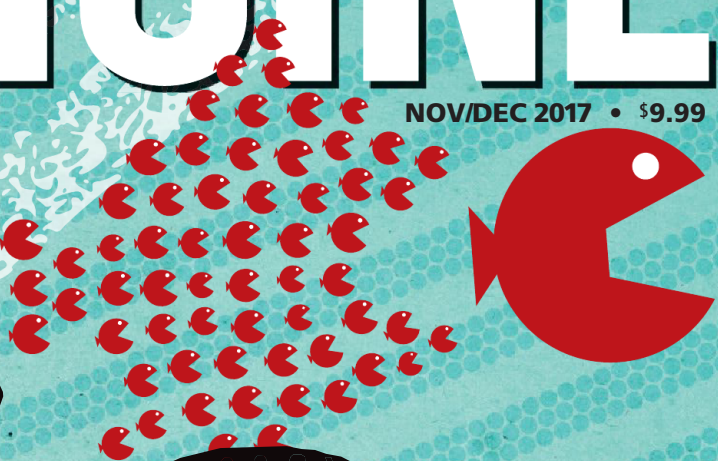


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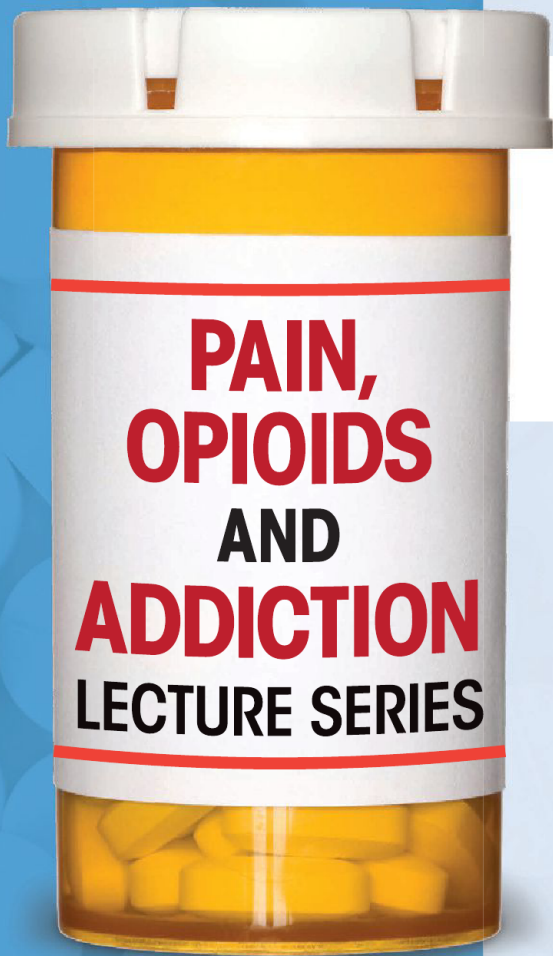
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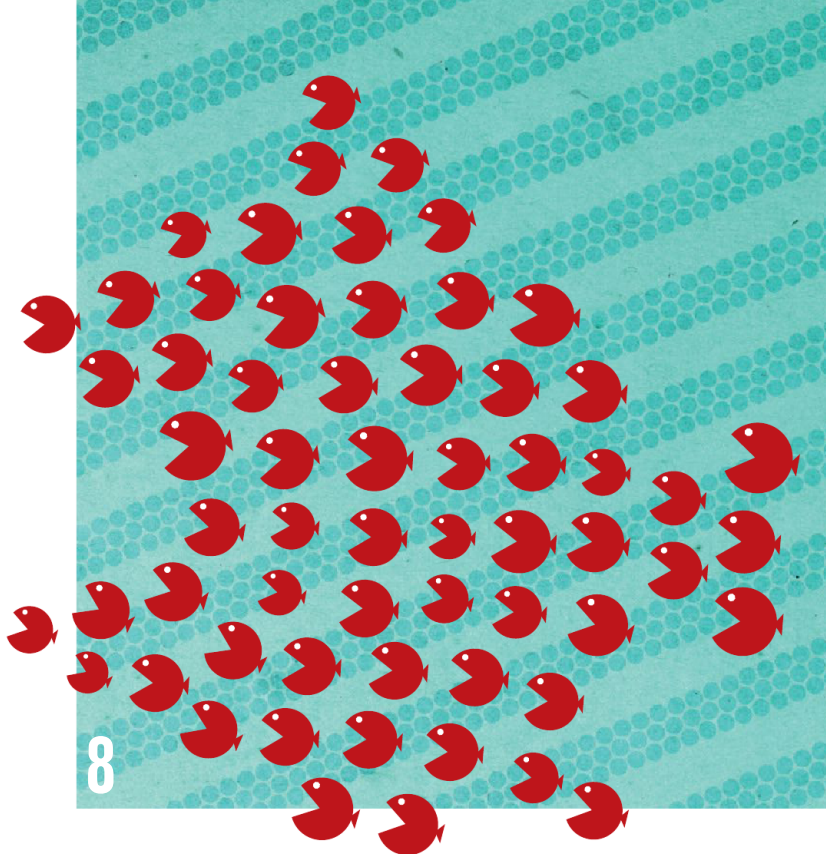
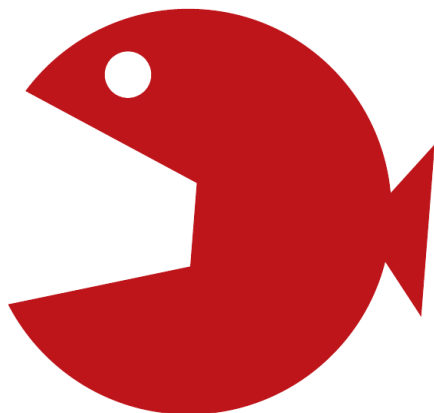
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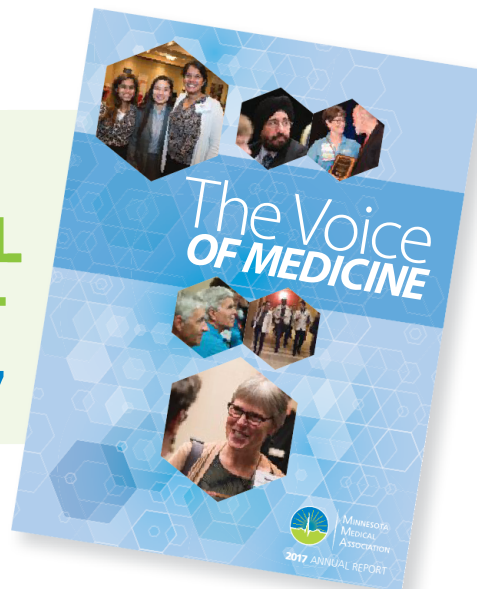
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Charles R. Meyer, MD, Editor in Chief

Bigness—which, since the Gilded Age, has held allure for American business—has become even more attractive.

MEDICINE, UPSIZED

Sizing up the practice landscape

The 2008 recession supplied lots of lessons and even more catch phrases, the catchiest of which was “too big to fail.” Convinced of the wisdom of this mantra, the federal government dove in to save those Goliathan companies whose failure, it was convinced, would sink the American economy. Thus, bigness—which, since the Gilded Age, has held allure for American business—became even more attractive.

Minnesota health care organizations certainly seem smitten, based on the recent flurry of mergers and consolidations that has altered the local medical practice landscape.

Minnesota has been a haven for “big health care” since the late 1970s, when our state was the epicenter of the HMO revolution. Group Health provoked the formation of the Physicians Health Plan, which inadvertently spawned United Health Care, and suddenly, the race was on to build health care organizations that did everything. No longer did corporations like Allina and Fairview just own and operate hospitals; instead, they blossomed into purveyors of physical medicine, ambulance services, home health care and physician services. Fearing potential effects of the proposed Clinton health plan in the early 1990, these organizations went on a spending spree, buying up independent doctor practices. The perception was that creating an integrated delivery system would allow an organization to control a larger part of the health care dollar.

Since then, the medical industry has changed multiple times, frequently in response to government or financial pressures. Most recently, the Affordable Care Act proposed the formation of Accountable Care Organizations (ACOs), which, using a 21st-century version of capitation, hold health care providers accountable for not only costs, but also quality.

As detailed in Howard Bell’s article (see Page 8), medical groups across the state have concluded that previous attempts at integration are now insufficient to meet the new demands of pay-for-value. In the anticipated future, fee-for-service will go the way of the one-horse shay, with providers and organizations being rewarded for meeting quality and value goals. Whether physicians and patients will find “value” in that new world, however, remains to be seen.

Five years ago, after more than 50 years of delivering internal medicine care, my small independent group of four internists closed its doors. We prided ourselves in caring for patients in the hospital and in an office with a near-familial ambience. Over the years, we briefly employed cardiologists, rented out space to specialists, bought an echocardiogram machine, and invested in an imaging partnership, all in an attempt to fight the reality that a general internist’s earning power was declining amidst the swirl of large corporations. In the end, we were too small to succeed.

Our little group certainly couldn’t have formed an ACO. Tracking the requisite quality measures to get rewarded for “value” would have been impossible without a full-featured electronic health record and integration with a larger system. And market share was a concept that never came up in our group meetings. The way we practiced was clearly not valued, and we couldn’t compete.

Small may come back as desirable in the medical practice landscape—although I doubt it. Meanwhile, today’s version of big is, as yet, a hope unfulfilled. MM

Minnesota Medicine Editor-in-Chief Charles R. Meyer can be reached at charles.073@gmail.com.



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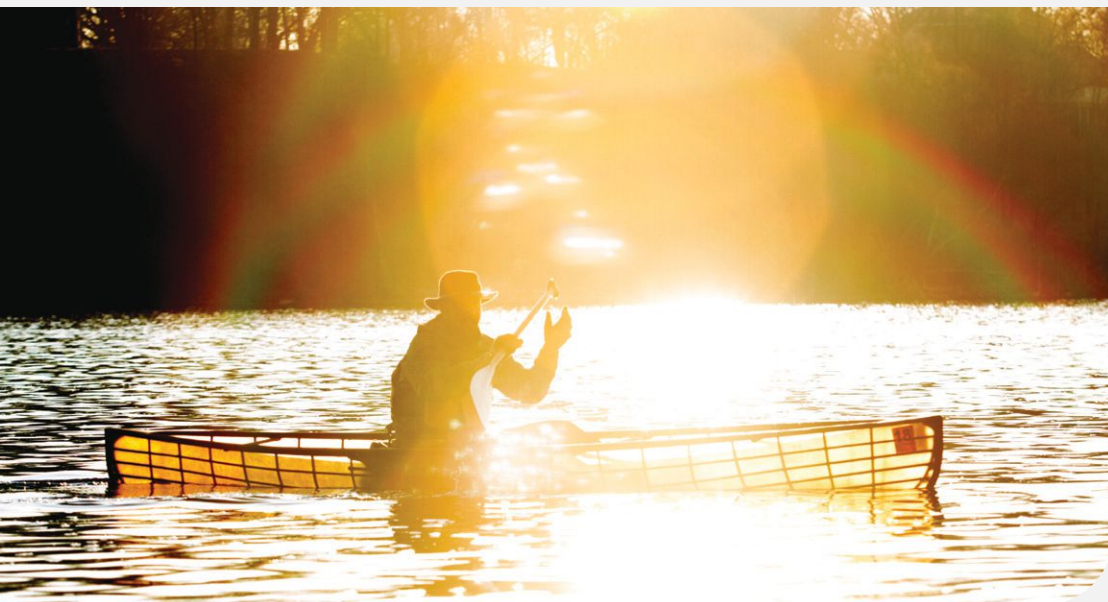


PHOTO BY ANDRA JOHNSON

Early morning sunlight reveals the oak ribs of Alexander Schad's hand-made craft.

Canoe commuter

Doctor's route to work literally floats his boat

When Alexander Schad, MD, makes his way to work, he doesn't jockey for position among an army of cars and trucks, and he doesn't watch out for drivers distracted by texting, applying makeup or eating breakfast behind the wheel. Schad shares his commute with geese, ducks, bald eagles, jumping fish, and an occasional raccoon or beaver. To get from his home in Sauk Rapids to CentraCare Health's St. Cloud Hospital and River Campus clinic, the nephrologist navigates the Mississippi River—by canoe.

"I'm an outdoors person, and it helps me stay connected with the natural world," Schad says. He finds the trip a convenient way to partake in a bit of exercise, avoid driving hassles, and start and end his day in a paddling-induced meditative state. "I typically have a better day when I canoe to work," he says.

Schad started paddling to work in 2012, after he bought a light but durable canoe from Urban Boatbuilders, a St. Paul nonprofit that teaches boat-building skills to youth. He even met the proud young woman who made his vessel, which she constructed using oak ribs and a nylon skin. Seeking ways to get more use out of

his new, treasured possession, Schad decided to give canoe commuting a shot.

It usually takes him 15 to 20 minutes to paddle to work and 25 minutes to go home. On the return trip, Schad goes up-



PHOTO BY ANDRA JOHNSON

Dr. Schad on the Mississippi River

stream and navigates the Mississippi's only set of rapids, where the Mighty Miss meets the Sauk River. Schad's canoeing season generally starts as soon as the ice breaks up in April or May, and it continues until November, when the river freezes. Sometimes it's dark during his trip; sometimes it's rainy or windy; but he doesn't mind.

In the morning, when Schad arrives near the hospital, he pulls his craft from

the river and finds it a parking spot in the bushes. He wears exercise clothes and a life jacket on the way to work, and he brings along a set of work clothes to change into. That routine proved especially wise one summer day when, upon exiting the canoe, Schad slipped on a stick and fell completely into the water.

Born and raised in the St. Cloud region, Schad grew up paddling, camping and guiding groups in northern Minnesota's Boundary Waters Canoe Area. It's a family tradition to take his children there when they turn 7, something he did with his

own father. So far, Schad has made the trip with two of his three kids, using the same Urban Boatbuilders canoe that carries him to work.

Schad went to medical school at the University of Minnesota, did his internal medicine residency at Hennepin County Medical Center, and completed a nephrology fellowship at the U of M. He wasn't planning to return to St. Cloud, but his brother, a nurse in CentraCare's kidney program, told him about a job opening right around the time their father got ill. The stars aligned and Schad moved home.

In the winter, when he can't canoe, Schad often rides his fat-tire bike to work. He stays active year-round by biking, running and swimming as he trains for triathlons and 100-mile bike races.

Although canoeing is just part of Schad's exercise regimen, it's the one that sparks the most conversations with patients. Many share his love of the outdoors, and talking about the hobby is an icebreaker. It also opens doors for Schad to discuss how to fit regular exercise into their busy lives.

