in quit rates between those using them and those using patches."

Currently, e-cigarettes are not regulated by the FDA. However, Minnesota has prohibited the sale of nicotine delivery products such as e-cigarettes to minors since May of 2010.

Some groups are urging the FDA to act. In mid-September, the Tobacco Control Legal Consortium at William Mitchell College of Law in St. Paul petitioned the FDA to regulate e-cigarettes. Others are not waiting for the FDA. The Duluth City Council passed an ordinance in September that bans the use of e-cigarettes in places where conventional cigarette smoking is already prohibited.

CDC Director Tom Frieden, M.D., M.P.H., characterized the increased use of e-cigarettes as deeply troubling. "Nicotine is a highly addictive drug," he said in a statement. "Many teens who start with e-cigarettes may be condemned to struggling with a lifelong addiction to nicotine and conventional cigarettes."

"This past legislative session, Minnesota made a giant leap towards reducing teen nicotine addiction by enacting a significant tobacco tax increase and closing the little cigar loophole," says Eric Dick, the MMA's manager of state legislative affairs. "The CDC report just reinforces the fact that our work is not done. We need to continue working to reduce nicotine's harm."

MMA meets with Congressman Paulsen on phase-out of SGR

In a September meeting with health care leaders that included representatives from the MMA, U.S. Rep. Erik Paulsen said a "permanent fix" to the Medicare Sustainable Growth Rate (SGR) formula is a priority for him this year.

"I feel good that there is synergy about getting this done this year," Paulsen told the group, which included MMA members Will Nicholson, M.D., Michael Tedford, M.D., Brian Rank, M.D., and Dave Renner, MMA's director of state and federal legislation.

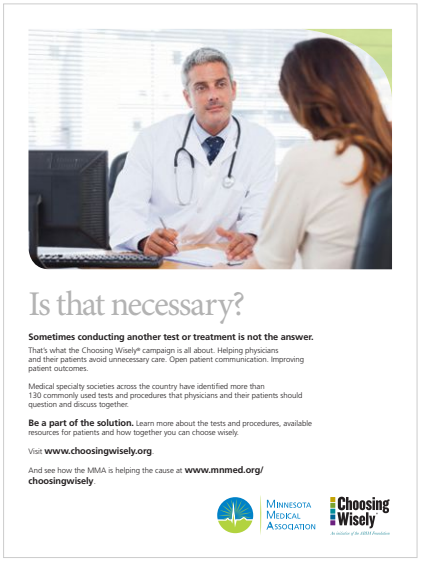
As a member of the U.S. House of Representatives' Ways and Means Committee, Paulsen will play a key role in maintaining the SGR repeal momentum. Ways and Means is expected to take up the discussion this fall. Earlier this year, the House Energy and Commerce Committee released a draft outline of a bill that repeals SGR and provides five years of annual 0.5 percent payment increases while Congress develops a new payment system that rewards quality and value.

"We made it clear to Rep. Paulsen that SGR has to be repealed this year," Renner says. "We appreciate the five years of updates, but 0.5 percent is less than the Medicare Economic Index and is not sufficient to allow physicians to sustain a practice."

Paulsen told Renner he appreciated physicians taking the time to meet with him and is open to further conversation.

MMA teams with ICSI and MHAG to form Choosing Wisely Minnesota

The MMA, the Institute for Clinical Systems Improvement (ICSI) and the Minnesota Health Action Group (MHAG) have partnered to create Choosing Wisely Minnesota, a collaboration to help Minnesota physicians and patients talk about medical tests and procedures that are often used but may not be necessary and may, in some cases, cause harm.



All three entities received grants from the ABIM Foundation earlier this year to help promote the Choosing Wisely campaign in Minnesota. An early outcome of the partnership is a new consumer-oriented website created in conjunction with *Consumer Reports*.

The website is designed to help patients work with their physicians to make wise choices about the care and treatments they receive.

Find the website at http://consumerhealthchoices.org/choosing-wisely-minnesota.

Patient experience surveys provide pleasing results

Describing them as "very strong results," MMA leaders were pleased with the findings of the first statewide patient experience surveys, known as the Clinician and Group Surveys-Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS), that were released in August by the Minnesota Department of Health and Minnesota Community Measurement.

"On average, 90 percent of patients gave the most positive response possible about provider-patient communication," says Dan Maddox, M.D., MMA president.

The other results were encouraging as well:

- 92 percent of patients gave the most positive response possible about office staff being courteous and helpful
- Nearly 80 percent rated their individual provider a 9 or 10 out of 10
- 60 percent gave the most positive response when asked about access to and timeliness of care.

"There is always room for improvement, but these results are extremely exciting," Maddox says. "Selecting and maintaining a relationship with a physician and clinic is a personal and complex decision. These results offer patients one more piece of information to consider, but—like most metrics—should not be used in isolation."

MMA petitions CMS to modify QHP grace period

In August, the MMA, along with the Minnesota Hospital Association (MHA) and the Minnesota Medical Group Management Association (MMGMA), sent a letter to the Centers for Medicare and Medicaid Services (CMS) asking the federal agency to reconsider its grace period regulation for certain MNsure plan enrollees.

A similar letter was also sent to Minnesota's eight U.S. representatives asking them for support on the matter.

A March CMS ruling provides health insurance exchange enrollees a 90-day grace period for nonpayment of Qualified Health Plan (QHP) premiums. According to the rule, providers' claims for payment made within the first 30 days of the grace period must be covered by the QHP. However, the QHP may "pend" any claims made in the following 60 days. This leaves providers at risk for increased uncompensated care costs—costs the Affordable Care Act intends to lower.

The letter asks CMS to modify its ruling so that any uncompensated costs are covered by the federal government and/or the QHP.

"Placing the financial risk on providers who deliver care and treatment with the good faith understanding that the patient continues to be covered is patently unfair," the letter says. "Moreover, it undermines the basic policy objective of continuing to provide coverage to people who are unable to pay premiums for a month or two."

The letters to CMS and the U.S. representatives were signed by MMA President Dan Maddox, M.D., MHA President Lawrence Massa, and MMGMA President Sandra Kamin.

ACA Medicaid primary care payment hike begins

As of August 13, providers who perform specific primary care services for patients in the fee-for-service Medicaid program are seeing enhanced payment rates. The increase is the result of a provision in the Affordable Care Act that provides Medicare-equivalent rates for primary care Medicaid services delivered in 2013-2014.

Claims submitted prior to August 13 will be reprocessed by the Department of Human Services. Additional details can be found on the DHS website at www.dhs.state.mn.us.

There continues to be delay, however, in implementation of the enhanced rates for Medicaid services provided to people enrolled in managed care Medicaid or the Prepaid Medical Assistance Program. DHS is awaiting approval by the Centers for Medicare and Medicaid Services (CMS) of its managed care payment rates and enhanced payment methodology. Approval by CMS has been

delayed, at least in part, because of controversy surrounding Minnesota's managed care rate-setting policies.

The MMA is working with DHS and others to try to expedite approval.

Blues provider service agreement revised

As a part of its ongoing contract review services, the MMA has prepared a summary of key changes to the Blue Cross/Blue Shield Aware Provider Service Agreement for 2013. View the changes at www.mnmed.org/BluesContract2013.

