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like many people, I usually start each New Year with an ambitious set of resolutions. However, as January passes and February begins, I often find that my resolutions fade into merely good intentions. This year, however, I resolve to live and promote a healthier lifestyle.

An NIH Public Access manuscript by Oberg and Frank titled “Physicians’ health practices strongly influence patient health practices” states that “physicians who practise healthy habits play a key role by helping their patients to adopt healthy lifestyles for primary prevention of chronic diseases. The health of general practitioners (GPs) is important because they serve as health role models and because they are more likely to counsel their patients about health behaviour change if they practise healthy habits themselves. One of the strongest predictors of health promotion counselling by primary care physicians is practising a healthful behaviour oneself – it is clear that many physicians report difficulty counselling patients about behaviours they themselves do not practise” and “the majority of people cite their physician as their primary source of information regarding healthy lifestyle decisions and are more likely to adopt a healthy behaviour when their physician recommends it.”

For over 25 years, America’s Health Rankings has annually assessed the nation’s health and assigned a state by state ranking. Four main groups of health determinants are evaluated. Firstly evaluated are behaviors including everyday activities, dietary and physical activity choices that affect personal health habits and practices. These behaviors can be modified with support of community, policy and clinical intervention. Secondly, community and environmental factors which influence quality of life and life expectancy are included. These consist of healthy and safe communities, clean water and air, vital neighborhoods and violence-free places to be physically active. Thirdly included are policies which influence the availability of resources to encourage and maintain health, promote healthy living and judicious consumption of health care resources. Lastly, clinical care availability includes the access, quality, appropriateness and cost of medical care. This year South Dakota ranked 18 which represented an improvement since last year’s ranking of 22. Hawaii ranked healthiest for the third year at number 1 and Mississippi ranked 50 for the third year. In the states around South Dakota, Minnesota ranked 6, North Dakota ranked 9, Nebraska ranked 10, Iowa ranked 24 and Wyoming ranked 25.

South Dakota’s challenges noted in the report include high prevalence of binge drinking rank 41, high occupational fatalities rank 40 which included fatalities in construction, manufacturing, trade, transportation, utilities, professional, and business services per 100,000 workers and low immunization coverage 54.7 percent (1 dose Tdap since age 10, 1 dose meningococcal vaccine, and 3 doses HPV for females) among teens ages 13-17 rank 46. Highlights included an 11 percent relative decrease in smoking rates from 22 to 19.6 percent of adults rank 29, immunization rates among children increasing to 73.8 percent rank 13, children in poverty decreasing to 13 percent rank 4 and preventable hospitalizations decreasing from 71.1 to 57.5 per 1,000 Medicare beneficiaries rank 28. This national assessment tool provides an opportunity to evaluate both South Dakota’s strengths and weaknesses and to provide corrective action on the weakness. The America’s Health Rankings website has resources to assist with action strategies.

In South Dakota, the Department of Health created the Office of Chronic Disease Prevention and Health Promotion which encouraged state partners to join with them in a unified effort to prevent and control chronic disease and promote healthy behaviors in communities, tribes, schools, workplaces and childcare facilities. Workgroups were formed and an annual meeting is held that includes presentations by a national speaker. A Chronic Disease State Plan was written to provide a comprehensive roadmap of proven effective strategies for making change. Good and Healthy South Dakota provides a hub for collaboration and allows national, state and local resources to be shared among partners. Their website contains a wealth of information on health promotion and I encourage everyone to visit it. Some of the resources include an Obesity Toolkit; a Call to Action on Walking, Exercise is Medicine with exercise prescriptions for patients and CME courses for providers. Health care providers are recognized as playing a vital role in preventing and controlling chronic disease from asking patients about their level of physical activity and diet during routine visits, to assessing smoking status and referring patients to the QuitLine, to providing health-related information, to ensuring that recommended screenings and vaccinations take place, to using health IT to ensure overall quality of care and by linking patients to community health and education resources. The partnerships we develop with our patients form the foundation for improved health and well being. Let’s all resolve to make Healthy South Dakota a reality in 2015.
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It’s Time!

By Suzanne Wiedel, Legislation Coordinator

In January, the 90th South Dakota legislative session opened. Staying informed of proposed and approved changes in health legislation is one of our roles as SDSMA Alliance members. Alliance members can help give state and federal elected officials an accurate assessment of the effect that health legislation has on patients and families. Alliance members have a voice as health care related bills make their way to the Capitol. How can you become a more effective advocate in your district? Register to vote and always vote! Learn who your state and federal legislators are and get to know your legislators in your community. Arrange a personal meeting with your legislators or send a personal note. Send prepaid U.S. post cards on specific issues or legislation. Make phone call or emails. Make your personal communication count. Increase your own advocacy clout and cultivate relations with staff members. The American Medical Association (AMA) Alliance has specific and detailed information on how to effectively accomplish each of these in the legislation section of the AMA Alliance website. The website also has a wide selection of resources including: AMA Alliance Action Network/Training, hot button topics, and a legislative advocacy guide. Visit the website at www.amaalliance.org.

It’s time to be informed on how a bill becomes a law and educate your members of this process. Follow the arrows in the figure to track the path of a bill from an idea to a new law.

It’s time to join the SDSMA PAC. The SDSMA PAC is a voluntary, non-profit organization that serves as the political arm of the SDSMA. Membership includes physicians and spouses, residents, medical students, clinic managers and SDSMA staff. The SDSMA PAC was created to impact public policy decisions through bipartisan participation in all aspects of the legislative process and advocate on behalf of South Dakota’s physicians and patients by supporting pro-medicine candidates at state and federal levels. Every year decisions are made in Pierre and in Washington that impact physician’s ability to deliver quality care. As health care policies takes shape, physicians and Alliance members cannot sit back and let others, many of who have no background in health care, decide the future of health care.

The SDSMA PAC provides opportunities for physicians and Alliance members to meet and develop relationships with lawmakers. The SDSMA PAC hosts “legislative meetings” where PAC members are invited to meet local lawmakers and to discuss medicine-related issues.

The SDSMA PAC supports physician friendly candidates and to date the SDSMA PAC has dispersed $34,900 in candidate contributions between the 2014 primary and general elections. Of the 53 candidates supported in 2014, 41 were elected to office.

If you’re not a member and would like to join please, contact the SDSMA office. Through your membership 100 percent of SDSMA PAC monies stays in South Dakota.

It’s time to join the SDSMA Alliance on February 5 in Pierre for a Day at the Capitol. The Alliance will be introducing the state health project Pills Are Not a Party to legislators. Pills Are Not a Party is a 15 minute animated DVD which educates middle school youths about the dangers of abusing prescription and over the counter medications. The DVD was created by the Green County Medical Society Alliance of Springfield, Missouri and won the 2013 AMA Alliance Health Awareness Promotion award. Please contact your district legislators and let them know you would like to visit with them while you’re in Pierre.

The University of South Dakota Sanford School of Medicine medical students will join the Alliance at the Capitol. While Alliance members are discussing the health project, medical students will help serve ice cream sundaes. The Day at the Capitol is a fun day and the Alliance loves the opportunity to introduce the students to legislators from their districts. Hope to see you in Pierre!
To the Editor:

In the article, “Keeping Baby Safe,” published in the June 2014 issue of South Dakota Medicine, Dr. Richard P. Holm discussed the study of infant deaths in the state. South Dakota has historically had a slightly higher infant death rate (6.5 deaths per 1,000 live births) than the six per 1,000 national average. But it is the South Dakota Native American population that has the highest infant death rate in the country at 12 per 1,000 live births.

According to Dr. Holm, preventing infant deaths is “up to Mom,” and moms who are healthy before getting pregnant and receive prenatal care will have healthier babies. To be sure, far better outcomes are associated with healthy moms and a healthy pregnancy. Yet this assessment does not take into account the uncontrollable factors that can harm a pregnant woman and her child.

The South Dakota Tribal Pregnancy Risk Assessment Monitoring System (PRAMS) has looked specifically at factors that affect these Native American mothers. For example, more Native American women received early prenatal care than the rest of the South Dakota population, but were unable to follow through due to lack of transportation, appointment unavailability, or racism from their health care providers. Furthermore, a shocking 9 percent of women surveyed by PRAMS were homeless at some point during their pregnancy. This data should be used to help decrease the infant death rate in this population.

So it’s not all mom’s fault – there’s more to the story. The issues that affect the South Dakota Native American population are part of a nationwide epidemic of infant deaths in low socioeconomic communities. This results in a vicious cycle of poor health and poorer outcomes. To give an expectant mother and her baby their best chance at health, a diverse array of social, systemic, and environmental factors must first be addressed and improved.

Sincerely,

Kelly Landeen, MS1,
University of South Dakota Sanford School of Medicine

Ashley Briggs, MD,
Chair for the ACOG Native American/Alaskan Indian Committee

REFERENCES


To the Editor:

Thank you to Dr. Briggs and Ms. Landeen for your letter, your interest, and your important input regarding the issue of infant mortality in South Dakota, and especially in Native Americans of South Dakota.

My essay, which was published in the June 2014 issue of South Dakota Medicine, was also used for the On Call with the Prairie Doc television production on April 17, 2014, with physician guest Kimberly McKay, MD, and PhD guest Bonny Specker. This show can be watched online by visiting: https://prairiedoc.org/media?cbp=projects/2013-2014.html.

I should add here that at the end of the show, you can watch the video version of the essay, and might note that by the time of the show, a revision of the essay was changed that didn’t appear in South Dakota Medicine. Added were the words, “Dad shouldn’t be off the hook, but” before the guilt-sounding admonition, “…after all, it’s up to Mom.” I apologize to all who this may have offended. Indeed no one burdened by uncontrollable factors of socio-economic suppression needs more encumbrances.

However, my intention was not to throw guilt at Mom, as one might understand reading the whole essay. It was and remains to empower her. Most experts advise that the most important way to effect change in areas or countries of poor socio-economic condition is to empower women, allowing for her to teach her children how to pull themselves out of poverty, how to empower her girls to seek education and use appropriate birth control, and to empower her boys to grow up to be responsible protectors of his family.

