

MINNESOTA MEDICINE

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“Palliative care is about helping seriously ill people live well.”

“Healing means improving their quality of life.”

“Sometimes we need to coax patients and families out of the bubble of hope that things are going to get better.”

“In palliative care our procedure is the family meeting.”

Misunderstood specialty

Many physicians still don't understand how **palliative care** works and how it differs from hospice.

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“We can have the conversations, resolve family disagreements and help families reach consensus on difficult decisions.”

“You see the best and the worst in people.”

Talking to patients about **END-OF-LIFE ISSUES**: Six tips for physicians PAGE 36

Understanding Minnesota's **RIGHT TO TRY LAW** PAGE 30

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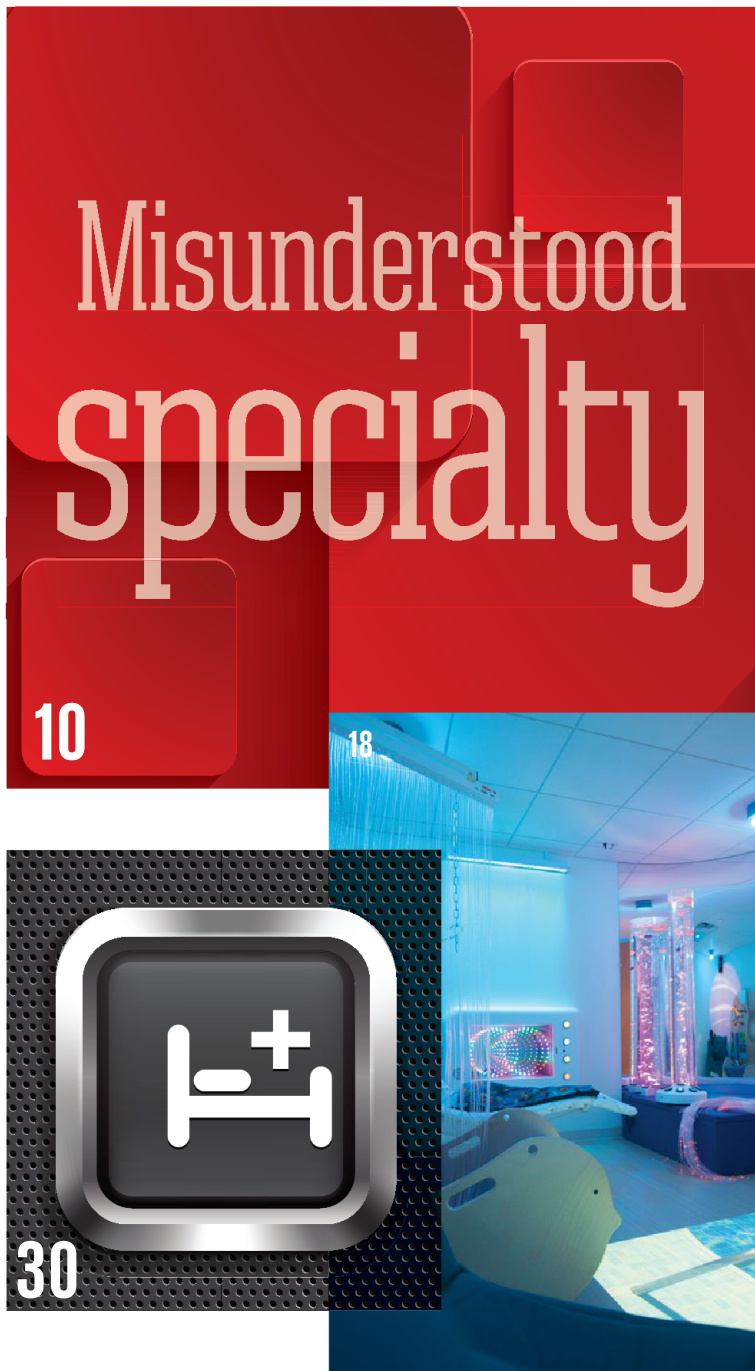
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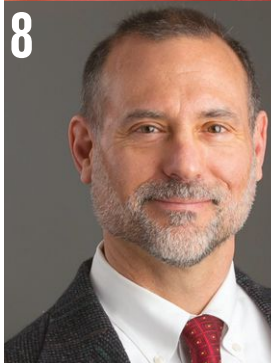
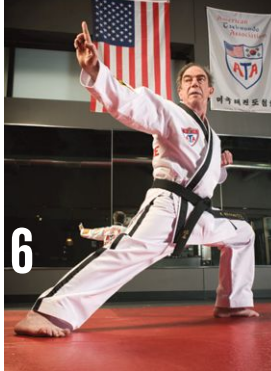
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PHOTO BY SCOTT WALKER

Charles R. Meyer, MD, Editor in Chief

During its early years,
palliative medicine
struggled to claim an
identity in the minds of
practicing physicians.

What's in a name?

Most medical specialties carry a moniker that's pretty descriptive. Recently added specialties such as hospital medicine and electrophysiology seem self-explanatory. Other new areas such as reproductive medicine and intensive care straddle two or more specialties. Admittedly, the list of medical specialties found on Wikipedia includes a few head-scratchers including phthysiology, physiurgy and neurotology. Palliative medicine, this month's theme, should be easy to understand. After all, palliation is a word we learn early in medical school, and most physicians would claim that palliation is part of what they do every day. Yet, during its early years, palliative medicine struggled to claim an identity in the minds of practicing physicians.

One of palliative care's hurdles has been hospice. Entrenched in the practice of medicine since the 1970s and given the approval stamp of Medicare reimbursement, hospice has become a humane final pathway for many patients. Its comfort-first principle is well-known to patients and physicians. Palliative care has had to carve out a niche in the care of those with chronic illnesses for whom cure is not an immediate option, insisting in the process that it really is "not hospice." As noted in our cover story, patients needn't be in the final days of life to benefit from the ministrations of palliative care.

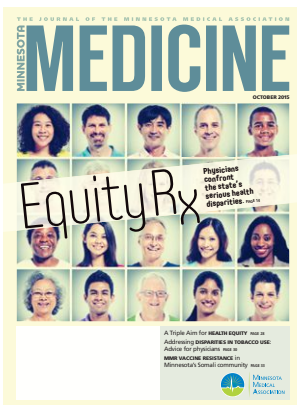
So what is palliative medicine and why didn't it exist until recently? Cory Ingram, a Mayo Clinic palliative medicine specialist, is quoted in the story as saying "palliative care is about helping seriously ill people live well." Twenty years ago, we didn't

have as many seriously ill patients as we do today, nor did we have as many tools to ease their lives. Patients now live longer sicker than they used to, and the advent of palliative care means, in part, that we have failed to meet the needs of those longer, sicker lives.

Why haven't primary care doctors been able to help these patients? Part of the answer is the dicing up of medical care of the seriously ill. One estimate I read claims that the average elderly patient in the United States sees seven physicians in four different practices each year. When patients have a doctor for each organ system, it's hard to find one to deal with something as mundane as pain. Primary care doctors are likely candidates for this job but most take care of outpatient problems in an ever-shrinking amount of time. The time it takes to sort out what will comfort a seriously ill patient is hard to find in a busy clinic schedule. Palliative medicine, whose primary "procedure" is the family conference, is geared toward addressing those issues.

So in recent years, palliative care has begun making a name for itself. Inpatient services are multiplying and the consult business is booming. Now we can figure out what neurotology is.

Charles Meyer can be reached at charles.073@gmail.com.



More tips for promoting health equity

Congratulations on your fine October issue, “Equity Rx.” The articles were provocative and enlightening.

I appreciate that you found my suggested “Tips for Clinicians” (p. 17) worthwhile. As I reread the article, I wanted to add two additional tips that have helped me work with people whose lives

Thanks again for your contribution towards health equity for all Minnesotans.

Christopher Reif, MD, MPH
 Director of Clinical Services, Community University Health Care Clinic
 Minneapolis

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are much harder than my own.

- Be prepared to stay present with your patients as they deal with the difficult and complex problems often compounded by the social determinants of health—problems such as diabetes, asthma, hypertension, depression, chemical use, HIV, domestic violence and unplanned pregnancy.
- Celebrate the fact that most people who experience health disparities are good people struggling each day to provide for their families in a system and society that continues to put on them the burden of racism, economic inequality and destructive stereotypes.



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Martial arts master

PHOTO BY MIKE KRIVIT

Being an emergency medicine physician for more than 35 years has made Kevin Kilgore, MD, a master of thinking on his feet—a skill that has helped him in the taekwondo ring as well as in the ER. Kilgore holds a sixth-degree black belt and has earned the title of master instructor in the sport.

Becoming a taekwondo master involves intensive training and mastery of increasingly difficult moves and techniques, then demonstrating those skills before high-ranking members of the American Taekwondo Association (ATA). Kilgore is one of 257 people in the world who hold the title, which takes nearly 20 years to achieve.

His participation in the sport started out as an activity to do with his younger son. It has since turned into a passion,



Kevin Kilgore says taekwondo helps alleviate the pressures of working in the ER. "Taekwondo has given me this huge outlet. There's persistence and perseverance, the commitment of seeing something through to the end, and being the best you can be along the way."

providing him with an opportunity to constantly test himself and refine his skills. Since 1994, Kilgore has competed in national and world tournaments, winning in several categories.

His immediate goal is to advance to seventh-degree black belt and pursue senior mastership. To earn that title, he must undergo another six years of intense training. Currently, there are 97 senior masters in the world. Kilgore hopes to eventually become an eighth-degree black belt and chief master, a title held by only 45 people.

Kilgore, who plans to retire from Regions Hospital in St. Paul this spring, sees parallels between his specialty and his sport. "Emergency medicine has been my style. I like improvising and adjusting to situations as they occur—kind of like taekwondo," he says. "Basically, I'm sparring with disease."

Kilgore's co-workers have supported his endeavor, often swapping shifts or filling in for him when he competed on the ATA tournament circuit. At one point, his travels took him across the country 25 times a year to compete in sparring (using offensive and defensive moves to beat your opponent), forms (demonstrating a series of movements, kicks and punches) and weapons (performing moves with weapons such as a long staff [*jahng bong*] and cane [*jee pahng ee*]). In 2004, he captured state titles in all three disciplines and a national championship title in weapons.

That success led to Kilgore being ranked among the top 10 competitors in the world multiple times in weapons, sparring and forms, and eventually going to the ATA World Championships. He became a world champion in weapons in 2006.

Although he no longer competes, Kilgore continues to pursue a higher ranking through study, practice, sparring and testing at the annual World Championships. He also teaches the sport at Fusion Martial Arts in Eagan.

Kilgore, who works out five times a week doing taekwondo, CrossFit and weightlifting, credits the sport with keeping him fit, strong and flexible, and providing relief from the stress of work. (He also co-directs an emergency medicine rotation for medical students at Regions.)

"I'm still learning," he says of taekwondo. "You never are as good as you want to be in this particular sport. There is always something to be learned or worked on, and the friendships I have made through participating are amazing."

—SUZY FRISCH

Med students honor choices

University of Minnesota medical students are learning how to talk with their patients about end-of-life wishes.

Starting in June, representatives from Honoring Choices Minnesota (HCM) began speaking to fourth-year students about advance care planning. Karen Peterson, executive director of HCM, says discussions with medical school faculty had been going on for a while. "Every year, they would tell us, this is really great, it's what med students should be learning, but we don't have a place for it in the curriculum," she says. This year, "someone saw a fit" in a palliative care component that was added to the ICU rotation.

Peterson, who often co-presents with HCM's medical director, Kenneth Kephart, MD, says the sessions provide students with an

overview of advance care planning: what a health directive is and why it's important, where to find it in the electronic health record, what to do if a patient doesn't have one, and why they as future physicians should take the time to read their patients' directives. They also discuss how to fill out a POLST (Provider Order Set for Life-

Cross-cultural talks

Honoring Choices Minnesota is offering three new videos aimed at encouraging members of the Latino/Hispanic, Somali and Hmong communities to complete health care directives and share them with their physicians and other health care providers. The scripts, which were developed by health care workers from those communities, aim to communicate the message in a culturally appropriate way. The videos are available digitally or on DVD at honoringchoices.org.

Sustaining Treatment) form, a doctor's order to emergency medical personnel and other health care providers indicating a patient's end-of-life wishes in the case of a medical emergency.

The students then engage in role playing. "They really value this," Peterson says, adding that today's medical students truly understand the concept of end of life. "If you listen to Atul Gawande or other big names tell stories about when they were in medical school 20 years ago, they never talked about advance care planning or end of life. It never entered their minds as medical students that they would be asked to do anything other than try to save a person," Peterson says. "Now, students come into medical school understanding that death is a part of life and not a failure on the part of the physician."

Peterson says they are also starting to take their message to residency programs and are encouraging both residents and medical students to do their own advance care planning. "Every year in Minnesota, we hear about someone who is in an accident and ends up in a condition where they cannot communicate and are unlikely to regain brain function. That can happen to any one of us at any time," she says. "If you haven't told anyone your thoughts on what you want, your family and medical team are left to guess." —KIM KISER

Honoring Choices Minnesota

wants to bring its presentations to residency sites and is looking for physicians to help with them. To get involved or schedule a talk, contact Karen Peterson at kpeterson@metrodoctors.com.

Cannabis and chronic pain

Brian Erickson, MD, has a perspective few, if any, physicians in Minnesota share regarding medical cannabis and pain. Erickson, medical director of Health East's Pain Clinic in St. Paul, previously practiced in Vermont, where severe pain has been a qualifying condition for medical cannabis use since 2007. (Medical cannabis became legal in that state in 2004.)

Erickson saw patients at the University of Vermont's pain clinic, where he certified some for medical cannabis use. With Minnesota's Commissioner of Health recently adding intractable pain to the list of conditions for which patients will be able to obtain medical cannabis, Erickson shared his thoughts with *Minnesota Medicine* editor Kim Kiser.

You're a psychiatrist. How did you get involved in treating patients with pain?

After medical school at the University of Minnesota and a psychiatry residency in Vermont, I practiced psychiatry in Duluth and worked with patients who had chronic pain and were taking antidepressants. We had a couple of psychologists in the group who did biofeedback and marriage and family therapy who also were working with patients who had chronic pain. It was something I wanted to learn more about because there is a lot of overlap between psychiatry and chronic pain. We set up a pretty involved chronic pain program at St. Mary's Duluth Clinic in 1993.

About 14 years ago, I returned to Vermont to practice at the University of Vermont's pain clinic. At the time, it was mostly anesthesiologists doing chronic pain treatment. I did a lot of medication management. During that time, I developed an interest in alternative and complementary therapies. A number of my patients had tried many different medications and found they weren't satisfactory or helpful. I really wanted to have alternatives.

What was the sentiment in the medical community about medical cannabis when Vermont was considering legalizing it?

There was very little public discussion or input from medical providers compared with what I've experienced here in Minnesota. There was a feeling that if a person was on opioids, we didn't want them to also be using marijuana. There was concern about addiction and misuse.

The law that ultimately passed in Vermont is a lot like Minnesota's in that the cannabis became available in the form of a tincture that could be used under the tongue or be vaporized, and physicians had to certify that patients have one of the qualifying conditions, which included HIV, nausea, cancer, and later, chronic pain. One distinction was that the patient had to have a six-month relationship with the certifying doctor, so the doctor knew the patient and their condition.

Did your patients ask you about medical cannabis?

Some of my patients started reading about medical cannabis, doing their own research and asking about it. Many of them were very sheepish—middle-aged teachers who had never used marijuana in their life, people who didn't want their kids knowing they were using it. These were people who were desperate and at the same time a little embarrassed. I ended up certifying between 60 and 80 pain patients for medical cannabis use during my time in Vermont.

Did it help their pain?

In my experience, patients ended up doing very well. Many of my patients were able

to decrease or get off opioids entirely. One who was on 100 mg a day of methadone got off of it entirely. Another who was on 80 mg a day of oxycodone got off of it entirely. It was very helpful for patients with peripheral neuropathy, back pain and headaches, who weren't responding to other medications.

Were there problems with addiction? How did you monitor patients?

There was concern about addiction, especially for patients who were on suboxone. We didn't want them using marijuana if they were in recovery with suboxone. But medical cannabis was different. The medical cannabis formulation used for chronic pain tends to be high CBD (cannabinoid) and low THC (tetrahydrocannabinol). THC is the psychoactive part of the drug. The high CBD is thought to be helpful for pain and anxiety and nausea. So the formulation they were using wasn't the sort



Brian Erickson, MD, saw how medical cannabis helped some of his pain patients in Vermont.

PHOTO COURTESY OF HEALTHEAST

of thing that would lead people to get high and have amotivational syndrome.

We would talk to patients' family members, therapists and suboxone counselors and make sure we knew how they were doing. In general, their pain was better, their function was better and they were able to get off opioids. There wasn't a problem with addiction, and I never heard from law enforcement about patients diverting it. The high-CBD, low-THC formulation wouldn't have the street value a formulation with high THC would have.

What are you hearing from your pain patients in Minnesota?