The agreement took effect July 1 and contains a number of changes relating to ACA implementation and the ICD-10 transition. The contract review highlights issues to watch for, processes that have changed and areas of ambiguity.

The MMA, in partnership with the Minnesota Medical Group Management Association and Twin Cities Medical Society, provides ongoing periodic contract review as a member service. If you have general questions, contact Teresa Knoedler, MMA policy counsel at tknoedler@mnmed.org.

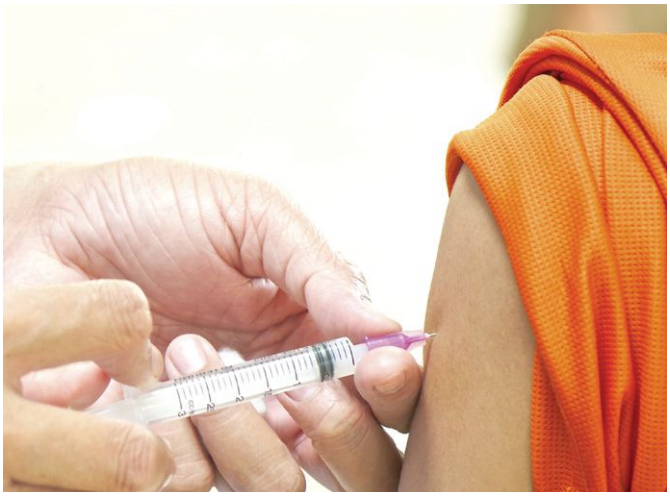
Judge rules in favor of immunization law changes

An administrative law judge determined in late August that the Minnesota Department of Health has the statutory authority to adopt revisions to Minnesota's school and child care immunization law. The judge also said that the proposed rules are needed and reasonable.

The changes, which take effect in September 2014, will affect school-aged children and children in child care and school-based early childhood programs.

The changes include:

- requiring children enrolling in child care and school-based early childhood programs to be vaccinated for hepatitis A and B
- requiring secondary students to get a meningococcal vaccination beginning in seventh grade
- replacing the current seventh-grade tetanus-diphtheria vaccine with one that also includes pertussis (Tdap).



In addition, the timing of the polio and DTaP vaccines would be changed to match current medically acceptable standards, and the age for the first varicella immunization would be changed from 18 months to 15 months for children enrolling in child care and school-based early childhood programs.

Health officials said these new vaccines will bring Minnesota's practices in line with the current recommendations from the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

Both Laurel Ries, M.D., chair of the MMA's Public Health committee, and Robert Jacobson, M.D., a Mayo Clinic physician and president of the MN Chapter of the American Academy of Pediatrics, testified in favor of the proposed changes before the judge on June 27.

MMA in action

Kathleen Baumbach and **Brian Strub**, the MMA's managers of physician outreach, met with Fred Nobrega, M.D., the Zumbro Valley Medical Society executive director, in Rochester to discuss strategies for increasing member engagement.

In September, the **MMA-Medical Student Section** (MMA-MSS) met to discuss the MMA Annual Meeting, to hear a recap from those who attended the AMA summer meeting in Chicago, and to welcome first-year medical students to the MMA and the MSS. For more information on the MMA-MSS, visit www.mnmed.org/medstudents.

Janet Silversmith, MMA director of policy, and **Dave Renner**, MMA director of state and federal legislation, met with Department of Human Services officials in early September to discuss the state's interest in pursuing a federal waiver in 2017 to unify and streamline the state's public programs.

Silversmith and **Robert Meiches**, M.D., MMA CEO, met with Brian Beutner, MNsure board chair, in September to discuss progress with the health insurance exchange's development and opportunities to ensure physician and care delivery perspectives in its design and operations.

In mid-September, Renner, Silversmith and **Eric Dick**, the MMA's manager of state legislative affairs, met with Minnesota Management and Budget staff to discuss a 2013-mandated study of state health care taxes and their relationship to the solvency of the Health Care Access Fund.

"Recovery"

When we are talking about mental illness, we need to define what we mean.

BY KEVIN TURNQUIST, M.D.

Although "recovery" is a term that is widely used in psychiatry, it is still a relatively new concept in our field—one that many of us have had little or no exposure to in our training. So it's no surprise there is confusion about what it means to recover from mental illness.

There are a number of competing models of recovery, each reflecting a different set of assumptions and beliefs. Knowing which assumptions and beliefs someone holds is important if we are to reach a common understanding.

The broken-leg model

This is the gold standard of recovery. The idea is that a person recovers from mental illness in the same way he or she recovers from a broken leg. After healing is complete, the limb is like it was before the break—perhaps even a little stronger. This model obviously appeals to mentally ill people and their families, and it frequently shapes their expectations about treatment.

One occasionally encounters people who have recovered in this way. They clearly suffered from schizophrenia or another major disorder yet now are symptom-free and manage to work in high-level jobs. Some of these folks work in the mental health field, educating professionals and the public about what is possible in terms of recovery from major mental illnesses.

There is no denying that this type of recovery exists. It represents an enormous human achievement. But the main problem with the broken-leg model is that it creates false expectations; it sets the bar so high that very few people will be able to achieve it.

The harsh reality is that very few people with schizophrenia and severe forms of other mental illnesses can go on to have the kind of lives and careers that they would have had they not had the illness. When family members compare their loved one with those few amazing individuals who seem to completely recover from a severe mental illness, they are usually sorely disappointed and may become angry with and blame the professionals charged with helping them.

The symptom-control model

This is the model almost universally embraced by psychiatrists. In fact, many of us never consider other possibilities. In this model, which grew out of the chemical imbalance theory of mental illness, control of symptoms is equated with recovery. Symptoms are seen as the result of ill-defined chemical imbalances. The psychiatrist's job is to prescribe medications aimed at correcting the imbalance so that symptoms go away. If the symptoms are well-controlled, then we've done our job.

Other mental health professionals are then charged with trying to make sure patients continue to take those medicines—which they usually must do indefinitely (often against their will). When symptoms do recur, it's assumed that the patient has stopped taking his medications or that he needs more of them. A flare-up of symptoms is almost always met with a trip to the psychiatrist's office or a psychiatric hospital so that adjustments to medications can be made.

There is certainly nothing wrong with focusing on symptom control. Psychosis, mania and depression can be disabling, and people usually function better when their symptoms are relieved. The problem comes when people believe that the control of symptoms will lead to recovery from the underlying illness.

When looking at patients' lives, one finds there is more to recovery than controlling symptoms. Millions of patients are given medications that help alleviate symptoms, but not all of them go on to become happier or more productive or functional. And many who have had their symptoms reduced through medications stop taking them at the first chance that they get. It turns out that having a sense of control over one's life is far more important than having symptoms reduced, especially given that many mentally ill people never believe they are experiencing the symptoms of a mental illness in the first place.

"The client costs the system less money" model

This is the model favored by administrators, politicians and policy makers. The goal of recovery is to move the client toward utilizing less-expensive services. If the person is hospitalized, the goal is to have him or her live in the community. If he or she requires services in order to get by in the community, the goal is for that person to function more independently. The ultimate goal is to have the individual working in a job that allows him or her to be self-sufficient. In this model, it's the client who no longer costs the system money who represents the ideal.

