

MINNESOTA MEDICINE

FEBRUARY 2013



THE HUNT FOR NEW RECRUITS

Employers are working harder to get and keep primary care physicians.

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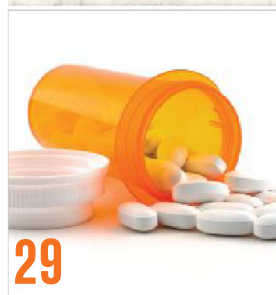
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PHOTO BY SCOTT WALKER

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

Primary care itself has had as many identities as I have since I began practicing in 1977, even though the idea is as old as the Rockwell painting of the family doctor.

Primary care's main draw

I have changed my specialty three times. When I finished my residency and joined a six-physician group with “consultants” in its name, I was an internist and my daily practice took me to two offices and multiple hospitals, where I not only took care of my own patients but also consulted on orthopedic, gynecological and family medicine cases, handling renal failure, ventilator management and even myocardial infarctions. Medical subspecialists existed at the time, but there were few of them even in my urban/suburban practice setting. When people asked me what kind of doctor I was, I usually said “general internist” and defined myself in terms of what I didn’t do: “I don’t take care of kids, I don’t do surgery, and I don’t deliver babies.”

Gradually, internal medicine residencies began cranking out subspecialists—pulmonologists who managed ventilators; nephrologists who did fluid, electrolytes and renal failure; and cardiologists who had started using catheters to treat those MIs I had been seeing. The name of our group, Consultants Internal Medicine (CIM), quickly became an anachronism. I continued to see patients both in the hospital and the office, but I saw only my own patients. When people asked me what kind of doctor I was, I said “primary care internist,” adopting the term, “primary care,” that had by then gained currency with the medical profession and by the general public.

Most recently, after CIM closed and I moved to a clinic in a large health care system, I stopped seeing my patients in the hospital and now restrict my activities to office practice. I still identify myself as a primary care internist, but my duties have further narrowed since my early days.

Primary care itself has had as many identities as I have since I began practicing

in 1977, even though the idea is as old as the Rockwell painting of the family doctor. Indeed, the general practitioner and his heir, the family physician, have for years epitomized the initial concept of primary care, taking care of patients and their families cradle to grave. But it soon became apparent that if primary care meant taking care of the everyday medical needs of patients, then internists, gynecologists and pediatricians also fit the title. Recent shortages of primary care doctors have encouraged the integration of nurse practitioners, physician assistants and even EMTs into primary care. In some settings, it is teams of providers who do the job of Rockwell’s doctor.

The shortages are the product of technological allure and economic forces. Subspecialists have all the gadgets, and using those gadgets pays better than listening to patients. For medical school graduates facing \$200,000 in educational debt, the choice of specialty sometimes boils down to simple financial arithmetic.

So what will lure future medical students into the ranks of primary care? Perhaps the advent of the team approach to medical care delivery will appeal to them. Perhaps the ability to deliver comprehensive care to a community will draw some. Perhaps the bonuses offered by large health care systems will tempt others. But the main draw now and always—the thing that keeps me at it and what is reiterated again and again in our article about why physicians choose primary care is relationships with patients. As one respondent said, “It’s all about the patients.” MM

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

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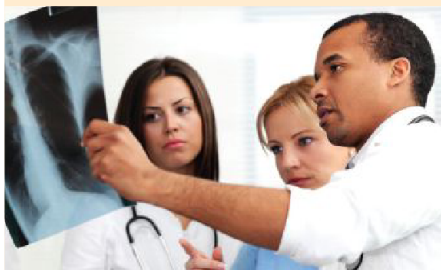
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Timely issue

I want to compliment you on the exceptionally informative, moving and timely issue of *Minnesota Medicine*. I read every article and learned things for my own practice, for medical education and curriculum, for understanding the Affordable Care Act, and about how a talented fourth-year student subtly unites the science and soul of medicine through the eyes.

Thank you.

Kathleen Watson, M.D.
Senior Associate Dean for Undergraduate Medical Education, University of Minnesota Medical School

Inspiring images

I can't believe you didn't credit the artist who did the striking cover and illustrations for the "Comfort of Home" piece. They got me to read the entire issue.

Mark DePaolis, M.D.
Minneapolis

We agree they're great. But we purchased them from a stock art company that doesn't provide the names of individual artists.



From good intentions to inflation, rationing, failure and turmoil

In Dr. David Thorson's Viewpoint column (December 2012, p. 29), he asked readers to respond to two questions: 1) What do you think of the results of the national survey of attitudes among some 14,000 physicians in which 84 percent thought the profession is in decline? And, 2) What do you think of our profession?

Regarding the survey: Many of my colleagues have felt the same way for some time. The same sense that the profession was in decline was noticeable during the first of two major transitions that have occurred in the nation's medical sector since the 1960s.

The first transition was the gradual change from a professional medical delivery system to a system dominated by commercial managed care organizations—HMOs—selling prepaid care disguised as insurance. In 1973, those organizations were given the perverse legal power to control use of the benefits they sold.

The trouble started in 1965 with the onset of abrupt medical cost-price inflation (for the first time in nearly 100 years) after passage of Medicare and Medicaid—a turning point when 85 percent of the populace (workers and the old, poor and disabled) suddenly had inexpensive tax-subsidized insurance. The good intention of legislating apparent “free” care paid for by insurance was suddenly followed by ever-lasting demand inflation. It is still considered political suicide to repeal a popular tax subsidy driving demand, thus “necessitating” rationing of supply.

It is no secret that HMOs were created as gatekeepers profit driven to ration use of politically popular tax-subsidized “free” care—the same function performed by socialized national health services abroad.

It is curious that after 1990, when the HMO industry gained control of a significant portion of the money in medicine, it was able to parlay its failure to control costs into unparalleled profits and market power through mergers and acquisitions and then into enormous political power in 2010 with enactment of a more powerful version of managed care: the Patient Protection and Affordable Care Act (PPACA). What is more curious is that the MMA and later the AMA became acolytes of both the first transition from a professional to a commercial system and of the second transition from a commercial to a cartel system.

The second transition was a more abrupt and massive change than the first. It began with the 2010 PPACA “fix” for the commercial HMO industry cost-control failure couched in the rhetoric of “rights” and “accountability.” The law mingles including corporate and government authorities into a public cartel system capable of fixing prices (of insurance and services) and franchising only provider gatekeepers in ACO insurance corporations.

“Customers” (businesses and people) are mandated by one cartel partner's legislation to buy the other partner's insurance. Government sovereignty shields the cartel from anti-trust, anti-self-referral, and anti-fee-splitting laws, which allows ACO mergers and collusion with HMO corporations to profitably ration care—the ultimate low utilization-driven profiteering big-box medical home. Some pundits predict that in the next decade, after many mergers and acquisitions, only four giant HMO/ACO-government backed “health services” will control the nation's medical sector.

To explain previous managed care gatekeeper failure and to sell implementation of PPACA “reforms,” government and corporate “payers” make three specious evidence-free claims: First that medical inflation is due to “poor quality” and profligate

care by culprit clinicians driven to ignoble avarice by an “evil” fee-for-service system. Second, that costs would be contained by transfer of the “payer” gatekeeping role to “culprit” providers by capitation payments for servicing “payer” populations (“payment reform”). Third, that physician gatekeepers could gain redemption, when their avarice is enlisted at the bedside in the more noble cause of conserving society’s “scarce resources”—and by no coincidence, “payer” treasure.

Thus is created a legalized financial conflict of interest between patient and gatekeeping doctor, whose pay is contingent on restricting care under the sophistry of “stewardship.”

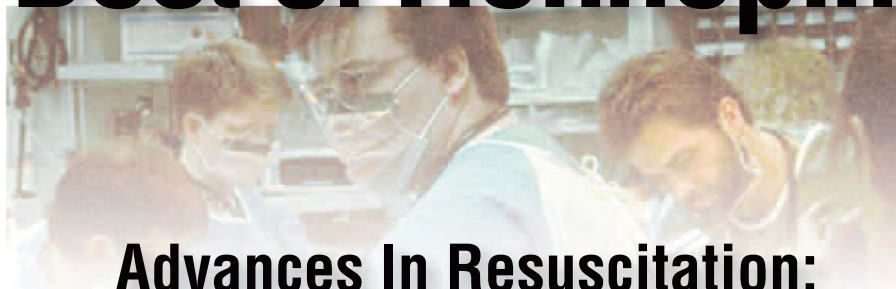
Regarding the profession: Is it any wonder that physicians are troubled amidst the turmoil? They run too fast trying to keep up with ballooning patient demand and medical knowledge. They have been demonized and assaulted by political hostility and blunt regulations. They are told that their moral path to salvation is to be “payer” gatekeepers of patient access—another rationing of supply scheme, this time at the bedside.

The pretext of a social good (cost control) is touted to justify questionable means (gatekeeping doctors). This is how professionals and professional medical organizations can lose their claim to patient and public loyalty, the very soul of medicine. It is a story of how patients can lose the protection of law and professionalism.

Amidst the turmoil this is what physicians’ sense has happened to our profession and those we serve. There are alternatives to authoritarian rationing panaceas for medicine’s cost ailment—alternatives that would return power to patients and foster affordable medical insurance. This is where the MMA ought to lead.

Robert W. Geist, M.D.
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Inner city insights

Medical students get immersed in the needs of the urban underserved.

BY NANCY CROTTI

Ben Pederson didn't follow the path that most of his classmates took during their third year of medical school. Rather than rotate from hospital to hospital in the Twin Cities doing clerkships, the University of Minnesota student spent nine months working with a group of family physicians and following a panel of patients at a clinic in North Minneapolis and working with specialists at North Memorial Medical Center in Robbinsdale.

Pederson, now a fourth-year medical student, was one of the first participants in the University of Minnesota's Metropolitan Physician Associate Program (MetroPAP), which places third-year students at the Broadway Family Medicine Clinic in North Minneapolis and North Memorial.

The three-year-old program is an offshoot of the university's Rural Physician Associate Program (RPAP), which for more than 40 years has dispatched third-year students outstate for nine months to cultivate their interest in rural practice. MetroPAP aims to help students appreciate the unique health challenges of the urban poor, according to director Kathleen Brooks, M.D.,

MetroPAP accepted two students in each of its first three years. Three will be accepted for the 2013-14 academic year. Brooks says because student demand has been high, the program has added a second clinic site, the Neighborhood HealthSource Clinic in northeast Minneapolis. Students will divide their time among the two clinics and the hospital.

Pederson and Anastasia Kolasa-Lenarz were the first MetroPAP participants. In addition to working in the hospital and clinic, each completed a mandatory project while in MetroPAP. Kolasa-Lenarz facilitated the opening of a satellite clinic at a homeless shelter for neighborhood youths. Pederson surveyed university faculty and residents about their impressions and understanding of medical homes. His poster presenting the data was displayed at the Society for Teachers of Family Medicine Conference in New Orleans in April 2011.

Both speak positively about their MetroPAP experience.

"Living in the community, walking to the clinic, knowing my neighbors—it was really the opportunity that I'd been looking for in medicine," says Pederson, who also found housing in the neighborhood. (Students in RPAP live in the community where they work. That's not necessarily the case with MetroPAP students.)

"I learned how very involved family medicine physicians and clinics can be in the communities in which they work and how involved they can be in the social determinants in health," Kolasa-Lenarz says.

Both say the MetroPAP experience has influenced their career path. Kolasa-Lenarz went on to earn a master's degree in public health before returning to medical school. She plans to become a family physician. Pederson spent a year in Kenya as a Fogarty International Clinical Research Scholar, leading a team that introduced a tuberculosis diagnostic device recommended by the World Health Organization into three rural areas. He plans to one day return to north Minneapolis to practice family medicine and says he would love to be a preceptor for MetroPAP.

"I so strongly believe in this type of educational programming," Pederson says. "It's really the direction we need to be going in how to train compassionate and reflective and very empowered medical students." ■■■

Nancy Crotti is a Twin Cities writer.



Ben Pederson

Anastasia Kolasa-Lenarz

an assistant professor of family medicine. Students are taught to provide culturally sensitive care; address barriers to health care such as lack of insurance and transportation; understand how the urban environment can affect individuals' health; identify resources for specialty care, home health, nutrition, rehabilitation and housing for patients; understand the underpinnings of health disparities; and advocate for patients and the community at the local and state levels.



The earnings gap

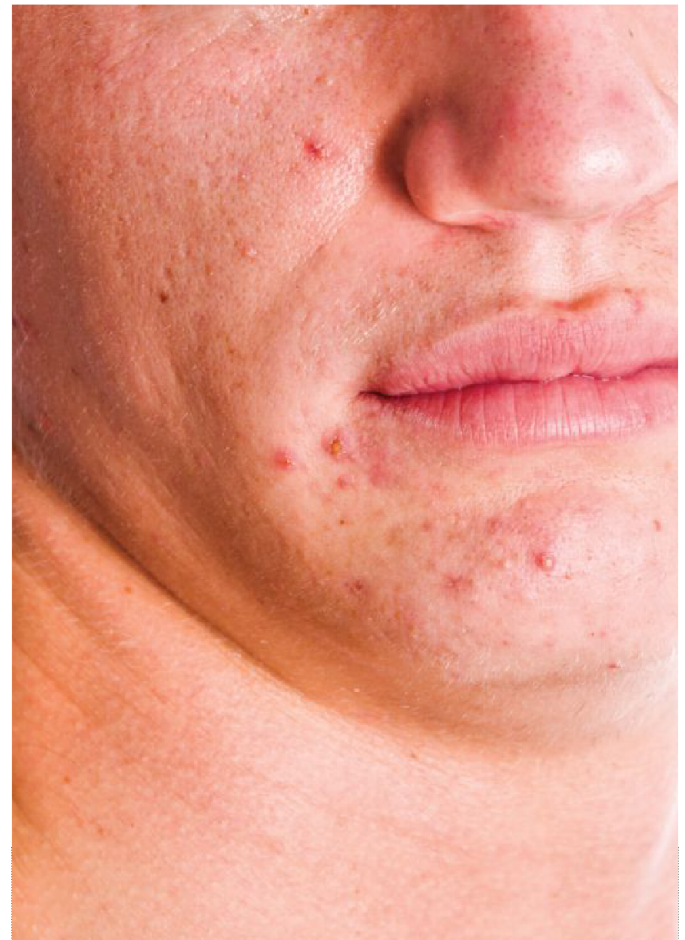
Primary care physicians earn between \$1 million and \$3 million less than other specialists over the course of their careers. That is the finding of investigators from the University of California, Davis, Center for Healthcare Policy and Research who evaluated incomes of more than 6,000 physicians in 41 specialties. Medical oncologists, for example, earned \$7,127,543 over a 35-year career, whereas family physicians earned an average of \$2,838,637.

When they divided specialties into four broad categories, they found lifetime earnings for physicians in

- surgical specialties were \$1,587,722 higher, on average, than for those in primary care
- internal medicine and pediatric subspecialties, \$1,099,655 higher
- all other specialties, \$761,402 higher.

The authors say that one reason for the lower primary care earnings was recommendations from the American Medical Association's committee on physician pay that priced specialty procedures higher than primary care office visits. Both Medicare and commercial insurers utilize those recommendations.

Source: *Medical Care*. December 2012;50(12):1093-101.



Why go to the doctor?

Skin issues are the No. 1 reason people visit their doctor, according to a recent report in *Mayo Clinic Proceedings*.

A team led by Mayo researcher Jennifer St. Stauer, Ph.D, M.P.H., analyzed the medical records of 142,377 Olmsted County residents who visited Mayo Clinic, Olmsted Medical Center and other health care providers in the county between January 1, 2005, and December 31, 2009. They found the five most common reasons for medical visits were:

- Skin disorders such as acne, cysts and dermatitis (42.7%)
- Osteoarthritis and other joint disorders (33.6%)
- Back problems (23.9%)
- Cholesterol issues (22.4%)
- Upper respiratory illnesses (22.1%).

Others in the top 10 were anxiety, depression and bipolar disorder; chronic neurologic disorders; high blood pressure; headaches/migraines; and diabetes.

The authors noted that they were surprised the most common reasons for doctor visits weren't chronic conditions related to aging but instead were concerns that affect both men and women of all ages.

Source: *Mayo Clinic Proceedings*. January 2013;88(1):56-67.



Keeping EMERGENCIES at bay

Community paramedics meet unmet needs.

BY JEANNE METTNER

At a recent check-up with his primary care physician, an elderly patient—we'll call him Jack—presented with weight loss, dizziness and loss of appetite. His medical history revealed a perfect storm for adverse health outcomes: He lives alone, and his only child (now middle aged) is attentive and compassionate but lives out of state. He has no connection to the community, no other family or social support nearby. He has high blood pressure, congestive heart failure and memory issues, and he is taking long-term anticoagulation medications.

Jack is the kind of patient who has fallen through the cracks in the health care system. He doesn't qualify for home care but is unable to manage his own health well. As a result, he is at high risk for hospitalization or ER visits. He's also the kind of patient who might be well-served by a community paramedic.

In 2011, Gov. Mark Dayton signed into law the Community Paramedics Bill, creating this new category of health care worker as one way to address health needs, particularly in underserved parts of the state. Minnesota is the only state in the country that has passed a law creating this new classification.

Physicians' eyes and ears

In this new role as community paramedics, specially trained paramedics may provide health screenings, mental health assistance, wound care, wellness care, immunizations, disease management, and medication compliance and reconciliation. Most will visit patients in their homes, although some will work out of mobile clinics. "I see the community paramedic as a provider who, under a physician's medical license, can be the eyes, ears and even hands of the physician in the home setting," says Michael Wilcox, M.D., medical director of the community paramedic program at Hennepin Technical College (HTC) and associate medical director for North Memorial Medical Center's ambulance service.



