THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

MINNESOTA MEDICINE

MARCH 2015

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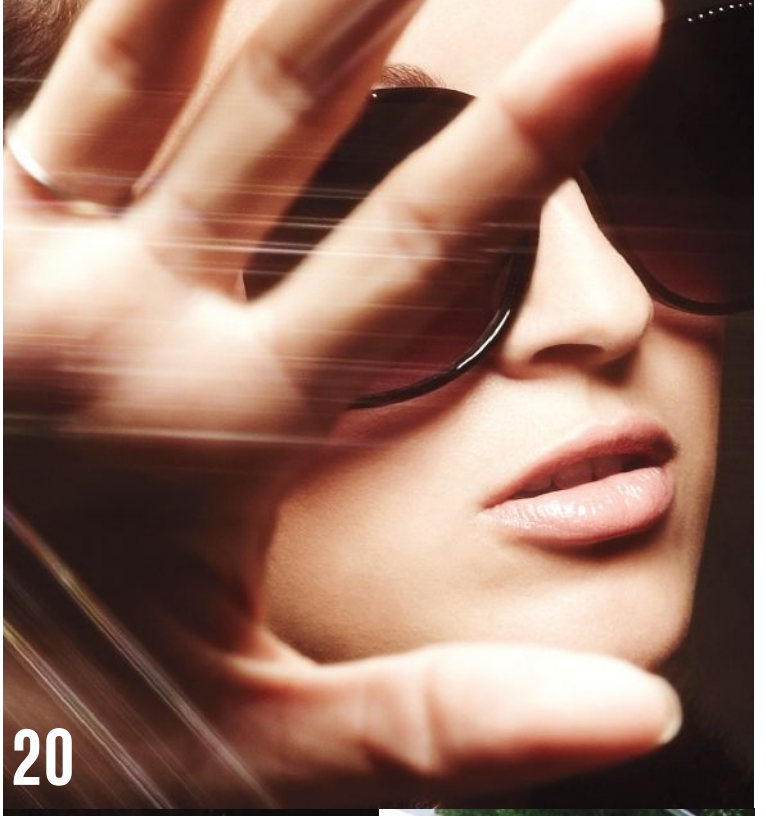

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CONTACT US
Minnesota Medicine
1300 Godward Street, Suite 2500
Minneapolis, MN 55413
PHONE: 612-378-1875 or 800-DIAL-MMA
EMAIL: mm@mnmed.org
WEB AND DIGITAL EDITION: minnesotamedicine.com

OWNER AND PUBLISHER
Minnesota Medical Association

EDITOR IN CHIEF
Charles R. Meyer, MD

EDITORS
Carmen Peota
Kim Kiser

PHYSICIAN ADVOCATE WRITER
Dan Hauser

ART DIRECTOR
Kathryn Forss

MMA COMMUNICATIONS DIRECTOR
Terry Ruane

CIRCULATION / WEB CONTENT
Mary Canada

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To submit an article
Contact Carmen Peota at cpeota@mnmed.org.

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PHOTO BY SCOTT WALKER

Charles R. Meyer, MD, Editor in Chief

Not-so-private practice

Celebrity can snatch medical issues from the privacy of doctor talking to patient and publicize them.

The practice of medicine is basically a private affair. When the exam room door closes, it is just patient and doctor tackling problems. Although operating rooms have lots of people in them, when scalpel hits skin, it's once again doctor and patient. The doctor-patient relationship is a special form of secrecy. And when a public person is the patient, that is challenged.

Caring for celebrity patients can be difficult. Aside from keeping clinical details away from public scrutiny, physicians may be asked to provide them with special access or unusual favors. Keeping the connection professional means insisting on strict clinical boundaries.

How much of a famous person's medical history to divulge has been a particularly treacherous balancing act for physicians who care for U.S. presidents as they juggle the public's "right to know" with the privacy of the individual holding the highest office in the country. As Abraham Lincoln lay dying of an assassin's bullet, scant press releases told a waiting country only that his wounds were "mortal." Frequent newspaper accounts following the shooting of James Garfield, the next president to be assassinated, kept Americans posted on his vacillating health.

The era of politically motivated nondisclosure of presidential illness began with Woodrow Wilson's debilitating stroke. Although it essentially prevented Wilson from performing the duties of president, the true extent of his dysfunction was concealed by his wife. FDR's paralysis was hidden behind podiums and a remarkable feat of assisted walking. And details of JFK's struggles with chronic back pain and Addison's disease were successfully suppressed during his presidency. Presidents and other famous individuals have a public persona to maintain and illness that might tarnish that image is sometimes seen as a liability.

The physicians who care for presidents have mostly lingered in the background, surfacing only for press conferences to explain the details of their patient's illness. One exception was Dennis O'Leary, MD, who was the articulate spokesman for George Washington Medical Center during Ronald Reagan's hospitalization for his gunshot wound. For a few weeks in 1981, O'Leary's name became a household word. Mayo Clinic's Ronald Petersen, who treated Reagan toward the end of his life, stepped into the spotlight only when Nancy Reagan asked him to do so.

Past eras have seen surgeons such as Michael DeBakey and Christiaan Barnard propelled into the spotlight by their scientific achievements. Today, doctors such as Sanjay Gupta and Mehmet Oz seek it out as they communicate a Tinseltown version of medical news that entertains more than educates. More often, however, doctors are happy to keep a low profile. That's true for Minnesota physicians Ray Christensen, Jon Hallberg, David Hilden and others, who via TV and radio bring articulate, informative discussions of medical topics to the public.

Whether it's famous doctors or patients, celebrity can snatch medical issues from the privacy of doctor talking to patient and publicize them, changing the role of doctor and patient.

I had my first brush with a celebrity patient in the early 1990s just after the first World Trade Center bombing. I saw actor Walter Matthau for a physical examination. A few days later, my receptionist told me that somebody on the phone wanted to question me in regard to the bombing. It was Matthau looking for the results of his lab work. Although treating celebrities may have its challenges, it certainly can be entertaining.

Charles Meyer can be reached at charles073@gmail.com.

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Are employed physicians really more satisfied?

The piece titled "9 signs of a satisfied physician" (February, p. 6), which shares some of the results from a survey of 1,527 physicians by Jackson Healthcare, caught my attention. In particular, I was struck by sign No. 7, which states that physicians who were satisfied were likely to be employed and never have worked in private practice. Is it really the case?

This article ignores other studies that asked the question "Who is more satisfied, employed physicians or those in independent practice?" and came up with different answers. Here are two:

- A 2014 Medscape publication, "Employed versus Self-employed: Who is better off?," reports results of a survey of more than 4,600 physicians that found both groups are equally satisfied (74% independent, 73% employed).
- Research done collaboratively by the American Medical Association and Rand Corporation found that independent physicians were more likely than employed physicians to be satisfied. The authors of "Factors Affecting Profession Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy" state the following in their summary: "In our sample, physicians in physician-owned practices or partnerships were more likely to be satisfied than those in other ownership models (hospital or corporate ownership)."

As an administrator and supporter of independent physician practices, I believe it's important that this additional information on this important question is shared. Clearly, there is recent evidence of high physician satisfaction among those in independent practice. Being independent does not mean being dissatisfied, and independent practice remains a rewarding and viable option.

In addition, independent practices continue to show their remarkable value by consistently delivering care that is of higher quality and lower cost than that of larger "employed" practices.

Mark Pottenger
Administrator, Northwest Family Physicians
Crystal

Article brought hidden costs to light

Thank you for the excellent article on high-deductible health plans "Hidden costs," January p. 22).

I am one of those who has what most would consider to be excellent insurance. But that really does not matter because if I use it, the deductible will break me.

I was scheduled for surgery last December, after I had met my deductible for the year in manageable increments. For reasons beyond my control, I was not able to have the procedure then. I will now have it in February. My deductible has more than doubled for 2015, and no portion of it has yet been met. I have no idea how I will pay this bill.

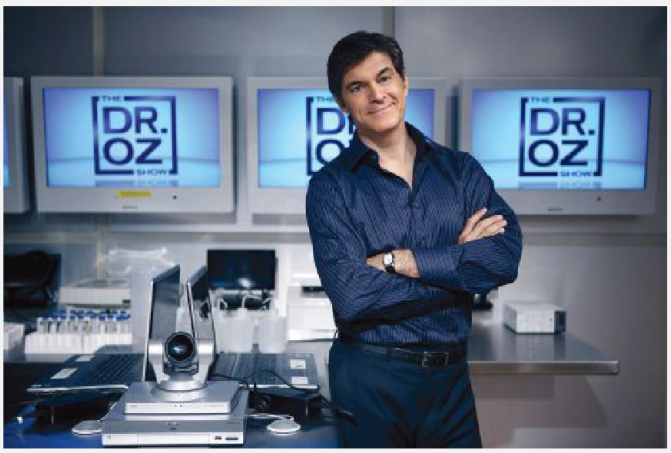
We need more articles like this one. Until you confront it, you may not even realize there is a deductible wall keeping people from accessing even the most rudimentary health care.

Deborah Mathiowetz
Eagan

Fair take on single-payer

Thanks for the very good article on single-payer ("Single-payer health care," January 2015, p. 16). Kim Kiser presented all sides honestly and with good material. The conversation goes on!

Chris Reif, MD
Minneapolis



Dissecting "The Dr. Oz Show"

Despite being criticized by scientists for relying on flimsy evidence, sued by a New York viewer who claimed to have received third-degree burns after following his recommendation to sleep with heated rice-filled socks, and scolded by a member of Congress for promoting dubious weight-loss products, Mehmet Oz, MD, host of "The Dr. Oz Show," continues to attract millions viewers. And those viewers often show up in physicians' offices asking about the advice and treatments discussed on the Emmy-winning daytime TV show.

So how valid are the recommendations touted on this and other medical talk shows? Researchers from the University of Alberta in Edmonton, Canada, attempted to answer that question by studying the extent to which the advice lines up with medical evidence. They watched 40 episodes each of "The Dr. Oz Show" and "The Doctors," a program co-hosted by six physicians, from 2013, and randomly selected 80 recommendations from each show to study.

They found support ("at least a case study or better evidence") for only 54 percent of the recommendations reviewed.

The researchers found evidence supported 46 percent of the recommendations from "The Dr. Oz Show" and contradicted 15 percent of the advice. Evidence was not available for 39 percent of the recommendations. The most common recommendation category on "The Dr. Oz Show": dietary advice.

"The Doctors" fared better. The investigators found evidence supported 63 percent of the recommendations, contradicted 14 percent and wasn't found for 24 percent. The most common recommendation category: consult a health care provider.

The researchers, who published their findings in the December 17, 2014, issue of the *British Medical Journal*, cautioned the public to be skeptical of advice given on such shows.

Agility champion

Kory Kaye, MD, strides onto the agility course at Twin Cities Obedience and Training Club (TCOTC) in northeast Minneapolis with a little brown-and-white Shetland sheepdog at her side, looking intense.

Kory Kaye on the course with Kaemon.

PHOTO BY MIKE KRIVIT

She gives the command to go, and the dog takes off running. Kaye runs alongside, directing him over hurdles, into tunnels, across a long bridge and through a slalom course. "Good boy," she says and rewards him with a piece of cheese—"the paycheck"—for his effort. "Dogs love the sport," she says. "And the humans tend to really like it, too."

Kaye, who works in the emergency department at Regions Hospital, is clearly one of them. "The reason I like agility is because it's a game of strategy," she explains. Participants face a unique course at every competition, "so you can't just run the same course over and over and get faster and faster." Rather, you study the map, walk it and think through how to best approach the obstacles in a way that capitalizes on your dog's strengths. "Within a second a dog can be on the wrong side of an obstacle," she says, adding that dogs successfully run the course less than half the time. "The typical pass rate is about 40 percent."

Kaye and her dogs are currently preparing to compete in the American Kennel Club's 2015 Agility World Team tryouts in May—the sport's equivalent of the U.S. Olympic trials. Over the years, they have competed throughout the United States and internationally. In 2011 and 2014, she and 7-year-old Keyme represented the United States at the European Open World Championships in Austria and Hungary (they took sixth place in the individual competition in 2014). She and 4-year-old Kaemon represented the United States at the FCI Agility World Championships in 2013 in Johannesburg, South Africa (they won the silver medal in the individual competition and were part of a bronze-medal winning small-dog jumping team).

Kaye grew up with dogs but stumbled onto agility by accident. After she got her first Sheltie pup in 1989, she started obedience training (her mother had been showing dogs in obedience). "It became the thing my mother and I did on Monday night," she says. "It was nothing more than that." Then one thing led to another, and Kaye began competing in obedience.

About five years later, the sport of agility came along. "I showed in the first AKC agility trial, which happened to be in this building," she says of the TCOTC facility. "I did it initially to support the club, but did pretty well. You get a couple of placement ribbons and the next thing you know, you're addicted." She now teaches agility at TCOTC—hoping to pass her love of the sport on to others.

Kaye says competing with dogs and practicing emergency medicine have similarities: Both are exciting and both require her to make decisions quickly and react to ever-changing situations. Agility, she says, "has all the highs and lows of the emergency department, but if something goes terribly wrong on an agility course, no one dies." – KIM KISER

On call, on the air

"If you have questions about varicose veins, leg cramps, peripheral artery disease or any kind of circulation and leg problems, now is the time to get your questions ready and call them in," family physician Ray Christensen, MD, tells members of the Duluth-area viewing audience as local and toll-free telephone numbers flash across the television screen.

Christensen is sitting in the host's chair for "Doctors on Call," a show on WDSE·WRPT, the PBS station in Duluth/Superior. With him are three other physicians: a family doc from Lake Superior Health Clinic, a vascular surgeon from St. Luke's Medical Center and an interventional radiologist from Essentia Health.

The program, which is in its 33rd season, is one of the longest-running medical advice shows in the United States. It averages more than 10,000 viewers a week and is the station's second-most-watched locally produced program.

"We've been up against sports and political figures, and our numbers haven't changed," says Christensen, who is associate dean for rural health at the University of Minnesota Medical School Duluth. He has been one of the show's hosts for nearly 13 years and now shares those duties with two other physicians from the medical school, Ruth Westra, DO, and Alan Johns, MD.

The show's format hasn't deviated during that time, either. Each Thursday night for 18 weeks starting in October, the host physician leads a panel of three physicians (usually one family physician and two specialists) through a half-hour discussion about a health topic. Three medical students man the phones, writing down questions from viewers. The host then throws the questions to the panelists, who provide answers and advice.

"When this program first hit the airwaves, it was pretty groundbreaking," says Producer Juli Kellner. "In the '80s, it was rare to find a television show featuring frank discussion about topics like prostate cancer." Kellner, who credits "Doctors on Call" with raising the level of medical knowledge in the region, works with Christensen and the other hosts to come up with topics. This season's lineup included shows on diabetes, heart problems, infectious diseases and immunizations and skin problems, as well as leg and circulation problems.

"Our viewing audience is an older audience," Christensen says. "We've tried shows for younger people on topics like sports medicine, and we don't get calls. If the phones don't ring, it's not easy to do the show."

Christensen says despite the show's longevity and popularity, it's becoming more difficult to get physicians to participate. When he first served as a panelist in the 1990s, the university and three medical societies (Lake Superior, Range and Douglas County in Wisconsin) supplied the physician experts. Now, the hosts and a program coordinator reach out to physicians from across northeastern Minnesota and northwestern Wisconsin.

Ray Christensen, MD (right), hosting the segment on circulation and leg problems. With him (from right) are Gregory Snyder, MD, Emily Onello, MD, and Mark Egington, MD.

"A lot of physicians are a little nervous about coming on the program," he says, adding that taking questions from callers can be a little like sitting for boards ("you never know what the questions will be, so you have to brush up"). Christensen says he usually asks the first question to get them warmed up, then moves on to those from viewers. "The nice thing about being on a panel is that if you don't know the answer, you can say you don't know," he says. "Sometimes none of us knows the answer, and it's our responsibility to be open about that."

He says the public—and patients—appreciate their efforts. "People enjoy seeing their doctor on the program," he says, adding that he's had patients suggest topics for future shows. "Last week, someone called in and thanked us for the information about diabetes. That was a first. He said he was very happy to have listened to our program." – KIM KISER

Longtime leader

Newly retired, Patricia Simmons is gearing up for the next phase of her life.

PHOTO BY GOSHA WEIVODA-MAYO CLINIC

On a snowy evening in February, Patricia Simmons is at the Capitol in St. Paul. Although she's an expert in pediatric and adolescent gynecology, she's not there to testify about a health-related issue. Nor is she there to report on the progress of the Destination Medical Center Corporation (she helped create its development plan for Rochester) or to gain support for the arts (she's on the boards of several arts organizations). This day she's wearing her University of Minnesota regent hat. Simmons is waiting to see if she once again will be nominated to serve by the higher education committees. "The way it works is, I'm an active regent until the minute the Legislature elects my replacement," she says.