My patients in Minnesota are very interested. Some have traveled to Colorado and California and used what's available there. They found it helpful. I have a number of patients who, despite our best efforts with pharmacotherapy, acupuncture and physical therapy, don't get the results they want. I do suspect they could get some benefit from medical cannabis.

Have you shared your perspective with other clinicians? What were their thoughts?

I talked about my experience at an MMA forum. A number of doctors were interested. Some had already certified their patients for other things. Others thought adding intractable pain was going to open doors to all kinds of problems and misuse. I can respect their opinions and concerns. Clearly, we should be concerned about adolescents and the developing brain, for example. Certainly, there is a risk for addiction to marijuana. But with the high-CBD, low-THC formulation, that risk should be relatively low. Some had concerns about patients using medical marijuana and driving. But we have those same concerns about patients who are on benzodiazepines and opioids.

In Vermont, did they collect any data or do any studies about medical cannabis' effect on pain?

They weren't doing any large-scale research on medical cannabis. So my in-

formation about the patients who got off opioids or decreased their opioid dose is anecdotal. However, a recent study from the University of Pennsylvania of 13 states that legalized medical cannabis reported a nearly a 25 percent reduction in the annual opioid overdose mortality rate after the cannabis laws were enacted.

There's a lot of fascinating work to be done with this. I think we'll see some good work around medical cannabis and PTSD, and I think there are going to be some interesting immunological findings that come from this.

At the national level, those who talk about medical cannabis and chronic pain are really saying marijuana has to be changed from a Schedule 1 to a Schedule 2 drug so it can be appropriately studied and understood. I think that's important, and it's a far cry from legalizing it for recreational use.

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Misunderstood specialty

Many physicians still don't understand how

palliative care

works and how it differs from hospice.

BY HOWARD BELL

Cory Ingram's palliative care moment came in 2008 when a co-worker with stage 4 ovarian cancer asked him to take care of her and her family for the rest of her life. "I did my best," says Ingram, who was a Mayo Clinic geriatrician at the time. "But I felt my best wasn't good enough." He saw how the treatments were taking a toll on his patient and that she wanted her discomfort to end. In addition, he realized that the system was set up to try to cure the incurable, regardless of the patient's desires. "Her relentless bowel obstructions, nausea and seizures were being treated in a reactive crisis-management way," Ingram recalls.

The patient also wanted answers to questions that went beyond medicine: How would she manage her condition at home? Who will help her husband cope with all of this? Who will take care of her mom? "Altogether, this complex of physical and nonphysical needs near the end of life was hard stuff to manage," Ingram says. "I had neither the training nor the time to deal with it properly."

The experience inspired Ingram to learn how to better care for patients in this situation. Two years later, he completed a one-year hospice and palliative care fellowship at Dartmouth-Hitchcock Medical Center in New Hampshire, then returned to Mayo where he now does inpatient palliative care consults at Methodist and St. Marys hospitals. He also teaches physicians and residents about palliative care locally, nationally and internationally.

One important message he imparts is that palliative care is not the same as hospice. Hospice is a type of palliative care that focuses on comfort, not cure, during the last six months of life. Palliative care alleviates pain and suffering for all seriously ill patients, including those who aren't near death and who are receiving other life-prolonging, curative treatments. "Palliative care is about helping seriously ill people live well," Ingram says. "You might ask, Doesn't the health care system do this? No, not well."

Problems with caring for the seriously ill are well-documented. The 1994 Open Society Institute Project on Death in America called for new ways to provide care that prevent poorly managed inpatient deaths as well as conflicts between caregivers and families that often lead to painful, unhelpful treatments. A 1995 ar-

ticle published in *JAMA* urged that all doctors be trained in end-of-life care, its bleak conclusion stating, “most Americans die in hospitals often alone and in pain after days or weeks of futile treatment, with little advanced planning and at a high cost.” In its 2014 report, “Dying in America,” the Institute of Medicine noted that seriously ill people often don’t get the care they want, but often get care they don’t want, and recommended that all doctors and nurses receive palliative care training.

Growing numbers, increasing need

The concept of palliative medicine emerged at a few teaching hospitals a couple of decades ago. Since then, inpatient palliative medicine programs have been established at all Minnesota hospitals with more than 300 beds and 45 percent of those with fewer than 50 beds. Since 2008, the number of board-certified hospice and palliative medicine physicians in the state has grown from 25 to 156.

The demand for the services offered by these programs has grown as well—and will continue to do so. One reason: an increasing number of patients are living for years after being diagnosed with an incurable disease. Those patients are specifying what treatments they want, for how long and under what circumstances. In addition, the science behind palliative medi-

cine is advancing, and specialists now can help with pain management and end-of-life symptoms such as shortness of breath, nausea and opioid-induced constipation in ways they couldn’t before.

Such care is paying off. A growing number of studies show that many patients receiving palliative care can better cope with their symptoms and treatments, are more satisfied with their care and report a higher quality of life. Because they are less likely to require emergency room visits and hospitalizations or undergo treatments that are ineffective or unwanted, palliative care can lower costs.

What palliative specialists do

Palliative specialists take care of patients with conditions such as incurable cancer, advanced progressive lung diseases, ALS, AIDS, degenerative brain disorders, and kidney, liver or heart failure. They help manage patients’ symptoms, have conversations with them and their families about their wishes and concerns, and serve as a bridge between the patient, family and the attending physicians. “Most doctors aren’t adequately taught this set of skills in medical school or residency,

nor are they given the time [to do this work],” Ingram says.

Typically, palliative care physicians work as part of a team that includes nurses, social workers and chaplains. In fact, palliative medicine is considered by some to be the ultimate team specialty. “That’s one of the things I like most about it,” says Carol Grabowski, MD, who was a full-time radiation oncologist until three years ago when she became board-certified in palliative medicine and started splitting her time between the two specialties.

Like most palliative medicine physicians, Grabowski begins her day at North Memorial Medical Center in Robbinsdale by meeting with the rest of the palliative care team. Together, they review patient needs, discuss successes and disappointments, and sometimes take a moment to remember patients who’ve died. Two years

“Palliative care is exhausting, emotionally draining work. Many days, either a patient, family or colleague is angry with one of us. Radiation oncology is much easier, and it pays a lot more. But I know that what we’re doing is incredibly meaningful. And as a team, we support each other. Sometimes at the end of the day we can say, you know, we did really good work today. We made lives better.”

CAROL GRABOWSKI, MD
NORTH MEMORIAL MEDICAL CENTER
ROBBINSDALE



PHOTO BY STEVE SILVERMAN

“When patients are in unstoppable decline and burdened with multiple treatments, healing means improving their quality of life. It’s very rewarding and very cool to see all the good we do.”

CORY INGRAM, MD
MAYO CLINIC, ROCHESTER



ago, Grabowski's team saw 12 to 16 patients per day. Now they see 30.

This collaborative approach to patient care is the secret ingredient to palliative medicine's success, according to Ingram, who refers to his morning team meetings as "the kitchen table talk." "These talks take time, but are well worth it to patients and families, and to the system, which is then better able to care for the patient more efficiently because we invested time on the front end," he says.

Much of what palliative medicine physicians do the rest of the time is manage symptoms, such as delirium, hiccups, constipation, itching, nausea, anxiety and shortness of breath, many of which are side effects of treatment. "Shortness of breath can be more distressing than pain," says Jeffrey Rubins, MD, director of the palliative medicine program at Hennepin County Medical Center. "Attending physicians are taught to ask about these symptoms, but don't always know how to make them go away." Rubins was a pulmonary/critical care physician at the Minneapolis VA for 21 years, where he helped create the inpatient palliative care unit in 2009. That unit became a model for other inpatient programs in the state and within the VA system. He's been at Hennepin since 2011 and has seen the program grow from 150 consults per year to 800.

Grabowski says changing medication regimens is a big part of what she does for her palliative care patients. "A patient might be on a narcotic that's the wrong dose or type," she says. "We put some patients on methadone, which can be really helpful, but few physicians outside our team would consider it."

She adds that her palliative care training has made her a better radiation oncologist. "I was always diligent about managing side effects of treatment, but now I have so many more options for treating the side effects of pain, diarrhea, nausea and depression." Some are quite simple. For example, radiation causes pain in the mouth, throat and esophagus. "By simply giving the patient IV fluids and medications in the infusion room, I keep them comfort-

Becoming a palliative medicine specialist

In 2006, the American Board of Medical Specialties (ABMS) approved creation of a hospice and palliative medicine subspecialty. Eight ABMS member boards offer board-certification in the subspecialty through the American Academy of Hospice and Palliative Medicine. Physicians must first be board-certified in one of those eight specialties before they can become boarded in hospice and palliative medicine. Since 2012, physicians must also complete a one-year fellowship in hospice and palliative medicine before taking the exam.

In Minnesota, 156 MDs are boarded in hospice and palliative medicine, according to the ABMS. Most of them also are boarded in internal medicine or family medicine, although all eight specialties are represented. One Minnesota DO is boarded through the American Osteopathic Association.

Most places hiring palliative medicine physicians now require completion of a hospice and palliative medicine fellowship. Mayo Clinic and the University of Minnesota both have fellowship programs. Mayo's began in 2004 and accepts three fellows per year. The university's started in 2008 and takes four fellows per year; those fellows rotate among the Minneapolis VA Hospital, Hennepin County Medical Center and Fairview/University Hospitals. The University of Minnesota also offers a one-year pediatric hospice and palliative medicine track.

Fairview is one of 10 national leadership training sites for the New York City-based Center to Advance Palliative Care (CAPC). Fellows at Fairview complete CAPC workshops that teach them how to start new palliative care programs and grow existing ones. —H.B.

able and out of the hospital. Avoiding hospitalization is huge, and it's such an easy intervention," she says.

Grabowski says her palliative medicine training also has made her more comfortable with what is often one of the most difficult and necessary parts of an oncologist's job—having end-of-life conversations with patients and families.

"In palliative care our procedure is the family meeting," says Kirstin LeSage, MD, a palliative medicine physician with Essentia Health in Duluth who also teaches palliative care to family medicine residents and medical students.

"We've been taught specific ways to do this that really help families feel supported," she says. Although they can be emotional, those meetings help patients and their families understand their situation, what can be done for them and the likely outcome of treatment. They also allow patients to discuss how they want to live and their priorities regarding treatment. Patients also are encouraged to complete an advance care planning document after they leave the hospital, if they haven't

already done so. This can help prevent family discord, indecision and unwanted treatments later on.

Such conversations can take an hour or more and must be documented in the medical record. "Hospitalists and other doctors don't have time for this," Grabowski says. "They're rightfully focused on the patient's immediate medical concerns." That's why attending physicians should request a family meeting with palliative care even if a patient is pursuing curative treatment.

Those conversations accomplish two important things. First, they inform physicians what the patient and family want. "The system moves seri-

"I witness amazing things when I'm invited to join a patient and family on their journey through serious illness. Everything is honest and raw. You see the best and the worst in people in a way most physicians don't get the opportunity to see. Helping people live how they want to live in the face of serious illness makes for a very meaningful job."

KIRSTIN LESAGE, MD
ESSENTIA HEALTH, DULUTH



ously ill patients on a conveyor past a buffet of interventions," Ingram says. "Instead of giving them everything on the buffet,

Where palliative medicine physicians work

Until recently, the only way to practice palliative medicine was to work in a hospice program. That's still a common setting, but many palliative medicine specialists now do inpatient hospital consults for non-hospice patients, an area that is growing exponentially, according to Jeffrey Rubins, MD, medical director of the palliative medicine program at Hennepin County Medical Center.

Some split their time between palliative care consults and another specialty. Carol Grabowski, MD, for example, divides her time between inpatient palliative care consults at North Memorial Medical Center and radiation oncology procedures as a locum tenens physician in Willmar and

other smaller Minnesota towns. Some internists trained in palliative care see general internal medicine patients in their clinic, then do palliative care consults in a hospital or nursing home.

In years to come, more outpatient palliative care clinics are expected to open, and palliative medicine is expected to find a place in nursing homes, home health services, and in oncology, urology and cardiology clinics. —H.B.

why not give them à la carte care that matches what is possible and what they want?” Second, it helps patients and families to be realistic about outcomes, and fully informed about treatments so they can make sound choices. “Sometimes we need to coax patients and families out of the bubble of hope that things are going to get better,” Grabowski says. “They need to know—there’s nothing we can do to make you better. Now that you know this, tell us how you want to live your life.”

As a patient’s illness advances and their desires evolve, palliative care doctors keep attending physicians updated in order to avoid what Rubins calls “the tragedy of fragmentation in health care.” “Everybody’s looking at their part of the body, which may be getting better, even though the patient’s dying,” LeSage says palliative medicine physicians communicate about both immediate physical concerns and “the big picture of who this patient is and what they want their health care to be.”

Money and misconceptions

Ingram says palliative care is not yet as much a part of medicine as it should be. One reason is the lack of reimbursement for such services. “The current reimbursement system is procedure-based and rewards rapid hospital turnover and late enrollment in palliative care,”

says Jim Risser, MD, medical director for HealthPartners hospice and palliative care program and for the palliative care program at Regions Hospital in St. Paul. Time spent on such things as family meetings often goes unreimbursed.

That, however, is starting to change.

On January 1, the Centers for Medicare and Medicaid Services began using two new diagnostic codes to reimburse up to one hour of advance care planning discussions between patients and licensed providers.

“We’re happy to see it as a profession,” says LeSage, who adds that primary care and outpatient palliative care providers will benefit most from the change.

“They’ll be better reimbursed for the lengthy conversations many of them are already having,” she says.

Some physicians have been slow to embrace palliative medicine because they don’t understand what these specialists do or when to involve them. LeSage says this is partly because of the way physicians are trained. “Doctors don’t like to ask for help,” she says. “We’re not trained to be collaborative and work in teams. I’ve had physicians tell me ‘I think I need help, but I’m not sure what help I need.’”

Confusion about what palliative care doctors do is understandable, LeSage says. “When a patient has a GI bleed, we know to call a gastroenterologist. But our skills don’t fit into one silo, so they’re sometimes harder to define and harder for others to understand.”

Rubins says even physicians confuse palliative care with hospice and that he

Palliative care resources

The American Academy of Hospice and Palliative Medicine offers webinars, self-study primers and other training (www.aahpm.org).

The Center to Advance Palliative Care offers online courses, webinars and a “Fast Facts” section on its website that addresses such topics as opioid-induced constipation, ALS, drug-induced acute urinary retention, palliative care consults in the emergency department, and how to deliver bad news (www.CAPC.org/fast-facts).

Vitaltalk.org offers short videos on how to establish rapport with patients and families, break bad news and conduct a family conference (www.vitaltalk.org).

“I like helping patients and families better understand their medical problems and treatment options to ensure that their wishes are followed, and to help them at a very intimate and unique moment in their life’s journey.”

JAMES RISSE, MD
REGIONS HOSPITAL, ST. PAUL



often hears: “My patient isn’t ready for palliative care.” A big part of Rubins’ job is explaining palliative care’s value to established physicians, which he says has been an uphill struggle. “I explain that it’s not the same as hospice,” he says. “It’s not just about the last six months. We aren’t stopping curative or restorative treatments. Studies show palliative care actually helps patients get through treatments better. Some chemo and COPD patients survive longer.”

“Death isn’t a stranger to me after my years practicing critical care. I feel grateful and privileged to help someone live the remainder of their life with their symptoms managed, with dignity, and receiving the type of care they desire.”

KEITH MANSEL, MD
MAYO CLINIC, ROCHESTER



Physicians also mistakenly fear that palliative care specialists will take control of their patient. LeSage says they actually provide an extra layer of support for both the physician and the patient. “We can have the conversations, resolve family disagreements and help families reach consensus on difficult decisions about medical issues and treatments—the things a lot of doctors don’t have time for or don’t feel comfortable doing.” She adds that once physicians see the value of palliative care they start asking for it earlier in a patient’s illness. This allows the palliative care team

to build a relationship with the patient and family.

System changes are coming

The first two decades of palliative medicine demonstrated that it improves the quality of care and patient satisfaction while lowering costs. The next decade will see health systems formalizing protocols, measuring outcomes, teaching basic palliative care skills to non-palliative care physicians, and making it easier for seriously ill patients to get

palliative care earlier in their illness, and not just in the hospital. “Everybody knows end-of-life care needs to change,” Risser says. “That change is easier when the system supports it.”

“Triggers” are one way health systems are taking the onus off physicians regarding when to call for a palliative care consult. At Regions Hospital, for example, consults are triggered for patients admitted with chronic heart failure or advanced COPD.

At North Memorial, palliative care consults are triggered for any patient with a stage 4 cancer admitted to the ICU, any nursing home resident admitted to the ICU, and all patients with chronic heart failure admitted to any unit. Grabowski tries to talk with the attending and make sure he or she approves the consultation. “A direct doctor-to-doctor talk with the attending is essential, rather than just relying on communication through the EMR,” she says.

Eventually, health systems will have better electronic medical record documentation of patient preferences and will give feedback to physicians about whether they followed best practices for having goals-of-care conversations with seriously

ill patients and their families, as they currently do for management of diabetes and hypertension.