"People like to watch out for me—they get a kick out of it, and it gives them a smile," he says. Schad treats many patients who have kidney disease and other serious illnesses. "Talking to my patients about canoeing lightens the mood and gives me a connection with them." — SUZY FRISCH



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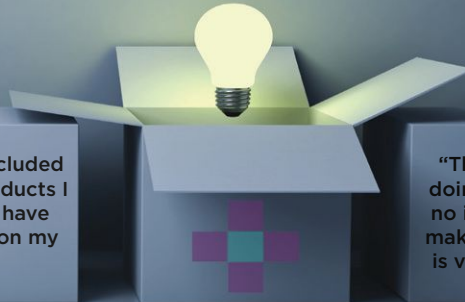
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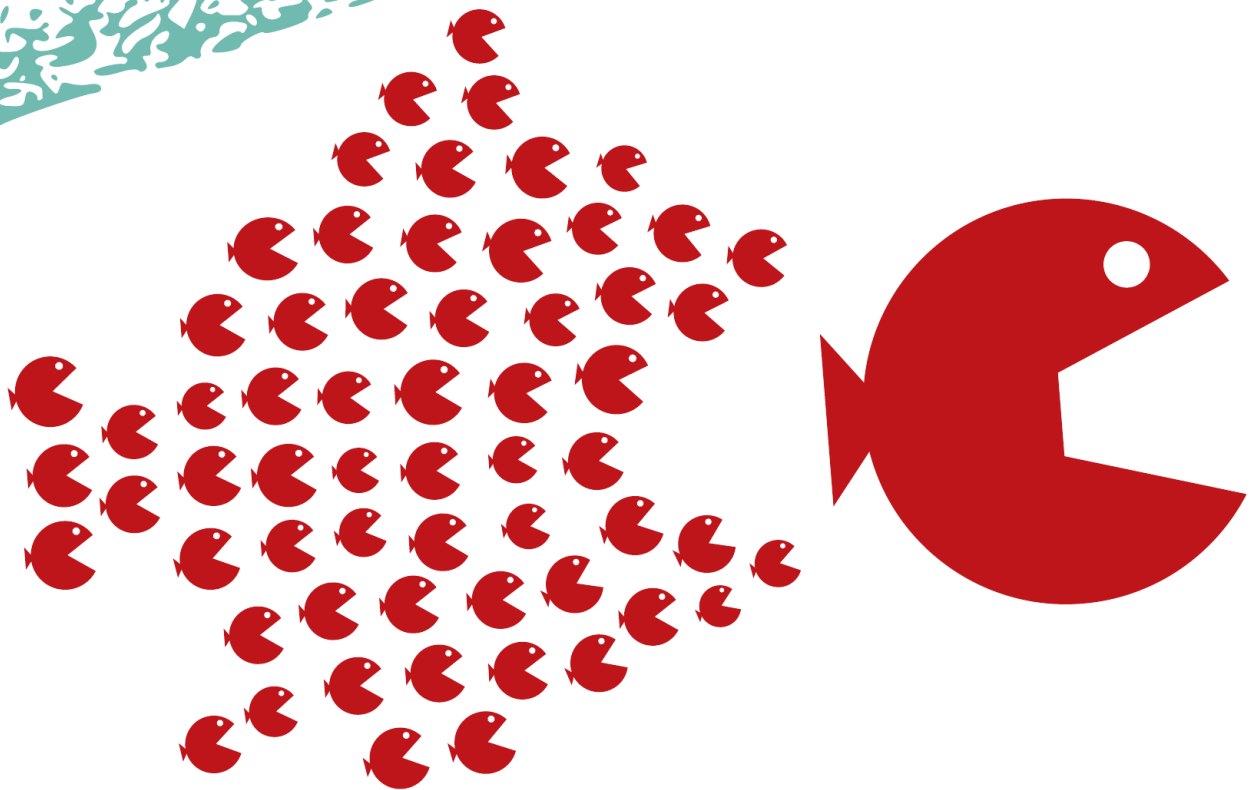
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BIG

Hospitals and clinics find
STRENGTH IN NUMBERS

BY HOWARD BELL



*Health care
has long been*
**BIG BUSINESS
IN MINNESOTA.**

But the state's hospitals and clinics have recently shown a new interest in joining forces.

The evidence is striking. In 2013, Park Nicollet Health Services, which includes Methodist Hospital, became part of HealthPartners. In June of this year, HealthEast and Fairview Health Services combined to create the state's largest health system in terms of

revenue and number of hospital beds. Alina Health recently created a joint venture company with Aetna, one of the nation's largest health insurers. And in September, St. Cloud-based CentraCare Health acquired St. Cloud Medical Group, which provides 80 percent of primary care physician services in the St. Cloud regional market.

Specialty clinics have gotten into the partnership act, too. In the Twin Cities, Metro Urology and Urology Associates have joined in what they call an "integration." Associates in Women's Health and OB/GYN Specialists have a similar ar-

angement. In St. Cloud, Midsota Plastic Surgeons was recently acquired by CentraCare.

In rural Minnesota as well, health care is increasingly in the hands of big regional systems. Patients in Grand Rapids, for example, have the option of getting care from Duluth-based Essentia Health and Minneapolis-based Fairview, which have facilities located across the street from each other in the town with a population of 11,000. During the past decade, Sioux Falls, South Dakota-based Sanford Health has more than doubled its presence in Minnesota, acquiring hospitals and clinics

from Bemidji to Luverne. And between 2010 and 2015, the number of Minnesota clinics that became affiliated or owned

by hospitals increased by 43 percent, according to the Minnesota Department of Public Health.

In addition, some rural clinics and hospitals are choosing to partner with one another to avoid being gobbled up by a big system—like fish schooling in a threatening sea. For example, nine northern Minnesota hospitals have banded together to create Wilderness Health, a collaboration they hope will help them adapt to change while remaining independent. In western Minnesota, ACMC Health, Rice Memorial Hospital and CentraCare are working to create a not-for-profit rural health co-op that allows them to collaborate while remaining locally controlled.

Whether partnering, merging or finding other ways to work together, clinics and hospitals are finding strength in numbers.

Motivated to merge

Health care providers and payers are joining forces for one of the reasons they always have (to gain negotiating power with insurers). Getting bigger increases a health system's market share; and serving more patients increases a system's power to negotiate better reimbursement rates from providers.

"It's an arms race," says Caroline Carlin, investigator for Medica Research Institute, which operates independently of Medica Health Plans. "Insurers consolidate to gain market power, so providers consolidate to keep up." Being bigger also makes it possible to compete for contracts that insure large employers, she adds. "If your competition gets bigger, you have to get bigger."

Stefan Gildemeister, Minnesota's state health economist and director of the Health Economics program at the Minnesota Department of Health, says there's another explanation. "Systems are truly trying to increase value," he assures, "partly because it's good for patients and partly because being a cost-efficient provider of good outcomes attracts patients and payers."

The main driver of the recent wave of health care consolidations and collaborations: pay-for-value reimbursement. With a new cost-consciousness among payers, traditional fee-for-service models are being replaced by pay-for-value or pay-for-outcomes reimbursement models (see glossary).

Making the FIRST MOVE

Midsota Plastic Surgeons was a small independent practice until last January, when the six-physician, two-physician-assistant group was acquired by CentraCare Health. "We approached them," says Paul Heath, MD, Midsota's physician leader. "It was getting harder to deal with payers. They don't want to work with small players and offer a reasonable reimbursement, and we weren't tooled up to compete for total-cost-of-care contracts. The direction medicine is headed was becoming quite clear." Heath likens the need to affiliate to a game of musical chairs. "When the music stops, we don't want to be the ones left standing."

Midsota kept its name, its location and its clinic culture of putting patients first. Once the practice's current payer contracts expire, CentraCare will use its much greater market power to negotiate future contracts. CentraCare also pays for staff recruitment, advertising and expenses. "New recruits feel it's less risky to join us now that we're part of a big organization," Heath says.

MIDSOTA PLASTIC SURGEONS and CENTRACARE HEALTH

Midsota previously had its own electronic medical record (EMR). Switching to CentraCare's Epic system came with predictable ramp-up hassles, but resulted in a more widely used, interoperable EMR that the practice has customized for its specialty.

In return, Midsota adds to the spectrum of services CentraCare offers payers, and it generates additional revenue for operating rooms. Heath admits it's sometimes frustrating to work with a larger, more cumbersome bureaucracy, and he misses managing the business side of the practice, but he declares the tradeoff well worth it. "Now I spend more of my time doing what I was trained to do," he says.

Pay-for-value reimbursement requires that clinics and hospitals work together to improve continuity of care and share financial risk with insurers to cover the cost of keeping patients healthy, explains Carlin. “Consolidation is a strategic response to payers’ cost-containment efforts,” she says.

One way to participate in pay-for-value contracts is to be part of an Accountable Care Organization (ACO), an entity authorized by the Affordable Care Act in

2010. ACOs are designed to reduce health care costs and improve quality by encouraging doctors and hospitals to form networks that coordinate patient care—and deliver that care at or below an estimated cost. Qualifying as an ACO requires offering capabilities across the health care con-

tinuum, including primary care, specialty care, and hospital services—and sharing of medical records.



PAY-FOR-VALUE GLOSSARY

Instead of rewarding the provision of care, pay-for-value models reward high-quality care provided efficiently and measured by outcomes achieved and the costs of achieving them. Value-based payment systems emphasize prevention, care coordination, and the use of evidence-based guidelines and quality measures to improve patient experience, improve the health of populations and reduce per-capita health care cost.

TOTAL-COST-OF-CARE CONTRACTS

To encourage timely, efficient, coordinated care delivered in the most appropriate settings, these reimbursement contracts pay a fee for service, but at less than market rates. At year’s end, savings are calculated based on the difference between the expected (market) cost minus the actual per-member, per-year medical loss ratio multiplied by the number of plan members. The insurer retains a small portion of the savings, while hospitals and physicians share the rest.

BUNDLED PAYMENTS (PACKAGED PRICING)

Physicians and hospitals are reimbursed on the basis of expected costs for clinically defined episodes of care. Bundled payments have been described as a middle ground between fee-for-service, which pays for each service provided, and capitation, which pays a lump sum per patient, regardless of how many services the patient receives.

PAY FOR PERFORMANCE

This umbrella term refers to any reimbursement model that rewards quality and efficiency rather than the volume of services provided. Bundled payments and total-cost-of-care contracts are examples.

SHARED SAVINGS CONTRACTS

These contracts offer hospitals, physicians and other health care providers a percentage of any net savings realized as a result of their working together in accountable care organizations to reduce spending for a defined patient population, while achieving a defined level of quality.

With such requirements, it's hard, if not impossible, for independent clinics and stand-alone hospitals to be part of an ACO or qualify for pay-for-value contracts.

"The changing way health care is provided and paid for creates anxiety that motivates clinics, hospitals and payers to jump into the consolidation game," Gildemeister says. "No one wants to be unaffiliated in an environment where it's perceived that affiliation is needed to survive."

When doctors join a hospital or health care system, it allows them to participate in pay-for-value contracts that require being in a full-service network. In addition, systems do the negotiating for their physicians, which usually results in higher reimbursement rates than independent physicians could obtain on their own. "Independent physicians have no negotiating power with major health plans," Carlin says.

That helps explain why it's getting harder to survive in independent practice—under any payment model. While reimbursements remain stagnant or decline, costs continue to rise. According to Carlin, electronic medical records (EMRs) alone are often enough to break the bank. She surveyed Minnesota independent physicians and found that EMR cost was one of the primary reasons that physicians—

Networking with NEIGHBORS

In west central and southwestern Minnesota, ACMC Health, Rice Memorial Hospital and CentraCare Health are in the process of creating a yet-to-be-named integrated health network based in Wilmar that they hope will legally begin operations in early 2018.

Smith says. "By working together, we can use the best ideas and practices each of our organizations brings to the table, make them even better, and implement those ideas together, throughout the network, at lower cost." ACMC, for example, has developed a toolkit to address opioid misuse and addic-

ACMC HEALTH, RICE MEMORIAL HOSPITAL and CENTRACARE HEALTH

The new not-for-profit will be governed by an independent board of directors, on which CentraCare has minority representation. That keeps leadership local, an important part of the deal, according to ACMC president and CEO Cindy Firkins Smith, MD.

"We understand our mostly rural patients," Smith says. "Administrators in a faraway urban system would have no idea what it takes to care for our patients. We serve many elderly and disadvantaged patients, and the money we're reimbursed to care for them is below or barely covers the cost of care. By collaborating, we can combine several departments and reduce costs."

Partnering better positions ACMC and Rice Memorial to compete for pay-for-value contracts, such as total-cost-of-care contracts and Medicare Shared Savings Program contracts, which require that hospital, primary care and specialty care be part of the same network. CentraCare, meanwhile, benefits by expanding its tertiary care referral range and by adding ACMC's 110 physicians and 70 advanced practice professionals to its provider network.

"If we all had to move in this direction on our own, we'd all be trying to create the same expensive, unsustainable systems,"

Smith says. "These types of quality initiatives will be used at every facility instead of each of us trying to invent them on our own," Smith says.

The partners will also collaborate on staff recruitment and retention. "There aren't enough health care professionals to go around in rural Minnesota," she says. "By working together, we hope we can engage the talented people we do have in the best, most collaborative ways."

After visiting ACMC to study its purchasing procedures, CentraCare took home ideas and streamlined its own processes—another example of the network's members benefiting by using the best ideas each has to offer.

Smith is optimistic about the plan. "For 50 years, ACMC was a physician-owned, for-profit clinic system," she says. "It worked well, but times have changed. We believe our new model is better-adapted to the changing health care landscape and that our integrated rural health network will be so successful that others will want to know how we did it."

Partnering with a PAYER

In early 2018, Allina Health System and Connecticut-based insurance giant Aetna will launch a joint venture called Allina Health and Aetna Insurance Company. Each entity will have a 50-percent ownership in the for-profit company,

outcomes aren't adequately reimbursed, or they're not reimbursed at all.

Such an out-of-sync relationship seems even less likely to work as health care shifts toward pay-for-value reimbursement models, Wheeler notes. "Pay-for-value does

ALLINA HEALTH and AETNA

which will have its own leadership team and emphasize reimbursements that reward cost efficiency and quality.

The new company will link one of the state's largest health systems with a national insurer that hasn't had much presence in Minnesota. Aetna will get access to a new market. Allina will help shape reimbursement, so that it receives what it considers adequate payment for services that lower costs and improve outcomes.

"This greatly accelerates our progress toward a care model where our success is more closely tied to how healthy we keep our patients, rather than the volume of services we deliver," says Allina CEO Penny Wheeler, MD.

Traditionally, payers and providers have had a somewhat adversarial relationship: Providers want adequate reimbursement; payers look for ways to contain reimbursements. Many argue that this tension never worked well in a productivity-based, fee-for-service model because many services that save money and improve patient

a better job of aligning reimbursements with the outcomes and affordability we want for our patients," she says. "Our joint venture with Aetna will give us a say in what those reimbursements are."

For example, Allina Health's cancer care coordinators recently helped keep 95 cancer patients from having to be hospitalized, saving \$1.2 million. But those services weren't reimbursed. "We lost \$600,000 in revenue because these patients weren't admitted to the hospital because our cancer care coordinators kept them well enough to not need hospitalization," Wheeler says. "We need some reimbursement benefit when we lower costs for payers."

Allina Health's LifeCourse service is another cost-saving quality improver that currently isn't reimbursed. It connects patients in their last two years of life to the health, legal and financial help they need. LifeCourse patients have 27 percent fewer inpatient days and 57 percent fewer intensive care unit stays, compared to com-

parable end-of-life patients nationwide. "On average, we save \$900 per month, per patient, on their care," says Wheeler. "Once again, we lose money because the service isn't reimbursed, but the patient benefits. We want to get paid for how well we deliver value to patients. Our joint venture with Aetna will make that happen."

That's because the collaboration aligns the interests of payers and providers by bringing actuarial thinking to care delivery. "We'll now work alongside each other to achieve the best outcomes for the dollars spent," Wheeler says.

The new venture will also make it easier for Allina and Aetna to track and measure patient outcomes, because medical records and claims data will be shared and monitored using advanced clinical data analytics that help Allina understand disease progressions and provide better preventive care, sooner. If people who develop "condition X" are found to have exhibited certain symptoms years in advance, Allina can use that data to find people who are exhibiting those symptoms now, and intervene.

Allina and Aetna hope to offer fully insured and self-insured value-based plans to employers by early 2018 and to Medicare patients soon after that. Aetna hopes to have at least 75 percent of its claims payments in value-based plans by 2020. "Since pay-for-value plans require providers to take on some financial risk, it makes sense to partner with an insurance company that's always assumed risk for keeping people healthy," Wheeler says.

Allina isn't the first Minnesota provider to partner with a payer. Bloomington-based HealthPartners has been both a provider and a payer for decades. Fairview Health Services owns PreferredOne, an insurance company in Golden Valley. "It's an exciting time to be in health care," Wheeler says. "We're transforming it from volume-driven to value-driven."

especially primary care physicians—want to sell their clinics to a system.

Is bigger better?

Allina Health CEO Penny Wheeler, MD, says consolidation is a good thing, “as long as the purpose is to defragment the health care system for patients, to knit together the seams in the system in order to improve the patient’s experience, improve their outcomes, and contain costs by

decreasing hospitalizations and emergency department use as much as possible.”

Some evidence, however, indicates that getting bigger, in and of itself, doesn’t lower costs. According to Gildemeister, if all a merger does is give a system power to demand higher reimbursements from insurers, premiums go up.