I join you both in your call to improve social, systemic, and environmental factors in all the impoverished areas of the world, the country, and especially our state of South Dakota. We must continue on this very challenging but not impossible quest, and maybe the first big step is to empower women.

Sincerely Yours,

Richard P. Holm, MD
Medical Editor for On Call with the Prairie Doc, shown Thursdays at 7 p.m. CST/6 p.m. MST on SDPB

Editor’s note: Dr. Holm’s revised article has been posted at www.sdsm.org in the South Dakota Medicine section.
Last month I was in San Diego attending the American Academy of Child and Adolescent Psychiatry when I struck up a conversation with a fellow attendee while standing in line to get coffee. He mentioned that his train from Los Angeles the prior evening had been delayed because a person had jumped in front of the train. Apparently this happens with enough frequency on a certain stretch of tracks that they have developed a protocol to efficiently deal with the situation in order to get the trains moving again. It seemed so cold and calculated to me; as if an occurrence such as this is an expected part of life in this large urban area. Upon hearing of this tragedy I couldn’t help but think about the recent spike in adolescent suicide in the 10-county region surrounding Sioux Falls which is noted in the “Regional Infant and Child Mortality Review Committee 2013 Final Report” (Wilson and Sideras) on page 57.

To what can we attribute the increase to five reported cases of adolescent suicide in 2013? Did the area’s increased population growth or increased diversity contribute to this increased rate of adolescent suicide? Using Centers for Disease Control and Prevention (CDC) data, which show the national rate of suicide in the 1- to 17-year-old population at 1.3 per 100,000, Wilson and Sideras would expect slightly one death per year in this age group. For the previous decade, there has been one case of adolescent suicide per year in the area. The incidence in 2013 was fivefold that. While there has been population growth in the area, it has not been a fivefold increase. Sioux Falls and surrounding counties have an increasingly diverse population. The report does not indicate the ethnicities of those who perished by suicide. The area also includes a sizeable Native American population. Multiple studies have shown that Native American teens have the highest suicide rate of any ethnic group in the nation.

Are there increases in other risk factors that contribute to this disturbing statistic? Major depressive illness is the most significant factor for suicide, increasing the risk by 20 percent. Other risk factors for suicide include substance abuse, exposure to family violence, a family history of suicide, impulsivity, and the availability of lethal methods. A child who has lost a parent from any cause before age 13 is at high risk for mood disorders and suicide. Data from large community studies have data which suggest that sexual orientation is a risk factor in suicide; youth that identify themselves as gay, lesbian, or bisexual have from twice to six times the rate of suicide as those who do not identify themselves in this category. About 40 percent of youthful persons who complete suicide have had previous psychiatric treatment, and about 40 percent had made a previous suicide attempt. Suicidal ideation is not a static phenomenon; it can wax and wane with time. The decision to make a suicide attempt may be made impulsively or may be the culmination of prolonged rumination.

Are the nation’s economic, political, or moral environment to blame for the increase in the area’s incidence of adolescent suicide in 2013? Do today’s youth have a greater sense of hopelessness than in previous generations? Going from one to five suicides in one year I hope is a fluke. Yet one suicide a year is too many. When I think back to my discussion with my colleague from California, I don’t want South Dakota to become a place where suicide is so commonplace such that we develop a protocol to deal with it. I believe that we are all made in the image of God regardless of race, creed, or ethnic background and because of this each life is to be valued. We need to continue to look out for our youth and each other and strengthen our commitment to those who are hurting and are at risk. This is how South Dakota must deal with it.

About the Author:
Tim Soundy, MD, Professor and Chair, Department of Psychiatry, University of South Dakota Sanford School of Medicine.
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Regional Infant and Child Mortality Review Committee 2013 Final Report

By Ann L. Wilson, PhD; and Jim Sideras, MSN

Abstract
The Regional Infant and Child Review Committee serves 10 counties in southeastern South Dakota and its mission is to review deaths of infants and children under the age of 18 so that information can be transformed into action to protect young lives. In 2013, the committee’s interdisciplinary team reviewed 32 deaths that met its criteria. The manner of 13 of these deaths was natural, nine accidental, one homicide, five suicide, and four undetermined. There were five infant deaths during sleep and each of these occurred in an unsafe sleep environment. The number of suicides in 2013 was considerably higher than the typical one death by suicide that previously has been observed per year in the area. The report provides the Committee’s recommendations for community action that could prevent future deaths of infants and children.

The Regional Infant and Child Mortality Review Committee (RICMRC) was established in 1997 with the aim of examining deaths of infants and children to identify preventive strategies that may decrease the risk of loss of young life in Minnehaha County. The Committee’s mission is “to review infant and child deaths so that information can be transformed into action to protect young life.” The Committee now serves Minnehaha, Lincoln, Turner, McCook, Lake, Moody, Union, Hanson, Miner and Brookings counties.

The Committee is chaired by the chief of Sioux Falls Fire Rescue and is composed of professionals representing expertise in pediatrics, medico-legal death investigations, nursing, law enforcement, child protective services, emergency medical services, and mental health. Sherriff and police departments from the participating counties are invited to be present for the reviews of deaths of children occurring in their counties. To operationalize its goal of prevention, these criteria are used for reviewing deaths of infants and children (under the age of 18):

- Residents of the RICMRC region whose deaths occurred subsequent to hospital discharge following delivery (or did not occur in a hospital) from causes sustained in the region; and
- Non-residents of RICMRC region whose deaths occurred in the region from causes sustained in the region.

Ninety deaths occurred in the 10-county review area in 2013 (84 in Minnehaha, two each in Lincoln and Moody counties, and one each in Turner and Brookings counties). For illustrative purposes, the age distribution of all childhood deaths of Minnehaha County residents (that represent 93 percent of the total deaths in the 10-county RICMRC review area) is presented in Table 1. Important to recognize in these 2013 data is that 29 percent of the Minnehaha County resident deaths of children under the age of 18 occurred in the first 28 days of life (neonatal) and some of these occurred within hours of birth. Noted in Table 1 is how the population of Minnehaha County has grown by almost 45 percent between 1990-2013. Apparent over this span of time is year to year variation in the number of infant and child deaths in the county. However, a comparison of the mean number of deaths for the intervals of 1991-2001 and 2002-2013 shows a slight decrease. The mean number of annual deaths was 26.4 for the first 12 years of this time interval and 25.5 for the more recent 11 year period of time. In light of the growth of the county’s population, this is an encouraging finding. Though caution must be exercised when calculating rates...
with the small population base of the RICMRC area, the 2010-2012 regional rate of death for infants (birth to age 1) of approximately five per 1,000 live births and is lower than what is observed nationally (six). Further, for children (ages 1-17), the regional rate of death (20.9 per 100,000) is comparable to the national rate of 20.3.

Thirty-two deaths met the Committee’s criteria in 2013 and all were reviewed (compared to 24 cases in 2012). Of the 32 reviewed cases, 27 were residents of Minnehaha County, two were from Moody County, two from Lincoln County and one from Turner County.

The reviewed deaths listed below are separated by their manner (natural, accidental, suicide, homicide and undetermined). The number of deaths for 2013 in each manner category is indicated in bold adjacent to its heading.

### Table 1. Minnehaha County Resident Deaths and Population

<table>
<thead>
<tr>
<th>Year</th>
<th>Infant</th>
<th>1-14 years</th>
<th>15-17 years</th>
<th>Total</th>
<th>Total Population</th>
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</thead>
<tbody>
<tr>
<td>2013</td>
<td>12</td>
<td>11</td>
<td>5</td>
<td>28</td>
<td>Est. 179,640</td>
</tr>
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<td>16</td>
<td>10</td>
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</tr>
<tr>
<td>2011</td>
<td>12</td>
<td>7</td>
<td>4</td>
<td>23</td>
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</tr>
<tr>
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<td>11</td>
<td>7</td>
<td>1</td>
<td>19</td>
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<tr>
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<td>17</td>
<td>6</td>
<td>2</td>
<td>25</td>
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<td>23</td>
<td>3</td>
<td>1</td>
<td>27</td>
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<td>22</td>
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</tr>
<tr>
<td>1990</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td>123,809</td>
</tr>
</tbody>
</table>

Population data from U.S. Census Bureau.

Numbers listed in parentheses represent the comparable number of deaths from 1997-2012. Care must be taken in comparing yearly data due to the addition of Lincoln County (1998), Turner County (1999), McCook County (2000), Lake and Moody counties (2001), Union County (2002), Hanson and Miner counties (2003), and Brookingss County (2004) in years subsequent to the establishment of the Committee’s work in Minnehaha County in 1997. However, as 74 percent of the reviewed cases are residents of Minnehaha County, some meaningful comparison of data between years is justified.

### Natural Deaths


In total, 13 children died in 2013 from natural causes. Six of these children had received care for congenital conditions, longterm illnesses, or malignancy. Five children died of complications of neurological/developmental conditions. One death was the outcome of rapidly progressing infection and another was the outcome of an unexpected home delivery of a pre-viable newborn. In 2013, similar to the two previous years, there were no deaths attributable to sudden infant death syndrome (SIDS). There were five deaths of infants that occurred during sleep whose manner was coded as “accidental” or “undetermined.”

### Accidental Deaths


The number of childhood deaths (n=9) caused by accidents in 2013 exceeds the mean number of these deaths observed in most recent years, but also reflects one motor vehicle crash whose cause remains unexplained and claimed the lives of two children who were wearing seat belts. This year, there were no crashes involving a teenage driver. One child died in a house fire where there were no working smoke alarms and one child died in a choking incident. Two toddlers also died of accidents that occurred as they became caught and asphyxiated while leaving their place of sleep. A drowning at Falls Park in Sioux Falls also occurred.

Figure 1 shows that the manner of two deaths of infants who died during sleep was certified as accidental and three as undetermined. In each of these five cases, the infants were found dead in an unsafe sleep environment and none of these deaths occurred in a crib. For the
previous five years (2008-2012), the mean number of infant deaths during sleep has been four, and the five such deaths in 2013 exceeds this mean. As noted in previous reports, in recent years there has been increasing awareness of the importance of death scene investigations of sudden infant deaths. When hazards are identified in the environments where these deaths occur, their cause is now increasingly identified as accidental, undetermined, or as natural with the cause listed as sudden unexpected infant death (SUID). SUID is a term that began to be used on a Centers for Disease Control and Prevention (CDC) investigation form issued in 1996. For SIDS to be identified as the cause of an infant death, it now cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history.