In addition, health systems are opening outpatient palliative care clinics. Hennepin County Medical Center has one for ALS patients. The University of Minnesota has four outpatient clinics at its cancer centers in the Twin Cities and a general palliative care clinic for other patients with serious illnesses. In the next few years, some oncology, urology and cardiology clinics in Minnesota are expected to offer palliative care to better serve patients with life-limiting illnesses who are still receiving treatment and are not enrolled in hospice.

Driven in part by the desire to keep patients at home when it’s safe to do so, health systems are experimenting with home-based palliative care. For three years, Mayo Clinic has offered home-based services for non-hospice patients in Eau Claire, Wisconsin, and Rochester. “It’s been very successful,” says Keith Mansel, MD, a Mayo palliative medicine specialist. “Quality of life improves, patients and families are more satisfied, and hospitalizations decrease.” Mansel, who initially practiced pulmonary critical care, made a career change after spinal stenosis made it difficult for him to stand for long periods. “Being on the other side of patient care was an eye-opener for me and one reason I went into palliative medicine.”

Mansel believes home-based palliative care is the future. Indeed, many experts believe that making palliative care available to the seriously ill at home or in community settings such as nursing homes may be the single largest opportunity to improve value in the U.S. health care system.

Making all doctors palliative medicine doctors

Another way palliative care’s reach is expanding is by training all physicians in it, which some feel is the best way to create widespread, sustained improvements in end-of-life care. North Memorial is teaching all of its physicians how to have ad-

“It can be emotionally challenging to be surrounded by patients you care about who are dying, and to see their loved ones grieve and deal with the stress of watching a loved one die. But it’s part of our training to know how to live with that, to remain professionally engaged with our patients, to stay focused, relieve suffering, and have careful, empathetic conversations to help them understand what’s going on. Most physicians spend some time talking to seriously ill patients about choices and desires. I get to do it all the time.”

DREW ROSIELLE, MD
UNIVERSITY OF MINNESOTA, MINNEAPOLIS



vance care planning conversations. HealthPartners is starting to teach its primary care physicians a basic set of palliative care skills and is developing a mentorship program to reach more of its physicians. Mayo Clinic has taught some of its primary care physicians palliative care principles, and by spring, Fairview/University Hospitals hope to be teaching palliative care skills to all of its physicians. Meanwhile, Risser says, residents and medical students are getting far more palliative care training than they used to.

“All specialties can provide palliative care,” Ingram says, “because all physicians desire to treat the patient, alleviate suffering and adhere to the patient’s desires for care.”

Drew Rosielle, MD, director of the University of Minnesota’s hospice and palliative care fellowship program, believes that once more physicians are trained in palliative medicine the question will change from, “When should a patient see a palliative medicine specialist?” to “When can a patient’s palliative care needs be met by a primary physician who’s been trained in basic palliative care?” “We don’t have the answer yet,” he says. “But what’s certain is that with all the benefits it offers, the specialty of palliative medicine will keep growing.” MM

Howard Bell is a medical writer and frequent contributor to *Minnesota Medicine*.



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SMALL COMFORTS

Children's hospitals add palliative care

BY JEANNE METTNER

Stepping through the doors of the Kiran Stordalen and Horst Rechelbacher Pediatric Pain, Palliative and Integrative Medicine Clinic at Children's Hospitals and Clinics of Minnesota in Minneapolis is like entering another

world—or at least a world far removed from a hospital.

The 10,000-square-foot space features natural materials—Wisconsin wood floors, baseboards made of oyster shells and walnuts, and stone tile. Large photos of Itasca State Park, the North Shore and plants

indigenous to Minnesota cover the walls of the waiting area, where kids and parents can manipulate digital images of cascading water and hear the sound of wind and loon calls. The lighting automatically adjusts based on the time of day, and the exam rooms look as comfortable as living rooms.

“We wanted to create a healing environment, and that meant having healing architecture,” says Stefan J. Friedrichsdorf, MD, medical director of the clinic, which opened in January 2015. “The idea is that when children and teens come into our waiting room and exam rooms, they won't be afraid. And that will engage them more in their care.”

The clinic, which combines pain medicine, palliative care and integrative medicine, is named after the founder of Aveda Corporation and Intelligent Nutrients and his wife. It is believed to be the first of its kind in the world. For Friedrichsdorf, who is also medical director of the department of pain medicine, palliative care and integrative medicine at Children's Minnesota, its opening is a long-awaited step toward bringing more humane care to kids who are suffering. He estimates his team was involved in more than 4,000 patient visits last year.

The clinic at Children's Minnesota may be one of the newest to focus on alleviating pain and distress in children, but it is not the only one. Over the past decade, an increasing number of children's hospitals in the United States have been incorporating palliative care into their offerings, often including it in their pain-management programs. One study published in the December 2013 issue of *Pediatrics* found nearly half of the 226 hospitals asked reported having pediatric palliative care available. Children's Minnesota, Gillette Children's Specialty Healthcare in St. Paul, Mayo Clinic, the University of Minnesota Masonic Children's Hospital and CentraCare/St. Cloud Hospital



The Kiran Stordalen and Horst Rechelbacher Pediatric Pain, Palliative and Integrated Medicine Clinic features natural materials, such as wood walls and rocks, and nature photos.

PHOTOS COURTESY OF CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA

are among those that offer pediatric palliative care in Minnesota.

According to estimates Friedrichsdorf compiled using federal data, about 237,000 children in the United States are currently living with chronic pain and discomfort as a result of cancers, metabolic or genetic diseases, neurodegenerative diseases, and cardiovascular and other conditions. Pediatric palliative care is designed to not only alleviate their physical discomfort but also to help both the child and his or her family deal with the stress of illness. “When we talk about managing pain, we are not talking just about physical pain. There are other elements to it—emotional, spiritual and social pain,” says Scott Schwantes, MD, head of the neuropalliative care team at Gillette.

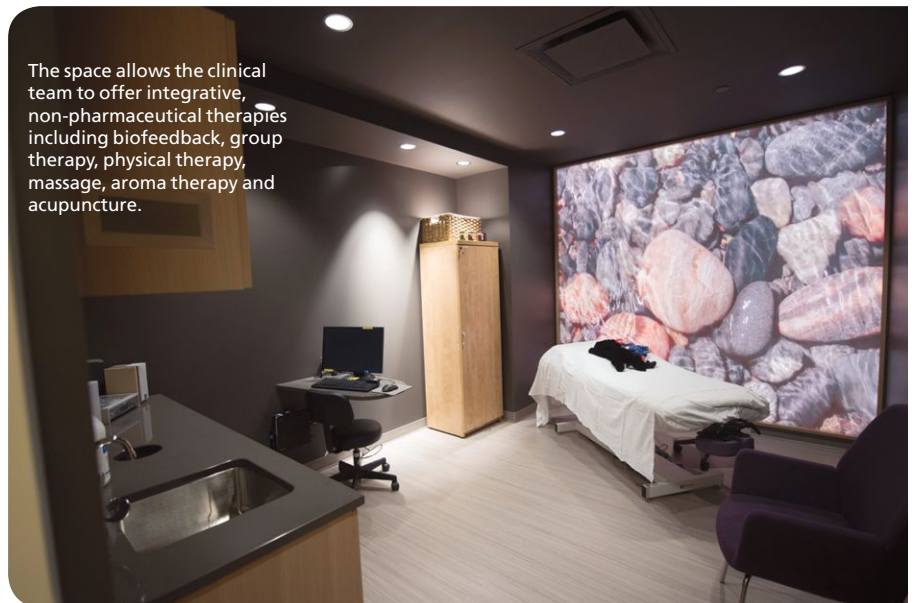
Although pediatric palliative care is becoming more common, families don’t always understand how their children can benefit from it. “A few years ago, the majority of people thought palliative care was synonymous with hospice or end-of-life care,” says Naomi Goloff, MD, a pediatric palliative care specialist at the University of Minnesota Masonic Children’s Hospital and medical director of the pediatric advanced complex care team. “Now, people—providers and patients—are starting to understand that palliative care adds an extra layer of support during a serious illness.”

Friedrichsdorf says their data show that children enrolled in palliative care live longer, have a better quality of life and are more likely to do something that adds meaning to their life. “We want to make sure that children live as long as possible, as well as possible,” he says. **MM**

Jeanne Mettner is a Minneapolis freelance writer.



The clinic’s multisensory (Snoezelen) room.



The space allows the clinical team to offer integrative, non-pharmaceutical therapies including biofeedback, group therapy, physical therapy, massage, aroma therapy and acupuncture.



The clinic also features natural light and soothing music.

Life and death in *Alzheimer's disease*

What happens when a family doesn't know a loved one's wishes.

BY JESS PRISCHMANN, MD

Eleven years ago, my grandmother began the slow, cruel decline of Alzheimer's dementia. During the early stages of her disease, I felt searing pain watching her try to live independently.

Little did I know that the early pain would pale in comparison with the agony of watching her body attempt to die.

Alzheimer's is not just a disease of lost memory. It is a terminal condition with no hope of recovery or cure. It not only robs individuals of their ability to remember the past, it also pillages virtually every other bodily function.

Unlike with other terminal diseases—cancer, for example—a person with dementia is often unable to participate in his or her own end-of-life care.

Eight months ago, my grandmother suffered a devastating stroke, which, among other things, impaired her sight and ability to swallow. She had to rely on nursing care for all activities of daily living. It seemed clear that this was the time to place her in hospice so she could maintain her dignity during her last few months of life. What I never anticipated was the difference of opinion among family members who felt that withdrawing care was a cruel way to prematurely terminate life.



The author as a child with her grandmother.

My grandmother had never vocalized her end-of-life wishes, and elders in the family argued that I had no way of knowing what she would have wanted. Withholding food and fluids, they said, was not an ethical way to allow someone to die. I, on the other hand, strongly disagreed with the assumption that death from dehydration was unduly painful.

I recalled a poignant, well-written supplement by the Alzheimer's Association that states: "Lack of hydration is a normal part of the dying process and allows a more comfortable death over a period of days. Using IV hydration can draw out

dying for weeks and physically burden the person."

Two weeks ago, my grandmother was found obtunded and rushed to the emergency department, where she was intubated and transferred to the intensive care unit. She was diagnosed with pneumonia and severe dehydration and, despite my strong objections, was started on life-saving measures. I was told that her doctors advised that the pneumonia and dehydration were potentially reversible.

Again, the family was given the atrocious challenge of deciding her fate. Why wouldn't they treat a revers-

ible medical condition?

In an article titled "Ethical Issues Near the End of Life," Dr. Muriel Gillick, director of the program on aging at Harvard Medical School writes, "Some have cautioned that excessive deference to patient autonomy has the potential to place unwanted and unreasonable responsibility for technical medical decisions on patients or their surrogate decision-makers. Given the array of treatments now available for advanced and chronic illness, it is difficult, and at times nearly impossible, for patients or their surrogates to fully comprehend the burdens and benefits of the available options."

PHOTO COURTESY OF JESS PRISCHMANN

Last week, I rushed to my grandmother's bedside. I held her cold, swollen, mottled hand and thanked her for everything. I told her to take care of my mother from heaven and provide the family *ashirwad*, a Hindi word for blessing.

I have stopped my efforts to end her suffering. I have no idea how or when she will die. I have peace in knowing that she is surrounded by those who love her deeply. They feel as strongly about her will to live as I do about her right to die. I will never know what she would have wanted, but I do know that my continued attempts to influence her care have fractured relationships in ways that will exist long after she is gone.

More than 5 million Americans have Alzheimer's disease. For their families, this chronic, terminal condition creates an ocean of swirling feelings: sadness, anger, frustration, exhaustion and, hopefully, peace.

I am left to wonder if this situation could have been avoided. Should we have discussed end-of-life care 11 years ago? Should an advance directive have been a mandatory part of the treatment course? Did her physicians take an active role in advising the family, or did they present all options as equal?

My grandmother was the family caregiver. She raised her own children and most of her grandchildren and never asked for anything in return. She had no enemies. Her ability to remain impartial was her greatest quality—in life and in death. MM



Jess Prischmann is the owner of Prischmann Facial Plastic Surgery in Edina. She writes:

"My grandmother died in March of last year, shortly after I wrote this essay. For a long time, I felt so much anger. In Indian families, the oldest son is often given the responsibility of making decisions on behalf of the family. Therefore, the power of attorney was assigned to my uncle, who felt very strongly that withdrawing care was not a good option. I was angry at him for keeping my grandmother as a full code until the very end. I was angry at my relatives, who I felt did not stand up to him.

"And then, someone told me that love is the force that keeps us all on Earth. My uncle loved her so much that he couldn't let her go. My grandmother's soul felt so loved that she couldn't depart her physical form. It no longer grieves me to think about the way she died.

"I think there needs to be a change in the way the medical community handles end-of-life care in Alzheimer's disease. We need to discuss patients' wishes before dementia impairs their ability to do so. As doctors, we must also realize the power and responsibility we have to help advise surrogate medical decision-makers when a loved one is dying. Until we have a cure for Alzheimer's disease, we need to see death as a natural end point, not an unfortunate outcome."

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The author being blessed by a Dominican sister during his first days of life.

PHOTO COURTESY OF DOMINIC DECKER

reminder of the most profound moments in life.

On that August day, I was placed on an altar and blessed by a woman who had dedicated her life to providing end-of-life care. The Dominican sisters have since turned operations of the hospice over to the Franciscan Health Community, who renamed it Our Lady of Peace Home. But my family's connections with them endure. While living in New York City, I did fieldwork for my master's thesis, which focused on storytelling at the end of life, at Rosary Hill Home, another free hospice.

My exposure to hospice made me realize how my preclinical training was almost solely focused on curative interventions. Lecture after lecture would outline disease pathophysiology and follow with slides on treatment modalities. One of those talks stood out. It was given by a pulmonologist on COPD. The treatment slides listed the usual interventions: bronchodilators, corticosteroids and pulmonary rehabilitation. Also included was the option of palliative care. This was one of the only mentions of palliative treatment during my preclinical years.

It wasn't until I transitioned to the clinical years that the role of the physician was reframed from someone who cures to someone who alleviates suffering.

I spent the first day of my fourth year in orientation for a rotation in a medical intensive care unit. It included a presentation on advance care planning by Honoring Choices Minnesota. This discussion of goal-oriented, patient-centered care shaped my month in the ICU. And it was with this in mind that I met Jim.*

Early one morning, I admitted Jim with acute-on-chronic renal failure in the setting of epistaxis, rectal bleeding and poor oral intake. The emergency department

*Patient's name has been changed.

Early *adopter*

Exposure to comfort care as a child helps a medical student chart his career path.

BY DOMINIC DECKER

At 6 days of age, I made my first visit to a hospice. It was the feast of St. Dominic, for whom I am named. My parents brought me to Our Lady of Good Counsel Home, a free hospice in St. Paul for terminally ill cancer patients, which

was staffed by a group of Dominican sisters. My mother and father had been volunteering there for several years. Bringing me to the home during my first week of life served as my birth announcement. It also created a rich image, the juxtaposition of birth and death, and served as a visible

note that preceded his arrival painted a grim picture: Emergent hemodialysis was being considered for his significant kidney injury and his hemoglobin was falling, raising the suspicion of an ongoing bleed. When I entered his room, I expected an obtunded patient and limited history. Instead, I found a pleasant man wrapped in blankets and ready to talk.

Jim confirmed what the ED had reported. The past few days had been particularly hard. He was living with a roommate in a nearby duplex and had been trying to return to his hometown, where more of his family and friends were living. He was charming, smart and ornery, a combination of personality traits that could make me laugh at 3 a.m. during my most demanding month in medical school.

Jim was transferred out of the ICU later that day after his condition had stabilized. I assumed I would never see him again.

As my month in the ICU came to an end, I prepared to begin my next rotation, an elective in palliative care. The pulmonologist who lectured on COPD and mentioned palliative treatment options became my attending. And the man I admitted a month earlier to the ICU at a different hospital once again became my patient.

Although Jim appeared more frail and gaunt, he still had a smile that belied his condition. He remembered me from the other hospital. Now, with a second admission in about a month, it was clear his health was deteriorating. The palliative care team responded by discussing his goals of care.

Jim's hospitalization was lengthy, affording me the opportunity to check in with him frequently and fully realize the medical student's role: to listen and be present at the bedside, to let the patient be the teacher. Our conversations picked

up where they left off in the ICU: We discussed home and family, the reality of disease and the inevitability of death. Jim confided in me that he was concerned about what death would look like for him. I told him how special he was to me and how much he taught me about medicine, something I had never before expressed to a patient.

Jim died on the last day of my palliative care rotation. He was in a quiet room in the hospital, disconnected from monitoring equipment, covered in a blue quilt. Family members were at his bedside and his favorite music was playing.


As I prepare for residency, I often think about Jim. It's my ongoing tribute to his life and its impact on mine.

Many of my most memorable patient encounters took place during my palliative care rotation. When asked during resi-

ducing why I wanted to become a physician, or train in internal medicine, it is this field that I refer to—a field that has quite literally been influencing me since my first days of life. **MM**



Dominic Decker is a fourth-year medical student at the University of Minnesota. He is applying for residency positions in internal medicine.



