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The words “if you’re in medicine you’re in politics” resounded from the podium numerous times during the recent American Medical Association (AMA) Annual House of Delegates (HOD) meeting in Chicago. Physicians were challenged with the concept that as one united voice, physicians represent a respected and highly influential voice. However, as small, splintered groups, their influence is greatly diminished. The SDSMA delegation members were in Chicago and able to play a role in shaping AMA policy regarding critical access hospitals (CAH).

The Balanced Budget Act of 1997 established the Medicare Rural Hospital Flexibility Program which authorized certain facilities participating in Medicare to become CAHs by reducing federal regulations and improving reimbursement. There was a recognition that small, rural hospitals face challenges including “remote geographic locations, administrative workforce scarcity, physician shortages and limited financial resources while providing efficient, cost effective care. In fact, Medicare spends 3.7 percent less per rural Medicare beneficiary than per urban beneficiary” (AMA Resolution 102). There were a number of conditions placed on CAHs including bed size under 25, length of stay less than 96 hours, 24 hour emergency services and location more than 35 miles (15 miles in mountainous terrain) from another hospital or CAH. However, states were allowed to designate certain additional facilities as CAHs if they were deemed “necessary providers.” CAHs now play a vital role in providing rural health care, make it possible for patients to receive care in their home communities and “play a vital role in economic security for families and seniors, as well as jobs to rural communities across the nation – a typical CAH has 141 employees and generates $6.8 million in wages. For every job at a CAH, these rural hospitals create an additional 0.38 jobs in their community, generating an added $1.6 million in economic impact” (AMA Resolution 102).

An August 2013 recommendation from the Office of the Inspector General proposed the elimination of the “necessary provider” provision. Estimates are that nearly two-thirds of America’s rural hospitals would be at risk of losing their CAH status. This would have the potential to negatively affect health care access and delivery in rural America and threaten economic viability of many rural communities. This recommendation could profoundly affect South Dakotans because 38 of our state’s 53 hospitals (Kaiser, 2011) have CAH designation. The OIG report estimated that if the CAH designation had been removed from half of the nation’s CAHs the government would have saved $373 million in 2011. However, this would be out of a total budget of $550 billion which would equate to a one-year savings of less than 0.0006 percent of the Medicare budget.

CAH physicians brought this concern to the SDSMA. The SDSMA researched this looming rural health care crisis and recognized that small CAHs or even the SDSMA would have a small impact on the federal decision-making process. For that reason, in March 2014 the SDSMA delegation brought a proposal for endorsement to the North Central Medical Conference (Iowa, Minnesota, Nebraska, North Dakota, South Dakota and Wisconsin) and received conference endorsement and drafted a proposal to be presented to the AMA HOD in June 2014. An AMA reference committee reviewed the proposal but recommended that it be referred. However, members of the SDSMA spoke out on the floor of the HOD and the resolution passed! It is still unknown what the final federal action will be, but rather than small, diverse voices from CAHs and state medical societies, the unified voice of the AMA is on record in support of rural health networks and in opposition to the elimination of the state-designated CAH “necessary provider” designation. Further, the AMA resolves to pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.

While the ultimate federal decision is still unknown, physicians in a strong unified voice have spoken. The SDSMA has had a pivotal role in the formation of important AMA policy. The future of health care, especially in rural America, is an important cause to champion and I encourage all physicians to answer the challenge. “If you are in medicine you are in politics.”

I look forward to beginning my visits to the SDSMA districts and to meeting face to face with my colleagues around the state. Please consider taking an active role in your SDSMA. There are many options available for involvement. Committees and districts are always looking for new input. Consider becoming a councilor, alternate councilor or joining the Executive Committee. Consider being a SDSMA Doctor of the Day in Pierre during the upcoming legislative session. Just do it!
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Leadership Development

By Mary Lou Pierce  
SDSMA Alliance

On June 8-10, the AMA Alliance held the Leadership and Development Conference in combination with the Alliance Annual meeting in Chicago. Past SDSMA Alliance President Grace Wellman and I attended the meeting and past SDSMA Alliance Co-President Jean Bubak was in attendance for the opening morning sessions. The conference theme was “Real life answers.” Marshelia De Van, senior communication specialist of EMO Enterprises, delivered the keynote address “Think like a Leader: Live Like a Leader.”

The morning was filled with workshops. “The Voice of Experience” was led by Barb Hanas, AHEI board chair and featured techniques for improving team skills. Ruth Ryan, AMA Alliance parliamentarian, gave a session on organizing and expediting your minutes. Board accountability and effectiveness was addressed by Pat Troy, AMA Alliance executive director. Doralee Billings, senior accounting consultant with Next Wave Group also presented “All Things Financial,” focusing on budget preparation, dues collection and audit questions. The final session was “Leveraging Social Media for Results.” This interactive workshop offered two concurrent sessions. One session for first-time conference attendees and one for members who are ready to take social media to the next level in the ever-changing digital world. A legislative update by Oklahoma State Senator Susan G. Paddock was the afternoon feature.

Our second morning opened with “The Resilient Physician Family: New Challenges, New Solutions” by medical marriage expert Dr. Wayne and Mary Sotile. Then Paul Vogel, CPA spoke on “Financial Smarts: From Medical School to Retirement.”

At the annual meeting session, AMA Alliance President Jo Terry introduced a new journal called The Physician Family which will be published by the AMA Alliance. Each issue of The Physician Family will feature articles focusing on the issues and challenges faced by medical families. Other articles will focus on relationships, health and wellness, work and life balance, financial and legal issues, making a difference and giving back, food, travel and much more. The Physician Family will be available quarterly on a digital basis through the AMA Alliance.

Our second day concluded with a reception hosted by Indiana and Ohio honoring President-Elect Sarah Sanders. The reception had a tailgate theme and all members attended wearing their favorite team’s jersey. Grace and I helped cheer President-Elect Sarah on by wearing our Kentucky Wildcats and Los Angeles Angels jerseys.

At the awards breakfast recognition was given to individual states for their accomplishments. We then attended a session on “Creating an Exceptional Member Experience” presented by Peggy Hoffman, president of Mariner Management.

This year’s AMA Alliance Leadership and Development Conference was a success. But the AMA Alliance faces many challenges in membership, recruitment and retention. The Alliance must be able to meet the needs of the state and district Alliances in order to continue on to the next generation. It must also be ready to meet the needs of physician spouses and families. With so many district and state alliances dissolving around us, an organizational assessment task force was developed. The goal of the task force is to build a community that can give locally, regionally and nationally. In order to do this we must look at our structure. Is the structure we have in place allowing us to mentor and create new leaders? How do we engage new leaders in our organization without making them feel they are serving indefinitely? Are we able to strengthen partnerships? Are we better off having the AMA Alliance collect our dues? Are members more willing to share leadership through a steering committee verses the traditional hierarchy of president? These are some of the questions that the AMA Alliance Organizational Assessment Task Force has been faced with. Grace Wellman is a member of the organizational task force and was appointed by the AMA Alliance to work with the North Central states this year.

The 2014 AMA Alliance annual meeting came to a close with recognition of national past presidents, introduction of current officers, committee and task force members, and installation of officers and directors. In closing, President Sarah Sanders of Ohio was given the oath of office by Ardis Hoven, MD, AMA president.

We networked and connected and we learned new ideas. But most of all we made new friends from across the country.
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Although much of the SDSMA’s work involves day-to-day activities, we’re also looking toward the future. The SDSMA has worked hard over the past year to propel its three strategic focus areas forward – including personal health and wellness, practice support, and leadership development – and we’ve made significant progress. The vision we had when we announced the launch of the Center for Physician Resources is now coming more clearly into focus, and I couldn’t be more excited to see what we accomplish next.

We’re beginning to provide support to physicians in the areas of personal health and wellness, as well as in practice support.

Our partnership with the Foster Group is in full swing, centered on bringing valuable information to medical students, residents and physicians to support their decisions related to personal finances. Educational events were held on many topics, and webinars and resource materials were developed so you can access the information whenever it fits your schedule. The topics include wealth preservation and investment strategies, wealth protection, wealth enhancement, charitable giving and tax mitigation, and wealth transfer.

After this energizing series on personal finances, the Center is working with the Foster Group to offer two forums on wealth integration this fall to discuss asset and wealth protection, tax strategies for 2014 and beyond, and planning for retirement. The forums will also provide information on understanding physician payment models of the future. They will be held in Sioux Falls on Tuesday, Sept. 9 and Rapid City on Tuesday, Sept. 16 so be sure to mark your calendar and make plans to attend.

Our practice support initiative aims to help providers mitigate risk in the clinical setting. For this educational series, we’ve teamed up with MMIC to leverage their expertise and make risk management easier to implement for physicians. In this first stage, we’ve focused on finding the ways to best conduct a clinical risk assessment of your medical practice and facility, mitigate or reduce medical liability with accurate and complete medical record documentation, and avoid HIPAA violations and the associated liabilities that accompany a data breach by ensuring privacy and securing of patient-level information. Additional programs will include effective patient communications, patient handoffs, and the utilization and supervision of allied health professionals.

We’re also making strides to better support our member physicians by developing a series of legal briefs that provide general information on topics of interest. And while the SDSMA legal briefs are not meant to be a comprehensive guide, nor are they to be construed as legal advice, the SDSMA legal briefs serve as an excellent source of information with regard to state statutes and regulations that impact medical practice.

To date, 45 legal briefs have been developed, and the topics range from advance directives to closing a medical practice and record retention, to terminating the physician-patient relationship and providing volunteer medical services. Recently developed legal briefs include Hearings and Investigations of the South Dakota Board of Medical and Osteopathic Examiners, Standing Orders for Immunizations, and Supervision of Physician Assistants and Collaboration with Advance Practice Nurse Practitioners. All legal briefs are available online through the SDSMA website at www.sdsm.org.