Barb Andrews, who received her community paramedic certification in August, coordinates North Memorial's program.

PHOTOS BY STEVE WERKA

Currently, HTC has the only community paramedic certification training program in the United States. To be accepted into the program, candidates must have worked as a paramedic full time for two years or more and have a letter of approval from the medical director of the ambulance service for which they work and under whose license they will likely practice. They must complete 112 hours of didactic and 196 hours of clinical training, which includes community assessment work, coursework in chronic disease management and pharmacology, refreshers in pathophysiology, and clinical rotations in primary care clinics, hospice facilities and at Children's Hospitals and Clinics of Minnesota. As of January, Minnesota had 24 certified community paramedics; nearly 80 more are likely to receive certification this year.

A different mindset

One of the challenges for community paramedics is changing the mindset of professionals trained to react in emergency situations. When they visit a patient, they are no longer wearing their ambulance services hat, says Kai Hjerstad, a certified community paramedic who serves as HTC's training director. "EMTs and paramedics are credited for being reactive within an emergency setting, but as community paramedics—even if we are only doing it very part time, as most of us are—you have to slow

down, get to know your patient, and make a well-thought out plan for him or her,” he says. “It’s totally different from what we are used to, where a call comes in and we race out to the truck and we go off with our lights and siren.”

Barb Andrews, a veteran paramedic and ER nurse, received her community paramedic certification last August and now coordinates the community paramedic program at North Memorial, the first organization in Minnesota to implement such a program. She and eight other community paramedics each spend about one day a week visiting patients who are referred through North Memorial’s primary care clinics. The majority of patients are those who do not qualify for home care or other services.

One of the first patients Andrews and her team saw was Jack. “We started by going to his home, organizing his medications, figuring out what he was taking and not taking, and how it was affecting his health,” she says. They found Jack’s INR to be abnormal and that he was taking twice the amount of Lasix and blood pressure medication prescribed by his doctor, even though his doctor had temporarily discontinued those drugs because he was dizzy and losing weight (Jack had forgotten his doctor’s instructions).

Andrews and her team came up with ideas for improving the situation. They put Post-it notes on bottles of medication Jack was not supposed to be taking and moved them to the top shelf of his kitchen cabinet, away from his other meds, and they started doing blood draws for his INR checks because he was missing his clinic appointments. With respect to his weight loss, they learned that Jack didn’t like to cook and often didn’t remember to eat. “These were just a few things that helped us come up with a plan,” Andrews says.

An evolving role

Although the concept of the community paramedic is new in this country, it is not elsewhere. In Canada, Australia and New Zealand, for example, emergency services personnel help treat patients with nonemergent conditions in order to prevent them from developing complications. When the idea of the community paramedic began percolating in Minnesota, it was to help keep ambulance services afloat in rural areas, allowing paramedics to stay busy during their downtime between runs. Then proponents started seeing it as a way to alleviate some aspects of the shortage of primary care providers in certain parts of the state.

“We realized we had a large need in the metro area, too,” says Buck McAlpin, director of government affairs for North Memorial. North Memorial got its program up and running in October 2012. It currently serves Minneapolis and western Hennepin County. “We needed to set the program up in a larger care system to understand how to run it with billing, integrate with EPIC (the electronic medical record system at North Memorial and many other area health systems), set up care delivery models and get used to working within a larger medical home framework,” he says, adding that they plan to add services.

Currently, North pays its community paramedics; others are paid through their county health departments or they volunteer their services. A 2012 law established a payment methodology for community paramedicine. McAlpin says once the federal government provides the state with matching dollars for these services, Medical Assistance will start paying for them.

In the meantime, the community paramedic idea continues to gain traction. The Minnesota Department of Employment and Economic Development awarded HTC, North Memorial, Allina and HealthEast a \$250,000 Job Skills Partnership grant to train 100 community paramedics over the next three years. The Minnesota Department of Health’s Office of Rural Health and Primary Care has provided funding to train the six paramedics in Park Rapids, where North Memorial has an ambulance service. Other paramedics from Hibbing, Cambridge, and Maplewood, as well as North Dakota, Idaho, Maine, Florida, California, Missouri, and New Jersey are signing on as well (many participate in classes remotely).

From Andrews’ perspective, community paramedicine is poised for success. Jack, the elderly patient receiving care through North Memorial’s program, is now receiving Meals on Wheels and gaining weight, is more compliant with his medication regimen, and is receiving other services from VA. “I have been in emergency care of one variety or another for 20 years, and throughout the past two decades, I’ve always felt like I was putting a Band-Aid on the patient’s issues,” she says. “With this program, I truly feel like we are making a difference.” MM

Jeanne Mettner is a Minneapolis writer.

Community paramedics take services to patients in their homes in much the same way as public health nurses do.



PRIMAR

Why one got in

Nephrologist Becky Dahlberg, M.D., decided primary care is where she'd rather be.

BY SUZY FRISCH

After finishing up her residency and fellowship in nephrology in 2010, Becky Dahlberg, M.D., was finally ready to put her years of training to work helping patients with kidney-related disorders. She and her husband, an allergist, moved that June from Madison, Wisconsin, to Pennsylvania to launch their careers. There, she began working in a small private practice.

But it wasn't long before Dahlberg realized nephrology wasn't a good fit. Although she had concerns during her fellowship, she kept hearing that her feelings would change once she got into practice. They didn't. "I found I wasn't terribly happy with the types of patients I was taking care of," she says. She knew that about 50 percent of dialysis patients die in about five years. "At times I was questioning, 'Why am I doing this? Why are we doing dialysis on an 84-year-old with pneumonia or a lady with multiple amputations who lives in a nursing home and has dementia? Why are we providing her with this life-saving modality?'"

In addition, the stress of working with chronically and terminally ill people—and often having to rush to the hospital in the middle of the night to deal with a crisis—made her truly dislike her job. She started questioning her decision to go into nephrology and even considered quitting medicine altogether.

Instead, she thought about what she liked best about being a physician and realized it was helping patients avoid becoming ill in the first place. So Dahlberg decided to move into primary care, which she had enjoyed during the early years of her internal medicine residency. She also welcomed the opportunity for a more stable and consistent work life.

Just how rare it is for a subspecialist to make the switch back to general medicine is not known. But it's clear that Dahlberg was bucking an overall trend in internal medicine. According to the American College of Physicians, only about 20 to 25 percent of internal medicine residents eventually practice general internal medicine now compared with 54 percent in 1998.



PHOTOS BY KATHRYN FORS

Y C A R E

and one got out

Cory Ingram, M.D., left family medicine for palliative medicine.

BY CARMEN PEOTA

For years before he went to medical school, Cory Ingram knew he wanted to be the kind of physician he'd seen growing up in Iowa. He'd take care of people of all ages, whatever their problems, and he'd come to know his patients as individuals. So after medical school and an internship in the Netherlands, he traveled to the University of Nebraska to do a residency in family medicine. He especially liked that program's focus on rural practice.

Ingram spent most of his residency working in a community health center frequented primarily by young families. When he completed the program, he was concerned that he really didn't know much about taking care of older patients. So he decided to do a fellowship in geriatrics at Maine Dartmouth. By the time he took a job at Mayo Clinic Health System in Mankato in 2006, he thought he was finally well-equipped to deal with any patient who walked through his door.

For three years, his family medicine practice went smoothly—with his geriatrics expertise, he saw a fair number of older patients with dementia—and his practice grew. That trajectory might have continued had he not been approached by a middle-aged woman with stage 4 ovarian cancer who asked if he would care for her until she died. She didn't want him to treat her cancer; other doctors were doing that. She wanted support through the final stage of her life.

Ingram agreed, not knowing what to expect, and did his best to help the woman control her pain and manage her symptoms. He tried to answer the hard questions she asked and provide supportive counsel. But after the woman died and he reflected on the experience, he concluded his attempts had been inadequate. "I thought we could do better."

Surprising discovery

As Ingram thought further about what caring for her had required of him—extra visits squeezed in at lunchtime or calls made late at night—he realized that not only did he not know as much as he should about caring for a dying patient, but also his family



PHOTO COURTESY OF MAYO CLINIC

Becky Dahlberg

(continued from page 12)

Specialty start

Dahlberg, a native of Mission, Kansas, attended the University of Kansas for undergraduate and medical school. She completed her residency and fellowship at the University of Wisconsin–Madison, gravitating toward nephrology because she

enjoyed the physiology and being able to base decisions on objective markers such as creatinine or protein levels.

But while practicing in Pennsylvania, Dahlberg was one of three doctors who every third week would round in the hospital from 7 a.m. to 2 or 3 p.m. seven days in a row, often returning for consults later in the day and evening. She spent most of the week on call, too. Other weeks she would be in the clinic all day or handle rounding with the dialysis patients. Over time, caring for a large population of chronically or terminally ill people took its toll. She felt worn down, constantly

Dahlberg couldn't be happier with her shift to primary care. "I can focus more on taking care of people before they have end-stage disease, and I have found that very rewarding," she says.

That's not to say the transition from nephrology was seamless. It took about four months for Dahlberg to fully reconnect with the knowledge she gained during the early years of her internal medicine residency. During that time, she did copious amounts of reading and attended a medical conference on current issues.

Although she was taking an unusual step, most physicians she spoke to were supportive of her move back to primary care, and she had little trouble finding a



Dahlberg now spends four-and-a-half days a week in the clinic and answers call questions over the phone.

“I can focus more on taking care of people before they have end-stage disease, and I have found that very rewarding.” – Becky Dahlberg

on edge waiting for that next emergency call in the middle of the night. Never being able to make plans or having to change them at a moment's notice started chipping away at Dahlberg's zest for medicine.

Other physicians sympathized. Several even told her that they wouldn't want her job, either. Although she had never met another specialist who moved from a focused practice to general medicine, Dahlberg was willing to give it a shot.

Making the change

When she and her husband, Paul, decided to relocate to the Twin Cities in October 2011, Dahlberg decided to make a career switch to internal medicine. After taking a few months off and

interviewing at three clinics, she started working in November at the Allina Medical Clinic–Woodlake in Richfield, where she sees patients who are 18 and older.

new job in the Twin Cities. "Other than one provider at our clinic who seriously questioned my desire to go back to primary care, everyone was pretty eager," adds Dahlberg. "I think docs like to have someone around to ask specialist questions of."

Now Dahlberg, the mother of an infant son, works four-and-a-half days a week, doesn't go the hospital at all, and answers call questions over the phone as needed. She enjoys the regular hours and not having to wonder whether she will get called in the middle of the night to set up dialysis.

She says she has had to make some adjustments to the way she practices. For example, she's had to relearn how to step back and look at the big picture rather than home in on kidney problems. And she has needed to get used to answering questions about all kinds of issues instead of only renal-related ones. To that end, she has shifted away from basing conversations with patients on information in their charts and instead takes a more flexible and relaxed approach to discussing their concerns and answering their questions.

"It's different. The pay is less, and there's not the glamour of being able to swoop in

and save the day when someone is having a crisis,” Dahlberg says. “But now my well-being is significantly improved by not always having to carry a pager every three weeks and thinking that when it goes off I’ll have to go to the hospital. To me, that was hard.”

Dahlberg doesn’t regret her time in nephrology. In fact she uses much of her training in her current practice. If someone has high levels of creatinine, kidney stones or hypertension, she can counsel them about what to do and what to expect, then direct them more quickly to a urologist or nephrologist. “I think my training and brief stint as a nephrologist makes me a better primary care doctor,” she says. “I can see people who have kidney disease and do some of the same work-ups I did before.”

But when the crisis hits, it’s in the specialists’ hands. And she’s just fine with that. **MM**

Suzy Frisch is a freelance writer from Apple Valley.

Cory Ingram

(continued from page 13)

medicine practice didn’t allow a him to properly care for such a seriously ill person. “As I thought about it, I asked, ‘Don’t people who have serious illness deserve a more dedicated approach than just relying on the exceptional efforts of somebody? Shouldn’t it just be regular medical care that does that? Why do people [physicians] have to do that in the middle of the night or on their lunch breaks or whatever? Shouldn’t we just have models of care dedicated to caring for seriously ill people?’”

The experience prompted Ingram to once again head back East, this time to do a fellowship in hospice and palliative care medicine at Dartmouth-Hitchcock. As he worked alongside experienced palliative care physicians, he began to see that

they had skills and knowledge he lacked, even after all his training. He appreciated their explicit lessons about such things as prescribing medications for pain and talking about difficult subjects, recalling how attention to symptom management and communication with the patient often had been treated as secondary concerns in his previous training. “It was a very professional approach to caring well for seriously ill people,” he says.

When he returned to Mankato, it was to practice palliative medicine. Today, he sees patients in the clinic at the Andreas Cancer Center and in the Mankato hospital.

Knowledge deficits and systems problems

Over the years, Ingram has continued to develop his ideas about what’s needed in order for physicians to be able to care for truly sick patients. And he’s distilled them into three main concepts: 1) Doctors need special skills to properly treat them; 2) they need to be able to devote their attention to those patients rather than “fit them in” with other daily demands; and 3) they need the time to do this, as discussions about death or dealing with agonizing pain can’t be done in a 10-minute visit.

He says the health care system doesn’t allow the average primary care physician to do this well. And he thinks family physicians, in particular, are hamstrung not only by the system but also by their specialty. “In 1969, when family medicine was conceived in the United States, it was designed to take care of everybody—cradle to grave. Then the time from serious illness to dying was short. But serious illness has changed,” he says, adding that family medicine training and practice have not.

He points out that family physicians are taught to do procedures such as endoscopies or C-sections but aren’t trained to see their patients through their toughest days. “For the 94 percent who don’t practice in really rural areas, who needs those skills?”

he says, of the surgical ones. He believes it would make more sense to train family physicians to not only care for relatively health people but also for those who are seriously ill and dying.

As an assistant professor at Mayo Clinic College of Medicine, he’s doing just that. He’s training Mayo medical students in palliative care, and this year, residents from the University of Minnesota’s family medicine residency program in Mankato will start doing a palliative medicine rotation with him and his team. In addition, practicing physicians from places as far away as South Korea are coming to learn as well. And Ingram has gotten his ideas before larger audiences as well. He won a speaking spot at Mayo’s 2012 Transform Conference, a multidisciplinary conference highlighting new ideas in a variety of fields. Ingram has also launched a communitywide effort called the Personal Caring Initiative to engage business leaders, the faith community and educators as well as other sectors of health care in the region in improving life for people with very serious illnesses.

“As I thought about it, I asked, ‘Don’t people who have serious illness deserve a more dedicated approach than just relying on the exceptional efforts of somebody?’”

— Cory Ingram

Ingram wants all physicians to understand that caring for the very sick requires having enough time and the specialized skills to do the work well. He thinks his ideas resonate with family physicians. “They might say, ‘My patient’s got a serious illness, and I haven’t seen them for two years because they’re in the oncology center.’” They want things to be different, he says. “Family physicians are hungry for this.” **MM**

Carmen Peota is managing editor of *Minnesota Medicine*.



The graduate glut

Why it's getting harder for international medical school graduates willing to take primary care jobs to get into residency.

BY KIM KISER

Dr. Mahamud Jimale was working as a general and thoracic surgeon and teaching at Somali National University's medical school in Mogadishu when civil war tore his country apart in 1991. After spending four years at a refugee camp in Kenya, where he worked alongside physicians from Doctors without Borders and other volunteer organizations caring for his countrymen, Jimale and his family made their way to the United States in 1996.

They eventually settled in Rochester, where Jimale found work in the general clinical research center and later as a medical and cultural consultant at Mayo Clinic. Hoping to one day practice medicine again, he also began studying for the USMLE exam.

Along the way, Jimale learned of a program offered by the University of Min-

nesota department of family medicine and community health to help immigrant and refugee physicians prepare for residency in the United States—something they need to do to practice medicine here. The Preparation for Residency Program (PRP) taught them about the American health care system, the culture of medicine in the United States, the types of conditions and patients they might care for, ethical issues that arise in practice, concepts such as team-based care and how to use electronic medical records. The goal of the program was to help these physicians get into residency so that one day they might provide primary care in underserved communities in the state. “We helped refugee

doctors earn a ticket to the tryouts,” says Will Nicholson, M.D., a hospitalist at St. John's Hospital and assistant professor of family medicine and community health at the University of Minnesota who directed the PRP.

After passing the licensing exam, Jimale applied to the seven-month-long program in 2011 with the idea of getting into a

family medicine residency program. “The first group of physicians [to go through the program] were all Somalis, and the good thing was they all managed to get into residency,” he says. Today, Jimale is applying to programs including those at the University of Minnesota, the University of Wisconsin and the University of Iowa. He



Dr. Mahamud Jimale

will find out in March whether he matches with one of them.

Getting into residency in this country has always been more of a challenge for graduates of foreign medical programs than for those of U.S. programs. Now it may be even tougher. For one thing, residency program directors are relying more on their applicants' performance on standardized tests than they used to.

"The hard reality," says John Andrews, M.D., associate dean for graduate medical education at the University of Minnesota, "is that many people who've trained elsewhere don't meet certain objective standards of performance on standardized tests, so they never get their application fully reviewed." In addition, growing enrollment in medical schools, a federal cap on residency slots and changes to the residency matching process are converging to create a bottleneck in the physician production process.

All this is occurring at a time when the need for primary care physicians has never been greater. (A recent report in the *Annals of Family Medicine* estimates the United States will face a shortfall of 52,000 primary care physicians by 2025.)