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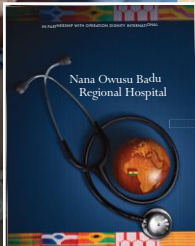




PHOTO BY KATHRYN FORSS

ROUND TWO:

MMA gears up for another prior auth legislative push

BY DAN HAUSER

Since the 2015 legislative session ended in May, the MMA has been hard at work preparing for the next one, which begins March 8. Again, the top priority is prior authorization (PA) reform.

“We made some good progress last session,” says Dave Renner, the MMA’s director of state and federal legislation. “But we can’t let up. We need to continue pushing for change. Legislators have a lot on their plates so it’s crucial for us to keep up our momentum.”

Last year, the MMA helped write legislation to transform prescription drug PA in Minnesota. The association also created a coalition of more than 40 partners representing both patient and physician groups to support this effort to change the process. (For more information, visit www.FixPANow.com.)

Bipartisan bills were introduced in both the House and Senate. The bill passed through four committees in the Senate with overwhelming backing. However, it never received a hearing in the House because of concerns that it would significantly hamper health plans’ and pharmacy benefit managers’ ability to control costs.

Since last session, MMA staff members have spent considerable time working with key lawmakers and coalition members to maintain and build support for passage in 2016.

However, the 2016 session will be short (it begins March 8 and concludes around May 20). That’s only 10 weeks and heavy lifting in the form of tax, transportation and bonding bills stands in the way. “As a result of the short session, it’s possible further concessions will need to be made to neutralize opposition and costs,” Renner says.

MMA staff organized receptions with several key legislators last fall. The first included Rep. Tony Albright (R-Prior Lake), the chief author of the House bill. At the reception, several physicians related stories about how PA has hurt their patients and cost their practice money and time.

“Prior authorization calls and follow up cost the average physician \$68,000 each year,” says Phil Raines, MMA manager of grassroots and political development. “That adds up to more than \$800 million

ICSI findings align with MMA bill

Minnesota’s health plans have acknowledged that the current PA processes need fixing through their participation in an Institute for Clinical Systems Improvement-convened group that studied medication prior authorization. The recommendations from the group mirror many of the components of the legislation drafted by the MMA. The MMA now needs to convince the health plans that a legislative solution is necessary to ensure patients access to needed medications.

for Minnesota clinics alone. It needlessly postpones and degrades patient care.”

Another event included Rep. Tara Mack (R-Apple Valley), chair of the House Health and Human Services reform committee. Afterward, Mack expressed her interest in working with the MMA on changes to the bill to remove some of the opposition.

The MMA's push continued in early December with a reception for Sen. Melisa Franzen (DFL-Edina), the author of the Senate bill. MEDPAC, the MMA's political action committee, continued the campaign with an event with Rep. Matt Dean (R-Dellwood), an influential leader on health care matters at the Capitol.

In addition, the MMA is tapping the Fix PA Now coalition to find patients who are willing to share their stories and testify at the Capitol about how the current process for medication prior authorization is getting in the way of their needed care and is adversely affecting them.

“To make a significant difference, we need patients to tell lawmakers in their own words how the process impacts their lives and that it needs to be fixed now,” Renner says. “They can do this by testifying in legislative hearings, writing letters and emails to their legislators, authoring op-eds for their local paper and agreeing to be featured in newspaper articles on prior auth.”

If you have a patient who has been adversely affected by prior authorization and is willing to tell their story publicly, please email Dan Hauser, dhauser@mnmed.org or Dave Renner, drenner@mnmed.org.

MMA makes electronic prior auth materials available

As of January 1, 2016, all Minnesota prescribers are required to submit, and payers are required to accept, electronic prior authorization requests for prescription drugs. Electronic prior authorization, or ePA, is part of Minnesota's Electronic Prescription Drug Program law. For more information, visit www.mnmed.org/Advocacy/Prior-Authorization. There, you'll find a fact sheet, answers to frequently asked questions, and a link to a webinar on how to comply with the law.

News Briefs

Intractable pain added to list of qualifying conditions for medical cannabis

In early December, Health Commissioner Edward Ehlinger, MD, added intractable pain to the nine qualifying conditions already allowed

in the state's medical cannabis program. Patients certified as having intractable pain will be eligible to receive medical cannabis



from the state's two manufacturers starting August 1, 2016.

In a statement to the media, MMA President Dave Thorson, MD, said: “The MMA remains concerned about the expanded use of medical cannabis, particularly for conditions such as intractable pain that are difficult to objectively certify. Treatment of severe and chronic pain deserves careful consideration and medical cannabis should never be a first-line therapy. Significant questions about the efficacy of medical cannabis remain and we continue to call for additional well-controlled studies. The MMA looks forward to further guidance from the health department regarding how intractable pain will be added to the state's medical cannabis program, and we will continue to provide education and information to Minnesota physicians who may be interested in participating in the program.” (See “Viewpoint,” p. 28.)

Five MMA members take part in opioid prescribing work group

The Minnesota Department of Human Services' opioid prescribing work group began meeting in November in an effort to improve prescribing and monitoring the use of these drugs in Minnesota. The group plans to meet through 2017. MMA members on the team include: **Chris Johnson**, MD, Emergency Physicians Professional Association; **Ernest Lampe**, MD, Minnesota Department of Labor and Industry; **Charles Reznikoff**, MD, Hennepin County Medical Center; **Jeffrey Schiff**, MD, MBA, Minnesota Department of Human Services; and **Lindsey Thomas**, MD, Hennepin County Medical Examiner's Office.

The work group is tasked with:

- Recommending protocols that address all phases of the opioid prescribing cycle
- Overseeing development of educational resources and messages for providers about communicating with patients about pain and the use of opioids to treat pain

- Recommending quality improvement measures to assess variation and support improvement in clinical practice
- Recommending two thresholds directed at physicians and other providers who work with patients enrolled in Minnesota Health Care Programs (MHCP) and have persistent, concerning prescribing practices: one threshold that will trigger quality improvement; the other termination from MHCP.



Magazine wins three MMPA Excellence Awards

Minnesota Medicine won three awards at the 2015 Minnesota Magazine & Publishing Association Excellence Awards held in mid-November. They included:

- Gold – How-to Article—“How 10 High Achievers Do

It” (August 2014)

- Gold – Single-topic Issue, Special Section or Special Supplement – the Arts Issue (July 2014)
- Bronze – Overall Excellence

International medical grad advisory group begins work

The legislatively mandated International Medical Graduates (IMG) Assistance Program’s Stakeholder Advisory Group met for the first time in late October. The group, which includes one MMA representative, **Amrit B. Singh**, MBBS, was created to guide and advise the IMG Assistance Program. The program grew out of work that began in 2014 when the Minnesota Department of Health convened a Foreign-Trained Physician Task Force, chaired by MMA member **Edwin Bogonko**, MD. Earlier this year, the Legislature created the assistance program and enacted many of the task force’s recommendations. The program is designed to help immigrant international medical graduates integrate into Minnesota’s health care delivery system.



Dionne Hart, MD

Member featured in book on black women in medicine

MMA member **Dionne Hart**, MD, is featured in a recently published book highlighting portraits and biographical accounts from more than 100 of the most prominent historical and contemporary black women physicians in the country. *Against*

All Odds: Celebrating Black Women in Medicine is the print companion to the upcoming documentary film, *Changing the Face of Medicine*.



MMA launches new initiative on reducing health care costs

The MMA is launching a significant new effort focused on health care affordability. The MARCH Campaign (Minnesota Action to Reduce Costs in Healthcare) initially will address three topics: 1) administrative burden and inefficiencies; 2) prescription drug costs; and 3) low-value and unnecessary care. A 15- to 18-member steering committee, which will meet six to eight times in 2016, is being assembled to help guide the campaign’s work.

Minnesotans named to medical license compact commission

Two Minnesotans, including one MMA member, have been appointed to the Interstate Medical Licensure Compact Commission by Gov. Mark Dayton. Minnesota is among 11 states that have enacted the compact, which allows for an accelerated process for eligible physicians to become licensed in multiple states. Dayton named MMA member **Jon Thomas**, MD, and Ruth Martinez, MA, as representatives from Minnesota. Thomas is an otolaryngologist and chief operating officer of Ear, Nose and Throat Specialty Care of Minnesota and a member of the Minnesota Board of Medical Practice (BMP). Martinez is the BMP’s executive director.



MMA Foundation event raises nearly \$50,000

“Care Where it Counts,” the MMA Foundation’s fall fundraising campaign, welcomed 70 guests and raised nearly \$50,000 at events held in Rochester and the Twin

Cities. The free gatherings highlighted the foundation’s Physician Loan Forgiveness program and featured an appearance by MMA member **Robert Jeske**, MD, who practices family medicine in Waseca. Jeske is one of six primary care physicians practicing in a medically underserved community who have received assistance from the Physician Loan Forgiveness program. The MMA

Foundation's goal is to improve access to care in underserved Minnesota communities and to support medical students through scholarships.



The AMA's Bruce Bagley, MD, spoke to independent physicians about managing their lives and practices.

Forum addresses opportunities and challenges for independent practices

Recruiting and retaining physicians. Sustaining a referral base in a consolidated market. Having to meet performance standards with limited resources. Feeling

like you have to know everything. Those are among the issues that keep physicians in independent practices awake at night,

according to those who attended an MMA-sponsored forum in November. The forum featured Bruce Bagley, MD, MAAFP, a family physician and practice redesign expert with the American Medical Association (AMA), who discussed how physicians can adapt to a changing environment, prevent burnout and utilize the AMA's STEPS Forward practice improvement program. About 25 physicians attended in person; 15 more attended online.

Medical student section elects 2016 leaders

The MMA Medical Student Section elected its new leaders in December, installing **Augustin Joseph**, Mayo Medical School, as chair; **Erica Sanders**, the University of Minnesota Medical School, Twin Cities campus, as vice chair; **Stephen Palmquist**, the University of Minnesota Medical School, Duluth campus, as delegate; **Annabelle Soares**, Mayo Medical School, as alternate delegate; and **Gretchen Hoff**, the University of Minnesota Medical School, Twin Cities campus, as secretary.

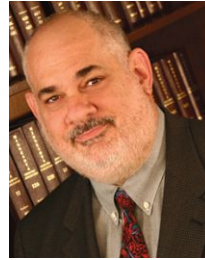
Trauma surgeon wins Bolles Bolles-Rogers Award

David J. Dries, MSE, MD, FACS, FCCP, MCCM, a trauma surgeon and critical care specialist at Regions Hospital in St. Paul, received the Charles Bolles Bolles-Rogers Award from the Twin Cities Medical Society Foundation.

On the calendar

Event	Date	Location
Day at the Capitol	March 23	DoubleTree by Hilton Hotel, St. Paul Downtown
2016 Annual Conference	Sept. 23-24	DoubleTree Park Place Hotel, St. Louis Park

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



Robert Meiches, MD



Mandy Rubenstein



Dave Renner



Janet Silversmith



Eric Dick

MMA in Action

In mid-November, **Robert Meiches**, MD, presented an MMA update at a Sanford Midweek Conference in Bemidji. Meiches and **Mandy Rubenstein**, manager of physician outreach, also met with the St. Cloud Medical Group Board of Directors.

Dave Renner, MMA director of state and federal legislation, is attending the AMA State Legislative Conference in January. While there, he will chair a meeting of the AMA Advocacy Resource Center Executive Committee.

Janet Silversmith, MMA director of health policy, presented on the Medicare Access and CHIP Reauthorization Act of 2015 to Allina Integrated Medical Network's board of directors in mid-November. She also presented on the topic at the Allina CEO Summit in early December. Silversmith also met with representatives from the Institute for Clinical Systems Improvement to review their prior authorization recommendations.

Eric Dick, MMA manager of state legislative affairs, presented the MMA's legislative priorities to a meeting of the Rural Health Advisory Committee in mid-November. The 15-member panel made up of health care providers, legislators, consumers and others advises the Legislature and governor on health care issues of concern to rural Minnesota. The committee is chaired by MMA member **Daron Gersch**, MD, a family physician from Albany, Minnesota.

VIEWPOINT

Questions about medical cannabis linger

On December 2 of last year, Health Commissioner Edward Ehlinger, MD, cleared the way for intractable pain to be added to the list of conditions that qualify patients for entry into the state's medical cannabis program. That means that come summer, your patients who suffer from lower back pain, for example, may start asking you a lot of questions. Are you prepared to answer them?

The state's medical cannabis program has been controversial, from a physician's point of view, even before Gov. Mark Dayton signed it into law on May 29, 2014. An MMA survey found that our members were divided on the issue. The MMA neither endorsed nor opposed the final legislation. We did work with lawmakers early on to ensure that we weren't put in the untenable position of having to prescribe a Schedule I drug. We also worked to incorporate some research capacity into the program.

To this day, there are many concerns about the drug's efficacy. There is nothing close to the stringent testing we have grown accustomed to with FDA-approved medications. And many physicians are even more cautious regarding its use for treating intractable pain, a condition that is more prevalent and difficult to manage.

Nonetheless, it is the law.

I am one of the 471 health care practitioners who is registered and authorized to certify patients for the state's medical cannabis program. My practice, Entira Family Clinics, signed on as a group certifier this past summer. What this means is that I can end up certifying a patient of one of my colleagues—a patient who I don't normally see. As of the end of 2015, I had certified just two patients. Overall, 822 individuals in the state had been approved to obtain medical cannabis.

One of the patients I certified actually decided against purchasing the state-approved cannabis, saying that it is cheaper to buy it on the street. Plus, I've heard from many people that the street version is preferable because they can smoke it, which they claim relieves their pain more quickly.

As physicians and scientists, we continue to question whether the data support the use of medical cannabis—or any other medication—until it is scientifically demonstrated to be an effective treatment. But, as caregivers, we can't deny the perception and anecdotes that it works for some people. We also can't be naive in thinking that very ill and worried patients won't seek alternatives—whether that be cannabis or another product.

It will be interesting to see if intractable pain dramatically alters the size and scope of Minnesota's medical cannabis program. If you haven't already been approached by a patient, there's a good chance you will be with the addition of this condition. Will you be comfortable in certifying your patient for use of medical cannabis? Will you dismiss them outright? Will you be ready to counsel them on more sound alternatives, even if they insist on cannabis? How do you respond if they say they are going to get the drug on the street so they can get it in smokable form?

In other words, there's a lot for physicians to contemplate over the next few months.

Good or bad, Minnesota's medical cannabis program is here to stay. We need to be prepared to support and advise our patients when they ask about it. The MMA will be continuing to provide physicians with information and education about the expanded program in the coming months.



Dave Thorson, M.D.
MMA President

PHOTO BY KATHRYN FORBES

Good or bad, Minnesota's medical cannabis program is here to stay. We need to be prepared to support and advise our patients when they ask about it.

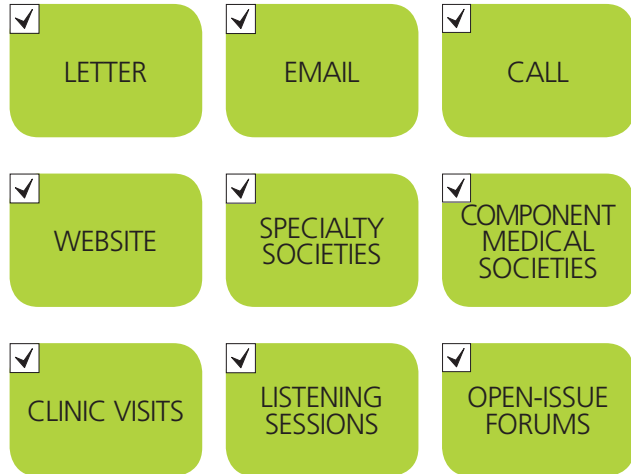
HOW TO BE HEARD

Got an idea that should become MMA policy? Follow these steps to get it considered.



STEP 1

Introduce your idea through one of these nine channels.



IF YOUR IDEA GENERATES INTEREST, PROCEED TO STEP 2



STEP 2

Your idea has moved forward for consideration by one of these three forums:



IF ONE OF THESE THREE GROUPS PASSES YOUR IDEA ON, PROCEED TO STEP 3



STEP 3

Last step! Your idea will be discussed and decided upon by the Board of Trustees.



DID THE BOARD OF TRUSTEES ACCEPT IT? CONGRATULATIONS!

SUCCESS!

Your idea made it all the way through, and has become **NEW MMA POLICY**.

Minnesota's Right to Try law

Physicians may be better off following the FDA's compassionate use process than turning to the state's new law to help the terminally ill access investigational therapies.

BY LAURA D. HERMER, JD, LLM

Patients with life-threatening illnesses who do not respond to current therapies often seek out alternative treatment options. Such patients may become frustrated when they learn that new therapies that are under investigation and available to patients participating in clinical trials are not available for general use. The Food and Drug Administration (FDA) does grant exceptions that allow patients who are not part of a clinical trial access to such therapies through a "compassionate use" process. However, gaining an exception has been criticized as being excessively arduous and time-consuming.