Looking ahead, there’s a lot more to come in this exciting area. SDSMA staff are currently working with a number of stakeholder organizations to develop a program to aid prescribers and dispensers in addressing prescription drug abuse and diversion. Additionally, the SDSMA is working with a consultant to develop four physician leadership programs to assist physicians with health care quality improvement, serving in the roles of a practicing and administrative physician leader, and serving as a physician advocate.

Association leadership and staff are proud to have a hand in the SDSMA’s work to provide relevant support to you and your colleagues, and you should be, too. We’re leading the charge into the future. Just imagine what we’ll accomplish by this time next year as we continue to work together.
Cardiovascular disease remains the number one killer in this country, with coronary artery disease (CAD) responsible for majority of these deaths. CAD has not only many faces, but also can affect patients across the full age spectrum of the adult population. In this issue of South Dakota Medicine, our cardiology fellows present two cases of acute myocardial infarction at the extremes of adult age.

The first case involves an 18-year-old female with ST elevation myocardial infarction (MI). The intramural hematoma is the likely mechanism of injury resulting in compromise of the coronary lumen. Thus, this very young patient required stenting of the coronary artery to return blood flow to the affected myocardium. The second case involves a 90-year-old patient with non ST elevation MI and evidence of ongoing ischemia in spite of maximization of medical management. Classical atherosclerosis progression has resulted in a life threatening condition in this elderly but active individual. The high risk percutaneous coronary intervention (PCI) was successful in returning this patient to her baseline functional status.

Both patients have had classic risk factors and presentation. The extremes of age, however, affected to some extent the management. PCI in both cases was performed safely and with good results, with expectation of morbidity and mortality benefit. Technological advances, especially over the last decade, have made PCI in the setting of acute MI safer and more effective. We present these cases to remind us all of the age spectrum that CAD can affect, and also to point out that no matter what the patient’s age is the treatment can be effective and beneficial.

The cardiology fellowship at University of South Dakota Sanford School of Medicine has successfully started over one year ago and at present includes four cardiologists-in-training (cardiology fellows), with a full complement of six fellows by July this year. Our fellows have already been productive in research, publishing in peer-reviewed journals and presenting at national and international conferences. Our faculty also plans to have the cardiology fellows regularly contribute to South Dakota Medicine for the benefit of its readers.

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18-Year-Old Female With Acute ST Elevation Myocardial Infarction

By Muhammad A. Khan, MD; Shahjehan Khan; Adam T. Stys, MD; Tomasz P. Stys, MD; and Naveen Rajpurohit, MD

Abstract

Acute coronary syndrome (ACS) is a rare disease entity among young female patients. Intramural hematoma is a diagnostic consideration in a population at low risk for classic pathophysiologic mechanisms underlying acute coronary syndromes, namely plaque rupture or plaque erosion. We describe a case of a young female patient presenting with acute coronary syndrome attributed to intramural hematoma.

Introduction

Coronary artery disease is the leading cause of death in the United States for both men and women. One-sixth of deaths were attributed to coronary artery disease (CAD) in the United States in 2009, with costs of $108.9 billion each year. Even though it has been regarded mainly as a “man’s disease,” deaths due to cardiovascular disease in women have exceeded that of men since 1984.1,2

Acute coronary syndrome (ACS) has a more variable presentation for women when compared to men. Women with acute coronary syndrome more often present with atypical symptoms such as back pain, neck pain, nausea or vomiting, dyspnea, palpitations or lethargy. Myocardial infarction can exhibit a more indolent course in women;3 moreover, almost two-thirds of women who die suddenly of coronary heart disease have no previous symptoms.4

Women, when compared to men, have higher mortality rates and more adverse outcomes after acute myocardial infarction (AMI), despite having a less significant degree of coronary artery obstruction and lower plaque burden, even though they exhibit similar plaque responses to intensive risk factor modification.5 The most common etiology of ACS is plaque rupture, although one-third also have plaque erosion, with a few having calcified nodules and embolism.6 Another notable cause of ACS especially in younger females is spontaneous intramural hematoma formation.7

We present a case of a young female with no past history of coronary artery disease, whose acute myocardial infarction was attributed to an intramural hematoma.

Case History

An 18-year-old Native American female presented with sudden onset of chest pain of two hours duration, which radiated to the left arm and was associated with diaphoresis. She denied having any fever, dizziness, headaches, dyspnea, abdominal discomfort and bowel or urinary complaints. She had type 1 diabetes mellitus since the age of 7, currently managed on insulin pump. Despite this therapy she has presented with diabetic ketoacidosis (DKA) several times in the past. She is a nonsmoker and does not abuse alcohol; however, she reported regular marijuana use up to three times per week. There is no family history of premature CAD. Examination revealed an anxious lady with normal vital signs. Cardiac examination revealed a non-displaced point of maximal impulse, normal rate and regular rhythm. No abnormal heart sounds or murmurs were identified. Rest of the examination was unremarkable. EKG revealed anterior ST elevation with reciprocal ST depression in the lateral leads. Laboratory work up revealed normal hematologic indices, and the basic metabolic panel was otherwise normal except for elevated blood sugar at 204 mg/dl.

The patient was taken emergently for coronary angiography which revealed complete occlusion of the proximal left anterior descending artery (LAD) at the bifurcation of first diagonal branch (Figure 1). Flow in LAD was restored with balloon angioplasty and aspiration thrombectomy. A
drug eluting stent was deployed in proximal LAD; however, due to plaque shifting (“toothpaste effect”) another stent was needed to cover this segment. Next, a simultaneous kissing balloon reconstruction of the LAD bifurcation was performed with optimal final result (Figure 2).

Echocardiogram showed moderate systolic left ventricular dysfunction with LAD territory regional wall motion abnormalities. The patient was treated classically with Aspirin, Clopidogrel, Lisinopril, Metoprolol and Atorvastatin. Her subsequent hospital course was uneventful and she was discharged home in good condition with recommendations including a cardiac rehabilitation program.

Discussion

Atherosclerotic coronary artery disease, as well as atherosclerotic manifestations elsewhere, is a progressive disease with generally a long latency period before symptom onset. Presentation of CAD is thus varied from asymptomatic or stable symptomatic coronary artery disease to acute coronary syndromes and sudden cardiac death. Presentation of acute coronary syndromes is varied as well and depends on many factors, including the degree of coronary artery occlusion. CAD rarely presents in very young adults. Younger women have somewhat of a lower risk of developing CAD as compared to men in the same age group. ACSs have a variable presentation for women when compared to men. Women are more likely to have no chest pain at the time of presentation. Interestingly, two large studies evaluating coronary artery disease presentation in young population did not have any patients below the age of 30. More young women with CAD had diabetes as compared to men. Unfortunately, young patients with coronary artery disease have poor long term outcomes. Specifically diabetic patients had a 15 year survival of only 35 percent.

We present an interesting case of a very young female who presented with ST elevation myocardial infarction (STEMI). Despite a few risk factors for CAD, her Framingham score at presentation puts her at low risk for underlying CAD. She denied symptoms suggestive of stable angina prior to that day. Coronary angiogram (Figure 1) revealed complete occlusion of proximal LAD. Given the fact that plaque rupture or plaque erosion are the most common reason for acute MI, this might be the case in our patient. On the other hand, our patient’s very young age lead us to consider alternate etiologies for acute coronary occlusion. Angiographic findings are clearly not suggestive of acute coronary artery dissection. No prior history of atrial fibrillation or mechanical heart valve makes embolization less likely. Her clinical presentation was not suggestive of infective endocarditis, which can result in embolization as well. There was no evidence of atherosclerotic disease elsewhere in the coronary tree which makes classical pathophysiologic mechanisms of ACS less likely.
Coronary medial hemorrhage (CMH) or coronary intramural hematoma (IMH), a rare etiology of ACS, is a likely possibility in her case. This is a poorly understood disease entity and has been reported predominantly in the form of isolated case reports. On review, it has been reported as either a complication of stent placement or as a spontaneous event. Incidence and prevalence of this condition is largely unknown as angiographic findings are notoriously similar to plaque rupture with thrombus formation. Almost all of the reported cases utilized intravascular ultrasound (IVUS) or optical coherence tomography (OCT) to diagnose this disease entity. Risk factors for intramural hematoma are not very well established. Increased risk appears to be associated with pre- and postpartum periods, trauma, hypertension, vasculitis, and use of contraceptives or illicit medications. Accurate diagnosis of this disease entity can be challenging and likely the reason for scarcity of data. In a patient, like the one reported in our case with complete occlusion of a coronary artery, precious time can be lost while using the more definitive diagnostic modalities including IVUS or OCT before adequate flow can be restored. After flow restoration with balloon catheters, anatomy of the lesion can be distorted enough to prevent diagnosing this condition.

Pathophysiologic mechanisms are not well understood but thought to be the result of ruptured vasa vasorum. Angiographic appearance can be indistinguishable from plaque rupture with thrombus formation. As described above, IVUS has been a better discriminator of IMH than conventional coronary angiography. OCT has also been used with success for diagnosing IMH.

There are no specific treatment guidelines for IMH. On reviewing previously reported cases, decision regarding revascularization depended on the degree of coronary occlusion, presence of symptoms and EKG changes. In the presence of any of the above, PCI with stent has been performed with successful restoration of flow. On the other hand, if adequate flow is observed on diagnostic angiogram, these patients have been observed with successful resolution of the hematoma over one to two months. This is an important observation as stent edge malposition has been documented on repeat IVUS imaging after stent placement.