Figure 1 presents how these unexpected infant deaths occurring in sleep have been certified over the past 13 years. The most recent national data available show that in 2011, the rate of SIDS was 0.5 per 1,000 live births that equates to zero to one death per year in the RICMRC 10-county area. As noted in Figure 1, since 2000, only in 2008 has that number of deaths due to SIDS been exceeded. Nonetheless, the annual number of infant deaths during sleep has been fairly consistent and demands community attention to the need to educate the public on environmental hazards for safe infant sleep.


A striking increase in the number of deaths due to suicide is apparent during 2013. These teens had been served in mental health or juvenile correctional care settings. The challenges of treating this population of vulnerable youth are recognized. National data from 2011 from the CDC present a rate of 1.3 per 100,000 for the population between the ages of 1-17 years. If this same rate was observed for the RICMRC population, slightly less than one suicide death (0.9) would be observed annually. As noted in the above data, this is what has been typically observed in the 10-county area. The number of deaths due to suicide in 2013 greatly exceeds these previous observations.


On average, there has been about one homicidal death of a child per year in the region and this was true in 2013. This death is certified as the result of an injury inflicted by a non-parental caregiver.


As described above and presented in Figure 1, there were three deaths of infants that occurred during sleep whose cause was certified as undetermined. In each of these cases, the infant was found dead in an unsafe non-crib sleep environment that could have potentially caused the death. Two of these cases involved co-sleeping with parents. A toddler also died during sleep with the cause of death undetermined.

Advocacy Issues

Data from the reviews of the 2013 deaths highlight the following actions that health care professionals, community leaders and citizens may take to prevent future loss of life of infants and children. Issues that are listed with an asterisk note those that have been discussed in previous reports and require ongoing attention.

1.*Data continue to show that many of the infants who die unexpectedly do so in unsafe sleep environments and that these deaths in the region are not decreasing. In 2013, all of the deaths of infants who unexpectedly died during sleep occurred in an unsafe sleep environment and none of these babies were in a crib at the time of death. The Committee applauds the televised public service
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announcements of First Lady Linda Dugaard that demonstrate how babies may be safely placed to sleep. Education of parents regarding safe sleep at the time of hospital discharge with their newborn is encouraged. Screening for parental need to receive a state-funded portable Pack and Play upon discharge from the hospital with their newborn must continue. Ease of parental access to these cribs is vital.

The National Institute of Child Health and Human Development in collaboration with other organizations has launched the “Safe to Sleep” campaign. Emerging from the former “Back to Sleep” campaign, this initiative focuses public attention not only on how infants should be placed to sleep on their backs, but also on how a safe sleep environment includes a flat surface free of soft bedding, bumper pads, toys, quilts or other materials. This message requires ongoing local dissemination. A review of pictorial media advertisements of furnishings for a nursery provides evidence of how public education is essential to prevent the purchase and use of materials that create risks for an infant’s safe sleep. Further, attention to the hazards associated with infant sleep on sofas, other furniture and in infant seats is needed. Controversy continues about the hazards of co-sleeping. Nonetheless, efforts to increase public awareness of the risks associated with this practice, especially when an adult is impaired by alcohol or other substances, is strongly encouraged.

2.*The Big Sioux River creates safety hazards for the region. Over time, the Committee has advocated for life saving equipment in Falls Park. The 2011 death of a child tubing on the river has prompted Sioux Falls Fire Rescue’s provision of education on water safety. These efforts are applauded and their continuation is encouraged as the river’s attractiveness as a venue for sporting activities will be an ongoing enticement for children. The 2013 death of a child who fell into an area adjacent to the falls and the person who attempted to rescue her, again emphasize the need for availability of equipment in the falls area that could be used for immediate life saving efforts. Increased signage regarding the dangers of the falls should also be enhanced. Close adult supervision of children who come near the falls area is essential to promote their safety in this dangerous, albeit attractive area.

3.*Adolescence is a time of vulnerability to social pressures and emotional volatility. Adult sensitivity to these issues and advocacy for mental health for teens must continue as suicide poses a threat to teenagers and a cause of trauma for survivors of this loss of life. The spike in deaths observed in 2013 heightens awareness to the complexity of providing care to this population of youth, yet how this challenge must continue to be addressed.

The Committee is pleased to learn that the South Dakota Department of Social Service has recently received funding by the Substance Abuse and Mental Health Services Administration to prevent youth suicide. This funding will be used in a new project that will identify, support, educate, and refer youth at risk for suicide to behavioral health services. It will also provide training for clinical service providers and direct care staff who work with youth at risk. A Committee member will serve as a link to this new project.

4.*The sleeping environments for all children and adults should be protected by working smoke detectors. Since 2008, eight children’s lives may have been saved by a functioning smoke detector. The Committee supports and encourages the ongoing efforts of local fire departments in educating the public about the need for families to install and service smoke detectors to assure their ability to provide life saving warnings of home fires.

5.*Maternal tobacco and alcohol use are known risk factors for SIDS/SUID. Maternal smoking, both during and after pregnancy, also represents a risk factor for SIDS/SUID. Secondhand smoke is an additional SUID risk factor. Parents should make every effort to restrict the use of alcohol, tobacco, and illicit drugs for the well being of their infants, both before and after the baby’s birth. We encourage the creation and use of programs that assist parents in abstaining from tobacco and alcohol use. After adherence to the safe sleep programs for infants, cessation of maternal smoking during and after pregnancy is the next best way to prevent sudden infant deaths.

6.*Care must be taken that all infants and children have periodic physical examinations to detect potentially preventable and treatable illness and immunizations. Vigilance in assuring that infants and children are up to date on immunizations may prevent loss of life from an infectious illness.

7.*Follow-up activities from the 2011 State Task Force on Infant Mortality convened by First Lady Dugaard includes coordination between the State Department of Health, RICMRC and the similar committee that reviews infant deaths in the Rapid City area. These two
7 out of 10

MORE THAN 50% OF ALL NEW CERVICAL CANCERS are in women who have never been screened or have not been screened in the last 5 years. And, 7 out of 10 women who are not screened, have a regular doctor and health insurance.* Don’t miss an opportunity to talk to your patients about regular Pap smears and HPV testing.
committees have begun to review infant deaths occurring in counties outside of their regions. The data base established by the National Center for Child Death Review is now being used by the state for recording and analyzing data collected regarding infant deaths. A statewide committee will begin to analyze these reviews of all infant deaths conducted by the state’s committees. Thoughtful review of data enables the development of strategies that are responsive to local causes of death. The state’s initiation of this effort is applauded.

Report submitted by the Regional Infant and Child Mortality Review Committee:
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4 http://wonder.cdc.gov/controller/dataquest/D77;jsessionid=7A28A882A5F4BC47D869A85B21E10D2A.

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Acknowledgement:
The authors express their gratitude to Brad Randall, MD for his review of this manuscript.
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Bowen-Conradi Syndrome: A Trisomy 18-like Autosomal Recessive Disorder Common in Hutterites

By Nic Torbert, DO; Suzanne Reuter, MD; Angela Myers, MD; Kristen De Berg, CGC; Patricia L. Crotwell, PhD; and Jason D. Flanagan, CGC

Abstract
Bowen-Conradi syndrome (BCS) is a common lethal condition amongst infants of Hutterite ancestry. We describe a newborn infant with features of BCS, which may mimic trisomy 18 and other conditions such as cerebro-oculo-facial syndrome (COFS) and CHARGE syndrome. We describe the constellation of clinical findings in BCS. We believe this is the first case of BCS clinically confirmed by molecular testing for mutation in the \textit{EMG1} gene.

Introduction
Trisomy 18 is often suspected in babies with fetal anomalies such as clubfeet and clenched hands. If trisomy 18 is ruled out, it is often difficult to determine the underlying genetic cause for the birth anomalies. When chromosomes were normal, the babies were often diagnosed with pseudotrisomy 18.

In 1976, Bowen and Conradi published an article that described two infants of Hutterite descent with micrognathia, finger contractures, and rocker-bottom feet. Since these features are often seen in trisomy 18, Bowen-Conradi syndrome (BCS) became part of the differential for babies suspected of having trisomy 18. Until recently, there was no way to confirm that non-Hutterite children with these features had BCS.

Armistead et al. described the mutation that causes BCS in the Hutterite condition in 2009. Although they were able to describe the mutation, no molecular clinical testing has been available to test for this condition in the U.S. Here we present what we believe to be the first molecularly confirmed clinical case of BCS in a child born of Hutterite descent. Because Armistead showed that non-Hutterite individuals did not have this mutation, we need to reevaluate what the natural history is for individuals with the common Hutterite mutation. We describe the clinical course and discuss the epidemiology, diagnosis, clinical findings, and the prognosis of patients with BCS.

Case Report
The patient was a male neonate born at 38 and 2/7 weeks gestation to a G1 23-year-old Hutterite female whose pregnancy was complicated by insulin dependent diabetes mellitus (IDDM) Class D. Her diabetes was treated via an insulin pump; her most recent hemoglobin A1C was reported at 7 percent (nl ≤ 6.5 percent).

At 22 and 4/7 weeks gestation, the mother was referred to a maternal fetal medicine clinic (MFM) for fetal ultrasound due to maternal IDDM. The ultrasound was significant for a left clubbed foot and poor fetal growth. Noninvasive prenatal testing (NIPT) was offered initially because of concerns for fetal aneuploidy, such as trisomy 13 or 18. Amniocentesis was also offered at that time. The testing was declined by the family.

At a follow-up visit at 27 and 4/7 weeks, fetal ultrasound indicated poor fetal weight at the 12th percentile, head circumference, abdominal circumference, and fetal length of less than 10th percentile, abnormal posturing of hands, suspected left club foot with dorsiflexed right foot and rocker-bottom feet. Prenatal chromosome testing was declined. Per maternal report, there was no known consanguinity and no immediate family history of syndromes.