In response to the perceived shortcomings of the FDA process, 25 states, including Minnesota, have recently enacted so-called "Right to Try" legislation. These laws are an attempt to circumvent the need for the FDA compassionate use process by granting permission at the state level to use investigational therapies in a non-investigational context. Because of possible legal and other problems, physicians and patients seeking access to investigational therapies would be well-advised to continue doing so by following the FDA process rather than assume they are protected under the new state law.

Minnesota's Right to Try law

Minnesota enacted Right to Try legislation in the spring of 2015. The law went into

effect in August. Similar to those enacted in most of the 25 other states with Right to Try laws,¹ Minnesota's new law is largely based on model legislation proposed in 2014 by the Goldwater Foundation, a libertarian organization based in Arizona.²

Minnesota's law allows eligible patients to access investigational drugs, biologics and devices that have successfully passed a phase 1 investigational trial, are the subject of an FDA clinical trial and are not yet available to the public.³ Eligible individuals include those whom a physician has deemed to have an illness that, "to a reasonable degree of medical probability, is not considered reversible and even with the administration of current FDA-approved and available treatments and the administration of life-sustaining procedures will soon result in death."⁴

In order to access an investigational treatment, three conditions must be met. First, the patient's physician must document that both he or she and the patient have considered, but not necessarily tried, all currently available FDA-approved therapies for the patient's illness.⁵ Second, the patient or, if the patient is incapacitated, his or her legal guardian, must provide written informed consent for the proposed treatment.⁶ Third, the physician must give the patient a prescription or recommendation for the investigational drug, biologic or device.⁷



The law does not ensure access to the therapy. Nor does it require a pharmaceutical company or device manufacturer to make the prescribed or recommended treatment available.⁸ Additionally, nothing in the law prevents a company from charging the patient for the cost of manufacturing the treatment.⁹ The law does not require a health insurer, state health program, state employee coverage plan, or state or local health program for inmates to cover the cost of the treatment.¹⁰ Thus, while the law may ostensibly give eligible patients the "right" to have an investigational treatment, it does not help them obtain or pay for it.

At the same time, the law does provide certain protections for prescribing/recommending physicians. It protects a physician from disciplinary or other action against his or her medical license for having simply prescribed, recommended or provided a treatment.¹¹ It also ensures that a provider or health care entity cannot be sued under Right to Try for damages that a patient may incur from using an investigational therapy, "so long as the health care provider or entity is complying with the requirements of this section [of the law]."¹²

The FDA and federal law

Minnesota's Right to Try law provides only theoretical access to investigational therapies outside a clinical trial. Although no

state Right to Try law has been challenged in court, it is likely that a court would find that the FDA has exclusive authority to permit or deny compassionate use of unapproved, investigational therapies. As such, the FDA's regulatory framework likely preempts Right to Try laws such as Minnesota's.

Congress provided the FDA with the authority to grant access to investigational drugs and devices to individual patients or groups of patients upon a physician's request.¹³ In order to grant such access, federal law requires the FDA to establish, with respect to each request for an investigational drug, that

1) The patient or patients have a serious or life-threatening disease or condition for which there is no comparable or satisfactory alternative therapy;

2) The potential benefit to the patient justifies the potential risks of the treatment and those potential risks are not unreasonable in the context of the condition to be treated; and

3) Providing the investigational drug for the requested use will not interfere with the initiation, conduct or completion of clinical investigations that could support marketing approval of the expanded access use or otherwise compromise the potential development of the expanded access use.¹⁴

In order to have the information necessary to make such findings, the FDA requires the requesting physician to submit an application for expanded access or compassionate use that certifies, among other things, the rationale for the intended use of the drug, a description of the patient's disease or condition, the "method of administration of the drug, the dose and the duration of the therapy," and information regarding the manufacture and pharmacology of the drug.¹⁵ Alternatively, the sponsor of the clinical trial may provide information regarding the therapy to the FDA, amend its investigational new drug (IND) application to include a protocol for individual use or allow a requesting physician to refer the FDA to the sponsor's IND for relevant information.¹⁶ In the case of an emergency, where treatment

must begin before the paperwork can be submitted (eg, "within a very limited number of hours or days"),¹⁷ this request may be made by telephone,¹⁸ with the understanding that the requesting physician must agree to submit a written application within 15 days of the FDA's authorization of use of the investigational drug,¹⁹ and report the emergency use to the relevant Institutional Review Board within five days.²⁰ The physician must also, under most circumstances, obtain informed consent for the use of the drug that takes into account its investigational nature.²¹ A sponsor may charge for making its investigational drug available; however, it may only recover its "direct costs," or costs per unit for manufacturing and shipping the drug.²²

What physicians need to know

Complying with FDA requirements for compassionate use or expanded access can be time-consuming. The FDA estimates that it takes approximately eight hours for a physician to complete the application for a patient to be considered for expanded access to an IND.²³ The vast majority of those applications are approved. Of the 1,069 emergency INDs that the FDA received between October 2013 and October 2014, 1,066 were approved. Of the 696 single-patient IND requests received during the same time period, 692 were approved.²⁴

In response to criticism about its expanded access process, the FDA released draft guidance in February 2015 that, if approved, would streamline the process.²⁵ It would establish use of a new simplified application form (Form FDA 3926), which the FDA estimates will take only 45 minutes to complete. However, until the guidance is approved, physicians should continue to submit Form FDA 1571.²⁶

Minnesota physicians and their patients may be better served by continuing to adhere to the FDA's requirements, rather than by attempting to take advantage of the state's Right to Try law. First, federal law would likely trump a state Right to Try law, should the latter ever be challenged in court.²⁷ Generally, if both the federal and

state governments have enacted legislation on a particular subject, federal law will trump state law unless the federal legislation expressly permits conflicting or additional state regulation, or unless federal law contains no express preemption provision, does not provide a complete regulation of the subject in question, and does not conflict with relevant state law. Congress expressly permits states to regulate drugs, to the extent state law does not conflict with federal law on the subject.²⁸ However, given that Minnesota's Right to Try law appears to conflict with federal law by pointedly diminishing the required safety provisions, it is quite possible that, if the state law is challenged, a court would hold that federal law preempts sections of Minnesota's law.

Second, it seems doubtful that anyone citing only the authority of state law and not also federal law would be able to successfully convince a commercial drug manufacturer to provide a patient with an investigational drug. PhRMA, the pharmaceutical research and manufacturing association, has stated:

"While these [Right to Try] bills may be well-intentioned, they seek to bypass FDA oversight and the clinical trial process, which is not in the best interest of patients and public health, and is unlikely to achieve our shared goal of bringing innovative, safe and effective medicines to patients as quickly as possible. Because of the FDA's critical role in ensuring the safety and effectiveness of prescription drugs, and the agency's ultimate oversight of clinical trials and new drug approvals, state-by-state 'right-to-try' legislation is unlikely to help optimize the existing federal expanded access process."²⁹

To date, it does not appear that any patient has successfully used a state Right to Try law to access an investigational therapy.

Next step

One might wonder about the purpose of the Right to Try laws. Although they ostensibly offer an option for providing terminally ill patients with access to investigational therapies not yet approved

by the FDA, they cannot be used to force manufacturers to provide patients with unapproved therapies, nor can patients use these laws to force physicians to prescribe such therapies. If the point of the Right to Try laws is to spur the FDA to make compassionate use more user-friendly, they may be achieving that goal.³⁰ In the meantime, patients likely will be best served if physicians continue to follow federal compassionate use regulations and urge the FDA to finalize its draft guidance streamlining the compassionate use process. **MM**

Laura Hermer is a professor in the Mitchell Hamline School of Law in St. Paul.

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We need to end the paper trail

Why all physicians need to use the state's electronic system for registering births and deaths.

BY MOLLY MULCAHY CRAWFORD

Every day, more than 300 births, deaths and fetal deaths occur in Minnesota. Physicians play a critical role in documenting these vital events quickly and precisely. Records of these events contain demographic and legal information, and important health and medical information as determined by a physician. This information is used to monitor mortality trends and identify public health concerns that need to be addressed.

Registering births and deaths

Registering a birth with the state is straightforward. One reason is that nearly 99 percent of the 69,000 births that occur in Minnesota each year take place in hospital birthing centers, where systems are in place for gathering and reporting such information.

Physicians have an indirect role in birth registration, as they are responsible for maintaining the mother and child's medical record. In almost all cases, a designated representative from the hospital (usually a health unit coordinator or a member of the medical records staff) manually enters information from those records into the Minnesota Registration and Certification (MR&C) system, the state's electronic vital records system. (Currently, electronic health record systems in hospitals and clinics are unable to exchange information with the state's vital records system.) Some of the information they enter includes the mother's hepatitis B status, abnormal conditions and congenital anomalies in the newborn, breast-feeding status and maternal morbidity. According to law, a birth, including the required medical information, must be registered with the state within five days.

Registering a death is more complicated. Unlike birth records, death records have two parts. One deals with facts, such as

demographic and legal information about the decedent. The other delineates the cause of death and includes relevant medical information. Although a death certificate can be issued with only the facts, both parts are required for a death record to be complete, and both parts are often needed to settle an estate.

Funeral establishments record the facts of a death, and Minnesota law requires that this information be filed with the state within five days of the event.

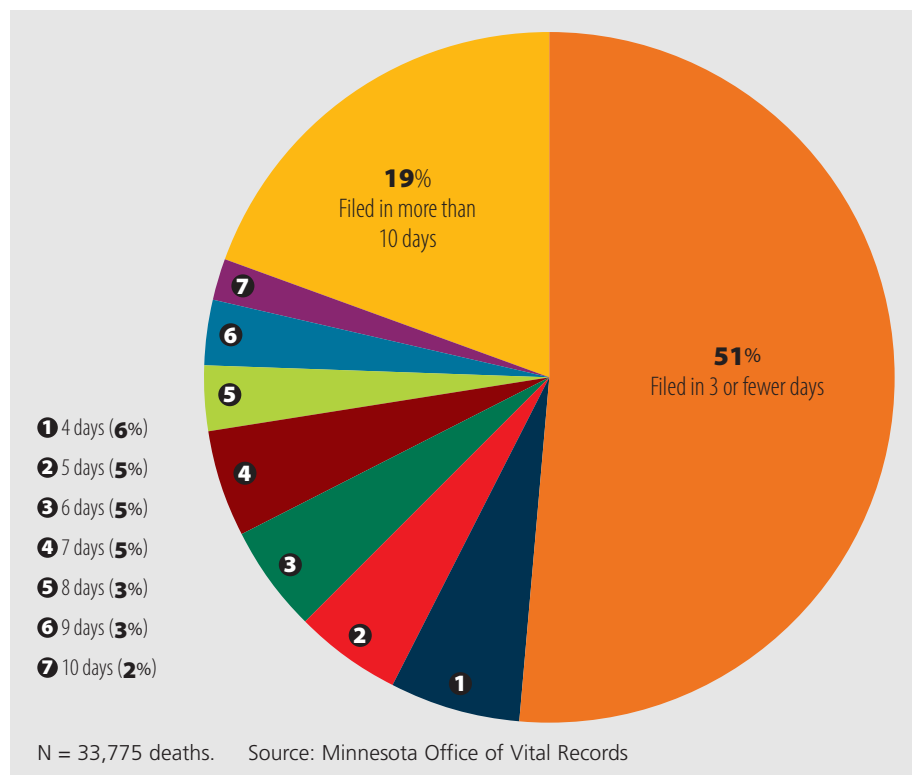
State law requires medical certifiers, including treating physicians, coroners and medical examiners, to document the cause of death and answer questions about it, including whether an autopsy was performed, the manner of death (natural,

suicide, homicide, accidental), whether the decedent was pregnant at the time of death, whether tobacco use contributed to the death and more (Minnesota Rule 4601.1800).

There is no statutory deadline for medical certifiers to register the cause of death. According to data from the state Office of Vital Records, the cause of death was provided within three days for more than half of deaths registered between January 1 and October 31, 2015 (Figure). It was provided more than 10 days after death in 19 percent of cases, often because the record was referred to a medical examiner or coroner or because the physician was waiting for toxicology findings or autopsy results.

FIGURE

Length of time after death during which medical information was filed by physicians in Minnesota, January 1 – October 31, 2015.



More than half of the 41,500 people who die each year in Minnesota are cremated. State law requires a body to be preserved if final disposition will take place more than 72 hours after death. To save costs, families often want cremation to take place within that period. Because Minnesota law requires that the cause of death be known and authorizations be obtained before final disposition, the onus is on the physician to file the necessary information about the cause of death in a timely manner. As more people choose cremation, prompt filing of the medical information about the cause of death will become even more important.

The paper problem

All births and deaths are registered electronically through the MR&C system. This system is used by all hospital birth registrars, funeral establishments, medical examiners and coroners, and issuance offices. Yet, only 81 percent of the records filed by physicians are done so electronically. Further, of the records that come to the Office of Vital Records for manual entry of cause of death information, 27 percent come from physicians who are signed up to use the MR&C system, but send paper. This perpetuation of paper is a problem for everyone involved in vital records activities.

If a physician doesn't use the MR&C system or if they use it but don't tend to emails notifying them that there is a death record needing their attention or check their MR&C work queue, it's up to the funeral establishment to make sure they submit the necessary information. More often than not, funeral staff end up faxing the physician a worksheet to use to complete the cause of death. Sometimes the physician will fax that to the state, only to get an email notification from the MR&C system telling them to provide the cause of death electronically. This can result in confusion and extra work for the funeral staff and the physician.

Continuing to provide cause-of-death information on paper also leaves room for error and can result in different reasons being recorded on the disposition

documentation and the death record. For example, functionality within the MR&C alerts physicians when data they provide seem unlikely, such as uterine cancer being the cause of death of a male or natural death being categorized as an overdose. These scenarios can go unchecked if the information is entered manually.

One way to maximize the use of the MR&C system is for physicians to designate a representative who can enter data on their behalf. Practices whose physicians want their partners to be able to register cause-of-death information in their absence were among the first to do this. Now, some large health systems including Mayo Clinic and Essentia Health have staff who act as death registrars and shepherd records through completion within their facilities. Internally, physicians provide the cause of death information to their designees who then document the information and assure that complete and accurate health and medical data are filed without delay.

In fact, of the death records that have cause of death filed directly into the MR&C system, only 25 percent are filed by physicians who log in with their user account and password. The other 75 percent are completed by their designated staff. Physicians need to work with the Office of Vital Records to appoint a designee to submit cause-of-death information on their behalf.

The importance of electronic data

Registering deaths electronically has public health benefits. Because of the improved timeliness for filing death records when people use the MR&C system, Minnesota now sends daily files to the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS). The NCHS automatically provides numerical codes from the International Classification of Diseases, 10 Revision (ICD-10) and returns the files to the Office of Vital Records. The quick turnaround allows the Minnesota Department of Health to share nearly real-time death data unlike ever before.

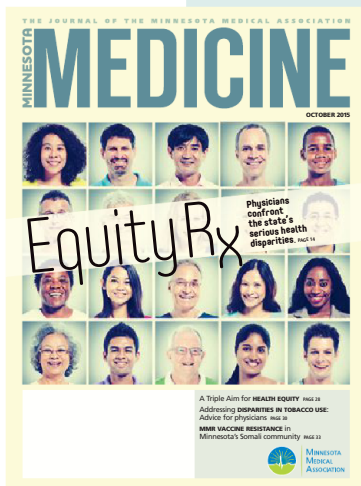
Local public health agencies are now using this information to conduct surveillance and plan prevention activities. Having real-time death data allows them to respond to emerging issues (eg, drug overdose deaths) in a more timely manner. It also helps them address persistent public health concerns such as traffic fatalities, infant mortality and sudden, unexpected infant deaths. In addition, the City of Minneapolis is incorporating 2014 death data into the Big Cities Health Inventory, a project designed to illustrate the major health issues that affect urban communities. The Metro Public Health Analysts Network, which consists of nine city and county public health agencies in the Minneapolis/St. Paul metro area, is exploring opportunities to use this data to conduct surveillance around 18 mortality indicators.

Less paper, greater benefit

Information about births, deaths and fetal deaths is important to families, public health agencies, health care organizations that monitor performance and conduct quality assurance activities, life insurance companies, and other entities. Physicians' commitment to recording health and medical information related to vital events is crucial to the success of the state's vital record system. With their voluntary compliance, we can work smarter and faster and with fewer resources, informing public health, serving families and improving lives one record at a time. **MM**

Molly Mulcahy Crawford is State Registrar in the Minnesota Department of Health's Office of Vital Records.

For more information about physician responsibilities and requirements when registering a death or to register a designee to submit medical data, contact the Office of Vital Records at 651-201-5993, 888-692-2733 or Health.MRCAdmin@state.mn.us. The Minnesota Department of Health also maintains information on its website specifically for medical certifiers at www.health.state.mn.us/divs/chs/osr/physician-me/.