The residency bottleneck

In 2006, the Association of American Medical Colleges (AAMC) called for a 30 percent increase in first-year medical school enrollment between 2002 and 2015—from 16,488 to 21,434—in order to prepare for a projected physician shortage. As of 2011, enrollment stood at 19,230—a 16.6 percent increase over 2002. Most of the growth (2,175 positions) has occurred at the 125 schools that were accredited as of 2002. The rest (567 slots) came from 12 new schools that have since become accredited (seven more have applied for accreditation). The size of the first-year class at the University of Minnesota Medical School's Twin Cities campus has remained fairly steady—166 in 2002 and 170 in 2012; enrollment on the Duluth campus increased from 53 in 2002 to 60 today. Mayo Medical School has increased the size of its first-year class from 42 in 2006 to 50.

At the same time, the federal government, which funds a significant portion of residency training through the Medicare program, has held the number of residency slots steady at approximately 115,000, according to a 2012 *Health Affairs* policy brief. "The number of residency positions was capped by the federal government at the 1996 level and hasn't changed," Andrews says. "We should be concerned that we might be graduating more medi-

Getting into residency in this country has always been more of a challenge for graduates of foreign medical programs than for those of U.S. programs.



Now it may be even tougher.

cal students than there are residency slots available. There are still more residency slots than U.S. graduates to fill them, but the gap has narrowed considerably. There will come a time when we have the fewer slots than we do graduates."

The AAMC is supporting legislation introduced last year that calls for 3,000 new Medicare-supported residency positions a year between 2013 and 2017 and that half of those positions be for primary care or other specialties in which there are shortages.

But numbers don't tell the whole story.

Changes to the National Residency Matching Program (NRMP) have also made it more difficult for graduates of foreign medical schools to get into residency. Last year, the NRMP eliminated the "scramble," a process used to fill slots that went unfilled during the Match (physicians who went through the Match as well as those who did not could participate in the scramble). "It was chaotic," Andrews says. "Your phone rang off the hook, your fax machine ran like a ticker tape, and your email box would soon exceed its quota as a crush of people tried to secure a spot." The NRMP replaced the scramble with the Supplemental Offer and Acceptance Program, which attempts to fill unmatched positions only with those people who participated in the Match.

This year, the NRMP is instituting what it calls the "all in" policy for the first time. Under this policy, all first-year residency positions must be offered through the Match. Previously, residency program directors could offer positions to promising international graduates outside the Match. "Graduates of allopathic medical schools in the U.S. had to use the Match to apply

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The distribution problem

In addition to their concerns about the number of available residency training slots, graduate medical educators are concerned about the distribution of those positions. Because of the way Medicare funds graduate medical education, most residency programs are based at teaching hospitals, and most of those are in metropolitan areas. A *Health Affairs* brief notes that most residents go on to practice where they do their residency. "The system's ability to create incentives to pursue GME in primary care disciplines and influence where [physicians] choose to go to work after finishing residency is really important," says John Andrews, M.D., associate dean for graduate medical education at the University of Minnesota. "We need to train people to work in primary care settings, rural areas and underserved inner-city areas." —K.K.

THE HUNT FOR





NEW RECRUITS

Employers are working harder to get and keep primary care physicians.

Exremely challenging. That's how Jodi Lorenson, a physician recruiter, describes the task of finding primary care physicians to staff Duluth-based Essentia Health's network of 68 clinics and 18 hospitals spread across northern Minnesota, Wisconsin, North Dakota and Idaho. In early December, Essentia had about 100 openings for physicians; 24 of those were in family medicine. "The need for family medicine is growing, but the pool of candidates is shrinking," Lorenson says.

The shortage of primary care physicians is just the most acute part of an overall physician shortage. The Association of American Medical Colleges estimates the nation faces a deficit of 90,000 doctors over the next decade. For several years, however, primary care physicians have been at the top of recruiters' wish

lists, according to the Association of Staff Physician Recruiters' (ASPR) annual benchmarking report. Each year, the ASPR surveys about 150 recruiters working in-house for hospitals, health systems and large medical groups. The 2012 report identified family physicians and internal medicine physicians as two of the top five health professionals most in-demand. Rounding out the list were hospitalists, nurse practitioners and physician assistants.

Organizations are also finding it's taking longer to fill those primary care positions and that more jobs are going unfilled at year's end. The median days-to-fill for primary care physician jobs (family medicine, geriatrics, general internal medicine, urgent care and pediatrics) was 151 days in 2011 compared with 125 days the previous year.

Demand for primary care physicians is likely to continue to grow as the population ages and requires more medical care

and as more Americans join the ranks of the insured as a result of health care reform. More primary care physicians are reaching retirement age, as well, and fewer medical students are choosing primary care fields, which traditionally have had lower pay and greater administrative responsibilities than other specialties.

Consequently, health care organizations across the country are spending more time and more money recruiting from a shrinking pool of qualified applicants, with some organizations now recruiting candidates as early as their first year of medical school.

The challenge is greatest in rural areas. Rural communities can't offer many of the lifestyle amenities found in major cities; and practices in those communities have fewer staff members to help physicians with administrative tasks. Clinics in smaller cities and rural areas not covered by the National Health Service Corps Loan Repayment Program are at the biggest disadvantage, says Lynne Peterson, who

**BY
TROUT LOWEN**

SOME ORGANIZATIONS ARE NOW RECRUITING CANDIDATES AS EARLY AS THEIR FIRST YEAR OF MEDICAL SCHOOL.



has worked as a physician recruiter for Fairview Health Services for more than two decades. The program allows primary care physicians to receive \$60,000 or more in loan repayment for committing to work full-time in areas designated as “medically underserved” by the federal government. These areas have few primary care providers, a high infant mortality rate, a high rate of poverty and/or a large elderly population. Fairview clinics in Princeton and Milaca, both about an hour outside of the Twin Cities, are not in areas designated as medically underserved, Peterson says, while the clinic in Onamia, just a 20-minute drive farther north, is in an area considered underserved. Vacancies in Princeton and Milaca take longer to fill.

“You have to utilize different types of resources and you may have to spend more

money than you would have to for a clinic in the metro area,” Peterson says. “You have to market a little bit differently, too. You really try to market to people’s interests and values.” Fairview touts the benefits of rural and smaller communities not just to physicians but also to their families, she says.

Loan repayment, stipends and signing bonuses

Loan repayment is at the top of most residents’ wish lists, recruiters say. The average medical school graduate leaves carrying a debt burden of \$160,000 to \$200,000 and faces monthly payments of \$1,500 to \$2,000 after residency, according to a report by the American Medical Association. Depending on location, loan repayment incentives can range from \$10,000 to \$20,000 per year, Peterson says.

Increasingly, organizations are also paying stipends to candidates who are willing to make a commitment during their residency years. The stipends, which range from \$1,000 to \$2,000 per month and can be used for living expenses and loan repay-

ment, are sometimes given in lieu of signing bonuses, Peterson says.

“There’s a lot of incentive to commit to practice early,” she adds. “That’s because people want to know who they have in the bank. And in some of those communities, it just takes that long to recruit anyway, so they’re often going [earlier] into residency.”

Fairview, Essentia and other organizations are beginning to target students during medical school, even as early as their first year in the case of those with connections to a specific community.

“If we know they have ties to the area, we’ll keep in touch with them,” Lorensen says. “If they’ve had really good exposure to us and we’ve been able to evaluate them in medical school, say through RPAP [the Rural Physician Associate Program], we will consider signing somebody after they finish medical school.”

Debt relief, residency stipends and signing bonuses are only part of the typical recruitment package, however. Even more than other specialties, primary care physicians are being lured by things such as flexible hours and team-style practices that contribute to work-life balance, recruiters say.

Fairview and other organizations have reduced the administrative burdens on primary care physicians by increasing the number of nurse practitioners and physician assistants on their care teams to allow physicians to cut down on tasks that are not directly related to patient care. That’s also the case in organizations such as HealthPartners that have less trouble recruiting primary care doctors because their clinics are in the metro area. “We have tried to focus on what is the role of the physician and what is the role of the extended care team,” says Beth Averbek, M.D., associate medical director of primary care for HealthPartners. “Certainly

physicians are capable of filling out forms, but other people are capable of filling out a lot of the information,” she says. “Just because a physician could doesn’t mean they should.”

Many organizations also are restructuring positions to make them more desirable, recruiters say. Essentia offers new physicians the opportunity to participate in a float pool, which allows them to live in Duluth and commute to more rural locations. Fairview offers flexible scheduling.

Salary and benefits have become so competitive from organization to organization, Lorenson adds, that it’s the intangibles that often make the difference. “Truly, I believe the No. 1 thing that makes someone say ‘yes’ is the partners they’re going to be working with,” she says. “Physicians really want to work somewhere they can click with the people they are working with.” They also want to work for an organization that shares their values.

Recruiters say those intangibles also affect retention. More physicians now work for health care organizations as opposed to independent practices. That means physicians who want to change jobs have more opportunities, and there is less financial risk in doing so. “I think there’s a lot of enticement with signing bonuses and so forth that people could go from organization to organization and quickly capture a patient base because there’s such high demand. In the past, they would have had to start from scratch,” Peterson says.

Opportunities for growth also give physicians a reason to stay with an organization. At Essentia, physicians are offered the opportunity to take on a leadership role by chairing a committee, leading a quality improvement initiative, or becoming a medical director, depart-

ment chair or section chief. “At every level of the organization there is a physician partner along with an administrative partner, and no decision is made exclusively by an administrator or a physician,” Lorenson says. “So physicians in our organization feel heard and valued.”

Pipeline trickle

Despite rising salaries, richer benefits and a higher profile, a significant number of medical school graduates, even those in internal medicine residency programs, continue to favor other specialties over primary care, says Colin West, M.D., Ph.D., an associate professor of medicine and biostatistics at Mayo Clinic.

As part of his work on physician well-being, West surveyed more than 50,000 internal medicine residents about their career plans. The results were published in the *Journal of the American Medical Association* in early December. He found only about one in five graduating residents plan to pursue a career in primary care. Two-thirds plan on going into subspecialties such as cardiology or gastroenterology.

“We knew from previous work that there was a fair bit of ebb and flow in career plans,” West says, “but what we saw was that even for the relatively uncommon resident who started out with a general medicine career plan, there was a strong likelihood that they were going to switch out of that plan by the time they were getting ready to graduate.”

That scenario was even more likely for international medical graduates, the study

found. Because the barriers are so high for international candidates just to get into residency, many of them may be willing to accept an invitation to any residency training program just to get a foot in the door. “Many of these residents may not ever actually have the intent or resolve to pursue primary care,” he says.

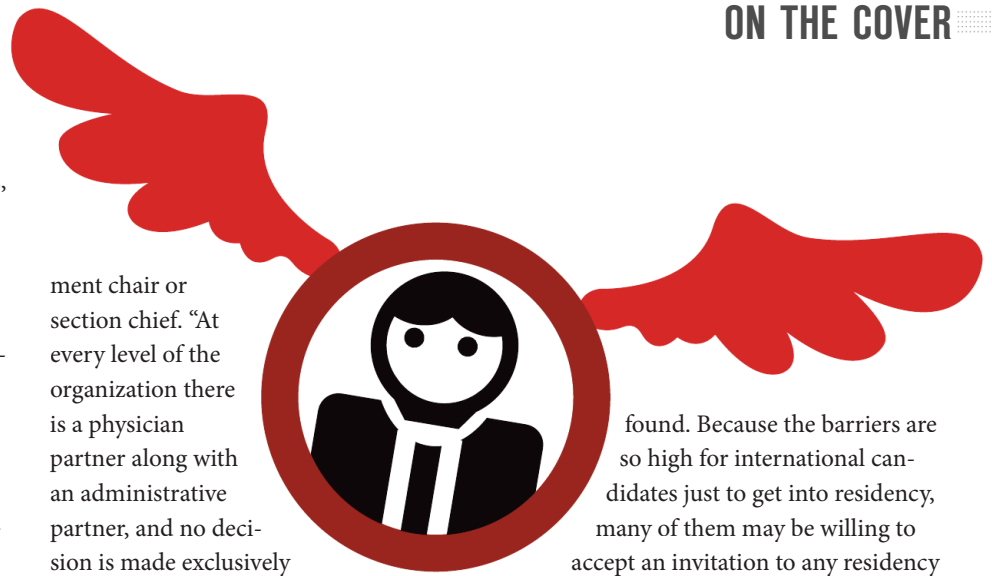
Fixing the system

West says creating more primary care training programs or residency slots, as some people have suggested, will do little to make primary care a more attractive career option. Rather, the current compensation system for physicians needs to move away from the “pay for procedures” model. Primary care physicians spend much of their time counseling patients, managing their health conditions and adjusting their medications—duties that aren’t well-compensated under the current reimbursement system.

Although health care reform with its emphasis on health care homes and accountable care is pushing changes to the clinical environment, West is skeptical that it will make primary care more attractive to future doctors unless those changes are accompanied by changes in compensation.

“I think the solutions are going to be more complicated,” West says. “We’ve got to fix the environment ... to make the practice of general medicine something that people are called to and feel respected for pursuing.” MM

Trout Lowen is a Minneapolis writer.



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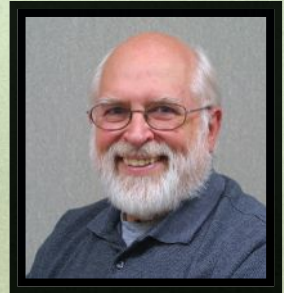


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PRIMARY CARE

Why they love it



Why did you choose primary care? We posed that question to physicians and medical students a few weeks ago. What is it, we wondered, that drew them to generalize rather than specialize? To opt for the office over the hospital? To deal with the whole spectrum of disease rather than a narrow slice?

Given the lower compensation for those who practice pediatrics, geriatrics or general internal or family medicine as compared with doctors in other specialties, we figured their answers were not going to be about money. And given that primary care physicians shoulder so much of the administrative burden of our ultra-complicated health care system, we also figured that they wouldn't say they liked that part of their jobs. We were right about those things. We weren't surprised to learn either that in many cases, a particular physician-mentor inspired someone to choose primary care. Nor were we surprised that many chose their specialty because of their desire to build long-term relationships with patients.

But we didn't expect to find so many to be so enthusiastic about their choice. Looking back on his career, Erick Reeber, M.D., wrote, "Family practice was the best job I could imagine." Looking forward to her career, Erin Morcomb stated, "I can't see myself doing anything else. I also love pediatrics, psychiatry, obstetrics, emergency medicine and geriatrics, and primary care affords me a way to combine all of these passions."

We also were surprised at how many found their work so intellectually challenging. As Mary Wagner, M.D., put it, "I'm a detective who gets to listen for the story, paying attention to what's said, what's implied, what I remember and what's in the chart to come up with a hypothesis and work on a solution."

In this day, when we hear so much about the systemic dysfunction in health care, it's good to be reminded that there are individuals out there who simply love what they do. We found their answers inspiring. We think you will, too. Here's what they had to say.





ERIN MORCOMB

Growing up in a small rural community, primary care physicians were all that I had contact with as a young girl. As a result, the field held a natural attraction for me. Participating in the Rural Physician Associate Program (RPAP) during my third year of



medical school solidified my interest in primary care, as I had several superb and supportive mentors during my time in Winona.

I really enjoy listening to patients' stories and forming long-term relationships with them. Sometimes the best medicine isn't any medicine at all; it is simply being there, showing your support and carefully listening to those in need,

which I feel is a strength of the primary care fields.

I think family medicine will be rewarding because I love interacting with people; it's what motivates and inspires me, and I can't see myself doing anything else. I also love pediatrics, psychiatry, obstetrics, emergency medicine and geriatrics, and family medicine affords me a way to combine all of these passions. It will be gratifying to feel like I am using everything I learned in medical school, not just focusing on one particular thing.

In primary care, you really get to know your patients and their life stories, and it is humbling to be allowed such a privilege. There is nothing more satisfying than giving back and enriching the lives of others, and I feel the primary care fields enable physicians to do this.

Erin Morcomb is a fourth-year medical student at the University of Minnesota.

KEITH STELTER, M.D., MMM

In medical school I really enjoyed all my clinical rotations and wondered how I could integrate a bit of everything in my eventual practice. I greatly enjoy following patients over time and providing medical care for multiple generations of the same family.



The most rewarding aspect of family medicine is having the ability to make a difference in the lives of patients I see daily in my community. I also enjoy having the opportunity to "morph" my career. I've gone into many different areas over time, from

clinical care to teaching to administration.

Keith Stelter is associate director of the University of Minnesota-Mankato Family Medicine Residency Program.

JACOB PRUNUSKE, M.D., M.S.P.H.

I wanted to make a difference in people's lives. I considered other specialties during medical school but found I was energized by the stories of people. I was strongly influenced by a retiring general practitioner, whom I worked with as a third-year medical student. I watched him care for patients he had known for 40 years. I was also influenced by a family physician from whom I learned the power of simply being present when patients needed it most.



As a primary care doctor, I help my patients with their daily concerns and issues that matter most for their quality of life and sense of well-being. I enjoy being able to focus on each patient as a person in the context of their family and community rather than as a health condition or disease process. I am sustained by the time I spend with my patients and the relationships I have built with them over time. I am rewarded by sharing the successes and triumphs of my patients as they go through life.

Jacob Prunuske is a member of the department of family medicine and community health at the University of Minnesota, Duluth campus.

KATHRYN MCKENZIE

I applied to medical school in order to become a rural family physician.



I grew up in southeastern Minnesota, where my father was a family physician. My first insights into the field came from observing his relationships with patients and the community. My admiration for the profession grew as I met other family physicians who were using clinical research to address health problems they were seeing in the clinic.

To me, the most rewarding aspects of primary care are building relationships with patients and being able to provide continuity of care. Additionally, primary care physicians are in a unique position to improve the health care experience for patients because they are able to see firsthand the barriers patients face in accessing medical care and taking charge of their health.

Kathryn McKenzie is a fourth-year medical student at the University of Minnesota.

BRIE BLOOMQUIST

I'm going into pediatrics because I love working with children, helping them to get better when they are sick and to stay healthy when they are well. At the end of the day, my patients will be what makes practicing medicine worth it for me, not any particular specialty or procedures.