The patient was born at an outlying facility at a gestational age of 38 weeks and 2 days. The delivery was via cesarean section for breech presentation. The baby was resuscitated...
with positive pressure ventilation by face mask and received tactile stimulation with oral suctioning. Apgar scores were 3 at 1 minute and 8 at 5 minutes of age. Because of dysmorphic features on clinical examination, the patient was transferred to a level III neonatal ICU (NICU) for further care and evaluation.

The patient’s birth weight was 2,732 g (ninth percentile), head circumference was 30.8 cm (below third percentile – 2.11 standard deviations), and length 43.9 cm (below third percentile –2.25 standard deviations). The physical examination was significant for severe micrognathia, microcephaly with prominent occiput and bitemporal narrowing. The patient appeared to have small palpebral fissures, squared low set ears with prominent antihelix, fleshy earlobe and hemangioma behind the left ear. The tests were high but palpable in the inguinal canals bilaterally. Musculoskeletal examination revealed bilateral rocker bottom feet with severe dorsiflexion and eversion of the right foot, clenched hands with overlapping fingers, and camptodactyly of the third and fourth fingers bilaterally with shallow distal creases. The patient’s neurological examination was unremarkable.

The patient’s hospital course was significant for poor feeding related to uncoordinated sucking reflex requiring nasogastric tube feedings. Initially, the patient had very shallow breathing, suggestive of central nervous system dysfunction. An echocardiogram showed non-life threatening findings.

A genetics consult resulted in testing with fluorescence in situ hybridization (FISH) for trisomy 18, which was negative. Based upon past experience with Hutterite families, BCS was considered a likely diagnosis. Blood was sent for diagnostic BCS testing at the Molecular Diagnostic Laboratory at Alberta Children’s Hospital in Calgary, AB, Canada. The targeted mutation analysis indicated homozygosity for the EMG1 c.257A>G mutation, which is consistent with a molecular diagnosis of BCS.2

The baby was discharged on day 4 of life with plans for a palliative care consult, nasogastric feeds, supplemental oxygen to maintain oxygen saturations greater than or equal to 90 percent. At 4 months of age, he died quickly and peacefully at home with his family present.

**Discussion**

BCS is an autosomal recessive ribosomal biogenesis disorder that has an estimated birth prevalence of one per 355 live-births in the Hutterite population,1 making BCS one of the most common autosomal recessive conditions in the Hutterite population,1 with a carrier frequency estimated to be one in 10. In the past, a diagnosis of BCS has been based on clinical presentation, with findings noted in Table 1, with a normal karyotype. Here we describe a case of BCS, molecularly confirmed by sequence analysis of the EMG1 gene, and identification of homozygosity for the missense mutation c.257A>G (p.D86G). EMG1 is the only gene currently known to be associated with BCS.

Most of our understanding of this gene comes from the study of yeast. EMG1 is believed to play a role in ribosome biogenesis.11 Armsstead et al. showed that in human fibroblasts the deletion decreased the amount of EMG1 protein due to degradation. Currently, it is postulated that there is enough protein available for biogenesis, but the limited amount affects the neurological development in BCS patients.2

There are obvious phenotypic similarities between BCS and trisomy 18.15 Trisomy 18 is the second most common autosomal trisomy in newborns, with a birth prevalence of approximately one in 3,000 to one in 8,000. The pattern in Trisomy 18 includes a recognizable constellation of major and minor anomalies, a predisposition to increased neonatal and infant mortality, and significant developmental and motor disability in surviving older children. Most infants pass away within the first year of life. Features of trisomy 18 include prenatal growth deficiency, prominent occiput, recognizable facies (narrow bifrontal diameter, low set, malformed ears, short palpebral fissures, inverted triangular face), distinctive hand posturing (overriding fingers, clenched hands, ulnar or radial deviation of hand), a short sternum, small pelvis, cryptorchidism, rocker bottom feet, and congenital heart defects.4 Patients with BCS do not have a short sternum or the other major structural birth defects described in trisomy 18 that are ultimately the leading cause of death in this population.3

Outside of trisomy 18, overlap with other conditions has been noted. For example, features of BCS are also seen in cerebro-oculo-facial syndrome (COFS), Pena Shokeir phenotype type 1, pseudotrissomy 18, and CHARGE syndrome (Table 1). Unlike these conditions, BCS is not currently believed to cause internal organ malformations.

The patient described here follows the typical presentation of BCS. We believe this is the first confirmed molecular
Table 1. A Comparison of the Physical Findings Present or Absent in BCS, Trisomy 18, Pseudotrisomy 18, Pena-Shokeir and COFS.

<table>
<thead>
<tr>
<th></th>
<th>Bowen-Conradi Syndrome</th>
<th>Trisomy 18</th>
<th>Pseudotrisomy 18</th>
<th>Pena-Shokeir Phenotype Type I</th>
<th>Cerebro-Oculo-Facial Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microcephaly</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Micrognathia</td>
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<td>X</td>
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<tr>
<td>Prominent Nose</td>
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<tr>
<td>Contractures</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Prominent Heel</td>
<td>X</td>
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<tr>
<td>Rocker-Bottom Feet</td>
<td>X</td>
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<tr>
<td>Intrauterine Growth Failure</td>
<td>X</td>
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<tr>
<td>Developmental Delay</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Blepharophimosis</td>
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<tr>
<td>Microphthalmia</td>
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<tr>
<td>Cataracts</td>
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<td>Neuropathology</td>
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<td>Focal Microgyria</td>
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<tr>
<td>Agenesis of the Corpus Collosum</td>
<td>X</td>
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<tr>
<td>Polyhydramnios</td>
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<td>X</td>
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<tr>
<td>Joint Contractures</td>
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<tr>
<td>Craniofacial Anomalies</td>
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<td>Coloboma</td>
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<td>Congenital Heart Defects</td>
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<tr>
<td>Omphalocele</td>
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<tr>
<td>Abnormal Posturing Hands</td>
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<tr>
<td>Ear Anomalies</td>
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<tr>
<td>Camptodactyly</td>
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<tr>
<td>Cryptorchidism</td>
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</table>

The clinical course and prognosis is variable for children with BCS. Mean age of survival is 13 months\(^\text{10}\) with reported length of life from 1 day to 9 years\(^\text{6}\). Feeding difficulties are prevalent at a young age and are accompanied by aspiration which frequently leads to recurrent aspiration pneumonia and death.\(^\text{3}\) The natural history of BCS has not been well established. With the advent of molecular testing, it will be important to delineate the natural history from the families known to harbor the EMG1 Hutterite mutation. Confirming the diagnosis of BCS may also help in establishing the medical management plan for these patients.

In conclusion, BCS is likely a common condition amongst Hutterite populations. Therefore, providers in these
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regions should learn to recognize and understand the impact this condition may have on a family. If BCS is being considered, a genetic evaluation should take place as many of the features of BCS overlap other syndromes. If features of BCS are noted, confirmation by molecular testing is warranted. Since BCS is autosomal recessive, the recurrence risk for such a couple would be 25 percent. This is in stark contrast to trisomy 18, which is a chromosomal aneuploidy generally quoted with a recurrence risk of approximately 1 percent. Therefore, while BCS and trisomy 18 have overlapping clinical features, they have different outcomes, prognoses and reproductive implications.

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The authors thank the family of the child described herein who gave permission to publish this case. The authors also thank Kimberly Gall and the members of the Molecular Diagnostic Laboratory at Alberta Children’s Hospital for facilitating the molecular testing for the patient described.

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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Paid for by private donations to the Department of Internal Medicine
Review of Acute Coronary Syndromes: Diagnosis and Management of Unstable Angina and Non ST-elevation Myocardial Infarction

By Naveen Rajpurohit, MD; Syed Z. Ayaz, MD; Jimmy Yee, MD; Muhammad A. Khan, MD; and Adam Stys, MD

Abstract
Coronary artery disease (CAD) is the leading cause of death in the U.S. Acute coronary syndrome (ACS), in specific, unstable angina (UA) and a non ST-elevation myocardial infarction (NSTEMI) are life threatening conditions that need prompt diagnosis and treatment. This is the second part of a two-part review series that aims to discuss the different types of ACS. The focus of this review is UA/NSTEMI, and it provides answers to some of the fundamental questions through evidence-based guidelines.

What is Angina? What are UA and NSTEMI?
Typical angina pain is characterized by 1) poorly localized chest or arm pain 2) physical exertion or emotional distress and 3) relieved with rest and/or the use sublingual nitroglycerin. Atypical angina is characterized by two of the characteristics listed above, and noncardiac chest pain is likely when one or none of the typical angina characteristics are present. While some patients may not have typical symptoms of chest pain or pressure, they can present solely with jaw, neck, ear, arm, shoulder, back, epigastric discomfort or with unexplained dyspnea. UA may be unveiled by three principle presentations. It may occur during rest, (which may prolonged up to 20 minutes), new-onset of angina of at least Canadian Cardiovascular Society (CCS) class III (Table 1) or previously diagnosed angina that has become distinctly more frequent, longer in duration, or lower threshold. UA/NSTEMI can be interpreted by electrocardiogram (EKG) changes with ST-depression, T-wave inversions and positive markers of cardiac injury (troponin, creatinine kinase, lactate dehydrogenase). This differs from the presentation of ST-elevation myocardial infarction (STEMI) as noted on EKG and is indicative of transmural ischemia. UA differs from NSTEMI with the lack of detectable release of cardiac markers of ischemia on blood work. UA/NSTEMI results from disruption or erosion of atherosclerotic plaque and a subsequent cascade of processes that decrease coronary blood flow and results in lack of oxygenation to the cardiac tissue.