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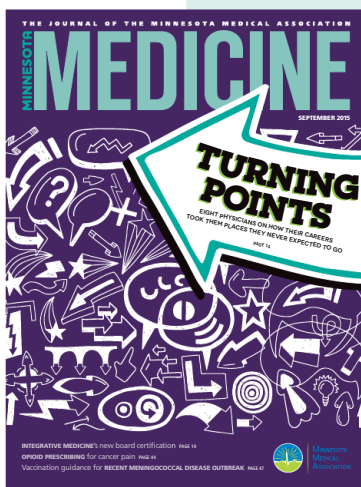


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Having a Meaningful Conversation with Patients about the End of Life

Six Tips for Physicians

BY JULIE BENSON, MD

Physicians receive little training in medical school and residency about how to talk with patients about their end-of-life wishes. Consequently, they often feel uncomfortable discussing the topic, even if the patient brings it up. As the population ages and as patients become more involved in their health care decisions, physicians will need to have more of these conversations. This article provides guidance for having these difficult conversations.

For many physicians, talking to their patients about serious life-limiting illnesses and end-of-life decisions is a struggle. It's a skill not regularly taught in medical school or residency. If they are exposed to training on how to have end-of-life discussions, it's often during clinical rotations and only if the subject comes up. One study found only 17% of medical school faculty reported having taught some aspect of end-of-life care to residents and medical students in the past year.¹ In medical school, students are required to spend four to six weeks doing clinical rotations in obstetrics and gynecology, but only 50% of the population is at risk for obstetric or gynecologic issues. Contrast that with the limited amount of time medical students and residents spend learning about a process that 100% of patients will experience—dying—and it's no surprise that many physicians have difficulty talking to their patients about their end-of-life wishes.

As the population ages, more and more people want to be informed about and involved in their own health decisions. And

that means physicians will need to have conversations with them about planning for the inevitable. In a recent survey of residents in three Minnesota communities, nearly everyone interviewed reported that they would want to talk with their doctor about hospice if they knew that their illness was serious or life-threatening.²

The topic of end of life, however, can be the elephant in the exam room. Patients often believe their physician will bring up the subject if and when it is necessary. Yet, physicians worried about taking away their patients' hope may not bring it up unless the patient inquires.³ Thus, no conversation ensues.

Physicians need to both initiate and skillfully conduct these conversations. The following is some basic guidance to help them sharpen their skills when it comes to talking to patients about their end-of-life wishes.

1. Identify the Need for a Conversation

Ideally, clinicians are talking with their patients about end-of-life issues over the course of their relationship. They especially need to have the conversation with certain patients at certain times. By ask-

ing yourself if you would be surprised if a patient died in the next year, you can often identify patients for whom end-of-life conversations are especially necessary. Ask yourself this question when a patient is admitted to the hospital, in a clinic setting, at the time a serious illness is diagnosed, or during follow up.

2. Clarify the Prognosis

Next, the clinician needs to understand the patient's prognosis and what it means in terms of life expectancy as well as morbidity related to treatment options. Note that understanding the prognosis isn't necessarily the same as predicting life expectancy. These are two different pieces of information. Prognosis speaks to the probable course a disease may take, whereas life expectancy is simply the average time a patient will live given a particular diagnosis. So even if life expectancy is unknown, the course of the illness can be explained by its pattern of exacerbations and possibility of recovery or partial recovery.

Unfortunately, determining the prognosis for many serious illnesses can be difficult. Cancers are the diseases about

which we have the best delineated prognoses (with or without treatment). But that's not the case with progressive end-stage diseases such as congestive heart failure, COPD and dementia. That does not mean you should not have conversations about the end of life with patients who have these conditions.

Be sure to gather the appropriate information before initiating the conversation. Consider the patient's primary diagnosis and comorbid conditions. The Palliative Performance Scale⁴ sometimes can help you determine a patient's life expectancy. Also, be cognizant of the patient's current clinical situation. Have they had a repeat admission to an ICU for respiratory failure? Are they in the clinic for follow up for slowly advancing dementia?

3. Prepare for the Conversation

If you are struggling with what to say about a patient's prognosis and potential life expectancy, then employ the "mom test." Imagine your mother sitting in front of you. What would you want her to know and how would you want her to hear it? Remember that most patients are emotionally connected to their physician and would rather hear difficult news from him or her than from a consultant they have not yet learned to trust. Honor that relationship.

When planning for such conversations, schedule enough time to have a thorough discussion. Block time for them as you would for a surgery or procedure. If possible, have these conversations earlier in the disease process, when a crisis is not occurring. Also keep in mind that it's better to have a difficult conversation and have the patient improve than to not have it and have to face a patient and family who are unprepared, scared and angry. Having these conversations is never a waste of time, as they lay the groundwork for subsequent talks.

If you feel you do not have the skills or the time or enough information to

proceed with an end-of-life conversation, then a referral to a palliative care service is indicated. Palliative care clinicians can aid in complex medical, spiritual or family situations. If a palliative care team is not available, a hospice nurse or social worker may be able to assist even if it isn't time for a hospice referral.

4. Determine the Goals of Care

Goals of care often are determined over the course of several conversations. The SPIKES mnemonic can help you share information and elucidate the patient's goals of care:⁵

S (SETTING). Make sure the setting in which you're having the conversation is comfortable and private. Limit distractions by turning off cell phones. Include family members and loved ones if the patient wants them present. Consider having another member of the care team, such as a representative from social services, present to answer questions that you might not be able to.

P (PERCEPTION). Understand how the patient perceives their condition and their prognosis. Are they in denial? Have they received inconsistent or even conflicting information from other specialists? If so, it might affect their ability to understand their prognosis. Ask the patient to explain their understanding of their medical condition to date. It will give you a chance to hear it from them. You can then use some of their own language and terminology when you share your news.

I (INVITATION). Ask the patient if it's all right to share new results. Ask how much he or she wants to hear. You might start with, "Are you the sort of person who...?" Accept the patient's right not to know or to decline details at this time. Some may even defer all information to a family member. If a family member insists that the patient not be told certain information, ask the patient how much he or she want to know. Not every patient wants to know all the details. Cultural differences may influence the way information is shared.

K (KNOWLEDGE). Present information in small chunks. Give a warning that bad news is about to be shared. Saying

something like, "I am afraid the results aren't what we were hoping for" allows the patient to prepare for the next piece of information. Disclosing too much at once makes it less likely that the patient will understand and remember the details. Also, speak in lay terms, using some of the same language the patient has used to describe his or her condition. Stop frequently and allow time for everyone to absorb the information. Also check in with patients to make sure they understand what you're telling them. Ask them to repeat what they have heard to make sure they understand it.

E (EMOTIONS). Consider the impact on the patient of news about his or her condition. Ask how he or she is feeling and let him or her know you understand how or why they're feeling the way they are. Patients who feel they have been heard and understood are more likely than others to trust you and follow your advice. Offer comfort. It is acceptable for them to know you are struggling with this news as well. Hiding your feelings may actually distance a patient from you.

S (STRATEGY and SUMMARY). Conclude the conversation by summarizing the information you've shared and discussing the next step. Keep in mind that any change in the patient's condition requires a review of the goals of care. Goals can change, and you need to be flexible and truthful.

5. Create and Document a Plan

Once goals of care have been clarified, you can develop a plan for the patient. The plan should outline how symptoms will be managed, what support services may be needed and when, and who the patient's surrogate decision-maker is should he or she become incapacitated. Fill out an advance directive (AD) form or a POLST (Provider Order Set for Life-Sustaining Treatment) form if appropriate. However, just filling out an AD or POLST form is not enough. The plan needs to be documented so other members of the care

team are aware of it and can follow it. Not documenting these discussions carefully is like not writing an operative or procedure note.

Discussions regarding resuscitation are critical to a plan. Clarifying a code status is not as simple as asking: “Would you like to be resuscitated or not?” To be fair, that is what many of us were taught to do. Patients often believe resuscitation will be successful if it is initiated. They deserve accurate information about the likelihood of a poor outcome in the setting of serious or terminal illnesses. It is imperative that clinicians truthfully share this information in a manner that is compassionate and respectful of the patient’s stated goals of care and in light of their prognosis. Sometimes their code status needs to be revised after a proposed trial of limited therapy. Keep in mind this is often the last decision over which patients feel they have control.

Resources

Improving Generalist Palliative Care.

A 40-page guidebook published by the Palliative Care Network of Wisconsin that focuses on the education and systems changes necessary to embed goal-of-care conversations into care for seriously ill hospitalized patients. The book includes a step-by-step guide along with a sample EMR template, quality improvement guidelines, clinician communication guidelines, clinician educational resources and more.

www.mypcnow.org/#!about1/c22s6

Vital Talks.

Web-based videos that teach physicians how to navigate tough clinical situations. www.vitaltalk.org/clinicians/cultivate-your-skills

6. Offer Support

Never tell a patient there is nothing more you can do. It can send an unintended message of abandonment. There may not be any further treatment to offer, but there is always more you can do in the way of providing support and making your patient comfortable. If you feel you do not have the resources to support the patient, ask for help from a hospice or palliative care team. Supporting the patient, family and care team is what they do.

Looking to the Future

The Institute of Medicine’s 2014 report “Dying in America” found clinicians’ ability to handle end-of-life matters to be so deficient that it recommended that educational institutions, professional societies, accrediting organizations, certifying bodies, health care delivery organizations and medical centers take measures to expand all clinicians’ knowledge about end-of-life care.⁶

Indeed, with the current focus on the Triple Aim and, in particular, increasing quality in health care, it is likely that institutions will require clinicians to have specific training and competence in end-of-life planning in the near future. The Palliative Care Network of Wisconsin has developed a guidebook focusing on how to embed goal-of-care conversations into routine care for seriously ill hospitalized patients.⁷ Some hospitals in Wisconsin and elsewhere in the United States now require all medical staff to receive training on how to have such conversations with patients.

Conclusion

Medicine is complex. Life is unpredictable. We prepare expectant mothers and their families for the birth of a child with regularly scheduled prenatal visits, birthing classes and opportunities for education. Those with serious life-threatening illnesses deserve to be similarly prepared for dying and offered the same type of longitudinal support. Atul Gawande wrote, “The purpose of medical schooling was to

teach how to save lives, not how to tend to their demise.”⁸ It is time for this to change. And it all starts with a conversation. **MM**

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Palliative Care in Rural Minnesota

Findings from Stratis Health's Minnesota Rural Palliative Care Initiative

BY DEB MCKINLEY, MPH, JANELLE SHEARER, RN, BSN, MA, AND KARLA WENG, MPH

Palliative care, which involves managing symptoms, controlling pain and addressing stress caused by a chronic or terminal illness, has been shown to keep patients out of the hospital and allow them to stay home and live more comfortably with their illness. Typically, it is provided by an interdisciplinary team led by a physician trained in palliative medicine. Rural areas have not always had access to such specialists. Yet, today, rural health care organizations are finding ways to create palliative care programs that meet the needs of their chronically ill and aging populations. This article describes a six-year initiative led by Stratis Health to advance palliative care in rural Minnesota. It highlights the work of FirstLight Health System in Mora and describes Stratis Health's Rural Palliative Care Measurement Pilot Project, an effort to develop and test measures for evaluating rural palliative care programs.

The goal of palliative care is to prevent and relieve suffering and support the best possible quality of life for patients with terminal illnesses and their families. Such care is provided by a team that may include physicians, nurses, social workers, home health workers, clergy and others. Palliative medicine specialists help patients understand their treatment options and address concerns such as pain, anxiety, shortness of breath, fatigue, nausea and loss of appetite. Members of the care team also provide emotional and spiritual support, and facilitate communication among all of the health care professionals involved in a patient's care. This approach has been shown to improve satisfaction among patients, their families and physicians.

Palliative care is not synonymous with hospice (a benefit covered by insurers for people who are in the last stages of a terminal illness) and can be offered alongside curative treatment at any point in the disease process.

Historically, palliative care has been offered in urban hospitals with patient

volumes large enough to allow staff to specialize in the field. All Minnesota hospitals with more than 300 beds report having palliative care programs, as compared with 90% nationally.¹

Minnesota has fared well in its efforts to bring palliative care to patients who need it. The Center to Advance Palliative Care's 2015 report gave Minnesota a grade of A for having palliative care teams in more than 80% of hospitals. It was one of 17 states to receive that grade. Currently, 82% of reporting hospitals in the state with 50 beds or more provide access to palliative care services; the national average is 78%. Only 45% of Minnesota facilities with fewer than 50 beds offer palliative care services; however, that percentage is still well above the national average of 29%.¹

Savings from Palliative Care

Palliative care aligns well with efforts to redesign care delivery in a way that focuses on value (a combination of outcomes, patient experience and cost). Care coordina-

tion is central to palliative care, and many new reimbursement models, including patient-centered medical homes (or health care homes) and initiatives to reduce hospital readmissions, offer incentives to coordinate care for patients with moderate to severe chronic conditions. Thus, palliative care has the potential to support both health care homes and efforts to prevent readmissions, as it has been shown to reduce emergency department visits and hospitalizations.

Studies have shown that 24% of health care costs can be attributed to persons living with long-term, serious illnesses.² Patients in this population are potential candidates for palliative care. One report estimates that having palliative care in hospitals with more than 50 beds can result in an average per-patient per-admission savings of \$2,659. That translates to an estimated \$1.2 billion in savings per year nationally for all patients currently receiving palliative care. Making such care available to all hospitalized patients who *may* ben-

efit from it would result in approximately \$4 billion in savings per year.³

Additional savings could be achieved through palliative care programs that operate outside of hospitals. Community-based services may be offered in clinics, long-term care facilities and even patients' homes. Recognizing this expansion of services beyond hospitals, The Joint Commission recently began offering a community-based palliative care certification for accredited home care organizations.

Community-based palliative care can reduce acute care admissions and hospital deaths at the end of life.⁴ It is also cost-effective. Some estimate the monthly cost of all the community-based, non-hospice palliative care services required for a patient to achieve optimal independence is \$800 to \$900.⁵

Growing Palliative Care in Rural Minnesota

Hospital-based palliative care programs led by a physician or advanced practice nurse are difficult to replicate in rural communities, as few clinicians in small hospitals are trained or board-certified in palliative medicine. However, rural communities are coming up with innovative ways to provide these services.

Between 2008 and 2014, Stratis Health supported 23 rural Minnesota communities as they participated in three two-year initiatives to develop palliative care programs. More than 150 organizations serving communities with populations of 1,200 to 200,000 people were represented.

They included hospitals, home care organizations, hospice programs, long-term care facilities, clinics, assisted living facilities, a college department of nursing, parish nurses, clergy and public health agencies.

Each community assessed its needs and resources as it sought ways to provide palliative care, then shared what it learned with the other participants. Through this work, 15 new rural palliative care programs were created. Other communities are now working to establish programs or to include palliative care principles in care delivery without creating a specific program.

The way services are provided in rural communities varies widely (Table). Most programs operate out of home care organizations or are led by a nurse or nurse practitioner based in a clinic or hospital. Services are directed toward patients receiving home care or outpatient services such as infusion therapy, or those in the hospital or nursing home.

One Health System's Experience

FirstLight Health System in Mora, Minnesota, a participant in Stratis Health's rural palliative care development initiative, began its community-based palliative care program in April 2011. The program serves a five-county region with 34,000 residents, many of whom are poor and have limited health literacy. Initially, COPD and chronic heart failure were the primary diagnoses for referrals. Now, patients with any end-stage chronic disease

can take part. The FirstLight program has an average daily census of 20 patients.

Its palliative care team is led by a social worker and a nurse who work closely with home care organizations, nursing homes, spiritual caregivers and volunteers. The team relies on ancillary services such as pharmacy and respiratory therapy to assist with symptom management and pain control.

A key aspect of FirstLight's program is its regular calls to patients, ranging from daily to monthly, depending on the patient's needs for symptom management or in-home or other services. Another aspect is individualized "urgency plans" that patients and the care team build together and reference in case of symptom exacerbation. Urgency plans often have standing medication orders, such as antibiotics and steroids for COPD patients who are known to have exacerbations. Patients also have access to a telephone number they can call for assistance 24 hours a day.

Because patients now tend to report symptoms sooner than they used to, the FirstLight palliative care team has at times been able to break the crisis care cycle (trips to the clinic, emergency room, hospital and/or nursing home followed by home care). In one case, a FirstLight palliative care nurse knew her patient's history well enough to suggest checking the patient's carbon dioxide levels when she showed signs of respiratory distress. The nurse was able to get the patient a BiPAP machine for home use. Since getting the machine, the patient, who had been in the

TABLE

Rural palliative care—variables in program structure

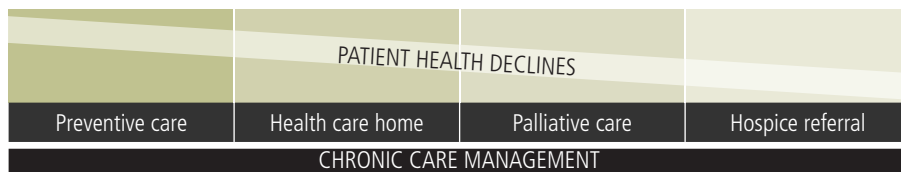
METHOD OF SERVICE DELIVERY	PALLIATIVE CARE TEAM	PATIENT FOCUS	COORDINATING STAFF
Home visits	All teams included physicians, social workers, nurses	Hospice-eligible but refused	Nurse practitioner
Clinic appointments		Infusion therapy	Registered nurse
Nursing home visits	Some had some of the following:	Home care with complex illness	Social worker
Inpatient consultation	Rehabilitation services	Inpatient consult when requested	Certified nurse specialist
Telephonic case management	Volunteers	Physician-referred with complex illness	Advanced practice nurse
Volunteer support visits/services	Nurse practitioners		
	Chaplains	Nursing home residents (triggered by MDS criteria, a clinical assessment used by nursing homes)	
	Pharmacists		
	Advanced practice nurses in psychiatry		

hospital up to twice a month, has not been hospitalized in more than six months and has been able to remain independent and at home.