Specific to this case is another important dilemma for the practicing cardiologist, that of pregnancy in a patient who has suffered from an acute coronary event. Overall, the incidence of AMI during pregnancy is extremely low, occurring at about one per 10,000 pregnancies. Prior myocardial infarction is not an absolute contraindication for subsequent pregnancy. Data regarding this specific population group is scarce, understandably, given the low number of patients in this situation. On review, there are no reported cases of a recurrent myocardial infarction in a subsequent pregnancy. Patients should be advised to delay a subsequent pregnancy for at least one year after myocardial infarction. Risk factors for coronary artery disease should be optimized as much as possible prior to initiation of pregnancy. Currently, combined OCP is not recommended for diabetic patients with vascular disease.

Progesterone only contraception is a safer option as compared to combined OCP regarding cardiovascular complications and will be the preferred choice.

Conclusion
There are many etiological factors behind the presentation of an acute MI. The main difficulty faced in determining the exact etiology is the short window period between presentation of symptoms and the demise of the patient. Albeit rare, intramural hematoma should always be taken into consideration when managing an acute MI, those requiring higher vigilance are young healthy females or diabetics that currently are known to suffer more from this disorder. There are no set guidelines on the management of such cases and standard AMI management strategies are currently being followed.

REFERENCES


Please note: Due to limited space, we are unable to list all references. You may contact South Dakota Medicine at 605.336.1965 for a complete listing.

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Stenting of the Unprotected Left Main Coronary Artery in a Nonagenarian Presenting with Recurrent Non-ST Elevation Myocardial Infarction

By Amol Raizada, MD; Marian Petrasko, MD; Tomasz P. Stys, MD; Adam T. Stys, MD

Abstract
Coronary artery disease (CAD) involving the left main (LM) artery has traditionally been considered an indication for coronary artery bypass surgery (CABG). With recent advances in the field of percutaneous coronary interventions (PCI), angioplasty and stenting of the unprotected LM has been performed in patients at high surgical risk. This is a challenging intervention as a large area of myocardium is at risk during the procedure. Features that make it especially high risk are distal stenosis of this vessel and presence of coronary disease in other territories. Left ventricular assist devices need to be considered in these situations so as to minimize the risk involved. We present a case of a 90-year-old female with myocardial infarction who underwent complex angioplasty involving the distal LM and proximal left anterior descending (LAD) coronary artery, without left ventricular assist device or balloon pump support.

Introduction
While coronary artery bypass surgery (CABG) has always been considered the standard treatment for significant left main (LM) coronary artery disease, angioplasty and stenting of this vessel is now being performed in patients who are considered high-risk for open heart surgery. We present a case of a high-risk LM stenting in a 90-year-old female with recurrent angina and non-ST elevation myocardial infarction that was done without a ventricular assist device or balloon pump support. The patient achieved good angiographic results and did well symptomatically on subsequent follow up.

Case Report
A 90-year-old female presented with crushing precordial pain at rest that was relieved with nitroglycerine. Physical exam was fairly unremarkable except for mild bradycardia. Her electrocardiogram showed sinus rhythm with first degree atio-ventricular block and a right bundle branch block with repolarization changes. The patient was continued on aspirin and heparin infusion was initiated. Beta-blockers were not given as the heart rate was in the 50s. Troponin-I was elevated, consistent with a diagnosis of non-ST elevation myocardial infarction (NSTEMI). The patient subsequently developed a third degree heart block with hemodynamic instability and a permanent pacemaker was implanted. She was also found to have concurrent deep venous thrombosis of the lower extremities associated with multiple pulmonary emboli and a right atrial thrombus on the transthoracic echocardiogram. An inferior vena cava filter was placed because of high clot burden and warfarin therapy was initiated.

The patient had been diagnosed with multi-vessel coronary artery disease (CAD), including LM disease, three months prior to her current presentation. At that time a peripheral endovascular intervention was complicated by ventricular tachycardia and NSTEMI. Coronary angiography revealed severe distal LM stenosis involving its bifurcation, left circumflex artery (LCX) ostial stenosis up to 99 percent and left anterior descending (LAD) ostial stenosis up to 95 percent (Figures 1 and 2). The right coronary artery (RCA) showed chronic total occlusion with collaterals from the LAD (Figure 2). Coronary artery bypass graft (CABG) was recommended, but the patient refused open heart surgery.

In view of recurrent NSTEMI, revascularization was considered. Given the location of the stenoses (unprotected distal LM bifurcation), advanced age and the presence of multivessel disease, percutaneous coronary intervention (PCI) was felt to be a high risk procedure. Periprocedural
intraaortic balloon pump or Impella (Abiomed, Danvers, Massachusetts) were contraindicated due to history of bilateral aortoiliac stenting. As the patient continued to have angina with minimal exertion on maximal medical therapy and refused CABG, PCI was performed.

After balloon angioplasty of LM and the proximal LAD, a drug eluting stent was successfully deployed in the distal LM and ostial LAD with good distal flow (Figure 3). LCX was “jailed” by the stent, but this did not significantly affect its already decreased flow. During the balloon predilation and stenting of the LM, profound hypotension ensued, but the pressure recovered quickly afterwards. The patient did well after the procedure and was subsequently discharged in stable condition. At one month follow up, the patient was doing well and had no symptoms of angina or heart failure.

**Discussion**

In patients with LM disease, CABG is associated with significantly better outcomes when compared to medical therapy\(^1\) and is usually the preferred modality of treatment given its long track record and safety. Recent prospective trials have shown non-inferiority of PCI to CABG with regard to the composite primary endpoint of all-cause mortality, myocardial infarction, stroke and target vessel revascularization in patients with unprotected LM disease in some patient groups.\(^2,3\) The primary endpoint tended to be better with PCI in patients with solitary LM disease and better with CABG in patients with coexisting triple vessel disease, although these differences were not statistically significant. Also, distal LM lesions were found to be higher risk than ostial or mid LM lesions for PCI.\(^4\) Given the increased risk of hemodynamic compromise with LM PCI,

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*Jailed: a coronary artery whose ostium is stented across while stenting the artery from which the jailed artery branches off. In the process, flow in the jailed artery may be compromised.
cardiac support with an intraaortic balloon pump or short-term left ventricular assist devices such as Impella is also recommended.

PCI with stenting of the unprotected culprit LM is currently recommended in patients presenting with ST elevation myocardial infarction if the distal coronary flow is compromised and PCI can be performed safely and rapidly when compared to CABG. It is also recommended in cases of unstable angina and non-ST elevation myocardial infarction if the patient is not a good surgical candidate. For stable ischemic heart disease with LM stenosis, PCI is recommended if the patient has a low CAD complexity anatomical score (SYNTAX score) and ostial or mid LM disease.²

Our case presented a challenging situation given the patient’s advanced age, distal location of the unprotected LM stenosis, presence of multivessel disease (no “safety margin” – global ischemia present), acute presentation, and inability to use left ventricular support device. In spite of the high risk characteristics, the patient did well. This case illustrates how recent techniques and equipment have resulted in the ability to perform successful PCI faster, safer and with better outcomes for lesions that were not too long ago considered to be the domain of surgery.

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Many physicians and coroners struggle with what degree of certainty they need to complete a cause of death statement. The regulations state that a certifier needs only to state a cause of death to a degree of simply more likely than not. In other words, you only need to be just a little bit more than 50 percent sure of a diagnosis to complete a death certificate.

Most certifiers like to be more certain than 50 percent, but clearly absolute certainty or even certainty beyond a reasonable doubt are higher levels of certainty in completing a death certificate than is necessary (or more often than not, even possible). As a certifier, where to set the level of certainty you need to complete a certificate is both a personal decision and one based on the consequences of the decision. A certifier, for example, may feel more likely than not is sufficient certainty for listing complications of coronary artery disease as a cause of death for a 79-year-old man collapsing suddenly at home after clutching his chest. On the other hand, a higher degree of certainty might be needed with a suspected infectious disease death (e.g., meningitis) where a large public health issue is present.

One way around the certainty issue can be to insert “probable” before your cause of death statement. This is perfectly acceptable and conveys to family and others that you aren’t completely sure of your cause of death statement. Remember, however, that when the cause of death statement is coded for epidemiologic purposes, the probable will be ignored.

Occasionally, you will be faced with trying to decide between two apparently equally likely but distinct causes of death. For example, there may have been definitive signs and symptoms of acute coronary artery disease present in a patient you know has end-stage lung cancer – and you cannot really decide if the coronary artery disease or the lung cancer represents the cause of death.

The regulations suggest that when you have two equally likely causes of death, you pick the one you think is just a little more likely as the cause of death and list the other in the other significant conditions section. If you really can’t decide, however, you can complete the cause of death as (with the example above) coronary artery disease versus lung carcinoma. For statistical purposes, however, only the first listed condition will be captured as the cause of death while the second listed process will be relegated to the other
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significant condition section.

If the regulations state that you only need to be slightly more than 50 percent certain to assign a cause of death, then the implication is that there will be cases where the degree of certainty doesn’t even rise to that level. I like to look at the degree of certainty that exists for determining a cause of death as existing along a continuum. At one end are those cases (for example, a teenager dying suddenly and unexpectedly) where after doing as thorough a death investigation as possible (autopsy, toxicology, and other studies) no cause of death is forthcoming. It is appropriate – indeed necessary – to certify those deaths as of unknown cause.

On the other end of the spectrum are those deaths where the cause of death is completely certain (a ruptured aortic aneurysm for example). The problem of course lies between these two extremes. In the middle of the spectrum we might have a death of a patient that has been thoroughly worked up in a hospital environment and where we suspect an underlying disease process but we just haven’t proven it yet. In most circumstances it is perfectly appropriate to list the suspected cause of death on the death certificate with or without the probable modifier.

More problematic, however, is the death occurring without an extensive medical workup – usually deaths occurring outside of the hospital or occurring shortly after admission. In these circumstances, the certifier needs to rely on softer information, such as family/witness statements and anecdotal medical information.