The farther one is removed from actual clients, the easier it is to assume that such a goal makes sense. We all assume that everyone else's mind works just like our own, so we tend to believe that approaches that would work for us will work for everyone else. As a result, our system now pushes to

have everyone working toward recovery in a linear fashion. "Achievable goals" are set. Problems are broken down into small pieces. Progress is measured at each step along the way so administrators will know which programs and approaches are moving clients toward self-sufficiency. Any treatment that has not been subjected to the necessary research to be considered a "best practice" or "evidence-based treatment" is looked upon with skepticism.

This approach is understandable, given the financial realities that health care system planners must deal with every day. Business models that emphasize cost-certainty and proven outcomes are awfully attractive to those responsible for a care system whose costs could spiral out of control at any moment. The problem is that recovery is not a commodity that can be regularly produced using proven formulas.

The clinical reality is that patients do not respond well to an approach that's intended to make them less burdensome to the system. Many will flee at the first glimpse of a workbook that is to be used to break their problems down into simplistic components. Others won't buy into *any* relationship in which a professional determines what's best for them. And some are able to smell when the goal of treatment is to make a professional look better and reject it right away.

The "get a life back that I can feel OK about" model

This is a new model of recovery that is beginning to catch on. Although it has been held up by patients for some time, we mental health professionals have been slow to adopt it. This model simply defines recovery in terms of quality of life. For many patients, feeling good about their life again is the only goal that makes sense.

This model recognizes that many severe mental illnesses stem from changes in the way the brain is structured. Implicit in that understanding is awareness that most mentally ill people will not become "normal" after having their brain chemistry readjusted. In addition, it acknowledges that symptom control alone does not equal recovery. Controlling symptoms may be very helpful—even essential—to leading a satisfying life after the onset of mental illness, but it's never enough. The work of accepting that life probably won't turn out as one originally dreamed must be done. Residual symptoms such as reduced stress tolerance, difficulties with motivation or reduced cognitive abilities have to be recognized and planned around. Use of medications must be weighed in terms of their positive versus their unwanted effects. Oftentimes a new social network must be established.

In this model, recovery is seen as a process, one that is different for each person. There is no expectation that progress will be linear or that its pace will be determined by the help of a professional. Becoming truly responsible for one's own life and the direction it takes is an enormous task for any human, so it's not surprising that this sort of recovery is not easy to accomplish.

The building blocks of recovery

The sad truth is that our current health care and social service systems are not set up to promote recovery from mental illness. For recovery to happen, some very basic things must be in place, and we don't yet do a very good job of providing them.

Foremost among them is the need to ensure that people with mental illnesses have a place they can call home. Almost no one can make significant progress toward recovery if they don't have a stable living environment. But in our system, mentally ill people are transferred from place to place depending on their symptoms or behavior at any given time. Frequent transfers between group homes, hospitals, apartments and halfway houses are common. Many clients live in several places throughout the course of a year. It's easy to forget that very few people without a mental illness could function well if they were never in one place long enough to get grounded.

To promote recovery, housing should be long-term and designed with supports to see people through various stages of their clinical condition. The living environment also must be safe enough so that the individual isn't under constant stress. Mentally ill people often live in situations that would make anyone anxious. High-crime neighborhoods and overcrowded housing are all too common. No brain functions well when the fight or flight response is constantly activated.

Even with safe, long-term housing, there is no guarantee that a person will "recover" from their illness. For life to be satisfying, an individual must find something or someone outside of themselves to which they can become connected. Without a connection to the real world—a sense of belonging to the greater human community—it's all too easy to become isolated in one's own mind. Hobbies, friendships, work, art and pets are just a few of the things that can provide someone with a sense of connection and having something to love.

Setting the bar too high?

People may find themselves uneasy as they contemplate the new model of recovery, as it raises the question "What makes any life satisfying and meaningful?" We Americans are at a stage where clear answers to that question seem elusive. The simple directives supplied by religion no longer feel adequate for many of us, but little has been offered up to replace them. Although we're preoccupied with status, sexuality and possessions, they don't make our lives feel complete. So defining recovery as having a life that one can feel good about may seem like setting the bar impossibly high.

But would any of us be willing to settle for anything less? Does any other model make sense for people with mental illnesses? These are questions of more than intellectual importance. The beliefs that we hold about recovery from mental illness affect every aspect of our mental health care system. More importantly, they shape the expectations, behaviors and lives of the people who suffer from these disorders. **MM**

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Making Your Practice More Welcoming to Patients with a Mental Illness

BY SUE ABDERHOLDEN, M.P.H.

On average, people with mental illnesses die at a younger age than people in the general population. In part, this is because they do not receive needed care for chronic medical conditions such as diabetes, cardiovascular disease and pulmonary disease. One reason people who have a mental illness may not get the care they need is that they fear discrimination and avoid visiting their clinic. This article offers clinicians advice on how to make their practices more welcoming to patients with mental illnesses.

People with mental illnesses have a shorter life expectancy than their peers who do not have a mental illness.[1] This has nothing to do with their mental illness itself; rather, it is because of uncontrolled chronic conditions such as diabetes, hypertension, metabolic syndrome, and pulmonary and cardiovascular diseases. Many of these illnesses are associated with weight gain, a common side effect of some of the medications they take.[1] In addition, people with serious mental illnesses have a high rate of smoking and are less likely than the rest of the population to obtain preventive care.[1,2]

Chronic illnesses are particularly devastating for persons with mental illnesses because they often don't access treatment. There are a number of reasons for this. For one thing, individuals may lack motivation to seek treatment for physical problems or may even fear getting health care. Further reducing their chance of getting needed care is the fact that providers face competing demands for their time and that the health care system is so fragmented.[3]

The stigma associated with mental illness also contributes to the problem. In 1999, Surgeon General David Satcher issued a landmark report on mental health, identifying stigma as a major problem for people with mental illnesses.[4] "When people understand that mental disorders are not the result of moral failings or limited willpower, but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate," he predicted. Nearly 15 years later, it's hard to say we've made much progress.

Adults and children who live with mental illnesses face discrimination in many areas of their lives, including during their encounters with the health care system. It manifests in big ways, such as insurance not covering necessary treatment, and seemingly little ones, such as patients not receiving get well cards when they are hospitalized.

Discrimination also shows up in the way physicians or nurses treat patients. In the opinion piece "When Doctors Discriminate," published in the August 10 *New York Times,* writer Juliann Garey noted, "If you met me, you'd never know I was mentally ill. In fact, I've gone through most of my adult life without anyone ever knowing—except when I've had to reveal it to a doctor. And that revelation changes everything. It wipes clean the rest of my résumé, my education, my accomplishments, reduces me to a diagnosis."[5]

Many people expressed agreement with her statements in postings on the National Alliance on Mental Illness (NAMI) Min-

nesota Facebook page and offered their own examples of how their physical needs have been discounted because they live with a mental illness. One recounted that the words "history of schizophrenia" were written on an X-ray order. She couldn't understand why the technician needed to know that. Another person wrote how her stomachache was attributed to her anxiety and no further tests were done.

