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Dr. Rif’at Hussain
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Governance – What Is It, and Why Should We Care?

By Daniel J. Heinemann, MD
SDSMA President

Governance is important to the operations of an organization. A governance structure is required to assure an organization meets the needs of its members and conducts its business in a way that decisions are made that are understandable, supportable and represent the members. Governance should be seen as fair, uncomplicated and representative. It must be open and inviting, yet responsible and credible.

The SDSMA has been operating with its current structure of governance for close to 15 years.

The change was made to increase involvement of members in a most efficient manner.

Currently, we have a governing Council made up of members from our districts and representatives from specialty societies who have been through an approval process. An Executive Committee made up of our officers (president, president-elect, vice president, secretary and treasurer) elected by membership, two councilors at-large, AMA delegate and alternate delegate elected by the Council, and our past president. The Executive Committee can act on behalf of the SDSMA between Council meetings. The actions of the Executive Committee are subject to the Council’s approval. The SDSMA’s bylaws are another very important part of our governance. The bylaws outline how the Council and Executive Committee conduct the business of the Association. I believe it is important for a dynamic and active organization to periodically review its governance structure. Recently, we identified challenges the SDSMA must address, and we want to be certain our structure can meet those challenges. Looking forward, some of these challenges are:

1. We need to explore other ways for membership to participate in our processes and work, i.e., teleconferencing, distance participation.
2. With the need to respond to the rapid pace of change in health care delivery, we must find ways for more discussion in the policy formation process.
3. As the Center for Physician Resources develops, we need to be sure it meets the needs of our members.
4. We need to meet all of the regulations and responsibilities of a member-driven organization.
5. We need to assure the needs of the organization are met when the ownership transfer of DAKOTACARE has been accomplished.

To meet this challenge, I have asked the Council to support a governance committee to work over the next 18 months to study various options for structure that will meet those challenges. I have asked Dr. Chris Dietrich of Rapid City (a Councilor at-large on the Executive Committee) to chair this task force and develop a plan and options. I will also appoint 10 to 12 physician members to help with this work.

I look forward to the committee’s findings and recommendations, and to their efforts to make sure our structure and process support the organization and to ensure the SDSMA remains relevant and responsive to our physician members.

I also want to wish you a happy new year and hope 2014 is a fruitful year for you.

Book Recommendations This Month

The World is Flat: A Brief History of the Twenty-First Century
by Thomas L. Friedman

Hot, Flat, and Crowded: Why We Need a Green Revolution and How it Can Renew America
by Thomas L. Friedman

That Used to be Us: How America Fell Behind in the World it Invented and How We Can Come Back
by Thomas L. Friedman and Michael Mandelbaum
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If you are a fan of social media such as Facebook, Instagram, Twitter, etc., you may be familiar with the word "selfie." It has been designated the word of the year according to Oxford English Dictionary. If you are not familiar with this term, you need to know that it describes taking a picture of yourself and posting it. Anyone can do this. The point seems to be to let the world know what you are doing. Celebrities post selfies like crazy, assuming that the world wants to know what they are doing every minute of every day!

As 2014 begins, I would suggest turning our view outward – kind of an un-selfie – instead of directing our thoughts, and those around us, back toward us. I was inspired to suggest this by an article by Matthew Bishop, U.S. business editor of the Economist. He noted that the second Tuesday of December has been dedicated as #GivingTuesday on social media. He joined with several organizations to create this effort last year as a part of our holiday giving effort. However, I would suggest that this could be part of our new year’s resolutions, which usually include some plans for self improvement. Instead of a one-day giving effort, we can create a long-term impact by resolving to "look outward" for the entire year.