The classic case is the octogenarian found dead at home in bed in a scene that doesn’t suggest that any unnatural factors played a part in the death. It may be that witnesses describe the deceased as complaining of chest pain the evening prior to his death and a bottle of nitroglycerine tablets is found opened next to the bed. In that instance, most certifiers would be happy to list the cause of death as complications of coronary artery disease or atherosclerotic coronary artery disease (note: to list the cause of death as acute myocardial infarction would not be correct by itself since something, i.e., the coronary artery disease, caused the myocardial infarction).

Often, however, with elderly individuals dying suddenly, there are no clues to an underlying medical condition. Then what? Where there is no suspicion of an unnatural manner of death in an elderly individual whose death is not unexpected, there are usually no resources for the type of thorough death investigation that would have been done on younger individuals dying suddenly and unexpectedly. Therefore, the certifier truly doesn’t know why this elderly individual died.

One option for the certifier, therefore, is to list the cause of death as unknown. While intellectually honest, this is unsatisfying both to the family and those coding the causes of death for statistical purposes. An unknown cause of death statement by itself leaves open a wide range of possible causes of death – causes that most likely are not even considered possible by the certifier. While there are legitimate times to use unknown as a cause of death, both the Department of Health and the National Centers for Health Statistics discourage the use of unknown as a cause of death except following a thorough and complete death investigation.

If the certifier chooses not to use unknown as a cause of death statement for these predominately sudden elderly deaths, then what should be done? There is no right answer to this question, but the certifier should look at what the most likely causes of death are for elderly individuals dying suddenly and unexpectedly in benign circumstances and then decide which fits best with a particular death.

Using this approach results in a disproportionate number of these deaths with a cause of death statement attributed to coronary artery disease. Studies have shown that using this approach over represents coronary artery disease and under recognizes malignancies and other chronic disease processes, but in the majority of instances is as accurate as determining the cause of death for in house hospital deaths.2,3

While neither solution to certifying cause of death for these sudden unexpected elderly deaths is correct, I prefer the second approach of listing the most probable cause of death for the given circumstances. I believe, however, that you should make clear to the family and others, should they inquire, that you are only giving your best guess for the cause of death. In these circumstances it is appropriate that this guess may not even rise to the level of “more likely than not.”

In the next installment I will discuss common problems and errors in death certification.

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Possible solutions to common problems in death certification. 2010

Instructions for completing the cause-of-death section of the death certificate 2002
http://www.cdc.gov/nchs/about/major/dvs/handbk.htm

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Preparticipation Physical Evaluations in Youth Sports: A Systematic Review of Current Recommendations

By Donella Headlee, MD, MEd; Wesley Nord, MD; and Mark K. Huntington MD, PhD

Abstract:

Background: Participation in youth sports is on the rise in America, and discourse exists regarding frequency and content of the preparticipation examination (PPE) to best identify risk factors and prevent injury. Our objective was to review current recommendations for PPEs proposed by the specialties that most commonly perform PPEs: the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Sports Medicine, and the National Athletic Trainers’ Association.

Methods: The evidence basis for the recommendations in PPE Campaign and Coalition for Youth Sports Health and Safety Fourth Edition and the National Athletic Trainers’ Association (NATA) position statement on PPEs were reviewed. Recommendations with a strong empirical basis (Category A and B) were distinguished from those which were opinion-based.

Results: A thorough review of all recommendations revealed only one Category A and three Category B recommendations. These recommendations were in the categories of orthopedic screening, medical/family history and general health screenings.

Conclusions: There is little evidence supporting the effectiveness of current recommendations in preventing primary and secondary injury in youth sports. The few recommendations which are evidence-based speak to the importance of a complete review of medical and family history and performing a thorough musculoskeletal exam.
Introduction

Youth sports participation is on the rise in America. The number of 7- to 18-year-olds that participated in sports increased 2.7 percent from 2001 to 2011, and 58.4 percent of high school students reported participating on high school sports teams in 2010 to 2011. At the core of primary care is the concept of identification of risk factors and the prevention of primary disease or injury. Preparticipation evaluations (PPEs) for athletes are an opportunity for physicians to do just this. Questions arise, however, about what needs to be evaluated in PPEs to best screen athletes and ensure their safety both on and off the playing field. Discourse regarding timing of examinations, setting, frequency, content and ancillary testing has long existed. With the continuing focus of evidence-based medicine we need to ensure that PPEs are effective in identifying and preventing injury and illness in youth sports.

Our objective was to review current recommendations for PPEs proposed by the specialties that most commonly perform PPEs: the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Sports Medicine (ACSM), and NATA. We reviewed the literature to clarify the evidence of effectiveness for specific recommendations.

Methods

Eligibility Criteria

A priori inclusion criteria were that the recommendations needed to be included in the official guidelines or position statements for the aforementioned societies and organizations. Recommendations were further defined by the National Heart, Lung and Blood Institute Evidence Scale. Only recommendations in evidence categories A and B would be considered in our review.

Information Sources


Study Selection

Thorough investigation into the recommendations of these medical academies and organizations revealed that six of the leading medical societies have formed the PPE Campaign and Coalition for Youth Sports Health and Safety to develop standardized preparticipation physical examination evaluations. The collaboration includes AAFP, AAP, ACSM, the American Medical Society for Sports Medicine (AMSSM), the American Orthopaedic Society for Sports Medicine (AOSSM), and the American Osteopathic Academy of Sports Medicine (AOASM).

The document is endorsed by both the American Heart Association (AHA) and NATA. The Fourth Edition of these recommendations was released in May 2010. NATA also has its own position statement regarding PPEs in addition to endorsing the PPE Coalition recommendations.

Therefore, the PPE Preparticipation Physical Evaluation Fourth Edition and the NATA position statement: Preparticipation Examinations and Disqualifying Conditions, were included in our review as the only recommendations meeting the a priori selection criteria.

Data Collection Process

NATA utilizes the Strength of Recommendation Taxonomy (SORT) criterion scale, while the Coalition employs the National Heart, Lung and Blood Institute Evidence Scale. For the purposes of this study, a Category A recommendation on the SORT would be considered equivalent to Category A or B recommendations on the National Heart, Lung and Blood Institute Evidence Scale. All Category A and Category B recommendations from the PPE Preparticipation Physical Examination Fourth Edition and all SORT A recommendations in the NATA Position Statement were extracted for review in this article.

Results

Study Selection

The NATA position statement gave 29 enumerated recommendations that fell into the following categories: medical and family history, physical examination, general health screenings, cardiovascular screening, neurologic screenings, orthopedic screening, general medical screening, nutritional assessment, health related illness, mental health, administration of PPE and determining clearance for participation. Of these 29 recommendations within their position statement, there is one Category A recommendation included in our review.

The PPE Fourth Edition also covered a broad number of topics, including the timing/setting/structure of PPEs, legal/ethical concerns, medical/family history, physical exam, and athletes with special needs. They further defined their topics into system-based history and physical examinations which included cardiovascular problems (including sudden cardiac death in athletes), CNS, general medical conditions (including heat illness, sickle cell disease, among others), the pulmonary system, the GI/GU systems, dermatological conditions, musculoskeletal concerns, and special considerations for the female athlete. The authors of this document explicitly state in the introduction: “While most of the content remains, as in previous editions, based on the expert opinion level of evidence, whenever there is higher-level evidence for the content, it will be noted in the text.”

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Although the recommendations were not enumerated within the text, each of the aforementioned subject areas did carry with them recommendations to carry out during the PPE. Thorough review of all of the recommendations in each subject area revealed three Category B recommendations and no Category A recommendations.

Synthesis of Results
Review of the recommendations and position statements of the medical societies that are primarily involved in preparticipation screenings for athletes in the United States revealed only one Category A recommendation and three Category B recommendations (Table 1).

Discussion
Certain evidence exists in literature to help guide medical professionals who perform PPEs to best assess risk factors and make recommendations for participation in athletics. However, far more recommendations exist than evidence supports. Of all of the aforementioned categories that these professional societies discuss in their position statements, orthopedic screenings, medical/family history and general health screenings are the only three categories with evidence-based recommendations. It speaks to the importance of practitioners’ clinical skills in taking a complete personal and family history and doing a thorough physical examination.

A result of this lack of a firm evidence basis is that there is no standardized recommendations or requirements from state to state or even within some states for what needs to be assessed in PPE or even how often to do them.

In South Dakota, the South Dakota High School Activities Association (SDHSAA) requires participants in organized high school sports to undergo a full PPE at least every three years, with completion of a preparticipation history in the interim years. There are no standard requirements for what are done with these interim history forms in between physicals, meaning that they do not have to be reviewed by coaches, administrators or medical professionals. Having the minimum requirement for participation being every three years and not having medical personnel review the interim history forms limits the number of opportunities we have to identify risk factors to injuries and underlying medical conditions that can have devastating effects on the lifelong health of youth. Data to determine optimal intervals for PPEs is lacking, and represents an important area for research. As practitioners we need to be aware of the requirements for the specific communities we provide care in and remain diligent in following up with our patients who sustain injuries and experience concerning symptoms to ensure they are safe to participate in sports from year to year.

The collaboration of the AAFP, AAP, ACSM, AMSSM,
AOSSM and AOA to develop the preparticipation evaluation guidelines was an effort to overcome another barrier: the lack of standardization of evaluation forms utilized in PPEs. By outlining subject areas and providing recommendations for individualized history and physical exams, this resource is useful in ensuring practitioners are doing thorough exams and considering unique health risks in the athletic population they serve. However, for all of the well thought out recommendations and forms it provides, the PPE coalition lacks in evidentiary support. In the entire document, there were only three Category B recommendations and no Category A recommendations. The authors do note, however, that if we as practitioners can adopt a more standardized method for performing our PPEs, we may be able to utilize the data we collect in research to support or disprove current recommendations and make changes to PPEs in the future that allow us to better prevent injury and illness in youth sports.