What are the Symptoms of UA/NSTEMI?
Special attention needs to be given to patients that present with chief complaints of chest pain that are characteristic of myocardial in origin. These include chest pain/pressure/tightness with radiation to the jaw, shoulders, back. Persistent shortness of breath and/or weakness, dizziness, loss of consciousness are also very concerning. Additional caution should be taken for patients with a history of known CAD, interventions in the past [i.e., coronary artery bypass graft (CABG), percutaneous coronary intervention (PCI)], and angina upon exertion. Patients are at an added risk of a cardiac event with a history of hypertension, hyperlipidemia, smoking, diabetes mellitus (DM), family history of CAD or cocaine/methamphetamine use. Special considerations should be given to the elderly and diabetics as they may present with a silent myocardial infarction (MI) without any symptoms

<table>
<thead>
<tr>
<th>Class Type</th>
<th>Characteristics of Angina</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 0</td>
<td>Asymptomatic</td>
</tr>
<tr>
<td>Class I</td>
<td>Angina only during strenuous or prolonged physical activity</td>
</tr>
<tr>
<td>Class II</td>
<td>Slight limitation, with angina only during vigorous physical activity</td>
</tr>
<tr>
<td>Class III</td>
<td>Symptoms with everyday living activities</td>
</tr>
<tr>
<td>Class IV</td>
<td>Inability to perform any activity without angina or angina at rest</td>
</tr>
</tbody>
</table>

Table 1. Canadian Cardiovascular Society Grading of Angina Pectoris or CCS Angina Grading Scale
or with isolated symptoms like sudden onset of dyspnea, or dizziness.¹

**What is the Initial Assessment for UA/NSTEMI?**
A detailed history and physical exam should be obtained in any patient presenting with chest pain. An EKG and basic labs along with cardiac markers should be obtained. The EKG may show ST-depressions, T-wave inversions or other non-specific changes. Repeat EKG should be performed to monitor for any dynamic changes. Patients should be risk stratified to assess their short and long term cardiac mortality and morbidity. There are various risk stratification scores available.⁶ One of the most commonly used risk stratification score is the thrombolysis in myocardial infarction (TIMI) score (Table 2).⁷

**Do all patients with UA/NSTEMI need a hospital admission?**
Patients should be evaluated thoroughly in the emergency department (ED) for safe observation or in an observation unit at a hospital with telemetry monitoring while trending cardiac enzymes. Patients deemed to be low risk for ACS (i.e., atypical chest pain, negative cardiac enzymes after trending with time, hemodynamic stability, no dynamic EKG changes) can be discharged for follow-up as an outpatient. In patients deemed to be high risk for ACS (i.e., continuous active chest pain with typical anginal symptoms, prior known CAD, high TIMI score, dynamic EKG changes, rising cardiac enzymes), admission to the hospital for further care is warranted. The decision for either invasive strategy or conservative strategy should be made by the physician based on the presentation and history of the patient (Figure 1).

A baseline echocardiogram (ECHO) should be performed to evaluate for any structural heart disease, wall motion abnormalities suggestive of ischemia or cardiac injury, and evaluation of cardiac function (i.e., ejection fraction, cardiac pressures, size of cardiac chambers, valvular abnormalities). Patients with low risk of ACS (TIMI score less than 2) without elevation of their cardiac markers should be considered for a stress test (exercise or pharmacological) to determine if signs or symptoms of ischemia can be provoked. This may be performed with a brief hospital admission or within 72 hours as outpatient. Low risk patients with a negative stress test can be managed as outpatient to further reduce underlying cardiac risks. Patients with abnormal stress test results indicative of underlying CAD and patients with underlying NSTEMI will benefit from a coronary angiogram to evaluate coronary anatomy and possible PCI regardless of its onset.²

Patients with ongoing ischemic symptoms upon presentation along with elevations of cardiac biomarkers and new ST-depression, T-wave inversion on EKG should be admitted in the cardiac unit. Patients found to have cardiac symptoms post-stress test with or without cardiac biomarker elevation should be also be admitted under the cardiac unit. Admission into the coronary care unit (CCU) is reasonable in patients with evidence of active cardiac ischemia along with hemodynamic or electrical instability.²

**What is the Immediate Medical Management of UA/NSTEMI?**
Patients with suspected UA/NSTEMI should be placed on telemetry monitoring for continuous assessment of their heart rate and rhythm. Supplemental oxygen should be given for the first six hours and continued if their oxygen saturation is less than 90 percent. Hemodynamics and hydration status should be assessed, and if warranted, intravenous fluid should be administered. They should receive a full dose aspirin (ASA) 325 mg along with sublingual nitroglycerin if chest pain continues. Resumption of medical management with beta-blocker, ASA, angiotensin converting enzyme inhibitors (ACE-I) should be considered if there are not any contraindications (i.e., evidence of heart failure, dyspnea, pulmonary edema, lower extremity edema, jugular venous distension, acute renal injury, previous intolerance to ACE-I) and if the patient is within 24 hours after of coronary event.

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### Table 2. TIMI Score Calculation

<table>
<thead>
<tr>
<th>TIMI Risk Score (1 Point for Each)</th>
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<tbody>
<tr>
<td>Age 65 or older</td>
</tr>
<tr>
<td>ASA use in the last seven days (patient experiences chest pain despite ASA use)</td>
</tr>
<tr>
<td>At least two anginal episodes within the last 24 hours</td>
</tr>
<tr>
<td>ST changes of at least 0.5 mm on admission EKG</td>
</tr>
<tr>
<td>Elevated serum cardiac biomarkers</td>
</tr>
<tr>
<td>Known CAD (coronary stenosis greater than or equal to 50 percent)</td>
</tr>
<tr>
<td>At least three risk factors for CAD (Hypertension or on antihypertensives, current cigarette smoker, low HDL cholesterol (less than 40 mg/dL), DM, family history of premature CAD (CAD in male first degree relative, or father less than 55, or female first degree relative or mother less than 65)</td>
</tr>
</tbody>
</table>

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[¹] Primers in Medicine
[²] Primers in Medicine
[³] Primers in Medicine
[⁴] Primers in Medicine
[⁵] Primers in Medicine
[⁶] Primers in Medicine
[⁷] Primers in Medicine
Non-steroidal anti-inflammatory drugs (NSAIDs) such as Ibuprofen should be avoided.\textsuperscript{2}

Patients admitted with definite UA/NSTEMI should be started on a loading dose of clopidogrel, prasugrel or ticagrelor along with maintenance dosing as soon as possible.\textsuperscript{4} Anticoagulation with unfractionated heparin (UFH) or low molecular weight heparin (LMWH) should be administered alongside antiplatelet therapy at the initial presentation of a NSTEMI patient. For patients at higher risk of bleeding, fondaparinux can be used as an alternative. It is recommended to continue anticoagulation for 48 hours during hospitalization or until hospital discharge with discontinuation considered if patient continues to be hospitalized after eight days. Discontinuation of anticoagulant therapy should be considered if medical therapy is pursued and coronary...
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angiography is not performed. In patients undergoing PCI, anticoagulation should be discontinued after cardiac catheterization. Selective use of GP IIb/IIIa (i.e., tirofiban, eptafibatide) is advocated in patients who are considered high-risk for ischemic events (elevated cardiac enzymes, ongoing chest pain, patients with DM, EKG changes such as T-wave inversions, ST-segment depressions), especially if PCI is planned. The risk of increased bleeding should be weighed against the benefit of reducing ischemic endpoints in patients who are started on GP IIb/IIIa.

What are the Indications for Coronary Angiography and Possible PCI?
Coronary angiography is usually performed for most patients with NSTEMI and UA patients with high risk features. High risk features include recurrent angina or ischemia at rest despite medical management, new ST-depression on EKG, development of heart failure symptoms, hemodynamic instability, concerning findings in noninvasive testing, high TIMI score, DM or with reduced left ventricular ejection fraction of less than 40 percent.

What is the Optimal Timing of Coronary Angiography in UA/NSTEMI Patients?
Most patients with UA/NSTEMI do not need to be emergently taken to the catheterization laboratory. Although the benefit of revascularization therapy as opposed to conservative medical therapy in NSTEMI has been proven in multiple studies, the optimal timing of revascularization remains a controversial issue. It has been shown that there is no clear benefit of early revascularization (less than 12 hours) versus delayed revascularization (greater than 12-24 hours).

According to the current ACC/AHA guidelines, the timing of coronary angiography in UA/NSTEMI depends upon the risk profile of the patient. Patients who are high risk for acute events (TIMI score greater than 5, active chest pain in spite of medical therapy, heart failure, hemodynamic or electrical instability), may benefit from an early invasive therapy (12-24 hours after hospitalization). A trend of better outcomes with early revascularization has been observed in this patient population in several studies.

What is the Antiplatelet Management for Patients with UA/NSTEMI?
Patients who do not receive coronary revascularization should continue medical management. Baby ASA (81 mg daily) should be continued lifelong unless contraindicated. A second antiplatelet agent should be continued for 12 months. In UA/NSTEMI patients who underwent a PCI and received stents, the duration of second anti-platelet depends upon the type of stent placed [drug eluting stent (DES) versus bare metal stent (BMS)]. As per ACC/AHA guidelines, clopidogrel/ticagrelor/prasugrel should be given for at least 12 months in patients receiving DES and up to 12 months for patients receiving bare metal stent BMS.

How to Risk Stratify Patients Before Discharge
An ECHO should be performed in all patients with suspected ACS. Patients with UA/NSTEMI who are at low risk for cardiac events or in whom a conservative strategy is adopted, a stress test can be performed to evaluate for ischemia (Figure 1). This can be pursued if the patient is chest pain free and without symptoms of heart failure. At discharge, the focus should be given on medication compliance, smoking cessation, and timely follow-ups. Cardiac rehabilitation should be considered in all patients to help lower risk factors and improve outcomes.

What are Primary and Secondary Prevention of UA/NSTEMI?
The main focus of primary care physicians should be on the primary prevention of cardiac disease. These include diminishing or optimizing underlying risk factors. In patients with a history of hypertension, and the goal should be to have a of blood pressure should be less than or equal to 140/90 mmHg. Diabetics should be on an optimal diabetic medical regimen with a goal of their glycated hemoglobin (HBA1c) less than or equal to 6.5 percent, in addition to weight control. Smokers should be encouraged to abstain from tobacco completely. Any patient with congestive heart disease (CHD) should be on a high intensity statin if no contraindications [i.e., rosuvastatin (20-40 mg daily), atorvastatin (40-80 mg daily)] and patients with dyslipidemia without a history of CHD should be on a statin. According to the most updated ACC/AHA guidelines, all patients who have had UA/NSTEMI should be on a high intensity statin.