The evidence isn't just anecdotal. A survey conducted by the national NAMI office and Harris Interactive in 2008 found nearly half (49%) of the people with schizophrenia who responded said doctors took their medical problems less seriously once they learned of their schizophrenia diagnosis, and 39% said the diagnosis made it more difficult for them to get care for their other health concerns.[6]

If you believe your health concerns won't be taken seriously or will be discounted, then why go to the doctor? If you believe your health care provider has negative views about mental illnesses, then why would you talk about emerging symptoms?

Resources on Mental Illness

National Alliance on Mental Illness (NAMI) Minnesota

Online classes for health care and mental health care providers, fact sheets on mental illnesses and booklets on specific topics

www.namihelps.org or 651-645-2948

Minnesota Department of Human Services

Information on the 10 by 10 project in Minnesota, including a form that patients, family members and health care providers can use to ensure that appropriate screenings are done

www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_147992

Make It OK

Information about reducing the stigma of having a mental illness and practical ways to do that, including phrases to use when approached by someone with a mental illness

www.makeitok.org

Substance Abuse and Mental Health Services Administration (SAMHSA)

Extensive information about preventing mental illnesses and resources for improving the lives of people who live with them

www.samhsa.gov/prevention/

Four Things Clinicians Can Do

Physicians and clinic staff can do a number of things to make patients with mental illnesses feel more welcome. Here are four of them:

1. If your waiting room has flyers about diabetes, cancer and other conditions, make sure there also is information about mental illnesses such as depression and anxiety and resources for dealing with them. Having such literature in the waiting area lets patients know you are open to talking about mental health concerns. This is especially important in primary care settings, as physicians and others who work in these practices are in an excellent position to help identify the early signs and symptoms of a mental illness. Approaching the issue with care and concern can encourage patients to talk openly about their mental health.

2. Educate yourself and your office staff about mental illnesses, the stigma associated with them and the importance of compassion. Empathy and understanding are hugely important to people with mental illnesses and their families, and they're often not offered. Make sure to let patients know there is hope, that they aren't alone and that their illness is not their fault. It takes great courage and determination to face these illnesses, and people need support and encouragement from their physician.

3. When treating a person with a mental illness, treat the whole person. Be sure to ask about their physical health as well as their mental health. Don't discount their physical concerns because they have a mental illness. And don't assume that the physical symptoms are related to their mental illness. Physicians should check and talk about glucose levels, weight gain, blood pressure, sleep patterns and metabolic levels.[7] Discuss the importance of eating a healthy diet, exercising and avoiding alcohol and make sure that patients who have mental illnesses have social connections and are not isolating themselves. When needed, and if the patient consents, connect with their mental health professional to coordinate care and treatment.

4. Don't be afraid to talk about smoking cessation. According to a February 2013 report by the Centers for Disease Control and Prevention done in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), 36% of adults with a mental illness are cigarette smokers, compared with only 21% of adults who do not have a mental illness. Between 62% and 90% of people with schizophrenia smoke.[8] Of the 435,000 deaths from smoking in the United States each year, about 200,000 occur among people with mental illnesses and/or substance use disorders.[9]

Some health and mental health care providers are reluctant to add this to the

list of things to discuss with their patients. But if we don't focus on it, we will continue to see people with serious mental illnesses die earlier than their peers.

Conclusion

In 2007, SAMHSA launched the 10 By 10 Campaign, a national effort to increase the life expectancy of people with mental illnesses by 10 years in 10 years. Improving the health of people with mental illnesses will not only require ensuring their access to medical care but also enhancing the quality of their interactions with their health care team. A number of resources are available to help physicians and their staff (see p. 41). By working to establish good relationships with persons with mental illnesses, primary care physicians are taking the first step toward improving their health and well-being. By attending to these patients' physical health as well as their mental health, they will be taking further steps toward extending their life expectancy. **MM**

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REFERENCES

1. Parks J, Svendsen D, Singer P, Foti ME. Morbidity and Mortality in People with Serious Mental Illness. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. October 2006.

2. Substance Abuse and Mental Health Services Administration. Why Wellness Matters for People with Mental Health Conditions. Available at: www.promoteacceptance.samhsa.gov/10by10/default.aspx. Accessed September 3, 2013.

3. Mitchell AJ, Malone D, Doebbeling CC. Quality of medical care for people with and without comorbid mental illness and substance misuse: systematic review of comparative studies. Br J Psychiatry. 2009;194(6):491-9.

4. Mental Health: A Report of the Surgeon General 1999. Available at: http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS. Accessed September 3, 2013.

5. Garey J. When Doctors Discriminate. New York Times, August 10, 2013.

6. National Alliance for Mental Illness. Schizophrenia Survey Analysis. Available at: www.nami.org/Content/NavigationMenu/SchizophreniaSurvey/Analysis_Living_with_Schizophrenia.htm. Accessed September 3, 2013.

7. Substance Abuse and Mental Health Services Administration. The 10 By 10 Campaign: A National Wellness Action Plan to Improve Life Expectancy by 10 Years in 10 Years for People with Mental Illness: A Report of the 2007 National Wellness Summit for People with Mental Illness. Available at: www.samhsa.gov/prevention. Accessed September 3, 2013.

8. Vital Signs: Current Cigarette Smoking Among Adults Aged ≥18 Years with Mental Illness — United States, 2009–2011. Morbid Mortal Wkly Rept. 2013;62(5):81-7. Available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a2.htm?s_cid=mm6205a2_w. Accessed September 3, 2013.

9. Grant BF, HasinDS, Chou PS, Stinson FS, Dawson DA. Nicotine dependence and psychiatric disorders in the United States: Results from the National Epidemiological Survey on Alcohol and related conditions. Arch Gen Psych. 2004; 61(11):1107-15.

What Clinicians Need to Know about DSM-5

BY JON E. GRANT, M.D., J.D., M.P.H.

The fifth version of the Diagnostic and Statistical Manual has been available since May 2013 and is now the guide for making psychiatric diagnoses. This article presents an overview of key changes in this version, debates on various topics leading to the revisions and reasons for the changes.

In late 2012, the American Psychiatric Association (APA) Assembly approved the fifth version of the Diagnostic and Statistical Manual, better known as DSM-5. The manual became available in May of 2013. DSM-5 was a massive undertaking, done over a 12-year period. It reflects progress in neuroscience, brain imaging, genetics and epidemiology. It also reflects the APA's desire to be in harmony with the World Health Organization's International Classification of Diseases (ICD), the official coding system used in the United States and other countries. According to the APA, DSM-5 provides clinicians, patients, families and researchers with "a clear and concise description of each mental disorder organized by explicit diagnostic criteria, supplemented, when appropriate, by dimensional measures that cross diagnostic boundaries, and a brief digest of information about the diagnosis, risk factors, associated features, research advances and various expressions of the disorder."[1]

The process of revising the DSM was fraught with robust debate and commentary.[2] Some of those discussions focused on the disorders themselves, which ones to retain, which ones to eliminate, whether there was a scientific basis for newly proposed disorders and whether the research on some disorders was reliable. Others focused on the process—whether it lacked transparency, whether decisions were being made based on scientific evidence, the effects of not having an independent scientific review, and the fact that many task force and work group members had conflicts of interest.

Although there are many opinions about DSM-5, it is the diagnostic manual currently used by the mental health profession. Therefore, clinicians should at least be aware of the changes that may have an impact on their clinical practice.[3,4] This article highlights some of those changes.