“The studies are irrefutable,” he says. “Mergers don’t lower costs for patients or payers. What we’re seeing is prices going up and premiums going up. When hospitals or systems merge, payers pay more, which raises premiums for patients. There’s nothing shady about this. Health systems operating in the market simply

take full advantage of their market and negotiating power. They still compete with each other, which limits how much prices go up, but they still go up.”

Carlin agrees. When a system acquires a clinic, she says, “there’s no guarantee that costs will lower for the system. Even if costs go down, there’s no guarantee any of this savings will be passed on to patients, their employers or health plans.”

For businesses that offer health insurance to their employees, consolidation in health care is providing no cost savings—only cost increases, according to a May 2017 report by the Minnesota Health Action Group, a coalition of large employers. The report stated that health care costs in Minnesota were up 7.4 percent in 2016, compared to a 2.4 percent rise, nationally.



CONSOLIDATION IS NOTHING NEW

Health care in Minnesota—especially in the Twin Cities—was already highly consolidated before the current wave of alliances began. A series of mergers and acquisitions began in the 1970s, when there were 35 independent hospitals in the metropolitan area. The consolidation pace quickened in 1982, when Medicare began using diagnostic related groups (DRGs) to limit reimbursements to hospitals, and private payers created HMOs to cap reimbursements for clinics and hospitals.

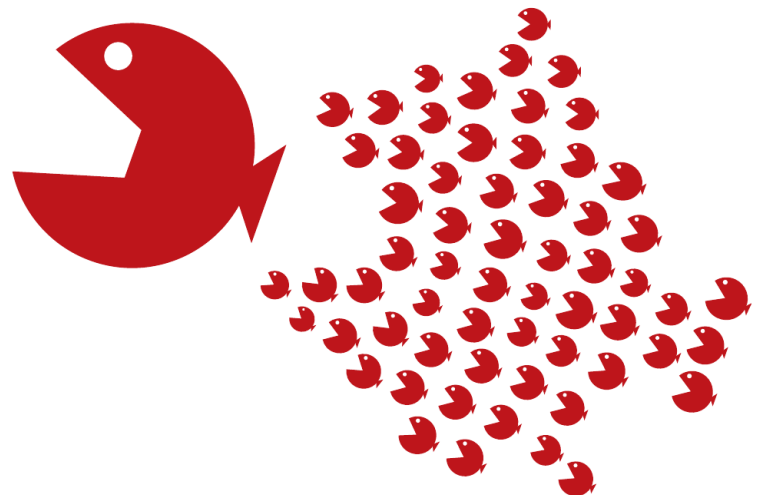
To gain market power and counter their declining leverage for negotiating reimbursements, hospitals continued to merge or be acquired into the 1990s. Health insurance plans countered by consolidating, too.

Another consolidation stimulus came in 1993, when a new state law began to require that health systems be structured as integrated service networks (ISNs). The hope was that ISNs operating under close government supervision would contain costs and improve quality.

The law led to a massive restructuring of health systems throughout the state. Insurers merged with or acquired hospital systems. Hospitals acquired clinics and other hospitals. Physicians sold their practices to hospital systems or health plans so they wouldn’t be left out of ISNs. Large hospital systems began hiring their own physicians in addition to acquiring practices.

All that activity created an ecosystem that resembles today’s medical practice landscape. Like DRGs, HMOs and ISNs did in the past, pay-for-value reimbursement is now powering a new wave of consolidations and collaboration in health care.

Source: Christianson JB, Carlin CS, Warrick LH. The dynamics of community health care consolidation: acquisition of physician practices. *Millbank Q.* 2014;92(3):542-567.



The payer landscape can be a chilly place for small, rural medical institutions that lack negotiating power. In November 2013, nine northern Minnesota hospitals came in out of the cold by creating the nonprofit Wilderness Health. The alliance is headquartered in Two Harbors. Each member hospital remains fully independent and has one vote on Wilderness Health's board of directors.

Members include Bigfork Valley Hospital in Bigfork, Community Memorial Hospital in Cloquet, North Shore Health in Grand Marais, Cook Hospital in Cook, Fairview Range Regional Health Services in Hibbing, Lake View Hospital in Two Harbors, Mercy Hospital in Moose Lake, Rainy Lake Medical Center in International Falls and St. Luke's Hospital in Duluth—the group's only large tertiary care center. Wilderness is in discussions with other small clinics and hospitals about joining.

"We all need to participate in accountable care organizations, total-cost-of-care

WILDERNESS HEALTH

contracts and other new reimbursement models if we're going to survive," says David Spoelhof, MD, Wilderness medical director. Yet, "these are challenging for small facilities to do unless they've partnered with others," says Wilderness executive director Cassandra Beardsley. In 2015, Wilderness became a Medicaid accountable care organization (ACO), which Medicaid calls an Integrated Health Partnership (IHP). Being a Medicaid IHP gives Wilderness members access to "a nice amount of useful data on utilization, types of medications most prescribed and most common diagnoses," says Spoelhof. A quality committee uses that data to improve efficiency

and lower costs, while subcommittees address emergency department use, opioid prescribing and depression care.

ACOs and other value-driven networks require that clinics, not just hospitals, be part of the organization. Some Wilderness members don't own a clinic; however, they all have close relationships with nearby

clinics that provide the physician component required to qualify as value-driven networks.

St. Luke's is large enough that it probably could have adapted to the changing reimbursement landscape on its own, Spoelhof notes, but the hospital—and its employed specialists—benefit from referrals from other Wilderness hospitals. "And," adds Spoelhof, "the other hospitals appreciate that St. Luke's sends their patients back." In addition, Wilderness members have saved money by volume purchasing capital equipment, medical and surgical supplies, and lab products and by sharing costs of equipment rentals and staff training.

Many Wilderness hospitals have only one human resources staff person. Collaboration among them has enabled more successful and efficient employee recruitment and retention, and it has helped

members report data required by health insurance mandates.

Wilderness members don't all use the same EMR, but they've purchased software that allows their systems to share quality improvement data needed to meet cost and outcome benchmarks for ACOs and total-cost-of-care contracts. "When it comes to EMRs and other expensive necessities, doing it together is the only way small hospitals can do it," says Spoelhof.

Wilderness members could have joined big integrated health systems, the way many small hospitals have. But Spoelhof says that wasn't their preferred course of action, so they forged a different path. "There's a strong desire among our members to stay independent and keep our local identity," he says. "That's what the communities we serve told us they want."

Coming in from the COLD

Prices that physicians charge go up after their clinic is acquired by a big system, according to a Medica Research Institute study of what happened when two Twin Cities-area systems acquired three multi-specialty clinics in 2007. Four years after the acquisitions, the clinics charged 32 to 47 percent more than they were expected to have charged had they not been ac-

quired, while average physician prices at “legacy clinics” (those owned by the systems before the new acquisitions) were 14 to 20 percent higher than expected.

The study looked at average overall physician charges, as well as procedure-specific charges, and it compared them with those of other, nonacquired clinics in the same market, to determine what effect

on prices the acquisitions had. “We found that physician prices go up,” says Carlin, who was the principal investigator. “But,” she adds, “we found no evidence that quality decreased. There’s not a lot of evidence that mergers are good for patients. But at least they don’t seem to be worsening care.”

The tendency for mergers and acquisitions to increase costs can be at least partially

Working with GOLIATH

What happens to the autonomy of primary care clinics that have a relationship with a big system when that big system merges with an even bigger

us to pause and wonder: What will happen in the next five years?”

Hernandez wonders if the focus on cost, quality and patient experience will devolve

that’ll be a problem. We want a truly collaborative relationship because there’s a lot of room for improvement in health care, and nobody’s figured out the answers, so we need everyone collaborating and having a say.”

Time will tell if practices like Entira can remain independent while maintaining affiliations with multiple hospitals that are part of different systems. According to Kevin Garrett, MD, East Region Medical Executive for Fairview,

ENTIRA FAMILY CLINICS, HEALTHEAST and FAIRVIEW HEALTH SERVICES

system? Tim Hernandez, MD, medical director for Entira Family Clinics, is waiting to find out.

Entira’s 11 east metro clinics have long worked closely with HealthEast. Entira physicians refer most of their patients to HealthEast hospitals and specialists. An accountable care organization (ACO) with HealthEast Medical Group gives Entira equal partnership and voting rights. And Entira has enjoyed a place at the HealthEast decision-making table, helping align clinical decisions and cost-control strategies—all while staying independent.

But that changed when HealthEast combined with Fairview Health Services last June. “We were caught off guard,” says Hernandez. “Now we’re in reactive mode. How will this merger play out? We’ve had a strong relationship with HealthEast. The dynamics of working with Fairview cause

into bottom-line, market-share concerns and if big systems will only collaborate with independent clinics that play by the big system’s rules—which include sending all patients to the system’s hospitals and specialists.

“We’re all walking a fine line,” says Hernandez. “We talk about seeking value, and we’re moving toward value-based payments, but we’re still operating in a fee-for-service environment, so some decisions are still being made on that basis.”

Keeping its options open, Entira has had discussions with multiple organizations about collaborative arrangements. “All of them clearly want some element of steerage toward their hospitals or specialists, which is understandable,” Hernandez says, “but we can’t send all our patients to one or two hospitals, and if all we’re going to be is a source of referrals, with no say in the system’s future vision and operations,

most systems in the metro area are acquiring clinics, rather than collaborating with them. “We may be the only system still interested in working with independent clinics like Entira,” he says. Garrett has an “if it ain’t broke, don’t fix it” view of Entira. “They’re a high-quality group of docs who consistently deliver good outcomes at low cost. They’re the type of group we want to work with,” he says.

That sounds good to Hernandez, but he cautions that collaboration between a small player and a goliath like Fairview requires a huge level of trust. “If the system says they want collaboration,” he says, “they have to walk their talk.”

attributed to the fact that physicians and hospitals still practice in a largely fee-for-service environment, Gildemeister points out. “For now, the health care ecosystem still rewards doing more procedures and using devices and technologies,” he says. “There’s always some-

Teaming to

INNOVATE

Since 2010, Allina Health and HealthPartners have collaborated through an accountable care organization (ACO) called the Northwest Metro Alliance, which seeks to improve outcomes and make care more affordable. The Alliance pilots new programs and patient care processes, then applies the successful ones to a larger population of patients. According to a recent five-year executive summary, the collaboration is succeeding.

Between 2010 and 2014, the Alliance increased outpatient services for its mental health patients and lowered hospital visits by 7 percent, or 259 fewer admissions. Mercy Hospital’s 30-day all-cause admissions were 11 percent lower than expected, avoiding 110 unnecessary readmissions and decreasing costs by an average of \$11,200 to \$13,000 per admission. After a pharmacy outreach program began in 2013, the number of patients who filled their prescriptions increased by 27 percent

NORTHWEST METRO ALLIANCE

in the first 18 months of the program. As part of a state demonstration project that began in 2013, medical costs for Northwest Metro Alliance Medicaid patients decreased nearly 2 percent, saving taxpayers more than \$7 million. The Alliance’s overall medical cost increases were more than 31 percent lower than the average increase for Twin Cities area patients with private insurance.

“This type of partnership was unique when we began,” says Andrea Walsh, HealthPartners president and CEO. “The Alliance brought together two delivery systems and a health plan, all committed to measurably improving health and reducing costs for our patients. Today, this is a model for other ACOs.”

thing new, faster and more precise. There are, of course, benefits to that approach, but we pay for it with higher prices.”

Once pay-for-value contracts are more the norm, Carlin notes, additional, long-term effects of mergers and acquisitions may start to emerge. “It’ll be interesting to watch what happens,” she says. “As current fee-for-service contracts end and are replaced by value-driven contracts, I’m optimistic prices will come down for patients, payers and providers.” She adds, however, that cost decreases will likely only be realized if—and it’s a big if—one more change is implemented. “In addition to rewarding value,” she says, “we need to re-engineer how health care is delivered.”

Gildemeister worries that hospitals and clinics may lose their nimbleness and potential for crafting creative solutions when they become part of large systems—and must conform to their system’s way of doing things. “Today’s health care climate is calling for us to do things differently,” he says. “Overconsolidation may stifle the innovation we hope will bring us closer to more affordable, sustainable health care.”

Whether the bigger-is-better approach improves quality while containing costs remains to be seen. One thing seems certain: Forces driving consolidation and collaboration will grow. As they do, Minnesota hospitals, clinics, and physicians will keep picking partners in one way or another, so they don’t have to navigate a complex, uncertain landscape alone. **MM**

Howard Bell is a frequent contributor to *Minnesota Medicine*.

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Hard conversations

Explaining to someone that she is going into labor at 19 weeks is hard. It's even harder when she is 18 years old and she only speaks Spanish.

Such a patient came to the emergency department when I was a third-year medical student on one of my first rotations (OB/GYN) after she'd felt a gush of fluid at home and developed a fever. I stood silently while residents and doctors told the patient that, because her cervix was dilated, she would likely pass the pregnancy in the next few hours. I think that in this circumstance, "pass the pregnancy" was a lot like the phrase "your loved one has moved on," used by a physician to tell a family that their loved one has died. In the cramped ED room stood a nurse, two residents, a physician, a translator, the patient's family, the patient and me. The sheer number of people present would have made the conversation difficult for anyone.

This patient sat there with a blank stare and slowly allowed it to sink in that she would not likely leave the hospital pregnant. I wanted to console her and tell her that the pregnancy wasn't viable, she didn't do anything wrong, and that as she was still a teenager she could hopefully expect to have many years of fertility ahead of her. From the look on her face, I sensed that she

felt as though something she had done had killed her baby. It was hard to watch

as she slowly shut down while everyone talked in hushed, calming voices in a language she didn't understand.

Once the patient was moved out of the ED and to her own room, the attending physician asked right away if she could sit on the patient's bed while they talked. She held her hand and repeatedly assured her that she had done nothing wrong. The attending laid out all of the options without placing more importance on any one of them. She allowed the patient time to

and hidden lessons

Musings on
an encounter
gone right

BY AUBREY THYEN

cry. She looked at her the entire time without glancing at the translator. In that moment, the attending showed me how to be strong in a very difficult interaction. This physician likely didn't know the impact she made—not just on the patient, but also on me, the medical student.

The phrase “hidden curriculum” is something all medical students hear about and encounter during their third and fourth years of medical school. Most of the time, I feel as though hidden curriculum is discussed in a negative way. The senior surgery resident is rude to you and belittles you in front of others? Hidden curriculum would call that “learning how to have thick skin.” Morning rounds are taking longer than normal and you don't have the opportunity to use the bathroom without falling behind? “Welcome to medicine,” hidden curriculum would say, “and please develop a steel bladder.” The interaction I witnessed between that attending

and her scared patient was another example of hidden curriculum—but one that cast the concept in a positive light. The doctor taught me how to respond to serious moments, such as when a shattered teenager who doesn't speak English needs someone to communicate with her about an unexpected miscarriage.

Since that interaction, I've tried to hold on to the positive lessons I've learned from the hidden curriculum, so they outweigh the negative ones that inevitably crop up. On my pediatrics rotation, I saw a senior resident carry an infant patient during rounds so the mother could have five minutes to drink her coffee. In palliative care, I saw a dying patient console a crying nurse during a care conference. In family medicine, I saw a physician discover the reason his patient had out-of-control diabetes despite being prescribed the correct medicine: The patient did not know how to read, and no one, not even her husband, had ever known.

I hope to remember these and other positive lessons from the hidden curriculum for years to come, as they will make me a better doctor. I also hope to remember the negative ones, as I know they will help me next year as a resident, when I interact with new third-year medical students. As for the lesson I learned by watching that attending physician communicate with her young, distraught patient? I expect it will continue to inform how I recognize—and respond to—strong emotions during tough conversations.

Such encounters confirm for me that my career is the privilege I've been dreaming about since I applied to medical school. Physicians are afforded opportunities to walk people through some of their best and worst circumstances. That makes me wake up every day excited about my chosen field. **MM**

Aubrey Thyen is a fourth-year medical student at the University of Minnesota Medical School.