We are all aware that a large proportion of total donations to charities are made in the final few weeks of the year. Our new year could begin with a careful examination of the causes you support and deciding which is really important. Think about your personal giving strategy. Decide to volunteer time to favorite movements, or connect with new organizations that support causes you cherish. My first choice, of course, would be giving time to the Alliance and its statewide health project, Cribs For Kids. Time is a precious commodity, but Alliance members "get it." They already know what it is like to be married to someone in the field of medicine. We all have the same things in common – call schedules, late night phone calls and untimely interruptions. You can give as much time or as little time as you want. A packet describing the need for the Cribs for Kids project recently arrived in the homes of district contacts. Also included were solid suggestions for supporting this project at the district level. Or, perhaps you can participate in the Day at the Legislature, which will be held during this legislative session. These are just a couple of suggestions, but however you choose to donate your time, I hope you will examine being an un-selfie closely and consider Alliance projects worth your time and part of your new year’s resolution. Plan to "look outward" this year.

Last month, our newsletter arrived with updates about Alliance activities. The first newsletter, four pages of mimeographed sheets, was printed in 1950-51 – 63 years ago! This month, Alliance members will spend a day with legislators in Pierre. The idea for holding a Day at the Legislature was something new when it was introduced in conjunction with the winter Board of Directors meeting in Pierre. What year did our Alliance Day at the Legislature begin?
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Scott McPherson, MD

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The title of this essay is inspired by Ken Kesey's novel, *Sometimes a Great Notion*. A particularly apt title is a thing of beauty. At times, I find myself envious that I haven’t thought of a certain title before someone else claimed it. Hemmingway was particularly successful in the title department with such novels as *For Whom the Bell Tolls* and *The Sun Also Rises*. The magic of a lyrical phrase can be akin to human interactions that spark enduring appreciation and resolve.

A friend from the past, Mead Bailey, comes to mind. On a number of occasions with the right word or action, he offered timely support and insight. Oftentimes, it seemed to me he took a notion and made just the right move to enrich the lives of those around him. I thought of him recently as my wife Mary and I were driving around the square mile section that includes our rural home. We remarked on how little we knew of the occupants whose houses we passed. Mostly rural folks stick to themselves. But not Mead. Some 35 years ago as Mary and I were working to make a home on our rural land, a strange figure came driving down our lane on an old blue Ford tractor. I especially recall his large straw hat, denim shirt and initial greeting of “Hi, I’m Mead Bailey, who are you?” He had driven some three miles on his tractor to make this appearance. From this unlikely introduction, a great friendship blossomed with Mead and his wife Jean. Had it not been for Mead’s initiative, we probably would never have met the old couple across the creek and on the other side of the section. It just wouldn’t have happened without someone having the notion and gumption to take the first step.

As I reflect on the kindness that Mead chose to bestow, I find myself focusing back upon medicine, my everyday lens to kindness. As it happens, I just recently encountered a patient and her brother in the office who recalled a kind incident from their past. When I introduced myself, this patient immediately indicated that she vividly remembered my nurse and me. A decade earlier, we had cared for her brother’s wife who was dying of ALS. She recounted how she spent many hours with her dying sister-in-law and was present when my nurse and I visited the home on two occasions. She became tearful as she talked about those memories, noting “our family has never forgotten this.”

In truth, I have only a vague memory of having made those home visits. I am not sure what prompted me to make that special effort. Certainly I don’t ordinarily visit patients in their homes, even when they are terminally ill. But I am moved and humbled by the enduring gratitude this family feels.

It seems to me that this reminiscence about Mead and the home visit both circle back to the title, *Sometimes a Great Notion*. Frequently, I believe, the most meaningful and enduring “notions” we adopt in medicine are basically expressions of kindness. Often kind actions are disarmingly easy to offer patients and families. Sometimes they are nothing more than an earnest explanation or a hand on the shoulder. Such actions can convey empathy and commitment. Of course, sometimes a kind action may seem time consuming and inconvenient. But the proportionate benefit can be stunning. In this special case, the home visits were an example of “a great notion.” Whatever time and effort those visits required of me have drifted from recall and now seem inconsequential. I am grateful for whatever forces prompted me to act.