I enjoy getting to know patients and ensuring they get the best care possible.

Brie Bloomquist is a fourth-year medical student at the University of Minnesota.



ANONYMOUS

It's all about the patients! Sharing their joy, pain, elation and sorrow is like delving into the deepest reaches of the human experience. Being a part of their lives, listening to their stories and guiding them through trying times—that is the true flavor of life itself!

COLIN WEERTS, D.O.

I chose primary care knowing full well I would make less money but would likely forge stronger relationships with those in my community and have a bigger impact on the overall health of those around me than my colleagues who were going into other specialties. There was probably no single event that made the decision for me. But the combination of many small events and observations in medical school led me to do a residency in family medicine. Specifically, I noticed the trust and genuine appreciation that long-standing patients should have with their family physicians. I also enjoyed the fact that on the same day I could be helping a patient start hospice care, doing an OB check, and performing a vasectomy and a well-child exam. I liked that there was not only variety but also that all of those visits could be with members of one extended family.

The most rewarding thing about primary care is the relationships that I can develop with patients. I also feel that my family values my role in primary care because it allows me to better assist them and answer questions in regards to their own medical needs.

Colin Weerts is in his first year of the University of Minnesota-Mankato Family Medicine Residency Program.



DAVE BUCHER, M.D.

I had excellent family physicians growing up in Iowa. Originally, I was headed toward teaching, but a high school guidance counselor planted a seed that grew and directed me to medical school. My mother, an

RN, also encouraged me to go in that direction. Mentoring by physicians in my neighborhood as well as experiences in medical school at the University of Iowa also were formative. Despite serving the tertiary and quaternary care needs for the state, the University of Iowa Carver College of Medicine had (and continues to have) a great primary care emphasis. During the late 1970s and early 1980s, it had a premier family medicine department headed by Bob Rakel, and the faculty were wonderful role models. Rotations in rural and agricultural medicine, caring for rural geriatric patients and having an ongoing working relationship with a family physician in nearby Cedar Rapids reinforced my decision to enter primary care.

The most rewarding thing about family medicine is that you have the breadth of training and ability to do most care for most people. Patients appreciate that you can help them throughout their lifespan with all kinds of issues. I love obstetrics, pediatrics, adult, and chronic and elderly care as well as the surgical procedures we do in the office. I now enjoy circling back as a residency faculty member and teaching our next generation of colleagues.

Dave Bucher is a family physician at United Family Medicine in St. Paul and is on the faculty of the University of Minnesota's Family Medicine and Community Health Residency Program.

ERICK REEBER, M.D.

When I was in medical school, each specialty was interesting and I wanted to do each one. The obvious way to do that was to go into general practice (the term "family practice" had not yet been coined at the time). So I took a rotating internship at Arnot-Ogden Memorial Hospital in Elmira, New York, where I spent a short period with each department in the hospital, and I was hooked.

As I practiced, I got to know entire families. Many times, I took care of four generations. I'd get invited to family gatherings, and the babies I delivered were "my" babies. I frequently got invited to their weddings 20 years later. I remember one where a guest asked me how long I had known the groom. I told her that I had known him longer than anyone, since I delivered him. Now, 11 years after retiring, patients still stop to talk to me on the street and tell me about their grandchildren. After my wife died, I received dozens of sympathy cards from former patients. I still live in the town where I practiced, since I know almost everyone here.

Family practice was the best job I could imagine. I loved it.

Erick Reeber is a retired general practitioner in Bagley, Minnesota.

MARY WAGNER, M.D.

At the start of my fourth year of medical school, I was discouraged and depressed. I disliked the academic health center in New York where I trained, with its politics and put-downs, and I found the specialty clinical rotations mostly esoteric and unappealing. Fortunately, I signed up for a family medicine elective at the local community hospital. It was an epiphany of life-changing proportions, as I saw physicians who listened attentively to their patients' stories, talked about the social and emotional aspects of illness as well as the biomechanical ones, and treated the medical students as junior colleagues rather than somewhat unpromising scut-monkeys. I felt these were the doctors I wanted to be like.



The sign on our office door should read "Creative problem solving: no

problem too large or too small, no patient too rich or too poor." Being a family doctor has been a great fit for me, both in terms of how I think and what I value. Primary care doctors think differently than doctors in specialized fields of medicine.

Being a generalist means being someone who is continually confronted with undifferentiated problems. I'm a detective who gets to listen for the story, paying attention to what's said, what's implied, what I remember and what's in the chart to come up with a hypothesis and work on a solution. I look at my patients through multiple lenses, from the microscopic to the family and community level. I generate plausible solutions and then put them to the test. I get to do synthesis as well as analysis. I live with ambiguity and work with systems. As a family doctor, I have the fun of helping people uncover their strengths, eliminate barriers to health and happiness, and navigate life transitions. In the process, I've learned from them and have grown more aware of my own humanity. I care for the poor, relieve suffering, make a good living and use the gifts I have been given.

Mary Wagner practices family medicine at Park Nicollet Clinic—Creekside in St. Louis Park. She also directs the University of Minnesota-Methodist Hospital Family Medicine Residency Program.

MARIA J. LOERZEL, M.D.

Going into medical school, I felt I was called to be in primary care. I just wasn't sure if it should be family medicine, internal medicine, OB or pediatrics. I had a wonderful primary care doctor growing up and loved the consistency and comfort I had as a child seeing the same doctor the majority of the time.



Doing the Rural Opportunity for Medical Education program as a third-year medical student at the University of North Dakota School of Medicine and

Health Sciences, which was modeled after RPAP here in Minnesota, cemented my passion for family medicine. I loved the diversity it offered, the continuity of care, and the fact that I would have the ability to care for the young and the old, handle the simple and complex, and do office procedures and obstetrics. When I was in my second year of family medicine residency, one of my OB/GYN preceptors tried to talk me into entering OB/GYN. I shared with him that I had no desire to give up the child to the pediatrician after he or she was born.

I love treating the entire family and watching the children I deliver grow and develop. It is so rewarding to discuss growth and development with the parents of a young child (especially during that first year of life) and share in their joy as they tell about their child's first smiles, giggles, strengths and development.

In primary care, we also have the opportunity to prevent disease and in some cases to reverse the disease process. We are not always reactionary. One of the challenges of family medicine is that you never know what kind of problem you are going to face nor what issue is going to walk through your door at 4:40 on a Friday afternoon. This challenge allows me to constantly learn from my patients and grow as a physician and a person.

Maria Loerzel practices in Willmar at Family Practice Medical Center, an independent family medicine practice.

Yael Smiley

I plan to go into primary care because I want to take care of patients throughout their lives. I also want to explore how the structures of poverty, immigration, education and environment converge to influence a person's health. I am drawn to this because of the impact that continuity, education and access to care can have on the lives of patients.



Yael Smiley is a third-year medical student at the University of Minnesota.

LINDSEY JOHANSEN

The variety along with having the ability to form long-term relationships are what drew me to primary care. Every clinical rotation I would go on during my third year of medical school, I would spend the first week thinking things like, “This is so awesome! I want to be a urologist!” or “I have got to go into surgery, this is so cool!” Then as the rotation went on, I found myself thinking, “This is all they do? The same thing every single day?” But I never got bored during my time in family medicine. The many experiences I had while doing RPAP (I spent nine months in Montevideo, Minnesota) solidified my desire to pursue family medicine. Every day brings something different, and the variety of patients, diagnoses and treatments will keep me challenged throughout my career.

The relationships with patients are my favorite part of primary care. Seeing a pregnant mom over a nine-month period, delivering her baby and then being able to provide care for that child as he or she grows up seems incredibly rewarding to me. Primary care physicians get to know patients over time, build trust and, as a result, provide high-quality care catered to each individual instead of treating them as just another patient.

Lindsey Johansen is a fourth-year medical student at the University of Minnesota.



KELSEY REDLAND

I chose family medicine because I was truly interested in everything in medical school. I felt that if I went into a non-primary care specialty, I would forget too many of the things I worked so long and hard to learn. I also felt I would be letting myself down if I chose to do something else. I knew family practice would be a challenge, but the variety of challenges makes it such an engaging field. Most importantly, I love the patient-physician relationship that can only be cultivated through longevity and continuity of care. Family physicians are welcomed to be a part of very intimate experiences throughout a patient's life. They are allowed to share in the joy of birth, the grief of death and everything in-between. There is simply no substitute for caring for individuals over a lifetime and families over generations.

Being a family physician is truly a privilege. During my third year of medical school, while on RPAP in New London, Minnesota, it quickly became apparent that this was my passion. While technology and politics in medicine are continually changing, the one thing that will remain constant in family medicine is the interaction between the patient and the physician. The healing power of compassionate family physicians will forever fill the gaps in medicine that technology simply can't. That is why I have chosen to go into family medicine.

Kelsey Redland is a fourth-year medical student at the University of Minnesota.



RAYMOND CHRISTENSEN, M.D.

I went into primary care because I grew up in rural America and was concerned about the distance to and quality of care available to farmers and other rural workers. I saw neighbors receiving care that seemed poorly done and having complications that did not occur in people from urban areas.

What I've found most rewarding is having the ability to see any patient and be able to either care for them or safely send them to others. I also appreciate coordinating the care done by several caregivers.

Raymond Christensen is assistant dean for rural health at the University of Minnesota Medical School. He practices at the Gateway Family Health Clinic in Moose Lake.





BRUCE W. YOUNG, M.D., PH.D.

One of the biggest influences on my decision to go into primary care was a family physician I met while doing a rotation in medical school at the University of Calgary. Dr. Sheila Malm was

a very bright, caring woman who showed me how, as a primary care doctor, you have to be able to see the whole patient and put together a lot of diverse findings and symptoms to make a diagnosis. She really impressed me, and primary care came across as a very challenging and enjoyable way to practice medicine.

I've found you have to have an investigative knack. In a given day, I see so many different patients coming

through the door with so many different problems. Primary care is very challenging intellectually.

One of the challenges we have in America is the cost of health care. It's going to become more and more important to have someone involved in patient care who can make sure things are being done in the most cost-effective and appropriate manner. We've de-emphasized primary care in our country for many years. With the way we're going, with accountable care organizations and a movement toward preventive care, we're going to see a bigger focus on primary care in the future.

Bruce Young practices family medicine at Allina Medical Clinic - Brooklyn Park.

The graduate glut

(continued from page 17)

for residency positions, but someone who graduated from medical school outside the U.S., say France or Somalia, didn't have to go through the Match," Andrews says. "If you were interested in an international graduate, you could offer them a position and reduce the complement of positions offered through the Match."

Further contributing to the bottleneck is the fact that graduates are applying to more programs than they once did, thus ramping up competition for spots. "People are anxious about their prospects when graduating from medical school," Andrews says, adding that this year the pediatric residency program at the University of Minnesota, which he formerly directed, saw a 25 percent increase in applicants over last year. "The irony is that more applicants may be more of a curse than a blessing. When students make a conscious decision to apply to more programs, they may not be applying to your program because of a focused interest. As a program director, you need to be selective about whom you interview. The best applicants have many options, and you may not be their first choice."

The challenge for residency directors is to make sure that the pool of applicants yields a highly qualified residency class.

Getting back in the game

The impending residency bottleneck led to PRP's suspension this fall. As a result, Nicholson and others involved with the program, including representatives from the university's department of family medicine and community health, HealthEast Care System, local groups representing international physicians and even some recent PRP graduates, have launched a new effort—the International Physician Workforce Initiative. Trying to increase the number of career options for immigrant and refugee physicians, they

are inviting educators and employers from across the state to help find new ways to get these doctors into health professions jobs. "The skills these doctors have are desperately needed in our state, and there are plenty of other opportunities for them," Nicholson says. Among the options the group is exploring are working in the public health sector, in emergency medical services, or as physician assistants or nurse practitioners.

"The shortage of residency opportunities shouldn't keep these talented people out of health care," he says. "We need all hands on deck. Someone who can treat sick people in a state with a shortage of physicians shouldn't be stuck driving a taxi." MM

Kim Kiser is senior editor of *Minnesota Medicine*.

If you would like to get involved in the International Physician Workforce Initiative contact Will Nicholson, M.D., at wnichols@umn.edu.



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In for the long haul

A desire to address prescription opioid abuse motivates task force members.

BY DAN HAUSER

A week before Christmas, William Dicks, M.D., a family physician at the Sanford clinic in Bemidji, made the four-hour trek to Minneapolis to attend a two-hour task force meeting. It's a long way to drive during a hectic time of year, and his doing so illustrates the concern he and other MMA members feel about the topic of prescription opioid addiction, abuse and diversion.

Dicks is just one of 17 physicians who have volunteered to sit on the MMA's Prescription Opioid Management Advisory Task Force. Each physician, resident and student serving on the task force likely has a different reason for taking part, but they all share a similar goal — stemming the tide of prescription opioid addiction, abuse and diversion.

Statistics show that prescription drug abuse is the fastest-growing drug problem in the United States. The Centers for Disease Control and Prevention has found that approximately three out of four prescription drug overdoses are caused by opioids such as hydrocodone, oxycodone, fentanyl, methadone and codeine.

Furthermore, opioids play a role in 15,000 deaths annually and account for more than 340,000 emergency department visits each year.

Here in Minnesota, one in five admissions (20.2 percent) to addiction treatment programs in the Twin Cities metro area during 2011 was for heroin or other opioids. This is compared with 8.7 percent of admissions in 2005. Oftentimes, the drugs causing addictions and overdoses are misused meds prescribed by physicians just doing their jobs.

“More and more people are becoming addicted to these medications that have been prescribed by physicians, and they will continue to need higher and higher doses as their bodies become physiologically tolerant of the effects,” says task force member Drew Zinkel, M.D., an emergency medicine physician at Regions Hospital in St. Paul. “This has become a major public health epidemic not only in our community but in communities all across the United States.”

Big issue, plenty of interest

In numerous settings, the issue of prescription opioid addiction, abuse and diversion has become an urgent topic. Given the role of physicians in prescribing opioids, the MMA knew it needed to get involved. The Board of Trustees authorized the creation of a task force to launch its analysis of the issue. The roster filled up quickly. In fact, MMA staff had to set limits on the number of members in order to ensure the group didn't become unwieldy because of its sheer size. The MMA wanted to include representatives from a number of key specialties: addiction/substance abuse, anesthesiology, emergency medicine, pain medicine, physical medicine and rehabilitation, family medicine, hospice and palliative care, internal medicine, occupational medicine and oncology.

As a pain medicine specialist, Alfred Anderson, M.D., was an obvious choice to include on the task force. After all, he deals with chronic pain sufferers daily at Medical Pain Management, Ltd. in St. Louis Park. His desire to take part, however, is predicated less on his concern about pre-

venting abuse and more on preventing a “chilling effect,” in which physicians prescribe less in order to curtail misuse.

Anderson can recite many stories that illustrate how prescribing opioids is supposed to work. For example, one of his patients is a 40-something woman who suffered from lower back pain for several years. Her pain became so bad that it prevented her from participating in recreational activities with her family. She underwent two lumbar surgeries, yet the pain persisted, limiting her ability to function. Anderson started her on a relatively low dose of hydromorphone, which was gradually titrated up until she had improved function. With the addition of a time-release form of the medication, she substantially increased her ability to exercise and take part in normal day-to-day activities. Last year, she took her children to Disney World, and only took a break when they needed to rest.

“She has been absolutely delighted with her new life, as has her family,” Anderson says. “She is now able to function daily at a nearly normal level of activity.”

Anderson is quick to add that his patients are concerned about the publicity regarding prescription medication abuse, and how it is going to affect their future care. “These medications have helped patients get back to work, increase their function with their family, and participate in recreational activities,” he says.

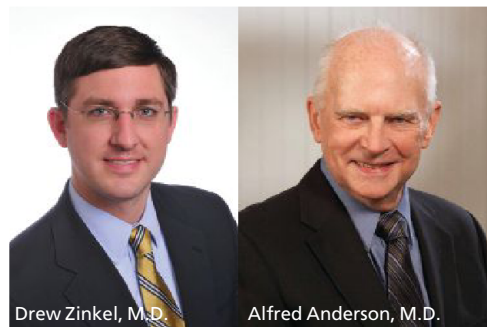
The good and the bad

Few would argue that prescription opioids are useful for patients striving to manage their pain. However, when the meds are abused or misused, it creates issues for other physicians.

“From my perspective, as an emergency physician, I have seen the negative impact that abuse and misuse of opioids has had on our community,” Zinkel says. “We see countless patients who have overdosed on these medications, both intentionally and unintentionally, and the impact and cost it has on the system of medical care as well as the health of the community.

“I would like to see a decrease in the negative impact opioid medications are having on our patients and our community,” Zinkel says. He would also like to see physicians prescribe fewer opioid medications and increase their use of non-narcotic therapies to treat pain, as well as increase use of Minnesota’s Prescription Monitoring Program.

Anderson points out non-narcotic therapies don’t always do the trick. “Most all of my patients have been through extensive previous treatment including conservative exercise programs, multiple spine surgeries and spinal implant procedures,” he says. Yet, he recognizes that



Drew Zinkel, M.D.

Alfred Anderson, M.D.

opioids are not the sole answer for treating their pain. In order to enhance their ability to function, chronic pain patients should engage in a treatment program that includes increased activity, dietary changes when necessary, psychological counseling and treatment, and encouragement and support as well as prescription opioids.

“It is a physician’s true nature to want to provide relief to their patients, as this is what patients seek,” Zinkel says. “However, if physicians don’t understand the risks and dangers of prescribing opioids to patients and explain this to the patient, we will continue to see the problem of opioid abuse on the rise.”

It’s clear by talking to just a few physicians that a lot of passion surrounds this issue. Task force members certainly have their hands full.