Most regents step down after two six-year terms, and that was Simmons' intent until a finalist with health care expertise withdrew and she was asked to reconsider. Simmons has already served two terms and is willing to do a third, if elected. She knows only that lawmakers will be voting on who will fill the slot some time during this session.

Whether she continues on as a regent isn't the only unanswered question for Simmons. By choice, not all of her plans are firm. She's just retired from Mayo Clinic and has stepped down from chairing the board of the Destination Medical Center Corporation's Economic Development Agency (EDA). As its first chair, she oversaw creation of the plan for spending the millions of dollars the state is pumping into the region. Although she's got ideas about what's ahead, she's taking a little time to see how the next phase of her life unfolds and how she can best contribute.

This is new for Simmons, who throughout her career has found herself leaning in more often than sitting back. For example, she's chaired the board of Mayo Clinic Ventures, been its executive medical director for health policy and served on its boards of governors and trustees. She's been on the boards of the Minnesota Chamber of Commerce, Minnesota Business Partnership and Minneapolis St. Paul Regional Economic Development Partnership. She's been an elder at her church and president of her professional society, and she currently sits on the boards of Minnesota Public Radio, American Public Media, the Guthrie Theater and the St. John's University's Hill Museum and Manuscript Library.

Those who know Simmons say there's a reason she so often gets asked to lead. She's good at it. Dawn Davis, MD, who has known her for 15 years and considers her a mentor, says Simmons has qualities that make her effective. "She's able to mentally juggle multiple situations at once and anticipate how they will intertwine," she says. "She's also very visionary. Patty can think in the future with regards to a project, whether it be tomorrow or next week or next year or 10 years from now."

Davis also says Simmons has that less-tangible quality of charisma. "She has an aura. It's not like she puts on a show or tries to prove herself. She just has a natural grace and presence and magnetism that draws people to her."

Sri Zaheer, dean of the University of Minnesota's Carlson School of Management and an EDA board member, says Simmons is a "natural bringer-together of people." "She's very good at persuading people, making sure everyone's opinions are heard, and yet keeping things moving along and on time," she says.

Simmons thinks her ability to keep the mission in sight is what makes her an asset to the organizations she works with. We recently asked her about that and what it takes to be a leader. Here's what she had to say.

What do you think it means to lead?
I think it takes an extraordinary commitment to mission in the nonprofit world. Maybe that's true in the for-profit world, too. Whatever level I'm functioning at, I keep my eye on the mission. I keep a strong sense of the values of the group, and I make sure there are commonly held principles as you keep everybody moving forward. Leadership is not just letting things roll along, it's facilitating the moving forward.

I honestly think one of the most important things a leader can do is help others succeed. If you're on a governing board, you help the president or CEO succeed. If you're in a leadership position in your department, you help those more junior or newer with their responsibilities. I love doing that.

Is leading a form of mentoring?
It's more than that. It's providing opportunity, guidance and support. It's helping change course when the course needs to change.

What does a good board chair need to do?
Keep people well-informed, keep yourself well-informed about what people are thinking. It's getting the ideas generated. It's lots of one-on-one work. Good boards have leaders who are working with each member of that board. It's the phone calls, it's the coffee, it's the outside meetings. It's so much more than leading a board meeting or a committee meeting.

Why is that one-on-one work so important?
Human beings are so wonderful because there are differences in the way we think, work and function. You'll have some people who are highly effective at getting things out on the table at a board meeting. You'll have other people who may be more passive at the meeting but who have really important ideas, experiences and perspectives to share. And you don't get that if you just hold board meetings. You want to get as much out of your board as you can, and your board will like that because everybody likes to feel valued, and they're valued if they're contributing.

How did you learn about leadership and governing?
Most of it has been on-the-job, being given responsibility and working hard to learn how to execute. With each new responsibility, I've gone to leaders across the nation and learned from them.

Have you ever felt intimidated by them?
People who've agreed to meet with me are good people who care about the work, the field, the community. They're people who are willing to share their knowledge and expertise. It's not intimidating, it's exciting.

You seem to have a very positive attitude. Do you work at that?
That comes by nature. I don't expect that things will always go well, but I stay optimistic because I know you generally get there and because I work with accomplished people.

What is the connection between practicing medicine and leading?
When you're a physician you care about people; you think about how your decisions affect people. That never leaves me.

Are you looking forward to the future?
It's been a long time since I've had the opportunity to say, "OK, what's next?" I don't know, but I like it. I have confidence that the next phase, my post-Mayo Clinic career, will be stimulating and exciting. – CARMEN PEOTA

THE CELEBRITY EFFECT

What happens when famous people reveal their health problems

BY CARMEN PEOTA

Shortly after movie star Angelina Jolie announced in a *New York Times* article in 2013 that she had undergone preventive double mastectomy, Twin Cities oncologist Barbara Bowers, MD, posted this on a blog site: "Kudos to Angelina Jolie, who had the strength of character to not only have a life-preserving treatment for familial breast cancer, but to share it with us."

Bowers thought Jolie not only had made a wise personal decision, as she was indeed at high risk for cancer because she had a BRCA1 gene mutation, but also that she had handled her announcement about it with aplomb. "She made a statement. She didn't make a huge number of appearances, and she didn't go into anything but the facts about her decision. That was a class act," she says.

What happened immediately following the announcement was another story. Jolie, considered by many to be one of the world's most beautiful women, became the topic of endless discussions online, in print, and on television and radio. Had she made the right decision? What should other women do? "There were so many people talking on both sides that it left young women who were in the same position confused," Bowers says. Many ended up in their doctors' offices.

Bowers, a breast specialist who practices with Minnesota Oncology, found herself trying to convince patients with small tumors that they were ideal candidates for lumpectomy and radiation rather than mastectomy. Others who had neither breast cancer nor a BRCA gene mutation thought they needed to make the same choice Jolie had made because a family member had breast cancer. With each concerned patient, Bowers carefully explained that a small group of women have a genetic predisposition. That only one in 10 women with breast cancer have a family history of the disease. That only about 50 percent of those have a genetic abnormality. And that there is no scientific benefit to having the breasts removed if there is no family history and genetic mutation.

Angelina Jolie and Michael J. Fox are two celebrities whose health issues have influenced the dialogue between patients and physicians.

Then she'd try to help them understand their own thinking. "I wanted them to acknowledge why they were making the decision and what they were basing the decision on," she says. "People are so involved with celebrities—they get to know them in their minds, who they think they are and what they are and what they represent—that when something like this happens, they take it personally and they start internalizing the emotion. And sometimes they make decisions they regret later."

Oncologists and surgeons around the world were having similar conversations with patients, and women were lining up for genetic tests. One study in the United Kingdom found demand for BRCA 1/2 testing almost doubled in the months following Jolie's announcement and there were many more enquiries about risk-reducing mastectomy. The impact of Jolie's announcement was so great that *Time* magazine put her on its May 27, 2013, cover with the headline "The Angelina Effect." By the end of 2014, the phrase had made it into the titles of six

articles indexed by the National Library of Medicine.

Worship culture

Of course, Jolie wasn't the first well-known personality with a health problem to cause a stir. Rock Hudson's 1985 announcement that he had AIDS brought that epidemic out of the shadows. Earvin "Magic" Johnson's 1991 revelation that he was HIV-positive further raised awareness and led to an increase in the number of people getting tested for the virus. Ronald Reagan's 1994 Alzheimer's announcement reduced the stigma associated with that disease. Katie Couric's efforts related to colon cancer sparked an increase in colonoscopies. Even former Vice President Dick Cheney's left ventricular assist device (LVAD) implantation and subsequent cardiac transplant made an impact: According to a study published in the *American Journal of Cardiology* last year, there was a significant spike in Google searches, YouTube videos and Twitter messages related to LVAD and heart transplantation during the time he was undergoing the procedures. (A similarly designed study found online information-seeking related to the genetics and risk-reduction resources available from the National Cancer Institute increased dramatically after Jolie's announcement as well.)

Why these revelations have such an impact on people's health behaviors and collective thinking is certainly related to our general interest in celebrities. There's no doubt we have an insatiable appetite for knowing the details of their lives. Psychologists call the fascination "celebrity worship" and say it can take forms ranging from the benign (entertainment) to the psychotic. An article in *HealthDay News* attempting to explain this following the death of super-celebrity Michael Jackson cited experts who said celebrities tap into the public's primal fantasies, that celebrity worship is a symptom of a rootless culture in which people feel a sense of isolation, and that as religion has waned, we've become more fascinated by celebrities.

We seem particularly intrigued by their infirmities. Search the web using the terms "celebrity" and "disease" and you'll turn up thousands of sites where you can read articles like "10 Sexy Celebrities Who Have Diseases," "10 Celebrities with Chronic Illnesses," "15 Celebrities with Autoimmune Diseases." There's even a "Celebrities with Your Disease" site, where you can pick your disease and find a rock star or actor who also has it.

How celebrities' influence affects our health choices is a question authors Steven J. Hoffman and Charlie Tan of McMaster University attempted to answer in an article published in the *British Medical Journal* in 2013. The authors examined theories and studies from psychology, economics, marketing and sociology. Among their findings: Celebrities activate our natural tendency to make decisions based on how others have acted; they influence us because we associate success in one area—say sports—with competence in another—say medicine; we follow the advice of those who match how we perceive or want to perceive ourselves. We follow their celebrity lead to gain social status. And on and on it goes.

The Fox factor

Arguably, no celebrity has made more of an impact on medicine than actor Michael J. Fox. Interestingly, that impact has been felt more by scientists than patients. Beloved particularly for the roles he played on the 1980s television series "Family Ties" and in the "Back to the Future" movies, Fox not only told the world in 1998 that he had Parkinson's disease but then leveraged his fame to start the Michael J. Fox Foundation for Parkinson Research, which since 2000 has funneled $450 million toward efforts to cure the disease.

University of Minnesota neurologist Paul Tuite, MD, recalls being skeptical when he first heard about the Fox Foundation. "We weren't sure what that was going to be," he says, explaining that there were already two large national organizations for Parkinson's. He was worried the Fox Foundation would compete with them for funds. However, he quickly saw how Fox's connections in Hollywood and elsewhere allowed him to tap sources the others hadn't. "They generated so much funding that the other Parkinson's organizations seemed to step aside," he says. The National Parkinson Foundation and American Parkinson Disease Association still fund grants, he says, but when it comes to large funds, Fox is the one to go to other than the NIH.

Further, the foundation altered the direction of research, establishing its own scientific advisory committee and setting its own priorities. "In essence, it generated massive amounts of funds and is dictating, not in a bad sense but in a good sense, what areas of research should get funded and how to leverage things so people can get larger federal funds as well as move towards a cure," Tuite says.

One of the things the Fox Foundation has done is push industry. Tuite notes there had been a dramatic slow-down in drug development for Parkinson's. "Big Pharma had dropped the ball because they view neuroscience as not a profitable area of drug development," he says. "Fox has pushed the study of isradipine, a blood pressure pill, which is now in clinical trials in the Twin Cities. So it's a new model of bringing drugs to the marketplace."

As a researcher, Tuite personally has felt Fox's influence. In addition to the isradipine trial, he's been part of a Fox Foundation-funded multi-center study called BioFIND. The goal is to discover and verify biomarkers of Parkinson's disease. The study is being carried out at eight academic sites in the United States. BioFIND is collecting clinical data and biospecimens, including blood and cerebrospinal fluid, from 120 people with well-defined, moderately advanced Parkinson's and 120 healthy controls.

Tuite says that for many years his Parkinson's patients did ask him about Michael J. Fox. "They all wanted to know what he was taking," he says. "Most people are not asking that anymore. But many are happy that he's out there and wonder how it's changing things research-wise." **MM**

Carmen Peota is an editor of *Minnesota Medicine*.

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Minnesota Medical Association

PICKING THE BEST?

How physicians get named to those top-doctor lists

BY SUZY FRISCH

PHOTO BY KATHRYN FORSS

Who doesn't like a thumbs-up for their work every now and then? For Clare Kearns McCarthy, MD, getting named to a local list of top doctors provides welcome validation that other physicians value her skills as an orthopedic surgeon.

McCarthy says the lists can be helpful to patients and other physicians. Patients see making the list like getting a *Good Housekeeping* Seal of Approval. "Patients like to see that you're on the list. It's a conversation starting point, and they are satisfied knowing their doctor is recognized. They are seeing someone who others trust as well," says McCarthy, a hand and upper-extremity surgeon for Twin Cities Orthopedics in Edina who has appeared on *MPLS.St.Paul Magazine's* list seven times and *Minnesota Monthly's* three times. She also believes being on the lists may be helpful for physicians who need to refer patients. "It gives them a level of confidence when someone is on the list."

There are numerous benefits to being named to a best-doctors list, say those who get cited. Physicians whose names appear on them often get props from their patients and other medical professionals. It also shines a light on their abilities, says Pamela Gigi Chawla, MD, a pediatrician and pediatric hospitalist at Children's Hospitals and Clinics of Minnesota and senior medical director of primary care. Chawla, who has been honored by *MPLS.St.Paul Magazine* and *Minnesota Monthly* more than a dozen times, says Children's receives a surge of calls from potential patients who want to see their doctors after the annual lists come out. "I don't think people really look at this and say that this is about me," she says. "It's more about highlighting my institution and all the people who make what I do even possible."

Peter Sershon, MD, chief of surgery at United Hospital and a urologic surgeon with Metro Urology in St. Paul, graced the cover of *MPLS.St.Paul Magazine*'s Top Doctors issue in 2013. He sees another benefit to the lists: They raise awareness about health and medical services. *MPLS.St.Paul Magazine* included an article about the robotic surgery program Sershon runs at United in conjunction with its Top Doctors list. He believes such attention might make screening for prostate cancer top of mind. "If this leads to more men with aggressive prostate cancer being diagnosed early because they read something about

it and got checked—even if it's one guy—then it's worth it," he says.

Behind the scenes

Minnesota Monthly started publishing its Best Doctors list about a decade ago, and *MPLS.St.Paul Magazine* has done Top Doctors lists for nearly 20 years. The issues in which those features appear happen to be some of the magazines' best-sellers.

So how do doctors get named to these lists? *MPLS.St.Paul Magazine* outsourced its research a few years back to Key Professional Media, which publishes "Super Doctors" and "Super Dentists" lists in national magazines. To generate nominations each year, it sends paper ballots to 5,000 licensed metro-area physicians and registered nurses asking them for names of one or more doctors they or a loved one have seen or would go to for care. The firm also emails all area physicians asking for nominations. This year, *MPLS.St.Paul Magazine* received 1,386 nominations.

In addition, the company does its own research. Staff members tap health-related government websites, volunteer and humanitarian organizations, universities, hospitals, medical societies and other professional organizations to add names to the list of nominees, including those of doctors who might work in smaller clinics or highly specialized areas. "There are numerous resources we use," says research director Becky Kittelson.

The research team then evaluates candidates based on years of experience, fellowships, leadership positions, hospital appointments, academic achievements and positions, professional activities, board certifications, publications and lectures, and other honors, awards and achievements.

The top-scoring doctors are named to a blue ribbon panel. Those physicians are asked to provide feedback on the nominees as well as other potential candidates from their specialty. Then the number crunching begins, taking into account all the points each candidate receives during the process, Kittelson says. From this, they generate the final list, which typically includes between 5 and 8 percent of local doctors.

"The rigor of our process is pretty astonishing," says Deb Hopp, publisher of *MPLS.St.Paul Magazine*. She notes that rankings of other professionals are often done by those who use their services. "Our Top Doctors list has always been rankings by expert peers."

For the magazine, the work is worth it, as newsstand sales for the Top Doctors issue are 30 to 40 percent over that of other issues, says Hopp. "It's huge," she adds. "People rely on it, and I think doctors are extremely proud to be on it. They've come to understand how carefully the research is done, and it's repeated every year." The magazine also gives clinics and health systems a plaque honoring the physicians named to the list and the opportunity to buy congratulatory ads in that issue.

Minnesota Monthly has a similar process. It obtains the names of all physicians

with active licenses in the 11-county metro area, plus Olmsted County to capture Mayo Clinic. Previously, the magazine sent those physicians postcards requesting nominations, but this year it hired Michigan-based Professional Research Services to administer the process. Now that company emails a group of approximately 10,000 doctors asking them to nominate physicians in about 30 specialty and subspecialty categories, says Editor Rachel Hutton. During a three-week period, those doctors can log onto a website and vote for up to three physicians per specialty. Hutton says the response rate varies from year to year, but they get a representative sampling. The research firm then determines the number of votes doctors need before they are named to the list. That threshold can vary slightly each year, depending on the number of responses.

> "It's only a popularity contest if that's the way doctors are voting."
>
> – Rachel Hutton

Minnesota Monthly's final 2013 list included 509 names. In 2014, the magazine added several specialties including addiction medicine and Alzheimer's disease, which expanded the list to about 700 doctors.