Approach and Organization

A key distinction between DSM-5 and previous versions is that it takes into account the severity of disease. Although dimensional views of disease were present in DSM-IV, earlier versions of the DSM have given users the impression that a psychiatric diagnosis is either present or absent—ie, that one either meets or does not meet the criteria for a particular disorder. To correct that simple dichotomized approach, DSM-5 includes an expanded approach to the dimensional aspects of diagnoses. For example, a clinician diagnosing stimulant-use disorder can now specify whether it is mild, moderate or severe. This was not an option in DSM-IV-TR, the revision of the DSM-IV published in 2000. With specifiers, subtypes, severity ratings and new tools for assessing symptoms, DSM-5 enables clinicians to better capture gradients of a disorder.[5] A new section in the DSM (Section III) includes a measure for assessing symptoms in 13 domains (including depression, anger and sleep problems) and encourages clinicians to be aware that symptoms may not fit neatly into diagnostic categories. Scores on the symptom measure may be tracked at each follow-up visit, and these can serve as a guide for additional inquiry and to assess response to treatment.

A second major change is the elimination of the multiaxial system. The multiaxial system was first included in DSM-III and was a means of facilitating a comprehensive and systematic evaluation

with attention to medical conditions, psychosocial and environmental problems, and level of functioning. In the multiaxial system, personality disorders and mental retardation (now referred to as intellectual disability) were listed as Axis II-level issues. In DSM-5, personality disorders and intellectual disability are no longer relegated to second-level importance. Also, in DSM-5, psychosocial stressors are considered "other conditions that may be a focus of clinical attention" and are coded using V-codes, which allow for more specificity. For example, instead of listing housing as a problem on Axis IV, the clinician would specify V60.0 homelessness, V60.1 inadequate housing or V60.6 problems related to living in a residential institution. Additionally, ability to function, previously conveyed as a score on the Global Assessment of Functioning in Axis V, is now indicated as a WHODAS 2.0 (World Health Organization Disability Assessment Schedule, version 2) score.[1] WHODAS 2.0 assesses disability across six domains (eg, self-care, getting along with people). The score reflects degrees of dysfunction in very specific domains (eg, whether a patient has mild or severe problems maintaining a friendship and making new friends).

A third major change is that the section on the cultural factors affecting mental health has been greatly expanded.[6] Additions include the Outline for Cultural Formulation and Cultural Formulation Interview. The Outline for Cultural Formulation is for assessing the patient's cultural identity, cultural conceptualization of distress, cultural features of vulnerability and resilience, and cultural features affecting the patient-clinician relationship. The Cultural Formulation Interview consists of 16 questions about the impact of culture on the patient's clinical presentation.

The manual's overall organization has changed as well. Chapters about specific diagnoses now follow those about development across the lifespan. DSM-5 also includes chapters on new disorders and new groups of disorders. Among the new chapters are ones on obsessive-compulsive and related disorders, trauma- and stressor-related disorders, elimination disorders, and disruptive impulse-control and conduct disorders.

Diagnoses

In addition to the changes in approach and organization, DSM-5 includes new diagnoses and revisions to several others to better reflect what is known about them. One important change is that autism disorder, Asperger's disorder, child disintegrative disorder and pervasive developmental disorder not otherwise specified (NOS) have been combined into a single diagnosis—autism spectrum disorder. DSM-5, however, includes specifiers to help reflect heterogeneity within the autism spectrum disorder diagnosis. For example, a person previously diagnosed with Asperger's disorder now would be diagnosed with autism spectrum disorder "without accompanying intellectual impairment" or "without accompanying language impairment."[5]

The decision to combine these disorders was met with considerable debate.[7-9] Some argued that high-functioning individuals would not meet the diagnostic criteria for autism spectrum disorder and thereby become ineligible for services and treatment. They called the removal of Asperger syndrome extreme. On the other side, some argued that the changes would make diagnosing patients easier and thereby enable clinicians to better identify those needing services. In the past, they said, clinicians often had difficulty differentiating between the disorders.

Another change is that DSM-5 has eliminated the diagnoses "substance abuse" and "substance dependence" and combined them into "substance use disorder" with the specifiers of "mild to severe" based on the number of symptoms. There were several reasons for this change. First, studies showed clinicians had trouble distinguishing between abuse and dependence. Many had assumed that abuse was often a prodromal phase of dependence, but several prospective studies showed that this was not the case. In addition, the division between abuse and dependence led to "diagnostic orphans," whereby persons with two criteria for dependence but none for abuse could go undiagnosed, although they may have as severe a problem as someone else with a diagnosis.

Furthermore, the chapter on addiction has been retitled "Substance-Related and Addictive Disorders" to allow for the inclusion of gambling disorder as a diagnosis. Based on research showing that gambling and substance-use disorders stem from common underlying genetic vulnerabilities and are associated with similar biological markers and cognitive deficits, the APA determined that gambling should be moved from the section on impulse disorders to the chapter on substance addiction.[10]

DSM-5 also has eliminated subtypes of schizophrenia (paranoid, disorganized, catatonic, undifferentiated and residual). There was little evidence to support either their clinical utility or predictive value. Because the course of schizophrenia is highly variable, it is not unusual for a person to meet criteria for several different subtypes. For that reason, DSM-5 uses course specifiers (eg, "first episode, currently in acute episode") and severity specifiers (eg, delusions "present and moderate") to reflect the heterogeneity of the disorder in a manner that is more clinically useful.[11]

In addition, DSM-5 reconceptualized schizoaffective disorder as a longitudinal, rather than cross-sectional, diagnosis. The most significant aspect of this change is that a major mood episode must be present for most of the duration of the illness in order to make a diagnosis of schizoaffective disorder (in contrast to diagnosing schizophrenia with mood symptoms).[12]

Finally, "major neurocognitive disorder" replaces "dementia" as a diagnosis in DSM-5. Neurocognitive problems that are not severe enough to cause significant impairment would meet the criteria for a new disorder: mild neurocognitive disorder. In addition to the core criteria for major and mild neurocognitive disorders, 10 specific etiological subtypes with separate diagnostic criteria are now included.

One of the most public debates during the development of DSM-5 involved proposed changes to the category of per-

sonality disorders. Over the years, various changes were proposed, including eliminating five of the 10 personality disorders and taking a dimensional approach to personality pathology. Although DSM-5 includes a new model for personality disorders that emphasizes pathological personality traits, the personality disorders in the text are the same as those in DSM-IV.

Conclusion

The changes to DSM-5 are too numerous to describe in a single article. In addition to those described here, the new version includes changes related to coding, new assessment measures, new disorders (eg, hoarding disorder and excoriation disorder) and new conditions included for further study (eg, attenuated psychosis syndrome and caffeine use disorder). Years of debate and controversy have not resolved all differences of opinion. Still, clinicians need to accept that DSM-5, for better or worse, is our new diagnostic manual, and they would be well-advised to become familiar with it. **MM**

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REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th Edition. Washington, D.C., 2013.

2. Frances AJ, Widiger T. Psychiatric diagnosis: lessons from the DSM-IV past and cautions for the DSM-5 future. Annu Rev Clin Psychol. 2012;8:109-30.