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Medical Practice Meets

THE LAW

A physician recalls
his first brush with
the legal system.

BY A. STUART HANSON, MD

It was a day like many others at the medical center in St. Louis Park, a first-ring suburb of Minneapolis, where I practiced.

I had made hospital rounds and seen my morning office patients when a receptionist said there was a man in the waiting room who insisted on seeing me. This was 1974, long before we were concerned about personal safety in our medical buildings in Minnesota. When I met the man in our waiting room, he asked, "Are you Dr. Arthur Stuart Hanson?"

"Yes, I am."

"I represent the Hennepin County District Court and am here to serve you this summons. Please sign here that you received it."

Thus began my first encounter with the law as a defendant.

The 1970s were a litigious time for those practicing medicine. Physician organizations like the American Medical Association were pushing for limits on liability and court procedures to reduce frivolous suits. Professional liability insurance was a significant cost for a medical practice. Now I was being pulled into this environment.

It took me the rest of the day to absorb what had happened. I had a full schedule of patients to see before there was time to read the packet of difficult-to-interpret documents. By evening, I had determined that I, three other physicians and Group Health of



Minnesota, a cooperative insurance plan, were being sued by the family of a deceased patient we had cared for two years earlier. For me—a young physician three years into private practice—it was devastating.

I remembered the case well. The patient was a 27-year-old, nonsmoking, married woman who presented to a Group Health Plan outpatient office with respiratory symptoms. Before I saw her, a general internist had treated her symptomatically. When she did not improve, an X-ray was taken. It showed what appeared to be pneumonia in the upper lobe of the right lung. Antibiotics led to some symptom improvement, but the lung appeared

worse on another X-ray. A chest surgeon was then consulted, and he performed a rigid bronchoscopy. (At the time, the standard of care was to inspect the trachea and central bronchial tubes with a rigid, hollow, silver-like tube passed through the vocal cords, a procedure conducted in an operating room under general anesthesia.)

The chest surgeon found no abnormalities, but he could not see the bronchus going to the right upper lobe, due to the angle it takes in relation to the trachea and right main-stem bronchus. Based on the X-ray, he knew this was where the problem was, but he could not get to it with the rigid instrument.

Here, I have to digress a little and provide some background information. When I began medical practice at the St. Louis Park Medical Center in 1971, Japanese manufacturers had started to market a flexible, fiber-optic bronchoscope designed to overcome the limitations of rigid instruments. It had a fiber-optic light source that allowed visualization around corners. It also had a small portal through which washings and biopsies could be taken under direct vision. During residency training in gastroenterology, I had used flexible scopes to visualize the esophagus and stomach. At that time, no one in Minnesota was using the new scope for airways.

When I started private practice, I lobbied for a flexible scope for our pulmonary department. I set up a protocol, trained an emergency department nurse assistant, and in 1972 performed several dozen procedures. When starting any new medical initiative, expectations are that you will evaluate your experience and report to the other members of your multispecialty group practice. That was especially important in this instance, since I was taking cases that chest surgeons and ear, nose and throat doctors had previously seen in their practices. I was given the opportunity to innovate, but I was also being held accountable.

By the time I gave my report to our 65-physician multispecialty group, I had accumulated many interesting and informative cases. I also had photographs inside normal and abnormal bronchial tubes: pictures of cancers, mucous plugs and foreign bodies, all associated with X-ray and pathological findings.

When the Minneapolis Society of Internal Medicine held its 1973 winter meeting, I made a presentation. That's when the larger medical community learned what we were doing in our group. No one else in the area was using the new Japanese bronchoscopes, and that is why the Group Health chest surgeon asked me to see one of his patients—the young woman with as-yet undiagnosed respiratory problems.

I went through a standard pulmonary evaluation and reviewed her X-rays. This was long before computer-assisted imaging tools such as CT, MRI and ultrasound were available. I saw no mass to suggest cancer. Her problem had started like an upper-lobe pneu-

monia, but now the whole upper lobe was collapsed. A skin test for tuberculosis was applied, and an outpatient fiber-optic bronchoscopy was scheduled for the next day, with the referring chest surgeon assisting.

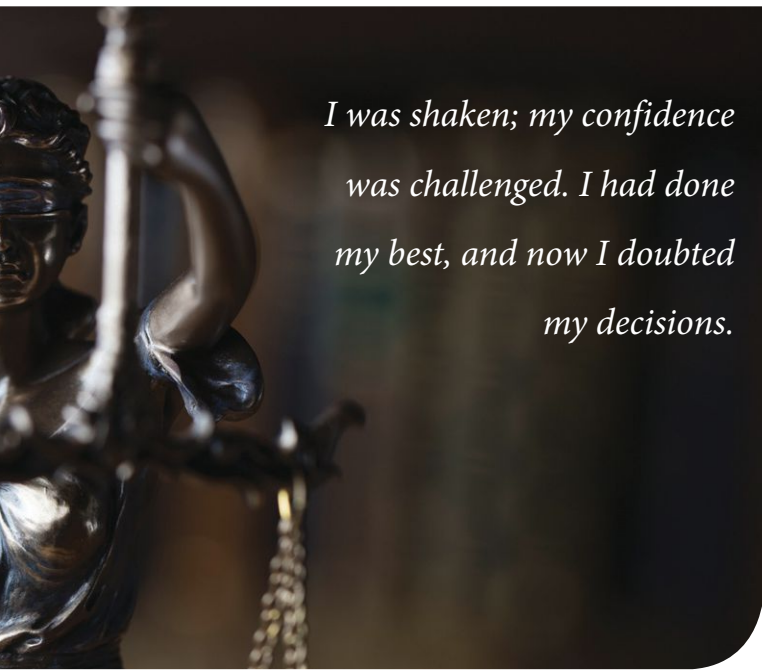
With the flexible instrument, we found that the trachea and other central airways were normal except in the right upper lobe. There, the airway narrowed, and was thickened and inflamed; but there was no tumor mass or foreign body. Biopsies, brushings, photos and cultures for bacteria, fungus and TB were taken. We hoped to make a specific diagnosis in the next few days.

We found no objective evidence for cancer or bacterial infection. Could this be a fungus or TB, we wondered. Those cultures would take weeks to grow.

I went to see the patient across town, where she was hospitalized, to read her TB skin test. To my surprise, it was positive! On further reflection, the patient remembered she had worked with two TB patients the previous year. With this new information, we still had no diagnosis, but we had some leads.

I recommended starting treatment for TB while we waited weeks for cultures to grow. If no infectious diagnosis could be made, and if the X-ray shadows had not improved, then we'd do a surgical exploration. The treating doctors took my recommendations.

I didn't hear anything more for about a month. Then, I learned the patient had gone to the University of Minnesota, where another rigid bronchoscopy found an invasive cancer in a blind biopsy of normal-appearing tracheal tissue. She and her husband decided to get her further care at the university. From that point on, I only received thirdhand information through the referring chest surgeon, until the day I was summoned to court.



I was shaken; my confidence was challenged. I had done my best, and now I doubted my decisions.

I was shaken; my confidence was challenged. I had done my best, and now I doubted my decisions. In the next days and weeks, I pored over my records. Was what I recommended right? Should I have done things differently? Did any delay in diagnosis make a difference in the final fatal outcome? I talked to the chest surgeon. I received a call from a lawyer hired by our liability insurance companies to represent us. I wrote a case summary. My nights were fitful. I thought about the case any time I was alone.

Eventually, I was asked to give a deposition. I gave my side of the case, and the plaintiff's lawyers questioned me. A court recorder took down everything I said. My attorney and several other lawyers were present. I gave my credentials, my summary of the case and my thinking. Then the plaintiff's lawyer cross-examined me.

"You are a pulmonologist, is that right?"

"Yes."

"Who are the leading authorities in your field?"

"There are 10,000 pulmonologists in the United States. Each one has specialized medical training and experience."

"Do you recognize one or two who stand out above the others?"

"There are many highly specialized physicians."

"Have you written any papers?"

"Yes, I submitted a bibliography."

"In this case, you thought she had tuberculosis?"

"No, that was one of the possibilities."

And so it went for almost two hours. Everything I said was now part of the court record, part of a fact-finding process that would grind on for the next 18 months. About a week later, I read my deposition. It read terribly. It recorded the way I talked, with all my "uhs" and "ahs." My lawyer thought it was fine. He assured me that there was nothing damaging, that I had not said there were other expert opinions to consider, and that I should not lose any more sleep.

I read the other physicians' depositions. The radiologist seemed straightforward, but his deposition also read poorly. The chest surgeon's read like the others, but suggested the thoughtful, confident, self-assured doctor that I knew him to be. The deposition from the primary care physician, who had seen the patient first, more or less put the ball in the chest surgeon's and my court. When the patient didn't get better after initial treatment, the primary care physician referred to specialists and followed their advice. So far, it looked like the chest surgeon and I were the responsible parties.

Any plaintiff bringing a professional liability action needs expert witnesses. We waited to see who they would be. Who would say we had not followed sound medical procedures? Who would say we did not meet the community standard of care?

Months went by as we waited for the fact-finding process to end. Then one day, I received a packet in the mail from the lawyer the insurance company had assigned to the primary care physician, the chest surgeon and me. It contained a letter asking for a

phone call after I had read the opinion letter (called an interrogatory) from the plaintiffs' expert witness.

The interrogatory letter was from an internationally recognized cardiothoracic surgeon from the University of Minnesota. He was also a surgery professor I'd had in medical school. As students, we feared him. He was an imposing figure with large hands, dark hair, a stern face and a stout body on a 6-foot frame. His weekly surgical conference was something to be endured. He would pick apart a case presentation no matter how hard the presenting student had studied and prepared. Fear, intimidation and harassment were his methods of teaching. He was said to do the same in the operating room. It was my fortune not to have operated with him. Now he was a professional witness against us.

I called our lawyer and said, "We have a bully here."

"What do you mean?"

"He is a formidable physician and a good surgeon, but we can't let him get away with an opinion that doesn't fit the facts. I don't understand why he is doing this. We have to defend this case."

"Are you willing to go to court and stand up to him? You and the chest surgeon will be the key defense witnesses."

"Right now I say yes, but I want to talk to my colleague."

When I did, he had a similar reaction. The reasoning of the plaintiff's witness—that any treating physician would know from the beginning that this was not a pneumonia and required early surgical intervention—was divergent from what we did, and our opinion had not changed. We resolved not to offer any settlement. If they wanted to go to court, we were ready.

More months went by, but finally, a court date was set. I began another comprehensive review of all the medical data, the depositions, the opposing expert's opinion letter and several defense lawyer conversations. Now we had three lawyers involved: one representing the radiologist and two representing the primary care physician, the chest surgeon, me and Group Health Plan. Several days before the court date, we were notified that the plaintiff's lawyer planned to put all four defending physicians on the witness stand. Were we ready?

.....
"Everyone, please rise."

The black-robed judge entered through a door in the back of the wood-paneled courtroom. I thought, "He has come from his office, and we are in his examining room."

He took his seat behind an impressive desk on a raised platform that obstructed our view of what he had in front of him. Even seated, he was 4 to 5 feet above us. We sat behind a wooden rail with our table and chairs facing his bench. A slightly raised witness stand was to our right. Further to the right were two rows of chairs in an empty jury box. The formalities had started.

"Please be seated," said the judge. "We are here today to hear a complaint about the way a patient was treated by doctors working for Group Health of Minnesota. The whole story will be forthcoming as the case is presented. We will now begin jury selection."

For the rest of the morning, potential jurors filed into the room and were questioned by both sets of lawyers and the judge. There were questions about their education and their work back-



Everything I said was now part of the court record, part of a fact-finding process that would grind on for the next 18 months.

grounds. Did they know the plaintiffs? The defendants? Had they heard about the case? Would they listen carefully to the testimony? Could they give an objective judgement? Lawyers on both sides removed a limited number of potential jurors they didn't want. During a recess, our defense team discussed those who remained. It was all new to me and more formal and detailed than any workers' compensation hearing I had attended or any TV show I had seen. Finally, six jury members and one alternate were selected and empaneled.

Our lawyers then moved to remove the three treating physicians from the case. "Counselors, approach the bench," said the judge, which led to a conference out of my earshot.

"Not granted," he replied.

Next, the radiologist's lawyer moved to have his client removed from the case. I thought this was odd since we had just lost our motion. There was another call to approach the bench; another conference; then another ruling.

"Granted."

I was stunned. What was going on? (Later, I found out that the plaintiff had no expert witness to counter the decisions made by the radiologist. Therefore, he could go back to reading X-rays and sleeping well at night, leaving the remaining three of us to defend our practice.)

The opening statements from each side seemed to drone on. They were the same words I had heard and read so many times over the past two years. My mind was getting numb. Then the plaintiffs' lawyer called the first witness.

The primary care physician had trained at Mayo Clinic as a general internist before being employed at Group Health. He had dark hair, greying sideburns and a hint of afternoon shadow. His round face and forehead perspiration made him appear nervous. He had trouble focusing on the plaintiffs' attorney's questions,

and his answers were indecisive and muddled. By the time our attorney had a chance to help him during cross examination, it was too late.

*What was happening?
I was being set up by my own colleague!*



We were not off to a good start. During a recess, our lawyers asked what we wanted to do. The plaintiffs were offering to settle. I looked at the chest surgeon, who we expected would be called next. He asked me what I thought. The trial had just begun, and I was not ready to give in. We resolved to forge ahead.

On the witness stand, after establishing his credentials and his involvement with the patient, the chest surgeon was asked why he did not operate when he couldn't make a diagnosis with the rigid bronchoscope.

"I did not want to operate on this young woman unless it was necessary," he replied. "I had read articles about a new flexible bronchoscope that might help me make a diagnosis before subjecting her to surgery. I was ready to send this young, nonsmoking woman anywhere in the country if it would help her. I wanted the best possible care and the best possible consultant available. A physician at the University of Iowa was using the new instrument, but none of my colleagues had any experience with his team. Then I learned Dr. Stuart Hanson had over a year's experience and had reported his work to the Minneapolis Society of Internal Medicine. I chose the best consultant I knew, and that was Dr. Hanson."

What was happening? I was being set up by my own colleague!

There was a pause. The plaintiffs' lawyers asked for a 10-minute recess. Our team retreated to a conference room behind the jury box. I told the chest surgeon I felt uncomfortable with the accolades he used to describe me. He said that was the way he felt. Our lawyers were reassuring and said I would likely be next. We all were anxious when we returned to the courtroom.

"Everyone, please be seated," the judge said. "Please proceed with your case, counsel."

"The plaintiff calls ..." He named the cardiothoracic surgeon from the University of Minnesota; my former professor; the writer of the interrogatory letter.

What? Not me? What was going on?

"You are the expert witness in this case. Will you give us your background and your experience treating lung diseases?"

We had known he would eventually be on the stand, and we had a plan. The chest surgeon and I were more convinced than ever that we had done nothing wrong. The patient had a bad disease and an unfortunate outcome, but we would not have altered our recommendations. We moved our chairs up to the rail, as close to the witness stand as we could get. From there, we fixed our gazes on the speaker. In a sense, we were challenging him in a court of law just like he had challenged us with his opinion letter.

"Would you read your interrogatory response?" The plaintiff's attorney asked. After the letter was read, a follow-up: "Is it still your expert opinion that the Group Health doctors and their consultants did not meet the standard of this community in caring for this patient?"

There was a pause. We kept our eyes fixed on the witness. He made eye contact. The pause continued. Now the courtroom was silent, and everyone's attention was drawn to his answer.

"Would you please repeat the question?" he asked.

The court recorder read the question again. "Is it still your expert opinion that the Group Health doctors and their consultants did not meet the standard of this community in caring for this patient?"

"I can not say that."

The judge interrupted. "You realize your expert opinion is the center of this case. Your letter states the doctors did not meet the standards of this community. Is that your opinion now?"

Another pause. Finally, he responded.

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"It is no longer my opinion."

The judge spoke. "Will counselors approach the bench?"

After a long private conference with the lawyers from both sides, he said, "Jurors, you are excused. I will meet you in the jury room in a few minutes to explain what has happened."