As this issue went to press, the group planned to begin its work on a detailed analysis of the Prescription Monitoring Program. The task force is expected to meet until late 2013. We will continue to keep you updated on its progress.

EDITOR’S NOTE: *Have an opinion or story about how the prescription opioid issue affects your practice? What are you doing in your practices regarding prescription opioids? Let us know. Send an email to Juliana Milhofer at jmilhofer@mnmed.org.*

Task force roster

- Alfred Anderson, M.D. (pain medicine)
- Richard Andrews, M.D. (family medicine)
- Beth Averbeck, M.D. (internal medicine)
- Beth Baker, M.D. (occupational medicine)
- Paul Biewen, M.D. (physical medicine and rehabilitation)
- William Dicks, M.D. (family medicine/pain medicine)
- Mark Eggen, M.D. (anesthesia)
- Howard Epstein, M.D. (chief health systems officer, Institute for Clinical Systems Improvement)
- Tom Flynn, M.D. (oncology)
- Donald Grossbach, M.D. (hospice and palliative medicine)
- Christopher Johnson, M.D. (emergency medicine)
- Zach Lopater, M.D. (resident)
- David Schultz, M.D. (anesthesia/pain medicine)
- Yael Smiley (student)
- Keith Stelter, M.D. (family medicine)
- Joseph Westermeyer, M.D. (addiction/substance abuse)
- Drew Zinkel, M.D. (emergency medicine)

Health care task force finalizes its Roadmap

After 65 public meetings in locales ranging from Rochester to Duluth, the Governor's Health Care Reform Task Force met for the last time and completed its "Roadmap to a Healthier Minnesota" in mid-December.

The Roadmap is a mix of recommendations that are likely to become health care-oriented legislation. Highlights include:

- bolstering the state's primary care workforce
- increasing support for health profession education
- increasing the number of health professionals in underserved areas of the state
- determining a private-public process for setting performance targets including goals for health care access, cost containment, quality, patient experience and population health
- expanding Medicaid to individuals with incomes up to 138 percent of the federal poverty level
- implementing a Minnesota-based health insurance exchange that uses a public-private governance structure.

Although the MMA was generally supportive of the recommendations, it asked for revisions to three "strategy elements" in the Roadmap. Ultimately, the task force did not agree to the revisions.

In a letter signed by MMA President Dan Maddox, M.D., the MMA spoke out against the task force's recommendation to "explore and remove regulatory barriers to the advancement of the nursing workforce," which involves enacting the Advanced Practice Registered Nursing (APRN) Model Act and Rules that would provide all APRNs with independent practice and prescribing privileges.

Noting that the Roadmap recommendations involve improving care coordination and integration of care, the MMA felt that "implementation of the APRN Model Act would run counter to that goal and would actually erode collaborative practice that is currently part of Minnesota's APRN law."

The MMA urged the task force to reject the idea of pursuing independent practice for all APRNs and noted that under current law, not all APRNs deliver primary care services. The MMA supports regulatory changes to ensure more effective and efficient inclusion of APRNs in the delivery of care, but



Doug Wood, M.D.

not if such changes will allow them to practice independently without a collaborative agreement with a physician.

In another strategy element, the "Roadmap" aims to "prepare for anticipated increased demand on safety net provider services by increasing reimbursement to safety net providers for primary care, mental health, substance abuse and community-based services provided to Minnesota Health Care Program recipients." Concerned that this recommendation is too narrow, the MMA urged the task force "to expand the recommendation to increase reimbursement to all providers serving Minnesota Health Care Program recipients."

The MMA specifically noted that as the individual mandate and other insurance coverage options take effect in 2014 as a result of federal health care reform, the increased demand on the health care system, particularly primary care physicians and other providers, could be significant. Yet, the state has failed to adequately invest in physician reimbursement for caring for Medicaid patients. There has been only one across-the-board increase in fee-for-service rates in 20 years; that occurred in 2000.

In a third strategy element, the Roadmap recommends use of a "public-practice process to set performance targets including goals for health care cost containment, health care quality, patient experience and population health." The MMA acknowledged the potential value of defining performance targets, but questions about the scope of this recommendation remain. For example: the composition of the public-private partnership, the need to avoid duplication of current measurement efforts, and the feasibility and value of imposing consequences if the targets are not met.

"The task force did a nice job of gathering input from a variety of Minnesotans," says Janet Silversmith, MMA director of health policy. "We certainly appreciate all of the physicians who attended meetings and voiced their opinions."

MMA members Doug Wood, M.D., and Therese Zink, M.D., served on the task force.

The final report is available at: <http://mn.gov/health-reform/images/TaskForce-2012-12-14-Roadmap-Final.pdf>.



Therese Zink, M.D.

VIEWPOINT

Collaborative care works best for the patient

BY DAVE THORSON, M.D.

Few people in Minnesota's health care industry would argue against the need for more primary care physicians, particularly in rural parts of the state. We are currently facing a serious physician shortage; there are too many patients and not enough doctors. Factor in the influx of newly insured patients that will come as a result of the rollout of the Affordable Care Act and we could have an even more serious shortage on our hands.

So how do we address it? One solution that has been proposed (and may result in changes to state law) is to grant advanced practice registered nurses (APRNs) more independence. The theory goes that if APRNs are afforded more autonomy for prescribing medication and performing other duties, it will make health care more accessible in areas where the physician shortage is most acute.

But can we allow this and still maintain our high standards of patient care? We don't think so.

APRNs have an extremely important role in the overall delivery of care. This is especially true as the industry moves toward patient-centered, team-based care in health care homes. But they are only one piece of the puzzle. Physicians, nurses, APRNs, physician assistants, dietitians, care coordinators and pharmacists all play a role on these teams. The key to making this approach to care delivery work is the emphasis on collaboration, with each

player performing the functions they have been trained to do.

Some may see this as a turf war, but it really is a patient safety issue as I told the *Star Tribune* in an article on this topic in December. APRNs do an excellent job but they do not have the same training and experience as physicians and should not be treated as if they did.

Compounding the situation is the fact that we face a growing problem of prescription opioid addiction, abuse and diversion in our state and across the country. Allowing for more independent prescribers such as APRNs, who have less training than physicians, could potentially add to the problem.

Current Minnesota law requires APRNs to practice in a collaborative role under "a mutually agreed-upon plan" with one or more physicians or surgeons. We support changes that ensure that APRNs are used in the most effective way. But we also strongly believe that the care of the patient should be our No. 1 concern, and we must ensure that they are receiving the right care from the practitioner best trained to provide it.

This is a sound medical practice that we should continue to follow. It speaks to professionalism in medicine, and it's best for the patient's welfare.



Dave Thorson, M.D.

PHOTO BY STEVE WEVERKA

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We must ensure that patients are receiving the right care from the practitioner best trained to provide it.

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News briefs

Group to study Minnesota primary care physician workforce growth

At its January meeting, the MMA's Board of Trustees approved the formation of a task force that will study how to increase Minnesota's primary care physician workforce.

Based on feedback from the Board, the task force will likely begin its work by defining "primary care" and whether the term encompasses more than family medicine, pediatrics and internal medicine.

"Another important task this group will address is planning and convening a summit to identify and share strategies on this issue," says Juliana Milhofer, MMA policy analyst. The summit will likely take place during the second quarter of 2013.

In addition, the task force will work to:

- Understand the various drivers affecting the capacity and future supply of Minnesota's primary care physician workforce

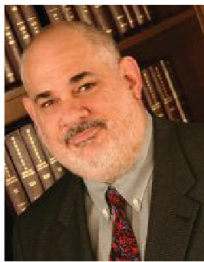
- Identify strategies for increasing the workforce in the state
- Determine roles for the MMA, as well as other potential stakeholders, in advancing specific strategies to increase the workforce
- Recognize the relationship between workforce expansion efforts and other nonphysician primary care workforce initiatives and
- Partner with others, as needed, to increase the visibility and importance of the issue of workforce capacity among policymakers and the public.

The task force, which will begin its work during the first quarter of this year, is expected to meet six times over the next 12 to 15 months. It will include 15 to 20 physicians from both academia and the community.

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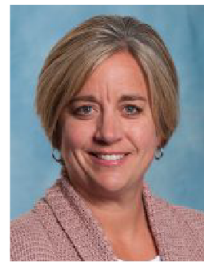
Dan Maddox, M.D.



Robert Meiches, M.D.



Jaime Olson



Janet Silversmith



Dave Renner



Eric Dick

MMA in action

In January, **Dan Maddox**, M.D., MMA president; **Robert Meiches**, M.D., MMA CEO; and **Terry Ruane**, MMA director of membership, marketing and communications, attended the Zumbro Valley Medical Society's annual meeting in Rochester.

Maddox attended the Twin Cities Medical Society's annual meeting in Minneapolis in January.

Ruane attended the Stearns Benton Medical Society board of directors meeting in December.

Jaime Olson, MMA manager of continuing education, and **Robert Moravec**, M.D., MMA speaker of the House of Delegates, attended the Accreditation Council for Continuing Medical Education State Medical Society conference in Chicago in mid-December.

The following MMA staff members met with Minnesota Hospital Association staff in mid-December to discuss the 2013 legislative session and health care reform: **Meiches**; **Janet Silversmith**, director of health policy; **Dave Renner**, director of state and federal legislation; **Eric Dick**, manager of state legislative affairs; **Juliana Milhofer**, policy analyst; and **Teresa Knoedler**, policy counsel. They also met with representatives from the Minnesota Department of Human Services in early January to discuss

the 2013 session, health care reform implementation, and the 2013-2014 Medicare rate increases for primary care.

In January, **George Lohmer**, MMA CFO; **Ruane**, **Meiches**, **Silversmith** and **Renner** met with Minnesota Medical Group Management Association staff regarding partnership opportunities and the 2013 legislative session.

In late December and early January, **Renner** and **Dick** met with the following health care committee chairs: Sen. Tony Lourey (Finance - Health and Human Services Division), Sen. Kathy Sheran (HHS Policy), Rep. Tom Huntley (HHS Finance) and Rep. Tina Liebling (HHS Policy).

Renner also attended the AMA's State Legislative Strategy Conference, an annual meeting of state and specialty medical society representatives in January. While there, he participated in the executive committee meeting of the AMA's Advocacy Resource Center, on which he serves as vice-chair. This group of 15 state medical society staff members helps direct the AMA's state legislative work.

In early January, the MMA Resident-Fellow Section hosted a "Taste of Thailand" at the Cooks of Crocus Hill in St. Paul.

News briefs

(continued from previous page)

Minnesota's exchange efforts continue moving forward

Minnesota's efforts to establish a state-run health insurance exchange reached another milestone in mid-December when the U.S. Department of Health and Human Services granted conditional approval of its plan. Then on the second full day of the 2013 legislative session, a bipartisan team of state lawmakers introduced a bill that would create a Minnesota-based exchange.

The exchange is a top priority for the MMA's legislative team. "Our main goal is to ensure that governance of the exchange is a shared public-private model with broad representation, including the voice of practicing physicians and patients," says Dave Renner, MMA director of state and federal legislation.

The MMA also wants the exchange to be funded either through the state's general fund or by those entities that most directly benefit from it.

The exchange is scheduled to be open to individuals and small employers by October.

MMA supports Health Department's cardiovascular care work

In late December, the MMA sent a letter of support to the Minnesota Department of Health recognizing its efforts to develop and implement statewide systems to optimize care for time-critical cardiovascular conditions.

"This work will assist Minnesota in developing effective policies and protocols for the diagnosis and treatment of patients with heart disease and stroke, and it will ensure that all Minnesotans have access to high-quality care," wrote MMA President Dan Maddox, M.D., to Health Commissioner Edward Ehlinger, M.D.

Although Minnesota's overall death rates due to heart disease and stroke are much lower than those elsewhere in the country, these conditions hit some communities harder than others. For example, coronary heart disease death rates are higher among American Indians, compared with other racial groups. In regards to deaths attributable to stroke, the rates are higher among American Indians, African Americans and Asians, compared with whites in Minnesota.

The letter is in response to a resolution submitted by the Twin Cities Medical Society and passed by the House of Delegates at the 2012 MMA Annual Meeting.

New physician joins MEDPAC board

Lisa Erickson, M.D., an OB-GYN at the Center for Reproductive Medicine in Minneapolis, has joined the board of directors for MEDPAC, the MMA's political action committee.

Erickson is active in both the MMA and the Minnesota Chapter of ACOG, the American College of Obstetricians and Gynecologists.

"The board is happy to welcome Dr. Erickson to its fold," says Will Nicholson, M.D., MEDPAC secretary-treasurer. "She brings great energy, passion and experience with legislative advocacy on behalf of medicine."

Several openings remain on the MEDPAC board. Interested MMA members should contact Eric Dick, MMA manager of state legislative affairs, for more information (edick@mnmed.org). You can also learn more about MEDPAC at www.mnmed.org/Advocacy/MEDPAC.

Insights article on "providers" leads to engaging discussion

An *Insights* entry denouncing the use of the word "providers" to describe physicians led to more than two dozen online and email responses in early December.

Apparently, the piece by Robert Meiches, M.D., MMA CEO, struck a chord.

"Addressing a physician as a 'provider' is demeaning and controlling, and I support any effort to roll back this practice," responded one physician.

"The term 'provider' in my personal opinion was introduced (and pushed for acceptance and wide use) to degrade physicians and the noble aspect of their profession," wrote another.

"It's about time someone addressed this issue," commented a third.

Launched in the fall of 2012, *Insights* is a quarterly email distributed to MMA members and penned by MMA leaders to take a stance on issues facing physicians. To read the latest entry, go to *Insights* beneath the "Publications" banner on the MMA website.

EDITOR'S NOTE: *Keep track of news through MMA News Now, which is delivered to your email box free each Thursday. To subscribe, go to www.mnmed.org and look for "MMA News Now" under the "Publications" tab.*

We are also on Facebook, Twitter, LinkedIn and YouTube.



Lisa Erickson, M.D.

The physician as captain

The way to reform health care is through physician-led, patient-centered teams.

BY JULIE ANDERSON, M.D., FAAFP

My oldest son, Elliot, began playing Squirt hockey this year. For those not familiar with hockey, this is the first year when the kids take to the full ice rink and start learning their positions and running plays. It is a big change from the previous year, when as Mites 8-year-olds vie for the puck no matter where they are on the ice and just try to get it into the goal. There is not much teamwork at this level of play. The kids follow only a few basic rules and do their best to stay upright and score. Watching my boys move through the ranks of hockey has reminded me of the efforts that family physicians and other primary care specialists are undertaking to reform health care.

Just as Elliot's knowledge of hockey has evolved, so has our understanding of the way health care services are delivered. In order to perfect our game, we physicians must not only know the rules, but we also must be the leaders who guide and coordinate complex plays. Our challenge is to move from playing an episodic, reactive and, at times, defensive game to one that is continuous, strategic and focused. I think you get the point. Although I could go on about icing and offsides, I will leave the hockey analogy and attempt to explain why I believe a physician-led, team-based model of patient-centered care (with patients as active participants) is the way to move medical care forward.

Understanding the game

Team-based care is commonly thought of as that in which two or more health care professionals, directed by a physician, work with the patient and their family, if appropriate, to achieve shared goals. This notion, as I see it, is just a small part of a much broader concept—that of the patient-centered “medical home,” which provides physician-led, coordinated, high-quality, patient-centered care.

The idea of the medical home was introduced by the American Academy of Pediatrics in 1967 as a way to provide coordinated services to children with special needs. It has gained traction in the last few years. In 2010, the state of Minnesota began certifying medical homes (called “health care homes”) and paying them to coordinate care for patients on Medical Assistance. The American Academy of Family Physicians (AAFP) has been a strong advocate for patient-centered medical homes since about 2004, contending that medical homes have the potential to address many of the problems that affect our current health care system. They even go so far as to call it the future of our specialty.

There are a number of well-recognized characteristics of patient-centered medical homes:

- Continuity of care with same-day appointments, after-hours coverage, and electronic and group visits

- Comprehensive care management for a particular population with an emphasis on disease prevention and chronic disease management
- Coordinated and managed care that makes use of community-based resources and collaborative relationships with other specialists, hospitals and care-transition teams
- Use of physician-led care teams that have a shared mission and vision, and emphasize effective communication and patient participation
- An emphasis on quality and safety that uses evidenced-based medicine when appropriate, considers patient satisfaction feedback, and measures and improves performance.^{1,2}

Recent studies in Minnesota and other states have shown that patient-centered medical homes that use a team-based approach to care can improve health, provide better care and reduce the overall cost of care delivery.³ Other studies have shown patient-centered medical homes lead to fewer hospital admissions and readmissions,³ decreased emergency department utilization,⁴ reduced hospital stays, better diabetes care, increased preventive screening rates and better access to care.³ Still others have shown lower outpatient costs per patient, particularly those with complex medical conditions, as well as improved patient and provider satisfaction.⁵ These studies highlight the fact that eliminating fragmentation can reduce the cost

of care for a given population and improve outcomes. Wouldn't we all like a system where abnormal test results are communicated correctly, work is not duplicated by multiple providers, care is documented and efficiently delivered to all involved with a patient, and potentially preventable hospitalizations are reduced?

Leading the team

We must acknowledge the fact that medicine has developed into more of a team sport. This concept is not new. We were all taught in school that there is no "I" in "team." We learned that a winning team has a clear focus, defined roles and good communication. Members are efficient and accountable for their actions. They adhere to the rules and come up with innovative ways to succeed. As health care delivery becomes increasingly complicated and regulated, we must rely on our associates in nursing, administration, information technology, pharmacy and social services to assist us in our practices. Gone are the days of seeing a patient, writing a few words in their chart and moving on. We now must be fact-gatherers, analysts and care-plan designers as well as loop-hole closers. We simply cannot do it alone.

