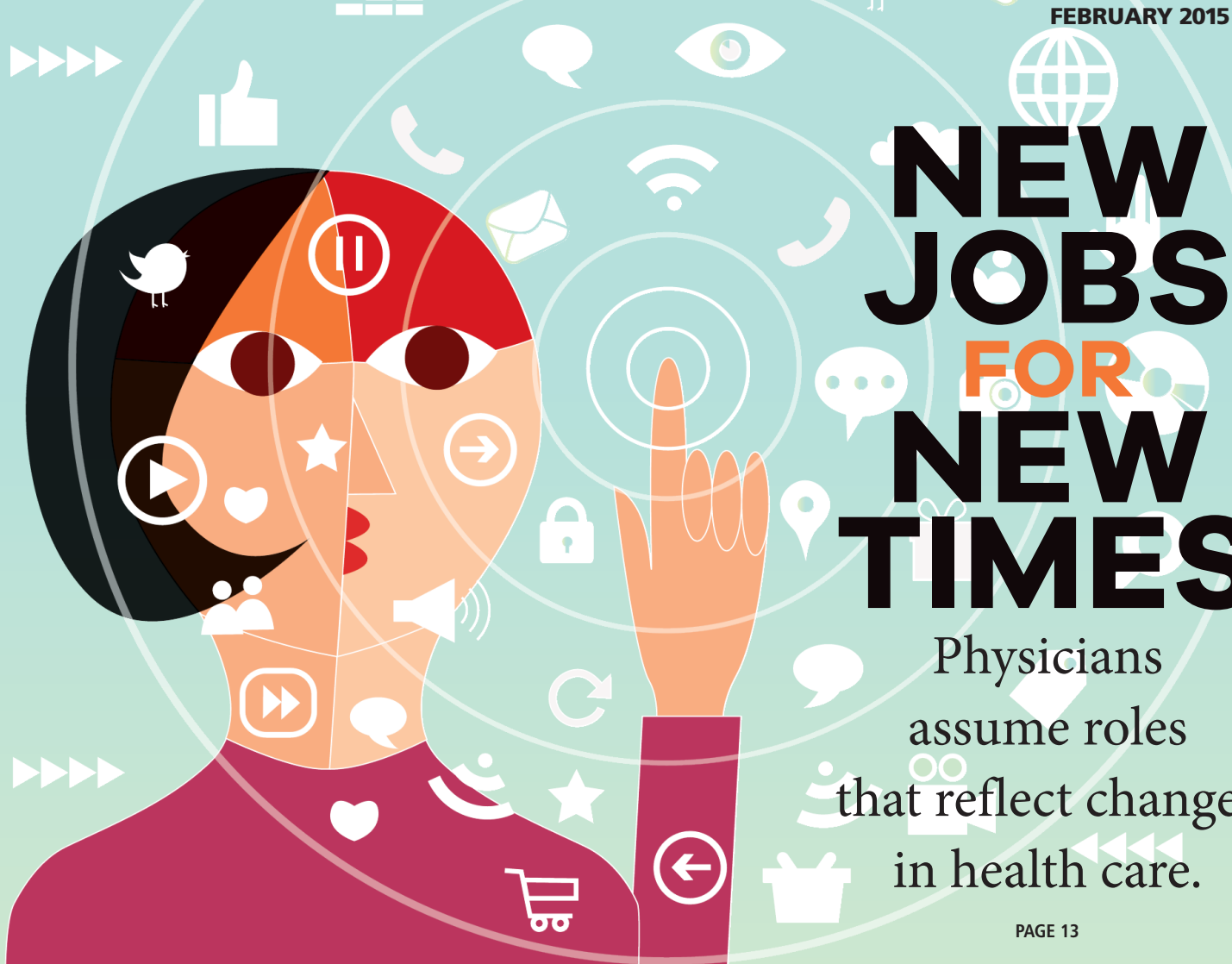


MINNESOTA MEDICINE

FEBRUARY 2015



NEW JOBS FOR NEW TIMES

Physicians assume roles that reflect changes in health care.

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Talking to patients about **HOSPICE** PAGE 29

First-line treatment for **ADOLESCENTS WITH ANOREXIA** PAGE 37



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PHOTO BY SCOTT WALKER

Charles R. Meyer, MD, Editor in Chief

There is no question that new roles for physicians demand new skills and altered attitudes.

Playing the part

My acting career started in second grade. Clad in a comically adult fedora, I played a man on a bus commenting on his fellow travelers. I delivered two timeless, memorable sentences with all the feigned emotion I could muster. Hollywood did not call, and that was my last foray into the thespian world—until I became a doctor. It's not that I think of my encounters in the exam room as stage performances; but actors' tools such as facial expression and vocal tone and volume do play a role in the explaining and cajoling that are part of doctoring. Indeed, physicians play a number of roles during their day.

Physicians are interpreters, translating for patients the foreign argot in which we conduct our business. Physicians are ministers, counseling and guiding patients through the perils of illness. As implied in the derivation of the word "doctor," physicians are teachers, instructing patients in the disciplines of wellness, therapeutics and rehabilitation. Some would say physicians are clerks, processing an ever-expanding morass of paperwork. And physicians are bosses, handing out orders to patients, pharmacists, nurses and laboratories. Most of these roles traditionally have placed doctors atop the control hierarchy, issuing commands to the crew like Charles Lawton in *Mutiny on the Bounty*. But the casting is changing.

New models of care have physicians sharing the lead with a host of other professionals. Nurse practitioners and physician assistants have long supplemented the work of doctors, but recently their duties have proliferated in creative ways, for example, doing preoperative exams for local ophthalmologists. Exam rooms are getting

crowded as nursing assistants and RNs perform a larger part of patient assessments and as scribes take over the documentation duties many physicians have found onerous. Increasingly, the practice of medicine involves a cast of cooperating colleagues with multiple co-stars sharing the limelight with physicians.

Most of these changes are intended to lighten a physician's load, leaving them free to do what they are trained to do. However, some physicians view the moves as incursions into a their space, undermining their authority and infringing on the doctor-patient relationship.

There is no question that new roles for physicians demand new skills and altered attitudes, both of which challenge doctors to be flexible. But over the years, physicians have proved to be adaptable. Most Minnesota physicians moved smoothly from the era of the solo practitioner to group practice. Over the past 40 years, they have, grudgingly, adapted to managed care in all its many guises. They even have taken on roles with titles like director of population health or director of integrative health.

The main threat of these recent changes is not that physicians will be dethroned as star of the show but rather that the breach between patient and physician will widen. If the changes in health care delivery insert more people, procedures or forms between a patient describing their problems and the physician trying to fix them, doctors will no longer be able to play their most important role.

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



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9 SIGNS *of a* SATISFIED PHYSICIAN

Physicians appear to be a pretty contented lot. A survey of 1,527 from around the country found 72 percent of them reported being satisfied with their career in 2014. That's up from 58 percent who said they were satisfied or somewhat satisfied in 2013. The survey, which was conducted by staffing firm Jackson Healthcare and took place between April 18 and June 25, 2014, also found only 9 percent were very dissatisfied with their work.

Physicians who were satisfied were likely to:

- 1 → Encourage a young person to pursue medicine as a career
- 2 → See the same number of patients in a day as they did last year
- 3 → Say patients are more knowledgeable about their health than a year ago
- 4 → Be between 25 and 45 years of age or older than 65
- 5 ← Have their income increase or remain the same as last year
- 6 ← See nurse practitioners and physician assistants taking on more duties as a positive trend
- 7 ← Be employed and have never worked in private practice
- 8 ← Say their practice is more focused on preventive care and population health than a year ago
- 9 ← Work eight hours a day

Beyond *THE* clinic

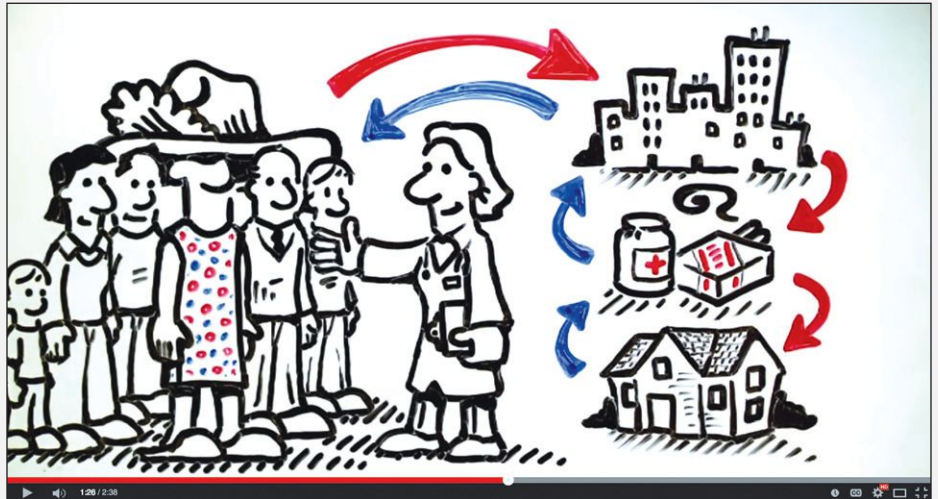
Leaders at the Bloomington-based Institute for Clinical Systems Improvement (ICSI) were already part of a growing chorus calling for health care to address the social determinants of health when the Robert Wood Johnson (RWJ) Foundation came calling a couple of years ago. The foundation wanted ICSI to help clinicians work with others in the community on nonmedical influences that had the biggest effect on people's health.

ICSI president and CEO Sanne Magnan, MD, had long championed the idea that health care organizations needed to do so if population health were to improve and health care costs come down. But what RWJ wanted was for ICSI to come up with practical guidance for doing that. "They said, 'Make it really simple and tell stories about how doctors, nurses and administrators can be more effective,'" Magnan says.

With \$150,000 from RWJ, ICSI launched "Going Beyond Clinical Walls" in 2014. As part of the effort, they've produced a white paper making the case for integrating health care and community resources, compiled stories about how others have done it, co-produced a video with Twin Cities Public Television to inspire conversation and created a step-by-step guide for clinics and hospitals wanting to get to work.

What might going beyond clinical walls entail? That depends on the community. One Seattle clinic partnered with a swimming pool in the neighborhood and now refers kids for lessons to ensure they develop life-saving skills and get active. In Woodbury, a health system teamed up with churches to provide diabetes education. In Minneapolis, a pediatric clinic works with a literacy organization and gives out books to kids.

Family physician Tim Hernandez, MD, who attended a session on Going Beyond Clinical Walls at last year's ICSI colloquium, says the time is right for this kind of initiative. For one thing, it has been becoming clearer to physicians that they can affect only a small portion of their patients' health. "As we've worked hard on



An image from the video "Hats Matter," which talks about the role physicians, patients and the entire community can play in improving health.

the more technical aspects of disease management with medicine and procedures, we've realized we can only get so far," he says, noting that working on smoking cessation, weight loss, and providing access to healthier food and places to exercise often have a larger impact on health than health care.

As medical director for quality for the 12 Entira Family Clinics in the Twin Cities, Hernandez also says the time is right because the payer community and government are pushing clinicians to be more accountable for the communities they serve. "The metrics are changing to population metrics," he says. "And the rewards, especially with arrangements with payers to lower total costs and improve the quality of the health for the communities that we serve, are aligning in a way to support those systems that can do this well."

Both Magnan and Hernandez say that if Going Beyond Clinical Walls is done right, clinicians as well as patients will benefit. "It's about finding ways to make connections that help clinicians be more effective, make their jobs easier, and make their patients' and families' lives better," Magnan says. "We've got to find creative ways to do that."

Going Beyond Clinical Walls appears to be attracting interest. The website has had more than 1,200 hits so far. "That's more than what we get for other initiatives," Magnan says.

— CARMEN PEOTA

Resources for clinicians

The Institute for Clinical Systems Improvement has created a series of tools to help clinicians, clinical staff and administrators connect with community partners.

They include:

- A white paper on solving complex problems
- A video, "Hats Matter"
- Real-life examples
- A guide to getting started

All can be found at www.icsi.org/beyondclinicalwalls.

The physician assistant will see you now

It can take a logistical wizard to plan the surgery schedule for a practice with multiple locations. Yet a single patient who hasn't been able to get in to see their primary care doctor for a preop physical can upend it.

It happened enough times at Minnesota Eye Consultants that the Bloomington-based practice decided it needed to do something about it. The solution: hire a physician assistant (PA) who could do preop physicals in-house. Not only would having a PA be more convenient for patients, it also would prevent scheduling hiccups for the practice. And a specially trained PA might help identify issues needing further evaluation by a physician.

Candace Simerson, president and chief operating officer, got the idea while attending a conference in 2009. It took about a year for her to develop a business plan, prepare space and acquire equipment, educate payers about the service and hire the right person.