One area that does not have a Category A or B strength of recommendation that has gained significant attention in recent years is the cardiovascular exam in athletes, specifically relating to prevention of sudden cardiac death (SCD). It is estimated that in 1- to 19-year-olds in the United States, there are anywhere from 3,000 to 5,000 SCDs per year, with 100 to 150 of these events occurring during participation in sports. Although the PPE Fourth Edition gives recommendations for cardiovascular screening, it is based upon expert opinion. The European Society of Cardiology (ESC) recommends that all preparticipation screening include family history with specific questions related to sudden cardiac death, a personal history from the athlete regarding their participation in sports and cardiac symptoms, a simple medical examination with blood pressure measurement, heart auscultation, and palpation of large vessels, as well as a resting 12-lead EKG (Figure 1). These recommendations are based largely on an Italian study that showed an 89 percent decrease of sudden cardiac death in young athletes.

![Figure 1. Cardiovascular preparticipation screenings of young competitive athletes for the prevention of sudden death: proposal for a common European protocol](image)

**Table 2. Key points for cardiovascular problems, PPE Fourth Edition**

<table>
<thead>
<tr>
<th>Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden cardiac death (SCD) in young athletes and children is caused by a diverse etiology of structural and electrical diseases of the heart.</td>
</tr>
<tr>
<td>A detailed patient and family history may identify athletes at risk for SCD.</td>
</tr>
<tr>
<td>Warning symptoms that require cardiac workup before returning to exercise include exertional chest pain, exertional syncope or near syncope, unexplained seizures, excessive dyspnea or fatigue disproportionate to the level of exertion, and palpitations or irregular heartbeats.</td>
</tr>
<tr>
<td>A family history of sudden unexpected or unexplained death, sudden death before the age of 50 due to cardiac problems, sudden infant death, unexplained drowning, near drowning or unexplained seizures may indicate the presence of a genetic cardiovascular disorder placing the athlete at increased risk for SCD.</td>
</tr>
<tr>
<td>Physical examination should focus on detecting the heart murmur of left ventricular outflow tract obstruction and the physical findings suggestive of Marfan syndrome.</td>
</tr>
<tr>
<td>Patients or families suspected or identified to be at risk of SCD should be referred to a cardiovascular specialist for further evaluation.</td>
</tr>
<tr>
<td>Careful activity recommendations involving temporary or permanent disqualification for athletes with identified cardiovascular disease should be made in consultation with a cardiologist.</td>
</tr>
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over a 26-year period. In this study, those who were found to have significant abnormalities were disqualified from sports, which begs the questions if they truly impacted mortality with the screenings or if they just decreased the number of events that occurred in sports venues. This study was also done in a region that experiences higher incidence of arrhythmogenic right ventricular dysplasia, bringing into question the generalizability of their findings. The ESC notes that even though there is an added cost to performing a resting 12-lead EKG on all athletes, it is actually more cost effective than screening without an EKG, which one may assume is in comparison to the cost of SCD in athletics.

Although these guidelines exist in Europe, in the United States there has not been a large scale adoption of including EKGs in preparticipation evaluations. A recent study published in the Journal of the American College of Cardiology examined the prevalence of EKG abnormalities in athletes and found that one in five of their greater than 10,000 participants (ages 14 to 35) had a potentially pathological EKG pattern. These findings are much higher than the actual incidence of SCD in this age group, leading one to question if blanket screening with EKG will be effective in reducing SCD or will merely increase the amount of inappropriate diagnostic testing or disqualification from participation in organized sport. The recommendations in Table 2 are the key points taken from the PPE Fourth Edition. Though based on expert opinion, in the absence of an evidence base they have the potential to provide some direction in the PPE. Further research is needed in this area to help guide practitioners in the utility of EKGs in PPE in the athletes they serve.

Participation in organized sports is on the rise. As primary care physicians and health care teams continue to strive to provide care for this unique community of individuals we need to be able to consistently and carefully assess risk factors in an effective and efficient manner. Current recommendations exist but there is very little evidence that supports the effectiveness of our examinations in identifying risk factors and preventing primary and secondary injury in youth sports.
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In 2009, Congress passed the Health Information Technology for Economic and Clinical Health Act, which provided federal funding to support the implementation of electronic health records by U.S. health care systems. There are numerous potential benefits from the implementation of health care technology, but the most commonly cited are improving quality outcomes and reducing errors. As hospitals, clinics, pharmacies, and healthcare systems across the country continue to implement various types of technology, researchers are trying to discern their true benefits for patients. From the pharmacy and medical perspective, there is particular interest in whether healthcare technology reduces medication errors and adverse drug events.

The Institute of Medicine estimated in 2007 that 1.5 million Americans were harmed or killed by medication-related mistakes each year. Specifically in hospitals, it was estimated that each patient was exposed to at least one medication error (ME) per day.1 Many of the new health care technologies are aimed at reducing specific types of ME. Computerized physician order entry (CPOE) is expected to reduce errors related to poor handwriting and look-alike drug names. Clinical decision support systems are intended to assist the provider by providing alerts or recommendations at the point of care, such as dosing guidance, drug interaction information, allergy alerts, reminders regarding laboratory monitoring of medications, etc. Bar-code technology is being used to improve the accuracy of medication dispensing and prevent errors at the point of drug administration. However, as these various technologies have been implemented, it has been recognized that some errors still persist and new types of errors are occurring. An observational study in community pharmacies looking at errors related to electronic prescriptions estimated that 5 percent of electronic prescriptions contained an error.2 A study of ME reported by hospitals and pharmacies in the Netherlands identified that 16.1 percent of all reported ME from March 2010 to February 2011 were related to technology.3 In community pharmacies, 21.5 percent of the reported ME were due to technology, and of those, 41 percent were due to errors in medication, dose, dosage form or strength. These errors were commonly attributed to confusion of medication name and poor design of computer screens. An additional 14.8 percent of technology-related errors were errors committed by prescribers or pharmacy staff entering prescriptions for the wrong patient. In hospitals, 12.6 percent of the reported ME were related to technology, of which 55 percent were attributed to problems occurring with CPOE including wrong patient, wrong medication, wrong dose or dosage form, duplicate entries and technology malfunctions.

Unfortunately, these studies have no comparators, so even though it is evident that technology is contributing to errors, it is unclear whether the overall rate of ME has changed. Studies that have attempted to assess this have been fraught with difficulties. Some have only evaluated voluntarily reported errors, which are known to significantly under-represent the total error rate. Others have only evaluated the effect of technology on a single class of medications or have evaluated a “home-grown” electronic health record, rather than the commercially available, integrated systems that are in use today. Some have included data on clinically insignificant errors such as late medication administration, which is a common error that rarely lead to harm. In addition, most studies have focused only on ME – errors made in the prescribing, dispensing, and administration of medications, without actually addressing whether the rate of adverse drug events (errors that actually reach a patient and cause harm) are affected. However, some useful studies have been published.

In 2010, a well designed study on the impact of the electronic medication administration record (MAR) and bedside barcode scanning was published.4 This was a before-and-after study evaluating the use of a manually transcribed paper MAR compared to an electronic MAR combined with bedside barcode scanning. The study used research nurses to collect data by direct observation of over 14,000 medication administrations and over 3,000 order transcriptions, and to specifically identify ME that were not related to timing of medication administration. They found the rate of ME was 11.5 percent on units without
electronic MAR and barcoding, and 6.8 percent on units with the technology (relative reduction 41.4 percent, p< 0.001). The rate of ME with a true potential to cause patient harm dropped from 3.1 percent to 1.6 percent (relative reduction 50.8 percent, p<0.001). Transcription errors were completely eliminated. The authors concluded that electronic MARs and barcoding clearly improved medication safety.

Computerized provider order entry systems have been evaluated in multiple studies. In 2014, a systematic review with use of random effects meta-analytic techniques evaluated nine high quality studies of CPOE and used their pooled results to estimate the effect of CPOE on ME nationally. Eight of the nine studies reviewed showed that CPOE reduced ME by a range of 7 percent to 100 percent; for seven of these, the reduction was statistically significant. The ninth study showed an increase in ME by 23 percent with CPOE, which was not statistically significant. The pooled results demonstrated a decrease in ME by 48 percent (95 percent CI 41 percent to 55 percent) after implementation of CPOE. The authors calculated that 26 percent of orders in the U.S. in 2008 were completed using CPOE, and used this data to estimate that ME were reduced by 12.5 percent nationally, or by approximately 17.4 million ME in that year. They did note that these are estimates of ME and do not necessarily mean that patient harm is reduced.

As technology has continued to advance, clinical decision support systems (CDSS) have been integrated into most CPOE systems, and studies have evaluated the effect of the combination of these technologies on ME. A review article from this year summarized the results of five systematic reviews, one narrative review, and two clinical trials of the impact of these technologies together on ME. This article attempted to determine not only if CPOE and CDSS reduce ME, but also whether they reduce adverse drug events (actual patient harm). Each of the six review articles evaluated between 10-44 studies and all six concluded that CPOE and CDSS together decreased the incidence of ME. However, data on reducing actual patient harm was not as strong. One review found five of 10 studies reporting statistically significant reductions in adverse drug events, and another review found that four of seven studies showed reduced adverse drug events with relative risk reductions of 30 percent to 84 percent. Two of the reviews found no effect on patient outcomes, and the other two did not find adequate information to assess patient harm. The two clinical trials from 2012 that were reviewed evaluated commercial CPOE and CDSS systems in a controlled, before-and-after format in more than one institution. One of these trials reported an overall increase in adverse drug events from 14.6 percent to 18.7 percent of admissions (p<0.03), but the rate of preventable events decreased significantly. The other trial reported a significantly decreased rate of prescribing errors, including those likely to cause harm, but did not specifically address incidence of patient harm. The authors of this review concluded that studies of CPOE and CDSS together have clearly demonstrated reduced ME, but have inadequate data to show an effect on actual patient harm. They also expressed concern that the new workflows may be leading to unintended consequences such as alert fatigue which may reduce the benefits of the intervention.