One could argue that this affects physician autonomy, and one would be right. I am the last one to want someone telling me that an A1C of 7.9 is better than 8 or that it is my fault that my patient won't stop smoking. But I am coming around to the realization that with a team approach, I can do more for my patients.

Although I do not yet practice in a team-based patient-centered medical home, I firmly believe it takes a village to care for patients. I count on my front desk staff to remind patients to come in for appointments, I need my nurses to efficiently room and check vitals on my patients, and I see the benefit of having a nurse follow up with a patient who has many medical problems to remind them of what we discussed during a clinic visit and see if they followed through with specialty referrals. We must remember that as the practice of medicine gets increasingly complicated for us, so it does for our patients. They need

our help more than ever to navigate the health care system. With more resources organized around a physician-led model, we can achieve more for our patients.

The question we should be asking is "How can I be a part of the solution?" rather than "How can I avoid transforming my practice?" If we as primary care physicians do not lead the way toward collaborative care, we will most certainly continue to have our future questioned, as nonphysician providers seek to fill our role in caring for our patients. We must remind ourselves and others that the major difference between us and these other professionals is that we are trained to diagnose and develop treatment plans; they are trained to follow through on those plans and implement the protocols we design.⁶

So, what makes the captain indispensable to the hockey team? (So I love analogies, humor me!) Quite simply, the captain is the person chosen for leadership ability, communication skills and knowledge of the game. He or she is the person who leads by example—on and off the ice. The captain speaks up for the team, defends the actions of his or her teammates, adjusts play on the fly and is able to implement the overall game plan. He or she is the hardest working player on the team—the first one to arrive at practice and the last to leave.

In order to be the captain of our health care teams, we must develop our leadership skills starting in medical school and continuing throughout our careers. We have strayed somewhat from the concept of being leaders, and we must get back to playing this role.

Making the play

Now that I have convinced you that a primary physician-led patient-centered medical home offers the best future for health care delivery in our country, how do we make it a reality? The sad truth is that until the payment method changes, it will prove difficult for many clinics to offer this type of care even to patients with the most complex medical needs. Although clinics that have been certified by the State of Minnesota as health care homes offer

coordinated care, it is limited to patients in certain health plans, and many private clinics cannot justify the cost of setting up these services without full support from third-party payers. We as physicians must convince purchasers of health insurance that this concept is worthy of notice.

At the American Medical Association's meeting in Hawaii last November, delegates approved a resolution affirming recommendations in a report addressing the need for team-based care. The language in that resolution was similar to a statement put forth by the AAFP. In addition to these efforts, we need all of our physician colleagues to advocate for team-based care at the grassroots level. If we don't succeed at creating a model of care led by physicians, I can assure you that we will be working under one led by administrators. **MM**

Julie Anderson is a family physician in St. Cloud and president of the Minnesota Academy of Family Physicians.

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Restrictive covenants—unnecessary harm

Minnesota needs to ban noncompetes in physician employment agreements.

BY GORDON J. APPLE, J.D., AND KIMBERLY WERNING, M.D.

As Minnesota's largest health care organizations become ever more dominant in both rural and urban parts of the state, restrictive covenants (noncompetes)* in physician employment agreements become increasingly punitive to doctors and the patients they serve.

The American Medical Association, in its recently adopted "AMA Principles for Physician Employment"¹ correctly asserts that a "physician's paramount responsibility is to his or her patients" and discourages physicians from entering into restrictive covenants that would keep patients from seeing their physicians upon termination of employment. Discouragement, however, is not enough.† Common sense dictates that there can be no justifiable reason for restrictive covenants that deny patients access to "their" physicians or deny physicians the right to practice where

they want and for whom they want. In the interest of the doctor-patient relationship, restrictive covenants in physician employment agreements in Minnesota should be banned. In doing so, Minnesota would follow states such as North Dakota, Hawaii and Massachusetts that correctly found that the public interest outweighed any potential harm to private interests when restrictive covenants for physicians were banned.‡

Restrictive covenants in Minnesota—the status quo

The majority of health care institutions and physician groups in Minnesota impose noncompetes on their employed physicians. By doing so, they seek to keep physicians from continuing to practice in a geographic area** because of the alleged economic harm that the employer might incur if the physician were to "compete" with it. These restrictive covenants a) de-

fine the geographic boundary that the physician cannot practice in, b) state a time (at least a year) during which the prohibition applies and c) state the scope of competitive activities the physician cannot engage in. Some restrictive covenants contain a buyout clause (liquidated damages) that waives the restrictive covenant, but at a very hefty price.

Courts in Minnesota and elsewhere have adopted a rule-of-reason analysis in determining the issue of the enforceability of noncompetes. This analysis generally seeks to answer the following questions:

- Is the restriction reasonably necessary for the protection of the employer's business?
- Is the restriction unreasonably restrictive of the employee's rights?
- Is the restriction prejudicial to the public interest?

* Although the terms "restrictive covenant" and "noncompete" are used interchangeably, from a public policy perspective, it is probably better to focus on the issue of competition and the rhetorical questions of how one physician can really be a threat from a competitive perspective and, even if he or she were, what that means in the context of whether the proper focus should be on patient freedom of choice.

† In the AMA's November 13, 2012, press release, an AMA board member is quoted as saying that "[t]he guidelines reinforce that patients' welfare must take priority in any situation where the interests of physicians and employers conflict." However by continuing its longstanding policy of not taking a hard-line stance on the issue of restrictive covenants, the AMA's equivocation undermines the basic premise of responsibility to patients upon which the principles are based.

‡ North Dakota and Hawaii ban restrictive covenants as restraints of trade regardless of profession, while the Massachusetts statute is specific to physicians.

** Examples of geographic restrictions in Minnesota include being prohibited from practicing in the seven-county metro area (2,972 square miles) or practicing within x miles of any of the employer's clinics or hospitals.

It is this last part of the analysis that has long been the reason why lawyers cannot be bound to noncompetes. And this is the reason why physicians should be treated no differently.

Physicians and lawyers should be treated the same

In an insightful law review article “Physician Restrictive Covenants: The Neglect of Incumbent Patient Interests,”² Professor S. Elizabeth Wilborn Malloy notes that it is the third prong of the rule-of-reason analysis that the courts have often neglected and that it is at the patient level that the traditional analysis over the reasonableness of noncompetes generally comes up short. Professor Malloy’s analysis is as follows:

Applying the rule-of-reason test, courts have only rarely invalidated physician restrictive covenants solely out of concern for the public welfare. This approach does not respect the unique role a physician can play in the community. Some factors courts have downplayed or ignored are the physician’s ability to provide optimal care and the patient’s ability to choose their physician freely. Surprisingly, nearly identical considerations have been applied by most courts to limit or completely bar the enforceability of attorney restrictive covenants. This strangely disparate treatment of two professional groups exists despite the fact that the physician-patient relationship is at least as important from a public policy standpoint as that of attorney and client. (Emphasis added – Id at 192-193.)²

As noted by Professor Malloy, the disconnect between prohibiting restrictive covenants for attorneys while allowing them for physicians is profound. Surely, by any measure, interference in the physician-patient relationship is as prejudicial to the public interest as interference with the attorney-client relationship.

In 2005, the Tennessee Supreme Court addressed the issue of the double standard head on in *Murfreesboro Medical Clinic, P.A. v. Udom*, 166 S.W.3d 674 (TN, 2005).³ The Court noted:

In analyzing this issue, we see no practical difference between the practice of law and the practice of medicine. Both professions involve a public interest generally not present in commercial contexts. Both entail a duty on the part of practitioners to make their services available to the public. Also, both are marked by a relationship between the professional and the patient or client that goes well beyond merely providing goods or services. These relationships are “consensual, highly fiduciary and peculiarly dependent on the patient’s or client’s trust and confidence in the physician consulted or attorney retained.” *Karlin*, 77 N.J. 408, 390 A.2d 1161, 1171 (Smith J, dissenting). In both contexts, restrictive covenants have a destructive impact on those relationships. The rules governing other businesses and trades are not relevant to either the legal or medical profession, as both often require the disclosure of private and confidential information such as, in the context of physician and patient, personal medical or family history. We agree with the dissent of Justice Smith in *Shankman v. Coastal Psychiatric Assoc.*, 258 Ga. 294, 368 S.E.2d 753 (1988) in which he stated:

The medical profession, like the legal profession, is one that of necessity must have the faith and confidence of its patients (clients) in order to give effective treatment. When a patient (client) has entrusted confidential information to the doctor (lawyer) this creates a relationship of confidence and the patient (client) does not wish to have that relationship involuntarily terminated. 368 S.E.2d at 754 (Smith J, dissenting).

The right of a person to choose the physician that he or she believes is best able to provide treatment is so fundamental that we can not allow it to be denied because of an employer’s restrictive covenant. (*Murfreesboro*

Medical Clinic, P.A. v. Udom, 166 S.W.3d 674, 683 (TN, 2005)

The Court in its opinion held that covenants not to compete were unenforceable against physicians except for restrictions specifically provided for by statute as enacted by the Tennessee Legislature.^{††}

Do no harm—really?

A restrictive covenant by its very nature punishes patients who depend on “their” physician and is antithetical to the ethical precept of “do no harm.” The reality is that restrictive covenants hurt every citizen in Minnesota. In other words, they hurt every patient. By restricting the power of the person trying to keep patients alive and healthy—their physician—many health care organizations in Minnesota are restricting patient choice for economic gain rather than continuity of care. Even assuming the worst-case scenario, in which an employed doctor leaves and sets up her practice across the street from her employer and her patients want to follow her, the greater harm from an ethical perspective must always be to deny those patients the right to continue with their physician based on a noncompete that is only designed to protect economic interests.

In addition to harm caused to patients, restrictive covenants harm the affected physicians, their families and their communities. This harm is especially great in rural Minnesota, where often restrictive covenants prohibit a physician from working within miles of any clinic or facility affiliated with the organization that employs them. For some organizations, that can be more than a third of the state. And in some cases, that can be surrounding states as well. The physician who wants to leave, for whatever reason, would likely have to move and leave his or her patients. If the patients were lucky, they would get a letter announcing that Dr. Smith has sought

†† Two years after the Tennessee Supreme Court’s ruling, the Tennessee Legislature effectively overturned the decision and now allows for noncompetes in a variety of circumstances, except for doctors who practice emergency medicine or radiology.

new opportunities without a forwarding address and contact information. If they were unlucky, there would be no letter and they would find out, to their surprise and consternation, that Dr. Smith was gone when they came in for or made their next appointment. The physician also would be forced to uproot her or his spouse and family to continue to practice and would have to leave behind the other roles in the community he or she played, for example serving on the school board or being active in service projects. In many cases, the physician's spouse is also a physician, who would then also have to leave behind patients and other commitments.

Restrictive covenants harm competition.^{##} In the age of health care reform, it makes no sense to hinder the small degree of competition that may be created by freeing physicians from noncompetes. Competition keeps organizations a little more honest. In rural areas, if there is only one option available for care, the price for that care will not be negotiable. It is best for the patient to be able to shop around. It is best for everyone if large health care organizations have to worry about their pricing and compete to keep their patients and employees happy.

In small towns where there is no competition, large organizations can limit access to care and charge as they wish for it. The patient may be charged excessively for a service that would cost less if another clinic could open up down the street. When there is only one health care

organization available to provide care, that care does not have to be good, affordable or even friendly.

Imposed conflict of interest

The interests of physicians and their patients should never be in conflict. Yet restrictive covenants, by their very nature, create such a conflict since they may cause physicians to fear, whether unfounded or not, that if they advocate too strongly for patients and ruffle too many feathers, they will not only lose their job but also suffer even greater losses. A recent *New York Times* article on the bind physicians are placed in when they become employees of large organizations noted that “[d]octors at numerous hospitals said it was often difficult to criticize the policies instituted by hospitals or investor-owned physician groups because, as employees, they could easily be fired. “We all have families, and we have mortgages,” an emergency room physician was quoted as saying. “If you get fired, it looks bad and it’s hard to get another job.”^{***}

Physicians should not have to worry about being forced to move, pay liquidated damages or lose their means of making a living because they advocate for their patients. More importantly, patients should not have to entertain the thought that the care that is being provided or recommended is being influenced by a physician's financial interest in keeping his or her job.^{***}

A call for legislative action

On so many levels, the public interest makes clear the need for Minnesota to prohibit the imposition of restrictive covenants on physicians except in a very few well-defined situations. Common sense and the common good require that no patient should be denied the freedom to continue to see the physician to whom he or she may literally have entrusted their life because that physician no longer works for a particular employer. **MM**

Gordon Apple is a health law attorney in St. Paul and a former chair of the Minnesota State Bar Association Health Law Section. Kimberly Wernsing is a family physician in Mankato, Minnesota.

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^{##} To restore competition for adult cardiology services, the Federal Trade Commission on November 30, 2012, approved a Consent Decree with Renown Health in Reno, Nevada, that required Renown to waive non-competes in employment agreements with up to 10 cardiologists who were part of group practices that Renown had acquired. This is the first time that the waiver of non-competes was part of health care-related FTC enforcement action (<http://www.ftc.gov/opa/2012/12/renownhealth.shtm>).

^{***}As noted by the AMA in its Principles for Physician Employment: “Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.” The Association of American Medical Colleges Task Force on Financial Conflicts of Interest in Clinical

Care issues a report in 2010 in which it noted: “The presence of individual or institutional financial interests in the patient care setting may create real or perceived bias in clinical decision making and may distort the values of medical professionalism.” Although the AAMC report was focused on relationships between physicians and the pharmaceutical, device and biotechnology industry, one may argue that a financial interest is a financial interest with the attendant conflicts and risks. (<https://members.aamc.org/eweb/upload/In%20the%20Interest%20of%20Patients.pdf>.)

The case for investing in diversity

Why we should continue funding two programs aimed at encouraging individuals from minority and disadvantaged backgrounds to go into medicine.

LEONID SKORIN, JR., D.O., O.D., M.S.

Although the population of the United States has become more racially and ethnically diverse, it isn't the case among the physician workforce. Racial and ethnic minorities comprise more than a quarter of our country's population, yet only about 6% of practicing physicians are Latino, African-American or Native American.¹

This has an effect on care and access to it. Studies have shown that minority physicians are more likely than nonminority physicians to care for poor patients, those insured by Medicaid, those without health insurance and those living in areas with a shortage of health professionals.² One report by the American Medical Student Association found nearly half the patients seen by African-American physicians and one-third of the patients seen by Asian and Pacific Islander and Hispanic physicians are on Medicaid or are uninsured.¹ Another study showed the percentage of minority medical school graduates planning to practice in underserved areas is more than four times that of other graduates.³ Yet another found that concordance in provider-patient race/ethnicity has the potential to improve health outcomes.²

In 1963, Title VII of the Public Health Services Act was enacted to increase access to health care providers. From that emerged several programs designed to increase health professions educational op-

portunities for educationally and/or economically disadvantaged students and underrepresented minority students. Among these are the Health Careers Opportunity Program (HCOP) and the Centers of Excellence (COE).

The HCOP provides assistance to institutions that help minority and disadvantaged students enter and graduate from osteopathic and allopathic medical schools as well as from behavioral and mental health, chiropractic, optometry, pharmacy, physician assistant, public health, dentistry, veterinary medicine and allied health programs other than registered nursing.^{4,6} The HCOP grantees consist of community colleges, medical schools, state university systems and other postsecondary educational institutions. To meet HCOP objectives, institutions must conduct the following activities:

- Recruit disadvantaged individuals
- Facilitate entry of disadvantaged individuals
- Provide counseling, mentoring and other services
- Disseminate financial aid information
- Expose students to primary health care in public or private community-based facilities
- Partner with other institutions of higher education, school districts and community-based organizations to develop a more competitive applicant pool.

The COEs fund college and university health professions education programs for disadvantaged and underrepresented minority students. Schools of medicine, dentistry and pharmacy and graduate programs in behavioral or mental health are eligible for support for three-year projects. The COEs seek to meet the following goals:

- Create a competitive applicant pool
- Improve academic performance
- Support faculty development to train, recruit and retain underrepresented minority faculty
- Attend to minority health issues in clinical training, curricula and information resources
- Support faculty and student research in minority health
- Provide community-based training in clinics serving large numbers of minority patients.