In January 2010, the practice put its first PA to work. Having the new position helped so much that Minnesota Eye Consultants hired a second PA in 2013. Together, the two PAs rotate through the practice's five Twin Cities locations.

With PAs on staff, the scheduler can properly time physicals for patients, many of whom need two cataract surgeries about a month apart. The PAs line up the physical—which insurers require within 30 days of surgery—so that it covers both procedures. If the timing doesn't work, they might schedule a second physical when the patient is at the clinic for follow-up after the first surgery. About 40 percent of patients take advantage of the in-house physical option, Simerson says. However, some need to see their own physicians because of complicated health histories.

PHOTO: MINNESOTA EYE CONSULTANTS



Physician assistants Laura Gundale (left) and Jill Englund do preop physicals at Minnesota Eye Consultants' five locations.

Jill Melicher, MD, a partner and surgeon at Minnesota Eye Consultants, says she and her colleagues are definitely pro-PA. "The biggest benefit is that we can offer a service to our patients with noncomplicated health histories in a short period of time under our roof," she says.

In addition to making surgical scheduling easier, the PAs also assist the ophthalmologists by screening patients for allergies, Sjogren's syndrome and other conditions that can affect the eyes. And they contribute in another way: They provide urgent care for the 250 staff members at the self-

insured practice, treating such problems as strep throat and ear infections. "It helps us contain our costs, and employees like not having to leave work to go to urgent care," Simerson says. "It's a real benefit because it helps us manage our productivity and costs."

Minnesota Eye Consultants was on the cusp of a trend when it started having PAs offer preop physicals. Since then, more than a dozen ophthalmology practices in Minnesota and across the country have contacted Simerson to learn more.—SUZY FRISCH



The PAs also attend to employees' medical concerns.

Ski enthusiast

With the largest ski resort in the Pacific Northwest down the road from his boyhood home in Sandpoint, Idaho, it's not surprising that David Rust is a skier. In fact, he was on Schweitzer Mountain by age 2, and he and his siblings skied many times a week throughout their childhood. "That's just what we did growing up," he says.

Now an orthopedic surgeon at St. Luke's Orthopedics and Sports Medicine in Duluth, Rust still loves skiing, and he's found a new way to be involved in the sport. Last year, he became medical director for the Spirit Mountain ski patrol. "I don't know that it gets me on the slopes more, but it gives me a reason to be involved more in the community atmosphere of the ski area," he says of the volunteer position.

It also gives him the opportunity to help ensure that anyone injured gets the best care possible from Spirit Mountain's first responders, as he helps review their policies and advises on medical care. "We have created policies for stabilizing boot-top tibia fractures and using traction splints for hip and femur fractures," he says. They're also finishing a study to determine the safest way to transport skiers and snowboarders with suspected head and neck injuries.



David Rust with his 2-year-old daughter, Marie.

PHOTO BY JEFF FREY

To get on the slopes himself, Rust skies weekly in an adult race league. And in an effort to pass along his passion to his kids, he gets his family out two to three weekends a month. He and his wife, pediatric hospitalist Erin Rust, got their son Paul, 4, on skis when he was 2. This year 2-year-old Marie joined them. Baby Lucy will sit out the season.

Rust says having an outlet is essential for physicians. "It would be pretty easy to let work and the day-to-day things you do in life take over." And although his first

love is skiing, he enjoys almost any activity any time of year and in any weather, as long as it involves being outdoors. "My philosophy is, if you're motivated, you don't have to let the weather slow you down."

Having skied most Monday nights last winter in record cold, that philosophy was tested. "A couple of nights," he says, "it was just a victory to brave the cold weather and get through the race course."

— CARMEN PEOTA



Noteworthy addition

Some physicians find using scribes improves their interactions with patients.

BY JEANNE METTNER

Eighteen months ago, Lance Silverman, MD, was at a crossroads. An independent orthopedic surgeon with a growing private practice, he was passionate about giving each patient individualized attention. But in his personal life, he was paying a price. After a full day of seeing patients, Silverman would spend countless hours dictating notes. “I wasn’t sleeping much; I would kill the weekend finishing the days’ clinic dictation because it would take so long to record it to my expectations,” recalls the founder of Silverman Ankle and Foot in Minneapolis. “And I was missing out on precious family time.”

Silverman had watched scribes migrate from emergency rooms to clinics. He talked with some orthopedic colleagues who had successfully incorporated them

into their practices and in January 2014 decided to try using one.

Silverman says working with the scribe allows him to have the best of both worlds: extensive one-on-one time with his patients and more personal time. “Adding one person to my clinic has led to an exponential improvement in my life,” he wrote in a March 2014 blog entry on his website.

A role born of necessity

Scribes entered the health care workforce about 10 years ago and secured their place after the American Recovery and Reinvestment Act of 2009 introduced “meaningful use” incentives to ensure widespread implementation of electronic health record (EHR) systems. (According to 2013 data published in *Health Affairs*, nearly eight of 10 office-based physicians are using some

form of EHR technology.) But the move to EHRs, which require physicians to enter and access patient information using a computer rather than a paper chart, has left many feeling overburdened. A 2013 study by the Rand Corporation and the American Medical Association found that physicians are “frustrated by systems that force them to do clerical work or distract them from paying close attention to their patients.”

Scribes help remedy that, as they sit in on the patient-physician exchange and enter information into the patient’s electronic record. Except in cases where a physical examination requires confidentiality or privacy, the scribe will stay throughout the visit to document exam findings and treatment recommendations, pull up relevant medical record data and

test results, order labs, enter billing codes and write preliminary summaries of the patient visit. Although scribes free physicians from the tether of the computer, the question remains as to whether their presence has an effect on the physician-patient relationship and on the way physicians practice medicine.

Third wheel?

In emergency departments, where scribes were first used, the physician-patient relationship isn't as much of an issue, as physicians rarely see their patients more than once. But when scribes started moving into outpatient clinics, some experts became skeptical. In a March 2014 Medscape video commentary, medical ethicist Art Caplan acknowledged the potential allure of scribes in the clinic setting but ultimately denounced their use, concluding that bringing a third party into the clinic visit may introduce errors and is simply putting a Band-Aid on the problem of "not having enough time in medicine to

“
In the last three years,
I have had only three
individuals ask not to have
the scribe present.”

– Frederick Townsend, MD

pay attention and listen carefully when we are face-to-face with our patients.”

Not all would conclude that. “I have a panel of 650 patients, and in the last three years, I have had only three individuals ask not to have the scribe present,” says Frederick Townsend, MD, FACP, an internist with Sanford Health's Broadway Medical Center in Alexandria. He says on the rare occasion when a patient indicates they want to speak with him privately, he will ask the scribe to step out. Townsend, who has been in practice for 37 years,

says that although practice will never be the same as it was before EHRs, having a scribe gives him more freedom to interact with patients and focus on the exam. “By not having to organize things on the computer in the exam room, I have more freedom to think diagnostically and try to reach a conclusion without worrying I might forget to record some significant symptom or finding at the end of the visit.”

Productive and patient-friendly

Before integrating scribes into his cardiology practice, Alan Bank, MD, director of research at United Heart and Vascular Clinic of Allina Health in St. Paul, decided to investigate their effect on his practice. He led the first prospective, controlled study evaluating the effect of using scribes on a clinic's productivity, revenue and patient interactions. During the research period, four of the clinic's 24 cardiologists spent 65 clinic hours with scribes and 65 hours without them (standard care). Although patient satisfaction was high both

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with and without scribes, when the physicians used scribes, they appeared to have more high-quality interactions. Among the differences: Physicians who used scribes had, on average, more than five extra minutes of face-to-face time with the patient, and the quality of their interaction—as assessed by an independent, experienced observer—was significantly better than without the scribe present. In an article in a 2013 issue of *ClinicoEconomics and Outcomes Research*, Bank and his co-authors noted that “a number of

“

What I am hearing from patients is that I focus on them more now, rather than stare at a computer screen.”

– Alan Bank, MD

patients commented to clinic staff about the benefit of having the physician’s full attention without distraction from the computer.” In addition, when the physicians used scribes, they saw 81 more patients and generated more than \$205,000 in additional revenue for the health care system over the 60-day period following the clinic visit.

Sticking with scribes

As a result of what they learned from the study, 10 of the 24 physicians at Bank’s clinic are routinely using scribes. Bank is one of them. “What I am hearing from patients is that I focus on them more now, rather than stare at a computer screen,” he says. Of his 1,500 patients, only one has requested that he not use the scribe during the visit.

Silverman, too, thinks his patients have accepted scribes. “No patient has ever looked cross-eyed at her [the scribe] and said they didn’t want her in the room,” he says.

Both agree that using scribes can be beneficial for patients and physicians alike. “There is a lot of good care that we are giving patients because we are using scribes and no longer being inefficient,” Bank says. “We are sleeping better, for one thing, but they are also allowing us be more productive and improve patients’ access to care. The bottom line is that every hour you save of doctors’ time is huge.” MM

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

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NEW JOBS FOR NEW TIMES

A stylized illustration of a woman's face and hand. The face is divided into several colored sections (black, red, orange, and white) and contains various icons such as a play button, a star, a heart, a speech bubble, a person icon, a lock, and a shopping cart. The hand is raised, pointing upwards, and is surrounded by icons like a Wi-Fi signal, a speech bubble, a hand icon, a location pin, and a circular arrow. The background is a light teal color with faint circular patterns and arrows.

Physicians assume roles that reflect changes in health care.

As editors of this journal, we're pretty attuned to trends in medicine and health care. In recent years, we've seen the advent of health care homes and accountable care organizations, and the shift in focus from individual to population health. We've witnessed the rise of big data and measurement. We've seen the number of physicians going into primary care and rural practice dwindle. And now, we're watching as marijuana becomes a legal medicine in Minnesota.

We've also observed that these changes have created new kinds of opportunities for physicians. Here are the stories of a few who have brand new job titles that reflect a trend.



PHOTO: UNIVERSITY OF MINNESOTA

aromatherapy, acupuncture and massage, as well as Native American herbal practices, aiming to expand and formalize her holistic approach to medicine.

Now as the first medical director of pediatric integrative health and well-being at the University of Minnesota Masonic Children's Hospital, Gershan is helping bring a broad range of options to more young patients. Since she started last summer, she has been developing a formal integrative medicine program for the hospital, replicating a similar one she started at Primary Children's Medical Center in Salt Lake City. "Integrative medicine is combining all aspects of healing that are grounded in evidence-based medicine and are safe, and it may involve any and all care providers that the patient chooses," says Gershan, who also is an associate professor of pediatrics. "We're looking at mind, body, spirit, and community and how to manage pain."

Adults have been seeking out nontraditional therapies for decades; however, demand in pediatrics has lagged. Only recently have parents started requesting such care for their children, and Gershan and other physicians have worked to develop appropriate treatments.

Although the university had made some integrative therapies available to children before, they were scattered throughout the system. Gershan intends to unite them into one cohesive offering. "We want to bring these therapies under one umbrella, so that integrative care appears seamless," she says. "Families can walk in the door and have a holistic experience and not have to ask for one of these and one of those."

Gershan envisions eventually having a nationally recognized program. She plans to expand the hospital's music therapy program, as well as its offerings in yoga, massage and aromatherapy. Much of her initial work will be with hematology, oncology and bone marrow transplant patients.

In addition to her role with the hospital, Gershan sees pediatric outpatients in the Journey Clinic. She helps them with anxiety, chronic pain and overall wellness to support healing, and provides them with coping skills to help build resilience. It's important work, she says, because today's children live in a very stressful world.

"Kids have to cope with more things than we did when we were younger, from global warming to 9/11 to school safety," she says. "How do we teach kids to function and feel empowered as decision-makers? That's what guides me, and I want to help with that."—SUZY FRISCH

THE INTEGRATOR

Lynn Gershan, MD

*Medical director of pediatric integrative health and well-being,
University of Minnesota Masonic Children's Hospital*

From her earliest days as a neonatologist, Lynn Gershan wanted to use a full playbook when caring for her most fragile patients. She sought to ease their pain and improve their quality of life in any way she could, from incorporating kangaroo care and dimming bright hospital lights to encouraging parents to do massage at home.

When Gershan shifted to general pediatrics about 20 years ago, she started exploring a broader range of nontraditional treatments. Over the years, she trained in Chinese medicine, hypnosis,

THE COMMUNITY CAREGIVER

Brendon Cullinan, MD

Medical director of population health and ambulatory services, North Memorial Health Care

As a high school teacher and hospital volunteer in Tampa, Florida, in the 1990s, Brendon Cullinan witnessed how people's emotional strife and economic challenges contributed to their health problems. He wanted to do something to help them. "It was motivation for me to go to medical school," he explains.

Understanding that economic, social and emotional factors affect health has been central to Cullinan throughout his career as a family physician. And in his new role as vice president and medical director of population health and ambulatory services at North Memorial Health Care in Robbinsdale, it's even more so.