Then he explained to the rest of the courtroom: "The court rules in favor of the defense. The plaintiff has failed to show cause. This matter is closed. Court dismissed."

We had defended ourselves without presenting a defense. I was elated, but shaken. I'd had my day in court without saying a word. The law had taken two years to grind through its processes to an abrupt conclusion.

I went over to greet the patient's husband, whom I knew from the day I did the bronchoscopy on his wife. He told me she had wanted him and their family to know: Would the outcome have been different if her illness had been treated another way? He said now he had closure, and he thanked us for caring for his wife.

The plaintiff's expert witness came over. "I really wasn't out to get you doctors," he said. "I wanted to get that socialist Group Health outfit. But I couldn't do it in court." I was not going to ask for further explanation, but he was known to be against doctors who shared patients in multispecialty group practices. He also had spoken out against a cooperative community-owned practice that he considered an example of socialism.

The bully had spoken! It was the last time I talked to him. Twenty years later, after he retired, a member of our medical staff asked if I could hire him as a part-time surgical professor. I was then the president of the research and education arm of Park Nicollet Health Services, the merged successor to the multispecialty group I joined in 1971, and I said I thought we could get him credentials in our hospital. But he wanted to be paid for his services, and I was never able to find the funds.

My initial experience with medicine and the law was an emotional trial. The years of uncertainty, the repeated reviews of the case, the interaction with lawyers, and the experience in the courtroom was a life-changing experience.

I grew as a physician. My confidence in making decisions became stronger. I gained a better understanding of the role that honest, complex information could play in disputes. My respect for the law and its professionals grew each time I had legal encounters. I had two more summons in the next 10 years. Neither progressed to court or led to settlements; during the fact-finding processes, both cases were dropped. These and other cases that were honestly and vigorously defended led to a reduction in frivolous medical liability suits in Minnesota. From my experiences, I developed confidence that, as slow as the legal process might be, the courts usually get it right.

As the years passed, I was asked to review other legal cases, and I testified as an expert witness. I tried to do my best. I insisted on having all the medical data, doctors' notes, nurses' notes, imaging files and pathological specimens, along with any other data about the case. I was an expert witness for plaintiffs, defendants and

We moved our chairs up to the rail, as close to the witness stand as we could get. From there, we fixed our gazes on the speaker. In a sense, we were challenging him ...

corporations. I always gave my best opinion. I told some lawyers they were unlikely to defend their case and should settle. But I also was willing to go to court when their case represented bad practice, or if I felt compelled to defend practice that was appropriate. It was hard work, and I did not seek it. But when it came, I could not refuse. The judicial system treated me well, and I still have faith that the rule of law and the courts will be fair and just as they sort through evidence and make their judgements. MM



Physician, Honorable Mention

Pulmonologist A. Stuart Hanson practiced at Park Nicollet for 41 years. Now retired, he's working on several writing projects, including memoirs about his medical career and his involvement in the Vietnam War.

ABOUT THIS PIECE

"I wrote about this experience because it matured me as a young physician. It made me more aware of the day-to-day responsibility a physician has and the life-and-death decisions some of us regularly make. The experience taught me to respect the legal process, to respect other physicians' decisions, and to hold both the legal and medical professions accountable."

NEGOTIATE CONTRACTS WITH care

When entering into employment agreements,
anticipate potential legal ramifications—
and consult with specialists, when necessary.

BY GORDON J. APPLE, JD

You wouldn't want your patients to undergo a complex surgery without being informed of the associated risks and potential complications. So it shouldn't be a stretch to apply the same logic when you approach an employment agreement. The reality is, such agreements have numerous financial and legal implications that you should fully understand before signing one, so if things go wrong, adverse outcomes are minimized.

For residents and fellows looking at the possibility of their first big paycheck, dollar signs shouldn't distract from contract provisions that have long-term career implications. For senior physicians, exit considerations are important. And for the lucky few at the height of their career, perhaps recruited to run a major medical center department, it's important to ask: "What are dreams made of?" They'll likely never have greater negotiating leverage.

Regardless of where you are on your career path, it's crucial that you scrutinize

your employment contract and strive to fully understand the following legal aspects of employment.

Compensation agreements

Although a guaranteed salary may be offered to new physicians for a period of one or two years, many physician agreements transition to compensation for production, the amount of which is based on achieving goals related to work relative value units and other factors such as quality and patient satisfaction guidelines. At that point, compensation may include a mix of salary, incentive payments, and bonuses or gain sharing. Knowing what to ask for (within reason) during the initial stages of an agreement period is important; but it's equally important to know what your compensation will look like in the future.

In physician-owned practices, compensation formulas often change once you progress from employee to shareholder,

and issues such as allocation of practice overhead come into play. In many cases, there may be ancillary businesses, formed by the group, which own medical buildings or imaging centers. That may present the opportunity at some point to buy into the investment and share in associated revenues. (For more information on this topic, see the section on shareholder agreements, below.)

Noncompetes

Many employment agreements include noncompete language that, for a period of time after termination, prevents you from practicing without adhering to certain restrictions. Some noncompete clauses don't go into effect until after you've been employed for a certain period of time, whereas others are effective the first day on the job. A typical noncompete clause might state, for example, that for two years following termination, you are prohibited from practicing within "X" miles of any

site at which you were regularly assigned while working under the employment contract.

Some noncompete restrictions can be especially problematic. A geographic restriction, for example, prohibits you from going to another employer located within a certain defined area. In the Twin Cities, that area can sometimes be as broad as

the seven-county metro region. For many specialty physicians, such a restriction could force them to leave town (or go to law school). Another concerning type of noncompete clause prohibits you from practicing within a certain radius of the employer's entire area of operation—not just the sites at which you worked.

Before entering into a contract containing particularly harsh noncompete language, think about whether you'll want to leave the region after termination. The issue is real. A number of my former Minnesota clients now live in other states as a result of their noncompetes and their inability (or unwillingness) to spend the

(continued on next page)



financial resources necessary to challenge their employment agreements in court.

Professional liability tail insurance

Tail insurance covers you after you leave a position, for professional liability exposures that occurred during your employment. Such policies can be relatively expensive, depending on your practice area and the potential for liability claims. Doctors leave employers for many reasons: a new job; being fired; retirement; and, in some cases, death or disability. When entering into an employment agreement, you need to know who'll be responsible for tail coverage in each of those circumstances—or, if the insurance is not offered, whether there is room for negotiation on the matter.

Loans and/or bonuses

With education debt being an increasingly common and large burden, some organizations offer to pay off student loans over a time frame, generally your first three to four years of employment. Other organizations offer signing bonuses with similar structures. In each case, one of the employer's goals is to ensure you stay with the practice for a certain, minimum amount of time.

Knowing what forms of financial compensation you can reasonably expect in any given circumstance is difficult if you're a new doctor fresh out of residency or a fellowship. Generally, the more difficult it is for the employer to recruit a physician to the practice area, the higher the likelihood that loans or bonuses will be part of the recruitment package. Clearly, negotiating favorable terms for loans or bonuses can have a substantial positive financial impact for you.

Severance agreements

When doctors are sought for senior positions—such as medical department chairs—severance agreements often come into play, with various types of possible triggers and payout provisions. For example, given the current environment of consolidation in health care, you might seek

a change-in-control provision that allows you to trigger the severance agreement for a period of time after a merger or buyout.

Other possible severance triggers include those that come into play if promises of support for program development are not kept or if you are terminated without cause during a defined period of time.

What you receive under a severance agreement can also vary, ranging from cash to health/life/disability insurance to compensation covering the costs of a job search firm.

Miscellaneous

Priorities are different for every physician, but additional clauses that may warrant a closer look include those related to intellectual property ownership, expense reimbursement for board certification and CMEs, call scheduling, disability leave, and benefits such as health and retirement plans.

Missing clauses

What's missing from an employment contract can be as important as what's present. Some potential employers take the position of “don't

ask, don't offer.” In other words, if you don't ask to have a bonus, loan or severance package included in your contract, such components won't ever be on the table.

Due diligence

Although it's not part of an employment agreement, conducting due diligence is important when considering a new position. Due diligence includes talking with

colleagues and mentors to get a feel for how your potential employer is viewed in the wider medical community. You shouldn't consider any one piece of information a reliable indicator in and of itself, but over time, as multiple sources weigh in and a picture of the organization emerges, you may have questions as to whether this new job will be a good fit.

When conducting due diligence, look at doctors who are current employees and think about their backgrounds. Some physicians want a career focused on treating patients. Others have an academic bent and seek to contribute to professional jour-

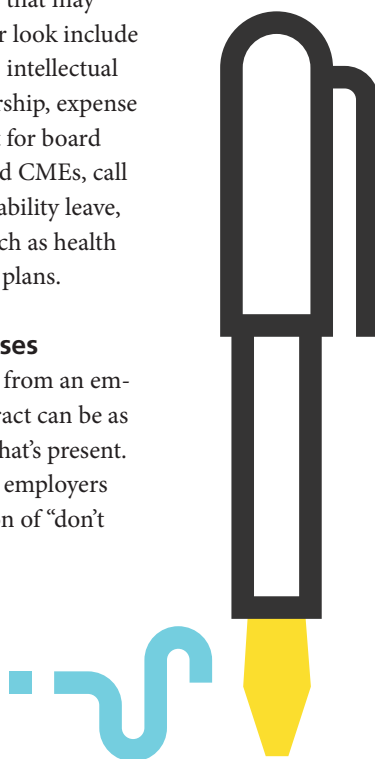
nals and/or serve in a teaching role. Others seek to influence public policy by becoming vocal health care advocates for certain constituencies. Examining what your potential colleagues do or have done in their careers can serve as a good indicator of whether the work environment will be suited to the career you want to pursue.

Shareholder agreements

Becoming a shareholder in a physician-owned practice is something doctors have strived for. Experienced physicians who bring a lot to the table might become shareholders as soon as they join a group, while new doctors generally have to wait one to four years before being offered such ownership opportunities. (Physician-owned organizations have a variety of

structures: They can be corporations with shareholders, partnerships with partners, or limited liability corporations with members. In this article, the term “shareholder” refers to all these types of ownership.)

Physicians may be shareholders in medical practices, ancillary service corporations (such as imaging centers), ambulatory surgery centers and physician-owned hospitals. It's critical that shareholder physicians have a good understanding of the



legal documents that govern such relationships. Aspects that need to be understood include the economics of the transaction as well as the risks—both financial and legal—that may be associated with it. If potential liabilities are significant, becoming a shareholder may be more of a curse than a blessing.

Termination and separation and release agreements

If you're terminated from employment for cause—aka fired, it's important to proceed with care and caution as you likely enter

into a separation and release agreement outlining obligations of both parties, post-termination. Such an agreement can also be part of the equation if you and your employer negotiate a departure with terms outside the norm.

No doctor should sign a separation and release agreement without consulting an attorney who can negotiate the terms on the physician's behalf. Often, one of the most critical aspects of such an agreement is not the money involved—i.e., continued salaries or payouts—but rather, the manner in which the former employer will respond to requests for employment references, credentialing and related issues. It can be bad enough to lose a job; but it can be even worse to be rendered unemployable because a former employer misstates what occurred or because someone providing a reference has a grudge. It's far better to reach an agreement about who will respond to requests for references, whether facts related to the termination will be in the credentialing file, and whether a report must be filed with the National Practitioner Data Bank or the Minnesota Board of Medical Practice. Although such reports are guided by state and federal statutes and regulations, I've encountered a number of instances where an employer mistakenly concluded that a

report was necessary when, in fact, the appropriate threshold had not been crossed.

For shareholders, termination also triggers buy/sell agreements. You may want to negotiate the timing of a shareholder payout, as it can have significant tax implications. Other important issues to address include continuation of insurance plans and cashing out or transferring of pension plans.

The bottom line is this: Upon termination, don't panic and sign whatever documents are placed in front of you. A lawyer, while not likely to

get you your job back, can help ease your transition to your next position.

Medical staff privileges

There is little that's more important to doctors who practice in a hospital setting than having the ability to practice medicine with "clean" medical staff privileges. Privileges are just that—privileges—and lapses in professional or personal judgment can have profound consequences if they lead to complaints, investigations, hearings and/or discipline. Potential negative impacts can range from minor inconveniences to the losses of your privileges, your job and—in extreme cases—your license to practice medicine.

If you ever have even a vague feeling that that a medical peer review investigation or similar proceeding is forthcoming—either a collegial one, which seeks to address minor shortcomings through a performance-improvement plan, or a more adversarial encounter that could, in the worst case, result in revocation of staff privileges—a consult with an attorney is appropriate. The point is to begin the process of (a) determining what the ramifications may be and (b) assuring that your procedural due-process rights are protected. When engaging in the peer-review process, your professional and personal peers will adopt a different demeanor,

and rightly so. It's vitally important to get ahead of this process as much as possible and, if it can't be avoided, to go through it with eyes wide open.

What can go wrong as a result of an adverse peer-review proceeding? Consider the following:

- Most physician employment agreements allow the employer to terminate the agreement if your medical staff privileges are limited or revoked.
- Restrictions will be reported to the state Board of Medical Practice and, if they're severe enough, to the National Practitioner Data Bank. The Minnesota Board, in a worst-case scenario, can revoke your license to practice.
- If your privileges are restricted or removed, every time you apply for privileges at a new institution, you'll have to answer "yes" to the query about whether you have been disciplined in the past.
- After restriction or revocation of privileges with one organization, it will be difficult, at best, to find a new employer who will risk hiring you—and a medical staff that will grant you privileges.

Simply put: If you're facing peer review, the stakes are too high to go it alone.

Seeking a specialist

Appearances can deceive when it comes to legal issues related to your employment—like when a new patient shows up at your practice. What seems a simple matter may actually be fraught with legal implications, requiring various consults. Meanwhile, issues that appear daunting might, in fact, be easily resolved. Patients seek physicians they can trust with their health. Physicians need lawyers they can trust with their careers. Your life may not depend on it; but your legal and financial well-being just might. **MM**

Gordon Apple has represented physicians for more than 30 years. He has been a member of the Minnesota State Bar since 1985 and is also admitted in New Mexico, Washington and Wisconsin. He wishes to thank Paul Gleich, MD, David Swanson, MD, and David Thorson, MD, for their reviews and comments.





Physicians and physicians-in-training enjoy “Great Minnesota Medical Get-Together” in Rochester

ALL PHOTOGRAPHY BY KATHRYN FORSS

More than 180 physicians, residents, medical students and guests gathered for policy discussions, CME and networking at the 2017 MMA Annual Conference, held September 23 at the Mayo Civic Center in Rochester.

Five awards presented

Three physicians and two students were honored with MMA awards during the event.

Distinguished Service Award

Benjamin Whitten, MD, received the Distinguished Service Award, which is given to a physician who has made outstanding contributions to medicine, the MMA and the physicians of Minnesota during his or her career.

Whitten served as MMA president in 2009. Currently, he is an internist at Abbott Northwestern General Medicine Associates in Edina. During his 31 years as an MMA member, he has served on several committees and task forces, and he’s

been part of the MMA’s delegation to the American Medical Association.

President’s Awards

Dionne Hart, MD, a Rochester-based psychiatrist, and Christopher Reif, MD, a Minneapolis family physician, received the MMA President’s Award, which recognizes physicians who have given much of their free time to help improve the association.

Hart is co-president of the Zumbro Valley Medical Society, a member of the MMA Board of Trustees, a member of the MMA Policy Council, and co-chair of the MMA Health Equity Advisory Group. In addition, she has served as a member of the MMA Health Disparities Work Group.



ABOVE: Benjamin Whitten, MD, accepts the MMA Distinguished Service Award from Board Chair Douglas Wood, MD, (left) and President David Agerter, MD. **RIGHT:** Whitten's family gathered in Rochester to show their support.



Reif is an assistant professor with the University of Minnesota's Department of Family Medicine and Community Health, and he is director of clinical services at the Community-University Health Care Center.

He currently serves as a member of the MMA Health Equity Advisory Group and the MMA Policy Council. Reif was also part of the MMA Health Disparities Work Group and the MMA Public Health Committee—where he served as a champion for the underserved.