"The threshold is set so the number of doctors named is large enough that it gives people a good selection," Hutton says. "We want to give people a few options in each category, if possible, but we also don't want to overwhelm them with five pages of cardiologists." She explains that they only include specialties that have enough practitioners so that there is a choice about who is named to the list. They also restrict both nominations and Best Doctor designations to local physicians who are in good standing with the Minnesota Board of Medical Practice.

Second opinions

Although most doctors feel honored to be chosen, many wonder why some truly excellent physicians don't make the lists. "Some argue that it's a popularity contest," Hutton says. "But it's only a popularity contest if that's the way doctors are voting," she adds. "It's all in the hands of the doctors. We ask them to vote for peers they think are most qualified and whose performance is excellent, and we rely on them to vote with integrity."

Jim Chase, president of the nonprofit quality improvement organization MN Community Measurement, says that when it comes to choosing a physician or clinic, he hopes patients also consider data on clinical outcomes and patient satisfaction. "The public thinks the lists are a good thing to have, and they are valid for what they are," he says. "But it's only providers who respond, and it's not every provider, and being named might have to do with who you know and not really the data." He notes that MN Community Measurement provides information on the quality of care at clinics and patient experience ratings on its Minnesota Health Scores website.

Tim Anderson, MD, a pediatrician with Southdale Pediatric Associates in Burnsville, agrees that magazine lists shouldn't be the deciding factor when choosing a physician. Anderson, who takes care of babies and children with complex mental and physical conditions, says he thinks the reason he's made *MPLS. St.Paul Magazine's* Top Doctors list is because he works with so many hospital specialists and nurses, so he is known and his name comes to mind when they're voting for pediatricians. Anderson says finding a doctor you feel comfortable with and can communicate with is what really matters. "Feeling listened to and understood at the end of a visit is the most important thing." **MM**

Suzy Frisch is a Twin Cities freelance writer.

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Main speaker

Tom Arneson, MD, research director for the state's Office of Medical Cannabis

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Date

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Location

University of Minnesota's Continuing Education and Conference Center

1890 Buford Avenue, Saint Paul

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Minnesota Medical Association

WHEN THE PATIENT IS

FAMOUS

WHAT IT'S LIKE FOR PHYSICIANS WHO TREAT CELEBRITIES

BY KATE LEDGER

Family physician Jon Hallberg was working at a downtown Minneapolis practice in the mid-1990s when a colleague began receiving calls from actors and crew members who were in town to film movies. Soon Hallberg was also getting those calls and found himself rubbing shoulders with the likes of some big-name Hollywood actors, including Walter Matthau, Jack Lemmon and Sophia Loren. Brushes with stars were exciting. "Those were the early days of my practice, and I had time to do house calls, or to drive to movie sets to treat bronchitis or see a performer who had a touch of laryngitis," Hallberg recalls.

Today, as medical director of the Mill City Clinic in Minneapolis, Hallberg often finds his schedule too packed to make house—or hotel—calls for stars. Frequently, when the last-minute requests come, he sends them on to other colleagues. But his patient panel still includes many big names, including stars who are in town to do shows at the State, Orpheum and Guthrie theaters or who have connections with local performing arts organizations such as the Minnesota Orchestra. He's also an official doctor for the Minnesota Twins. Like many who frequently treat celebrity patients, Hallberg points out that the work, although interesting, presents some challenges.

THE NOT-SO-GLAMOROUS SIDE

For one thing, working with celebrity patients is often fast-paced. "It's always an emergency or an urgent issue—two days ago," Hallberg says. And there can be added pressure. "Tens of thousands of dollars may rest on a star's being able to perform," he says. "The adage often applies, that the show must go on."

Ophthalmologist Richard Lindstrom, MD, who has flown to Palm Springs to do surgery on Frank Sinatra and to the Middle East to care for royalty, and who treats Twins and Vikings players at Minnesota Eye Consultants, says caring for celebrity patients comes with additional and even onerous responsibility. Physicians know that even an unavoidable complication might make it onto the evening news, and that can be devastating for a practice. "You have to be able to handle the pressure," he says.

The high stakes of an expensive performance, or an athlete's contract, can add anxiety to what already might be a complicated doctor-patient relationship. A 2002 article in the *Primary Care Companion of the Journal of Clinical Psychiatry* found that celebrity patients pose many of the same problems as "difficult" patients—those who rile physicians because they are demanding, blameful, manipulative, or even try to engage the physician in a power struggle. (A University of Southern California study published in the *Journal of Research in Personality* found celebrities are 17 percent more narcissistic than average people and that, unlike in the general population, celebrity women are more narcissistic than their male counterparts.)

Lindstrom has found celebrities can have unrealistic expectations. In his case, they may fail to imagine that the typical risks of surgery apply to them, too. Some are on tight schedules and want their doctor to cut corners to speed up treatment. Where Lindstrom does not waver is in the requirements for pre- and postoperative care. In fact, he has declined to do surgery on patients who have told him they were flying out of town and wouldn't be able to make their postop appointments.

Some journal articles have noted that fame actually can get in the way of good treatment—a phenomenon known as "VIP syndrome." A 2012 article in the *Journal of Nervous and Mental Disease* points out that some VIPs don't receive proper supervision or their entourage gets in the way of clinicians. Others have noted doctors may become overly deferential, even obliging, when dealing with famous patients. They may be so star-struck they lose their objectivity or feel too embarrassed to ask necessary questions while taking a history, for example. Lindstrom has steeled himself against VIP syndrome: "You have to take extra care to treat them the way you'd treat anybody else."

NO MONKEY BUSINESS

What it takes to treat famous patients, according to Minnesota doctors, is an awareness of the pitfalls—and a firm stance on providing the best care possible.

Paul Rondestvedt, MD, is unyielding about what care he will provide to rock stars who come to perform in the Twin Cities. A family doctor who works in the Fairview ER in Wyoming, Minnesota, he frequently sidelines as a "rock doc." When a band is heading into town, he often gets

a call from the tour's local promoter asking if he can be on site for the performers and the crew. (He often works for free but as a perk gets tickets and sometimes backstage passes to shows.)

Most frequently, he says, the job is nuts-and-bolts medicine, providing care to a busload of people who have been sharing the same germs for weeks on end. The most typical medical issues he sees: laryngitis and upper bronchial infections, ear aches and gastrointestinal issues. He sometimes helps performers get last-minute referrals to specialists in town. Once he recognized that a singer was critically ill and wound up using his own car to give the person a lift to an ER. (He keeps medical records for the patients he sees, so he can address follow-up calls from their own doctors when they get home.)

Older rock stars sometimes request injections of vitamin B12, which they claim boosts energy to deliver performances, and Rondestvedt will oblige. "I don't know if it does anything," he acknowledges, "but it's not going to cause any harm."

Rondestvedt, who has worked with rock bands for 20 years, lets his patients know he won't prescribe painkillers or sleep aids, or get involved in "any monkey-business." "They know me by now, and they know I won't provide prescriptions." He was horrified when news came to light about Michael Jackson's physician, a cardiologist who was administering propofol to help the singer sleep. "It's my license. It's my livelihood," Rondestvedt says. "I'm not about to put that on the line."

> "YOU HAVE TO TAKE EXTRA CARE TO TREAT CELEBRITIES AS YOU'D TREAT ANYBODY ELSE."
>
> —RICHARD LINDSTROM, MD

SAME MEDICINE, HIGHER SECURITY

Some medical institutions in the state actually cater to the rich and famous. Mayo Clinic's service for elite clientele goes back a number of years, when it began making a concerted effort to meet the needs of executives and high-profile patients seeking routine care. The service expanded over time as increasing numbers of international patients, including royalty such as King Hussein of Jordan and the Dalai

Lama, have made their way to Rochester for care. Today, a hospitality team consisting of 10 patient-relations specialists works to ensure their stays go smoothly.

Although amenities are important to high-profile patients, two issues are paramount: maintaining security and privacy, says Lindsay Norgaard, who supervises the patient-relations staff. She says the team asks a series of questions as they determine how best to meet a celebrity's needs. For instance, is the person likely to be recognized by passers-by? Is he or she of governmental importance? Then, often in collaboration with a celebrity's own management or security personnel, the team tailors the services they'll provide during the visit to the person's needs. That might include adding layers of security to already confidential electronic medical records (the most secure are not only locked and require special access codes, but also reveal who has viewed the record). Team members will escort the celebrity through the hospital, taking him or her through less-traveled halls, using staff elevators and avoiding crowded areas. If a patient's health needs change, or doctors request a new test, the team quickly devises a new route. "Our job requires that we're constantly thinking on our feet," Norgaard says.

Mayo has a few special suites, hotel-like apartments with tastefully hidden medical equipment, where the well-to-do can stay if they're there for routine visits or when they're recovering from surgery. Occasionally, when there are security concerns, the team will request that medical staff make visits to the suite instead of having the patient in the hospital. The patient relations staff is on call to fulfill even mundane requests, whether it's to deliver a particular type of coffee or, in the case of one international patient, live chickens. Staff members take notes so that they can replicate positive elements during subsequent visits, for instance having a preferred type of chair or furniture arrangement.

Despite all the special treatment, Norgaard emphasizes that the medical care is the same for everyone. Neurologist Ron Petersen, PhD, MD, concurs: "It's important not to deviate from your normal diagnostic procedures and to yield the same kind of care you would provide for any patient. I try not to be influenced by their celebrity status." And Petersen should know. Among the very high-profile patients he has treated are former President Ronald Reagan and country music singer Glen Campbell.

THE BIGGEST ISSUE FOR DOCTORS IS KNOWING THAT THE PRESS WILL BE INTERESTED IN THE DIAGNOSIS AND TREATMENT.

He says the biggest issue for doctors is knowing that the press will be interested in the diagnosis and treatment, as was the case when Peterson treated Ronald Reagan after the former president had begun to show signs of Alzheimer's disease. In 1994, Nancy Reagan had decided it was time to make a public statement about her husband's diagnosis. "We [doctors at Mayo] had a phone conference with Mrs. Reagan and other physicians in Washington. It was reinforced with us, this is the last time we would discuss his case unless we received special dispensation by her," he recalls. After the following day's press conference, "10 minutes later there were media outlets calling the Mayo Clinic, asking 'Can you fly out and be on TV tomorrow?' The answer was 'no,'" he says. However, several years later, Mrs. Reagan put the producers of "Larry King Live" in touch with Petersen, and he went on a show to discuss Alzheimer's and the Reagans with her permission.

More recently, Petersen has been in the spotlight with country music superstar Glen Campbell, who told his story in the movie "Glen Campbell: I'll Be Me." As one of the physicians involved in Campbell's care, he agreed to participate in the film to raise awareness about Alzheimer's and discuss how doctors diagnose the disease.

Petersen is careful about maintaining his role as a care provider. Even though many famous patients decide to become advocates for a disease, "that's really up to them," he says. If patients bring up that they'd like to become an advocate, raise public awareness, or raise money for a disease, he'll engage them in a conversation. "But that's a secondary consideration as far as I'm concerned," he says. "My primary responsibility is to them, caring for them and making the best recommendations for their care."

JUST LIKE EVERYBODY ELSE

In some health care settings, celebrities receive no special treatment. Such is the case at the Hazelden Betty Ford Foundation, which sees its share of the famous and well-to-do who are undergoing treatment for addiction. (Hazelden, headquartered in Center City, Minnesota, merged with the Betty Ford Foundation in 2014.) The Minnesota treatment site has been an attractive place for stars eager to escape the pressures of New York or Hollywood. When they get to the facility, however, some bristle when they find they have to share rooms and eat meals with others in treatment. Because studies have shown that individual therapy tends to be less effective than group therapy for people who have addiction, celebrities are expected to attend group sessions

with other patients, says chief medical officer Marvin Seppala, MD. "Addiction is a disease of isolation," he explains.

The center faces other challenges when it comes to celebrities. "We take all our patients' privacy really seriously, but in the case of celebrities, even more so," Seppala says. The center has shooed away paparazzi who have tried to get onto the campus. Privacy is also critical to effective care. Patients need to be able to focus on their treatment, and even the staff is frequently reminded not to fawn over celebrities or to divulge patient information. The center flat-out refuses requests from reporters interested in talking with any current patient. Even so, the effort to keep celebrities' treatment under wraps sometimes gets foiled by the celebrities themselves. "We [as an institution] won't say anything, and then we find the celebrity has had their PR people put out a report," he says.

Even though its addiction treatment is aimed equally at all patients, the center is aware that aspects of celebrities' lives make their cases unique. Many celebrities and VIPs have had managers or staff members who have enabled their substance abuse, even smoothing over any negative consequences. In treatment, they sometimes are encouraged to change staff or involve others in their finances so they have safeguards against falling into dangerous old habits. Although the recovery rate for celebrities is about the same as for the general public, Seppala points out that the well-off frequently have more resources that enable them to avoid or delay treatment: "It's a little easier to ditch a treatment program if you can have a private plane pick you up. Yes, that's happened."

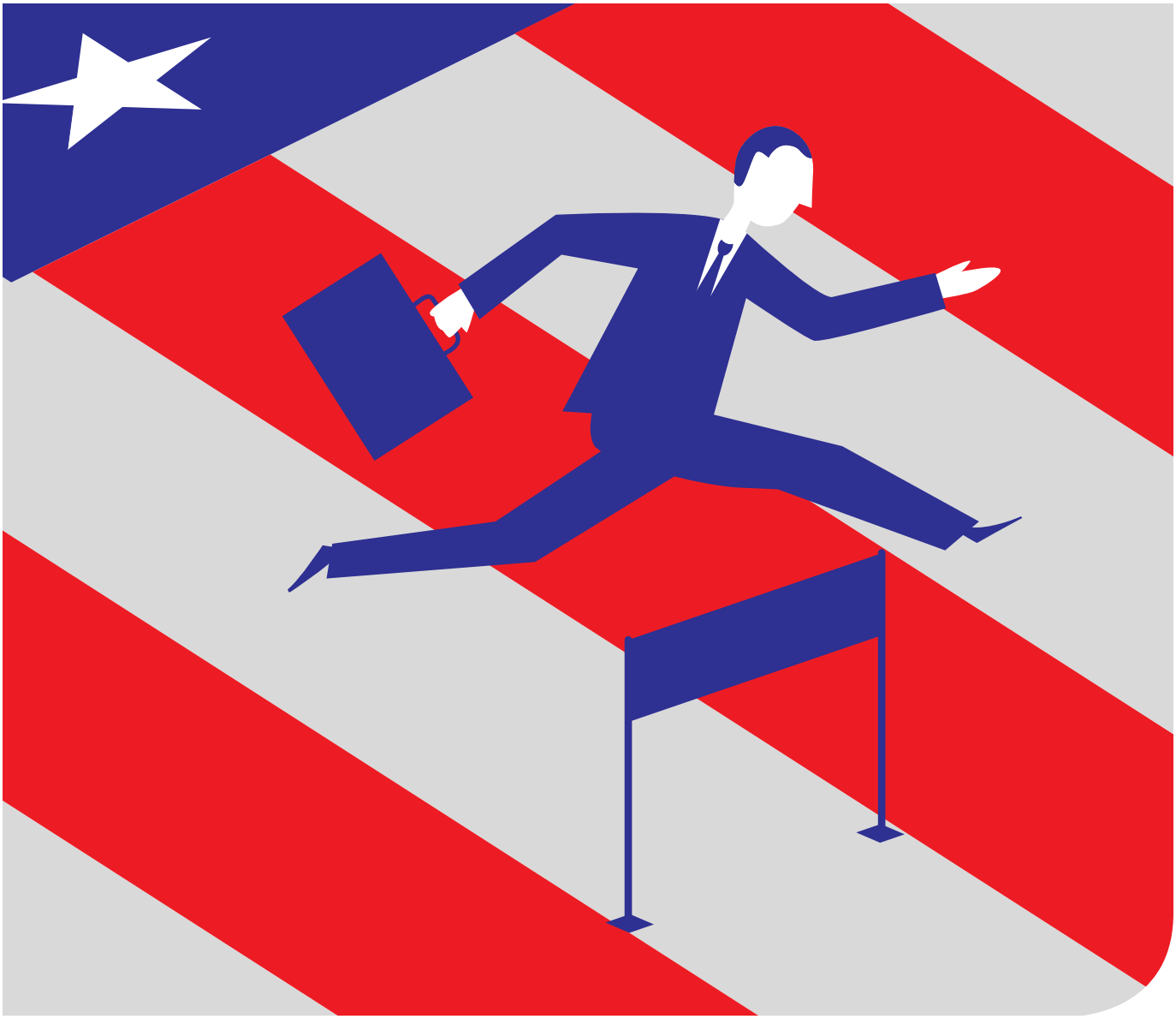
THE TEAM APPROACH

For doctors who treat celebrities, the ultimate goal is to provide the best care and refuse to be deterred in doing so. Some articles have suggested that health care *teams* accustomed to VIPs may do the best at managing celebrities, especially those who have special expectations of doctors and health care settings. A team may be less likely to be swayed by unusual requests or allow an individual doctor to feel pressured.