Cullinan, who assumed the job in October 2014 and held a similar position with HealthEast, is responsible for going beyond the confines of the clinic to improve the health of patients served by the North system. That may involve making sure a person's insurance is maintained, that they go to a pharmacy where their native language is spoken, that they have a place to live, that their transition from home to assisted living is managed. "It's all about holding out that patients' values are respected, that they're listened to, that they have good outcomes or are moving in the right direction," he says.

One way he plans to do that is to increase the use of home health nurses, care coordinators and community paramedics to provide patients who need it with more attention than they can get during a clinic visit. By working with patients in their homes or communities, these other professionals can help them integrate their physicians' recommendations into their daily lives.

"Often, the care coordinator, community paramedic or home health nurse can really see the struggle a patient is having because they spend more time with them," Cullinan says. That may involve helping a patient with diabetes come up with a realistic plan to cut down on fast food consumption, then regularly checking

in with them to see whether they're making progress. "Health coaching is important to our efforts," he adds.

Cullinan knows North's clinics are already doing some of these things. For example, he strongly supports their efforts to integrate mental health care and addiction treatment with primary care and their recent collaboration with Vail Place, which has a client-run drop-in center where people with mental illnesses can get meals, apply for jobs, get help securing housing and find support. "It's very much a vision of how addressing patients' illnesses can work hand in hand with addressing their mental health and behavior issues," he says. "We have a lot of opportunity in this area."

Cullinan, who also sees patients one on one at North's Camden Clinic, is trying to convince payers that such services are cost-effective in the long run. "We'd like to see the health plans partner with us more aggressively around risk-based contracting, or else there's no way for us to continue to innovate and expand such programs."—KIM KISER



PHOTO BY KATHRYN FORSS

THE DATA MAN

David Ross, MD

Medical director of patient relations and communication, Affiliated Community Medical Center

David Ross's title doesn't tell the full story of what he does.

A family physician who practices in Affiliated Community Medical Center's (ACMC's) Litchfield clinic, Ross has handled patient relations since 2004, the year he became associate medical director. But as health care began relying more on data to measure quality and determine payment, the southwestern Minnesota medical group found its needs changing. Someone had to understand all the information that was coming in from payers and how it could be used to provide more effective care at a lower cost.

As he sat in on board meetings, Ross, who was finishing his MBA at the time, noticed that there wasn't anyone from IT involved in those discussions. "I brought up to the board the idea that IT ought to be at our board meetings and that the role of IT in health care, as big data comes on line, will be critically important as we move forward and as we go from fee-for-service to capitation or total-cost-of-care contracting," he says.

In 2012, Ross, who considers himself "relatively tech-savvy," became the liaison between the board and the IT department and was given the new title of medical director of patient relations and communication. The organization has since hired a chief information officer, with whom Ross frequently meets to brainstorm ideas or discuss best practices before taking them further.

In his expanded role, Ross also leads several new committees. One is charged with bettering the patient experience; another focuses on data analytics. "It's an important committee for us," he says. "We receive mountains of data from payers regarding claims and costs." He explains that the committee is responsible for finding ways to identify complex patients and document their medical conditions so the practice won't be penalized for having high costs in pay-for-performance or shared-savings arrangements. "The documentation needs to be bulletproof," he says.



PHOTO: ACMC

In addition to involving IT in planning and decision-making, Ross also is the physician champion for ACMC's social media efforts. He says using Facebook, LinkedIn and blogs, some of which he writes, is essential for reaching a younger workforce and medical students, residents and young physicians who may be considering a career with ACMC. "When you're talking about recruiting and retention both on the physician side and with the staff, and you're dealing with a younger patient population, you need a different medium," he explains.

Ross says the fact that he still practices has helped when it comes to getting physicians to go along with some of the changes he's promoted. "If you're under the same stress as they are and you're taking call and dealing with life-and-death situations, complex patients, difficult patients, it goes a lot better," he says. "You have common ground and can empathize with the demands of the job." —KIM KISER

THE NEGOTIATOR

Michael Schmitz, DO

Total-cost-of-care medical director, CentraCare Clinics

On a Tuesday in early December, Michael Schmitz was getting ready to do something his medical training didn't prepare him for: meet with an insurer, in this case, Medica, to set CentraCare Clinics' quality goals for 2015. As total-cost-of-care medical director for the St. Cloud-based health system, a role he took on in January of 2013, Schmitz has to understand the nuances of insurance contracting and what meeting goals can mean to CentraCare's bottom line.

"If we achieve all our quality goals for 2014, it will be worth \$4.7 million. It has nothing to do with revenue or how many people we see, it's just how we do on quality measures," he says of that one contract. "That's no small potatoes."

Schmitz, who also practices family medicine at CentraCare's Northway Clinic and works in the emergency department at Sauk Centre Hospital, regularly meets with both practicing physicians and physician leaders to let them know whether the system is meeting its goals.

Before Schmitz became involved, the staff who handled the system's fee-for-service payer contracts and members of the executive committee negotiated the system's first total-cost-of-care contracts. After that first round of negotiations, CentraCare's president and CEO felt they needed someone with a medical background to serve as the liaison between the insurers and the administration and clinical staff. "They wanted to make sure what we're doing makes sense," he says.

Since Schmitz, who was in leadership at Mayo Clinic Health System before joining CentraCare in 2009, was tapped for the part-time position, he's been building the job description from the ground up. "There was no outline," he says, explaining that he spent the first few months meeting with and learning from the payer contracting staff and health plan medical directors. He says it took a good six months before he felt comfortable with the language and the concepts, but "now I can follow along meetings with insurance people and make constructive suggestions."

A big part of his job is leading a work group that monitors the total-cost-of-care contracts CentraCare has with Medica, Blue Cross and Blue Shield of Minnesota, HealthPartners and the



PHOTO: CENTRACARE HEALTH

Minnesota Department of Human Services to make sure they're hitting their targets. The group also makes recommendations that can help the organization improve care, reduce costs and redundancies, and avoid potentially preventable hospital readmissions, ER visits and complications.

Schmitz also educates his fellow physicians about payment models that reward value and quality of care, rather than volume. "Part of my job is planting that seed," he says. "I'm trying to get them thinking differently about case management and to let them know that the provider payment dynamic is changing."

Although Schmitz has not encountered other health systems that have a physician dedicated to contracting, he believes it's a matter of time before they do. "Insurers are telling us, if we don't have an interest in pursuing value contracts, then our current contracts won't be as attractive. We need to adopt processes that provide better quality at a lower cost."—KIM KISER

PHOTO: MINNESOTA DEPARTMENT OF HEALTH



cal cannabis. Arneson will be collecting data on those patients and tracking which forms of cannabis product work best for their conditions, the dosages that are most effective, medication interactions and side effects.

With a background in preventive medicine and public health and research, Arneson was already exploring ways to put his experience to use when he heard about the job opening. The idea of investigating medical cannabis and helping develop policies for its use intrigued him. “The job was a bit of an unknown, and that was part of the appeal,” he says. “I wanted to find something that was challenging and interesting intellectually, that would draw on my professional experience and background, be of some importance to the state, and promote health in communities. The research component and the registry were different than other states, and all of those reasons made the opportunity attractive.”

Arneson also liked the idea of being able to build something innovative from scratch. He started the job last fall, making it his first order of business to publish an exhaustive review of cannabis clinical trials and observational studies that are relevant to Minnesota’s program. (The report is available at www.health.state.mn.us/topics/cannabis/practitioners/dosage.pdf.) This will be especially useful to the two manufacturers and the pharmacists who will work at the eight distribution centers. Those centers will open in July of this year.

Arneson believes Minnesota’s medical cannabis program will attract interest. “The research component of this program will help patients and health care professionals build their understanding of the benefits, risks and side effects of medical cannabis extraction products,” he says. “I think there will be substantial interest in this from around the country.” —SUZY FRISCH

THE CANNABIS CZAR

Tom Arneson, MD

*Research manager,
Minnesota Office of Medical Cannabis*

As Minnesota embarks on a new course as one of 23 states that allow use of some form of medical marijuana, Tom Arneson will be providing the roadmap, at least for certain aspects of the journey.

Arneson, who is research manager for the state’s new Office of Medical Cannabis, is charged with leading an effort to answer some of the many questions about the drug’s use. Under the law, patients with certain conditions will be allowed to obtain medi-

THE RECRUITER

Richard Wehseler, MD

Medical director of recruitment and retention,
Affiliated Community Medical Center

Richard Wehseler is in the business of selling rural practice. As we wrap up our conversation, he can't help but give his pitch: "Tell everyone they should come to work for ACMC."

As medical director of recruitment and retention for Affiliated Community Medical Center (ACMC), a practice with clinics in eight southwestern Minnesota communities, he delivers that message to medical, nursing and physician assistant students, graduating residents and practicing physicians looking for a change. "I spend my days talking to people about how great it is to live and practice in a rural area," he explains.

Wehseler has served in this part-time role since it was created in 2012. At the time, ACMC leaders saw the need for a physician to focus specifically on recruiting and retaining other physicians, which can be a challenge for small communities. Since then, he has helped hire 12 new primary care physicians along with specialists in infectious disease, nephrology, psychiatry, orthopedics, hand surgery, obstetrics/gynecology and hospital medicine.

In addition to bringing physicians into the practice and keeping them there, Wehseler practices family medicine at ACMC's New London Clinic—a job he discovered he wanted during medical school. As a student in the University of Minnesota's Rural Physician Associate Program in the early 1990s, he worked alongside two physicians at that clinic. "I decided when I finished training that I wanted to join their practice," he recalls. "I think the time spent there really helped give me a very solid idea of what that practice could look like, so when I made the decision to move there, there weren't any surprises."

Wehseler now arranges for preceptors and oversees rotations for medical, nursing and physician assistant students. "To develop a healthy medical staff, we need to take one step backward and look at student development," he says. "We want to make sure they have a meaningful experience." In fact, one of the medical students he mentored will join the New London practice next summer.

When hiring new physicians, Wehseler emphasizes the importance of matching the right person to the right position. To

PHOTO: ACMC



gauge whether someone is a fit, he often asks potential recruits to describe their ideal practice. If it's similar to the reality that is ACMC, he has the person come in for a formal interview.

Once a physician is hired, Wehseler pairs that person with a mentor—"an established physician with a healthy practice." The mentor helps the new doc settle into the practice and the community and offers guidance and a listening ear when needed.

The commitment to the new recruit's success doesn't end once the physician is established. Wehseler, whose area of interest outside clinical practice is professional development, says all physicians are offered the opportunity to take a sabbatical after seven years to help prevent burnout. "They go off for a minimum of a month to learn a new skill or to practice in a different country," he says. Recently, one physician went to Central America to practice and brush up on his Spanish.

Wehseler says the chance to work with students and new physicians invigorates him. "It's so much fun to interact with them, to really get to know some of the talent that's coming up through the system," he says. "It certainly makes the future look bright."

—KIM KISER

Common bond

On the limitations of a shared faith

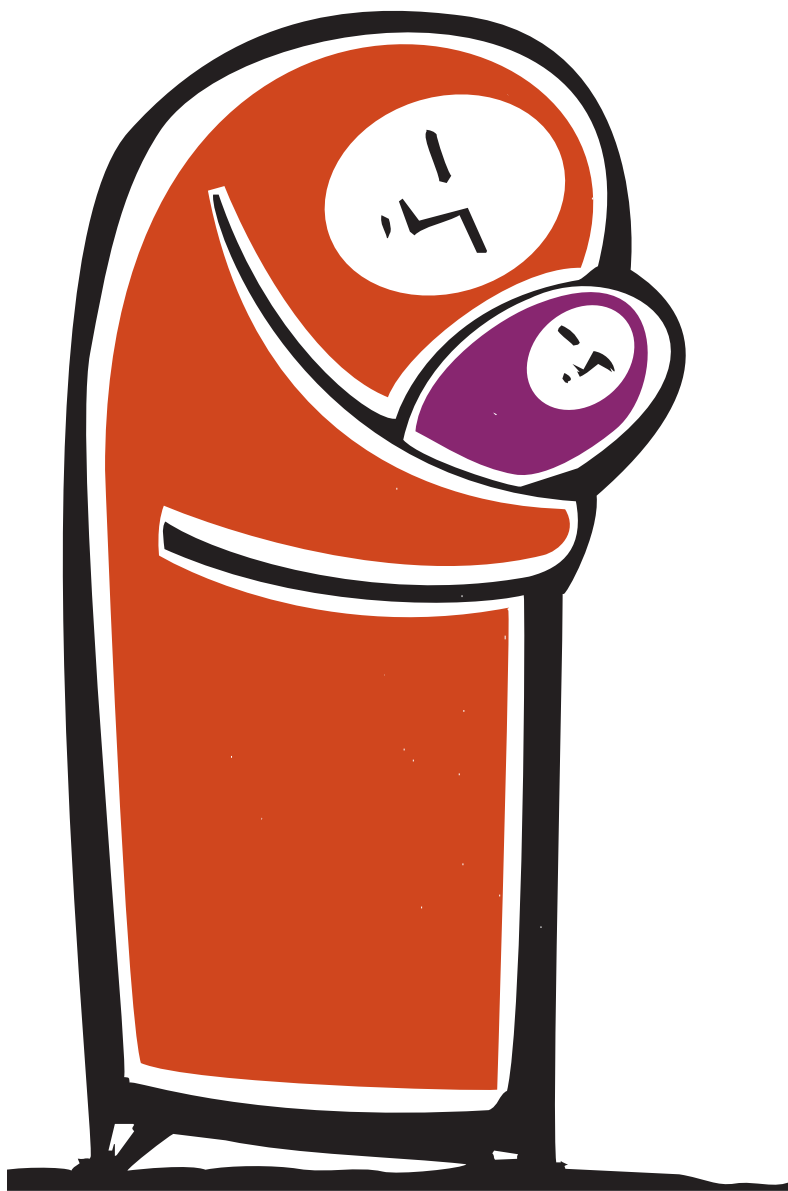
BY BESMA JABER

There is a special feeling I get when I walk into a room and encounter a Muslim patient. I see warmth and immediate trust in their eyes. No matter what language you speak or what country you call home, sharing something as personal as religion creates an instant bond.