Alexander Feng accepts the Medical Student Leadership Award



Nathan Rätner accepts the Medical Student Leadership Award



Dionne Hart, MD accepts the President's Award



Christopher Reif, MD accepts the President's Award

Hart is also a delegate for the American Medical Association (AMA)'s Minority Affairs Section, a representative to the American Psychiatric Association Assembly, and program manager of the Lesbian, Gay, Bisexual and Transgender Affirmative Action Committee at the Federal

Medical Center. In 2014, she was named Psychiatrist of the Year by the Minnesota Psychiatric Society. She has also been awarded an Exemplary Psychiatric Award by the National Alliance for Mental Illness.

Medical Student Leadership Award
Alexander Feng and Nathan Ratner received the MMA Student Leadership Award, which recognizes medical students who demonstrate exemplary leadership in service to fellow medical students, the profession of medicine and the broader community.

Feng is interim chair of MEDPAC (the MMA's political action committee), a member of the MMA Policy Council and an active volunteer with the AMA. He's

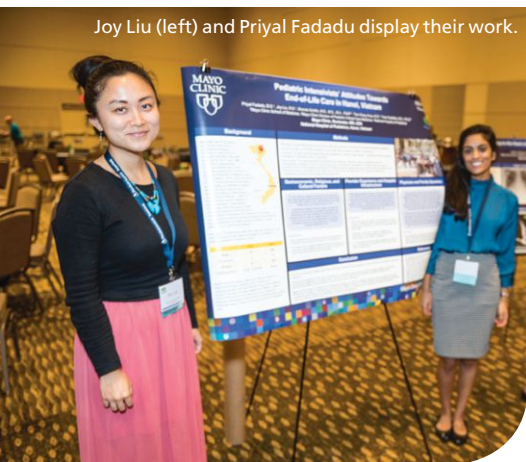
working on his medical degree as well as an MBA. Feng is a fourth-year medical student at the University of Minnesota Medical School.

Ratner currently serves as secretary of the MMA Medical Student Section Executive Committee. He received the Rural Emerging Leader Award, the Medical School Duluth Student Service Award, the Fisch Arts in Medicine Award and the Roy Wilkins Community Fellowship Award. He is a third-year medical student at the University of Minnesota Medical School.

Poster symposium

In addition, two medical students won \$250 each in the MMA's poster symposium.

Joy Liu (left) and Priyal Fadadu display their work.



Nathan Ratner won for his poster titled *The Effect of Patient-Centered Care and Diabetes Empowerment on Type 2 Diabetes Medication Adherence Among American Indian Patients*. Priyal Fadadu won for her poster titled *Pediatric Intensivists' Attitudes Towards End-of-Life Care in Hanoi, Vietnam*.

Next year's Annual Conference is scheduled for September 21 and 22, 2018, in St. Paul.



LEFT: Sen. Carla Nelson and Rep. Rod Hamilton discuss health care and politics at a pre-conference reception.

BELOW: Incoming President George Schoephoerster, MD, (left) sings the "Sounds of Silence" with his brother, Ken.



The Theater of Public Policy performs its improv comedy with MMA member Paul Matson, MD (wearing tie).



Outgoing AMA delegate Sally Trippel, MD, shares a laugh with Board Chair Douglas Wood, MD.

News Briefs

Senate Select Committee examines health care costs in Minnesota

The Senate Select Committee on Health Care Access and Affordability, chaired by Sen. Scott Jensen (R-Chaska), a family physician, has been meeting regularly to discuss issues related to health care access and cost in Minnesota. Jensen is joined on the select committee by Sen. Matt Klein (DFL-Mendota Heights), a hospitalist at Hennepin County Medical Center.

The committee's mid-September meeting, which focused on efforts to change payment systems from a "fee-for-service" to a "total cost of care" approach, included presentations by Julie Sonier, president of Minnesota Community Measurement, and Tim Rice and Teresa Fisher from Lakewood Health System in Staples, Minn.

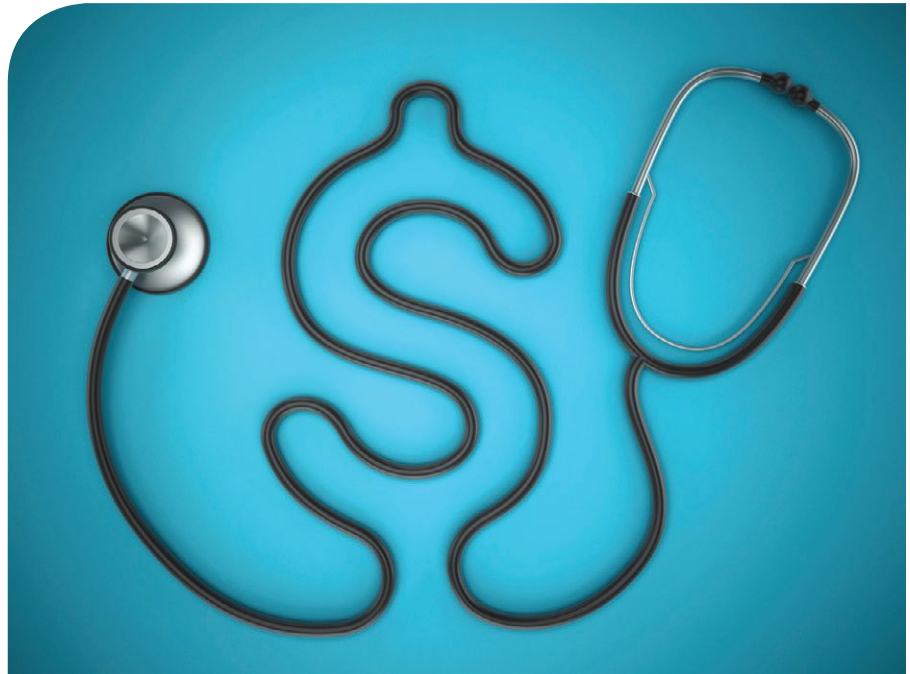
In addition, the committee heard presentations about rising prescription costs, given by Rick Smith, representing the Pharmaceutical Research and Manufacturers of America, and Stephen Schondelmeyer, PharmD, PhD, a professor of pharmaceutical economics in the College of Pharmacy at the University of Minnesota.

The committee also heard a presentation on end-of-life issues by Ken Kephart, MD, Sue Schettle from Honoring Choices Minnesota, and Bill Hanley, co-founder of The Convenings, an organization that is collaborating with Honoring Choices to facilitate community discussions around the state on the issue of advance planning.

At its meeting in early September, the Senate Select committee focused on "low-value medical services" and featured a presentation by Stefan Gildemeister, the Minnesota Department of Health's state health economist, about the volume and impact of low-value health care in Minnesota. For the purposes of his presentation and research, low-value health care is defined as health care services or procedures shown to "provide little benefit and, in some cases, have the potential to cause harm."

The low-value services studied included 10 diagnostic imaging tests, five screening tests and three preoperative tests. In 2014, use of these low-value services was estimated to have cost approximately \$54.9 million. The analysis was based on information in the state's All Payers Claim Database (APCD), which contains de-identified health care claim and administrative data.

Gildemeister reported that waste, fraud and abuse account for



30 percent of national health care spending. Legislators were particularly interested in his statement that more than 27 percent of that total is related to administrative complexity, directed toward managing electronic health records, addressing prior authorization hurdles, and conducting other work not directly related to patient care.

Deb Krause, vice president of the Minnesota Health Action Group—a coalition of health care purchasers including small and large businesses, nonprofits and public employers—provided committee members with a review of the Choosing Wisely campaign. Choosing Wisely is a national effort led by the American Board of Internal Medicine Foundation to spark conversations between patients and physicians about medical tests, treatments and procedures that may provide little benefit. The MMA has long been a Choosing Wisely partner and a champion of this effort.

In mid-August, the committee focused on the rising costs of pharmaceuticals. Many legislators expressed frustration and anger about the skyrocketing costs of drugs, and several lawmakers seemed to signal a willingness to consider legislative or regulatory action to counter the price increases.

On the calendar

Event	Date	Location
2018 Day at the Capitol	March 14	St. Paul
2018 Annual Conference	September 21-22	St. Paul

Schondelmeyer provided the committee with an overview of drug costs in Minnesota and nationwide. The pharmaceutical marketplace, he noted, is a unique one, evidenced by the monopoly manufacturers have while a drug remains on patent.

In all settings (including retail, clinic and hospital), prescription drug spending accounts for 17.5 to 20 percent of the nation's total health care spending. While drug costs overall are rising quickly, prices of specialty drugs (those administered in a hospital or clinic), in particular, are spiking.

Schondelmeyer also explored the role of pharmacy benefit managers (PBMs). Formed in recent decades with the goal of finding savings via negotiation with drug companies, PBMs, complicate the task of understanding the market, he noted. PBMs often have perverse incentives to steer consumers toward higher-priced brand name drugs over generics, as doing so will maximize profit for the PBM, Schondelmeyer said.

Charles C. Muscoplat, PhD, a University of Minnesota researcher involved in bringing several drugs to market, led legislators through the rigorous process of seeking FDA approval for new drugs, noting that the vast majority never come to market, despite significant financial investment from the manufacturer.

The committee will continue meeting through the start of the 2018 session.



PHOTO BY KATHRYN FORSS

Save the date: MMA's 2018 Day at the Capitol is March 14

The MMA's annual Day at the Capitol is a fantastic opportunity to get directly involved in the advocacy process at the Capitol and to meet with state legislators. The 2018 session starts Feb. 20, so our Day at the Capitol is the opportune time to start influencing pro-medicine legislation. Get it on your calendar today!

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PS Form 3526, July 2014 (Page 1 of 2) See instructions on page 47. PSN 753022-00-0001 PERMIT NOTICE: See rate schedule on www.usps.com



MMA, AMA continue support for DACA

Before President Trump's decision in early September to end the Deferred Action for Childhood Arrivals (DACA) program (for "dreamers"), the MMA and the American Medical Association (AMA) had raised concerns.

In February 2017, the MMA Policy Council considered an urgent request from the Zumbro Valley Medical Society to consider the impacts of potential changes to DACA and other visa programs on physicians and physicians-in-training. People with DACA status who are interested in medical careers offer potential to diversify Minnesota's physician population and to combat health care disparities. People with DACA status come from all over the world, are commonly bilingual and bicultural, and could improve access to care for minority and non-English speaking patient populations.

The MMA Board of Trustees supported the Policy Council's proposal and adopted policy opposing deportation of undocumented medical students, residents, fellows and practicing physicians who came to the United States as children due to the actions of their parents, and who have, or are eligible for, DACA status.

Furthermore, the MMA supports the J-1 and H-1B visa programs, which support graduate medical education training for international medical graduates and increase access to physician care for thousands of people in rural and underserved communities.

Based on these policies, the MMA delegation to the AMA submitted a resolution to the AMA urging the Trump administration to immediately reinstate premium processing of H-1B visas for physicians to prevent any negative impact on patient care in underserved communities. During the AMA's annual meeting in June, this language was adopted as AMA policy, which, along with other directives, addressed the impact of immigration barriers on the nation's health.

The AMA sent a letter to congressional leaders on September 5 opposing the Trump administration's action against DACA.

Petitioners seek to add new conditions for medical cannabis eligibility

Advocates for a number of medical conditions have officially begun lobbying the Minnesota Department of Health (MDH) to expand

the number and variety of conditions that would make an individual eligible to participate in the state's medical cannabis program.

In early September, the Office of Medical Cannabis announced 10 conditions for which petitions have been submitted. They include anxiety, autism spectrum disorder, corticobasal degeneration, dementia, endogenous cannabinoid deficiency syndrome, liver disease, nausea, obstructive sleep apnea, Parkinson's disease and peripheral neuropathy.

Under the legislation that authorized the medical cannabis program, citizens are given the opportunity to petition the MDH to add qualifying conditions. The petitions are reviewed by the Review Panel on Adding New Conditions, a group that includes physicians, other providers and patient advocates. The group makes recommendations to the health commissioner, who has authority to either adopt or reject them.



Dave Renner



Eric Dick



Janet Silversmith

MMA in Action

In mid-September, **Dave Renner**, CAE, director of federal and state legislation, presented to the Minnesota Society of Plastic Surgeons on "Advocacy 101." In October, he attended the Leadership Conference for Associations North in Duluth. Also in October, Renner and **Eric Dick**, manager of state legislative affairs, presented the MMA's key legislative issues to Minnesota House Republicans staff.

Janet Silversmith, director of health policy, presented on implementation of Medicare's Quality Payment Program—part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)—during the Minnesota Association of Community Mental Health Programs Annual Conference, held in September at Saint Paul RiverCentre. In October, Silversmith met with the Mankato Clinic's leadership team about MACRA implementation and expected legislative issues in 2018.

In late September, Silversmith (at the invitation of MN Community Measurement) attended the Network for Regional Health Improvement's National Health Care Affordability Summit in Washington, DC.

VIEWPOINT

Big shoes to fill

I'm not sure what's more intimidating: the challenges of modern-day medicine, which complicate the relationship between physicians and their patients, or the fact that I now walk in the shoes of the 150 physician leaders who came before me as president of the Minnesota Medical Association.

I will try to do my best. Physicians, in general, rarely lack for opinions. And though I may not agree with all of those opinions (or even many of them), over the 31 years that I've been engaged in the MMA, I've been continually impressed by the drive and determination that physicians have when it comes to advocating for their profession and their patients. With that history, I'm confident we will succeed.

As the MMA's 151st president, I suggest you measure our organization's success by my ability to champion three goals:

- Make Minnesota the healthiest state in the nation, by promoting structures in our health care system that Minnesota physicians say will best support that effort.
- Ensure that Minnesota is the best place in the nation to practice, by supporting and promoting only those laws and regulations that enhance our work.
- Continue making the MMA a great resource to help advance our profession.

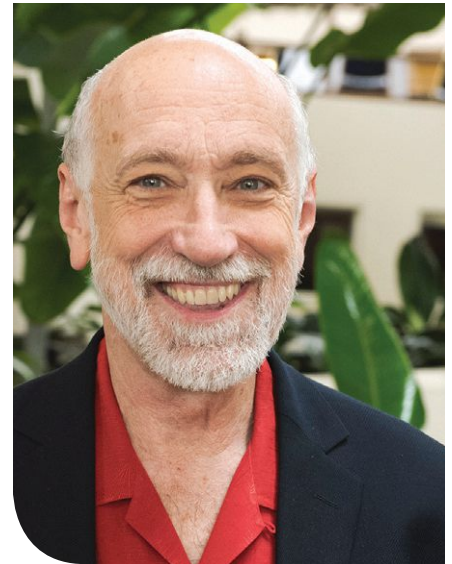
My topmost goal will be to represent the MMA in giving a voice to all the physicians and physicians-in-training of Minnesota—be they rural or urban; primary care or subspecialty; American-taught or foreign-trained; big-system or small-practice; male or female; just beginning training or about to retire. I plan to use my listening skills to help find common ground among our disparate physician communities to

help all Minnesota physicians benefit from achieving the MMA's goals and carrying out its vision.

The MMA is in a time of transition. Our CEO of nearly 15 years, Robert Meiches, MD, is leaving. Our CFO, George Lohmer, after almost 40 years of working for the MMA, is retiring. We have a new board chair, Randy Rice, MD. And as I reminded everyone at my inauguration, the role of the president is fleeting because it changes every year.

One way that I will assist during these transitions is as part of the CEO Search Committee. We are well underway in the process of filling that position, and we expect to have a person in place by early 2018. Transitions always afford an opportunity for change, which has potential to bring new energy, enthusiasm and wisdom to the organization.

After all our new leadership is on board, I plan to name four or five areas I would like to focus on in 2018. Please let me know how I'm doing. Send me a note at mma@mnmed.org at any time with your feedback. This is your organization. All physicians and physicians-in-training who are members should have the opportunity to weigh in on how we can accomplish our goals. And those of you who are not members, please consider joining. The more members we have, the more influential we will be when it comes to fighting for medicine in Minnesota.