In summary, studies of the use of electronic MAR, barcode technology, CPOE, and CDSS clearly show reduced rates of medications errors which should have a significant impact when they are fully implemented nationwide. Though some studies also show reduced rates of either potentially harmful ME or adverse drug events that actually reach a patient and cause harm, the data is inconsistent and further study is needed to assure that the reduction in ME translates to reduced patient harm.

REFERENCES


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In an effort to improve health care quality and safety, the health care leaders of today are increasingly realizing and placing emphasis on the importance of including the perspective of patients and families – a perspective that for too long has been missing from the health care equation. The experience of care, as perceived by the patient and family, is a key factor in health care quality and safety.

Bringing the perspectives of patients and families directly into the planning, delivery, and evaluation of health care, and thereby improving its quality and safety, is what patient- and family-centered care is all about. Studies increasingly show that when health care administrators, providers, and patients and families work in partnership, the quality and safety of health care rise, costs decrease, and provider and patient satisfaction increase.

The core concepts of patient-centered care and engagement include:

- Dignity and respect – Health care providers listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated in the planning and delivery of care.
- Information sharing – Health care providers communicate and share complete and unbiased information with families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- Participation – Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- Collaboration – Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation, and evaluations; in facility design; and in professional education, as well as in the delivery of care.

One of the most common sources of patient dissatisfaction is not feeling properly informed about (and involved in) their treatment. Shared decision-making, where patients are involved as active partners with the clinician in treatment decisions, can be recommended as an effective way to tackle this problem. Health care providers and patients can work together as active partners to clarify acceptable medical options and choose appropriate treatments. While not all patients want to play an active role in choosing a treatment – because of age-related and cultural differences – most want clinicians to inform them and take their preferences into account.

In addition, educating patients about self-management can improve their knowledge and understanding of their condition, coping behavior, adherence to treatment recommendations, sense of self-efficacy and symptom levels. Of note, self-management initiatives appear to work better when integrated into the health care system, instead of being organized separately. The role of health care providers in guiding patients through the process is critical to successfully implementing these initiatives.

The goal of self-management is to enable patients to perform three sets of tasks:

- Managing their illness medically – for example, taking medication as directed or adhering to a special diet;
- Carrying out normal roles and activities; and
- Managing the emotional effect of their illness.

Patients are empowered and motivated to manage their health problems when they feel confident about their ability to achieve their goal. Interventions for improving self-care should focus on building confidence and equipping patients with the tools (knowledge and skills) to set personal goals and develop effective strategies for achieving them.

All patients have a fundamental right to expect quality of care that takes into account their beliefs and values; respects their right to provide input into their care process; and respects their dignity. All of this can be achieved through effective communication, which is a significant factor in improving patient satisfaction, and reducing patient injuries and malpractice claims.
SDBMOE Board News

By Margaret B. Hansen, PA-C, MPAS, Executive Director
South Dakota Board of Medical and Osteopathic Examiners

Federation of State Medical Boards June Visit

The following South Dakota Board of Medical and Osteopathic Examiners (SDBMOE) members were re-elected as officers: Mary S. Carpenter, MD – president, Dr. Walter Carlson – vice president, and Dr. Brent Lindbloom – secretary.

Current Statistics for the SDBMOE

The dedicated Board conference room is now operational. This is a functional DDN site so meetings related to the Board (regular, advisory committee, task/work groups) can be held using the distance participation.
The Centers for Medicare and Medicaid Services (CMS) recently made some announcements about restructuring within the Quality Improvement Organization (QIO) program. In past QIO contracts, the local state-based organizations worked with providers in two main areas – case review and quality improvement. To eliminate any perceived conflicts of interest and to gain efficiencies, CMS has divided the case review and quality improvement work into two separate contracts moving forward. The 11th Statement of Work contracts, first announced in December 2013, were structured to not allow a single organization to work in both areas.

Case Review
After a full and open contract proposal competition, two organizations nationally were selected and will become Beneficiary and Family-Centered Care (BFCC) QIOs, tasked with the case review work. The two BFCC QIO contractors are Livanta LLC, located in Annapolis Junction, Maryland, and KePRO, located in Seven Hills, Ohio. Case review services for South Dakota will be provided by KePRO.

At the local level, the South Dakota Foundation for Medical Care (SDFMC) will be reaching out and contacting our physician reviewers to notify them about the upcoming changes. We will continue to do case review work for South Dakota Medicaid, but will no longer review cases for Medicare beneficiaries. SDFMC has contacted KePRO to plan the transition of the case review work over the next few months.

To see the full press release by CMS on these case review changes, visit www.CMS.gov, click the Newsroom Center, and review the May 9 press release titled “CMS launches improved Quality Improvement Program.”

Quality Improvement
In the 11th Statement of Work contract, CMS asked QIOs to bid on a three to six state area, effectively regionalizing the quality improvement work as well. These organizations will be called Quality Innovation Network (QIN) QIOs. The Kansas Foundation for Medical Care, CINMO of Nebraska, North Dakota Health Care Review, Inc., and SDFMC have aligned to form a new not-for-profit organization – the Great Plains Quality Innovation Network. Each of these organizations has a long history of working collaboratively together, serving as their state’s QIO and improving the quality and efficiency of health care in the region. We are excited about the opportunity to work closer with these partners to improve quality.

CMS plans to announce the awards for the quality improvement work in July 2014, with the 11th Statement of Work scheduled to begin on Aug. 1, 2014. This fall, we will notify South Dakota health care providers how they can participate in our quality improvement projects, join a learning and action network, and receive the technical assistance and support they need.
Help Shape the Future of Medicine in South Dakota

The South Dakota State Medical Association Foundation, the philanthropic arm of the South Dakota State Medical Association, is a tax-exempt 501(c)(3) non-profit corporation, was established to assist and support medical research, medical teaching and medical education at the Sanford School of Medicine.

On average, medical students graduate with $130,000 in debt. Contributions to the South Dakota State Medical Association Foundation provide financial assistance to students at the Sanford School of Medicine and are all designated for scholarships, grants and low-interest loans for students.

Any amount can be donated at any time throughout the year. If you have questions or want more information, please call Laura Olson at 605.336.1965.

Send Your Contributions Today To:
South Dakota State Medical Association Foundation
PO Box 7406
Sioux Falls, SD 57117-7406
www.sdsma.org
Everyone wants to find a way to prevent aging.

Let's face it, we will all grow old, that is unless we die early from a motor vehicle accident, cancer, or an early stroke or heart attack. Of course even if we took every precaution, one of those causes for early death might occur. But nowadays don't we know how to prevent aging arteries, heart attacks and strokes?

Not surprisingly, in a response to the call to prevent early death, there has been an effort to just look or act younger in this country. The pharmaceutical industry has developed estrogen and testosterone replacement, as well as Viagra to help sexual function; Botox and special creams to erase wrinkles; and even steroids and non-steroidals to treat arthritis.

But what have we done to find ways to protect our aging blood vessels? In the 1990s, researchers started blaming aging on excessive oxidation, and not long after, we heard advertisers talking about anti-oxidant effects trying to sell this product or that supplement. We've been advised to eat this diet and buy that book each holding the secret to an antioxidant long healthy life. Unfortunately, we have learned that the main oxidative driver is simply too much food, and there's no pill for that.

After scientific researchers found high cholesterol as a mild predictor for vascular disease, many have been focusing on cholesterol lowering medicines in an attempt to prevent aging arteries and atherosclerosis. Despite the fact that lowering cholesterol has been disappointing in the prevention of vascular disease, sales for statins, the main cholesterol-lowering group of meds, have grown to be a $5.5 billion yearly business.

All in all, these medicinal short cuts to prevent vascular aging have too little effect, and pale in comparison to the most powerful preventative treatment.

Recently the World Health Organization stated that three-quarters of all cardiovascular deaths and disease are connected to lifestyle. Say it another way: three-quarters of all cardiovascular deaths could be delayed by making lifestyle changes. We're talking use of tobacco, unhealthy diet habits, psycho-social stress, and most important, physical inactivity. Indeed the real fountain of youth comes from lifestyle, and not medicines. There are no shortcuts.

The way to prevent premature aging is not by a pill, but by the way you live.
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Simply put, habits are hard to break, and bad habits like sedentary lifestyle, overeating and tobacco usage are making our population sick. Who in the health care system can tackle these issues before they lead to chronic disease? With limited time in a doctor’s office, who can educate these individuals on lifestyle and behavior change? There certainly is a need for “someone” to work with patients in the days and weeks between physician appointments, and that “someone” is a new group of health care professionals known as health and wellness coaches!

At DAKOTACARE, our population health team is not only a team of health care professionals (registered nurses and exercise specialist), but we are all certified health and wellness coaches as well. We are trained to help people change their lifestyles using a customized approach along with the tools of compassion, motivation and self-efficacy building. Now that I have your attention, you might still be asking: what does this really mean? What does a health and wellness coach do? How can they support me and my practice’s efforts to further improve patient care?

Wellness coaches work with individuals to define personal goals for a healthier lifestyle. We help individuals create action plans and identify possible barriers. Using our specialized training and personal experiences, we provide individuals with the tools, resources and education needed to achieve their wellness goals. We work to identify high risk factors and target them by encouraging overall well-being. We work with individuals to help stretch themselves toward their dreams – to think bigger, to go farther, to be committed, to grow and achieve more than they’ve dared to imagine.