Sometimes, to doctors' surprise, celebrities are relieved to be treated like everyone else. They want their health care team to remain low-key, and they'll sit in the waiting room like other patients.

According to Lindstrom, most of the time, celebrity patients are "very nice, very respectful," and he considers taking care of them a privilege. "You feel good when you know you operated on someone who's an all-star in their specialty," he says, "and then they're able to continue to perform around the world in their chosen profession, singing or playing sports, or whatever they do. That comes with a great deal of satisfaction." **MM**

Kate Ledger is a St. Paul freelance writer.



MMA goes head on against medication prior authorization

BY DAN HAUSER

The MMA is taking an aggressive stance toward fixing prior authorization (PA) for medications this legislative session.

Working with authors from both parties in the House and Senate, the MMA introduced legislation in mid-February that would completely change the process. The chief Senate author is Melisa Franzen (DFL-Edina); the chief House author is Tony Albright (R-Prior Lake).

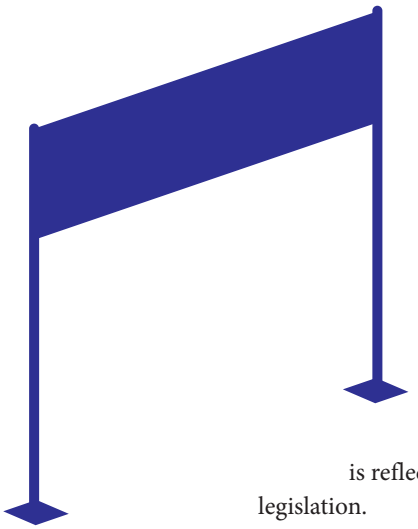
The legislation would end prior authorization for most drugs and instead permit insurers to conduct retrospective reviews of prescriptions for purposes of quality improvement. PA could still be required for medications that are not on a health plan's formulary.

The legislation also would:

- Require insurers to provide consumers with information about medication coverage and cost-sharing prior to their purchasing insurance
- Limit the type and frequency of formulary changes a health plan can make during the enrollment year
- Create a 60-day transition period for patients changing insurance plans to prevent gaps in their access to medications.

In addition, the MMA-backed legislation calls for creating a task force to monitor trends in medication coverage and formulary design. It also would mandate use of Minnesota's existing prior authorization and formulary exception form, and require health plans to provide better information to prescribers about covered alternatives when an initial prescription is denied and make decisions about coverage faster.

The MMA launched its work on medication PA in earnest in June 2013. Member George Schoephoerster, MD, led this effort, talking with a variety of physicians and clinic administrators to gather their PA "horror stories." The MMA tried to work with the health plans to improve the PA process but met with resistance. A task force was formed in 2014; it provided recommendations to the Board of Trustees in January. The board opted for the most aggressive stance, which is reflected in the proposed legislation.



The MMA continues to gather stories about problems with PA at www.mnmed.org/PriorAuth and has created a website to provide a quick overview of the issue and share physician and patient stories, www.fixPAnow.com. Physicians are also encouraged to use the hashtag #fixPAnow and tweet their feelings about PA.

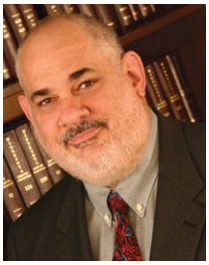
For an in-depth look at the issue, read "The prior authorization burden" (p. 18) in the November/December 2014 edition of *Minnesota Medicine*.

Donald Jacobs, MD

Barbara Daiker

Eric Dick

Mandy Rubenstein



Robert Meiches, MD

Dave Renner

MMA in Action

In late January, MMA President **Donald Jacobs**, MD, and **Barbara Daiker**, MMA manager of quality, spoke on "Physician Collaboration: Meeting the Challenges of Modern Medicine" at New Ulm Medical Center.

Eric Dick, manager of state legislative affairs, and **Mandy Rubenstein**, manager of physician outreach, traveled to Fergus Falls in January to provide a legislative update to physicians at Lake Region Health Care. Dick shared the MMA's 2015 legislative priorities and gave an update on what's happening with those issues. Dick also gave a legislative update, focusing on issues of interest to ENTs, at the Minnesota Academy of Otolaryngology's winter meeting in Minneapolis in late January.

MMA members **John Abenstein**, MD, **Maya Babu**, MD, MMA CEO **Robert Meiches**, MD, and **Dave Renner**, director of state and federal legislation, attended the AMA's Advocacy Resource Center State Legislative Strategy Conference in New Orleans in January. The conference, which attracts more than 200 physician leaders and medical society staffers, offers participants an opportunity to share their states' legislative priorities with other state medical societies.

MMA Board Chair **Douglas Wood**, MD, testified before the House Health and Human Services Reform Committee in late January to highlight the MMA's key legislative priorities for the session.

Will Nicholson, MD, testified before the Senate Health and Human Services Finance Division in early February regarding Gov. Mark Dayton's budget recommendations. He made a plea for increased loan forgiveness funding for physicians willing to work in underserved parts of the state and for reinstating the Medical Assistance payment increase for primary care services. The following week, **Donald Jacobs**, MD, testified on the same issues before the House HHS committee.

MMA and Board of Medical Practice member **Jon Thomas**, MD, and MMA staffer **Teresa Knoedler**, JD, testified on behalf of interstate licensure compact legislation in February.

News Briefs

State to study medical cannabis use for intractable pain

A Minnesota Department of Health advisory committee is examining the issue of intractable pain and whether it should be added to the list of conditions eligible for inclusion in the state's medical cannabis program. The committee, which includes two physicians with expertise in pain and a primary care physician, will meet throughout 2015. The current list of conditions in the state's program are: cancer; glaucoma; HIV or AIDS; Tourette's syndrome; ALS; seizures, including those characteristic of epilepsy; severe and persistent muscle spasms, including those characteristic of multiple sclerosis; Crohn's disease; and terminal illness with a probable life expectancy of less than one year. Legislation passed last session requires that a study be conducted before conditions are added to the list.

Upcoming MMA Events

Event	Date	Location
"Cannabis conversation: What physicians need to know"	March 31 6 to 8 p.m.	University of Minnesota Continuing Education and Conference Center, St. Paul Campus
Policy Council health policy conference	April 25 9 a.m. to 4 p.m.	DoubleTree by Hilton Hotel Bloomington-Minneapolis South

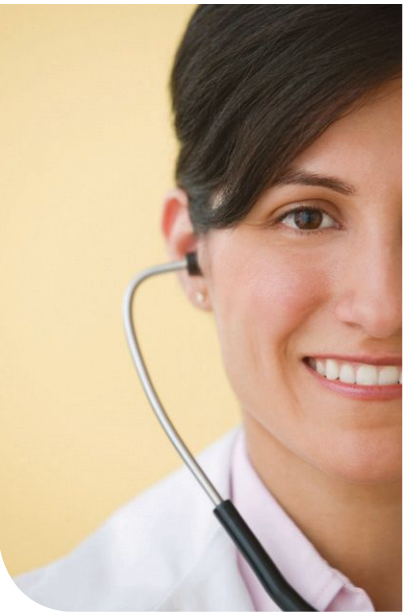
Check the MMA's website (www.mnmed.org/events) for more information and to register.

Department of Health releases report on physician workforce

The Minnesota Department of Health's Office of Rural Health and Primary Care has released a report on Minnesota's physician workforce in 2013-2014. Data from the report comes from the Board of Medical Practice and a 2013 Minnesota Department of Health Physician Workforce Survey. A few findings from the report: There are 21,669 physicians with active Minnesota licenses;

14,977 of those physicians reported a Minnesota address as their primary business location; 30.7 percent went to medical school in Minnesota; and 29.2 percent work more than 56 hours a week.

Immigrant docs underutilized in Minnesota



A task force convened by the Minnesota Department of Health at the request of the Legislature has released a report that recommends the state better utilize foreign-trained immigrant physicians, many of whom came here as refugees.

The 15-member task force, chaired by MMA member Edwin Bogonko, MD, is asking the state to take the lead on addressing barriers that prevent those experienced physicians from practicing in the United States. Among the task force's findings:

- Minnesota is currently home to an estimated 250 to 400 unlicensed immigrant physicians. Most of those physicians are trained as primary care providers.
- Integrating more immigrant physicians could result in significant cost savings to the state, including reducing costs associ-

ated with preventable hospitalizations and treatment of chronic disease. One study suggests Minnesota could save more than $63 million by tapping those foreign-trained physicians to serve in areas designated as medically underserved.

Health disparities report released by state

A new, first-of-its-kind report released by MN Community Measurement in January shows great health disparities across the state. The "Health Equity of Care Report: Stratification of Health Care Performance Results in Minnesota by Race, Hispanic Ethnicity, Preferred Language and Country of Origin" includes data collected from patients seen in medical groups throughout the state and evaluates health care outcomes in the following areas: optimal diabetes care, optimal vascular care, optimal asthma care for adults, optimal asthma care for children and colorectal cancer screening.

Smoking rates trend downward; e-cigarette use troublesome

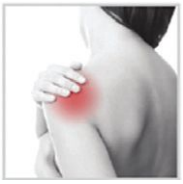
Minnesota's adult smoking rate is the lowest in the state's recorded history, and many of those surveyed cite the increased tobacco tax as their main reason for quitting, according to the latest Minnesota Adult Tobacco Survey, conducted by ClearWay Minnesota

and the Minnesota Department of Health. Around 580,000 Minnesota adults (14.4 percent) still smoke, a significant decrease since the last study in 2010. However, the survey found that the percentage of Minnesota adults using e-cigarettes at least once in the past 30 days during 2014 was up to 5.9 percent. In 2010, that figure was 0.7 percent.

APCD gets its first workout

An examination of the state's all-payer claims database (APCD) has revealed that about 83,000 Minnesotans received chronic pain procedures each year between 2010 and 2012, according to the Minnesota Department of Health. The report, released in January, does not estimate the cost of chronic pain care in the state, but further analysis of the APCD could provide that information. The analysis found back disorders were responsible for the highest volume of chronic pain procedures.

Lecture series/CME on pain, opioid addiction now online



As part of its efforts to fight prescription opioid misuse, the MMA is partnering with the Steve Rummler Hope Foundation and the University of Minnesota Medical School to offer a lecture series on pain, opioids and addiction. The series is available to medical students, residents and practicing physicians. CME is available. Visit www.mnmed.org/painseries for more details.

MMA Legislative Priority	Status at the Capitol
Prior authorization	Bills in both the House (HF 1060) and Senate (SF 934) were introduced in mid-February.
Reinstate Medicaid payments	The MMA has testified before various committees to request that lawmakers fund Medicaid payments at Medicare levels.
Primary care loan forgiveness	Bills have been introduced (SF 3 and HF 211) and are working their way through committee hearings.
Interstate licensure	Bills have been introduced (SF 253 and HF 321) and are working their way through committee hearings.
Reducing nicotine's harm	At press time, the MMA was still trying to find legislators to carry bills that would place more restrictions on e-cigarettes.
Repeal the provider tax	No legislation has been proposed so far this session that would derail the scheduled repeal.

VIEWPOINT

We need to fix PA now

Douglas Wood, MD
MMA Board Chair

Medicine has become more complex and costly given advances in imaging technology, development of implantable devices and the advent of new drugs. Prior authorization (PA) is a technique used by health plans and payers to help control some of the costs of these innovations. Controlling costs is a laudable goal. However, the processes for obtaining medication PA are widely variable and complex, and decisions often are not based on medical evidence.

In fact, a task force convened by the MMA to study the issue found that of the approximately 1,036 medications requiring advance approval by six Minnesota health plans, only six were on all of the lists. This suggests something other than science is determining which drugs health plans will pay for.

Prior authorization adds considerable burden and cost for physicians and pharmacists, as well as administrative expense for health plans and payers. More troublesome is the fact that PA creates needless worry and, in some cases, harm for patients.

The MMA initially attempted to work with the health plan community to address the wide variation in PA practices, but we faced significant resistance. In January, the Board of Trustees voted to seek a legislative solution to the problems related to PA and health plan prescription drug coverage. In particular, the MMA is looking to shift from PA to a quality-improvement activity that retrospectively identifies and reviews prescribing practices that fall outside the norm.

According to data from the Minnesota Council of Health Plans, between 76 and 86 percent of initial PA requests are approved. Wouldn't it be a better use of time and resources to focus on the outliers rather than needlessly forcing the overwhelming majority of prescribers to jump through complex hoops?

The MMA is also looking to apply some commonsense requirements in Minnesota such as requiring payers to disclose in advance which drugs they cover and what the patients' share of the cost for those drugs will be; limiting the frequency of formulary changes; and providing patients with a 60-day supply of a drug to accommodate changes to a formulary or transition to a new health plan.

Physicians have the enormous responsibility to prescribe the most clinically and cost-effective medications for their patients. Yet most payers make it extremely difficult for them to know which medications are covered and to what extent patients must share in the cost. And because of the differing rebates and discounts that an individual payer might negotiate with drug manufacturers, the least-expensive drug for a patient covered by one payer is likely to be different from the least-expensive drug covered by another.

I am optimistic that we can find a solution to the PA problem that will benefit everyone—one that will result in a process that is less onerous for physicians, less disruptive to patient care and more cost-effective for insurers. Patients deserve to have clear and accurate information about the medications that will be covered under their insurance policy; they deserve to have those medications covered for the term of their policy; and they deserve to have their medications uninterrupted if their condition is well-managed. And physicians deserve to have their medical expertise and clinical knowledge recognized.

Prior authorization adds considerable burden and cost for physicians and pharmacists, as well as administrative expense for health plans and payers.

HOW TO BE HEARD

It's easy to bring your issues to the MMA

STEP 1

Share your idea *through one of these nine channels:*

- ☑ LETTER TO THE MMA
- ☑ EMAIL
- ☑ CALL THE MMA
- ☑ MMA WEBSITE
- ☑ LISTENING SESSION AT YOUR CLINIC
- ☑ POLICY COUNCIL OPEN-ISSUE FORUM
- ☑ CLINIC VISITS
- ☑ SPECIALTY SOCIETIES
- ☑ COMPONENT MEDICAL SOCIETIES

UPON RECEIPT, YOUR ISSUE PROCEEDS TO STEP 2

STEP 2

Issues are triaged.

- ☑ BROAD IMPACT ON MINNESOTA PHYSICIANS?
- ☑ WITHIN MMA'S ABILITIES/ EXPERTISE?
- ☑ LEGALLY PERMISSIBLE?
- ☑ FURTHER INFORMATION NEEDED?
- ☑ ALIGNED WITH MMA'S MISSION?

ISSUES WITH THE HIGHEST IMPACT MOVE TO STEP 3

STEP 3

Issues are considered through one of these three forums:

- ☑ POLICY COUNCIL
- ☑ STANDING COMMITTEES
- ☑ TASK FORCES

IF ONE OF THESE GROUPS ACTS ON YOUR ISSUE, IT PROCEEDS TO STEP 4

STEP 4

Last step! Issues are acted upon by the Board of Trustees.

- ☑ BOARD OF TRUSTEES

ADOPTED IDEAS BECOME MMA POLICY

NEW POLICY!

SHARING YOUR ISSUE MADE A DIFFERENCE!

Coming to grips with an end

In his new book on his father's final days, Atul Gawande unravels why our health care system so often misses the mark for patients at the end of their lives.

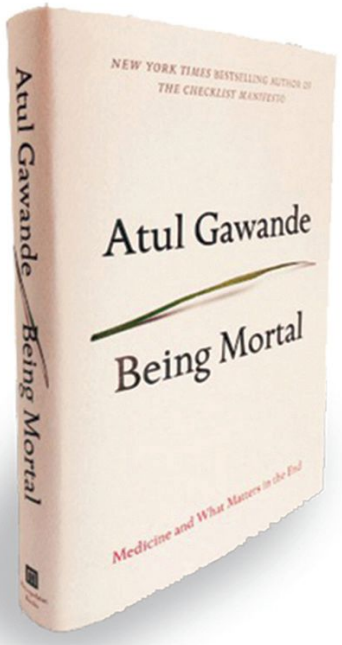
REVIEW BY CHARLES R. MEYER, MD

"What should I do with mom?" The daughter's voice was urgent, almost pleading. Her 90-year-old mother had been admitted to the hospital with a bowel obstruction. Having weathered lung cancer with what proved to be curative radiation 10 years before, her strong-willed mother insisted that she had seen the last of aggressive medical care as she settled into her self-imposed vigil, waiting for her own death. On her rare visits to my office, she reiterated, "I don't know why I'm alive." So now she had an unrelenting bowel obstruction, resistant to medical therapy. Her choice was surgery or hospice. She looked at the surgeons circling her bed and said "no." She was sure about her choice; her daughter wasn't.