George Schoephoerster, MD
MMA President

Transitions always afford
an opportunity for change,
which has potential
to bring new energy,
enthusiasm and wisdom to
the organization.



The Voice *OF MEDICINE*



MINNESOTA
MEDICAL
ASSOCIATION

2017 ANNUAL REPORT

Overcoming Challenges **Reaching for New Opportunities**

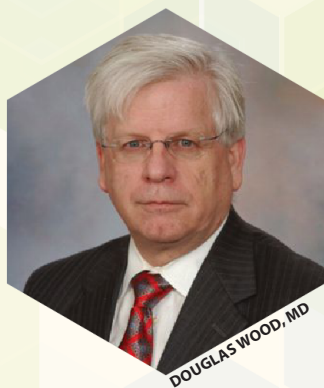


Every year provides its own set of challenges. Often times, the challenges come in the form of laws that affect how we practice medicine. This past year, though, the challenges lay before the MMA like a hurdles race – one after the other with no time to rest. The challenges took many forms – legal, legislative (both locally and nationally) and leadership.

A lawsuit with MMIC, which began in early 2016, continued through early 2017 when we reached an amicable settlement. The lawsuit diverted significant resources and impacted staffing levels. But, we are now well-positioned for long-term fiscal health.

For the first half of the year, our legislative team worked the halls of the Capitol on several key priorities. Some succeeded, others stalled. We continue to be frustrated by the inability for our sensible medication prior authorization reform legislation to move forward in the House.

In late April, CEO Robert Meiches, MD, MBA, who has led the MMA for nearly 15 years, announced that he was moving on to other pursuits. He has agreed to see us through the transition to a new CEO. A search firm has been retained and we expect that the new leader will come on board in the first quarter of 2018.



In the pages of this Annual Report, you'll learn how the MMA continues to remain Focused on Success and its three strategic priorities: Making Minnesotans the healthiest in the nation; Making Minnesota the best place to practice; and Advancing professionalism. You'll also see a number of our members, both practicing physicians and physicians-in-training, who are truly making a difference for medicine.

We will continue to persevere. But we could use your help. We are stronger when we are many. If you are already a member, thank you. If you are not, please join us. With more members, we can get past any challenge before us, and continue to serve as the voice of medicine.

A handwritten signature in black ink, appearing to read "David Agarter, MD".

DAVID AGERTER, MD
MMA PRESIDENT

A handwritten signature in black ink, appearing to read "Douglas Wood".

DOUGLAS WOOD, MD
CHAIR, BOARD OF DIRECTORS

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MMA PRESIDENT-ELECT

George Schoephoerster, MD

Healthiest in the

*Improving quality, ensuring
access, reducing disparities*



Health Care Reform

When Republicans assumed control in both bodies of Congress as well as the presidency, it seemed likely there would be significant changes in health care, given the GOP has been calling for the repeal of the Affordable Care Act for seven years.

The MMA did not weigh in loudly when the ACA was first proposed and passed, instead deferring to AMA for national advocacy and support. But, the MMA has resisted past and current efforts to repeal the ACA, while acknowledging that improvements are needed. The MMA has long supported insurance coverage for all and, as such, spoke out against the House's American Health Care Act and the Senate's Better Care Reconciliation Act, both of which would have resulted in 15 or more million Americans losing coverage.

We sent letters to the Minnesota Congressional delegation asking them to keep in mind the health care reform principles endorsed by the MMA:

- *Preserve patient-physician relationship*
- *Insurance coverage for all Minnesotans*
- *Ensure access to appropriate care for all Minnesotans*
- *Improve affordability of care*
- *Invest in public health and prevention*
- *Promote health equity*
- *Support innovation in care delivery and payment*
- *Advocate for broad-based, stable and adequate financing*

In late April, we convened a forum at the University of Minnesota and online that covered the following topics: health care priorities for Congress and the Centers for Medicare and Medicaid Services (CMS); challenges and opportunities for Minnesota; the future of the individual market, Medicaid and MinnesotaCare; and the politics of reform. Featured speakers included: Jean M. Abraham, Wegmiller professor and master of healthcare administration, program director at the University of Minnesota; Emily Johnson Piper, the commissioner of the Minnesota Department of Human Services; and Richard Deem, the senior vice president of advocacy for the AMA.

Nation

The Opioid Epidemic

As the opioid epidemic continued to grow, take lives and frustrate the health care field, the MMA increased its work to educate physicians and develop strategic partnerships.

The MMA continues to be a strong supporter of the Minnesota Prescription Monitoring Program (PMP), but we recognize that mandatory use of the PMP would be a cumbersome administrative requirement, given the PMP's current limitations, most notably its lack of interoperability with most electronic health record systems (EHRs). In 2016, the MMA's Prescription Opioid Management Advisory Task Force reconvened, and provided guidance to the MMA in its efforts to address the opioid epidemic. In order to provide physicians with access to patient data within their clinical workflow, one of the task force's recommendations highlighted the need to embed the PMP into EHRs.

In 2017, the MMA continued to add content to its online *Pain, Opioids and Addiction Lecture Series*, a partnership with the Steve Rummel Hope Network and the University of Minnesota Medical School. By mid-2017, 21 lectures were available for viewing online. Since its launch in 2014, it's been viewed by approximately 1,000 health care professionals around the world including 43 states, Europe, Asia, Australia and New Zealand.

This year's Annual Conference dedicated much of its content to the opioid epidemic. The keynote session featured experts Charles Reznikoff, MD, FACP, and Erin Krebs, MD, MPH, who addressed the epidemic, focusing on treatment guidelines, the regulatory landscape, and referral and treatment options for substance use disorders. In separate breakout sessions, Reznikoff and Krebs dove deeper into the topics addressed in their keynote.



Best Place to

*Reducing administrative burdens and
championing system improvements*



Medication Prior Authorization

At nearly \$83,000 per physician per year, the administrative costs associated with medication prior authorization and other interactions with health plans demand relief. Hoping that the third time would be the charm, the MMA's medication prior authorization legislation, authored by Sen. Carla Nelson (R-Rochester), once again progressed swiftly and in a bipartisan fashion through the Senate. But, progress was denied for a third session in a row by the House. This, despite a pared-down version of the bill that was first introduced in 2015. In an effort to get it through the Republican-controlled Legislature, the MMA focused the bill on:

- *Prohibiting plans from withdrawing coverage for a drug a patient is on during the patient's enrollment year*
- *Improving communication during the enrollment process so that enrollees know exactly what medications are covered and what their cost-sharing obligations will be*
- *Requiring any formulary change to be communicated to prescribers and enrollees at least 60 days prior to the change.*

At the request of House author Rep. Rod Hamilton (R-Mountain Lake), HHS Finance Committee Chair Rep. Matt Dean (R-Dellwood) gave the bill an informational hearing near the end of the 2017 session. Much of the discussion among legislators from both parties was supportive of the proposal, with pointed questions directed at the bill's opponents, particularly pharmacy benefit managers.

Practice

Provider Tax

Early in the session, Gov. Mark Dayton proposed reinstating the 2 percent provider tax. He said it would be “a serious mistake to eliminate such an essential source of state funding for health care.” While the MMA agrees that the public programs funded by the provider tax are essential, the state should find other revenue sources.

The 2 percent tax, often called “the sick tax,” is scheduled for repeal at the end of 2019, to which the MMA remains committed.

After Dayton revealed his plan, the MMA sent out an Action Alert to physicians encouraging them to contact their state representative and senator to oppose Dayton’s provider tax recommendation. The governor’s push for the provider tax never gained momentum.

Aligning Quality Measures

The MMA supported efforts at the Capitol to better align state and federal quality measures and reduce reporting burdens for clinics. The MMA remains supportive of efforts to measure the quality of health care provided to patients, but those efforts must be focused on improving care and be as efficient as possible.

As a result of passed legislation, the Minnesota Department of Health is now required to cap the number of state-mandated statewide quality measures (SQRMS) to six for a single-specialty clinic and 10 for a multi-specialty clinic. These measures must also align with the measures defined by the new Medicare physician payment system (MACRA). The measures shall be selected in consultation with a stakeholder group for implementation no later than Dec. 15, 2018.



Advancing

Protecting the core values of the medical



Biggest Day at the Capitol Yet

More than 150 physicians and physicians-in-training descended on the newly refurbished Capitol in mid-February to meet with their legislators as part of the MMA's annual Day at the Capitol.

Along with health care reform, attendees discussed reforming medication prior authorization, ensuring the sunset of the provider tax, aligning quality measures and fighting the opioid epidemic in Minnesota.

"Now more than ever, physicians, medical students and residents need to band together and speak out on behalf of their patients and their profession," said MMA President David Agerter, MD. "All signs point to a lot of uncertainty ahead in St. Paul and Washington, DC, regarding health care reform. When decisions affecting physicians are made, we need to be at the table."

Guest speakers included: Sen. Michelle Benson (R-Ham Lake); and Sen. Matt Klein, MD (DFL-Mendota Heights), who is one of two physicians in the Senate.



A New Kind of Doctor's Lounge

Dozens of physicians, residents and medical students gathered at socials in the Twin Cities, Rochester, the St. Cloud area and Duluth this past spring. The socials - which include free food, wine, beer and other beverages - are now in their third year. They are designed to be a celebration of medicine, a thank you to members, and a welcome to new and prospective members. It's a perfect, relaxed setting for physicians and physicians-in-training to connect and discuss the issues of the day.

Profession **ionalism**

Stronger Together

When we combine forces, we are much stronger and our voices are much louder. In 2017, the MMA continued to collaborate with the state's specialty societies in a number of ways. This past May, MMA leadership and representatives from specialty societies gathered in St. Paul to discuss top strategic priorities. We also continue to provide lobbying services for four specialty groups: Minnesota Academy of Family Physicians, the Minnesota Chapter of the American Academy of Pediatrics, the Minnesota Orthopaedic Society and the Minnesota Academy of Otolaryngology. In addition, we partnered with several specialty societies to host our annual Day at the Capitol and a special forum on health care reform in late April.



Members Making a

Shining stars, each and every one of the following physicians and physicians-in-training. Being a physician is a full-time job, but some are called to serve in additional ways — be it in their community, their state or their country. This year, the MMA recognizes six physicians and two medical students who have gone beyond their day-to-day duties to help improve health care in Minnesota (and the world).



The Do-er Lynn Hassan Jones, MD

Jones certainly keeps busy outside of her Mankato radiology practice. She recently became a board member for MN Community Measurement. This is in addition to her volunteer work at the MMA, having served on the MMA Health Disparities Work Group, and currently serving on the MMA Health Equity Advisory Group.



The Veteran Paul Huddleston, MD

Huddleston believes in service to his patients as well as his country. The Mayo Clinic orthopedic surgeon is also a lieutenant colonel in the U.S. Army Reserves. As such, he has made a number of trips to war-torn parts of the globe to help perform surgery in less than ideal conditions. Huddleston has completed tours in Afghanistan in 2008 and in Iraq in 2003, 2006 and 2011. He also spent three weeks in Haiti after that country's devastating 2010 earthquake.



The Vaccinators Erica Sanders and Elizabeth Fairbairn

As if medical school isn't challenging enough, Sanders and Fairbairn, both medical students at the University of Minnesota Medical School, are spending much of their free time trying to increase vaccination rates in Minnesota. Sanders and Fairbairn are spearheading a student-led effort called Hands on Advocacy. The group's current campaign is to work on materials to prepare medical students and physicians to have influential, effective conversations with parents who have concerns about vaccines.



Difference

The Convener Benjamin Whitten, MD

It is one of the most controversial topics the MMA has handled over the past few years – physician aid-in-dying. It's an issue that splits our membership and also split a task force convened specifically to delve into the topic. It takes quite a bit of diplomacy to navigate the issue and to come out with a result that is supported by two-thirds of MMA members polled. Whitten, MMA president in 2009, deftly chaired the group. It was another feather in the cap for a long-time MMA volunteer.



The Testifier Caleb Schultz, MD, MPH

In early May, Edina became Minnesota's first city to raise the minimum legal sale age for tobacco products from 18 to 21 thanks to the tireless efforts of people like Schultz. Schultz, a member of the MMA's Policy Council, the Twin Cities Medical Society board and the Physician Advocacy Network, presented the issue of raising the tobacco purchasing age to 21 to the Edina City Council and testified in support of the ordinance. Edina's success served as an impetus for various other cities now considering T21 (Bloomington, Mankato, Robbinsdale, Frazee and Detroit Lakes) and the introduction of state legislation.



The Advocate Ken Kephart, MD

Honoring Choices Minnesota (HCM), a public health initiative of the Twin Cities Medical Society (TCMS), continues to gain momentum under Kephart's able leadership. This year, it has partnered with MPR's Cathy Wurzer and KARE-TV to take its message of advance care planning across the state as part of The Convenings series. In his role as HCM's medical director, Kephart testifies before the Legislature, meets with regulators and interacts with the media. Kephart has been active in organized medicine his entire career. He has chaired the MMA's governance task force, serves on the MMA's Policy Council, and is a member of MMA's POLST Minnesota Steering Committee. He has also served on the TCMS's board and served as TCMS president in 2015. Earlier this year, he received the *First a Physician Award* for 2016.

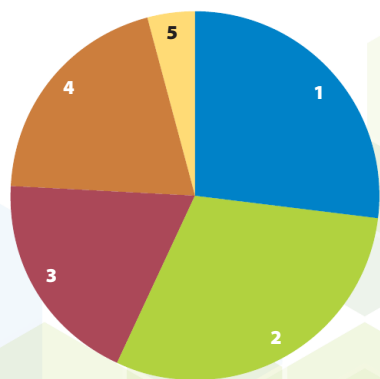


The Activist Renee Crichlow, MD

Crichlow is a multi-dimensional activist -- In person. On social media. On the radio. Wherever she can make an impact. In her role as the associate program director of the University of Minnesota North Memorial Family Medicine Residency Program, advocacy and serving the underserved is just part of the job. Her main focus this year has been generating support for the University of Minnesota Medical School's budget increase request with the Legislature by organizing students and working with the Minnesota Academy of Family Physicians. In June, she was featured on an MPR program in which she advocated for better communication between physicians and their patients.

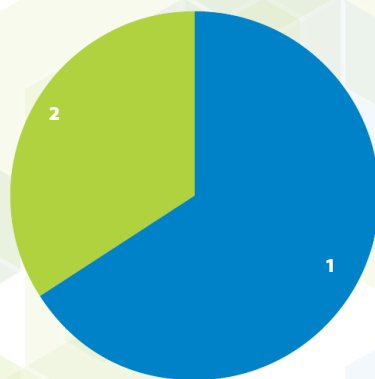


2017 FINANCIAL HIGHLIGHTS



How your dues are used

- GOVERNANCE 27%**
MMA Board, AMA delegation
- ADVOCACY 30%**
Legislative and regulatory lobbying, payer relations, quality, public health
- COMMUNICATIONS 19%**
Minnesota Medicine, *MMA News Now*, website, special reports
- MEMBERSHIP 20%**
Member relations, Annual Conference, outreach, education, events
- OTHER 4%**
Accreditation, co-sponsorships, credentialing, component society staffing



Total MMA Revenue: \$2,610,508

- DUES 66%**
Dues payments from members
- NON-DUES REVENUE 34%**
Includes:
 - revenue earned from advertising sold in *Minnesota Medicine*, *MMA News Now* and on the MMA website
 - revenue earned by the MMA for accreditation, sponsorships and lobbying support for medical specialties
 - income from investments, grants and events.