The impact on diversity

Institutions that receive funding for diversity programs recruit and graduate up to five times the number of disadvantaged and underrepresented minority health professionals as institutions that do not receive such funding.⁷ Seventy percent of participants in HCOP, for example, are accepted into health professions schools and such students are up to 10 times more likely to practice in medically un-

derserved areas when they finish their training. Underrepresented minority physicians are also more likely than their nonminority counterparts to conduct research to help reduce racial disparities in health care.¹ Since 1972, at least half a million individuals, more than 400,000 of whom are minorities, have participated in the HCOP and COE programs.^{8,9}

Every year, HCOP and COE grantees submit data on participating students to the Health Resources and Services Administration's Disadvantaged Assistance Tracking and Outcome Report (DATOR) database. This is reconciled with data from the American Medical College Application Service and the American Dental Education Association, which track individuals applying to medical and dental schools. Information gleaned from these centralized databases indicates that HCOP and COE program participants are successfully matriculating into U.S. medical and dental schools. In 2006, 9,807 students who participated in HCOP or COE programs were reported in the DATOR system with the number increasing to 15,547 in 2007. Of these, 2,199 met the inclusion criteria of attending college and having an interest in medicine; that number rose to 2,404 students in 2007. Nearly 30% of these students had matriculated into medical schools and nearly 2% into dental schools by 2008.¹⁰ Specifically, 39% of African-American and 46% of Hispanic medical school applicants who had been in HCOP- or COE-funded programs matriculated into medical school.¹⁰ These findings add to the evidence that structured health and science career-oriented enrichment programs at the college level, supported by HCOP, COE and other funding sources, are important to enhancing opportunities for minority and disadvantaged students interested in pursuing careers in health-related professions.¹⁰

The funding question

The House Appropriations Committee released a draft of the Labor, Health and Human Services funding bill for fiscal year 2012 that cuts funding to the HCOP and COE programs. In addition,

the Senate Appropriations Committee cut funding to HCOP but allowed funding for COE programs.¹¹ Proponents of defunding COE and HCOP argue that these programs are duplicative, inefficient and excessively wasteful, as well as irresponsible and fiscally unsustainable. They prefer to fund more critical programs and services that benefit more Americans and not just selected groups of individuals.¹²

Those who support continued funding of COE and HCOP are concerned that defunding would result in the reduction or elimination of vital education and training opportunities for health care workers. Furthermore, defunding would diminish diversity in the health care workforce and reduce access to care for the nation's most vulnerable and underserved communities. The American Public Health Association, which supports continued funding, makes two points about the impact of these programs: 1) Primary care physicians who graduate from them are two to four times more likely than other primary care physicians to practice in medically underserved communities; 2) Funding these programs supports the education and training of more than 10,000 underrepresented minority graduates, residents and faculty each year.¹³

Closing the gap

Enhancing the ability of health professions schools to recruit and retain racially and ethnically diverse students is critical to meeting the health care needs of our nation.¹⁴ Although more underrepresented minority students are matriculating into the health professions schools than in previous years, there is still a gap between where we are now and where we need to be if the composition of our health care professions workforce is to mirror that of the overall population. The best way to rectify this discrepancy is to strengthen the educational pipeline. Faculty in school districts with large numbers of minority and low-income students need to be made more aware of career opportunities within health care. Additionally, students need to be connected with people who can expose them to health-related careers. Health

career tracks also need to be established in high schools and community colleges. Finally, there should be more outreach to encourage health care professionals to mentor minority students at all educational levels.

Certainly, multiple approaches are needed to build diversity in the workforce and meet the health care needs of underserved populations. Various industries and foundations have created some interesting programs that health care might emulate. There are new federal efforts as well. For example, the Health Equity and Accountability Act of 2011 (H.R. 2954) proposes new training opportunities for professional and allied health workers that would effectively serve minority populations.¹⁵

These initiatives will help narrow the gap, but they won't close it completely. Funding for HCOP and COE should be maintained if we are truly committed to creating a more diverse health care workforce. Both programs are designed to increase minority representation in the health professions and to improve access to care in medically underserved areas, and the evidence shows that they are accomplishing their stated goals. **MM**

Leonid Skorin Jr. is president of the Minnesota Osteopathic Medical Society. He wrote this while participating in the American Osteopathic Association's Health Policy Fellowship Class of 2012.

The author would like to thank Barbara Ross-Lee, D.O., Norman Gevitz, Ph.D., and Nancy Cooper, American Osteopathic Association Health Policy Fellowship Coordinator, for their input regarding this paper.

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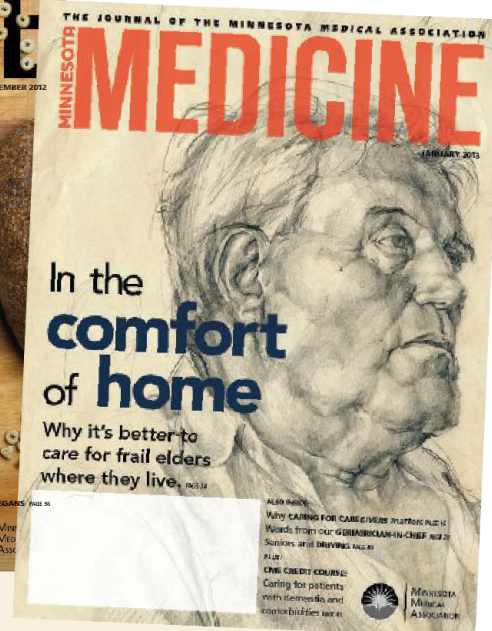
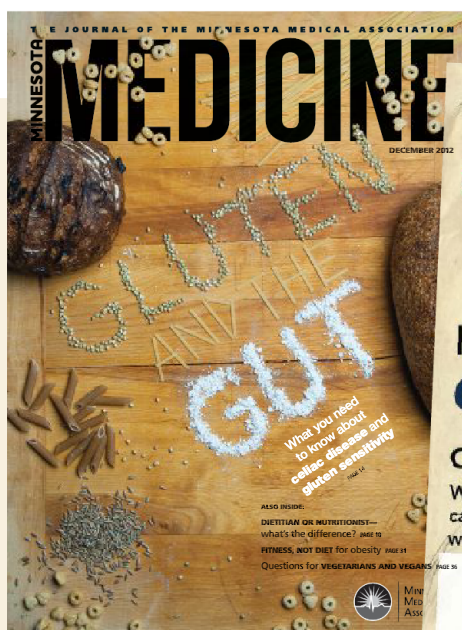
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Primary Care is at the Heart of Health Reform in Minnesota

BY MARK SCHOENBAUM, M.S.W., AND EDWARD VAN CLEAVE, PH.D.

Both the United States and Minnesota are facing an impending shortage of primary care physicians and other providers just as the population is aging and needing their services more than ever. At the same time, policy makers are heralding primary care as essential to health care reform. This article explains why primary care is the focus of so much attention. It also summarizes the work of the Governor's Health Care Reform Task Force and reports its recommendations for increasing access to primary care in Minnesota.

Increased attention to primary care is coming from many directions. Health care reform and practice transformation efforts often place primary care physicians at the helm of the teams responsible for the ongoing care of patients and increasingly make them responsible for patient outcomes. Population health activities such as those supported by the State Health Improvement Program to reduce obesity and tobacco use also call for broad inclusion of primary care providers. In addition, shortages of mental health care providers, OB/GYNs, geriatricians and other specialists, especially in rural areas, are placing greater demands on primary care physicians, who are being asked to provide these services. All of this is happening at a time when the United States is facing a shortage of primary care physicians and other providers.

Primary care was central to Minnesota's 2008 landmark health care reform legislation, particularly the establishment of the state's Health Care Homes program. In its recent work, the Governor's Health Care Reform Task Force made an explicit connection between the goals of health care reform and the capacity of the primary care workforce and created a work group dedicated to integrating strategies for in-

creasing the workforce into a comprehensive health care reform framework.

As part of its mission, the work group explored the expectations for primary care and the extent to which Minnesota's workforce is positioned to meet them. In this article, we look at the numbers and describe the recommendations for increasing access to primary care in the Task Force's "Roadmap to a Healthier Minnesota."

Minnesota's Primary Care Workforce: Supply and Demand

As of March 2011, 15,872 physicians with Minnesota mailing addresses held active licenses to practice medicine in the state. Of that total, nearly 29% (or roughly 4,584 physicians) were primary care practitioners—that is, they had earned single general board certifications in family medicine, internal medicine or pediatrics. Although there is no consensus about which specialties comprise the primary

care physician workforce, this admittedly conservative definition is consistent with Minnesota Statute 137.38, which defines primary care physicians as family physicians, general pediatricians and general internists.*

The distribution of these physicians is as important as their overall numbers. Nationally, the U.S. Agency for Healthcare Research and Quality (AHRQ) has found that although primary care physicians are more likely to practice in rural areas than non-primary care specialists, they are still more concentrated in urban areas than rural ones. Family physicians, it should be noted, are more likely than either general internists or pediatricians to practice in rural areas. In Minnesota, the geographic distribution of general internists and pediatricians roughly mirrors that of the nation, with the majority of these practitioners working in urban areas (Table 1). Minnesota's family physicians, in contrast,

*The Minnesota Department of Health's primary care physician counts originated with data from the Minnesota Board of Medical Practice and includes only those with an active license and who have earned a single general board certification in family medicine, internal medicine or pediatrics. Relying on specialty board certifications, however, does not address primary care-trained physicians working in non-primary care settings such as those employed as hospitalists, in emergency medicine, occupational medicine or in rehabilitation. It also excludes 4,455 licensees with no specialty board certification attached to their Minnesota Board of Medical Practice record, some of whom may or may not be practicing primary care. Therefore, the Department of Health's physician measure using board certifications serves as a proxy for examining distributions of likely primary care providers.

practice in rural areas to a far greater degree than their counterparts in other parts of the country.[†] This is because our state has done a better job of encouraging family physicians to practice in rural settings through initiatives such as the University of Minnesota’s Rural Physician Associate Program, its Duluth medical school campus and the state’s loan-forgiveness program.

The distribution of advanced practice registered nurses, especially certified nurse practitioners (NPs), and physician assistants (PAs) is also uneven. Of 2,373 NPs and 1,605 PAs who have Minnesota licenses and mailing addresses, the vast majority were located in urban parts of the state (Table 2). Although these professions were established in large part to address the uneven distribution of primary care physicians, many of these providers are not practicing primary care. A recent AHRQ report estimated that only 52% of NPs and 43% of PAs in the United States practiced in primary care settings.¹ However, given the low numbers of specialty physicians in rural Minnesota, it may be reasonable to assume that the majority of mid-level providers practicing in those areas are working in primary care settings, as PAs must work under the supervision of a physician and nurse practitioners must have a collaborative written agreement with a physician in order to prescribe medications.

Another concern is that the state’s primary care workforce is aging. More than a third of Minnesota-based primary care physicians are 55 years of age and older, as are nearly a third of the state’s NPs. In contrast, only 12% of PAs are 55 years of age or older (Table 3). Table 4 shows that certain primary care specialties and certain parts of the state will feel the effect of the aging workforce more quickly than others.

The supply of primary care physicians in Minnesota is on a collision course with population trends. Between 2010 and 2025, the percentage of Minnesota’s popu-

TABLE 1

Geographic Distribution of Primary Care Physicians—United States and Minnesota

Location	FAMILY PHYSICIANS		GENERAL INTERNISTS		GENERAL PEDIATRICS		POPULATION	
	MN	US	MN	US	MN	US	MN	US
Urban	65%	78%	89%	90%	89%	91%	69%	80%
Large rural	16%	11%	8%	7%	8%	6%	13%	10%
Small rural	12%	7%	2%	2%	2%	2%	7%	5%
Isolated rural	7%	4%	1%	1%	1%	1%	10%	5%
Total (%)	100%	100%	100%	100%	100%	100%	100%	100%
	(N=2,357)		(N=1,526)		(N=701)			

TABLE 2

Geographic Distribution of Nurse Practitioners and Physician Assistants—Minnesota

PROVIDER TYPE	NP	PA
Urban	81%	80%
Large rural	9%	10%
Small rural	5%	6%
Isolated rural	5%	4%
Total	100%	100%

TABLE 3

Provider Distribution by Age—Minnesota

	LESS THAN 35 YRS	35 TO 44 YRS	45 TO 54 YRS	55 TO 64 YRS	65 + YRS	TOTAL
Family physicians	5%	28%	31%	29%	7%	100%
General internal medicine physicians	14%	31%	23%	22%	10%	100%
General pediatricians	11%	31%	23%	22%	13%	100%
All primary care physicians	9%	30%	27%	25%	9%	100%
Physician assistants	41%	31%	16%	11%	1%	100%
Nurse practitioners	16%	24%	29%	26%	5%	100%

lation age 65 years and older will rise from 12% to 18%, increasing by almost 457,000 people, according to the state demographer. By 2035, the percentage of those age 65 and older will increase to 22% of the population. These are also the people who tend to use the most health care resources.

Looking Ahead

Although it is not possible to predict exactly what will happen in terms of physicians or other primary care providers retiring and leaving practice, analysts agree the demographics point to significant shortages.^{2,3} Minnesota is expected to have a shortage of between 1,000 and 3,000 primary care providers, and demand for up to 14,000 physicians in all specialties. As far back as 1992, the Minnesota Legislature charged the University of Minnesota

[†]Minnesota physician data in Table 1 originated with the Minnesota Board of Medical Practice and was aggregated for the analysis by Minnesota Department of Health. The Agency for Healthcare Research and Quality (AHRQ) used the American Medical Association Physician Masterfile for its estimates. The AHRQ adjusted for retirement and also included physicians self-reported as practicing geriatrics.

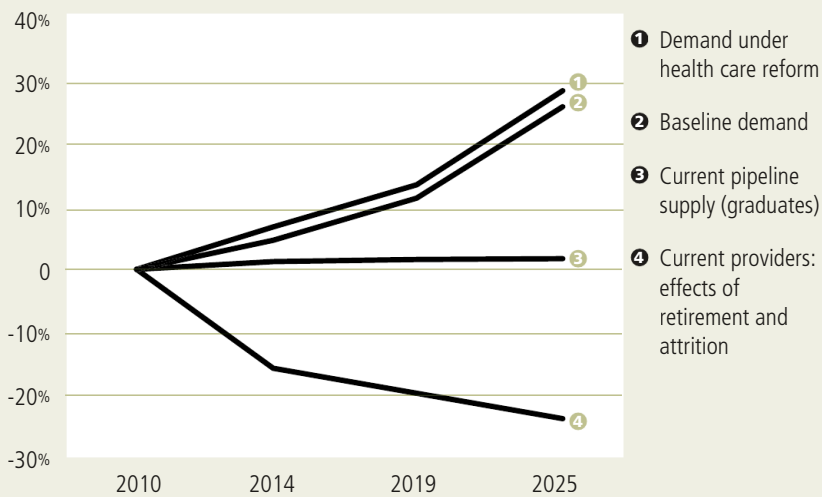
TABLE 4

Median Age of Primary Care Physicians by Specialty and Location—Minnesota

SPECIALTY	URBAN	LARGE RURAL	SMALL RURAL	ISOLATED RURAL	TOTAL
Family medicine	50	51	49	53	50
General internal medicine	46	51	51	45	47
General pediatrics	48	50	44	58	48
All primary care physicians	48	51	49	52	49

FIGURE

Primary Care Provider Supply and Demand—Minnesota



with pursuing strategies to increase the number of medical school graduates who enter primary care and choose to practice in rural and underserved areas. Although the university and other higher education institutions in the state have been increasing class size and opening new programs to train more physicians and other primary care providers, their rate of production is far lower than what will be needed to replace the clinicians leaving practice. At current rates, state medical schools will produce approximately 1,200 new primary care physicians in the next 15 years. Both nationally and in Minnesota, this spells a clear gap in provider capacity by 2025 (Figure).⁴⁻⁶

The Primary Care Workforce and Health Reform

Developing needed primary care capacity will require ongoing investments in both the production and the distribution of providers. It will also necessitate support for the type of practice transformation—such as health care homes and community care teams (teams of people from multiple organizations that address patient and family health needs) that is central to reform. Minnesota cannot train its way out of these expected shortages; therefore, it also must make changes in the way care is delivered.

The Health Care Reform Task Force's recommendations, outlined in "Roadmap to a Healthier Minnesota," published in December 2012, call for a comprehensive approach to reforming health care. The

Roadmap describes eight broad strategies to achieve the Triple Aim in Minnesota, ranging from paying for the value, rather than volume, of care to centering care around patients, engaging communities and measuring performance. Central to their recommendations is strengthening the health care workforce.

Of its seven recommendations regarding the state's health care workforce, five directly relate to primary care. They are:

1. Invest in high-need infrastructure and workforce services to increase access and foster interprofessional competency.

Support is needed to increase access to mental health and substance abuse care by primary care and traditional mental health and substance abuse professionals. In this vein, the Task Force recommends:

- Providing educational and training grants and fostering interprofessional competencies in the delivery of mental health and substance abuse care. Efforts are needed to better integrate these disciplines with medicine and to improve the capacity of primary care providers to respond directly to the mental health and substance abuse issues they are regularly presented with in their practices.
- Improving access to a broad range of medical, mental health and other health services in rural Minnesota by supporting and expanding telehealth and related technology.

2. Explore and remove regulatory barriers to the advancement of the nursing workforce.

Nursing is by far the largest sector of Minnesota's licensed health care workforce, and nurses play critical roles in all health care settings. The Task Force recommends:

- Removing practice barriers by adopting the Advanced Practice Registered Nursing (APRN) Consensus Model and enacting the APRN Model Act and Rules. Currently, Minnesota's Nurse Practice Act mandates that APRNs must practice in settings that provide for a collaborative arrangement between an APRN

and a physician. In addition, only those APRNs who maintain a signed written prescriptive agreement with a physician have prescriptive authority.

- Funding a study of the impact of Minnesota joining the Interstate Nurse Licensure Compact, including an analysis of state reciprocity and barriers to using telehealth. The Compact allows nurses licensed in a participating state to practice in any other state that belongs to the Compact without obtaining an additional license.

3. Support existing health professions training sites and funding new sites for primary care physicians, APRNs, physician assistants and pharmacists through the Medical Education and Research Costs (MERC) program.

MERC is the state's investment in Minnesota's clinical training system. The Legislature reduced funding for MERC in 2011 in order to close a budget gap. Increasing MERC funding will greatly stabilize health professions training. In addition, investing new resources specifically in primary care training will support the shift to team-based, primary-care-centered care, which is a foundation for achieving health reform goals. Specifically, the Task Force recommends:

- Increasing MERC funding through the existing mechanism.
- Establishing a new state-based fund for primary care training of physicians, APRNs, physician assistants and pharmacists.

4. Increase the number of health professionals in underserved areas by increasing funding for the state's Health Professional Loan Forgiveness Program and opening the program to a wider group of providers.

Loan forgiveness is a proven strategy to encourage health professionals to practice where they are most needed. Research also confirms that providers who are offered loan forgiveness if they practice in an un-

derserved area tend to stay there, making a long-term contribution in exchange for a relatively modest upfront investment by the state. The Task Force recommends increasing funding for loan forgiveness and expanding eligibility to include not just physicians, nurses and physician assistants but also licensed mental health professionals, licensed alcohol and drug counselors, dental therapists and advanced dental therapists, dental hygienists, occupational therapy practitioners and physical therapy practitioners.