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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No teddy bears and blankies at sleep time?
According to the new safe sleep guidelines, baby needs to sleep alone, on her back, with no toys or blankets.
Find out why at forbabysakesd.com
Vaccine-preventable diseases are a public health burden contributing to unnecessary adult morbidity and mortality. In 2008, these diseases accounted for 1.2 million hospital stays and cost the U.S. health care system approximately $32 billion.\(^1\) Immunization coverage for children and adolescents is relatively high, but adult immunization rates remain inadequate – far below the Healthy People 2020 goal. According to results of the 2010 National Health Interview Survey released in February 2012, adult immunizations rates have remained low and fairly flat or showed only slight increases in the last year.\(^2\) Considering 99 percent of the 40,000-50,000 vaccine-preventable deaths in the U.S. that occur each year are in adults, significant improvement in coverage is needed to decrease the burden of vaccine-preventable diseases among adults.\(^3\) In order to appropriately promote adult vaccinations, it is important to be familiar with the new adult immunization recommendations. These recommendations have been released by the Advisory Committee on Immunization Practices (ACIP) over the past year and are incorporated in the CDC’s recently published 2012 immunization schedules available at www.cdc.gov/vaccines/schedules/index.html.\(^4\)

In recent years, there have been several outbreaks of pertussis across the country. In 2010, there were 27,350 reported cases of pertussis in the U.S. – the highest number since 1959.\(^1\) According to 2012 provisional data, the number of reported cases has dropped to 15,216 in 2011.\(^5\) Due to the waning immunity of the vaccine, adults 19-64 years old need one booster shot of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine (Tdap), of which around only 8 percent of adults get.\(^2\) The new guidelines expand the routine use of Tdap to include pregnant women and adults age 65 and older who have contact with infants.\(^4\) These new recommendations are geared to enhance the cocooning effect and help protect infants who are unable to receive the vaccination and are most susceptible to the devastating effects of the disease.

Two types of Tdap vaccines are marketed in the U.S. Boostrix, licensed by GlaxoSmithKline Biologicals, is approved for use in persons aged 10 years and older; whereas Adalcel, which is licensed by Sanofi Pasteur, is approved for use in persons aged 11-64 years. Boostrix is recommended for use in patients 65 years and older when possible, but the CDC recognizes that both vaccines will provide protection to patients aged 65 years and older so recommends administering whichever vaccine is available instead of missing an opportunity to vaccinate.\(^5\) Pregnant women who have not received Tdap after week 20 of pregnancy should be vaccinated, but it is not contraindicated to receive it earlier, especially if tetanus toxoid is needed for tetanus prevention following a wound.\(^2\) Pertussis is a highly contagious disease – it is important to remain vigilant and increase efforts to vaccinate adults to prevent its spread.

Adults with type 1 and type 2 diabetes aged 19-59 years old should routinely be vaccinated with the hepatitis B virus (HBV) series since they are now included in the high-risk population.\(^4\) This decision was supported by outbreaks of HBV of which a majority were reported in diabetic residents of long-term care facilities who received assistance with blood glucose monitoring. The vaccine series should be started as soon as possible after diagnosis is confirmed. Patients 60 years of age or older may be vaccinated at the discretion of their health care provider taking into account the following considerations: 1) the probability of acquiring HBV infection, including the patient’s increased risk from requiring help while performing blood glucose monitoring in a long term care facility, 2) if infected, the higher risk of progression to chronic infection and subsequent sequelae, and 3) the ability of the patient to mount a proper immune response to the vaccine (patients that are more frail are less likely to achieve adequate immunity).\(^8\)

Other updates to the 2012 adult immunization schedule include recommendations for routine use of the
National Doctors’ Day

Each year, the SDSMA Foundation celebrates National Doctors’ Day on March 30 by honoring our dedicated physicians who serve our communities. This is a national day set aside to recognize physicians for their passion and commitment.

Making a donation to the SDSMA Foundation provides you with the opportunity to honor a physician of your choosing in celebration of National Doctors’ Day. Your gift is a meaningful way to say “thank you” to a friend or colleague. A personal acknowledgement will be sent informing the physician of this gift.

Your tax-deductible gift will provide scholarship assistance to medical students at the Sanford School of Medicine of the University of South Dakota and support health improvement programs that address the SDSMA’s public health priorities.

To make your National Doctors’ Day donation, send your contribution to:
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Donations received by February 9 will be recognized in the March issue of South Dakota Medicine.

Volunteers Needed!

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quadrivalent human papillomavirus vaccine, Gardasil, in males ages 11-12, in males ages 13-21 who have not yet received the series, and in males 22-26 years who have sex with men or are HIV positive or are immunocompromised for prevention of genital warts, anal cancer, and anal intraepithelial neoplasia.4

The FDA has approved herpes zoster vaccine for adults beginning at the age of 50; however, ACIP did not change their recommendation from routinely vaccinating adults starting at the age of 60 due to a concern over vaccine supply and uncertainty of the need for a booster dose if given earlier. Finally, the new recommendations note that an egg allergy is no longer a strict contraindication for receiving the influenza vaccine.7

Healthcare providers play a vital role in promoting adherence to recommended adult vaccination schedules. Lack of recommendation by the physician and the belief that vaccination is not needed due to good health, are two major reasons cited by adult patients for not receiving immunizations.5 A healthcare provider’s recommendation is one of the strongest predictors of whether a patient will be vaccinated – most patients will be immunized if a health care provider recommends vaccination, even those who have negative attitudes toward immunization.10

Unlike childhood vaccinations, more urgent concerns tend to take over the office visit of the adult patient. The same is true for inpatient stays, but remember, mild acute illnesses are not contraindications for most immunizations and incorporating standing orders into practice has been shown to be consistently successful. The physician-approved protocol will allow qualified nurses and pharmacists to screen for and give needed immunizations.11

Start with you and your staff – immunization rates of health care providers remain low, and this population has increased risk of exposure to vaccine-preventable diseases.2 If exposed, healthcare providers also risk spreading the infection to those with already weakened immune systems or those most vulnerable to the ill effects of the disease. By becoming familiar with the updates to adult immunizations recommended by ACIP and the CDC, as well as educating adult patients about the need for vaccinations and promoting them, the morbidity and mortality adults experience from vaccine-preventable diseases can be reduced. Visit www.immunize.org for more information and other helpful resources. Inpatient providers can also find useful tools at www.immunizeadults.org.

REFERENCES


About the Author:
Brittney Meyer, PharmD, Assistant Professor, College of Pharmacy, South Dakota State University.
Hopefully by now you have had the time during these cold winter nights to digest last month’s quality primer article. Our focus now will be on specifics of the focal points for DAKOTACARE as it relates to health care quality. For the next three months I will be speaking in generalities, with plans to focus on very specific quality parameters (reviewed and approved by our Clinical Oversight Committee) within South Dakota beginning in the spring. Within those reports we will be publishing quality analytics which compare various provider groups within our provider network, based upon nationally recognized standards. For full disclosure, our plan is to send out advance notifications to impacted providers prior to all publications, so that there are no surprises if/when your clinic is listed in one of the reports.

My personal epiphany regarding the importance of health care information transparency began with hearing a presentation by Marty Makary, MD, pancreatic cancer surgeon from Johns Hopkins, last year at an industry meeting. I was impressed enough by his passion towards maximizing healthcare quality that I purchased his book, Unaccountable. Some of you who have attended recent SDSMA Council meetings have heard me advocate this publication to all physicians as a must-read. The basic premise he attempts to support is whether simple accountability via making cost/quality data (both are important to determine the overall value of health care services) transparent can transform a health care market. He makes many valid points that I think are applicable to our market. Without divulging too much of the book’s offerings, I was especially taken by his assertion that the response by hospital employees to one question: “Would you feel comfortable receiving medical care in the unit in which you work?” statistically is superior to all of the organizations or websites which advocate to best compare/rank hospital and physician quality. For those of you with roles in administrative leadership at hospitals, I challenge you to query your employees with this one simple question. You may be surprised with the response.

If you were like me in private practice, you were too busy with direct patient care to spend strategic time reviewing quality outcomes of your patients. I hope that mindset has changed dramatically in the last seven to eight years. If you’re not monitoring quality within your own facility and specialty, you can almost certainly be guaranteed someone else (probably a payer with a vested financial interest in how you and your partners are performing) is. I commend the South Dakota Association of Hospital Organizations (SDAHO) for maintaining the website www.sdhospitalquality.org which offers at least the beginnings of a comparator for South Dakota hospitals. Their PricePoint system even offers a price comparator tool. Unfortunately with many of our, mostly critical access, hospitals there just is not enough volume to offer valid comparison data. Perhaps we need to consider adopting Dr. Makary’s “one question quality validator” query to allow at least some comparison across the board for all hospitals?

It’s now time that similar comparison tools are developed and disseminated in a similar public fashion for physician quality information, with broad physician input. The American Medical Association (AMA) has clear standards on this issue as well. Market forces will push this process forward, initially by large self-insured groups looking to steer their members towards the highest value (value=quality/cost) providers. As mentioned above, physicians need to be integrally involved in the development of these tools, through partnerships such as the South Dakota Quality Collaborative (of which DAKOTACARE has been a strong supporter since its inception).

Bottom line: be ready for transparency of your health care quality information, which will be viewable by your peers and your patients. If you’re doing an exemplary job, the data will speak for itself.

Epilogue: You have my reading recommendation for the month. From a musical standpoint, try the new Ray LaMontagne album Supernova – a significant departure from his historical blues/folk compositions.
The Interstate Medical Licensure Compact: What Physicians Should Know

What is the Interstate Medical Licensure Compact?
The compact would be a new pathway to expedite and simplify physician licensing for those seeking to practice medicine in multiple states. The compact would strengthen public protection because it would help states share investigative and disciplinary information.

The proposal could:
• Increase health care access for underserved or rural areas; and
• Allow medical expert consult by telemedicine technologies.

Is the Interstate Compact a national license?
No. Each license to practice medicine will be issued by a state medical board and physicians must be licensed in the state where the patient is located. A licensed obtained through the expedited procedure will provide the same

Can a physician ineligible to participate in the Compact still obtain multiple licenses?
Yes. Physicians who are ineligible for the expedited licensure process facilitated by the Interstate Compact may seek additional licenses in those states where they desire to practice and will apply through the respective traditional licensure processes.