Too often our opportunities for kindness can be fleeting. Thinking compassionate thoughts about a patient’s situation is an insufficient response. What counts is what we do, whether we make the effort. Mead Bailey certainly didn’t need to take a slow tractor ride around the section to greet his new young neighbors, but he did. He responded to a notion. And in the clinical world, when something more seems needed, kindness generally shows us the way. Each of us is enriched by the kindnesses we’re able to offer. Opportunities abound but our gestures have magnified impact in illness care. At times, it seems, all that is required is a great notion.
You and baby

For Baby’s Sake is a new website for expectant moms and all South Dakota parents, families and providers.

We invite you to share this resource with your patients and help give every baby the best possible start to a healthy life.

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The State of South Dakota’s Child: 2013

By Ann L. Wilson, PhD

I extend to you my greetings for this new year!

This annual report on the “State of South Dakota’s Child” presents sobering data about our state’s infant mortality in 2012. Though yearly shifts in rates are expected with small populations of annual births, Dr. Wilson’s analyses identify how the data from 2012 differ from those of recent years. As an advocate for women’s health, the state data on prenatal care are of special interest and concern to me. They clarify the need for continued examination of how services may be developed to prevent unintended pregnancies and best deliver care to reach women early in pregnancy. This attention is especially needed for American Indian women and those of other minorities.

Mary D. Nettleton, MD, MS, MACP
Dean, USD Sanford School of Medicine
Vice President for Health Affairs
University of South Dakota

Abstract

In 2012, South Dakota experienced a 2.1 percent increase in births over the previous year. Despite an overall decrease in low birth weight, in 2012, the South Dakota infant mortality rate (8.6) surpassed its rate for the past 12 years with a 30 percent increase over its mean rate for the previous three years. The neonatal rate of death in the first 27 days of life for 2012 increased 38 percent and the postneonatal rate increased 13 percent over of previous three-year mean rates. An increase in mortality among newborns with birth weights of 500 to 999 grams and deaths due to congenital anomalies contributed to the 2012 spike in infant deaths. Overall, the 2012 rate of infant deaths for minorities was 2.3 times higher than for whites.

Introduction

Data that describe births and infant mortality for the 2012 cohort of South Dakota’s newest citizens are presented in this article. Survival during the first year of life has long been recognized as a marker of societal well being. The complexity of the interactions between infants, parents, families and communities are revealed in numbers of births and sad deaths of new life.

Births

In 2012, 12,092 newborns became residents of South Dakota, representing a 2.1 percent increase in births from 2011. This increase in births, apparent in Figure 1, is an “echo” of the uptick in births noted approximately 30 years ago. The declining number of births between the mid 1980s and 2000 is also apparent in Figure 1. These declining numbers impact the state’s demography and economy.

Figure 1. Live Births in South Dakota, 1965-2012
Consistent with observations made in recent years are the 2012 data showing a sustained shift in the racial composition of the state’s annual cohort of births. As noted in Figure 2, in 2012, there was a slight increase in the percentage of newborns representing racial minorities. The current percent of minority births in South Dakota (24.7 percent) exceeds the 23.6 percent observed nationally, in 2012, 65 percent of the minority births in South Dakota were represented by American Indians and 35 percent by “other races,” a percent that has doubled in recent years and likely reflects the influx of foreign immigrants into the state.

Birth weight is a parameter of vital importance to perinatal health. Nationally, 8.1 percent of all births are low birth weight (less than 2500 grams) and until recently this percent was increasing. Historically, South Dakota’s percent of low birth weight (LBW) has been lower than that observed nationally, but rates have paralleled national trends. In 2012, 6 percent of all South Dakota births were LBW. Figure 3 differentiates the percent of very low birth weight (0 to 1499 grams) and the mid low birth weight (1500 to 2499 grams) newborns for South Dakota and the U.S. In 2012, the percent of very low birth weight (VLBW) in South Dakota increased slightly from 1.11 percent to 1.13 percent but was lower than the mean (1.18 percent) for the previous three years. The 2012 increase in VLBW was only observed in the white population. The overall percent of mid low birth weight (MLBW) decreased, though there was an increase in the percent of these births among the minority populations.