Physicians today need to decide about doing things to people at ages unimagined 30 years ago. Those decisions involve not only the precise medical calculus of determining the right treatment for a given disease but also the slipperier consideration of what is right for the old elderly. That is the conundrum tackled by surgeon and *New Yorker* contributor Atul Gawande in his recent book *Being Mortal.*

Gawande looks at America's care of the elderly in their waning years and finds it wanting. Scientifically trained physicians encounter dilemmas like my 90-year-old patient and try to fix the medical problems only to find that the larger issues are unfixable. "For a clinician, therefore, nothing is more threatening to who you think you are than a patient with a problem you cannot solve," Gawande writes. We can't fix mortality, but modern medicine tries. Gawande terms this approach "making mortality a medical experience" and points out "it is just decades old. It is young. And the evidence is it is failing."

Gawande argues that the ice-pick view of a patient as a medical problem without social or psychological considerations leads to care that results in the "waning days of our lives … given over to treatments that addle our brains and sap our bodies for a sliver's chance of benefit. They are spent in institutions—nursing homes and intensive care units—where regimented, anonymous routines cut us off from all the things that matter to us in life."



Being Mortal: Medicine and What Matters in the End, Atul Gawande, Metropolitan Books, 2014

In addition to recounting numerous stories of his own patients, Gawande's analysis most poignantly contrasts the final days of his grandfather and his father. A farmer in a small town in India, his grandfather lived to 100. In his later years he became infirm, walking with a cane and giving up his work in the fields. Rather than suffering the American solution of nursing home placement, he was surrounded by a large extended family that cared for him until his death. Modernization in American society, according to Gawande, has not demoted the elderly. "It demoted the family. It gave people—the young and the old—a way of life with more liberty and control, including the liberty to be less beholden to other generations. The veneration of elders may be gone, but not because it has been replaced by veneration of youth. It's been replaced by veneration of the independent self." Without a family cocoon, "our elderly are left with a controlled and supervised institutional existence, a medically designed answer to unfixable problems, a life designed to be safe but empty of anything they care about."

In Gawande's opinion, our health care system needs to be redesigned, not only because it costs too much but also because it doesn't provide humane solutions to end-of-life problems. Our challenge, he says, is to "build a health care system that will actually help people achieve what's most important to them at the end of their lives." And he confronted that challenge when his father neared the end.

A vital, athletic surgeon practicing into his 70s in Athens, Ohio, Gawande's father, Atmaram, began having weakness and numbness in his extremities. Evaluation revealed a cervical spinal astrocytoma. The diagnosis triggered a cascade of difficult decisions over the ensuing years—surgery, radiation, chemo, hospice and whether to treat pneumonia at the end. Each decision involved the complex interplay between

Gawande's father, the family and Gawande. None of the decisions were clear-cut, and Gawande does a masterful job of painting the uncertainties they encountered and the unpredictability that bedeviled even a medically trained mind like his. He concludes, "At root, the debate is about what mistakes we fear most—the mistake of prolonging suffering or the mistake of shortening valued life." He and his family recurrently asked whether the father was, at the end, sensing that further treatment was futile but fearing "the mistake that loomed largest … the possibility of failing to preserve his life long enough."

His father's death was neither tidy nor idyllic. Deaths rarely are. But Gawande hopes we can change our health care system to ease the last days of patients' lives. Achieving that goal requires acknowledging our human limits. "Being mortal is about the struggle to cope with the constraints of our biology, with the limits set by genes and cells and flesh and bone," he writes. "Medical science has given us remarkable power to push against these limits, and the potential value of this power was a central reason I became a doctor. But again and again, I have seen the damage we in medicine do when we fail to acknowledge that such power is finite and always will be." Finding where the finite stops is a hazardous journey that must be informed both by medical training and the sage voices of the patient and family. **MM**

Charles Meyer is editor in chief of *Minnesota Medicine*.

Call for Papers

Minnesota Medicine invites contributions (essays, poetry, commentaries, clinical updates) on these and other topics:

Emergency medicine
Articles due March 20

Privacy and medicine
Articles due April 20

Medicine and the arts
Articles due May 20

Dreaded diagnoses
Articles due June 22

Manuscripts and a cover letter can be sent to cpeota@mnmed.org. For more information, go to www.minnesotamedicine.com or call Carmen Peota at 612-362-3724.

Call for Entries

Minnesota Medicine's Annual Writing and Photo Contests

Write on!

Have a story about a patient who touched your heart, an experience that changed your perspective or a mentor who influenced your life that you want to share? Do you write poetry? Essays? Enter your work in *Minnesota Medicine*'s "Medical Musings" writing contest.

DEADLINE:
May 4, 2015

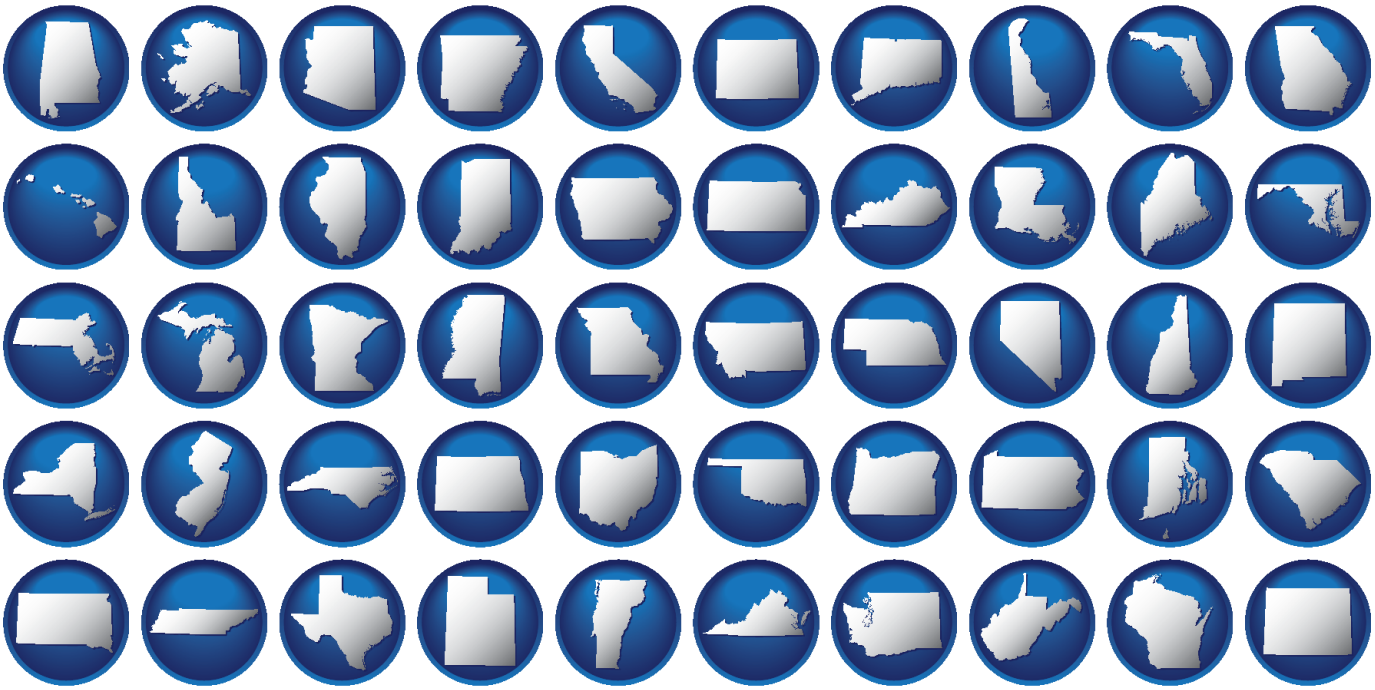
Capture a moment.

Taken a photo that tells a story? Or reveals the beauty or drama of a place and time? Enter it in *Minnesota Medicine*'s photography contest.

The contest is open to practicing and retired physicians in Minnesota, physicians in Minnesota residency programs and students in Minnesota medical schools. The best submissions will be published in the July 2015 issue of *Minnesota Medicine*.

For more information or to enter go to:
www.MinnesotaMedicine.com/Contests.

DEADLINE: May 11, 2015



Medical licensure and the changing world

An interstate compact could expedite things for physicians who wish to be licensed in other states.

BY TERESA KNOEDLER, JD

In order to treat a patient, a physician must be licensed in the state where the patient is located. A number of factors are making it desirable—and at times necessary—for some physicians to seek licensure in more than one state. For example, a physician may work in a practice that has clinics on either side of a state's border or practice in a large multi-state system that wants its professionals to collaborate. In addition, a physician with a telemedicine practice who wishes to care for patients across state lines will need to be licensed in the states where those patients are located.

Currently, a physician wishing to be licensed in a particular state must apply to that state's medical board and go through its licensure process. It often takes months before a license is granted. This can be challenging and frustrating for physicians and delay care for patients.

In an effort to address these concerns, the Federation of State Medical Boards (FSMB), which represents the 70 state medical boards for allopathic and osteopathic physicians in the United States, conceived of a way to expedite the licensure process. In 2014, it drafted language that would create an interstate medical licensure compact. The compact would permit qualified physicians to obtain expedited licensure in member states. As of early February, more than 25 states have begun the process of joining the compact. Minnesota is one of them.

About the proposal

Interstate compacts are contracts between states that permit them to collaborate without the federal government's involvement. They are voluntary and are com-

Underlying principles of the proposed interstate medical licensure compact

- Participation creates another pathway for state licensure but does not otherwise change a state's existing Medical Practice Act.
- Regulatory and disciplinary authority will remain with the participating states' medical boards and will not be delegated to any entity that would administer a compact.
- A physician practicing under a license obtained through the interstate compact will comply with the statutes, rules and regulations of the compact state where he or she chooses to practice.
- State boards participating in an interstate compact are required to share complaints and investigative information with each other.
- If a physician's license is revoked by any of the compact states, it will be immediately revoked by all other member states for at least 90 days.

monly used to address border issues such as water rights and conservation practices. The interstate compact that directly affects most of us is the Driver License Compact, which provides for the portability of a state driver's license and permits some limited sharing of driving-related information among states. An interstate compact can, in theory, be almost any legal agreement between two or more states, and the states involved must agree to the contract in order for it to take effect.

The proposed interstate medical licensure compact would become effective once seven states have passed legislation adopting it. As of early February, compact legislation had been introduced in 10 states, including Minnesota.

Thus far, the idea has received broad support in Minnesota. The Minnesota Medical Association, Minnesota Hospital Association, the Minnesota Board of Medical Practice, many large clinics and hospital systems, and several specialty societies have all endorsed the compact.

Several of the states that have introduced legislation are moving quickly to pass it, making it likely that the seven-state threshold needed to establish the compact will be met in 2015. (States may continue to join the compact after it is formed.)

Once the compact is established, a commission composed of two representatives from each member state will be formed to administer it. The commission's duties include making rules to bring specificity to compact processes, providing resources to physicians who are interested in gaining expedited licensure, and providing education about the compact.

Gaining expedited licensure

In order to obtain expedited licensure in compact member states, a physician would have to get licensed in his or her home state in the "traditional" way (in accordance with the requirements of the state's medical board). In most states, he or she would have to:

- Have graduated from an accredited medical or osteopathic school
- Have successfully passed the USMLE or COMLEX-USA exam in fewer than three tries
- Have successfully completed a graduate medical education program (internship, residency, fellowship)
- Hold a specialty certification or a time-unlimited certificate
- Hold a full, unrestricted license from a member state
- Have no criminal record
- Have not been disciplined by any state medical licensing board
- Have not been disciplined for any action relating to controlled substances
- Not be under active investigation by any agency.

The FSMB estimates that approximately 80 percent of all physicians in the United States meet these qualifications.

The physician then would proceed through the interstate compact process and be granted or denied compact status. Most likely, the physician's "home state" medical board will have to provide the commission with documentation of the physician's qualifications. The commission will review that documentation and verify that the physician meets the standards for expedited licensure. If eligible, the physician will then let the commission know which member state licenses he or she wants, and the commission will facilitate communication between the physician and the member states. (Physicians would be able to request licensure in more than one member state.) Ultimately, the member state from which the physician seeks licensure will issue a license directly to the physician.

For physicians who go through the expedited process, licensure will take days or weeks rather than months and require less paperwork. The commission will help physicians who are licensed through the compact manage the administrative details of maintaining multiple licenses by making sure they meet the CME and other necessary requirements and by coordinating the reapplication process and payment of renewal fees.

For physicians who go through the new process, licensure will take days or weeks rather than months.

Conclusion

Because of concerns about professional integrity and public safety, medical licensure must remain state-based. Yet as health care evolves, the need for licensure in multiple states has increased. The interstate medical licensure compact is an elegant solution to a problem that affects many physicians. If Minnesota joins the compact, physicians in the state will have a faster, more efficient option for obtaining licensure in multiple states. **MM**

Teresa Knoedler is the MMA's policy counsel.

Toward safer EHR use and documentation

Tips for reducing malpractice risk

BY TRISH LUGTU, BS, CPHIMS, CHP

The launch of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs in 2009 triggered a surge of health information technology implementations, most of which were undertaken with little consideration of their potential to contribute to malpractice risk. When designing EHR systems, vendors remained neutral on risk management practices in order to avoid liability. This left physicians vulnerable. Predictably, technology-related safety events have occurred, and management of technology-related malpractice risk has emerged as a concern.

In the years since the launch of the incentive programs, we have amassed a growing base of EHR-related malpractice claims data. Analysis of that data is yielding lessons that will help physicians produce better EHR documentation and more effectively manage risk related to health information technology.

A sea change in medical practice

It is important to understand that the EHR is more than just a tool for documentation. The EHR-enabled medical practice represents a "huge change in the way health care is delivered," according to Dean F. Sittig, PhD, a professor in the School of Biomedical Informatics at the University of Texas Health Science Center at Houston.[1] EHRs enable clinicians to communicate with each other about patients and to view patient data in ways that can affect the quality of care as well as the way in which they work.

Sittig describes EHR-enabled health care as having a number of components, only some of which are technical in nature but all of which must be managed in order to avoid negative consequences. Thus, in designing an EHR system, it is essential to not only consider technical concerns but also how people will interface with the technology and how it will affect workflow, care, policies and procedures.

A recent example that shows how problems can arise as a result of these factors not being well-managed was the missed Ebola diagnosis at Texas Health Presbyterian Hospital in Dallas last fall. When Thomas Duncan was admitted to the emergency department, a nurse recorded his recent travel to West Africa. But the workflow was not configured so that this crucial information was communicated to other clinicians caring for him. This delayed Duncan's diagnosis and treatment. One wonders if the outcome would have been different had risk managers, clinicians and health IT staff considered both the human and the technical factors in the initial EHR design.

Although this story made the national news, many more remain out of the spotlight. Claims analysis is uncovering more and more evidence on the risks generated by EHRs. One study by Boston-based CRICO Strategies, a division of the Risk Management Foundation of Harvard Medical Institutions, involved analysis of 147 malpractice claims in which the use of EHRs was a contributing factor.[2] In 9% of those claims, the problem was attributed to "failure of system design"—much like what occurred in the case of Thomas Duncan.

Making EHR documentation safer

The EHR may have introduced compelling new ways to manage patient health; however, it is primarily used to document the care that is delivered. Documentation deficiencies (lack of consistency, coordination, accuracy, timeliness and objectivity) can lead to significant consequences including patient injury. And many malpractice cases hinge on these deficiencies, as the medical record is the primary source of evidence used to determine whether a physician or health care facility is liable for malpractice. Our experts estimate that the defense of 35 to 40 percent of malpractice claims filed is jeopardized by documentation problems within the medical record.

Faulty data entry is alarmingly common. In a study of EHR documentation in the Veterans Affairs health system, 84 percent of progress notes analyzed contained at least one documentation error; on average, the notes contained 7.8 documentation errors.[3] However, not all errors are created equal. Through analysis of

malpractice claims data, *incorrect information* was found in 20 percent of all cases studied, making it the leading EHR-related risk factor.[2] Adding to the risk is the proliferation of EHR data—whether accurate or not. Copies of information exist in backups, patient portals and other clinical systems. To avoid the risk of incorrect information finding its way into the EHR, consider these best practices:

Double-check information. In the CRICO analysis, faulty data entry led to the selection of incorrect units that distorted dosing calculations; unanticipated autoconversion of numbers (eg, 2.5 becomes 25); and information being entered into the wrong patient record when the user accidently opens the wrong file. Although template design can reduce the likelihood of faulty data entry, even with all their checks and balances, EHRs simply do not eliminate human error. Therefore, double-checking remains the best defense.

Avoid pre-populating templates. A significant contributor to incorrect information is pre-populated workflow templates—ie, templates that default patient assessments to "normal" or which require clinicians to "uncheck" normal findings. Such templates have high potential not only for contributing to diagnostic errors but also to billing fraud, as every system marked "normal" may not actually have been assessed.