3. Black DW. Changes to DSM-5 are not as drastic as they may seem. Ann Clin Psychiatry. 2013:25(3):161.

4. Black DW. Proposed changes for DSM-5: are they clinically useful? Ann Clin Psychiatry. 2012;24(4):253.

5. Regier DA, Kuhl EA, Kupfer DJ. The DSM-5: classification and criteria changes. World Psychiatry. 2013;12(2):92-8.

6. Lewis-Fernández R, Krishan Aggarwal N. Culture and psychiatric diagnosis. Adv Psychosom Med. 2013;33:15-30.

7. McPartland JC, Reichow B, Volkmar FR. Sensitivity and specificity of proposed DSM-5 diagnostic criteria for autism spectrum disorder. J Am Acad Child Adolesc Psychiatry. 2012;51(4):368–83.

8. Swedo SE, Baird G, Cook EH Jr, et al. Commentary from the DSM-5 workgroup on neurodevelopmental disorders. J Am Acad Child Adolesc Psychiatry. 2012;51(4):347–9.

9. Mahjouri S, Lord CE. What the DSM-5 portends for research, diagnosis and treatment of autism spectrum disorders. Curr Psychiatry Rep. 2012;14(6):739-47.

10. Petry NM, Blanco C, Auriacombe M, et al. An overview of and rationale for changes proposed for pathological gambling in DSM-5. J Gambl Stud. 2013 Mar 23. [Epub ahead of print]

11. Tandon R, Gaebel W, Barch DM, et al. Definition and description of schizophrenia in the DSM-5. Schizophr Res. 2013 Jun 22. pii:S0920-9964(13)00283-1. [Epub ahead of print]

12. Carpenter WT, Tandon R. Psychotic disorders in DSM-5: summary of changes. Asian J Psychiatr. 2013;6(3):266-8.

A Plan to Align Substance Abuse, Mental Health and Primary Care Efforts in Minnesota

BY NEAL HOLTAN, M.D., M.P.H., PH.D., MELISSA C. ADOLFSON, M.S., MICHELE MARUSKA, M.S.W., AND KRISTIN DILLON, PH.D.

The Minnesota Department of Human Services convened a coalition in 2011 that included representatives from the primary care, mental health and substance-abuse prevention communities to develop a statewide plan to align efforts to prevent, screen for and treat substance abuse and mental health concerns. This article describes the plan that grew out of their efforts.

Primary care is the entry point to health care in the United States. Primary care clinicians see patients with a variety of concerns including mental health and substance abuse problems. Because those issues usually are not their first priority, they can miss opportunities to provide much-needed screening and care.

Individuals with mental health and substance abuse problems are frequent users of the primary care system because they have a higher rate of other health problems such as heart disease, diabetes, respiratory disease and infectious disease than the general population.[1] In addition, research has found that 90% of individuals with a mental health problem (with or without a substance use disorder) have seen a primary care provider for some reason just prior to their being diagnosed with a mental illness.[2]

Because of stigma or lack of access to services, persons with mental health or substance abuse disorders may look to their primary care physicians for care rather than seek help from a mental health or substance use professional.[3] In other cases, patients with mental illness or substance abuse disorders may not be able to see a mental health specialist without a referral from their primary care provider.[4] For all of these reasons, mental health and substance-abuse prevention, screening and treatment efforts need to be better integrated with primary care.[5] Yet it is commonly believed by mental health and substance-abuse prevention experts that primary care providers are underused allies.

In September 2011, the Minnesota Department of Human Services (DHS) Alcohol and Drug Abuse Division received a one-year grant from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) to produce a five-year plan to align efforts of mental health providers, substance-abuse prevention specialists and primary care providers in Minnesota to screen patients for substance abuse and mental health concerns. DHS submitted the completed plan to SAMHSA on August 1, 2012. This article briefly describes the plan and how it was created.

Assessing the Problem

Staff at DHS started the planning process with a comprehensive analysis of data related to alcohol consumption, mental health issues, and the costs and consequences of mental illness and substance abuse. Following are a few of the findings.

Alcohol Consumption

- Minnesota was among the 10 states with the highest rates of binge drinking (consuming five or more drinks in a row on one occasion for males, four or more for females, during the past month) among persons age 12 and older in 2008-2009. Binge drinking was reported by 25.8% of Minnesotans age 26 and older compared with 22.3% nationally. When broken down by age group, binge drinking was reported by 33% of Minnesotans ages 18 to 24 years in 2010, 25% of those ages 25 to 44, 13% of those ages 45 to 64, and 3% of residents age 65 and older.[6]
- Minnesota was among the states with the lowest-perceived risk of binge drinking, meaning that people either underestimated the danger of heavy alcohol intake or didn't recognize their behavior as binge drinking.[6]
- A survey of college students in Minnesota found that 41% of 18-year-olds and 77.2% of 22-year-olds had consumed alcohol within the past 30 days.[7]
- Four percent of sixth graders, 19% of ninth graders and 41% of 12th graders reported using alcohol in the past 30 days.[8]

Mental Health Problems

- Roughly one-third of youths reporting mental or emotional problems lasting at least 12 months had not receive treatment for them.[8]
- Approximately 90% of individuals who complete suicide have experienced a mental or substance use disorder or both.[9]

Consequences of Alcohol and Drug Abuse

- The economic costs associated with alcohol misuse in Minnesota amounted to an estimated $5.06 billion in 2007—about $975 for every person in the state and 17 times more than the $296 million in tax revenues collected from alcohol sales that year.[10]
- The total estimated cost of alcohol and drug abuse in the United States is $343 billion per year; that includes the cost of treatment, property damage and lost earnings.[11]
- The estimated cost of serious mental illnesses (including disability benefits, health care expenditures and loss of earnings) in this country is more than $317 billion annually.[12]
- Individuals with co-occurring disorders are much more likely to be hospitalized than those with a mental health disorder or a substance use disorder alone. The number of hospitalizations each year for people with substance abuse disorders only was 23 per 1,000 individuals; the number for those with mental health disorders alone was 87 per 1,000; and the number for those with co-occurring disorders was 457 per 1,000.[11]
- People with serious mental illnesses, on average, die 25 years earlier than the general population.[13]

Developing the Plan

More than 200 people from government, public health, advocacy organizations and clinical medicine contributed ideas for the plan during interviews and small group discussions. Afterwards, DHS convened a 21-person consortium composed of experts in mental health, primary care, substance abuse and public health to develop a plan to align efforts to identify and treat mental illness and substance abuse before they become problematic. Physicians were well-represented with participation by a cardiologist connected with the Minnesota Medical Association, an internist and former medical director of primary care at a large urban hospital, a public health medical director, and a family physician doing a preventive medicine fellowship at Mayo Clinic.

The consortium set a number of goals. One was to enhance state-level collaboration among the Department of Human Services, other state agencies and primary care to prevent substance abuse and suicide and identify and treat mental illness. A second was to build capacity to implement best practices, particularly evidence-based practices, to prevent substance abuse and suicide and identify and treat mental illness. A third was to support and empower communities to prevent substance abuse and suicide, and to support individuals identified in primary care settings as having or being at risk for mental illness.