During my nearly 15 years in the field of health and wellness, I have seen many changes. The demand for health and wellness professionals is primarily increasing from business, health professionals and insurance companies who are all aiming to reduce the negative effects of obesity, sedentary lifestyles and unhealthy behaviors. Rather than continuing to focus on the medical conditions caused by the obesity epidemic, health and wellness coaches have an opportunity to actually do something about it – to be the solution for many people who desperately want to live healthier lives, but simply don’t know where to start. Health coaches don’t focus solely on things like reducing calories or increasing exercise. Instead, we teach the principles of behavioral modification and help individuals overcome the psychological barriers that keep them from achieving their well-being on a daily basis. We work with individuals to make permanent and positive changes in their lives and commit to working toward living a healthier lifestyle today, tomorrow and for the rest of their lives. From the overworked executive to the new mother adjusting to life with a newborn, health coaches can offer the guidance and tools these individuals need to overcome their challenges and regain a greater level of health and well-being.

So how can we support you? In our role, we are able to bring relevant information to your medical team while also helping to motivate the patient in following appropriate medical recommendations which you have provided. We advocate for community healthcare resources and truly encourage individuals to take charge of their personal health care.

It’s been said that a physician takes an average of 18 seconds to determine a patient’s course of action. With medical information available from multiple sources, consumers are more eager to see caregivers who can help them sort out their options and answer their health questions. Increasingly, individuals want more control over their choices and a growing number of individuals welcome their caregivers to be genuine partners in their quest for better health. Thus, the new interest in health coaching and why DAKOTACARE believes in providing a balance to support one’s plan of care while being a resource for health care professionals who feel their patients could benefit from our services. Want to learn more about a certified health and wellness coach? Contact me, Trisha Dohn, Director of Health & Well-Being, at 605.334.4000 and I would be happy to “coach” you and your DAKOTACARE patients toward achieving an overall well-being!
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At MMIC, we believe patients get the best care when doctors, staff and administrators are humming the same tune. So we put our energy into creating risk solutions that help everyone feel confident and supported. Solutions such as medical liability insurance, physician well-being, health IT support and patient safety consulting. It’s our own quiet way of revolutionizing health care.

To join the Peace of Mind Movement, give us a call at 1.800.328.5532 or visit MMICgroup.com.

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Thank you to these organizations for their support of SDSMA’s Annual Meeting

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Representatives of the SDSMA attended the American Medical Association (AMA) 2014 Annual Meeting June 7-11 in Chicago. Attendees included AMA Delegate Herb Saloum, MD, SDSMA President Mary J. Milroy, MD, medical student Teresa Maas, and SDSMA CEO Barb Smith.

Among the new policies adopted by the House of Delegates (HOD) at the meeting was a resolution drafted by South Dakota regarding critical access hospitals (CAHs).

President Obama’s fiscal year 2014 budget called for cuts to CAHs’ Medicare reimbursement and elimination of the designation affording cost-based payment for facilities within 10 miles of any hospital, regardless of whether the nearby hospital is capable of providing the services that would be lost if the CAH closed. These cuts would be detrimental to CAHs in South Dakota and throughout the country — impeding their ability to provide high-quality care. CAHs play a vital role in providing access to health care, economic security for families and seniors, and jobs to rural communities across the nation. These hospitals provide inpatient and outpatient services, as well as 24-hour emergency care and make it possible for patients with complex medical needs to remain at home in rural communities.

The resolution calls on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks and opposes the elimination of the CAH necessary provider designation, and asks that the federal government fully funds its obligations under the Medicare Rural Hospital Flexibility Program. The Medicare Rural Hospital Flexibility Program gives states the authority to develop a rural health plan to create one or more rural health networks, to promote regionalization of rural health services, and to improve access to hospitals and other health services for rural residents.

The SDSMA worked to bring additional states on board in support of the resolution — Iowa, Minnesota, Nebraska, North Dakota and Wisconsin. After a committee referred this issue for further study, SDSMA members spoke against referral at the HOD, and the testimony led to the HOD voting against referral and instead voted to pass the resolution on the HOD floor.

Other new policies adopted include:

• Asking President Obama to provide timely access to entitled care for eligible veterans via the health care sector outside of the VA health care system until the VA can provide health care in a timely fashion. This policy also directs the AMA to urge Congress to quickly enact long-term solutions so eligible veterans always can have timely access to entitled care.

• Designating cheerleading a sport;

• Calling for better electronic data interchange, to include requiring all pharmacies to accept ePrescriptions and promoting improvements in electronic health record (EHR) usability; and

• Evaluating current data or conducting new studies to secure more information about the overall GME picture, and exploring innovative funding models to increase residency positions.

Read more about the 2014 AMA Annual Meeting in the August issue of South Dakota Medicine.

Source: SDSMA staff
The Issue Is...

Medicaid and CHIP Increase

The Centers for Medicare and Medicaid Services (CMS) recently released its update on Medicaid and Children’s Health Insurance Program (CHIP) enrollment data, covering the period through April 2014.

The report shows continued growth in Medicaid and CHIP enrollment across states. This continued growth reflects the fact that enrollment in the programs is not limited to the open enrollment period for Marketplace coverage and continues year-round. Preliminary data for April 2014 show that 1.1 million additional people enrolled in April compared to March in the 48 states that reported data for both periods, bringing total Medicaid and CHIP enrollment to over 65 million. With this latest increase, more than 6 million additional individuals have enrolled in Medicaid and CHIP compared to average monthly enrollment in the three months leading up to the start of open enrollment in October 2013. This represents an average enrollment growth rate of 10.3 percent between summer 2013 and April 2014 across all 48 states that reported data for both periods.

The enrollment increase is higher than historic enrollment trends from other data sources. Historic data show that Medicaid and CHIP enrollment grew by 8.5 percent across all states at the height of the most recent economic downturn, and then growth slowed to 1 to 3 percent between December 2011 and 2013 as economic conditions improved. Among Medicaid expansion states, reported enrollment growth since open enrollment began far exceeds these historic trends. Reported growth in the non-expansion states is closer to the most recent historic trends, but does suggest some increased enrollment activity compared to earlier periods.

Source: CMS and Kaiser Family Foundation

"The Issue Is" is the SDSMA's monthly update on key policy issues of importance to physicians.

Mary Milroy, MD, Inaugurated as SDSMA President, Other Officers Elected

Mary J. Milroy, MD, of Yankton became the 133rd president of the South Dakota State Medical Association (SDSMA) during the 2014 Annual Meeting May 30 in Rapid City. Outgoing president Daniel J. Heinemann, MD, presented the presidential medallion to Dr. Milroy at the SDSMA’s Presidential Banquet at the Ramkota Hotel & Conference Center. “I am honored to provide leadership that promotes patient care and quality of our providers across the state,” Dr. Milroy said. “I look forward to working with physicians across specialties to tackle some of health care’s most challenging issues.”

Dr. Milroy, a board-certified surgeon, has been a member of the SDSMA since 1992. She received her medical degree from the University of South Dakota School of Medicine and completed a surgical internship at Highland Alameda County Hospital in Oakland, California. Upon completion of her internship, she spent three years in Sisseton at the Indian Health Service hospital as a member of the U.S. Public Health Service Commissioned Corps. She entered surgical residency in the integrated program in general surgery at Michigan State University (MSU), and after completing her residency, she taught in the MSU Department of Surgery for three years.

In 1991, Dr. Milroy moved to Yankton and joined the Yankton Medical Clinic and has been practicing there ever since. She originally entered general surgery practice, and after two years, devoted her practice to breast disease. Dr. Milroy has been involved in the leadership of organized medicine in South Dakota for several years. In addition to the SDSMA, she is a member of the American Medical Association and is a fellow of the American College of Surgeons.

Prior to becoming SDSMA president, Dr. Milroy has held offices within the SDSMA’s Executive Committee, as well as serving as a member and chair of the SDSMA Committee on Medical Practice. Dr. Milroy has also volunteered for the SDSMA’s advocacy efforts during state legislative sessions by participating in the SDSMA Doctor of the Day program.

Dr. Milroy is married to Dan Johnson, MD, an orthopedic surgeon in Yankton. They have four daughters: Carrie, Laura, Leslie and Amy.

Other officers elected during the session were:
- President-elect – Timothy M. Ridgway, MD, of Brandon;
- Vice President – H. Thomas Hermann, MD, of Sturgis
- Secretary – Christopher T. Dietrich, MD, of Rapid City
- Treasurer – Robert E. VanDemark, Jr., MD, of Sioux Falls
- At-Large Executive Committee Member – Michelle L. Baack, MD, of Sioux Falls
- At-Large Executive Committee Member – Robert J. Summerer, MD, of Madison

Source: SDSMA staff
The SDSMA honored South Dakota physicians at the organization’s annual banquet held on Friday, May 31.

The SDSMA’s Distinguished Service Award recognizes a physician or lay person who has been of outstanding service to the medical profession in South Dakota. This year’s Distinguished Service Award was presented to Donald Humphreys, MD, of Sioux Falls. Dr. Humphreys has devoted his professional life to teaching, scholarly activities, and service to the profession. He has been an educator of medical students and residents in internal medicine, and has received numerous teaching awards from his students. After being granted emeritus status, he continues to teach.

The Outstanding Young Physician Award was presented to Shawn VanGerpen, MD, of Sioux Falls. The Outstanding Young Physician Award was initiated by the Young Physicians Section of the SDSMA to be given to a young physician under 40 or within the first eight years of professional practice after residency and fellowship training. This physician is recognized for outstanding achievements, dedication and service to the community and the SDSMA at the local, state and national levels. Dr. VanGerpen is an exceptional leader, serving as the University of South Dakota Sanford School of Medicine psychiatry residency program director. He has worked to improve access to care throughout the state and has advocated for physicians at the state and national levels. He is an active member of the SDSMA, serving on the Council of Physicians and Committee on Legislation.