Avoid cut-and-paste/copy forward. Although this function may seem like a great timesaver, it can contribute to incorrect information proliferating across many notes and even across other systems as records are exchanged. Use of the cut-and-paste or copy-forward functions should be limited to demographic information only. Do not cut and paste information that has not been independently obtained or verified, as patients' histories and recollections may change depending on who is asking the questions, how questions are asked, the patient's pain or anxiety levels, their current medications, and the presence of family members at the time of questioning.

Be cautious when amending documentation. Amendments describe a range of alterations that are intended to clarify information. The processes for amending documentation are more complex with EHRs than with scanned, imported or transcribed notes, as the nuances are captured behind the scenes in metadata, which increases the importance of clarifying how each is defined. The following definitions of amendment types are adapted from the American Health Information Management Association's Amendments in the Electronic Health Record Toolkit:[4]

- **Addendums.** An addendum is used to add information to a completed entry. Methods to attach or connect addendums to an original document depend on the EHR's capabilities, so it is important to design them so they are visible and to implement processes for filing and viewing them. Addendums must include the date of documentation and be completed according to your organization's documentation completion policy. (Each practice must have documented processes for completing an entry and define when an entry is completed.)
- **Corrections.** Corrections are intended to fix an inaccuracy in an entry. Information may be corrected before or after an entry is completed. Your organization's policies should specify the procedure for making corrections to a completed entry and identify who is allowed to make such corrections. When correcting comingled records (moving an entry from one patient to another), steps must be taken to avoid a privacy breach. For example, simply striking through misplaced patient information is not sufficient enough to hide it and prevent unauthorized disclosures.
- **Retractions.** Retractions are used to correct invalid information or documentation made in error by hiding it from general viewing. Keep in mind, the original information remains archived and is not completely erased from the system. It is crucial to be able to hide incorrect information that may lead to an inappropriate medical judgment.
- **Deletions.** Deletions completely eliminate information from an EHR. Only with some EHRs is it possible to perform true deletions. If at all possible, deletions should be avoided. If they are allowed, your practice should have a clear policy about when they can be used; monitor and audit their use; document them in a log outside of the EHR; and control who is able to perform deletions.
- **Late entries.** Late entries relate to an original entry but are created at a later date. Late entries also may be defined by type of documentation, such as direct template entry outside the point of care. It is important to clarify when a late entry must be included as an addendum.

Final considerations

Electronic health records have changed the way physicians and other clinicians work. However, they are primarily used to document the care doctors, nurses and others provide. In the end, when memories fade, it is this documentation that physicians rely on to manage a patient's health. That same documentation is what stands in your defense of a medical malpractice claim or lawsuit. It is ultimately the physician's responsibility to understand the ins and outs of the documentation their EHR creates, along with the risks that come with poor-quality documentation. Remember, it is your signature, albeit digital, that completes the entry. **MM**

Trish Lugtu is associate director of research for MMIC's Patient Safety Solutions team.

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Medicare Annual Wellness Visits

Understanding the Patient and Physician Perspective

BY MARY SUE BERAN, MD, MPH, AND CHERYL CRAFT, RN

Since 2011, Medicare has covered annual wellness visits (AWVs), yet few who are eligible for this benefit take advantage of it. To better understand why, we interviewed physicians and patients within our St. Louis Park-based health system. The interview questions were designed to identify physicians' and patients' perceptions of the value of the AWV and reasons people don't take advantage of this Medicare benefit. This article presents the results of this qualitative study and offers strategies health care organizations can adopt to promote more effective, consistent use of AWVs. These strategies include standardizing policies regarding the AWV across the organization and incorporating them into team care.

Several types of wellness visits are available at no cost to Medicare beneficiaries. Since 2005, Medicare has covered a one-time "Welcome to Medicare" visit that includes measurement of weight, blood pressure and BMI; a review of medical and family history; education and counseling about preventive services/screenings; and end-of-life counseling. Since 2011, Medicare has covered annual wellness visits (AWVs).[1] The purpose of these visits is to update the patient's medical history; screen for common problems such as risk for falls, depression and cognitive impairment; and discuss prevention recommendations.

Coverage for Medicare wellness visits affords clinicians and patients an opportunity to make preventive care a priority. In the Medicare population, prevention is often overshadowed by acute concerns and chronic health problems.

Although these visits are free, they are underutilized.[1,2] This is most often the case among Medicare fee-for-service enrollees. Their usage rates for the annual preventive care visits are 10 to 20 percentage points below those for patients with private coverage or who have coverage through a Medicare HMO.[2] In a 2012 John A. Hartford Foundation survey, 68% of patients age 65 years and older had not heard of the AWV, and only 17% had received an AWV.[3] That percentage may be high, as the Centers for Medicare and Medicaid Services 2012 Medicare Current Beneficiary Survey (MCBS) indicates that only 8.8% of Medicare patients had received an AWV.[4]

There are several possible reasons for the underutilization. One is that many patients are simply unaware that Medicare provides coverage for preventive care.[5] Other possible reasons are that patients lack understanding about what these visits include and don't perceive them as being valuable,[4] as acute problems tend to take priority over preventive care. In addition, some seniors pay extra for insurance that covers a "yearly physical," so they may not feel they need a Medicare wellness visit. The MCBS findings also revealed regional variation in perceptions about the value of these visits, indicating that local marketing of the AWVs may influence utilization rates.[4]

Physicians may be partially responsible for the underutilization of these visits. Little is known about physicians' perspective on Medicare wellness visits, but some non-peer-reviewed articles suggest they may be uncertain about what to cover in the wellness visit and how to bill for it.[6] They may undervalue the visit because it does not address acute issues or chronic diseases. Time constraints in the office also may keep patients and clinicians from talking about scheduling these visits.[7-9]

To better understand why patients are not taking advantage of the AWV benefit, we interviewed patients and physicians within a Minneapolis-based nonprofit, integrated health care system that was designated one of the 23 Pioneer Accountable Care Organizations.[10] The interviews were conducted between August and October 2013. In 2013, the system saw 72,673 Medicare patients but billed only 1,867 visits as AWVs.

Our study aimed to answer the following questions:

- Do patients value AWVs?
- Do physicians value AWVs?
- What are the barriers to Medicare patients utilizing AWVs?
- What are the barriers to physicians encouraging the use of Medicare AWVs?

- What are physicians' thoughts on having registered nurses (RNs) perform AWVs?

Our main hypothesis was that patients' lack of awareness is the primary reason why they do not receive wellness visits for which they are eligible. We also hypothesized that physicians undervalue these visits as compared with traditional office visits.

Methodology

We used a mixed-method approach to survey patients and physicians. The study was approved by our health system's Institutional Review Board.

Patients

We identified all patients within our system who had undergone a Medicare AWV within a seven-day period, as determined by billing codes G0438 (initial Medicare Annual Wellness Visit) and G0439 (subsequent Medicare AWV). Between August and September 2013, we identified patients who received an AWV during the preceding week. From this list, we conducted two to three telephone interviews per week, on average, for a total of 20 patient interviews. We attempted to identify patients of various physicians from multiple clinic sites within the organization. We reviewed physician documentation of the visit prior to conducting the interview. The telephone interviews lasted 10 to 15 minutes and were semi-structured with questions about their recent AWV. Verbal informed consent was obtained.

Clinicians

We identified all primary care physicians in the health system who had performed AWVs in 2012. From this list, our team identified 10 physicians based on clinic site and volume of AWVs (range eight to 209 total per physician). Physicians with higher volumes of AWVs and those with recent visits (within the last six months) were given priority consideration for participation. Physicians were invited by email to take part in a 20- to 30-minute in-person interview. They received a $50 monetary incentive for participating and were offered a small snack or meal if the interview was done during mealtime. Our team interviewed a total of eight physicians and one nurse practitioner. (Two physicians did not respond to the email request.)

All interviews were conducted by two members of the research staff. Each interview was taped and transcribed. The researchers identified and reached consensus on themes in the transcripts.

Results

Our survey yielded the following findings, with regard to the study's primary aims.

Do patients value Medicare AWVs?

Patients' perceptions about the value of the AWV varied widely. Most said they had an agenda for the visit that was broader than reviewing and discussing preventive care. They often requested medication refills and wanted to review chronic problems or discuss new concerns during these visits. Patients found the visit less valuable if their agenda was not incorporated into it. We repeatedly heard that patients valued having time to discuss their health with their doctor. However, they perceived their health agenda/concerns as being of greater importance than discussions about routine prevention.

Here are some of the questions we asked and the patients' responses:

Did you schedule this visit as a regular physical or was it scheduled as an Annual Wellness Visit?

When I called to schedule this visit I asked for a yearly check-up. I needed to go over my medications because I needed new prescriptions. [The scheduler] asked me if it was the Medicare wellness visit. I guess I must have said no because she then said I would have to pay for this visit. I kind of looked at her blankly and then she said, Did I want the Medicare wellness visit and then I said, yes.

What was your understanding of what this visit would include?

… the way it was explained to me was that it was more of a talking-type visit. For the more extensive "head-to-toe" physical I would need to check with insurance, which I did. She [the phone call agent] also mentioned that I could check once I got there [at the appointment] and change my mind then if I wanted to. I was still confused as to what was the point, what is the difference. I almost cancelled, because I thought, what is the point in going? What I wanted to find out is if I am diabetic…Then I have some other problems too, blood pressure, and I thought it was time for a check.

The schedule person said it would just be a conversation with the doctor—not hands on. I didn't have to get undressed.

I don't know. When I checked in, the receptionist asked again what kind of visit [I was having]. I still didn't know. I asked the nurse and the doctor—they said they thought it should be an Annual Wellness Visit.

I received information in the mail of what they would do at the visit and a copy of the appointment time. I understood that it would include everything it said on the paperwork that I received—"a good physical." I thought it would be comparable to what I had in the past for yearly physicals.

Can you think of one or two things that would have made this visit more helpful or valuable to you?

What this visit includes should be made more clear. Medicare should let people know it's a screening visit. The scheduler should say it could be combined with another visit.

It is ridiculous that Medicare doesn't cover a physical! But it's better than nothing.

Would you schedule this type of visit again next year?

No. I felt it was wasting his [the physician's] time or taking advantage of his time. I knew that I wasn't supposed to ask about problems I was having, but I needed to ask about the pain in my feet.

Do physicians value Medicare AWVs?

Physicians said they saw value in discussing prevention with patients; however, they often felt pressure because of competing expectations for the visit—specifically, their own and those of the patient and Medicare. The boundaries between these blurred, and physicians usually ended up "doing it all" during the AWV: addressing new patient concerns, reviewing chronic problems, completing the AWV questionnaire and check list, and conducting a full physical exam. Physicians felt overwhelmed by the number of items to be covered at a visit and felt they needed to accommodate their patients' expectations for "the free Medicare visit."

Here's what some of the physicians said when asked: What are your thoughts regarding these [Medicare Annual Wellness] visits?

The AWV doesn't typically cover what they are used to having. The visits are muddy to me. Patients usually say they want what they had in the past. If they want the AWV, I sometimes cover other problems. Or we may switch to a different visit type.

If there are many problems I'd like to have them come back so that we have more time. I struggle with this conversation.

Medicare said we should focus on depression, dementia, falls, diet, exercise—things you would do anyway … ADLs, smoking. I didn't get a sense there was a huge difference from the usual preventive exam…The biggest controversy is what do patients think? What do they understand? What is it they want? The patient says they want the AWV, but then they say I want the whole physical examination.

What are the barriers to Medicare patients' utilizing AWVs?

Many patients were unaware of the Medicare AWV, even after having had such a visit. A number of patients had heard about the visit from an organizational mailing that encouraged them to schedule one. Others had called the phone center to schedule their "yearly physical" and were asked whether they instead wanted to schedule an AWV. This was often the first time patients had heard of these visits, and they seemed confused about whether to schedule one or not. Patients expressed confusion regarding which visit was most appropriate for them and implied that having some direction/guidance from their physician would be helpful.

Here's what one patient said:

The process could be less confusing. I didn't know how to ask the right questions. If a senior citizen calls for this appointment, and then just has a review of the questionnaire, does the person have to wait a whole year for another appointment? What is the process for follow-up if there is an item that needs to be looked at?

What are the barriers to physicians' encouraging use of Medicare AWVs?

Most physicians interviewed did not feel that AWVs provided additional benefit outside of what they were covering at yearly visits. The majority indicated that it was a positive step that Medicare is allocating money for preventive care for seniors, yet they found the visits confusing and often unhelpful. They expressed confusion regarding the parameters of the visit and how to incorporate additional patient expectations into the limited time allotted.

Here's what physicians said about barriers to encouraging AWVs:

Part of the problem is the mechanics and the confusion. Our front-line schedulers … knowing the difference regarding these visits. I never have confidence that if it shows up on my schedule as an Annual Wellness Visit that that is really what the patient wants. So I spend time trying to confirm that is what they really want.

Here's what they said when asked: Do you typically include an exam with this type of visit?

Yes, I do a physical exam on everyone. I found it took me 10 minutes to explain why a physical wasn't included in this visit and only five minutes to do the physical. If I don't touch someone, they feel gypped; they feel that I didn't do anything.

Well, I did the whole exam; he didn't have many medical problems. I billed as the AWV because the patient would be upset if I billed it as a preventive visits, and his insurance company wouldn't cover it. Patients are not understanding what's necessary. The concept of people getting preventive exams is pretty worthless anyway, and I have concerns about what this AWV requires of me.

Opinions on having a registered nurse do the AWV

Physicians expressed mixed feelings about having an RN perform the AWV. Some suggested promoting RN visits, but others questioned whether that idea would be well-received by patients.

Two patients had had an AWV with an RN. One patient, an older widow, found it helpful to review diet, exercise and other wellness activities. And since she knew that she was meeting with a registered nurse, she did not expect an exam, medication refills or medical problems to be addressed. The visit met her expectations.

The other was a healthy 66-year-old male. He did not find the visit helpful or a good use of his time. He said he was already doing most of the recommended lifestyle suggestions. He also informed us that his friend had had the same visit, and it had been done by his doctor. The patient was confused as to why he saw a nurse instead of a doctor.

Here's what physicians said when asked about having RNs do these visits:

[Having an RN perform the visit] seems like a no-brainer. We should take advantage of what the government wants to pay us. Encourage it, promote it, pull them in. The clinic could set up a [non-physician]

employee to go through the questions and preventive services. It's cookbook medicine; click the button.

I wouldn't have a problem with that, but I think my patients would … maybe it would be OK if it was done by my nurse whom they know. I'm not sure I see the value in having an RN do this.
We're moving to a more holistic style of medicine; I don't want to give up my interaction and preventive part of my practice with my patients. I think if we fragment patient care more, we will lose something.

I don't have a problem giving up the preventive piece. I have no lock on telling people to give up smoking or to exercise. I would like to think I would have the power to change people's behavior by suggestion, but I'm not sure I do. I don't know if I have more power of suggestion over a nurse or not.

Discussion

The Medicare AWV was rolled out more than three years ago. Yet the physicians and patients who participated in this study remain confused about its purpose. We did not analyze specifically how their confusion affected overall health outcomes. Previous research, however, has demonstrated that lack of familiarity with the components of Medicare is associated with adverse outcomes—including inability to access care effectively, delaying or avoiding care, increased reports of decline in health, multiple emergency care visits and lack of prescription medication use.[11]

In addition to the lack of understanding of the purpose of AWVs, there is confusion about what the AWV does and does not include. Patients were often unclear about what services they could expect at the visit, particularly regarding their acute or chronic medical problems. Physicians were well-informed about Medicare's criteria for the visits but seemed to struggle with whether to include chronic disease management or address acute concerns. Most physicians interviewed were going far beyond the Medicare criteria for the visit, and this appears to be a reason why they avoid recommending the AWV to eligible patients.

Because Medicare allows nonphysicians to perform the AWV, one way to better ensure their utilization is to have back-to-back paired visits, sometimes called shared medical appointments,[12] in which the RN reviews and recommends routine preventive services and the physician addresses acute and chronic medical problems. This would help clarify the boundaries of the AWV for both patients and doctors. Most of the physicians felt positive about RNs performing these visits, particularly if they were paired with a physician visit about acute and chronic medical concerns.

Our study was limited by the small number of patients who receive Medicare wellness visits as compared with the total number of Medicare patients seen throughout our organization each year. Our small sample size and qualitative study design did not allow us to generalize our results to a broader population, but our study does provide helpful insight into patients' and clinicians' thoughts regarding these visits.

Conclusion

More than ever, physicians are pressed for time during patient appointments. They often find themselves addressing multiple chronic conditions, acute concerns and psychosocial issues in one visit. This leaves little time for prevention and wellness discussions. Yet improving health, particularly the health of the aging population, is necessary if we are to ensure the sustainability of our health care system. Prevention is critical to making that happen.