MEMBERSHIP OVERVIEW

Year	Total Members	Year	Total Members
2000	9,089	2009	11,330
2001	9,162	2010	11,250
2002	9,109	2011	10,106
2003	9,116	2012	10,347
2004	9,297	2013	9,998
2005	10,858	2014	10,309
2006	10,835	2015	10,257
2007	10,909	2016	10,171
2008	10,969	2017	10,260*

*Numbers as of Aug. 2, 2017 for the membership year ending 12/31/17

MEMBERSHIP TYPES

Member Type	2017 Count
Regular	4,559
Resident/Fellow	2,511
Retired	1,712
Student	1,478

MEMBERSHIP

NORTH CENTRAL TRUSTEE DISTRICT 392
 South Park Region 58
 Stearns-Benton 229
 Upper Mississippi 76
 West Central 17
 Wright 12

NORTHEAST TRUSTEE DISTRICT 65
 Range 65

NORTHWEST TRUSTEE DISTRICT 242
 Headwaters 123
 Heart of the Lakes Region 57
 Red River Valley 62

SOUTHEAST TRUSTEE DISTRICT 3,626
 Freeborn 52
 Goodhue 71
 Rice 37
 Steele 62
 Wabasha 9
 Winona 15
 Zumbro Valley 3,380

SOUTHWEST TRUSTEE DISTRICT 598
 McLeod-Sibley 20
 Nicollet-Le Sueur 25
 Prairie 545
 Waseca 8

TWIN CITIES TRUSTEE DISTRICT 4,605

AT LARGE 732

TOTAL: 10,260

Includes: regular/active, retired, students, residents/fellows

Note: Resident and Student numbers can fluctuate significantly throughout the year due to large additions or subtractions.



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2017 American Academy of Pediatrics Minnesota Poster Competition Winners

Each year, the American Academy of Pediatrics encourages its state chapters to invite medical students and residents to take part in a scientific poster competition. At the Minnesota chapter's annual meeting in Minneapolis this year, residents and medical students submitted posters for consideration.

The pediatric training programs at the University of Minnesota and Mayo Clinic were each represented with submissions in clinical vignette and research and quality improvement categories. A post-resident category was also offered this year.

Posters were judged by practicing pediatricians, pediatricians from the state's academic medical centers, and peers. Judges' criteria included clinical relevance, originality, and written and visual presentation. Special thanks to Andrew Olson, MD, Dana Irrer, MD, and Michael Pitt, MD, for coordinating the competition.

Minnesota chapter winners presented their posters September 15-19 at the 2017 American Academy of Pediatrics annual meeting in Chicago. We present abstracts from those winners below. Congratulations to all of the contest participants for their excellent work.

The next American Academy of Pediatrics Minnesota poster competition will be held in May 2018. For information, contact cairns@mnaap.org.

MEDICAL STUDENT CLINICAL VIGNETTE WINNER

DANIELLE FRANZEN AND TORI BAHR, UNIVERSITY OF MINNESOTA

Severe pediatric thrombocytosis and its use in diagnosis of hepatoblastoma

An 18-month-old boy with a history of chronic constipation presented with 5 weeks of fatigue, irritability, and pale appearance. Mother was concerned by his lack of interest in toys and social interaction and by his decreased talking. Progressive abdominal distension, thought by his mother to be due to constipation, was also reported despite no change in the patient's gluten- and lactose-free diet.

Initial evaluation found the patient nontoxic but pale and fatigued, with normal vital signs. A physical exam was significant for cervical lymphadenopathy and hepatomegaly. Initial laboratory work-up was significant for microcytic anemia with hemoglobin 10.2 g/dl and MCV 72 fl, severe thrombocytosis with platelet 960 k/

ul, and isolated AST elevation to 333 U/L. Abdominal X-ray showed hepatomegaly. Abdominal ultrasound findings were significant for an 11-cm vascular-appearing hepatic mass. Subsequent work-up ultimately led to a liver biopsy, which revealed an epithelial-type hepatoblastoma. Further testing revealed alpha fetoprotein (AFP) 546,230 ng/ml, and a chest CT showed metastases to bilateral lungs.

Hepatoblastoma is the third most common intra-abdominal tumor and most common liver tumor of childhood. The age of onset is variable, but most cases present before 3 years of age. Hepatoblastoma is generally associated with nonspecific signs and symptoms and is most often diagnosed after incidental imaging. Elevated AFP is a common indicator of hepatoblastoma. However, when severe thrombocytosis is present, this should also

raise suspicion for hepatic malignancy. In the setting of hepatoblastoma, thrombocytosis develops as a result of abnormally produced thrombopoietin by malignant liver cells. Normally, thrombopoietin is a hormone produced in the liver and kidneys that regulates the production of platelets.

This case demonstrates a rare but clinically significant addition to the differential diagnosis for thrombocytosis. We review the nonspecific presenting symptoms of hepatoblastoma and the association of thrombocytosis to the pathogenesis of this tumor, with the goals of increasing awareness and potentially expediting diagnosis in future cases.

MEDICAL STUDENT RESEARCH AND QUALITY IMPROVEMENT WINNER

LEAH KRAUSE, WENLIANG GENG, MATTHEW THOMPSON, SHANE MCWHIRTER, ERIN BALAY, PATRICIA HOBDA, SHANNON WAGNER, THERESA CAHILL, LUCIE TURCOTTE, DAN NERHEIM, AND JEFF LOUIE, UNIVERSITY OF MINNESOTA

Febrile neutropenia in the emergency department: barriers to timely antibiotic administration

Background

A central line (CL) is a catheter surgically inserted into a central vein, which is commonly placed in children with blood or solid tumors who are undergoing chemotherapy. These children often present to the emergency department (ED) with fevers and neutropenia. Giving timely antibiotics, within an hour, is an oncology and ED benchmark and has proven to reduce mortality in children who are in septic shock. In our ED, we initiated a quality improvement (QI) project to determine barriers to timely administration of antibiotics.

Methods

To identify barriers, we first distributed an electronic survey (using Survey Monkey) to all ED and float pool nurses to determine current perspectives on common barriers to accessing a patient's CL and ad-

ministering antibiotics. Specifically, nurses were asked to estimate the percentage of children who receive antibiotics within an hour, the percentage of parents who can recall port type and needle length, and the percentage of children who arrive with EMLA cream in place. Responses from the nurses were averaged to identify potential barriers. We then developed a key driver diagram to outline our approach.

Results

A total of 17 of 22 (77%) nurses responded to the survey. Respondents felt a majority of children (74%) do receive antibiotics within an hour. Common barriers to administering antibiotics included: Only 31% of parents can recall the child's port type; only 25% of parents can recall the needle length; and less than half (45%) of children presenting to the ED have topical anesthetic covering their port site. The

respondents felt that the port information can be found in the electronic medical record (EMR) within 10 to 30 minutes.

Conclusion

Our results found 4 potential barriers to timely administration of antibiotics: 1) lack of parental knowledge of port type; 2) lack of parental knowledge of needle length; 3) absence of topical anesthetic covering the port; and 4) delays finding port information in the EMR. We worked with the oncology team, and now port information is readily available in the EMR. We have also developed an infographic brochure and a wallet card to remind parents about their child's port information, explain what will happen in the ED, and remind them to place topical anesthetic prior to leaving home.

PEDIATRIC RESIDENT CLINICAL VIGNETTE WINNER

ARIEL STEIN, MD, HELENA MOLERO, MD, DONAVON HESS, MD, MARK LUQUETTE, MD, AND MICHAEL PITT, MD, UNIVERSITY OF MINNESOTA

Under pressure: tension pneumothorax with evolving cysts in an infant with RSV

The inpatient management of infants with bronchiolitis secondary to respiratory syncytial virus (RSV) tends to be uneventful. Atypical presentations of infants with RSV can present diagnostic and therapeutic challenges.

Case

A 1-month-old term male infant was transferred from an outside hospital for further management of a persistent air leak after chest tube placement. He was admitted 12 days prior to transfer for mild respiratory distress. Chest X-ray (CXR) on admission revealed patchy infiltrates consistent with viral pneumonitis. Over the

following days, he remained well-appearing, afebrile, without respiratory distress.

On hospital day 3 he became tachypneic with desaturations not relieved with supplemental oxygen. On further evaluation, he was found to have elevated RSV titers. CXR showed a large pneumothorax with mediastinal shift. A chest tube was placed, leading to resolution of the pneumothorax. However, persistent air leak led to reaccumulation of the pneumothorax. At this point, the infant was referred to our institution for evaluation for surgical intervention.

Evaluation after transfer revealed a well-appearing infant, not requiring

supplemental oxygen, with a persistent air leak. CXR revealed a small pneumothorax and a moderate cystic lucency in the right upper lobe, not seen on prior images. A chest CT showed a moderate right-sided pneumothorax and two large cystic lesions in the right upper lobe. The acute appearance of new cystic lesions was difficult to explain given the clinical course. We considered a congenital pulmonary airway malformation exacerbated by illness leading to air leak, though we thought this unlikely, given the absence of lesions on prenatal ultrasound. Lack of evidence for bacterial pneumonia and the short temporal course of the illness argued against a

post-infectious pneumatocele. Barotrauma leading to the expansion of previously undetected cystic lesions was considered, but altitude of helicopter transport and walled features argued against this.

On day 17 of his hospitalization, the infant underwent segmental resection of his right upper lobe. Pathologic examination showed air-filled cystic areas lined by chronic inflammatory tissue with foamy

giant cells, suggesting a post-obstructive expansion of a mucous plug, which re-sorbed, leaving cystic lesions that ruptured into the pleural space, leading to a pneumothorax with tension physiology.

Discussion

Secondary air leaks and cyst evolution as sequelae of RSV are exceedingly rare. This case highlights the potential for cystic

changes in the lung secondary to accumulation of an intrapulmonary mucocele. RSV is a frequent cause of pneumonitis in infants, rarely resulting in complications, but it is important to recognize the possibility of such complications, which may occur even as the primary infection is resolving.

PEDIATRIC RESIDENT RESEARCH AND QUALITY IMPROVEMENT WINNER

IFELAYO P. OJO, MBBS, MPH,¹ ETA Q. OBEYA, MD,¹ DANIEL A. GABDERO, MBBS,² AND TINA M. SLUSHER, MD^{1,3}

¹UNIVERSITY OF MINNESOTA; ²BOWEN UNIVERSITY TEACHING HOSPITAL, OGBOMOSO, OYO STATE, NIGERIA;

³HENNEPIN COUNTY MEDICAL CENTER

Evaluation of ThermoSpot for measurement of body temperatures in Nigerian infants receiving phototherapy and validation of caregiver ThermoSpot temperature reading

Severe neonatal jaundice is a major cause of death and/or disability among newborns in resource-limited settings. Conventional phototherapy (PT) is often unavailable. Filtered sunlight phototherapy (FSPT) is efficacious in jaundice treatment, but neonates under FSPT are prone to both hypothermia and hyperthermia. ThermoSpot, a liquid crystal display thermometer designed as a noninvasive hypothermia indicator, changes color when the neonate's core body temperature changes. It has been proven to accurately detect hypothermia. However, no studies have been performed on neonates outdoors. We designed a cross-sectional study to determine whether ThermoSpot accurately displays temperature range in Nigerian neonates receiving either PT or FSPT.

Methods

Baby-caregiver dyads receiving phototherapy at Bowen University Teaching Hospital in Ogbomoso, Nigeria, were recruited after informed consent was obtained. A brief education was provided to caregivers about ThermoSpot color markers, which were applied to two predetermined spots—skin over the liver, in the armpit, on the temple, or on the neck. Data was recorded hourly indicating disc position and color, axillary temperature, and caregiver and health care worker action. Data analysis was performed using Microsoft Excel.

Findings

Thirty-two neonates (40 patient days) had ~5 valid temperatures/day for each patient. In the majority (95%) of the 216 observations, the neonates were normothermic (36.0-37.9°C), and the ThermoSpot was green. Six infants had temperature >38°C recorded for 9 observations and at least 1 ThermoSpot was blue. However, 3 of the hyperthermia observations were discordant between either caregiver and health care worker observation, or the 2 discs placed on the same infant. One infant was hypothermic at 35.7°C and ThermoSpot was red. Caregivers and health care work-

ers treated temperature deviations appropriately. No neonate had hyperthermia or hypothermia without appropriate changes in the ThermoSpot noted.

Conclusion

ThermoSpot accurately displayed temperatures for neonates receiving PT or FSPT. Caregivers identified appropriate action(s). Challenges included insufficient variability in temperatures, too high of a high temperature cut point, and decreased stickiness of ThermoSpot discs after 2 or 3 uses. Future research will include development of a new disc with improved hyperthermia cutoffs. These revisions could dramatically improve the ThermoSpot's usefulness in neonates under FSPT and those in nurseries in low-resource settings.

POST-RESIDENT WINNER

LESLIE KUMMER, MD, LAUREL DAVIS, PHD, NAOMI DUKE, MD, MPH, AND IRIS BOROWSKY, MD, PHD, UNIVERSITY OF MINNESOTA

Context matters: interpersonal and community influences on U.S. breastfeeding outcomes

Background

Human breast milk is the optimal form of nutrition for most infants and provides numerous health benefits to the mother-baby dyad. Yet U.S. breastfeeding initiation and 6-month exclusivity rates remain below the Healthy People 2020 goals of 81.9% and 25.5%, respectively. Breastfeeding is a health behavior that is influenced by a complex web of individual, interpersonal, community and policy factors. The social ecological model (SEM) of health promotion provides a framework for conceptualizing these factors. The objective of this study was to determine whether the interpersonal and community contexts within which mother-infant dyads live are associated with breastfeeding behavior, independent of previously established individual-level predictive factors.

Methods

We analyzed data from the 2011/2012 National Survey of Children's Health (NSCH), a cross-sectional, nationally representative survey. Analyses were limited to mothers of children aged 6 months to 5 years for whom breastfeeding data were available (N = 27,511). Logistic regression models were estimated for associations between independent variables representing the interpersonal and community levels of the SEM and the dependent variables of breastfeeding initiation and exclusive breastfeeding for 6 months. All models were adjusted for individual-level socioeconomic status (SES) factors including maternal age, maternal education level, child's race/ethnicity, generational (U.S. or foreign-born) status of the parent, and poverty level.

Results

Overall, 78% of children in the sample had ever been breastfed and 21% were breastfed exclusively for 6 months. After controlling for individual-level SES factors, several statistically significant associations were found at the $P < 0.05$ level. Children of single mothers had 46% lower odds of ever being breastfed and 30% lower odds of being breastfed exclusively for 6 months, compared to children living in 2-parent households. Parental perception of increased neighborhood amenities (e.g., parks, playgrounds and libraries) was associated with increased odds of breastfeeding initiation. Perceptions of increased neighborhood social support and safety were associated with increased odds of exclusive breastfeeding to 6 months. Children with a primary care provider

(PCP) had 14% higher odds of having any breastfeeding, but 19% lower odds of being exclusively breastfed to 6 months, compared to those without an identified PCP.

Conclusions

Addressing the barriers to successful breastfeeding requires a holistic understanding of the relationship between individual mother-baby dyads and the environments in which they live. Our results suggest that neighborhood context, family structure, social support, and use of a primary care provider have varying effects on the odds of breastfeeding initiation and 6-month exclusivity, and that these effects are independent of individual-level SES factors. Our findings highlight potential opportunities to promote and protect breastfeeding through interventions targeting the social and built environments in which mothers live.

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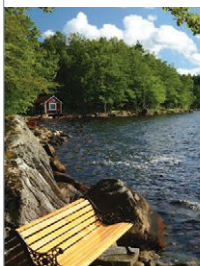


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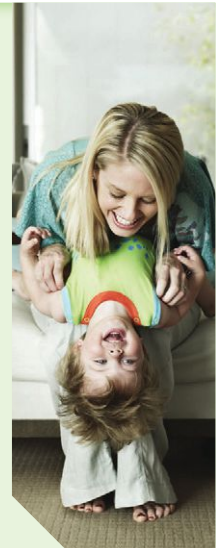
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Publish or Perish

BY E. KENNETH WEIR, MD

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less thoughtful
than the thinker
thought.

Published thought
does not make
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2017
WRITING
CONTEST

Physician, Honorable Mention

E. Kenneth Weir is a professor of medicine at the University of Minnesota. Now retired from clinical work, the former Minneapolis VA chief of cardiology has published more than 180 articles and edited 11 books.

ABOUT THIS PIECE

"In academic medicine, one gets no credit for any original thought or research unless it is published. On the other hand, just because an article (or poem) is published, it does not necessarily follow that the concept is valid. This poem arises from observations made during 50 years of publishing in the medical literature."



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From the MMA



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DAVID AGARTER, MD PRESIDENT

RPAP Student, 2016

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