As an Arab-American Muslim woman, I am acutely aware of the fact that I am in a unique position to build rapport with Muslim patients, to engender trust and understanding. I've felt this on every one of my rotations, but I became especially aware of it in obstetrics and gynecology, where the sensitivity of the subject matter makes it difficult to truly put patients at ease. Even so, having such a connection doesn't ensure a patient will follow your advice.

The 30-year-old Somali woman, G2P1 at 39 weeks with a history of severe preeclampsia in her last pregnancy, came into triage one Friday afternoon. She was sent down to the hospital's labor and delivery department from clinic for a preeclampsia work-up. It was immediately obvious that she and her husband were excited to see me walk into the exam room. The hijab on my head is an unmistakable clue that I am Muslim. They asked me all kinds of questions about my ethnic background and about how many years it would be until I was officially a doctor. I scooped up their toddler, who had sidled over to me and held out her arms, and proceeded to conduct my standard patient interview and exam. I explained why we were concerned, that we would be running some important tests, and that a resident and I would be back to see them shortly.

The labs indicated the patient was preeclamptic, and the indications for induction were clear. But the woman and her husband wanted to wait and go into spontaneous labor. I listened as the



chief resident talked to them about why that decision would be against medical advice. I quietly stood next to the woman and nodded my head in agreement as the resident described seizures and fetal demise and all sorts of complications that would terrify me if I were the patient. I also listened as the woman and her husband explained that this pregnancy was different. The woman, who had been highly symptomatic the last time, said she felt fine this time.

I listened as the woman and her husband demonstrated clear understanding of the risks of going home. I watched them as they smiled at the resident and profusely expressed their appreciation for the concern and care we were offering. I nodded while the

husband said they would not hesitate to return if any new symptoms arose, and I listened as he explained that they wanted to err on the side of caution, but did not want to be induced. I did not agree with their decision, but I accepted it.

As the resident gathered the paperwork, I stood at the patient's bedside and held her hand. I told her I was worried about her and the baby. She said, "I know, but the baby is OK now, right?" and I said, "Yes, right now, the baby is OK."

I encouraged her not to miss her clinic appointment the following Monday. Then I watched them leave with mixed feelings. I worried about what might become of them and the baby, and I wondered what else I could have done to convince them to stay. Ultimately, I felt frustrated. In spite of my best efforts to communicate the gravity of the situation, they made the decision to leave.

This was not the first time I disagreed with a patient's decision and it will certainly not be the last. But this encounter will stay with me because it is an example of a concept I struggle with when caring for some of my Muslim patients who have cultural backgrounds different than mine. In some cultures, it is believed that no intervention will prevent what has been destined for you by God. Although this concept is present in Islam, most of the Muslim world also believes that God wants us to do everything in our power to achieve our desired outcomes and that only after exhausting all options should we leave the rest to God. I try to convey to my patients that allowing for medical intervention does not mean they are interfering with God's plan. It can be hard to explain this to some, but I feel obligated to try.

I feel I have a solid grasp on Islamic teachings and can put things in a context my patients can understand. Yet I know a five-minute conversation with me is not going to override generations of cultural

A five-minute conversation with me is not going to override generations of cultural influence.

influence. Ultimately, I cannot tell people what to believe. I would find it unacceptable if someone did that to me. I will have a powerful role to play as a physician, and I am already proud of the times I have been able to convince my Muslim patients to get Pap smears, pelvic exams and routine vaccinations by making it "OK" for them. But with every patient interaction, I realize again and again that I have a lot to learn about knowing when to step back and accept an individual's wishes without

letting my emotional investment consume me. It is a work in progress, but I am able to take something away from every patient interaction I have, and I hope my patients are able to do the same.

About a week after I saw the woman and her husband, they returned to the hospital, the woman in spontaneous labor, sweaty and exhausted, with her seemingly ever-upbeat husband at her side. They warmly welcomed me into the room, and the woman clasped my hands and told me she was happy to see me again. No happier than I was to see them moving toward the healthy, natural birth they so desired. In all honesty, relief is more apt to describe my emotion at that time. If only every patient outcome could be this joyful. **MM**

Besma Jaber is in her fourth year at the University of Minnesota Medical School.

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A new kind of paternalism

A son reinterprets his father's approach to his patients.

REVIEW BY CHARLES R. MEYER, MD

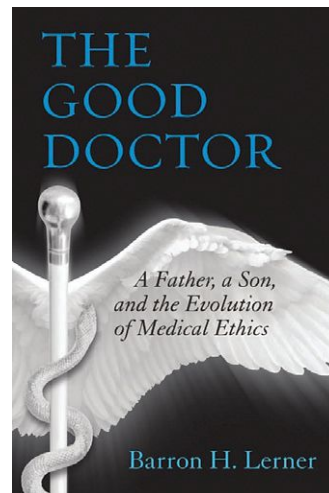
Thirty years ago, I sat in silent amazement as an older internist told the assembled physicians in the hospital doctors' lounge about taking a syringe of Demerol into the nursing home room of his 95-year-old demented mother and giving her the last medication of her life. It had happened a few years before he related the tale, but given the atrocious quality of her existence and what he knew were her wishes, he had no qualms about what he had done. That scene replayed again and again for me as I read Barron Lerner's *The Good Doctor*, in which he recounts the life and views of his infectious disease specialist father, Phillip Lerner, who believed adamantly that modern medicine had overreached its humane boundaries in keeping alive patients with no hope. Phillip knew what medical futility was before the current ethical debate about futility had even started.

A startling anecdote opens Lerner's unfolding of his interaction with his dad. When he discovers that a patient of his who was considered terminal and beyond hope was about to be resuscitated, the elder Dr. Lerner laid down on top of him to prevent CPR from being done. This dramatic action capsulized Phillip Lerner's approach to doctoring. Eminently trained by Louis Weinstein and other legends of infectious disease, he saw himself as his patients' physician and, therefore, the one to make all decisions, from the trivial to the terminal, about their medical care. His training and his era, according to Barron, preached paternalism in the doctor-patient relationship. "Whether he was caring for a friend, a relative, or a stranger, my father's

clinical interactions were always dominated by a paternalistic philosophy. It made sense to him that, since physicians trained for decades, spent long hours in the hospital, and devoted themselves to the care of both the poor and the wealthy, they should call the shots, and patients should acquiesce."

That philosophy first clashes with his son's when Barron, finished with his initial medical training, is working on a PhD in bioethics and writing his dissertation about invasive procedures performed on skid row patients without adequate consent. With his next book, *The Breast Cancer Wars*, which told stories of surgeons performing deforming procedures to remove every evidence of cancer without total patient consent, Barron became a crusader for patient autonomy and a virtual expert in paternalism run amok.

The conflict between father and son crystallized when the elder Dr. Lerner began taking care of family members in their last days. Caring for his Aunt Libba, Phillip decided that no surgery or other aggressive therapy should take place and wrote in his journal, "Have Aunt Libba in the hospital, trying to perform 'passive euthanasia.'" To Barron, the enlightened bioethicist, not only was his father violating the precept against caring for family members, but he was ignoring patient



The Good Doctor: A Father, a Son, and the Evolution of Medical Ethics, Barron H. Lerner, Beacon, 2014

autonomy by unilaterally choosing comfort care without Aunt Libba's consent. His father insisted that he knew best what was right for his patients, and he decried the trend in medicine to continue therapy even when it was futile. "My father believed that many well-meaning physicians and hospitals had lost sight of the basic human gesture of allowing a person to die in peace, free from suffering," Barron

writes. "It was his job, he thought, to encourage—even insist—that they do so."

The Good Doctor contains one epiphany and one irony. Barron eventually realizes that his father's medical care was not driven by blind paternalism, but by a comprehensive understanding of his patients that informed his decisions about them. "It is not as if my dad disregarded patients' wishes and simply told them what to do. To the contrary, he believed that it was his job to incorporate what he had learned about them into his ultimate medical recommendations." Ironically, at the end of Phillip's life Barron takes charge of making decisions about his father's care. "I was not just a doctor's son, but a son," he wrote as his father clung to life, opting for the type of aggressive treatment he had railed against for so many years.

So for the younger Dr. Lerner, paternalism and patient autonomy end up

Barron eventually realizes that his father's medical care was not driven by blind paternalism but by a comprehensive understanding of his patients.

being not simple evil and good. He decides that patients need empathetic, almost parental, guidance in making tough decisions about their medical care. "Research has shown that the more options patients are given, the more likely they are to throw up their hands and ask the doctor what to do," he writes. "Just as paternalism's historical moment came under fire, so, too, has the historical moment of pure autonomy."

Lerner fears that in this era of specialists and hospitalists, finding that empathetic, knowing physician who can best guide patients might be difficult. "The emphasis in the doctor-patient relationship has shifted from physicians getting to know patients and their illnesses to physicians doing things for patients and their illnesses." Yet even when the doctor knows the patient like a son, the decisions will never be simple. **MM**

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



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Physicians prevail on Avera Marshall autonomy case

BY DAN HAUSER

After three years of legal wrangling, the news is finally good for Minnesota physicians in the case of the Avera Marshall Regional Medical Center Staff vs. Avera Marshall Regional Medical Center.

On the last day of 2014, the Minnesota Supreme Court ruled that a medical staff is a legal entity that may sue on behalf of its member physicians, and that bylaws agreed to by a hospital and its medical staff constitute a contract to which both parties must adhere.

After this favorable ruling, the high court remanded the case to the district court, which earlier ruled in favor of the hospital's administration in the lawsuit against the hospital brought by the medical staff. The district court will re-examine the case in light of the Supreme Court's decision.

The lawsuit is the result of an impasse with Avera Marshall administration and its board of directors regarding the role of the medical staff and its officers and committees as set forth in the medical staff bylaws. Both Avera Marshall and the medical staff had approved the terms of the bylaws in 2010. However, in January 2012, the hospital's board unilaterally voted to repeal the bylaws and replace them with a new set with no input or action by the medical staff. In doing so, the board did not follow the process for changing the medical staff bylaws that is described in the older bylaws, which require involvement of the medical staff.

Since February 2012, the MMA and the AMA Litigation Center have provided professional support to the Avera Marshall medical staff through friend-of-the-court briefs. The American

PHOTO BY STEVE WEWERKA



Jane Willett, DO, and Steven Meister, MD, represented the medical staff through the entire legal process.

Academy of Family Physicians, American Osteopathic Association, Minnesota Academy of Family Physicians and Minnesota Academy of Pediatrics have also supported the physicians pursuing the case.

“This is an important victory for all physicians,” says Donald Jacobs, MD, MMA president. “An independent, autonomous medical staff serves a critical role in facilitating and maintaining quality patient care in a hospital setting and should have a strong voice in the decision-making process regarding that care.” (Read Dr. Jacobs' Viewpoint on the case on page 27.)

Jacobs commended the medical staff for having the courage to stand up for its rights and the care of its patients. In particular, he cited Steven Meister, MD, and Jane Willett, DO, for championing the suit through the District Court and the Court of Appeals.

Meister and Willett said in a statement to staff: “This action was started to protect the fundamental and unique role that we physicians serve in a hospital's decision-making process that impacts patient care, a role that is reinforced in the medical staff bylaws.”

“Patients were the big winners as the Minnesota Supreme Court re-established an appropriate balance of responsibilities between physicians and administrators at Avera Marshall Regional Medical Center,” said AMA President Robert Wah, MD, in a statement. “The ruling will help promote hospital policies that align with the best interests of patients.”