5. Increase diversity in the health care workforce by supporting a range of health professions diversity programs.

Members of ethnic and racial minority groups are not proportionately represented in Minnesota's health care workforce. The Task Force recommends:

- Providing opportunities for students to explore health careers and emphasizing science, technology, engineering and math competencies throughout the K-12 curriculum.
- Supporting programs that train and mentor students from underrepresented minority groups to pursue health care careers.
- Assisting foreign-certified physicians and mental health professionals in obtaining Minnesota licensure.

Strategies to increase reimbursement to safety net providers for primary care, mental health and substance abuse treatment are among the Task Force's other workforce recommendations. In addition, the Task Force recommends exploring improvements to and expansion of the state's health care home program, which pays certified clinics to provide care coordination, and improving access to dental care by integrating dental therapists and advanced dental therapists into dental practices.

Conclusion

The Health Care Reform Task Force developed its Roadmap during a year-long process that included formal meetings, testimony and structured conversations across the state. Unique among Minnesota health policy efforts, the Roadmap acknowledges the centrality of the primary care workforce to the state's health reform goals and its efforts to transform the health care system. It also presents an opportunity to address the state's need for primary care physicians and other providers as state and federal health reform efforts unfold. **MM**

Mark Schoenbaum is director of the Minnesota Department of Health's Office of Rural Health and Primary Care. Edward Van Cleave is senior workforce analyst in the Office of Rural Health and Primary Care's Health Workforce Analysis Program.

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2012 American College of Physicians Minnesota Poster Competition Winners

Each year, the state chapters of the American College of Physicians (ACP) invite medical students and internal medicine residents to take part in a scientific poster competition. Last November, residents and students submitted 218 posters for consideration at the Minnesota chapter's annual meeting in Minneapolis. Each of the internal medicine training programs in the state (the University of Minnesota, Abbott Northwestern Hospital, Mayo Clinic and Hennepin County Medical Center) were well-represented with submissions in the clinical vignette, quality improvement, research and medical student categories. In addition to winners in each category, a "People's Choice" award was selected by popular vote.

Posters were judged by practicing internal medicine physicians, internists from the state's academic medical centers and chief residents. "Poster Rounds" were conducted for the peer judging process. The judges' criteria included clinical relevance, originality, and written and visual presentation. Special thanks to Charles Reznikoff, M.D., and Andrew Olson, M.D., for coordinating the competition.

The winners will present their posters at the ACP's annual meeting in San Francisco, April 9-13, 2013. Earlier this year, two of the 2011 Minnesota winners won national awards from the ACP.

Congratulations to all of the participants on their excellent work.

Clinical Vignette Winner

AIDS Masquerading as Dermatomyositis: Underscoring the Importance of Sexual History

BY SHAUNA MORROW, M.D.,
ABBOTT NORTHWESTERN HOSPITAL

Sexual history continues to be one of the least reliably obtained components of the medical interview in primary care settings, leading to lost opportunities for appropriate STI (sexually transmitted illness) screening as well as counseling regarding safe sexual practices. In this case, obtaining a routine sexual history may have prevented a delay in diagnosis of HIV and subsequently AIDS for one patient.

That patient, a 53-year-old man with a longstanding diagnosis of amyopathic dermatomyositis, was admitted to the hospital for evaluation and treatment of steroid unresponsive interstitial lung disease. On admission, the patient demonstrated significant hypoxia (oxygen saturation 74% on room air) with peripheral cyanosis and moderate respiratory distress. He was later admitted to the ICU for respiratory support with noninvasive positive pressure ventilation and intravenous steroids. CXR revealed diffuse ground glass opacities thought to be consistent with interstitial pulmonary disease. However, given the patient's deteriorating respiratory status, ongoing weight loss and lack of support for a dermatomyositis diagnosis (negative ANA, ENA and anti-Jo 1, skin biopsy nonspecific), an alternative etiology was suspected. Sexual history revealed that the patient had several sexual encounters with male partners five years prior. His HIV screening was positive and CD4 count was 9 cells/mm³.

The man was empirically treated for *Pneumocystis pneumonia*, which was later confirmed by biopsy obtained during bronchoscopy. He was also found to have CMV viremia and was treated with valganciclovir. With appropriate management, his condition improved and he was discharged from the hospital. HAART (highly active antiretroviral therapy) was initiated, and the patient's CD4 count rebounded.

This case illustrates the importance of obtaining a sexual history in all patients, including those perceived to be at low risk for STIs. This patient was a husband and father, which may have contributed to the failure to obtain a sexual history. Recent stud-

ies indicate that the sexual history is often omitted in the primary care setting; only 35% of primary care providers state that they often (75% of the time) or always take a sexual history.¹ Physicians cite embarrassment and time constraints as reasons for excluding discussion of sexual health.

The sexual history is an underutilized and cost-effective means for early detection of STIs as well as a gateway to discussion of safe sexual practices and behavioral risk reduction. An adequate sexual history should include documentation of sexual orientation, previous and current sexual partners, sexual practices and use of barrier protection.

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Research Winner

Asymptomatic Transaminitis in Newly Arrived Refugees to Minnesota

BY MALINI DESILVA, M.D.,
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The Minnesota Refugee Health Assessment is a clinical evaluation performed within 90 days of a person's entry to the United States. More than 95% of newly arrived refugees in Minnesota undergo this examination. HealthPartners Center for International Health (CIH) in St. Paul provides care for many of these refugees.

Since 2008, Burmese and Bhutanese Nepali refugees have been two of the largest groups arriving in Minnesota. There is limited published data on the health status of these groups; however, a recent study of Karen (Burmese) refugees in Australia showed elevated ALT in 16.1% of patients using 40 U/L as an upper normal limit. Unpublished observations from health practitioners at CIH suggest a significant number of new Bhutanese and Burmese refugees have asymptomatic mild elevations of ALT and AST discovered during new arrival screening.

We performed a retrospective cohort study of refugees presenting to CIH for new arrival screening between May 1, 2009, and September 30, 2011, to evaluate for any significant differences between refugee groups and to explore possible associations with asymptomatic transaminitis, if present. This study was approved by the HealthPartners Research Foundation with a waiver of informed consent because of the retrospective data collection and large study size. Demographic and clinical data obtained during initial new arrival screening were extracted and audited to ensure accuracy. Statistical analysis was performed using SAS v9.2.

We found a statistically significant difference in ALT levels between groups, with the prevalence appearing to be much higher in the Bhutanese Nepali and Karen/Karenni/Burmese groups than in all other refugee groups. In addition to ethnic associations, multivariate analysis showed associations between increased BMI, male gender and hepatitis B infection, and transaminase elevation. Hypothesized etiologies of transaminitis include alcohol use in refugee camps and lack of access to alcohol when arriving in Minnesota with slower degradation of ALT than AST, a viral hepatitis not routinely screened for in new arrivals, administration of hepatitis B vaccination in refugee camps prior to departure, a nutritional deficiency or environmental/toxin exposures in refugee camps. Further analysis of collected data and future prospective analysis will help elucidate the etiology and clinical implications of this transaminitis.

Quality Improvement Winner

Venous Thromboembolism Prophylaxis for Medical Patients: Implications for a Standardized Order Set

BY DARYN COLLINS, M.D., M.P.H., AARON GRAUMANN, M.D., KATIE LORENTZ, M.D., ADAM FOSS, M.D., ERIC BOMBERG, M.D., AND PAULA SKARDA, M.D., UNIVERSITY OF MINNESOTA

Each patient admitted to Regions Hospital in St. Paul is evaluated for risk of venous thromboembolism (VTE). Based on their degree of risk, patients receive

mechanical prophylaxis, chemical prophylaxis, both or neither. The current admission order set follows the Institute for Clinical Systems Improvement guidelines to determine degree of risk. Using the newest guidelines published in *Chest* in 2012, which make use of the Padua Prediction Score, we set out to determine if Regions Hospital is over- or under-utilizing chemical prophylaxis for VTE.

Methods: A chart review was performed on patients admitted to a general medicine or critical care service at Regions Hospital between February 1, 2012, and March 31, 2012. Risk factors for VTE were tabulated based on the Padua Prediction Score for each patient. It was noted if the patient received VTE prophylaxis (mechanical, chemical or both). The type of chemical prophylaxis was recorded (unfractionated heparin, enoxaparin, dalteparin, fondaparinux or warfarin continued from the outpatient setting). Data analysis was performed comparing those patients in high-risk groups with those in low-risk groups, as defined by the Padua Prediction Score.

Results: Four hundred and eighty-six patients were admitted to a general medicine or critical care service at Regions Hospital during the study period. Patients were excluded from further analysis if they were admitted to the intensive care unit or if they were on chronic anticoagulation. The final analysis included 322 patients. Being at high risk for VTE was defined as having a score greater than or equal to a Padua Prediction Score of 4. Of the 322 patients, 269 were considered low-risk. One hundred forty of those patients (52%) did not receive chemical prophylaxis, while 129 (48%) did receive chemical prophylaxis. Fifty-three patients met the criteria for being at high risk. Eighteen of those patients (34%) did not receive chemical prophylaxis, while 35 (66%) did.

Conclusion: A significant number of patients who were considered to be at low risk for VTE, based on the Padua Prediction Score, received chemical prophylaxis. This may have implications for modification of the current hospital order set and for significant cost savings.

Medical Student Winner**Effect of Group Visits on Care of Patients with Type 2 Diabetes**

BY JOSH DORN, QI WANG, M.S., AND BRIAN SICK, M.D., UNIVERSITY OF MINNESOTA MEDICAL SCHOOL

We conducted a retrospective cohort study of individuals with type 2 diabetes who attended group visits in the University of Minnesota Primary Care Clinic from 2006 to 2012. It was hypothesized that patients who attended group visits would experience improved diabetes care compared with patients who had only outpatient clinic-based care, and that there would be a positive correlation between outcomes and the number of group visits attended.

Methods: We defined two cohorts. The first, the group-visit cohort (n=48), was composed of those who partook in group visits along with outpatient clinic visits. The second, the comparison-group cohort (n=44), was composed of those who attended outpatient clinic visits only. Data

were collected via chart review for patients in the group-visit cohort before their first group visit and after their final visit. Data on the comparison group were collected over a time period that was equivalent to the average timespan that the group-visit cohort attended group visits (for those who attended more than two group visits). Outcomes measured were the ones set forth by the American Diabetes Association for optimal diabetes care including LDL cholesterol, A1C, blood pressure and health maintenance (foot exams, eye exams, vaccinations); overall optimal care also was measured.

Results: For patients who attended more than eight group visits, there was a 36.4% increase in the number who received optimal care, whereas there was an 11.4% decrease in the number who received optimal care in the comparison group (overall difference $P=.04$). For patients who attended more than two group visits, there was a 13.8% increase in the number with an up-to-date foot exam

versus a 29.5% decrease in the comparison group ($P=0.01$). For current eye exams, there was no change in the group visit group and a 43.2% decrease in the comparison group ($P=0.017$). No other results reached statistical significance.

Conclusion: Group visits for patients with type 2 diabetes at the University of Minnesota Primary Care Clinic were associated with statistically significant increases in the number who met goals for up-to-date foot and eye exams. Additionally, optimal care was most improved among those who attended the greatest number of group visits. Possible reasons for these improvements are increased time with the provider, additional time dedicated solely to type 2 diabetes care and the camaraderie of fellow patients who are facing similar problems. It is hoped that these results, along with other studies, will help group visits become a standard of care in treating type 2 diabetes. **MM**



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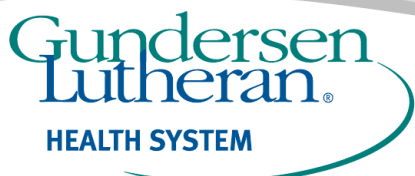
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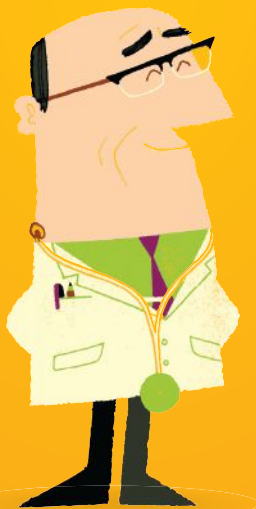
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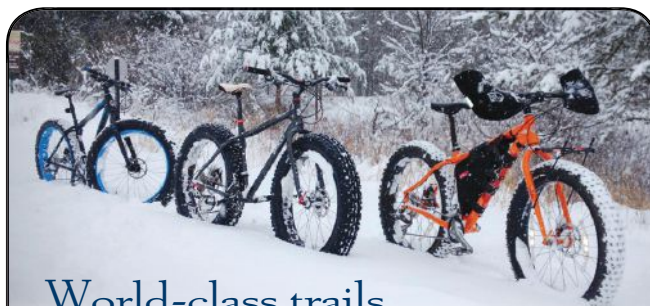


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BY HARRISON H. FARLEY, M.D.

I was just beginning my surgical career in 1962, when I was asked to change a gastrostomy feeding tube in a child. I gathered a Foley catheter and kit from the supply room and with one of the nurses went to see the patient.

On entering the boy's room in the B building of Swedish Hospital in Minneapolis, I was startled at the sight of a child with an enormous hydrocephalic head, with his eyes upturned and unseeing, propped against the headboard. The nurse was accustomed to caring for this patient, and she showed loving concern toward him. I proceeded to go about changing his tube and while doing so tried to communicate with him. It was as if I were talking to a manikin; he made little response to whatever I said or did. Although the procedure itself was simple and went smoothly, the visit was distressing.

Curious, I checked into the details of this case.

I learned the boy's injury resulted from an accident in the home of a happy well-to-do couple two years ago. It was an accident with terrible repercussions. The boy's father, fearing a home break-in, kept a loaded revolver in the drawer of his nightstand for protection. One afternoon his two sons, ages 2 and 7 years, were innocently playing upstairs, running from room to room. For some reason they entered their parents' bedroom. The older boy, as a curious child of 7 is apt to do, opened the nightstand drawer. He saw the revolver, picked it up, playfully pointed it at the head of his brother—and, in jest, pulled the trigger.

The bullet exploded across the toddler's head. He survived emergency surgery, but his head began to

swell. The fact that his cranial sutures were not yet fused undoubtedly allowed for the swelling and prevented herniation of the brain stem. This probably saved his life, but at a tremendous cost, for permanent hydrocephalus resulted.

The older brother was distraught at what had happened from a prank gone wrong, and to make matters worse his father blamed him for the incident. The boy became deeply depressed and eventually required hospitalization and long-term psychiatric care.

The mother and father had great difficulty relating to their youngest son and their visits to the facility where he lived became infrequent. The mother blamed the father and shut herself off from him. The father began to seek solace in alcohol and became severely depressed himself, so much so that he became unable to work. Their marriage fell apart.

I was thoroughly upset after that hospital visit. I had a .38 special in my own house. Although I had taken precautions against just such an accident occurring, I asked myself whether the protection the gun afforded was worth running the risk of such a calamity. One can be critical of the father's judgment in keeping a loaded gun at his bedside; but if a gun is to provide significant protection, it must be handy and probably loaded. In any case, I got rid of mine. A gun has no mind of its own. It can kill or maim without remorse. I have nothing against anyone wanting to protect self and family with a handgun, but they should carefully weigh the risks before doing so. **MM**

Harrison Farley is a retired surgeon living in St. Paul.

Peace, love and litigation support.

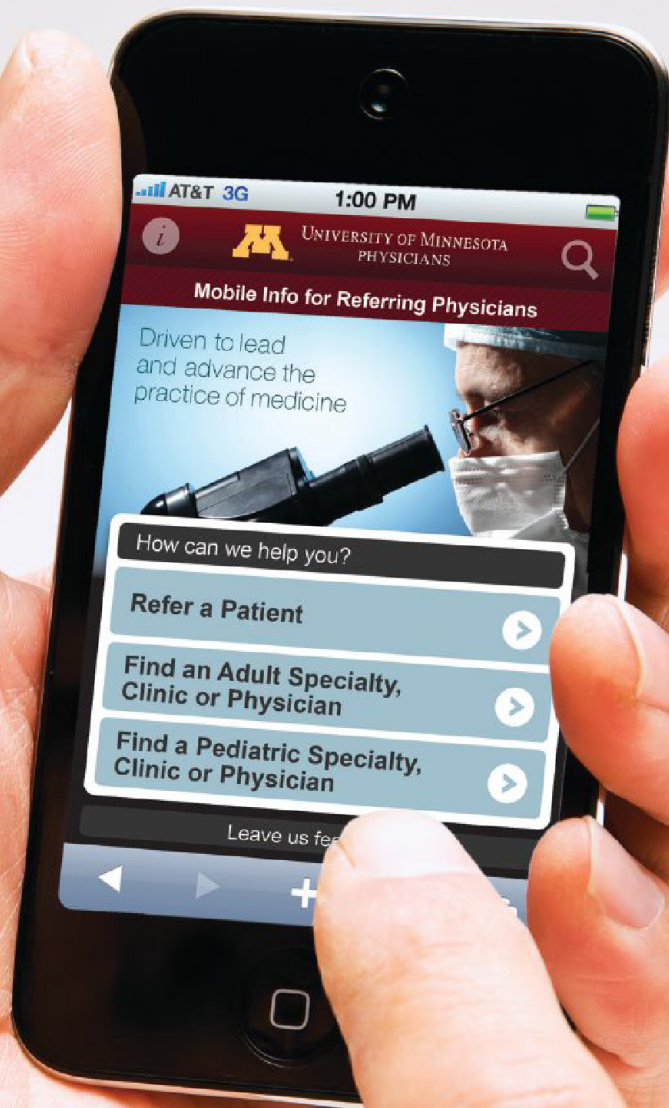
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