Figure 4 provides low birth weight data for South Dakota broken down by specific weight cohorts and racial groups. Further, this figure provides comparisons of percent of infants born in 2012 in 500 gram low birth weight cohorts with their mean percent for 2009-2011. Apparent in the 2012 data for white newborns is the slight decrease in percent of births in each weight cohort compared to the mean for each cohort between 2009-2011. This was true also for the minority newborns except for a slight increase in births in the less than 500 gram cohort and a 1 percent increase in the 2000 to 2500 gram cohort.

In 2012, 3 percent of all South Dakota births were multiple with slightly less than 9 percent of them VLBW. Figure 5 discerns the contribution of multiple and single births to low birth weight showing that in 2012 there was a slight decrease in MLBW for singletons and a slight increase of MLBW for multiples. The 2012 percent of
VLBW for multiple and singletons was essentially unchanged compared to the previous year.

The 2020 public health goal for the nation is to increase the first trimester prenatal care from its current rate of 71 percent to 77.9 percent. Between 2010 and 2012, 69 percent of all women in South Dakota received first trimester care during pregnancy. These data are broken down in Figure 6 for the state’s racial groups showing apparent disparities in these rates. Nearly three-quarters of white women access first trimester prenatal care but this is true for only 45 percent of American Indian pregnant women, 60 percent of those with two or more racial heritages, and 52 percent of those of “other” racial backgrounds.

**Infant Mortality**

The small number of annual births in South Dakota requires that caution be exercised as the state’s infant mortality rate (expressed per 1,000 live births) is examined for any specific year. Nonetheless, in 2012, there were 104 infant deaths in the state, which represents a 32 percent increase over the mean of 79 deaths for the previous three years and requires focused attention to identify their possible correlates. This 2012 spike in infant mortality, apparent in Figure 7, yields an infant mortality rate (IMR) of 8.6 for the state, which is the highest rate for the state since 1999 and is considerably higher than the U.S. rate of 6.05 for 2011. In all likelihood, the 2012 rate will place South Dakota among the states in the nation with the highest rate of mortality for infants.

The IMR for minorities in 2012 was 2.3 times higher than it was for whites. Overall, there was a 40 percent increase in infant mortality for minorities and a 15 percent increase for whites. This finding is apparent in the data presented in Figures 8 and 9 that present the trends in mortality for the first 27 days of life with neonatal mortality rates (NMR) and between the 28th and 365th day of life with post neonatal mortality rates (PNMR). A 2012 spike for the NMR rate for both the white and minority populations in the state is apparent in Figure 8 and these rates exceeded the U.S. rates. Specifically, in 2012 the NMR increased over the mean of the previous three years by 29 percent among whites and 47 percent for minorities. Data in Figure 9 show that in 2012 the PNMR decreased by 15 percent from the mean of the previous three years for whites but increased by 33 percent for minorities.
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12  South Dakota medicine
To further assess racial disparities present in the 2012 data, Figure 10 presents the percentage of all births represented by racial groups and their percent contribution to the total number of infant deaths. Apparent in these data is the disproportionate number of infants representing minorities who died in 2012. While 25 percent of all South Dakota births were minorities in 2012, 38 percent of all neonatal deaths and 56 percent of post-neonatal deaths were represented by these groups of infants.

Birth weight specific mortality provides a measure of progress in perinatal care. Data showing these trends are presented in Figure 11. Figure 11 shows a notable increase in mortality among the 500 to 999 gram cohort of newborns. While percentages of births in the 500 to 999 gram category were identical for whites and minorities (0.4 percent), the mortality among minority infants was over twice as high as for whites. In 2012, mortality for white infants in this weight cohort was 33 percent (compared to a mean of 19 percent in 2009-2011) and 75 percent (compared to a mean of 33 percent in 2009-2011) for the minority population. Increases in mortality in 2012 also occurred in the 1500 to 2000 gram and 2000 to 2500 gram birth cohorts.