Avera Marshall lawsuit timeline:

- **January 2012** – Avera Marshall administration approves new medical staff bylaws without input from the medical staff; medical staff sues
- **February 2012** – The MMA's Executive Committee votes to support the Avera Marshall medical staff; soon after, the AMA's Litigation Center agrees to join the MMA in support of the lawsuit
- **March 2012** – The MMA and AMA ask permission to file an amicus (friend-of-the-court) brief in support of the medical staff
- **April 2012** – Lyon County District Court denies the MMA and AMA's amicus brief request
- **July 2012** – Lyon County District Court rules that the medical staff is not an independent legal entity that could sue or be sued by the hospital
- **September 2012** – Lyon County District Court rules that the medical staff bylaws do not constitute a contract between the staff and the hospital and that the hospital can, in effect, unilaterally change the bylaws
- **November 2012** – The medical staff appeals the district court's ruling
- **December 2012** – The MMA and AMA file a request seeking permission to provide an amicus brief to the Minnesota Court of Appeals
- **May 2013** – Court of Appeals hears oral arguments on case
- **July 2013** – Court of Appeals rules against medical staff
- **October 2013** – Minnesota Supreme Court agrees to hear case
- **December 31, 2014** – Minnesota Supreme Court rules that a medical staff is a legal entity that may bring suit on behalf of its member physicians, and that the bylaws agreed to by a hospital and its medical staff constitute a contract to which both parties must adhere.



Janet Silversmith



Eric Dick



Dennis Kelly



Brian Strub



Kenneth Kephart, MD



Dave Thorson, MD

MMA in Action

Janet Silversmith, MMA director of health policy, discussed accountable care organizations with residents and faculty from the St. Cloud Family Medicine Residency Program in early January.

Eric Dick, MMA manager of state legislative affairs, traveled to St. Cloud Ear, Nose and Throat in mid-January to offer an update on the 2015 legislative session. Dick shared his take on the political "lay of the land" at the Capitol and presented the MMA's legislative priorities for the session.

In mid-December, **Dennis Kelly**, chief executive of the MMA Foundation, **Ray Christensen**, MD, an AMA delegate for the MMA and assistant dean at the University of Minnesota-Duluth Medical School, and **Brian Strub**, MMA manager of physician outreach, presented John Lundy, a reporter with the *Duluth News Tribune*, with the MMA Foundation's Excellence in Medical Journalism award for an article addressing the primary care physician shortage in the Duluth area.



Ray Christensen, MD, (left) presents John Lundy with the Excellence in Medical Journalism Award.

In January, both the Twin Cities Medical Society (TCMS) and the Zumbro Valley Medical Society (ZVMS) held their annual meetings. TCMS appointed **Kenneth Kephart**, MD, as its president for 2015. **Dave Thorson**, MD, MMA president-elect, and **Terry Ruane**, MMA director of membership, marketing and communications, attended. ZVMS appointed **Dan Maddox**, MD, as its president. Ruane, Kelly and **Donald Jacobs**, MD, MMA president, attended.

News Briefs



Student Loans

Loan forgiveness receives early attention at Capitol

On day three of the 2015 Legislative session, state senators introduced a bill (SF3) that addresses loan forgiveness, one of the MMA's top legislative priorities. The bill calls for creating a health professional education loan forgiveness program for a variety of health care professionals including physicians, nurses and dentists who agree to practice in designated rural areas or underserved urban communities. The bill is authored by Sen. Greg Clausen (DFL-Apple Valley), co-chair of the Legislative Health Care Workforce Commission. To be eligible for the program, individuals must agree to serve full time for a minimum of three years.



Total cost of care data released in December

In mid-December, MN Community Measurement released a first-of-its kind report on the total cost of care for patients in 115 medical groups, representing 1,052 clinics statewide. The analysis found that the average cost of medical care per patient is \$435 a month. The average cost for adults is \$514 per month, while the average cost for children is \$216 per month. Eighty percent of the medical groups included in the report had total costs within

the average range, with 6 percent of groups having costs below the average and 14 percent having costs above the average. The TCOC measure includes the allowed payment amounts (paid by both the health plan and any patient cost-sharing) for all services received by patients who were attributed to the medical group based on the majority of outpatient visits during the measurement year (2013). These services include: professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services provided directly by the medical group or externally.

MinnesotaCare is nation's first Basic Health Program

On January 1, MinnesotaCare, the publically funded health insurance program for people unable to afford health insurance in the private market, became the nation's first Basic Health Program (BHP). The Centers for Medicare and Medicaid Services approved Minnesota's proposal in mid-December. This action allows the Department of Human Services to receive funding for MinnesotaCare under a new federal authority created by the Affordable Care Act that will help offset the state's cost to run the program.

MMA adopts member-generated policies

The MMA has adopted new policies that grew out of ideas submitted by MMA members as part of the open-issues forum held at the 2014 Annual Conference in September. The policies address climate change; aligning MMA policy on abortion with AMA policy; placing age limits on tobacco and e-cigarette sales; reporting requirements for the National Practitioner Database; hospital admitting privileges; and use of APRNs. Eighteen policies were submitted and discussed at the Annual Conference forum. The MMA's Policy Council deliberated on and revised several of the proposals. The Council decided to retain one item for future discussion. Four measures were not adopted, and seven were referred to MMA policy committees for further analysis. The Policy Council does not have independent decision-making authority, so its recommendations for policy on six items were submitted to the MMA Board of Trustees.

Minneapolis cardiologist receives 2014 Shotwell Award

The West Metro Medical Foundation of the Twin Cities Medical Society presented its 2014 Shotwell Award to Robert G. Hauser, MD, FACC, FHRS. The Shotwell Award is presented annually to a Minnesota physician who has made significant contributions in the field of health care. It was established by Metropolitan Medical Center in 1971.



VIEWPOINT

A victory for physicians and patients

If you are like me, the recent Minnesota Supreme Court ruling on the Avera Marshall case made you smile. You felt a small thrill of victory upon hearing that the high court sided with physicians by holding that medical staffs are legal entities and that medical staff bylaws constitute a contract between physicians and hospitals. I hope you celebrated this victory for physicians. I think it has enormous practical and symbolic meaning.

Historically, a hospital's medical staff has been a respected and largely independent entity that served several crucial functions—overseeing peer review, setting and revising clinical standards and processes, and giving physicians a vehicle for formally communicating with hospital administration.

With the increasing integration in health care and ever-growing hospital systems, many of us have felt the vitality of the medical staff eroding. It has seemed, at times, as though medical staff autonomy has been compromised by administrative and business pressures.

And then along came this case, in which the Avera Marshall medical staff found itself hamstrung when the hospital's administration unilaterally rewrote its bylaws. Peer review was compromised, credentialing and privileging happened without medical staff input and nonphysicians were placed on the medical executive committee by the hospital. The Avera Marshall medical staff had no choice but to pursue legal action.

As the litigation unfolded, it felt as if everything we thought and understood about the rights and responsibilities of a medical staff was called into question. The future of the medical staff seemed unclear. Fortunately, the Minnesota Supreme Court

reminded us all that medical staffs are necessary and important to the successful functioning of a hospital.

A robust medical staff is key to physician participation in setting clinical practices. A medical staff allows physicians to focus on patient care and quality clinical processes without being swayed by hospital business imperatives or politics. In short, the medical staff is a safe haven in which physicians are able to focus on the practice of medicine. As health care organizations consolidate and hospitals and clinics become increasingly integrated, this sanctuary must be preserved.

This victory also affirms the vitality of the MMA as an organization that supports physicians and physician advocacy. From the get-go, we were on board helping and supporting the Avera Marshall medical staff both in spirit and financially. We engaged in the court battle with a strong amicus presence; we heard from judges and attorneys that the MMA's amicus briefs were read carefully and heeded.

Finally, the MMA offered the Avera Marshall medical staff intangible support. The physicians who took on the case knew their peers stood behind them. It was clear to them that the sacrifices they were making in order to pursue litigation—personal time, emotional energy and lots of money—were recognized and valued by their peers and their professional association. There's no way to put a price on that.

The MMA offered the medical staff their support because it was the right thing to do: When a member goes to bat on behalf of the entire profession, that member deserves our support. That is what a medical association *should* do.



Donald Jacobs, MD

The Minnesota Supreme Court reminded us all that medical staffs are necessary and important to the successful functioning of a hospital.



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Let's talk to our patients about hospice

Too many who could benefit from it are learning about the option too late.

BY BARRY BAINES, MD, AND JANELLE SHEARER, RN, BSN, MA

Hospice care can provide patients who have life-limiting illnesses with relief from pain and other physical symptoms; help with the emotional, spiritual and psychosocial issues associated with the end of life; and a better quality of life during the time they have left. It is also cost-effective. A Duke University study showed that hospice use reduced Medicare expenditures during the last year of life by an average of \$2,309 per patient,¹ as it can ward off problems that can lead to hospitalization.²

Many Minnesotans who could benefit from hospice care, however, are not receiving it in a timely manner. All too often, the hospice option is mentioned too late by physicians and others involved in the patient's care. In addition, many people have misconceptions about hospice.

Although coverage for hospice services is available through Medicare, it is underutilized because Medicare beneficiaries often do not understand how the benefit works. As a result, many people don't know they are eligible for hospice care. Also, they may believe they can get hospice care only if they have a short time to live. The national average length of stay in hospice is 70 days. In 2011, Minnesota Medicare patients were in hospice an average of only 56 days.^{3,4}

In addition, a number of patients and their families believe hospice care ends after six months—and that they will be



“kicked out” if they still need care. That is not the case. After six months, patients can be recertified for the hospice benefit. Typically, the hospice medical director or a nurse practitioner conducts a face-to-face evaluation to determine if the patient still meets the hospice criteria (ie, if the patient's illness were to follow its expected course, their prognosis would be six months or less).

Patients aren't the only ones who are misinformed about hospice. Some physicians don't understand what it means to

care for a patient who is in hospice. At one hospice, a man who was dying from cancer and suffering from frequent urinary tract infections (UTIs) was not given IV antibiotics. When asked about treating the UTI, the patient's doctor responded, “I thought he was in hospice.” This physician did not understand that aggressive treatment for the UTI was still appropriate care for someone in hospice, given that the goal of the treatment is comfort.

Misconceptions on the part of both physicians and patients have contributed

to low hospice use across the nation. Also contributing to low use is the fact that on average physicians overestimate patients' prognosis by 500 percent (they think a patient has five months to live, but the patient actually has only one).^{2,5} That optimism may lead physicians to a later hospice referral—or none at all.

Identifying barriers to hospice

In 2013, Stratis Health launched a one-year project called Targeting Resource Use Effectively (TRUE) to explore ways to increase use of hospice services. The project, funded by the Centers for Medicare and Medicaid Services' Quality Improvement Program, focused on three Minnesota communities—Alexandria, Mora and Waconia. We chose those communities because we recognized there was a significant opportunity to improve the use of hospice services in them.

We then worked to identify barriers to hospice care in all three. To do that, representatives from each of the communities had conversations with members of the general public, health care providers, patients who were currently in hospice or had used hospice in the past and their families. We asked them how they would describe hospice, whether they would consider it if they were facing a life-threatening illness and if they had concerns about hospice.

We learned from those conversations that the patients nearly all agreed that if they knew they had a life-limiting illness, they'd want to know about hospice. We also identified the following barriers that stood between them and hospice care.

Patients don't understand their illness.

When we spoke with physicians, many said the biggest barrier to referring patients to hospice care was patients being in denial about their illness and/or not accepting that they have a serious condition. Patients may not fully understand their condition. Without this fundamental knowledge, they can't even begin to ask questions about options for their care.

Their lack of questioning could be construed as denial or lack of acceptance.⁶

Patients don't understand differences in treatment goals.

Hospice program staff said that in their conversations with patients who have a serious illness, many don't understand what their illness means relative to their prognosis. They may not understand that their treatment will only slow down the course of the disease rather than cure it.

Other research has yielded similar findings. A study at Dana-Farber Cancer Institute, for example, found that 70 percent of patients with advanced lung cancer and 81 percent of patients with advanced colon cancer believed the chemotherapy they were receiving would cure them (the actual cure rates for these advanced cancers is near zero; the five-year survival rate for advanced lung cancer is approximately 1 percent and for advanced colon cancer 11 percent).⁷

Patients wait for physicians to talk about their illness and hospice and physicians wait for patients to bring it up.

We found many doctors are willing to have a conversation about serious illnesses with patients and their families, assuming the patient initiates the conversation. At the same time, we found patients were waiting for their doctors to start the conversation and bring up hospice.

There is lack of clarity about who should conduct end-of-life discussions.