FirstLight sees palliative care as part of the continuum of care (Figure). If a patient's health declines, he or she is promptly referred for palliative care and later for hospice when that service might be appropriate. FirstLight expects to be certificated as a health care home by the state in 2016, which will allow it to focus efforts earlier on the continuum. The health system credits its readiness to be-

FIGURE

The care continuum



come a health care home and to participate in chronic care management for Medicare reimbursement to the work it did to establish the palliative care program and its experience with care coordination for patients in that program.

FirstLight is also focusing on implementing more rigorous measurement of palliative care's success and savings using metrics developed through Stratis Health's Rural Palliative Care Measurement Pilot Project.⁶

Quality Measures for Community-Based, Rural Palliative Care

Palliative care quality measures have been tested primarily in urban and hospital-based programs. From 2012 to 2013, Stratis Health worked with five rural Minnesota communities to test standardized quality measures, based on National Quality Forum-endorsed measures for palliative care. Measures fell into four categories: operations, cost, clinical quality and patient/family experience.

The organizations involved in the measurement pilot, one of which was FirstLight, received training on the measures

and data-collection tools, and submitted data quarterly to Stratis Health. Information came from chart abstraction, patient and family experience surveys, patient-level health care utilization records and program-level operations surveys.⁷ Information from 138 palliative care patients was included.

The study showed that the 38 preferred practices the National Quality Forum recommends to improve palliative and hospice care (end-of-life planning discussions, informing patients of the availability of spiritual care resources, and holding care

conferences with the patient and family, for example)⁸ are relevant and applicable in rural communities. And, while most small rural communities lack the resources to employ the range of medical specialists that are typically part of a palliative care team in a large hospital (pain management specialists, for example), many have partnerships that allow them to access specialists from larger communities as needed.

Conclusion

Studies increasingly are documenting how palliative care enhances patient outcomes and satisfaction and reduces costs—making it a win-win for value-based care delivery. Rural communities are establishing palliative care programs that utilize resources available to them. The next step is for these communities to evaluate the quality of the palliative care they are providing in order to add to the argument that payers and insurers should further extend reimbursement to nonmedical services such as care coordination and social work. **MM**

Deb McKinley is communications director, and Janelle Shearer and Karla Weng are program managers with Stratis Health.

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USPSTF Recommendations—2015 Update

Use in Primary Care and Other Practices

BY BARBARA P. YAWN, MD, MSC

Each year, the U.S. Preventive Services Task Force makes recommendations on the preventive services the nation's doctors and other health care providers should offer their patients. Although clinicians may be aware of these recommendations, they may not always know how best to implement them in practice. This article provides an explanation of how the Task Force arrives at its decisions and what its recommendations mean. It highlights recent changes to recommendations that represent significant changes for practice, and presents cases illustrating ways to apply the recommendations to individual patients.

Prevention is an important part of medicine's efforts to improve health, prolong life and lower the burden of chronic illness. Commonly considered the job of primary care physicians, providing preventive services is the responsibility of all, including those who work in specialty clinics, emergency departments, hospitals, mental health facilities—any place where there are interactions with patients for any health-related reason. As such, all clinicians need to be knowledgeable about recommended prevention activities and the evidence for their use.

In the United States, several groups provide guidance for selecting and implementing prevention activities. The Advisory Committee on Immunization Practices (ACIP), supported by staff from the Centers for Disease and Control and Prevention (CDC), produces a yearly immunization schedule that outlines all recommended immunizations by age and risk group (www.cdc.gov/vaccines/acip/recs/). This schedule has become the standard for school and work requirements, quality metrics for practices and payment decisions by insurers. The Community Prevention Task Force is also supported by the CDC and makes recommendations for community-based prevention and policy decisions such as the use of seat belts and

infant car seats, reducing tobacco use and secondhand smoke exposure, violence prevention and workplace safety (www.the-communityguide.org). The U.S. Preventive Services Task Force (USPSTF), supported by the Agency for HealthCare Research and Quality (AHRQ), reviews and recommends prevention activities to be incorporated into routine care for individuals of all ages. (It does not address those issues reviewed by the ACIP or the Community Prevention Task Force.)

The list of USPSTF recommendations is long and can be intimidating. But when broken down by age, sex and risk factors, the list is a little more manageable. And, when approached as something to be done not at a single visit but as part of ongoing care, delivering the recommended services becomes more doable. What follows is an explanation of how the Task Force develops its recommendations, an explanation of its "grading" system, recent changes to recommendations, and case presentations showing how to implement the recommendations.

How the Task Force Works

The USPSTF is made up of physicians and doctoral-level nurses who are selected by the Department of Health and Human Services because of their expertise and ex-

perience in evidence-based decision-making and daily clinical practice. The topics it considers (eg, aspirin use to prevent MI or vision screening in preschool children) are suggested by health care professionals, health care and advocacy organizations, insurers and the public. The Task Force selects topics for full review based on their frequency within the general population and the availability of evidence that can be reviewed and used to make a recommendation. It also updates existing recommendations.

An in-depth review of all of the evidence for a topic is completed by a team at an Evidence-Based Practice Center, which then writes a comprehensive report for the USPSTF to consider. Those reports are usually published in peer-reviewed journals and can be found online by searching for "USPSTF evidence reports."

After reviewing the evidence, the Task Force gives the proposed recommendation a grade ranging from "A" to "D," depending on its strength, or makes an "I statement" if there is insufficient evidence to make a recommendation (Table 1).

When assigning grades, the Task Force assesses the balance of benefit versus harm and the certainty of that assessment. *High certainty* means that the available evidence includes consistent results from

TABLE 1

Strength of recommendations (grade and level of certainty)

A = The USPSTF recommends the service. There is high certainty that the net benefit is substantial.

B = The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

C = The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.

D = The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.

I = The USPSTF concludes that the current evidence is insufficient to assess the benefits versus the harms of the service. Evidence may be lacking, be of poor quality or conflicting, or the balance of benefits and harms cannot be determined.

Source: www.uspreventiveservicestaskforce.org/Page/Name/methods-and-processes/

well-designed, well-conducted studies in representative primary care populations. These are studies that assess the effects of the preventive service on health outcomes. Their conclusions, therefore, are unlikely to be strongly affected by the results of future studies. *Moderate certainty* means that the available evidence is sufficient to determine the effects of the preventive service on health outcomes but confidence in the estimate is constrained by factors such as the number, size or quality of individual studies; inconsistency of findings across individual studies; limited generalizability of findings to routine primary care practice; or lack of coherence in the chain of evidence. *Low certainty* means the available evidence is insufficient to assess the effects on health outcomes because of the limited number or size of the studies; im-

TABLE 2

Additions and modifications to USPSTF recommendations with A and B ratings since 2013

INFANTS AND CHILDREN

- Prescribe oral fluoride supplementation beginning at 6 months of age, if no fluoride in waterB
- Apply fluoride varnish to primary teeth, starting at age of primary tooth eruptionB
- Provide education or brief counseling to prevent initiation of tobacco use.B

ADOLESCENTS

- Intensive behavioral counseling for STI prevention if sexually activeB
- Provide education or brief counseling to prevent initiation of tobacco useB
- Screen for HIV beginning at 15 years of age. A

PREGNANCY

- Ask about and advise stopping smoking, offer behavioral intervention for smoking cessation . . . A
- Screen for perinatal depression if follow up and therapy availableB
- Screen for gestational diabetes at 24+ weeksB
- Use low-dose (81 mg) aspirin after 12 weeks in women at high risk for preeclampsiaB
- Screen all pregnant women for HIV, even those presenting in labor. A

ADULTS

- Screen for high blood pressure beginning at age 18 years A
- Screen all adults, including postpartum women, for depression.B
- Screen overweight and obese adults 40 to 70 years for abnormal glucoseB
- Offer behavioral counseling or referral to promote healthful diet and activity in adults with CVD risk factors who are overweight/obese.B
- Screen for interpersonal violence in women of childbearing age.B
- Screen for alcohol misuse and provide brief behavioral counseling if involved in risky or hazardous drinkingB
- Identify women at high risk of breast cancer
 - If at increased risk, and if benefits outweigh harms, offer tamoxifen or raloxifeneB
- Screen women for family history of breast, ovarian, tubal or peritoneal cancerB
 - If positive, screen for association with harmful mutations in BRCA 1 or BRCA 2B
 - If positive, refer for genetic counseling and counseling for BRCA if appropriate
- Screen average-risk women with biennial mammography from age 50 to 74 years (Expect update early 2016).B
- Screen men 65 to 75 years of age who have ever smoked for abdominal aortic aneurysm.B
- Recommend annual low-dose CT screening for adults 55 to 80 years who are current smokers with 30 pack/year use or those with 30 pack/year history who have quit in the past 15 years.B
- Provide intensive behavioral counseling for STI prevention for all at increased riskB
- Screen for *Chlamydia* and gonorrhea in sexually active women <25 years of age and older women who are at riskB
- Screen for hepatitis B in adults at high risk who are not pregnantB
- Screen all who are high-risk and those born between 1945 and 1965 for HCV.B
- Screen all adults up to age 65 years for HIV. A

Source: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

portant flaws in study design or methods; inconsistency of findings across individual studies; gaps in the chain of evidence; the findings not being generalizable to routine primary care practice; and lack of information about important health outcomes. Recommendations about which there is moderate or low certainty are likely to change as more information becomes available.

In general, a grade of “A” or “B” means the recommendation should be implemented in all appropriate patients. A grade of “C” means the recommendation should be discussed with certain patients (Table 2). A “D” grade means the recommendation is not to be implemented in routine practice but may be appropriate in select individuals for specific evaluations. The “I” grade indicates there is little support for

the recommendation in clinical practice. However, the “Clinical Considerations” section of “I” statements often provide suggestions for how to incorporate a topic when engaged in shared decision-making with patients (Table 3).

New Recommendations by Age Group

Each year, the USPSTF makes new recommendations and updates old ones. Table 2 presents the new or modified recommendations made in 2013, 2014 and 2015. A few that significantly change practice for physicians are discussed below.

Changes in Recommendations for Children and Adolescents

The focus on dental health and the recommendation to apply fluoride varnish is new for most family physicians and pediatricians. Assuring that oral fluoride supplementation is prescribed for those without fluoride in their water (bottled, tap or well) will require clinicians to have additional discussions with many parents.

Most physicians will appreciate the new recommendations’ confirmation that providing education and brief counseling for patients of all ages, including pre-adolescents, regarding prevention of tobacco use is appropriate.

What could be considered a major change is the recommendation to screen all adolescents for HIV beginning at age 15. This is likely to be of concern to many physicians, as they may be reluctant to discuss sexuality with young adolescents and their parents. Some may feel they have rapport with the patient and their family and believe they know that no increased risk is present. But data suggest that risk is not always clear and not all sex among adolescents and young adults is consensual, putting even those not choosing to be sexually active at risk. In Minnesota and its surrounding states, assessment for suspected sexually transmitted diseases can be done without parental permission. This extends to screening for STIs in sexually active adolescents; it does not, however, extend to adolescents who deny sexual activity. Screening for HIV can be combined

TABLE 3

Recent “I” Statements (2013-15)

INFANTS AND CHILDREN

- Screen for dental caries by primary care provider
- Screen for speech and language delays and disorders in children up to 5 years of age
- Screen for primary hypertension
- Offer interventions to prevent child maltreatment

ADOLESCENTS

- Screen for suicide risk
- Advise and counsel adolescents about alcohol misuse, if use is uncertain

PREGNANT WOMEN

- Screen for gestational diabetes before 24 weeks
- Screen for iron deficiency anemia
- Provide iron supplementation
- Provide pharmacotherapy interventions for smoking cessation
- Provide electronic nicotine-delivery system intervention for smoking cessation

ADULTS

- Screen for thyroid dysfunction in asymptomatic adults
- Provide electronic nicotine-delivery system intervention for smoking cessation
- Screen women 65 to 75 years who have ever smoked for aortic aneurysm
- Screen for cognitive impairment
- Screen men for *Chlamydia* and gonorrhea
- Screen adults of all ages for suicide risk
- Screen for vitamin D deficiency
- Recommend multivitamins for CVD or cancer prevention
- Recommend single or paired-nutrient supplements for CVD or cancer prevention
- Screen elderly and vulnerable adults for abuse
- Screen for primary open-angle glaucoma
- Screen for oral cancer in adults who are asymptomatic
- Screen for PAD or CVD with ankle-brachial index (ABI)
- Recommend use of vitamin D and calcium in men
- Recommend use of <400 IU vitamin D3 plus 1,000 mg calcium for primary fracture prevention in non-institutionalized, post-menopausal women

Source: www.uspreventiveservicestaskforce.org/BrowseRec/Index

with behavioral counseling for STI prevention and tobacco use prevention.

Changes in Recommendations for All Adults

Several major changes have been made to recommendations for adults. These include a recommendation to counsel them about eating a healthful diet, exercising and not misusing alcohol. This is among the first recommendations to suggest advising specifically on healthful diet as well as an active lifestyle.

In 2015, the USPSTF gave strong support (an “A” recommendation) for asking all adults, including pregnant women, about smoking. Providing advice and behavioral intervention for smoking cessation was added in 2015. However, support for the provision of FDA-approved pharmacotherapy for cessation is limited to non-pregnant adults.

The USPSTF also recommended screening for abnormal blood glucose as part of cardiovascular risk assessment in adults 40 to 70 years of age who are overweight or obese. It also calls for intensive behavioral interventions to promote a healthful diet and lifestyle for those with abnormal glucose.

The 2015 recommendation for blood pressure screening for all adults 18 years and older has an interesting twist, encouraging blood pressure being measured outside the clinical setting before starting treatment.

Also new is a recommendation to screen for infections that are often transmitted through sex or blood including STIs, *Chlamydia* and gonorrhea in women, and hepatitis B and C and HIV in both men and women.

For men who have smoked, one-time screening for abdominal aortic aneurysm is now recommended. For both men and women with long-term histories of smoking, annual screening for lung cancer with low-dose CT is suggested. Accessibility of the required procedures and therapies must be considered. Many practices, especially those in smaller communities with fewer resources, will need to do thoughtful planning to identify ways to improve ac-

cess for their patients. For example, mobile CT scanners likely could add low-dose CT lung scans to their offerings.

New Recommendations for Women

New for women is the recommendation to screen for family history of breast, ovarian, tubal and peritoneal cancer to determine the need for BRCA testing and consideration of preventive tamoxifen or raloxifene use in those at high risk. These are major changes to the recommendations for high-risk women. In addition, there is a new recommendation for screening for interpersonal violence for women of childbearing age—the age group at greatest risk.

When adding any of these to your practice, it is necessary to have clear follow-up plans in place that go beyond simply referring someone somewhere. For example, the recommendation for screening all adults annually for depression, which was expanded in 2015 to include women during pregnancy and the postpartum period, also requires that appropriate treatment such as cognitive behavioral therapy be readily accessible.

Mammography screening recommendation updates are near finalization. The 2015 draft recommendations published and opened for public comment recommend biennial mammography in low-risk women ages 50 to 74 (B recommendation) with a C recommendation for screening women 40 to 49 and an I recommendation for women 75 and older. All other forms of breast imaging, such as ultrasound and MRI for women with dense breasts remain I statements. A final recommendation about mammography screening is expected to be published in 2016.

Using USPSTF Recommendations in Practice

Young Patients

Case 1. M, a healthy 16-year-old male, comes in for a school sports physical. He has no family history of early CVD and only one grandparent with a history of cancer (colon cancer). Neither parent smokes. M denies smoking and sexual

TABLE 4

Recent “D” recommendations (2013-15)

ADULTS

Offer any preventive therapy for women who are not at increased risk of breast cancer

Assess women who do not have family history of breast, ovarian, tubal or peritoneal cancer for BRCA

Screen women 65 to 75 years who have never smoked for aortic aneurysm

Screen the asymptomatic, general population for carotid artery stenosis

Screen in nonpregnant individuals for Hepatitis B who are not at risk or symptomatic

Recommend use of <400 IU vitamin D3 plus 1,000 mg calcium for primary fracture prevention in noninstitutionalized, postmenopausal women

Recommend beta-carotene or vitamin E supplementation for CVD or cancer prevention

Source: www.uspreventiveservicestaskforce.org/BrowseRec/Index

activity even after his parents leave the exam room. To complete the USPSTF recommendations for M, you will want to discuss tobacco use to prevent initiation. You have already screened for obesity with routine height and weight measurements and found no need for referral. Depression screening was completed using the PHQ 2 (two questions) by the nurse who roomed M. The nurse also took his vital signs and completed medication reconciliation (M uses occasional nonsteroidal anti-inflammatories for muscle aches when training for track). Skin cancer prevention—use of sunscreen—is easy to emphasize while completing the exam and can be mentioned to the parents if M doesn’t use it regularly. You will have to decide if today is the correct time for HIV screening.