The SDSMA’s Community Service Award is presented each year to a physician who separates himself or herself through outstanding work in the area of community affairs. This year’s recipient is Martin Christensen, MD, of Mitchell. Dr. Christensen served in the U.S. Army as a staff physician and in the Army Reserve. While in the Army Reserve, he deployed to Iraq three times. He organized and started the first Advanced Cardiac Care instructor class in Iraq and developed a tracking system to follow injured soldiers from the battlefield to hospitals. He created Trauma Battle Boxes so the equipment needed during a mass casualty can be at a provider’s fingertips. For his extraordinary service, he received a Bronze Star. He sees patients in a busy practice, and as medical director of the Mitchell EMS system, he works with EMS providers to help them improve their training and skills.

The Young at Heart Award is presented to a physician who has inspired young physicians as a mentor, role model and leader. This year’s recipient is Gary Timmerman, MD, of Sioux Falls. Dr. Timmerman has led by example and been there for young surgeons when they’ve encountered difficult cases in the operating room. He was instrumental in starting a general surgery residency program in South Dakota – the first of its kind in South Dakota since the 1980s – which helps train the next generation of rural general surgeons for South Dakota and the rest of rural America.

Robert L. Allison, MD, of Pierre, received the SDSMA’s Past President’s Award. This award is presented each year to the immediate past president of the SDSMA in recognition of their many years of work and dedication to organized medicine.

Seven other physicians were recognized with the SDSMA’s 50-Year Award for medical practice in South Dakota. Physicians who received that award were: David Bean, MD, of Sioux Falls, Jerome Eckrich, MD, of Aberdeen, Kenneth Halverson, MD, of Yankton, Harland Hermann, MD, of Rapid City, James Hovland, MD, of Aberdeen, Karl Kosse, MD, of Aberdeen, and Richard Porter, MD, of Sioux Falls. These physicians have been practicing medicine for a half-century and have contributed greatly to the medical profession.

Outgoing President Dan Heinemann, MD, presents the 50 Year Award to Harland Hermann, MD, and David Bean, MD.

Source: SDSMA staff
**Variety of Speakers Featured at SDSMA Annual Meeting**

SDSMA members gathered in Rapid City May 30-31 for the annual meeting. Members heard from national speakers during in-depth educational sessions, attended networking events, and raised money for medical student scholarships at the annual Alliance scholarship fundraiser. During the meeting, attendees had the opportunity to exchange ideas with experts and colleagues.

Mary D. Nettleman, MD, dean of USD Sanford School of Medicine, kicked off the event on Friday morning, May 30, speaking about the medical school and plans for expansion.

Robert M. Wah, MD, president-elect of the American Medical Association, spoke to attendees about the AMA’s advocacy efforts and how forces at play in Washington, D.C., are impacting patients and physicians.

Other presentations included two sessions about prescription drug abuse – Christopher T. Dietrich, MD, gave the presentation entitled, “Prescription Drug Abuse and Diversion,” followed by a panel discussion.

In addition, the SDSMA Center for Physician Resources brought attendees three presentations which covered team-based care, patient and team communication tools, and philanthropy.

At the SDSMA PAC breakfast, former Sen. Larry Pressler spoke to attendees. Pressler is an independent candidate for the U.S. Senate seat being vacated by Sen. Tim Johnson this November.

Speakers’ PowerPoint presentations are available online at www.sdsmma.org. They are found under the About tab and follow the Annual Meeting link.

Mark your calendar for the 2015 SDSMA Annual Meeting May 29-30 in Sioux Falls.

Source: SDSMA staff

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**Reportable Diseases and Events**

A physician attending a person diagnosed with or suspected of having a reportable disease or condition must report the disease or condition to the South Dakota Department of Health (SDDOH).

In many cases, state law dictates how and when such a report must be made. In most cases, the physician remains obligated to make the report despite designation of another person to make such report. Reports mandated by state law are allowable under the HIPPA mandated federal medical privacy requirements.

Category I diseases and conditions are reportable immediately by telephone. Category II diseases and conditions are reportable within three days after recognition or strong suspicion of disease.

In addition to communicable diseases, physicians are required to report information regarding the performance of abortion, auditory or visual impairment, cancer, child abuse, elder abuse, fetal alcohol syndrome, incidents of fetal death, gunshot wounds, certain metabolic disorders, ophthalmia neonatorum, patient drug diversion, syphilis, tuberculosis and certain venereal diseases.

For more information, download the SDSMA legal brief Reportable Diseases and Events at www.sdsmma.org. Through the SDSMA Center for Physician Resources, the SDSMA develops and delivers programs for members in the area of practice management, leadership and health and wellness.

Source: SDSMA staff
Memorial News

Scholarships Awarded to Medical Students

Medical school scholarship recipients were announced at the Presidential Banquet during the 2014 SDSMA Annual Meeting May 30. Thank you to those who contributed to helping ease the significant financial pressure placed on students to pay for medical school, and for supporting the next generation of physicians.

The following scholarships were awarded. Congratulations to all scholarship recipients.

**Third and Fourth Year DAKOTACARE Scholarships:**
- Marcella Knauf, Spearfish
- Jeremy Pepin, Hot Springs

**First Year DAKOTACARE Scholarship:**
- Natalie Schnabel, Emery

**Freshman Scholarship:**
- Dylan Powell, Sioux Falls

**Howard & Mary Ann Saylor Scholarship:**
- Joshua Doorn, Sioux Falls
- Elizabeth Helsper, Brookings
- Carrie Kastein, Springfield
- Anthony Loewen, Huron
- Emily Thornton, Sioux Falls

**J. Michael McMillin Scholarship:**
- Garett Steers, Miller
- Ethan Young, Harrisburg

**Mickelson Memorial Scholarship:**
- Alexandra Higgins, Sioux Falls
- Ann Palmer, Rapid City

**SDSMA Alliance Scholarship:**
- George Ceremuga, Rapid City
- Nicholas Gau, Sioux Falls
- David Kapperman, Vermillion
- Seth Parsons, Sioux Falls
- Wade Paulson, Sioux Falls
- Michael Reopelle, Sioux Falls
- Rachel Thies, Sioux Falls

**Surgical Associates, Ltd Scholarship:**
- Corbin Cleary, Sioux Falls
- James Dreesen, Freeman

**T.H. Sattler Scholarship:**
- Deanna Lassegard, Rapid City
- Michael Reopelle, Sioux Falls

**Wulbers Memorial Scholarship:**
- Sara Pepper, Geddes
- Spencer Schilling of Sioux Falls

Source: SDSMA staff

Natalie Schnabel, Ann Palmer, Emily Thornton, Garett Steers, Deanna Lassegard, Wade Paulson, Nicholas Gau, and Sara Pepper were among the scholarship recipients in attendance at the banquet. The students are pictured with H. Thomas Hermann, Jr., MD, SDSMA Foundation Board President.

Your Updates Are Needed for the SDSMA 2015 Member Directory

The SDSMA staff are in the process of developing the 2015 SDSMA Member Directory. Your help is needed to make updates to your personal contact information to ensure you are accurately reflected in the directory. Over 2,500 directories are printed and distributed across the region annually. We want your information to be accurately reflected for all those who use this widely-referenced directory.

Your help is needed to ensure the member profile information listed for you in the directory is accurate and your photo is current. Update your information today:

**Online:** Visit www.sdsm.org. Log in and choose “Update My Profile.”

**Form:** SDSMA has mailed you a document with your current information listed. Review the information and return the form by fax or email to the SDSMA office.

**Photos:** Please email a professional photo or headshot membership@sdsm.org.

Updates must be received by Aug. 15.

Those with questions about the directory or updating information may contact Laura Olson, Director of Administrative & Member Services, at 605.336.1965 or loolson@sdsm.org.

Source: SDSMA staff

July 2014 293
CME Events

Continuing Medical Education events which are being held throughout the United States (Category 1 CME credit available as listed)

### July 2014

- **July 9**
  - Internal Medicine Grand Rounds: Recurrent C. diff Infection: Role for Fecal Transplants
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.usd.edu/cme

- **July 9**
  - Transforming Behavior and Culture at Work: Engaging Physicians and Staff in Coaching Models to Achieve Risk Reduction
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.mmicgroup.com/risk-management/webinars

- **July 16**
  - Surgery/Trauma Grand Rounds: Trauma
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.usd.edu/cme

- **July 25**
  - VA Medical Center CME Activity: Post Traumatic Stress Disorder
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.usd.edu/cme

- **July 26**
  - Mayo Clinic Oncology Review
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.mmicgroup.com/risk-management/webinars

- **July 30**
  - Internal Medicine Grand Rounds: ICD-10 Coding Process
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.usd.edu/cme

- **July 30**
  - The Evolving Role of the Post-Acute Medical Director
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.mmicgroup.com/risk-management/webinars

### August 2014

- **Aug. 4**
  - Effective Clinical Management of Borderline Personality Disorder
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.mayo.edu/cme

- **Aug. 13**
  - Surgery/Trauma Grand Rounds: Hidradenitis
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.usd.edu/cme

- **Aug. 27**
  - Cardiovascular Disease in Women
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.usd.edu/cme

- **Aug. 27**
  - Transforming Behavior and Culture at Work: Who Heals the Healer
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.mmicgroup.com/risk-management/webinars

- **Aug. 29**
  - VA Medical Center CME Activity: Skin/Wound Care
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.usd.edu/cme

### September 2014

- **Sept. 4-7**
  - Mayo Clinic Gastroenterology and Hepatology Board Review
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.mayo.edu/cme

- **Sept. 10**
  - When Time is of the Essence: Early Recognition of Acute Change of Condition in Long-term Care
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.mmicgroup.com/risk-management/webinars

### October 2014

- **Oct. 1**
  - Internal Medicine Grand Rounds: Management of Urinary Incontinence
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.usd.edu/cme

- **Oct. 8**
  - Internal Medicine Grand Rounds: Treatment of Varicose Veins
    - AMA CME Category 1 Credit(s)™ available
    - Register online: www.usd.edu/cme

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**DO YOU HAVE A CME EVENT COMING UP? WOULD YOU LIKE TO HAVE IT LISTED HERE?**

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