Who is eligible to seek licensure through the Compact process?
To be eligible, a physician would have to possess a full and unrestricted license in a member state, be board certified in a medical specialty and have no history of being disciplined, penalized or punished by a court, a medical licensing agency or the Drug Enforcement Administration. Initial surveys estimate that nearly 80 percent of the physician population licensed in the U.S. would be eligible for expedited licensure.

How do I apply for expedited licensure?
An eligible physician would designate a member state as the state of principal licensure and select the other member states in which a medical license is desired. The state of principal licensure will verify the physician’s eligibility and provide credential information to the Interstate Commission. The Interstate Commission will collect applicable fees and transmit the physician’s information and licensure fees to the additional states. Upon receipt in the additional states, the physician would be granted a license.

What state can serve as the state of principal licensure?
The physician must possess a full and unrestricted license to practice medicine in the state of principal licensure, and the state must be:
• The state of primary residence for the physician, or
• The state where at least 25 percent of the practice of medicine occurs, or
• The location of the physician’s employer, or
• If no state qualifies, the state designated as state of residence for purpose of federal income tax.

How long will it take for me to be licensed in other states?
The compact will substantially reduce the time it takes to receive multiple licenses. As soon as eligibility is verified and fees are transferred, additionally selected states will issue a full and unrestricted license to the physician.

Will the Compact be used for renewing licenses?
As long as a physician remains eligible for the Compact, expedited licenses granted by a member state will be renewed through a process created by the Interstate Commission.

Where can I learn more about the Interstate Compact?
http://www.fsmb.org/state-medical-boards/interstate-model-compact/

Support from the U.S. Senate
In a letter sent Jan. 9 to the Federation of State Medical Boards (FSMB), a bipartisan group of 16 U.S. senators applauded the progress being made by the state medical boards in the development of an Interstate Medical Licensure Compact.

In the letter, the senators noted that the proposed compact system retains important patient-protection advantages of the current state-based medical licensing process. “We agree that allowing states to share information while allowing each state to retain jurisdiction over physicians who choose to practice in the state is in the best interest of both physicians and patients,” the letter said. The senators noted that the new expedited licensure system would help ensure telemedicine is practiced in a “safe and accountable manner.”

The letter was signed by: John Thune (R-SD), Michael Enzi (R-WY), Lamar Alexander (R-TN), John Barrasso (R-WY), Roy Blunt (R-MO), John Boozman (R-AR), Tom Carper (D-DE), Tom Coburn (R-OK), Thad Cochran (R-MS), Al Franken (D-MN), James Inhofe (R-OK), Johnny Isakson (R-GA), Tim Johnson (D-SD), Amy Klobuchar (D-MN), John D. Rockefeller IV (D-WV), and Mark Warner (D-VA).

REFERENCES
Adapted from multiple sources including the FSMB FAQ documents by Margaret B. Hansen, PA-C, MPAS, and Tyler J. Klatt, MPA.
Hanging on the wall of my community hospital is an idealistic image of what it might have been like practicing rural medicine in South Dakota back in the very early 1900s. It’s a John Redman painting of a country doctor’s horse and buggy standing outside a warmly-lit farmhouse, next to a windless pond with a formation of wild geese framing the sunset. We imagine the physician is inside with his black bag beside him, delivering a perfect baby. It is too ideal to be real... or is it?

There is still much idyllic about the world of the modern country or prairie doctor. She or he still makes rounds at the small town hospital every day managing the severely sick; still sends them home to follow later in the office; still has to understand an encyclopedic medical knowledge to nail the diagnosis; and still senses the life story of many patients having watched and even helped them through the joys and tough times of years of living. The country doc is still around.

There are some differences from that painting, though. Now the country doctor consults the specialist by e-consult over a video screen; co-manages the sickest patient in the local hospital with e-ICU; keeps up on rapidly changing medical knowledge with teleconferences and internet learning; summons information about medicine side effects through a smart phone; if needed flies the emergency crash victim by helicopter to a trauma center; and so on.

But as rewarding as this great life for the doctor may be, there are fewer medical students drawn to it, and for many reasons. Now the country doc called a primary care provider, spends too many hours filling out forms or computer records instead of seeing patients; is paid less than almost all of the other specialties; in the larger cities gives up seeing hospitalized patients to the "hospitalists;" most of the med student teachers are specialists from the big city; and the list goes on. The country doctor is in danger of going the way of the horse and buggy. And the big loser in this picture will be the patient.

In both the city or country, especially with all the advances in medical science, we desperately need the patient advocate and coordinator who is expertly trained to know the whole picture of his or her complicated patient.

We shouldn't let the idealistic life of the country doctor become just a painting.
The Centers for Medicare and Medicaid Services (CMS) currently maintains a number of websites designed to help consumers make decisions about where they get their health care. The Hospital Compare website includes readmission measures, infection rates, patient satisfaction scores, and even cost measures such as Medicare spending per beneficiary. The Nursing Home Compare website has implemented a five-star rating system, and nursing homes are rated on their health inspection results, quality measure performance, and staffing levels.

The Medicare Physician Fee Schedule for 2015 includes a number of significant changes for reimbursement of physician services effective Jan. 1. Chronic Care Management (CCM) services provides payment to primary care providers for non-face-to-face services to Medicare beneficiaries who have multiple, significant chronic conditions. The final rule from Nov. 11, 2014 includes the standards that must be met for reimbursement of CCM services:

- The provision of 24-hours-a-day, 7-days-a-week access to address the patient’s acute chronic care needs. To accomplish this, the patient must be provided with a means to make timely contact with health care providers in the practice to address the patient’s urgent chronic care needs regardless of the time of day or day of the week.
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Care management for chronic conditions including systematic assessment of the patient’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
- In consultation with the patient, any caregiver and other key practitioners treating the patient, the practitioner furnishing CCM services must create a patient-centered care plan document to assure that care is provided in a way that is congruent with patient choices and values.

The care plan is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues, and typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the billing practice will be directed/coordinated, identify the individuals responsible for each intervention, requirements for periodic review and, when applicable, revision of the care plan. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.

- Management of care transitions within health care, including referrals to other clinicians, follow-up after the patient’s visit to an emergency department, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities. The practice must facilitate communication of relevant patient information through electronic exchange of a summary care record with other health care providers regarding these transitions. The practice must also have qualified personnel who are available to deliver transitional care services to the patient in a timely way so as to reduce the need for repeat visits to emergency departments and readmissions to hospitals, skilled nursing facilities or other health care facilities.
- Coordination with home and community based clinical service providers required to support the patient’s psychosocial needs and functional deficits. Communication to and from home and community based providers regarding these patient needs must be documented in the patient’s medical record.
- Enhanced opportunities for the beneficiary and any relevant caregiver to communicate with the practitioner regarding the beneficiary’s care through, not only telephone access, but also through the use of secure messaging, internet or other asynchronous non face-to-face consultation methods.
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**Here are the details.**

From 2008 to 2013, SD QuitLine coaching participants had the option of self-selecting a cessation medication (Chantix or Zyban) or product (nicotine replacement therapy-NRT), if interested.

To determine the effectiveness of these services, a follow-up telephone survey was conducted 7 months after enrollment. Survey participants were asked if they had used tobacco in the past 30 days.

A total of 16,138 callers were reached and answered questions related to current tobacco use and use of a cessation product or medication in their effort to quit. QuitLine callers who responded to the survey were quite successful at quitting, with nearly one-half (46.2%) reporting no tobacco use. The majority had selected to use Chantix (59%), followed by NRT (27%), Zyban (6%), and no medication (5%).

The common factor shared between groups that selected various cessation medications or products was the coaching received.

Less than 10% variability in the quit rate (30 dpp) existed between the different types of medications, NRT, or coaching only (range 41.7% to 49.7%).

Coaching plus Chantix and coaching plus Zyban were at the top of the range, and coaching plus NRT and coaching alone were on the lower end.
The SDSMA Center for Physician Resources presents the final of six programs designed to offer physicians information on mitigating risk in clinical practice. This educational program is being offered as part of the Center’s Practice of Medicine education series and is not a sales presentation.

Register now for this important webinar!
“Liability Issues with Physician Extenders”
Thursday, February 19, 2015 • 7 p.m. CT

Free registration for any SDSMA member and a guest.
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Whether you’re a medical student, a young physician just out of residency, or you’ve been actively practicing medicine for 5, 10 or 15 years, it’s important to know how to protect yourself against liability claims by identifying and mitigating risk in your clinical practice.

The SDSMA Center for Physician Resources invites you to “Liability Issues with Physician Extenders,” which will provide information on:

- The upside of physician extenders (PEs)
- The liability risk and the common errors that lead to liability claims
- Minimizing your risk when utilizing PEs

Presenter: Robert S. Thompson, RT, JD, MBA, serves as the Director of Education at MMIC. Mr. Thompson has a diversified background in law, medicine, medical professional liability insurance and health care risk management. Mr. Thompson specializes in patient safety, risk management and health care communication.

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http://doh.sd.gov/prevention/oralhealth/
SDSMA Meets with Gov. Daugaard

SDSMA President Mary J. Milroy, MD, and SDSMA CEO Barb Smith met with Gov. Dennis Daugaard on Jan. 14 in Pierre, the day after the 2015 legislative session began. Among the topics discussed were:

- The Interstate Medical Licensure Compact – this would allow states to work together to expedite the licensure process for physicians seeking licensure in multiple states. The SDSMA supports this legislation.
- Medicaid expansion – South Dakota will lose in excess of $1 billion in federal money through 2020 if it does not expand Medicaid, which would increase the state’s GDP by an estimated $308 million and would create an additional 4,030 jobs by 2020. The SDSMA supports expanding Medicaid for those earning up to 100 percent of the federal poverty level.
- Options for parents of children with autism to obtain early interventional services that are evidence-based and medically necessary.
- The dangers of indoor ultra violet (UV) tanning – the SDSMA supports restricting indoor UV tanning only to individuals age 18 and older. In 2014, the Food and Drug Administration reclassified indoor UV tanning products from a risk-level of Class I to Class II.