Another problem we discovered was physicians not knowing which clinician should initiate end-of-life discussions. A specialty physician caring for a seriously ill patient may believe that the primary care physician will talk to the patient about hospice. The primary physician, on the other hand, may believe the specialist should have that talk because the patient's allegiance as well as responsibility for care management may have been transferred to the specialist. As a result, no discussion occurs, misconceptions about hospice aren't corrected, and patients and families lose out on hospice benefits.

Finding solutions

As part of the TRUE project, we sought to find ways to help qualified patients get timely hospice care. To encourage patients to ask their physicians questions so that they might better understand their condition and prognosis, the first thing we did was create brochures and wallet cards that list the following questions:

- Do I have a serious or life-limiting illness?
- Can my illness be cured?
- If my illness can't be cured, are there treatments that can slow down my illness?
- What kind of care is available that focuses on making me comfortable?

The brochures and cards were placed in local gathering places in the three communities: churches, beauty salons, restaurants, libraries, senior centers and clinics.

Second, we wrote sample scripts physicians can use to initiate the dialogue with patients who have serious illnesses about various treatment options—curative, remissive and palliative—early on in the course of their illness. The scripts help them have those discussions at a level patients and families can understand. In addition, because we knew primary care physicians tend to share information about expectations and survival prognosis soon after a patient's diagnosis, we encouraged them to give patients the opportunity to ask questions about where they are with their illness at all visits.

Third, to get physicians to think differently about when hospice is appropriate for a certain patient and to help them identify patients who might benefit from hospice earlier in the course of their illness, we asked them to ask themselves the following question: Would you be surprised if you saw a certain patient's name in the local newspaper's obituary column in the next year? If the answer was no, they knew that this was a patient for whom a hospice conversation would be of value.

Early results from our research show that both hospice use and the average length of time in hospice had increased in all three communities. For 2013, the mean length of stay was 33.3 days; for 2014, it was 36 days. If the number of referrals continues at the current rate, the 2014 count was expected to be 916, as compared with 804 actual referrals in 2013.

Let's start talking

In today's health care environment, it is rare to meet a physician who doesn't believe in the value of hospice. Both primary care physicians and specialists are responsible for starting the conversation about hopes and goals for care when they see a patient with a serious illness. That conversation should include a discussion about hospice, and patients should be referred for evaluation when appropriate. Patients need to be assured that a referral does not indicate that the physician has given up on them; rather, it will help them better understand their options. The physician

The materials created as part of the TRUE project are available at www.stratishealth.org/providers/hospice.html.

might compare it to meeting with a financial planner to discuss hopes and goals for retirement.

The TRUE project has shown that when patients and their care providers talk about hospice with their physicians, appropriate hospice use increases. We hope others can learn from this project and make use of the materials we created for it.

We encourage all physicians to start hospice conversations soon after a patient is diagnosed with a life-limiting illness. That way, patients can receive the many benefits of hospice sooner rather than later and live their last days more fully. **MM**

Barry Baines is a hospice medical director and Stratis Health consultant. Janelle Shearer is a program manager at Stratis Health.

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Minnesota's new APRN law

What it means for physicians and their practices

BY TERESA KNOEDLER, JD

Since a high-profile Institute of Medicine report in 2010 called for all in health care to practice to their full potential, there has been a growing national movement to allow advanced practice registered nurses (APRNs) to practice independent of physician supervision.

An advanced practice registered nurse is a nurse who has post-baccalaureate education in nursing and expanded skills and knowledge. APRNs include:

- Certified nurse practitioners (CNPs), who generally provide primary care in the areas of adult medicine, pediatrics, geriatrics, women's health and mental health
- Clinical nurse specialists (CNSs), who often specialize in clinical management, quality improvement, mental health and women's health
- Certified nurse midwives (CNMs), who work in obstetrics and delivery
- Certified registered nurse anesthetists (CRNAs), who administer anesthesia and generally practice in hospitals and surgical centers. (Some CRNAs are moving into pain management, but this is controversial.)

Historically, physicians and APRNs worked collaboratively through practice agreements. Many states, including Minnesota, have long required APRNs to maintain a collaborative practice agreement with a licensed physician. Over the last decade, APRN professional associations have argued that APRNs have enough training and expertise to be able to practice independently. This led to successful efforts in a number of states to expand APRNs' scope of practice.

In 2014, the Minnesota APRN Coalition proposed legislation to revise the Minnesota Nurse Practice Act, allowing APRNs to practice independently. Physician groups, including the Minnesota Medical Association, opposed the bill, as they were concerned that complete APRN autonomy would compromise patient care and safety. These groups led efforts to modify the bill, and they successfully narrowed its scope. Ultimately, that legislation passed with broad bipartisan support.

Physicians across the state have a number of questions about the new law, which took effect January 1. They want to know what their obligations are under it and what options remain. Most important, they want to know how they can continue to facilitate team-based care. This article describes what has—and has not—changed under the new law.

What's changed

Licensure

Under the new law, all APRNs (CNPs, CNSs, CNMs and CRNAs) will be licensed by the Minnesota Board of Nursing. Previously, they were only licensed as RNs and registered with the Board of Nursing as APRNs. In order to obtain licensure, an APRN must have completed the appropriate educational requirements beyond a baccalaureate RN degree and be certified by a national nursing certification organization approved by the Board of Nursing. For example, a CNP wanting to practice in family medicine would need to have completed a master's or doctoral degree and passed a board-certification exam in family medicine. New APRNs must also

complete a clinical practice requirement. The law includes a provision for the grandfathering of APRNs who were on the registry in July 2014 but do not otherwise meet the requirements for APRN licensure.

Independent practice

The new law will have the biggest impact on CNPs and CNSs, as it grants them the authority to practice independently, including to prescribe. It also removes the requirement that CNPs and CNSs practice under a collaborative management agreement and have a written prescribing agreement with a physician. In order to practice independently, however, a new CNP or CNS must have completed 2,080 hours of clinical practice within a collaborative management setting in a hospital or integrated clinical environment in which APRNs and physicians work together. The clinical component must take place under the oversight of an APRN or physician with experience providing care in the same or a similar field.

CRNAs can continue to provide anesthesia services in a hospital or surgical center without physician supervision. Those CRNAs who provide nonsurgical therapies for acute and chronic pain are required to have a "mutually agreed-upon plan" with a physician who designates the scope of collaboration needed to provide those treatments. CRNAs who provide nonsurgical therapies for chronic pain must have a written prescribing agreement with a physician that defines the delegated responsibilities related to prescribing drugs.

CNMs are least affected by the law, as they have had the authority to practice independently for many years. Most CNMs work closely with obstetricians and will continue to do so.

Prescribing

Most APRNs have full independent prescribing authority under the new law. They may prescribe scheduled drugs with proper DEA registration. It will be up to each hospital, clinic or practice group to set its own standards regarding prescribing.

CRNAs will continue to need a written prescribing agreement in some cases. For example, they will be required to have a written prescribing agreement with a physician who practices in the same clinical setting if they prescribe medications for patients with chronic pain.

Oversight

The Minnesota Board of Nursing regulates APRNs. Like the Board of Medical Practice, the Board of Nursing is complaint-driven, meaning that in general licensees are investigated only after the board receives a complaint. The Board of Nursing has the authority to investigate any complaints made about the care given by an APRN. Although this was the case before the law change, the *license* of APRNs under investigation—not just their *registration*—will now be on the line.

The law established an advisory committee, composed of APRNs and physicians who work with APRNs, to advise the Board of Nursing on emerging APRN practice trends, aggregate prescribing trends, the overlap between advanced practice registered nursing and medical practice, and other issues related to the practice and regulation of APRNs. This committee will not be involved in investigations of complaints or disciplinary actions taken against APRNs.

Liability under the law

APRNs who practice independently will assume additional medical liability exposure. As a practical matter, APRNs who engage in more independent practice should carry increased malpractice coverage. This is true even though neither physicians nor nurses are required by statute to carry malpractice insurance. The risk of personal liability, coupled with hospital privileging and health plan credentialing standards, renders medical malpractice coverage mandatory for all health care providers who practice independently (and even for many who do not practice independently, such as RNs and PAs).

Most APRNs carried malpractice liability coverage in the past and will continue to do so under the new law. Whether that coverage is carried by the individual or by the hospital or clinic on behalf of the APRN will depend on employment status or other factors.

Physicians who collaborate with APRNs may assume some oversight responsibility, as was the case before this law went into effect. This may expose them to some liability risk related to the APRN's decisions. Most of the time, however, physician liability and APRN liability are separate issues.

What hasn't changed

Credentialing

The law does not mandate changes to credentialing or privileging. Health plans will credential APRNs according to their own standards, and hospitals will determine privileging according to their own standards.

Physician supervision in certain clinical settings

As before, the standard of care in certain settings may require some APRNs to be supervised at times. For example, it would be outside of the standard of care for an APRN to perform a heart transplant; however, it would be well within the standard of care for an APRN to work collaboratively with a physician to provide care before, during and after transplant. The new law does not change the standard of care.

Therefore, it may be appropriate for physicians to supervise APRNs in certain clinical settings in order to meet the applicable standard of care. Employment relationships, clinical relationships and personal choice will continue to inform when and how physicians supervise or collaborate with APRNs.

Although the new law does not require CNPs and CNSs to have collaborative management agreements with physicians, it is important to note that it does not prohibit such agreements from being used. It is up to each hospital, clinic or practice group to set its own standards regarding clinical care and collaboration.

Also, a physician who has clinical experience in the CNP's or CNS's field of practice and who works in an integrated setting may agree to participate in the clinical training required for licensure. To do so, the physician and the CNP or CNS must have a mutually agreed upon collaborative management plan. Physicians are not required to supervise the training of a new CNP or CNS.

Conclusion

In Minnesota and many other states, the distinctions between the practice of nursing and the practice of medicine have become less clear. Many things that were historically done by physicians are now done by APRNs and other clinicians.

Before the new APRN law went into effect, there was already overlap between the practice of nursing and the practice of medicine. The area of overlap will continue to grow. The changes the new law brings may seem broad, but their effect is likely to be moderate because of practical considerations such as employment agreements, privileging and credentialing imperatives, and medical liability realities. The law was difficult for many physicians to accept; however, now that it is in effect, they can comfortably renew their focus to ensuring high-quality, team-based care for all Minnesotans. **MM**

Teresa Knoedler is the MMA's policy counsel.

Telemedicine for Postoperative Visits at the Minneapolis VA Medical Center

Results of a Needs Assessment Study

BY KATIE STYPULKOWSKI, BS, SARIKA UPPALURI AND STEVEN WAISBREN, MD, PHD

The Minneapolis VA Medical Center initiated a telemedicine program in the early 1990s as a way to streamline care and increase convenience for patients and clinicians. In this study, we explored employing telemedicine for postoperative visits for patients in the general surgery clinic. We surveyed 346 veterans about their preferred method of follow-up. In addition, we asked about their need to complete insurance paperwork, use of VA satellite clinics, distance from the VA Medical Center and from the nearest satellite clinic, and need for travel assistance. We found half of the respondents preferred face-to-face follow-up while the other half preferred follow up using some form of telemedicine. These findings suggest there is a demand for remote postop visits using telemedicine and that such visits may have advantages over face-to-face clinic appointments, especially for patients who have to travel long distances. Further studies are ongoing to determine the actual acceptance of remote visits by the patients and surgeons and to determine if there have been delays in recognition of postoperative complications.

Problems with the Veterans Affairs (VA) health care system made headlines around the country last year. Complaints about long wait times for care—significantly longer than the two weeks mandated by the VA central office—have been attributed to a lack of clinic space and staff and as well as limited clinic hours. Lengthy waits were a factor in the problems that led to fraud allegations at the Phoenix VA.¹

For the most part, wait times at the Minneapolis VA have not been as big of a problem. All consults to the general surgery service are immediately triaged on the day they are requested. Nonetheless, the wait for general surgery appointments averages six weeks for *nonemergent* cases, and some delays may be attributable to high demand for surgical services. In 2013, the Minneapolis VA Medical Center served more than 97,000 veterans, averaging almost 2,000 outpatient visits per day and an in-house census of 138 patients. More than 700,000 outpatient visits were

made in 2013, exceeding the total from the previous year by more than 27,000.²

In 2014, the VA released its strategic plan for efficiently and effectively providing medical services to veterans. This was published well before the frenzy that led to the resignation of Secretary for Veterans Affairs, Gen. Eric Shinseki. One of its stated goals was to “increase the percent of patients who access VHA health care using a virtual format (eg, video, smartphone or online services)” between 2014 and 2020.³

Use of electronic communication technologies to provide health care is generally referred to as “telemedicine.” As the hardware has improved and become more accessible, telemedicine has been increasingly used to deliver timely, convenient and effective medical care. It is often used for “remote visits”—appointments that allow for personal care via an audio/video link.