We need to be creative in our efforts to work as teams and integrate prevention and wellness into patient visits. Specifically, we would like to see health care systems consider incorporating AWVs more consistently into routine care and standardizing their delivery. Having non-physicians conduct the AWV may be one way to do this, as it would enable physicians to focus their efforts on chronic disease management and acute medical concerns. **MM**

Mary Sue Beran is a clinician investigator and Cheryl Craft is a senior research clinician with Park Nicollet Health Services in Minneapolis.

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The Psychiatric Assistance Line

One Solution to the Child and Adolescent Mental Health Crisis

BY TODD ARCHBOLD, LSW, MBA

Having timely access to mental health care is critical for children with psychiatric disorders. Because there is an extreme shortage of child and adolescent psychiatrists in the United States, initial assessment and treatment of children with psychiatric disorders often occurs in the primary care setting. To increase the likelihood of positive health outcomes for these children, primary care physicians need to be better equipped to meet their mental health needs. One way is to offer them easier access to child and adolescent psychiatrists. The Psychiatric Assistance Line (PAL) is a service that does that. It allows primary care physicians and other clinicians immediate access to child and adolescent psychiatrists so they can either treat the patient in the primary care setting or refer the child to an appropriate specialist. This article describes the service and the extent to which it has been used since its inception in June of 2014.

One in five children in the United States will suffer from a diagnosable mental illness, and approximately 70 percent of them will exhibit symptoms before age 14.[1] A vast majority of these illnesses are highly treatable with appropriate evaluation and intervention. However, because there is a shortage of child and adolescent psychiatrists in this country, young people with psychiatric problems often face lengthy waits for appointments in outpatient settings or must seek care in hospital emergency rooms.

The shortage is more acute in some states than others. For example, Massachusetts has the most practitioners per 100,000 children (21.3 per 100,000), while Alaska has the fewest (3.1 per 100,000). Minnesota, which has approximately 70 board-certified child and adolescent psychiatrists (not all of whom are practicing), has one of the lowest rates, with only 5.8 per 100,000 children.[2] It is estimated that we would need 350 of these specialists to adequately meet the needs of youths in our state.

Because of the shortage of child and adolescent psychiatrists, much of the burden of providing mental health care has shifted to primary care clinicians. These clinicians are prescribing the majority of medications used to treat depression, anxiety and other mood disorders; however, many say they feel ill-equipped to manage patients with complex psychiatric illnesses.[3]

Psychiatric Consultation

Because they are on the front lines, primary care physicians tend to enjoy positive and trusting relationships with children and their families; have extensive knowledge about child development, allowing them to detect problems early; and work in settings that are not associated with the stigma of behavioral health treatment.[4] For all those reasons, primary care physicians are often in the best position to assess and treat children with behavioral health issues.

Since the early 2000s, nearly 32 states have experimented with ways to better equip primary care clinicians to care for these children. Many have designed programs to extend the reach of child and adolescent psychiatrists. The most well-known of these is the service developed by the Massachusetts Department of Mental Health in 2004. In 2010, the Minnesota Legislature authorized the Department of Human Services (DHS) to establish a similar program, the Minnesota Collaborative Psychiatric Consultation Service. The service, which was composed of five health systems (Mayo Clinic, Essentia Health, Allina Health, Sanford Health and PrairieCare), was tasked with providing 1) voluntary and mandatory consultations to primary care physicians by board-certified child and adolescent psychiatrists, 2) clinical mental health triage by a licensed clinical social worker and 3) training on the assessment and treatment of youths with mental illnesses. Services could be accessed by calling a toll-free number.

The Minnesota Collaborative Psychiatric Consultation Service operated for two years (from August 2012 to May 2014). During that time, it received nearly 1,800 phone calls from clinicians seeking advice regarding young psychiatric patients. However, the majority of calls were from physicians required by a state-funded health plan to call before prescribing a certain medication. The service also provided training in pediatric psychopharmacology to nearly 80 primary care providers statewide.[5] At the end of its initial two-year period, the members of the collaborative service did not apply for renewal of funding.

A New Model

In June 2014, PrairieCare applied for and received a grant from the Minnesota Department of Human Services to run a new service, the Psychiatric Assistance Line (PAL). The biggest difference between PAL and the Minnesota Collaborative Psychiatric Consultation Service is that physicians will not be required to contact PAL for medication authorizations.

Before launching PAL, administrators at PrairieCare informally surveyed pediatricians in the Twin Cities metro area to find out about the services they most needed when caring for patients with mental illnesses. The majority said they wanted help with psychotropic medications. Another two-thirds wanted assistance with diagnosing or assessing patients. More than 40 percent wanted help with triage and referrals to behavioral health services. About half said they had "never" or "rarely" had access to child and adolescent psychiatry services.

PAL is designed to provide clinicians with information they need to diagnose and treat young patients with mental health conditions. It is staffed Monday through Friday from 8 a.m. to 5 p.m. by a clinical social worker who has immediate access to a child and adolescent psychiatrist. The psychiatrist's role is to support the primary care physician and offer suggestions as needed. The social worker provides assistance with triage and referrals (see "How PAL Works").

How PAL Works

CASE 1

A 13-year-old female experiences anxiety and panic attacks. She is described as always having been a "worrier" and now avoids school. She is academically advanced, having skipped a grade, and is in an accelerated program. Initial trials of Prozac and Zoloft were unsuccessful. Two weeks ago, she was prescribed citalopram (20 mg) with Atarax. The patient saw a counselor for about 18 months but stopped going last summer. Now, her anxiety is worsening and she showing symptoms of OCD. The caller's main question: Should we try increasing her Zoloft to 150 mg or try another medication?

Consulting psychiatrist: Suggests restarting cognitive behavioral therapy and trying Celexa up to 40 mg, if needed. Also discusses temporarily using benzodiazepine while titrating up on the Celexa and/or using Atarax as needed and augmentation with other medications including Intuniv, Neurontin, Abilify/Seroquel or risperidone.

Social worker: Encourages the family to talk with the school about evaluation for a 504 Plan or Individualized Education Program to address the patient's problems at school. Provides information about the University of Minnesota's Anxiety Clinic.

CASE 2

An 8-year-old male with ADHD, dyslexia and anxiety has been through a number of medication trials. The patient has tried Dexedrine, Strattera and Intuniv and has been taking citalopram for a month. The parent reports that the child has "lost control" on the last three medications—yelling, screaming, etc. He has displayed those behaviors in the pediatrician's office. He has experienced similar problems at school and is currently in a setting III special education program. The caller's main questions: What should we try next? Are other services needed, if medications are unsuccessful? Should the patient see a psychiatrist?

Consulting psychiatrist: Notes reactivity to and some benefit from previous stimulant trials. Reviews multiple medication options and suggested Abilify, then revisited stimulant options. Reviews risks, side effects and benefits of low-dose Abilify or Seroquel at bedtime, then revisits using Dexedrine or an alternative stimulant.

Social worker: Suggests skills program through local counseling center and/or through special education. If medication changes are unsuccessful, will help set up psychiatry appointment.

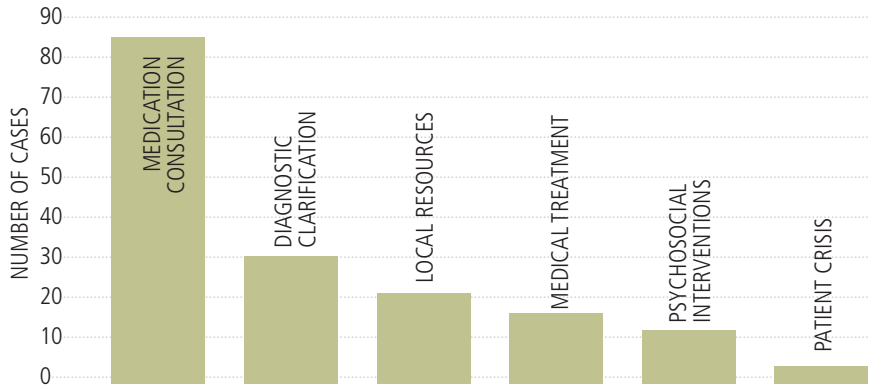
CASE 3

A 4-year-old male has been diagnosed with PTSD after multiple hospitalizations for urethral surgery. The patient just finished a month-long hospital stay and panics as soon as it gets dark. He will not sleep at night. In addition, he goes into flight mode when buckled into a car seat or high chair. Neither clonidine nor melatonin has helped. The child weighs 36 pounds and naps one to two hours a day.

Consulting psychiatrist: Discusses changing clonidine doses and possibly using the drug during day. Suggests Vistaril as needed at bedtime (can repeat dose if child wakes during the night). Notes that trials of antihistamine and/or alpha agonist may be helpful as well.

Social worker: Offers referrals for therapy, including play therapy, or hospital services that help kids who have had traumatic medical experiences.

FIGURE 1

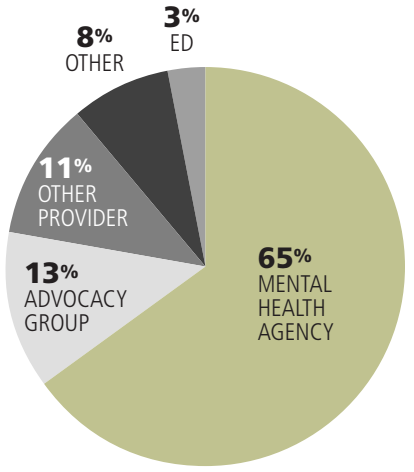


To assess whether this new effort is effective, the Department of Human Services is tracking data on the service. One hundred consultations were performed through PAL during the first six months. More than 60% of users called the service; 40% accessed it on line. Seventy-three percent of those who used it were pediatricians; 6% were family physicians.

The patients they inquired about ranged in age from 3 years to 39 years. (Although PAL is intended for physicians treating youths, the psychiatrists who staff the line are also knowledgable about treating adults.) Fifty-nine percent were male and 41% female. The most common working diagnosis has been anxiety, followed by depression and ADHD.

Almost all of the users cited multiple reasons for contacting PAL, with a majority wanting answers to questions about a medication protocol for a specific patient (Figure 1). The majority of the calls lasted 10 to 20 minutes and the most common suggestion was for a change to the dosage or timing of medication. In only one case did the consulting psychiatrist recommend discontinuing a particular medication. Also, nonmedication therapy was recommended in almost every case, if the patient wasn't already seeing a therapist. Other inquiries involved recommendations for medication titrations, tapers and changes in dosing times or frequency. In two cases, the social worker recommended a referral to an emergency department. Of the referrals made through PAL, 65% were to a mental health agency, 13% to an advocacy group and 11% to another type of provider (Figure 2).

FIGURE 2



In its first six months, PAL served 74 clinicians from 41 clinics. It is on target to provide more than 300 consultations in its first year. After each consultation, users are asked to complete a brief survey. Thus far, 100% of respondents have stated they felt the consultation was helpful, and 98% said they felt more confident in their ability to manage psychiatric conditions after talking to an expert.

Conclusion

With PAL, primary care physicians are empowered to treat psychiatric conditions in children and adolescents. We believe it is an efficient, cost-effective way to meet a tremendous need. When pediatricians, family physicians and their staffs can effectively manage their patients' mental health problems in the primary care setting, children and their families are better served and child and adolescent psychiatrists can focus on treating those patients with the most complex problems. If children are to have adequate and timely mental health care, innovations such as PAL must be available and used. **MM**

Todd Archbold is chief development officer for PrairieCare.

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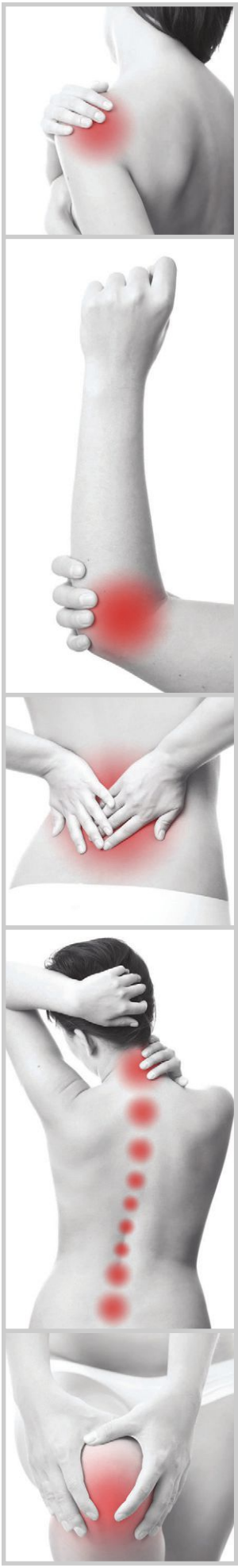
The Psychiatric Assistance Line can be accessed by calling 855-431-6468 or online at www.mnpsychconsult.com. Online inquiries are answered via secure email.



Pain, Opioids and Addiction
LECTURE SERIES

The Minnesota Medical Association (MMA), the Steve Rummler Hope Foundation (SRHF), and the University of Minnesota Medical School began a collaboration to bring medical education on the topic of opioids to medical students, residents, and practicing doctors. The lectures are recorded live at the University of Minnesota Medical School and made available for CME on the MMA website, with underwriting by the SRHF. The hope of the series is to create a medical curriculum on pain, opioids, and addiction, as it should be in a medical school setting: balanced, practical, evidence-based information free of commercial bias.

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VIDEO 1: "Opioid Addiction and Pain, A Quagmire for Healthcare Professionals"
Marvin D. Seppala, MD, Chief Medical Officer, Hazelden Betty Ford Foundation

VIDEO 2: "An Editorial on Pain"
Bret Haake, MD, MBA, HealthPartners Medical Group, Regions Hospital

VIDEO 3: "Pain Psychology, Mental Status Exam, and Non-Opioid Options for High Risk Patients"
Charles Reznikoff, MD, Division of Addiction Medicine, Hennepin County Medical Center, Assistant Professor of Medicine, University of Minnesota Medical School

Adeya Richmond, PhD, LP, Senior Clinical Psychologist, Psychology Department, Hennepin County Medical Center

Sebastian Ksionski, MD, Pain Program/CMC Director, Hennepin County Medical Center

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James R. Miner, MD, FACEP, Chief of Emergency Medicine, Hennepin County Medical Center, Professor of Emergency Medicine, University of Minnesota Medical School

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Steve Rummler® HOPE FOUNDATION
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2014 American College of Physicians Minnesota Poster Competition Winners

Each year, the American College of Physicians encourages its state chapters to invite medical students and internal medicine residents to take part in a scientific poster competition. Residents and medical students submitted 171 posters for consideration at the Minnesota chapter's annual meeting in Minneapolis November 7, 2014. Each of the internal medicine residency programs in Minnesota (the University of Minnesota, Abbott Northwestern Hospital, Mayo Clinic and Hennepin County Medical Center) were represented. Abstracts also were received from medical students and residents in Minnesota, North Dakota, Iowa and Wisconsin.

Posters (in the clinical vignette, quality improvement and research categories) were judged by practicing internal medicine physicians, internists from the state's academic medical centers, chief residents and peers. Peer judging was done through "Poster Rounds." The judges' criteria included clinical relevance, originality, and written and visual presentation. Special thanks to Charles Reznikoff, MD, and Andrew Olson, MD, for coordinating the competition.

The winners will present their posters at the 2015 American College of Physicians' annual meeting in Boston in April. Congratulations to all of the participants on their excellent work.

RESIDENT RESEARCH WINNER

Ofatumumab for Rheumatoid Arthritis A Cochrane Systematic Review and Meta-analysis

BY VIDHU ANAND, MD, SACHIT ANAND, SUSHIL KUMAR GARG, MBBS, ANGELES M. LOPEZ-OLIVO, MD, AND JASVINDER A. SINGH, MD, MPH, UNIVERSITY OF MINNESOTA

Ofatumumab is a unique anti-CD20 monoclonal antibody with its epitope more proximal and distinct from the epitope recognized by rituximab or other anti-CD20 monoclonal antibodies. The proximity of this epitope probably accounts for its high efficiency of B-cell killing and makes it ideal for use in rheumatoid arthritis (RA). We conducted a systematic review and meta-analysis assessing the benefits and harms of ofatumumab in reducing disease activity and pain and improving function in people with RA. To date, there has been no systematic review or meta-analysis assessing ofatumumab for treatment of RA.

Methodology

We searched the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2014, Issue 1), MEDLINE (from 1946), EMBASE (from 1947), ClinicalTrials.gov and the International Clinical Trials Registry Platform (ICTRP) search portal for randomized controlled trials comparing ofatumumab alone or in combination with disease-modifying antirheumatic drugs (DMARDs) or biologics to placebo or DMARDs or biologics alone or in combination with DMARDs, with no restrictions regarding dosage. Two authors independently assessed the search results for trial quality and risk of bias, and extracted data. Our search identified three trials with low risk of bias that included 654 patients (383 receiving ofatumumab and 271 receiving placebo) for analysis. A stable methotrexate dose was allowed in all patients.