The SDSMA is closely monitoring these issues and more this legislative session.

Source: SDSMA staff

Meyer Selected for AMA Medical Student Committee

Medical student Benjamin Meyer has been selected to join the American Medical Association (AMA) Medical Student Section Committee on Legislation and Advocacy (COLA).

COLA is responsible for creating and maintaining a network of Medical Student Section (MSS) chapters to accomplish grassroots political action. It advances key student issues through a coordinated campaign at each national meeting as well as providing strategy, sample letters, talking points and additional information and resources to fuel grassroots campaigns for specific priority issues. The committee works with the MSS Governing Council on accomplishing advocacy goals.

Mr. Meyer a third-year medical student at the University of South Dakota Sanford School of Medicine (SSOM) and co-president of the SSOM AMA Student Section. He serves as alternate delegate for Region 1 of the AMA Medical Student Section and is the student councilor on the SDSMA Council of Physicians.

Source: SDSMA staff
Become a Certified Medical Examiner

All commercial motor vehicle drivers are now required to have physical examinations performed by a certified medical examiner listed on a National Registry. The SDSMA is prepared to assist you in the process to become a certified medical examiner.

The SDSMA is now a registered training provider for health care professionals seeking to be listed on the National Registry. The SDSMA’s online training course is designed to meet the core curriculum requirements for medical examiners according to the Federal Motor Carrier Safety Administration.

To register or learn more, visit http://sdsma.essentialeducationwebinar.com/.

Training Features
• Delivered 100 percent online;
• Ability to start/stop/pause training according to your schedule;
• Instant certificate/proof of participation upon completion; and
• 9.5 CME AMA PRA Category 1 Credit(s).

Source: SDSMA staff

National Doctors’ Day – Honor a Physician!

Each year, the SDSMA Foundation celebrates National Doctors’ Day on March 30 by honoring our dedicated physicians who serve our communities. This is a national day set aside to recognize physicians for their passion and commitment. Please honor a friend, family member, or colleague with an SDSMA Foundation donation. Your gift is a meaningful way to say thank you. A personal acknowledgement will be sent to your honoree informing them of your generosity with this gift. Your tax-deductible gift will provide scholarship assistance to medical students at the University of South Dakota Sanford School of Medicine and support health improvement programs that address the SDSMA’s public health priorities.

To make your National Doctors’ Day donation, please complete a donation form at www.sdsma.org. Honorees will be recognized in the March issue of South Dakota Medicine for forms and donations received by Monday, Feb. 9.

Legal Brief Highlight: Registration of Births

Every live birth occurring in South Dakota must be registered with the State Department of Health. If a physician is in attendance at the birth, the he or she is responsible to register the birth within seven business days. If a birth occurs in an institution, the physician in attendance at the birth or the physician’s designee must obtain the personal data and the medical information required by the certificate within five business days.

A death of a fetus at the gestational age of not less than 20 weeks must be filed with the Department of Health. The physician or other medical provider in attendance at or after the delivery must file the report of fetal death with the Department of Health within seven days of delivery. If there is no physician or other medical provider on attendance, the coroner must complete and file the report within 24 hours after taking charge of the case.

For more information, download the SDSMA legal brief Registration of Births at www.sdsma.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
SDSM A President Com pletes Visits to Districts

SDSM A President Mary J. Milroy, MD, has com pleted her travels to each of the 12 district medical societies, with the final meeting hosted by the Seventh District Medical Society Jan. 19 in Sioux Falls.

Dr. Milroy and physicians attending the meetings discussed issues facing patients and physician practices, the challenges faced in health care in South Dakota and nationwide, and ways physicians can work together toward common goals. Members also discussed Gov. Dennis Daugaard’s fiscal year 2016 budget proposals and the SDSMA’s advocacy issues for the 2015 legislative session. Read more about the SDSMA’s 2015 Advocacy Agenda in this issue’s Member News feature, “The Issue Is.”

Source: SDSMA staff

SDAHO CEO Announced

Scott A. Duke of Billings, Montana, has been named the new president and CEO of the South Dakota Association of Healthcare Organizations (SDAHO).

Duke has 28 years of senior leadership experience in health care including CEO of a critical access hospital (CAH) and as a regional system executive. Most recently, Duke served as vice president of regional operations with the Billings Clinic. He is a past American Hospital Association board member and past chair and board member of the Montana Hospital Association.

Source: SDAHO

Legislative Session Begins

The South Dakota State Legislature began its 2015 session on Jan. 13 with Gov. Dennis Daugaard’s State of the State address in which he outlined his top priorities.

At the top of Gov. Daugaard’s list were road and bridge improvements, juvenile justice reforms, and workforce development.

In addition, Gov. Daugaard provided an update on the state’s continued efforts to reduce infant mortality. The rate has decreased from 8.6 deaths per 1,000 live births in 2012 to 6.5 in 2013. Safe sleep kits have been distributed to more than 4,000 parents and other caregivers in low income families without a safe sleep option. The media campaign “For Baby’s Sake” remains active, focusing on safe sleep, early signs of pregnancy, and the importance of prenatal care and immunizations.

The SDSMA was disappointed that the governor did not weigh in on Medicaid expansion in his speech. The association supports Medicaid expansion for those making less than 100 percent of poverty, and SDSMA’s 2015 Advocacy Agenda calls for reforming Medicaid to ensure that physician payment keeps pace with rising costs and is based on outcomes and value, support for Medicaid health homes to coordinate care for individuals with chronic conditions, and opposition to further exemptions from certain childhood immunizations. Making sure patients have the opportunity to make well-informed decisions when it comes to a provider’s training, certification and field of expertise is also a priority for the SDSMA.

In addition, the SDSMA has long been an advocate for increased funding for medical education as the state’s need for physicians will only increase as our population ages. Last year, the legislature approved Gov. Daugaard’s proposal to expand medical school slots by 44 students over the next four years at the University of South Dakota Sanford School of Medicine. The SDSMA looks forward to continuing work with Gov. Daugaard and the legislature to address the state’s shortage of physicians to ensure access to high-quality care for South Dakota patients.

The SDSMA’s 2015 Advocacy Agenda is available at www.sdsla.org under the Advocacy tab.

Source: SDSMA

“The Issue Is “ is the SDSMA’s monthly update on key policy issues of importance to physicians.
## CME Events

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

### February 2015

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Category &amp; Credit</th>
<th>Register Online</th>
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<tbody>
<tr>
<td>Feb. 2-6</td>
<td>Arrhythmias &amp; the Heart: A Cardiovascular Update 2015</td>
<td>AMA PRA Category 1Credit(s)™ available</td>
<td><a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
</tr>
<tr>
<td>Feb. 4</td>
<td>Internal Medicine Grand Rounds: Acute Coronary Syndromes: Review and Updates</td>
<td>AMA PRA Category 1Credit(s)™ available</td>
<td>usdssom.learningexpressce.com</td>
</tr>
<tr>
<td>Feb. 5-7</td>
<td>3rd Annual Collaborative Symposium Update in Minimally Invasive Gynecologic Surgery 2015</td>
<td>AMA PRA Category 1Credit(s)™ available</td>
<td><a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<tr>
<td>Feb. 6-8</td>
<td>Rehabilitation Medicine Update</td>
<td>AMA PRA Category 1Credit(s)™ available</td>
<td><a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
</tr>
<tr>
<td>Feb. 7</td>
<td>Advanced Radiology Life Support Course</td>
<td>AMA PRA Category 1Credit(s)™ available</td>
<td><a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
</tr>
<tr>
<td>Feb. 7-8</td>
<td>Collaborative 3D Printing in Medical Practice</td>
<td>AMA PRA Category 1Credit(s)™ available</td>
<td>usdssom.learningexpressce.com</td>
</tr>
<tr>
<td>Feb. 11</td>
<td>Internal Medicine Grand Rounds: Chronic Hepatitis C Update</td>
<td>AMA PRA Category 1Credit(s)™ available</td>
<td><a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<tbody>
<tr>
<td>Feb. 16-20</td>
<td>18th Annual Endocrine Update Course</td>
<td>AMA PRA Category 1Credit(s)™ available</td>
<td><a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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**DO YOU HAVE A CME EVENT COMING UP?**

**WOULD YOU LIKE TO HAVE IT LISTED HERE?**

Contact: Elizabeth Reiss, South Dakota Medicine, 2600 W. 49th Street, Suite 200, Sioux Falls, SD 57105 | Phone: 605.336.1965 | Fax: 605.274.3274 | Email: ereiss@sdsma.org
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**Clinic Only Positions** (all sites qualify for H1B):
- Eau Claire: phone call of 1:26; 4 ½ day work week; participate in Urgent Care rotation
- Urgent Care (Eau Claire)- shifts are flexible, on average 36 hours/week

**Traditional Positions:** (90% clinic, 10% hospital, Critical Access Hospital (CAH) locations, established daytime Hospitalist program at most locations. All sites qualify for H1B.)
- Barron: OB/OB optional, site qualifies for J1, Call 1:6 without OB; Call 1:5 with OB
- Chetek: OB/OB optional, site qualifies for J1, Call 1:6 without OB; Call 1:5 with OB; admit to CAH located 15 minutes away
- Rice Lake: OB/OB optional, site qualifies for J1, Call 1:6 without OB; Call 1:5 with OB; admit to CAH located 15 minutes away
- Osseo: Interest in Women’s Health preferred, call 1:4
- Bloomer: Traditional, call 1:7
- Menomonie: OB/OB optional, call 1:10

If you wish to learn more or to express interest in these positions, contact Karly Wallace Toll Free: 1-800-573-2580; email: wallace.karly@mayo.edu; or fax: 715-838-6192.

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**Don’t forget to send in your favorite scenic photo for South Dakota Medicine front cover consideration.**

Send photos to ereiss@sdsma.org.
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Lornell Hansen, M.D., is Board Certified by the American Board of Venous and Lymphatic Medicine and has a background in family medicine. Dr. Hansen performs vein procedures in Sioux Falls, Sioux City, Sioux Center and Watertown.

Jeff Heier, M.D., is a Board Certified Internist specializing in Phlebology. Dr. Heier performs vein procedures in Sioux City, Sioux Center and Watertown.

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