Case 2. G, a 17-year-old, presents for an oral contraceptive refill. Although G reports that she seldom misses a pill, she says her boyfriend hates condoms and refuses to use them. During your visit,

G says she is excited about going to Florida for spring break and is worried about sunburn, so she is going to a tanning salon in preparation. You note that her BMI is 31. The two-question depression screening was negative. Pelvic examination and Pap smear are no longer recommended for females of her age and profile; the recommendations suggest completing a genital exam only if she has symptoms of an STI, although she should have a *Chlamydia* screening. Should you also suggest folic acid supplement because of her sexual activity?

How many other things can you cover during the visit—STIs, HIV, skin cancer, obesity, tobacco, alcohol misuse and illegal

drug use? Most likely, you will choose topics related to recent or upcoming events, especially her upcoming trip to Florida. You can talk about use of sunscreen and strongly recommend against continuing tanning. Although counseling for alcohol misuse is considered an “I statement,” you can spend a little time to discuss the risk of drinking, and drinking and driving, and admonish against riding with anyone who has been drinking. Intimate partner violence screening is also appropriate, as the comment about her boyfriend’s refusal to use condoms may suggest G does not have an equal say in the relationship. Sending her for blood tests to screen for HIV and gonorrhea, but not syphilis (a D recommendation), can be accompanied by a discussion of lack of STI protection when condoms are not used.

Visits for school, college, sports physicals and contraception are excellent opportunities to assess for and discuss preventive measures. Unfortunately, not all adolescents will have such visits and the required preventive interventions will need to be incorporated into visits for colds, minor trauma and other acute problems. If that is the case, you will need to select what you feel is most important to the teen, even if the subject is not something you’re comfortable discussing.

Most teens will have more than one visit during the teen years, and counseling can be divided among those visits, repeating the most important topics, which usually range from STI prevention to smoking to skin cancer prevention. Bringing up HIV screening may be easier if you include statements about the importance of early detection and treatment even for those you may not suspect are at risk.

Adult Patients

Case. J, 66, whom you haven’t seen for five years, comes in because his wife read about “some lung screening he is supposed to have because he won’t quit that awful smoking.” J reports he is healthy and works on his farm daily. He denies any symptoms. From the medical assistant’s notes, you learn he uses no regular medications, his PHQ-2 is 0, his BP is 158/94 and his

BMI is 30.8. The medical assistant gave him his flu shot, a PCV12 and a Tdap, and he was given a referral and prescription for HZ vaccination to take to his pharmacy. You comment on the importance of these vaccines. Now what?

J’s blood pressure remains high when you recheck it, so that requires follow up. According to the USPSTF, J needs a low-density CT scan (the one his wife was referring to), abdominal aortic aneurysm screening, screening for lipids, and a fasting blood glucose test, as well as screening for hepatitis B and C. Colon cancer screening is also recommended.

That is not all. J also is a candidate for tobacco counseling and cessation therapy and screening for alcohol misuse (the medical assistant did the CAGE assessment and it was negative). He also may need daily aspirin therapy since he is obese and appears likely to have sustained high blood pressure; this also requires discussion about eating a healthful diet and exercising and perhaps a referral for intensive weight-loss counseling. As a farmer, J is certainly a candidate for discussion about skin cancer prevention and sunscreen use. And, finally, he is in the age group for discussions about fall prevention.

Even listing all of that may take longer than the 15 minutes scheduled for his visit. So how do you strategize? You begin by agreeing that his wife was correct and you’re glad he came. You note that because of his smoking other testing is also necessary. Ask if he is ready to think about quitting. If he isn’t, proceed with the visit. Before talking about the tests he came for, you mention that his blood pressure is a little high. You explain that you would like to do at least a partial exam of his lungs and heart. As he takes off his shirt you should comment on his “farmer tan” and ask about sunscreen. Since he is wearing a hat, you can mention that wearing a hat is good for sun protection. When completing the head, neck and chest exam, you can discuss his elevated blood pressure and the need to check that a couple of times, perhaps at the local drug store or at the clinic.

You suggest that you want to see J again in two weeks, after he has the lung CT and

TABLE 5

Incorporating recommendations into patient care

The following is an example of how to incorporate USPSTF recommendations when treating a teenaged girl.

PRE-VISIT PLANNING

Medication reconciliation + immunization assessment

If the patient is known to be sexually active—contraceptive visit, discussion of STI prevention

Vitals to include BMI, smoking status and PHQ-2

“TALK” ROUTINE

Skin cancer—If a patient mentions they’re planning a spring break trip, it provides a great opening

Tobacco—Based on answer in vital signs assessment

Intimate partner violence—Discuss as part of personal safety during spring break trip

Obesity—Come back for follow up and consider a referral

ROUTINE STI SCREENINGS

Discussion of STI prevention during examination and *Chlamydia* screening

Prewritten lab orders for HIV and GC screening

an abdominal ultrasound for abdominal aortic aneurysm screening (he can have both during the same hospital visit). In two weeks, you'd like him to come in having fasted, so you can do a fasting blood glucose test to screen for diabetes, lipids and HIV, HCV and HBV. You discuss J's concerns about the cost and whether Medicare will pay for these tests. Both J and his wife agree that they see no reason for the HIV screening and think that J probably was screened for HBV and HCV when he gave blood at a local blood drive. You agree and order only the fasting blood glucose and lipids for two weeks from today. You decide to delay the discussion about diet and activity until the next visit, when you will have information on glucose and lipids. The lack of any family history of colon cancer and J's history of heavy smoking help you decide to make the low-dose CT and abdominal aortic aneurysm screening a priority over the colon cancer screening. It is very likely that J will require therapy for hypertension, which will provide you with additional opportunities to address colon cancer screening.

It is important to remember that for patients like J, not everything can be accomplished during one annual visit or even at a single age. Some of the "one-time" recommendations that are to begin at age 60 may be started at 58 or 59 or not be accomplished until age 61 or 62. Considering our low levels of completion of these recommendations, a slight delay as a result of addressing some of these over several visits will still be a major improvement and may help your quality scores.

Every physician knows that you must address the patient's or family's immediate concerns. During visits for these concerns, you can also highlight prevention recommendations. Use the margins of your paper notes or the special features of your electronic health record to prioritize and remind yourself of one or two issues you want to address at each future visit. These may change, of course. For example, with a smoker who comes in with a "bad cold that will not go away," you will, of course, talk about smoking and assess readiness to quit. But you also can try to discuss other

smoking-related issues such as the low-dose CT screening for lung cancer and the abdominal aortic aneurysm screening while addressing the acute bronchitis and smoking. Your choice of topics can be seasonal as well. For example, you might talk about skin cancer prevention and sunscreen use in the spring and summer, and fall prevention in the winter.

Some clinics and health systems use birthday letters (paper or electronic) to invite patients to come in for age-appropriate prevention measures such as colon cancer screening or mammography. Some may even provide a link to a site that discusses use of low-dose aspirin for prevention of heart disease. Posters about prevention placed in exam rooms not only provide patients with reading material while they wait but also may prompt them to ask questions about prevention activities. Also, patient newsletters, inserts into bills and electronic patient portals can be used to inform patients about the importance of prevention activities.

Finally, remember that the USPSTF also provides guidance for testing that does not provide the average person with more benefit than harm—the D list (Table 4). This list is also important to review, as you can use it to help explain why you are not suggesting a test.

Conclusion

The USPSTF makes its recommendations based on extensive reviews of the best available evidence. Yet, no list of recommendations is right for every patient, and the long list of USPSTF recommendations can be overwhelming for physicians and other clinicians already struggling to incorporate a growing list of requirements into daily practice. When thinking about how to address the recommendations with patients, consider the patient's age, sex and behaviors. Then look for ways to individualize the process, setting realistic goals and developing a plan to provide the recommended care and counseling over multiple visits and even multiple years with the help and support of your entire staff and your electronic medical record (Table 5).

Prevention is central to improving the health of our patients, prolonging their lives and lowering the burden of chronic illness on them. The USPSTF aims to support us in our efforts to achieve those goals. **MM**

Barbara Yawn spent 14 years in rural family medicine practice and the past 26 years doing clinical research in primary care. She served as a member of the USPSTF for four years and has served on seven national and international evidence-based guideline panels.

Use the App

The USPSTF and AHRQ have developed an app, ePSS (Electronic Preventive Services Selector), that will help you quickly identify all the A, B and D recommendations for a particular patient. Enter your patient's age, sex, pregnancy status, if they are a tobacco user and if they are sexually active. It then generates a list of all A and B recommendations as well as the D recommendations. The app works on PCs, tablets and smart phones. It also can provide email notifications about updates and new recommendations. The app is free and can be downloaded at <http://epss.ahrq.gov/>.

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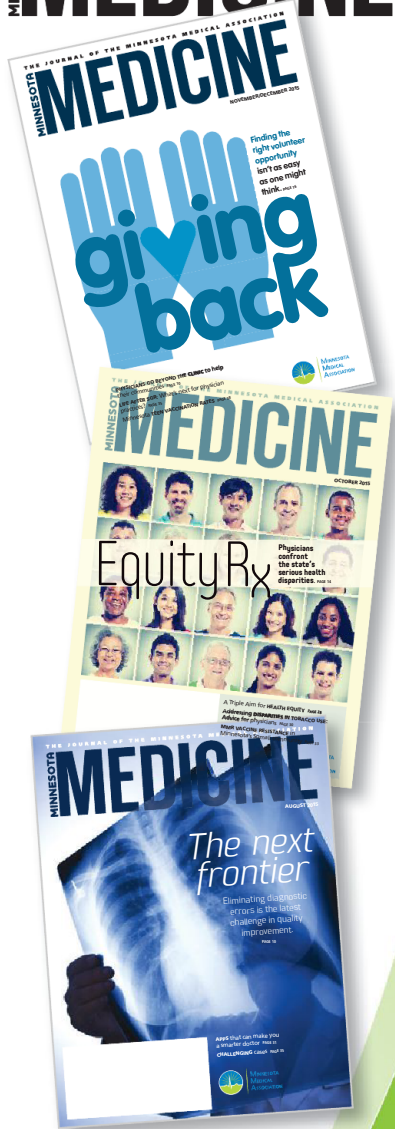
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- Collaborative network of hospitals, clinics, nursing homes, senior housing and pharmacies
- CentraCare Health was voted "Best Place to Work in Minnesota"

Contact:
Cassie Tinius, Physician Recruiter
CentraCare Health | centracare.com
320-656-7085 | tiniusc@centracare.com

CENTRACARE Clinic
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Family Medicine

Minnesota and Wisconsin

We are actively recruiting exceptional board-certified family medicine physicians to join our primary care teams in the Twin Cities (Minneapolis-St Paul) and Central Minnesota/Sartell, as well as western Wisconsin: Amery, Osceola and New Richmond.

All of these positions are full-time working a 4 or 4.5 day, Monday - Friday clinic schedule. Our Minnesota opportunities are family medicine, no OB, outpatient and based in a large metropolitan area and surrounding suburbs.

Our Wisconsin opportunities offer with or without obstetrics options, and include hospital call and rounding responsibilities. These positions are based in beautiful growing rural communities offering you a more traditional practice, and all are within an hours' drive of the Twin Cities and a major airport.

HealthPartners continues to receive nationally recognized clinical performance and quality awards. We offer a competitive salary and benefits package, paid malpractice and a commitment to providing exceptional patient-centered care. Apply online at healthpartners.com/careers or contact diane.m.collins@healthpartners.com, 952-883-5453, toll-free: 800-472-4695. EOE



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Lakeview Clinic is seeking BE/BC physicians to join our independent, multispecialty, physician-owned group in the southwest metro. Enjoy the best of all worlds, from rural to suburban in one of our 4 sites. Our top-notch group consists of family physicians, internists, pediatricians, OB/GYNs, and surgeons.

- Outpatient Position
- 4-day work week, 32 contact hours, occasional Saturday.
- Call is phone only coverage from home
- Opportunities for leadership
- Excellent work/life balance
- Outstanding compensation and benefits with profit sharing/401K
- Top notch schools, private/public
- Signing bonus

Now hiring for the following positions:

- Internal Medicine*
- Family Medicine*
- Family Medicine/OB (In/Outpatient)*
- Pediatrics (In/Outpatient)*



CONTACT:
Sandra Beulke, MD
PHONE: 952-442-4461
EMAIL: administration@lakeviewclinic.com
WEB: www.lakeviewclinic.com



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Affiliated Community Medical Centers is a physician owned multispecialty group with 11 affiliate sites located in western and southwestern Minnesota. ACMC is the perfect match for healthcare providers who are looking for an exceptional practice opportunity and a high quality of life. Current opportunities available for BE/BC physicians in the following specialties:

- Dermatology
- ENT
- Family Medicine
- Gastroenterology
- General Surgery
- Geriatrician
- Outpatient Internal Medicine
- Hospitalist
- Infectious Disease
- Internal Medicine
- OB/GYN
- Oncology
- Orthopedic Surgery
- Pediatrics
- Psychiatry
- Psychology
- Pulmonary/Critical Care
- Rheumatology
- Sleep Medicine
- Urgent Care

FOR MORE INFORMATION:

Kari Lenz, Physician Recruitment | karib@acmc.com | (320) 231-6366

www.acmc.com | discoveracmc.com

Sioux Falls VA Health Care System “A Hospital for Heroes”

Working with and for America’s Veterans is a privilege and we pride ourselves on the quality of care we provide. In return for your commitment to quality health care for our nation’s Veterans, the VA offers an incomparable benefits package.

The Sioux Falls VAHCS is currently recruiting for the following healthcare positions.

- Cardiologist
- Emergency Medicine
- Endocrinologist
- ENT (Part-time)
- Gastroenterologist
- Hospitalist
- Primary Care/Family Practice
- Psychiatrist
- Pulmonologist
- Urologist (Part-time)

Applicants can apply online at www.USAJOB.S.gov

They all come together at the Sioux Falls VA Health Care System. To be a part of our proud tradition, contact:



Human Resources Mgmt. Service
2501 W. 22nd Street
Sioux Falls, SD 57105
(605) 333-6852

www.siouxfalls.va.gov



NEEDED:

Community-Based Geriatric Physician

Minneapolis/St. Paul metro area

FTE STATUS: 1.0

SCHEDULE: Monday - Friday

EXPERIENCE LEVEL: Experience preferred

Our mission is to improve the care and professional experience the frail elderly receive from their physicians. We have a progressive business model that provides you the time and support needed to deliver expert geriatric medical care. That care is provided in one of three service lines: Long Term Care Facilities, consultation services given in Transitional Care Units and primary care in our Home Visit Program. We seek a BC Family Physician or Internist to work as part of an expert team in one or more of these service lines. We offer a supportive provider peer group that attracts successful physicians with an interest in complex care.

Our Geriatricians deliver innovative, but old-fashioned primary care. This is a unique opportunity for a high-performing, compassionate, primary care physician with the ability to provide care outside of usual pathways. Expect salary and CME allowance above usual primary care range. CAQ or Geriatric Fellowship desired but not required.

If interested, contact:

DR. NICK SCHNEEMAN
CEO and Medical Director of Geriatric Services of Minnesota (GSM)

EMAIL: nick.schneeman@gsmllc.org

WEB: www.gsmllc.org

BEYOND TREATING, THERE’S CARING

WELL AND BEYOND

Fairview Health Services seeks physicians with an unwavering focus on delivering the best clinical care and a passion for providing outstanding patient experience.

We currently have opportunities in the following areas:

- Allergy/Immunology
- Dermatology
- Emergency Medicine
- Family Medicine
- General Surgery
- Geriatric Medicine
- Hospitalist
- Internal Medicine
- Med/Peds
- Neurology
- OB/GYN
- Orthopedic Surgery
- Pain Medicine
- Pediatrics
- Psychiatry
- Sports Medicine
- Urology
- Vascular Surgery

To learn more, visit fairview.org/physicians, call **800-842-6469** or email recruit1@fairview.org

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Dying's not so bad

BY MELISSA EELKEMA

This week in medical school I learned that dying's not so bad.

This week in the hospital I had two patients I wished would die.

When I recognized that wish, I felt a deep sadness and slight nausea.

In my defense, I wanted them to die for their sake.

The first: Delirious, septic, calling out in pain. Worsening despite full treatment. Standing in her room made my throat constrict with pity. Please, just let her go.

The second: Comatose, severe stroke, poor prognosis. The family wants him alive no matter what. But I don't think they understand the "what." Emptiness filled his room. Please, just let him go.

This week in medical school I learned that dying's not so bad.

Sometimes death is desirable.

Sometimes Hope is the enemy of Peace.



Melissa Eelkema is a fourth-year medical student at the University of Minnesota. She wrote this after a difficult week on inpatient service. "Two of my patients had very poor prognoses yet remained full code. My experience caring for them had a profound effect on how I see life, death and the treatments we choose for our patients."

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Day at the Capitol



Wednesday, March 23, 2016

Noon

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