The group then selected tactics for achieving these such as the following:

- Inform primary care providers and others about which mental health promotion and substance-abuse prevention programs are effective for young patients
- Identify communities or agencies that implement evidence-based practices for prevention of mental health and substance abuse problems and replicate the successes
- Encourage new staffing models in which primary care physicians and their staffs work with community-based organizations to support patients suffering from substance abuse and mental health disorders.

Findings and Future Directions

Minnesota was one of seven states to receive funding to send a delegation to SAMHSA's 2012 State Policy Academy on Preventing Mental and Substance Abuse Disorders in Children and Youth. Representatives from several state agencies, including health, human services and education, received technical assistance to implement the strategic plan and later visited the state of Washington to observe successful efforts to align prevention systems there. During the past year, officials from these agencies have continued to work together on coordinating mental illness and substance-abuse prevention efforts at the state level and to discuss ways to promote prevention and early identification and treatment of mental health and substance abuse problems in primary care settings.

Everyone who participated in the development of the plan hopes to see prevention of substance abuse and mental illness given more attention within the primary care community. We ask individuals and organizations to consider how they can contribute to that goal. **MM**

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REFERENCES

1. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2002). Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders. Available at: www.samhsa.gov/reports/congress2002/ Accessed September 17, 2013.

2. Kathol RG, Melek S, Bair B, Sargent S. Financing mental health and substance use disorder care within physical health: A look to the future. Psychiatr Clin North Am. 2008;31(1):11–25.

3. Feinman JA, Cardillo D, Palmer J, Mitchel M. Development of a model for the detection and treatment of depression in primary care. Psychiatr Q. 2000;71:59–78.

4. Hile MG. Mental health and substance abuse screening in primary care. J Tech Human Services. 2003;21(3):21–34.

5. Butler M, Kane RL, McAlpine D, Kathol RG, Fu SS, Hagedorn H, Wilt TJ. Integration of mental health/substance abuse and primary care (AHRQ Publication No. 09-E003). 2008. Available at: www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf. Accessed September 12, 2013.

6. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of national findings (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4586 Findings). Rockville, MD. Available at: www.samhsa.gov/data/2k9/2k9Resultsweb/web/2k9results.htm. Accessed September 12, 2013.

7. University of Minnesota College Student Health Survey (2011). Available at: www.bhs.umn.edu/surveys/index.htm. Accessed September 12, 2013.

8. Minnesota Student Survey. Available at: www.health.state.mn.us/divs/chs/mss. Accessed September 9, 2013.

9. Rodgers P. Understanding risk and protective factors for suicide: A primer for preventing suicide. Suicide Prevention Resource Center. 2011. Available at: www.sprc.org/library_resources/items/un. Accessed September 12, 2013.

10. Boeke M, Clarke J, Griffin T, Lewis R, Louricas M. The Human and Economic Cost of Alcohol Use in Minnesota. Minnesota Institute of Public Health for the Minnesota Department of Health. April 2011. Available at: www.health.state.mn.us/divs/hpcd/chp/cdrr/alcohol/alcpdf/HumanandEconomicCostofAlcoholUseinMinnesota.pdf. Accessed September 17, 2013.

11. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Substance abuse prevention dollars and cents. 2009. Available at: http://store.samhsa.gov/product/Substance-Abuse-Prevention-Dollars-and-Cents/SMA07-4298. Accessed September 12, 2013.

12. Insel TR. Assessing the economic cost of serious mental illness. Am J Psychiatry. 2008;165(6);663-5.

13. Parks J, Radke AQ, Mazade NA. Measurement of health status for people with serious mental illnesses. 2008. Available at: www.nasmhpd.org/docs/publications/MDCdocs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf. Accessed September 12, 2013.

The complete strategic plan to align substance abuse, mental illness and primary care prevention efforts in Minnesota is available on the DHS website: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6578-ENG.

A Model for Educating Children and Adolescents in a Psychiatric Care Setting

BY TODD ARCHBOLD, L.S.W., M.B.A.

Children who are hospitalized for psychiatric treatment not only face social, emotional and physical challenges, they also face academic ones when their schooling is disrupted. This article describes a model for schooling youths receiving psychiatric care in the inpatient and partial hospital programs offered by a Twin Cities psychiatric hospital.

Each year, more than 680,000 youths in the United States are hospitalized for psychiatric treatment. These hospitalizations may last anywhere from a few days to several weeks.[1] In the Twin Cities, an estimated 27,000 school-aged youths annually have psychiatric symptoms that require intensive treatment.[1] This can significantly disrupt their education, which can have a detrimental effect on their academic and social development and their resiliency.

In 2007, Intermediate District 287, a consortium of 12 west metro school districts that provides educational opportunities for children with special circumstances and needs in the Twin Cities area, and PrairieCare, a psychiatric hospital that provides both inpatient and outpatient treatment, formed a partnership to better meet the educational needs of youths receiving care in PrairieCare's inpatient and partial hospital programs in Edina and Maple Grove. This article describes that partnership and the approach they developed.

About the Partners

PrairieCare is a free-standing psychiatric hospital with 20 inpatient beds for patients 21 years and younger. It also operates two partial hospital programs, which provide a slightly less-intensive level of acute care services for outpatients. The clinical programming offered in both the inpatient and partial hospital programs is very similar.

Inpatient hospitalization is available for individuals who may pose immediate harm to themselves or another and require 24/7 monitoring and observation. These individuals may have suicidal ideation, severe aggression, impulsivity or psychotic features that require intensive treatment. The primary goals of inpatient hospitalization are safety and stabilization. The average length of stay for inpatients is usually seven to 10 days.

The partial hospital program is often used as a step-down level of care after inpatient hospitalization. The primary goals are stabilization and assessment to create a plan for continued healing. On average, patients participate in the partial hospital program for three to five weeks.

District 287 offers more than 129 programs and services to help meet the unique learning needs of students in its member school districts. It provides services to more than 13,000 students at more than 20 locations.[2] Students are referred by their district of residence. In some cases, students and parents can choose to enroll directly.

How the Program Works

Upon admission to PrairieCare's inpatient or partial hospital program, patients are temporarily enrolled in District 287.

PrairieCare manages their clinical treatment plan, and District 287 manages their academic instruction. The district provides the curriculum, and licensed teachers deliver the instruction.

Students and their families complete a release of information, so the clinicians and educators at PrairieCare and District 287 can communicate with educators at the student's home school district. Patients at PrairieCare have come from more than 50 school districts in four states.

The learning environment at Prairie Care is similar to that of a regular school but it also offers students more support. The idea is to create an opportunity for patients to practice being students to facilitate re-entry into their home school upon discharge.

The classroom is run by licensed special-education teachers and educational support professionals. Educational services are offered for two hours each day during the time patients are receiving intensive psychiatric treatments. Although there is a clear distinction between "treatment" and "education," clinicians and teachers work together closely. Educational staff attend weekly treatment rounds and discuss students' symptoms, behaviors and overall functioning in the classroom with behavioral health providers.

The Challenges

Providing educational services to youths receiving short-term treatment (fewer than 30 days) is challenging. The short duration requires both the child's home school district and District 287 to quickly enroll and "unenroll" students. Both treatment and educational staff have to be able to adapt as patients may transition in or out of care and school with as little as one or two days' notice. These ongoing changes require staff to promptly and succinctly communicate with one another and with the patient's family and outside care providers and educators. Finally, the severe psychiatric symptoms that some youths experience may impede their ability to learn. When symptoms are acute or severe, teachers must understand that psychiatric treatment takes priority over educational services.