Benefits

Compared with those in the placebo group, patients in the ofatumumab group were 2.3 times more likely to achieve an

ACR20 (20% clinical improvement) response (RR 2.3, 95% confidence interval (CI) 1.76 to 3.01). Similarly, patients in the ofatumumab group were 3.1 times more likely to achieve an ACR50 (RR 3.12, 95% CI 1.98 to 4.91). The number needed to treat to achieve an ACR50 response was six. Only one trial found improvement in ACR70 response. A significant reduction in disease activity was found in ofatumumab-treated patients as compared with those in the placebo group. Quality of life also significantly improved with the ofatumumab treatment, as measured by SF-36 summary score (MD 2.48, 95% CI 2.23, 2.73).

Harms

Total withdrawals and withdrawals due to adverse events were not statistically different in ofatumumab and placebo users. However, withdrawal due to lack of efficacy was four times higher in the placebo group as compared with patients treated with ofatumumab (RR 0.24, 95% CI 0.10 to 0.60). The risk of adverse events was 1.5 (95% CI 1.37 to 1.72) in the ofatumumab group as compared with the placebo group. The incidence of serious adverse events, however, was not significantly different in patients treated with ofatumumab and those who received placebo (RR 1.72, 95% CI 0.91 to 3.26). The heterogeneity of the trials was low (I^2=0%).

Conclusion

This systematic review and meta-analysis suggests that ofatumumab is an efficacious and safe treatment for patients with RA as compared with placebo. The adverse events profile appears to be acceptable, but long-term trials and postmarketing surveillance are required to assess sustained efficacy and harms. **MM**

RESIDENT CLINICAL VIGNETTE WINNER

Pneumonia Masquerading as a Rash

BY CYRIL VARGHESE, MD, KOROSH SHARAIN, MD, MATTHEW KOSTER, MD, AND CLEMENT MICHET JR., MD, MAYO CLINIC

Mycoplasma pneumonia is a community-acquired infection that usually presents as an upper respiratory tract infection. A constellation of cough, pharyngitis with atypical dermatological and/or mucosal findings should prompt *Mycoplasma* antibody testing, even if chest X-ray is negative. In addition, having repeated pneumonias as a child or teenager should prompt testing for immunological disorders.

Case

A 34-year-old man developed a sore throat and productive cough followed by a one-week history of generalized rash, subjective fevers, injected eyes and intense myalgias. He did not report any sick contacts or recent travel outside the United States. The patient reported to an urgent care center with these symptoms two days later and was given a Medrol dose pack. His symptoms persisted, so he presented to the hospital for further evaluation two weeks after developing symptoms. His past medical history was significant for six episodes of pneumonia requiring hospitalization since childhood. Social history was significant for regular marijuana use.

On presentation, the patient was vitally normal and stable with a diffuse morbilliform rash over his face, torso and extremities. He had conjunctival injection and crackles at bilateral lung bases. He did not have any oral ulcers or tonsillar exudates. CBC was significant for leucocytosis (WBC: 23.4X10^9/L with a left shift). However, infectious workup was negative for Anaplasma, Ehrlichia, ASO, Lyme ELISA, RMSF AB, GAS PCR, HIV, Babesia, Adenovirus, CMV, EBV, and measles virus. Rheumatological workup was negative for ANA, rheumatoid factor, PR3, CCP AB, SSA/SSB, Sm AB, Scl 70, Jo 1 AB, Myeloperoxidase. Chest X-ray did not show focal consolidation.

His constellation of symptoms, including cough with sore throat, injected cornea and atypical rash, prompted *Mycoplasma pneumonia* IgM and IgG antibody testing, both of which were positive. And his history of recurrent pneumonia in childhood and early adulthood warranted further investigation with Complement levels, including C1q, C2, C3 and C4, all of which were low. The patient was discharged on oral doxycycline and showed remarkable improvement of symptoms.

Discussion

Mycoplasma pneumonia usually presents as a self-limiting upper respiratory tract infection that has evolved into pneumonia, with the typical diffuse reticular interstitial findings on chest X-ray. In rare cases, *Mycoplasma pneumonia* can present with other manifestations including morbilliform rash or mucositis involving the eyes, genital, anal or oral mucosa. Although "walking pneumonia" is a common presentation among young adults, having had repeated bouts of pneumonia during childhood or young adulthood warrants further investigation. Dysregulation of complement activity can predispose patients to autoimmune or infective process. Our patient had a mixed complement deficiency. In general, deficiencies of the early components of the complement pathway (C1Q, C4 and C2) result in autoimmune disorders like SLE. On the other hand, deficiencies in late complement components (C3-9) lead to recurrent infections. **MM**

RESIDENT QUALITY IMPROVEMENT WINNER

Reducing Unnecessary Routine Lab Tests for Hospitalized Medical Patients

BY JOEL BEACHEY, MD, URSHILA DURANI, ELSIE T. MENSAH, MD, PRIYA VIJAYVARGIYA, JOHN T. RATELLE, MD, AND SARA REPPERT, MD, MAYO CLINIC

Routine ordering of basic blood tests in the hospital drives up health care costs, increases risk of iatrogenic anemia and nosocomial infections, and extends length of stay. Reducing unnecessary labs may ultimately improve patient safety and outcomes, increase satisfaction and lessen financial burden.

Objective

We aimed to reduce the number of routine complete blood counts (CBCs) and electrolyte panels ordered on the medicine teaching services at Mayo Clinic's St. Marys Hospital.

Methods

This quality improvement project involved two general medicine teaching services on the St. Marys Hospital campus in Rochester. Stakeholders were identified and included patients, providers, nurses, lab technicians and hospital administrators. Interviews were conducted with members of each group in order to determine factors contributing to the problem. A root-cause analysis was performed outlining those factors and barriers to change. Factors contributing to the ordering of unnecessary lab tests included resident inexperience, unclear expectations set by supervising physicians and ease of ordering daily morning labs. Based on the root-cause analysis, provider education was selected as the intervention strategy. For the initial Plan-Do-Study-Act (PDSA), residents were asked to list "Daily Labs" as a numbered problem in their progress notes and indicate whether daily CBCs and/or electrolyte panels were necessary for each patient. Total numbers of CBCs and electrolyte panels were measured for three days before and after the intervention, and data were compiled in a run-chart. The outcome measured was the average number of routine labs per patient per day.

Results

Fifty-four patients were admitted to the medicine 1 and 3 teaching services during our six-day analysis period. Seventy-one CBCs and 125 electrolyte panels were ordered on 32 patients in the three days preceding the intervention. Forty-five CBCs and 68 electrolyte panels were ordered on 34 patients in the three days post-intervention. The average number of labs per patient-day for the three days prior to the intervention was 2.7. The average number of labs per patient-day for the three days after the intervention was 1.8.

Conclusion

Encouraging providers to routinely consider and document the necessity of daily labs led to a 33% reduction in tests ordered per patient-day. Although the duration of this initial PDSA cycle was limited, results indicate that provider training and accountability can potentially decrease unnecessary routine lab tests. Future PDSA cycles can be designed to assess sustainability and applicability of this intervention in addition to assessing the impact on patient outcomes and cost of care. MM

MINNESOTA STUDENT CLINICAL VIGNETTE WINNER

Seizing the Opportunity to Avoid Premature Closure

BY MAROS CUNDERLIK AND ANDREW OLSON, MD, UNIVERSITY OF MINNESOTA

Determining the etiology of an apparent syncopal episode is essential to the subsequent treatment and prevention of future episodes. The diagnostic process is often complicated by the fact that other diseases can mimic syncope. Although most syncope is not associated with a life-threatening etiology, less common causes should be considered.

Case

A 49-year-old man working as a custodian was found on the floor of an elevator one evening by his colleagues. In the emergency department, he reported waking up to people slapping him in the face. The episode was not directly observed, and the last thing he recalled was walking into the elevator approximately 30 minutes earlier. His pants were wet when he arrived in the ED, but he was unsure if he was incontinent. He had no complaints of tongue-biting, chest pain or dyspnea and reported no prodromal symptoms. He did report two similar episodes in the past three months, neither of which was witnessed. Past medical history was significant for a distant history of head injury as a teen and meningitis at 9 months of age with subsequent right arm contracture. The patient's physical exam was normal with no cardiovascular or neurological abnormalities except for right arm weakness with contracture. Further workup, including ECG, head CT, electrolytes and glucose, showed no abnormalities.

The patient was admitted to the hospital overnight for further evaluation. The next morning, he was noted to be "out of it" and briefly lost consciousness. ECG showed sinus slowing without PR prolongation leading to a sinus arrest with 24 seconds of asystole. As a result, a permanent pacemaker was placed. However, the patient continued to have episodes of hypoxia, pacemaker-dependent bradycardia and altered mental status. Given those findings, a video EEG was performed that revealed interictal epileptiform discharges in the right frontotemporal area consistent with seizure activity. Consequently, the patient was treated with levetiracetam and remains seizure- and asystole-free at six months following the initial hospitalization.

Conclusion

Ictal asystole is a rare but potentially life-threatening complication of epileptic seizures. As this case demonstrates, an episode of apparent syncope with evidence of sinus slowing or asystole warrants both detailed cardiac and neurologic evaluation. Evaluation of the patient should not "stop with the heart." MM

NORTH DAKOTA STUDENT CLINICAL VIGNETTE WINNER

Atypical Tularemia Presentation with Primarily Gastrointestinal Symptom

BY JUSTIN SHIPMAN, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE

Six major clinical forms of tularemia have been described: ulceroglandular, glandular, oculoglandular, pharyngeal, typhoidal and pneumonic. Tularemia is a challenging diagnosis because of its varied presentation; however, it is considerably more difficult to identify when it presents in an unusual way.

Case

A 43-year-old male sought medical care on June 9. He had a constellation of symptoms including fever, vomiting, cough and severe diarrhea. On the day of admission, he had begun to suffer from orthostasis. The patient was a member of a family that had been involved in a community clean-up on May 29. Several had presented with similar symptoms. The family members had been exposed to urine and animal feces during the clean-up; others involved had not been exposed.

The patient's physical exam findings included decreased air flow in the lungs bilaterally, diffuse abdominal pain with no hepatomegaly and an enlarged lymph node on the side of his neck. Laboratory data showed elevated WBCs and liver enzymes, hyponatremia and hypokalemia. Chest X-ray revealed patchy opacities bilaterally, right perihilar infiltrates and blunting of the right costophrenic angle. Emperic therapy with doxycycline, metronidazole, piperacillin/tazobactam and amphotericin was started to treat what were likely bacterial organisms.

The patient was tested for *C. difficile*, *Legionella*, *Giardia*, *Cryptosporidium*, *Salmonella*, *Shigella*, *Campylobacter*, *E. coli*, *Aeromonas*, *Norovirus* and *Yersinia*. A hepatitis panel and HIV antigen test also were done because the patient had a past history of drug use. All tests came back negative.

During this time, empiric treatment was switched to vancomycin, ciprofloxacin and piperacillin/tazobactam following a recommendation by infectious disease. Further laboratory testing was done for tularemia, Q fever, leptospira, rotavirus and adenovirus. All tests came back negative, except for tularemia, which had a titer of 1:40. Additional testing was done a month later and the titer was 1:2560, which was considered diagnostic for tularemia.

The patient spent a total of 10 days in the hospital. His nausea, fever and diarrhea slowly improved, and he was discharged after these symptoms resolved. One month after admission, he continues to have headaches and he remains 30 pounds below his pre-sickness weight because of the severe diarrhea and appetite loss caused by tularemia.

Conclusion

This case illustrates the severity and variability of symptoms that can be present in a patient with tularemia. Not only did this patient have an unusual presentation with primarily gastrointestinal symptoms, but he also was outside the typical geographic areas where tularemia is found. This case demonstrates the importance of maintaining a broad differential in order to diagnose a disease that is presenting in an uncharacteristic pattern and geographic region. **MM**

MEDICAL STUDENT RESEARCH AND QUALITY IMPROVEMENT WINNER

Deep-Brain Stimulation of the Nucleus Accumbens for Patients with Central Post-Stroke Pain

BY PRAKRITI GABA, G.W. MALLORY, MD, W.S. GIBSON, P.H. MIN, MD, C.Z. ZHAO, MD, P. SANDRONI, MD, D.A. GORMAN, MD, S.M. STEAD, MD, B.T. KLASSEN, MD, AND K.H. LEE, MD, MAYO MEDICAL SCHOOL

Deep-brain stimulation is a widely accepted therapy for a variety of neurologic disorders. However, results of deep-brain stimulation for chronic pain have been variable. The periventricular gray region (PVG) and the ventralis caudalis of the thalamus have been the primary targets either alone or in combination. We recently implanted electrodes in the nucleus accumbens, a new target, in combination with the PVG for central post-stroke pain in three patients. Here, we present extended follow-up.

Methods

We compared visual analog pain scale (VAS) scores prior to implantation and in the perioperative period with follow-up VAS scores. fMRI studies were conducted in two of the patients. A formal pain disability index and patient satisfaction questionnaire also were administered.

Results

Short-term results at 3 to 11 months demonstrated a sustained reduction in VAS scores from a baseline of 9 to 4 in all three patients. All three saw improvement in activities of daily living and social interaction after surgery. Two of the patients have been implanted for more than 2.5 years; one continues to have significant benefit with maintained reductions in VAS ratings (a VAS score of 5) and a significant reduction in the pain disability index from 46 to 29 (out of 70). The other experienced a subsequent stroke that has resulted in further debility and a recurrence of pain between follow-up intervals (with VAS score of 10). fMRI studies of two of the patients indicated BOLD signal in the insular and pre-frontal regions, suggesting potential involvement of these neural structures in pain reduction.

Conclusion

The nucleus accumbens may be an effective adjunctive target for central post-stroke pain as improvements were seen with respect to the pain disability index and VAS in all three patients, with one patient showing sustained benefit more than 2.5 years after surgery. Our imaging findings suggest that downstream signals to the insular and pre-frontal regions may underlie the benefit of nucleus accumbens deep-brain stimulation in central post-stroke pain. However, further prospective studies are warranted to verify these results. **MM**

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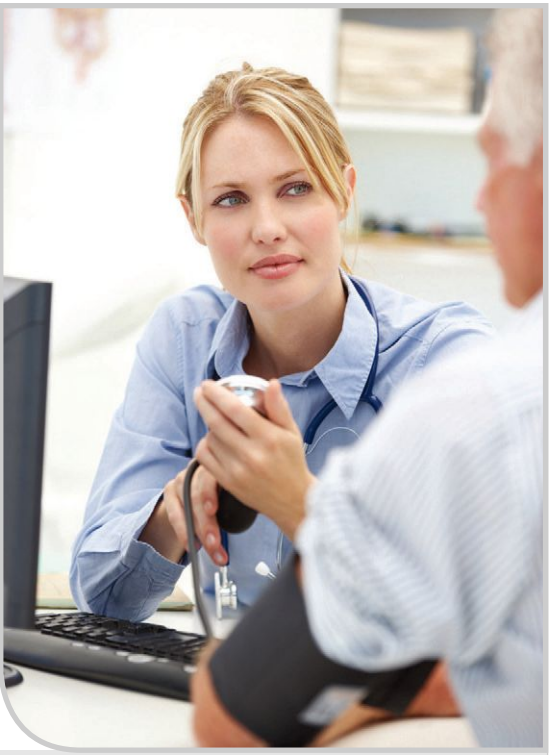

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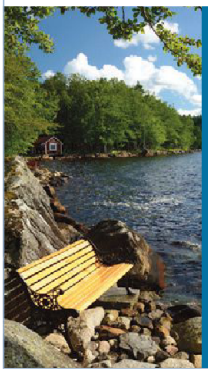

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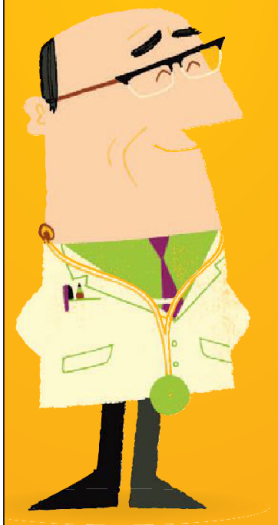

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Differential diagnosis

BY E. KENNETH WEIR, MD

The boots still showed
the dirt of South Dakota.
The gravel in his voice
sprang from that soil.

"It hurts here." A finger
pointed center shirt.
Exercise? "Not much
except Bull Poker."

Bull Poker? "A hundred dollars
on the forehead of the bull;
him with the fastest feet,
quickest grab gets the dough.

"No. There's no pain when
I ride the bull, though
I'm hells focused then."
Nitro? "No nitro, just vodka neat.

"No heart problem? Thanks, Doc,
but why the pain?
Oh no, not the drink.
The day I quit, I quit the game."

E. Kenneth Weir retired as chief of cardiology at the Minneapolis VA Medical Center in 2008. He is currently on the faculty of the University of Minnesota doing research part-time.

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