The Minneapolis VA started a program called Clinic Video Telehealth in the early 1990s, in which clinicians based in Minneapolis use telemedicine technology to

communicate with patients in remote locations. It is now used in more than 30 departments ranging from hematology to home oxygen. In fiscal year 2014, 13,139 remote visits were conducted through the program. Most patients were located at community-based outpatient clinics (CBOCs), which are satellite clinics within the VA system; however, a few were as far away as San Francisco, Salt Lake City, Pittsburgh and Nashville.

Staff in the Minneapolis VA's department of surgery began considering remote visits for the simplest, least complex encounter—the routine postop visit—when we recognized just how far many of our patients traveled to see us. Postop visits usually take place about three weeks following surgery and tend to be very brief: We interview the patients and examine their wounds. They usually tell us they feel great and then thank us. Sometimes, they have to fill out insurance paperwork. The entire visit, including documenting it in the medical record and having the patient

fill out the occasional insurance form, usually takes about 10 minutes.

We looked at the experience of other programs to determine the feasibility. ENT surgeons at the Marshfield Clinic in Wisconsin, for example, reported success when using telemedicine to evaluate postop parathyroidectomy patients. They found the telemedicine visits provided significant convenience and financial benefits to both the patient and provider.⁴ Others found using telemedicine to deliver health care in remote and rural areas saved travel costs and time.^{5,6}

Prompted by these successes and the needs of our diverse patient population, we initiated a study to determine the desire for and potential benefits of remote postop visits following general surgical procedures at the Minneapolis VA Medical Center.

The Survey

We received institutional approval to survey all patients who presented to the general surgery clinic between April and November 2014. No information that could be used to identify a patient was included in the survey. Data were aggregated and descriptive statistics calculated.

All patients who were seen in the general surgery clinic were given a 10-question survey by a member of the nursing staff. Specific data collected included preferred method of follow-up, remaining insurance paperwork, use of CBOCs, and the distance and travel time to both the VA hospital and the nearest CBOC, if applicable. The survey also asked whether the patient had a caregiver or aide accompany them, used a VA van or provided their own transportation. The cost of travel was calculated using distance and the 2014 government reimbursement rate of \$0.56 per mile.

Findings

A total of 346 surveys were returned. As shown in Figure 1, 50.1% of patients said they preferred face-to-face follow-up appointments as compared with any other follow-up method. The mean \pm standard

deviation distance to the VA hospital from the patients' homes was 25.5 ± 23.6 miles. Forty-five percent of the patients surveyed received some care at a CBOC, and patients reported having received care at 18 different CBOC sites, the majority of which were located in Minnesota (Figure 2). The mean cost of a round trip to the Minneapolis VA was $\$64.62 \pm 66.11$,

FIGURE 1

Preferred Method of Postoperative Follow-Up Appointment

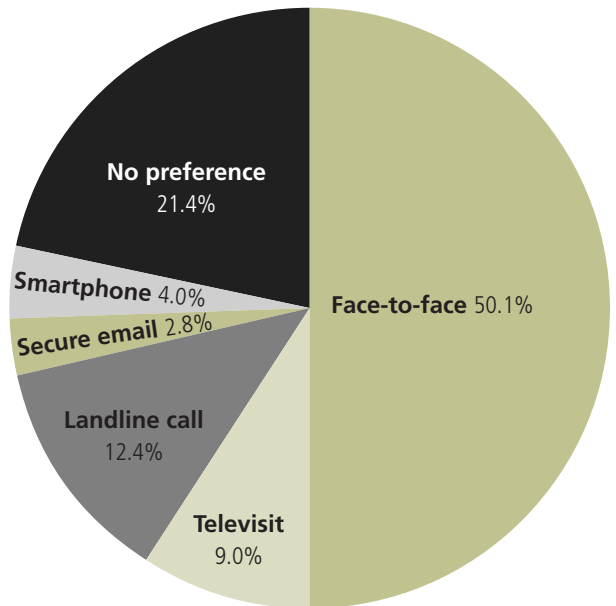
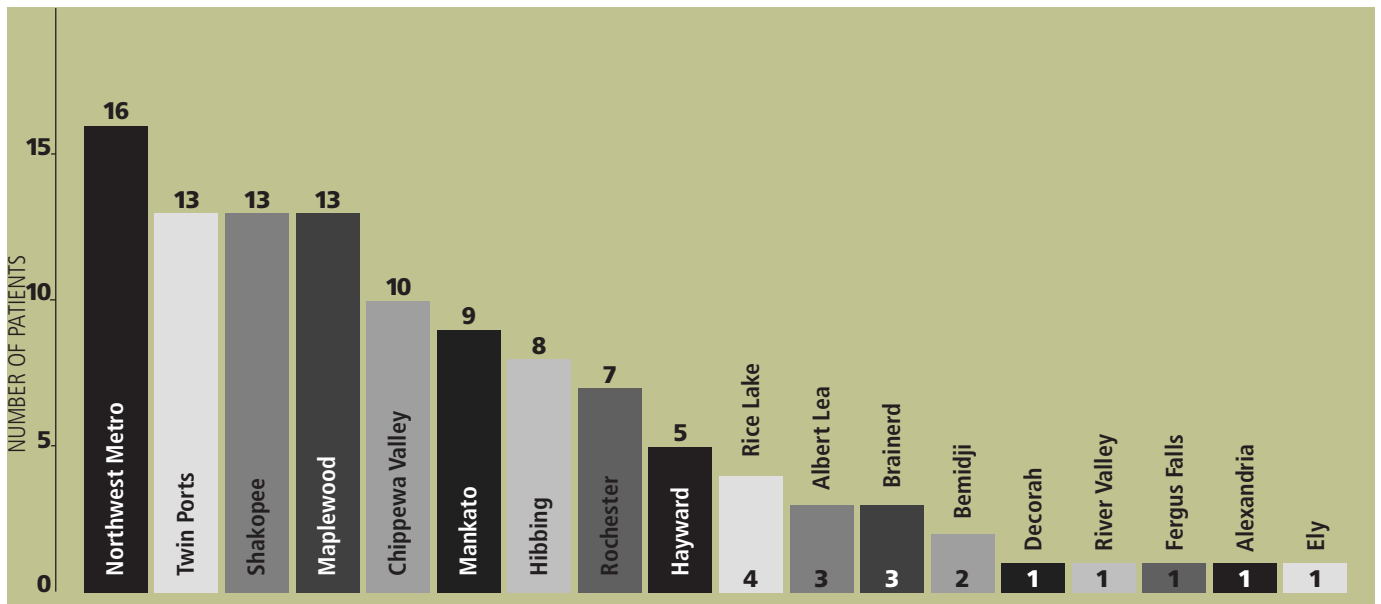


FIGURE 2

Reported Usage of Community-Based Outreach Clinics by Patients Who Had Surgery at the Minneapolis VA



with an average of 118 ± 119.1 miles and 2.8 ± 1.9 hours of travel time. The average cost of a round trip to the patient's nearest CBOC was $\$27.88 \pm 26.07$ with a mean of 51 ± 47.23 miles and 1.4 ± 0.76 hours of travel time. About 20% of patients needed a friend or family member to assist them in reaching the VA, while 28% used a VA-supplied van to get to their appointments. Only 10% of patients received mileage reimbursement from the VA. Less than 9% had insurance paperwork that needed to be completed. Of those patients, 17 reported that they would be willing to mail it in; four said they would not.

Discussion

This is believed to be the first study that investigates patients' preferences with regard to postoperative follow-up care. Although half of the patients surveyed said they would prefer a face-to-face follow-up visit, the other half indicated they would prefer using some form of telemedicine or had no preference. Patients also reported use of 18 CBOCs across Minnesota and neighboring states, showing that the possibility of implementing a remote visit program at these sites would reach a widespread group of veterans receiving care. Considering that 28% of patients needed more than four hours to travel to and from their clinic appointments at the Minneapolis VA and 5% needed more than eight hours, employing remote visits at the CBOCs would undoubtedly benefit many of our patients.

Remote visits at a CBOC also appear to generate substantial savings in terms of cost. Veterans may be particularly appreciative of these savings because only 10% received reimbursement for their mileage. Our study did not factor in the cost of lost work time for patients.

These visits also may ease the burden on caregivers, as 20% of patients required the assistance of a friend or family member to travel to their follow up appointment. Anecdotal reports from patients living as close as Anoka acknowledged the importance of convenient parking at their local CBOC as opposed to having to make the long trek from the parking lot to

the surgical clinic at the Minneapolis VA. The finding that so few patients needed to fill out insurance paperwork at the postop visit suggests that this will not impede the implementation of remote visits. Furthermore, those who had insurance paperwork to complete were amenable to filling out the forms and mailing them in.

Although telemedicine may be an ideal method for delivering health care to patients who live a significant distance from their health care providers, there are obstacles that must be overcome to successfully implement a telemedicine program. First, surgeons must decide which hardware to use. We asked our surgeons if they would prefer to provide these services from their offices with relatively inexpensive, poorer-quality video equipment or in a more centralized location using high-definition technology. They chose the centralized location using equipment that offered better resolution. However, finding a room for these visits in a space-cramped academic institution is a challenge. Surgeons also said they were somewhat reluctant to invest the time needed to learn this new way of seeing patients. However, getting buy-in from the providers has become easier because of the push by hospital administration to limit the wait times for surgical care.

Privacy is an extremely high priority for the VA. Although smartphones may be more convenient than expensive video equipment, using them to deliver such care is currently against VA policy because of their lack of security. This is remarkable, considering that the strategic initiative from the Secretary of Veterans Affairs reads, "Veterans and eligible beneficiaries increasingly expect to receive VA communications via the Internet and on mobile devices."² We know of no current plans to change this policy.

Implementation and Conclusion

The Minneapolis VA's department of surgery started a pilot study of telemedicine for postop visits in December of 2014. Participating patients travel to their nearest CBOC, where they are checked by a medical assistant, then sit in front of a

camera and connect with clinicians at the Minneapolis VA. As of January, we had done eight remote postop visits and are collecting data on patient and clinician satisfaction, the distance between the veteran and the Minneapolis VA, the distance to their nearest CBOC, whether the veteran needed a friend or family member to drive them to the postop visit, whether they had insurance paperwork to fill out, and whether they had any complications after surgery (and whether those complications were diagnosed late because of the telemedicine visit). Future investigations will determine whether the remote postop follow-up program will yield the anticipated cost and time savings benefits.

Clinicians and administrators at the VA want to expand the use of telemedicine services in order to make care more timely and convenient for patients. This program and others that grow out of it may help alleviate the problem of long wait times for surgical care at the Minneapolis VA Medical Center. **MM**

Katie Stypulkowski volunteers at the Minneapolis VA Medical Center. Sarika Upaluri is an undergraduate student at Case Western Reserve University. Steven Waisbren is a staff surgeon at the Minneapolis VA and an assistant professor of surgery at the University of Minnesota.

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The Role of the Generalist in the Initial Treatment of Adolescent Anorexia Nervosa

BY ROBERT P. WILFAHRT, MD

Anorexia nervosa is a potentially serious illness characterized by the sufferer having a malignant fear of gaining weight and being fat. It was believed to stem from psychosocial problems. Treatment of the adolescent with anorexia has typically involved an inpatient stay in a specialized center where he or she can receive therapy aimed at changing thinking and exploring family dynamics. A newer strategy, family-based treatment, focuses on the young person's physical state. It can be initiated by a primary care physician during an outpatient visit. This article introduces this new paradigm for treating anorexia nervosa in adolescents and outlines the role of the primary care physician in diagnosing, treating and supporting the patient.

Eating disorders are potentially serious mental illnesses in which an individual has a malignant fear of gaining weight and being fat. These conditions can have life-threatening complications and are the most lethal of mental health problems in adolescents.¹ Even so, physicians historically have not given them the same level of attention that they have other illnesses, and many feel they lack the knowledge needed to treat a patient with an eating disorder. Thus, when a young patient presents with the symptoms of anorexia nervosa or a parent suggests their child may have the problem, many physicians believe they need to immediately refer the patient to a specialized program without beginning therapy.

Newer thinking suggests that primary care physicians have an important role to play in helping young patients with anorexia. They can introduce family-based treatment (FBT), which focuses on weight restoration. Sometimes referred to as the

Maudsley Method, FBT has been shown to be effective as an initial treatment of anorexia and for preventing relapse.² The conversations required to introduce it and support the family as the patient progresses through treatment are comfortably within the primary care or generalist physician's usual scope of care. Thus, physicians need not delay starting treatment while their patients await specialty care.

This article describes the use of FBT for anorexia nervosa and outlines the role primary care physicians can play in introducing it.