PrairieCare has made efforts to educate school staff about the mental health needs of children. As part of the training, they learn about behavioral interventions and de-escalation strategies and ways to managing stress. In surveys, staff from District 287 reported that this improved both their ability to work with patients in the program and their comfort level in dealing with them. Staff have requested that the training program be ongoing.

Conclusion

The educational program offered by District 287 provides patients being treated at PrairieCare with academic support during a time when they are vulnerable and fragile. Being able to continue their schooling helps them maintain a sense of normalcy while going through treatment.

The goal of this initiative is to help patients/students establish and build skills that will enhance their chances of succeeding academically. Approximately 95% of PrairieCare's patients participate in the school program. Of those who do, 75% return to the educational setting from which they came. The remaining 25% may be referred to another program that can better meet their needs. Of those who do go back to their home school, most eventually return to their normal routine.

PrairieCare is opening another facility in Chaska next year and plans to work with School District 112 to create a similar program. This model of combining treatment and education can be replicated in other short-term psychiatric or behavioral health care settings. Doing so requires the following:

- Strong collaboration and communication between the education provider and the care and treatment provider
- Educating teachers about mental health assessment and disorders
- Teachers who are engaging and can adapt to changing dynamics.

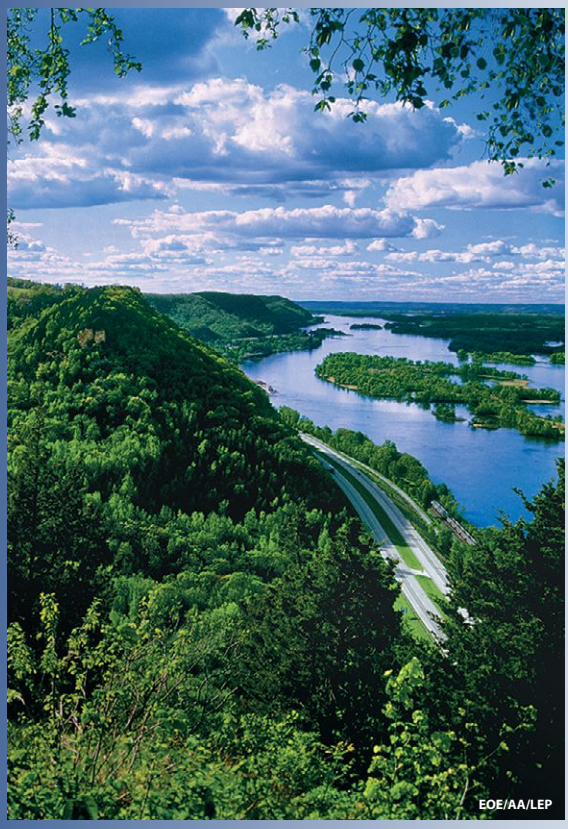
The needs of youths with mental health problems are great. Ensuring these vulnerable young people don't fall behind academically while they are in treatment for their psychiatric disorder is important—and one more step toward helping them succeed. **MM**

Todd Archbold is chief development officer of PrairieCare Psychiatric Hospital and Clinics and practice manager for PrairieCare Medical Group.

REFERENCES

1. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Child Health USA 2011. Rockville, Maryland: U.S. Department of Health and Human Services, 2011.

2. Intermediate District 287 website. Retrieved on April 25, 2013 from: http://www.district287.org/index.php?submenu=About_287&src=gendocs&ref=About287&category=Main



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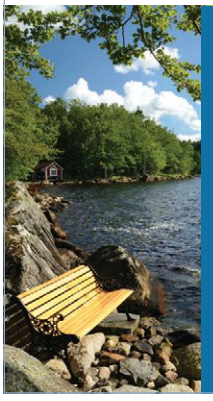

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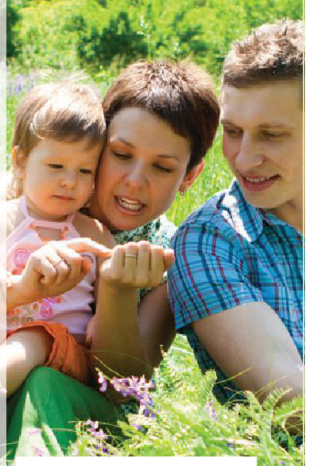

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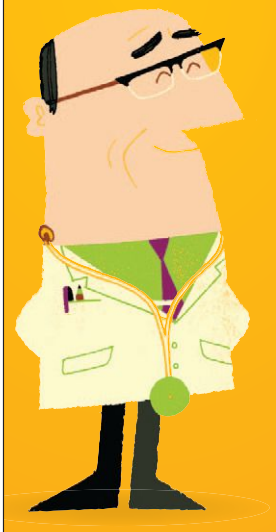

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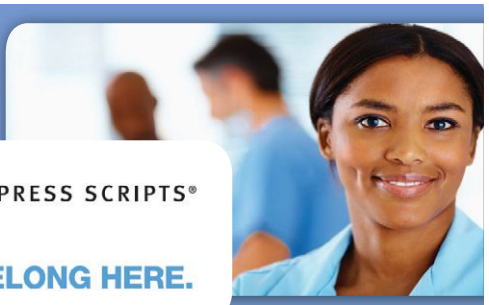

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Adeline's mother

A glimpse at the person in the patient.

BY MARGARET NOLAN, M.D.

We have her on a mandatory 72-hour hold, since she has a history of alcohol withdrawal seizures. She came down from the ICU this morning, where she had been intubated for respiratory failure after inhaling an unknown substance. She is so young, thin and frail. Her clavicles are like bridges, rising over a sea of ink-soaked skin tattooed with roses and crosses and initials that do not match her own.

She says she can't stay. She needs to get home to her daughter, Adeline. Hearing her name makes me pause; I did not expect it, somehow so full of love and care, so carefully chosen and purposefully given.

She says all her problems started when her fiancé died. She lets this sit between us for a moment. I remember from the chart it was an overdose. It occurs to me she doesn't know that I know this. It feels unsettling that I do. She says her fiancé's family is suing for custody of Adeline. She needs to get clean so she can keep her daughter. She must get home to be with her.

I listen as air whistles in and out, down her trachea and bronchioles and out into nothingness—her alveoli in wispy pieces from chemical damage of some kind. Her lungs gurgle and crack like rapidly boiling water. I'm not sure what she inhaled—only she knows, and perhaps her fiancé, who is now dead. I try to get her to tell me and she begins to cry but doesn't answer.

She reaches into the pocket of her hospital gown and pulls out a tube of lip gloss, the sparkly kind that hangs on the aisle ends at Walgreens and comes in flavors like "cherry burst" and "cotton candy cream." I watch her apply it and something in me stirs. I know she uses alcohol, marijuana, heroin, meth, OxyContin … but she also uses Bonne Bell lip gloss, and suddenly she becomes real. **MM**

Margaret Nolan is a second-year family medicine resident at Mayo Clinic in Rochester. This essay received honorable mention in the 2013 Medical Musings writing contest.

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