The Old and New Paradigms

The medical community has long assumed that treatment of eating disorders is best provided by specialists, often in inpatient settings. This thinking is not surprising, given that eating disorders have long been viewed as a psychological problem stemming from family dynamics. In fact, Sir William Gull, who named anorexia ner-

vosa in 1873, said, "The patients should be fed at regular intervals, and surrounded by persons who would have moral control over them; relatives and friends being generally the worst attendants."³ Jean Martin Charcot was no more charitable when he endorsed separating the patient from their father and mother, "whose influence, as experience teaches, is particularly pernicious."⁴ These observers assumed that psychopathology in the family contributed to or caused anorexia; thus, separating the patient from the parents' control was believed to be necessary to restore health. Treatment systems built on such thinking are characterized by extended inpatient stays aimed at restoring nutrition.⁵ The generalist physician's job was only to refer the patient to such a treatment program. Research has since demonstrated the limited benefit of this approach, as many inpatients lose weight after discharge and are subsequently readmitted.⁶



Certainly, psychosocial factors play some role in causing eating disorders—up to a 41% contribution, according to studies of covariance.⁷ But even before they develop disordered eating, many who are subsequently affected are noted to have had goal-directed personalities.⁸ The success they've felt making and meeting one weight-loss goal, and then the next one, is reinforcing. The eating disorder is considered “ego-syntonic” or satisfying rather than “ego-dystonic” and isn't identified as being maladaptive. In fact, many adolescents with anorexia are at least mildly anxious at baseline.⁹ The loss of energy induced by starvation paradoxically reduces their anxiety and can, therefore, become a relief.

It would be reasonable to expect that addressing the patient's anxiety or maladaptive behaviors through counseling might be of benefit, as counseling clearly is effective for treating other eating disorders. But that is not the case with anorexia. Studies of cognitive behavioral and dialectical therapy, group and individual therapy, or inpatient versus outpatient treatment for adolescents with anorexia have consistently shown these approaches fail at similar rates.^{10,11} Only FBT seems to show success, at least over the short term.¹²

That an individual's physical condition affects their cognition and behavior is both common-sensical and, as it applies to eating disorders, supported by a growing number of studies.¹³⁻¹⁵ Perhaps the first to show the effects of disordered eating on mental state was the landmark starvation study done at the University of Minnesota during World War II. Conscientious objectors to military service were recruited to help researchers determine the nutritional requirement for soldiers and generate nutritional recommendations for eastern Europeans suffering from war-related malnutrition. Healthy and “well-adjusted” male volunteers were fed a diet designed to induce a 25% weight loss over a 12-week period. After several days of caloric restriction, irritability and loss of concentration were observed. Over

a period of weeks, the men went on to develop sleep irregularities, overt mood disorders and even psychosis; one man cut off three of his fingers in an apparent attempt to be removed from the study. Upon refeeding, some of them described a fear of weight gain similar to the fear described by sufferers of anorexia. The treatment for their starvation-induced psychiatric disorders was food, and all of the symptoms resolved after nutrition was restored.¹⁶

With these ideas in mind, some postulated that eating disorders might cause or exacerbate psychosocial issues rather than be caused by them. They proposed that the physical problem—starvation—needed to be corrected before the patient's psychosocial problems could be addressed.

The Gist of Family-Based Treatment

Family-based treatment has been shown to be effective for young people with anorexia and is now considered a first-line treatment.² It assigns no blame for the circumstances that preceded starvation, focusing instead on a route forward for the family. It assumes that an adolescent's expected biopsychosocial development has been arrested or partially reversed by starvation and that providing adequate nutrition will correct or minimize their emotional distress and begin to improve intra-familial dynamics.

The parents' job is to facilitate the return to normal development by freeing the child from the eating disorder as they direct refeeding. Only after nutrition is restored does the adolescent regain autonomy, and only after nutrition is restored can pre-existing or comorbid psychiatric or intra-familial conflicts be addressed through counseling. In some cases, nutrition alone (without follow-up counseling) is enough to fully restore a patient's function.¹⁷

In FBT, family members are coached to “externalize” the eating disorder, naming it as if it were an undesirable second personality wholly separate from the adolescent. In the early phase, parents are counseled

about the immediate barriers to adequate caloric intake and how to address eating disordered behaviors as if they were an unwanted houseguest, with polite-but-consistent firmness.

Refeeding is accomplished using a strategy referred to as “the Magic Plate.”^{18,19} Parents choose the adolescent's foods and portion sizes without input or help from the adolescent; the pre-arranged plate magically appears, and the teen is expected to eat all of the food. Calorie-dense foods are chosen, providing the (possibly massive) energy required for a return to health without the discomfort that could arise if larger volumes of food were introduced to a shrunken gut. If the patient asks about ingredients or menu alternatives, their inquiries are met with brief, vague answers such as “This food has just what you need.” Failure to eat all that is provided triggers a loss of the next day's exercise privileges or some similar consequence constructed by the family. Expectations about the timeliness of a meal's consumption also can be put into place: For example, the parent might say, “Life resumes after you eat.” Rebellion is met with calmness. One parental support group suggests parents tell themselves, “I am a brick wall,” so as not to allow the intensity of the situation to escalate.¹⁹

In many cases, by not having to plan the next meal or to count calories the patient feels as if a heavy psychic burden has been lifted, and FBT is perceived as freeing rather than constraining. As nutrition improves, patients tend to become less resistant to feeding, and the family's mood relaxes. Once weight is restored, a therapist leads the family back toward allowing the adolescent to manage their own food intake and exercise schedule. Circumscribing parental control to eating and exercise during the initial phase of treatment, rather than allowing them to take over all aspects of the adolescent's life, eases this process. Reintroducing previously avoided foods such as desserts or stressful food-related situations while the parents retain control of the rest of the

teen's calorie balance can minimize anxiety about the transition back toward independence.¹⁸

The Office Visit

The primary care physician's first task is to recognize anorexia. The diagnosis is sometimes suggested by a family member out of concern for their loved one, but it can be masked. For example, anorexia may not be diagnosed as promptly in someone who is or has been overweight as it would be in someone who starts from a normal or thin habitus.²⁰ Rather, obese or overweight individuals are often rewarded or congratulated for their efforts to lose weight, to their eventual detriment. This delay in diagnosis can allow obstinate or manipulative behaviors to become firmly established and the biophysical consequences of starvation to deepen.²¹ In almost no case is it appropriate for a child to lose weight; at most, weight can be held while growth occurs. Because weight-control interventions in primary care settings have not been shown to be effective²¹ and may cause harm,²² any weight loss in an adolescent should prompt consideration of an eating disorder.

The physician must consider a differential diagnosis of weight loss, which might include esophageal motility problems, reflux or ulceration, or substance abuse.²⁴ Additional psychiatric comorbidities must be considered and, depending on the physician's level of comfort, addressed concomitantly with the anorexia. However, it must be noted there is no reliable pharmacologic treatment for anorexia.

During the assessment, the clinician determines whether it is safe for the patient to be treated as an outpatient. Suicidality or extreme malnourishment with milder electrolyte abnormalities does not necessarily preclude outpatient FBT. If hospitalization is required, however, it should be short and focused on medical safety; full refeeding needs to happen at home.

Once a diagnosis is made, the physician needs to explain FBT and the critical importance of refeeding to the family or

to the parents alone and offer them resources (see box). Whether to include the patient in the discussion is a decision that should be made on a case-by-case basis. It is reasonable to tell the family to aim for an average weight gain of 1 to 1.5 pounds per week. Expectations for the duration of refeeding must be managed; parents should be told refeeding may take as long as a year.

Perhaps the most serious mistake a physician can make is to partially treat the anorexia by failing to restore the adolescent to their previous or expected weight as identified by pre-illness growth curves, even if their pre-illness weight was above the 50th percentile for their height.²⁵ (Note that weight targets may need to be adjusted as the adolescent grows.) For girls, return of menses, which often requires 95% or more of expected (not ideal) body weight, may be an appropriate early goal.²⁶ Complete remission of the eating disorder behaviors with return of pubertal development, reversal of medical complications and restoration of normal cognitive patterns are the ultimate goals of therapy.

Once the family commits to FBT, the physician's job is to provide them with support and help them build confidence.

Resources

Maudsley Parents—A volunteer organization of parents who have helped their children recover from anorexia and bulimia through the use of family-based treatment. maudsleyparents.org

F.E.A.S.T. (Families Empowered and Supporting Treatment of Eating Disorders)—An international organization for caregivers of patients with eating disorders. feast-ed.org

Help Your Teenager Beat an Eating Disorder by James Lock and Daniel Le Grange. New York: Guilford Press; 2005.

Because some still assert or imply that parents must have done something to cause the adolescent's illness, clinicians might underestimate how powerful their affirmation is that parents are not to blame and how important it is to honor their efforts and encourage them to generate their own solutions as problems arise. Using counseling phrases during a clinic visit can be useful; a good example is referring to "the eating disorder" as being separate from the patient, or reminding parents that they may be growing frustrated with the eating disorder and not with their child. Physician visits might become infrequent once the patient starts gaining weight.

It is important that well-meaning clinicians not undermine FBT and allow the premature return to freedom of nutritional choice.¹⁷ Emotionally attuned clinicians who would normally strive to honor the autonomy of the adolescent might find the feeding style unusual or be uncomfortable with it. They must instead assume that the adolescent has become unable to make good nutritional choices and needs the firm intervention of the parents in making those choices for them, mimicking a much earlier stage in their life.

Conclusion

Primary care physicians are often the first to identify mental health concerns in children and adolescents. With appropriate specialty support, they often can treat depression, anxiety, ADHD and other conditions with medications. Primary care clinicians also can and should identify anorexia nervosa in young patients and should not hesitate to address it while any needed specialty care is pending. The remedy for anorexia is food and parental support. **MM**

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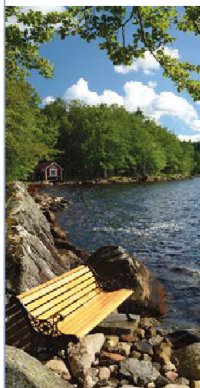
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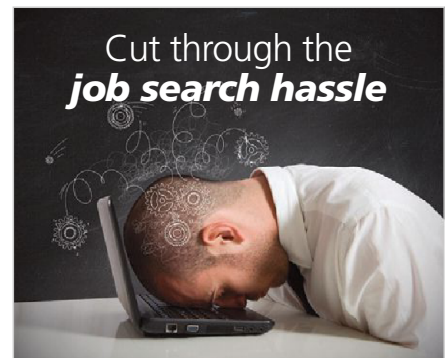
Nola Mattson (STC.HR@VA.GOV)

Human Resources
4801 Veterans Drive
St. Cloud, MN 56303
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I am a pediatrician

BY RUCHI KAUSHIK, MD

I am a **healer**. I tend to both your child's and your family's physical and nonphysical ailments.

I am an **educator**. I provide anticipatory guidance regarding growth, development and safety.

I am a **learner**. I approach new research and policy recommendations with an open mind and apply them to my daily practice.

I am a **parent**. I struggle with some of the same issues you do in my own home.

I am a **friend**. I listen to your frustrations and fears and celebrate your strengths and successes.

I am a **salesperson**. I sell children's health.

I am a **researcher**. I study new ideas and how they can benefit the health of our children.

I am a **travel agent**. I help families plan their journey and how they would like to experience it.

I am a **liaison**. I bridge the gap between primary care and public health.

I am a **lobbyist**. I work with policymakers to make sure the future of our children is at the top of their legislative priorities.

I am a **journalist**. I write articles for various publications to educate parents and other caregivers.

I am an **attorney**. I represent and advocate for innocent and eager young minds.

I am a **confidante**. I provide young adults with a safe environment where they can discuss their choices and behaviors.

I am a **mediator**. I help settle disputes among caregivers about parenting methods.

I am an **advocate**. Amidst family dysfunction, I stand up for the vulnerable youth.

I am a **pediatrician**.

Ruchi Kaushik wrote this while practicing at Mayo Clinic. She is now at Children's Hospital of San Antonio.



Pain, Opioids and Addiction LECTURE SERIES

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

Lectures:

VIDEO 1: "Opioid Addiction and Pain, A Quagmire for Healthcare Professionals"

Marvin D. Seppala, MD, Chief Medical Officer, Hazelden Betty Ford Foundation

VIDEO 2: "An Editorial on Pain"

Bret Haake, MD, MBA, HealthPartners Medical Group, Regions Hospital

VIDEO 3: "Pain Psychology, Mental Status Exam, and Non-Opioid Options for High Risk Patients"

Charles Reznikoff, MD, Division of Addiction Medicine, Hennepin County Medical Center, Assistant Professor of Medicine, University of Minnesota Medical School

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

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

VIDEO 4: "Pain Management in the Emergency Department"

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

CME Available: This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint providership of the Minnesota Medical Association and The Steve Rummeler Hope Foundation. The Minnesota Medical Association (MMA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The Minnesota Medical Association designates this enduring material for a maximum of 1 AMA PRA Category 1 Credit(s)[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For more information or to register:

mnmed.org/painseries



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