Rates of infant death by their cause are presented on Table 1. South Dakota 2012 infant mortality rates for whites and minority infants are presented here with mean rates for the state for 2009-2011 and for the U.S. for 2010.1,6,8,9 The birth weight specific mortality presented in Figure 11 is reflected in South Dakota's 2012 rate of death due to perinatal causes, which is typically lower than the national rate. This rate rose above its previous three-year mean and the national rate for 2010. This rate of death was over twice as high for minority infants than for whites. The rate of death due to congenital anomalies also increased over the state's previous five-year mean and was almost twice the most recent national rate. Seventy-two percent of these deaths due to congenital anomalies occurred in the neonatal period with 69 percent of them white and 21 percent of them American Indian.

The state's 2012 rate of sudden infant death syndrome (SIDS) is similar to the national rate, but the rate of death due to accidents and homicides increased. Four of the deaths in this category were coded due to “suffocation or strangulation in bed,” causes that in the past may have been identified as SIDS. In 2012, all of the deaths in the “accident and homicide” category occurred in the post neonatal period of time with 36 percent white, 46 percent American Indian, and 18 percent other minorities. The rate of these deaths for minorities is over five times higher than for whites. The 2012 rate of death in the “other” category, which includes infections, was similarly higher for the minority than white infants.

Data in Figure 12 relate infant mortality to prenatal care. Compared to the mean IMR from 2007 to 2011, the apparent increase in rate of death for infants whose mothers received no prenatal care in 2012 is notable.
The data in Figure 11 also highlight how mortality for all prenatal care groups was higher in 2012 than the mean for the previous five years. Slight changes in the small numbers represented in these data impact the rates. Nonetheless, 14 percent of all infants who died in 2012 received no prenatal care or only care in the last trimester of pregnancy. Half of these deaths were neonatal and half were post neonatal.

Comment

The increase in total number of infant deaths in 2012 arouses concern. Indeed, a decade has passed since the state's IMR surpassed what was observed in 2012. As previously noted, with its small number of annual births, year to year fluctuations in mortality rates are expected, but the increase noted in this recent year requires attention. While during 2012, there was a very slight increase in very low birth weight newborns, mortality for infants in the 500 to 999 weight cohort increased and was twice as high for minority infants. Perhaps there was an increase in a clustering of newborns with weights at the lower end of this weight cohort that affected survival. Overall there were 14 more deaths due to perinatal causes than observed in the mean for the previous three years. These observations suggest a possible need to examine issues related to access to perinatal services for high risk pregnancies and preterm infants, especially for minorities. This need is reinforced as data on utilization of prenatal care are examined.

Prenatal care has long been recognized as a vital service for all pregnant women. Not only can it be protective of fetal and maternal well being through education of women, it can treat high risk conditions to prolong gestation and promote fetal health. The data from South Dakota provide evidence that affirms the relationship between a woman's receipt of this service and the risk of death for her infant. Assuring that this service is affordable and accessible should be a societal expectation, yet even if these potential barriers are removed, some women may not avail themselves of its care. Such failure to use prenatal services warrants concern about the nurturant and protective care an infant may receive following birth.

In 2012, there were also ten more deaths due to congenital anomalies than was observed in the mean for the previous three years. A review of the specific causes of these deaths due to anomalies does not highlight a spike in any one attributable cause.

The observation that there were only six deaths due to SIDS is important. While this number represents a decrease in this cause of death, the possible shifting of how sudden infant deaths are coded may explain this decrease. Increases in death scene investigations identify hazards in the sleep environments of infants who suddenly die. Such deaths are currently not coded as SIDS but rather as having undetermined or accidental causes. Persistence is needed in disseminating educational messages about “safe sleep.” Indeed, a message released in September 2013 from the federal sudden unexpected infant death/sudden infant death syndrome workgroup asked “all organizations who reach families and health care providers through media, print, and education to show infants sleeping alone, on their backs, and in a clutter-free crib, bassinet, or play yard.”

Local community reviews of South Dakota infant deaths identify how they continue to occur in hazardous sleep environments. Such observations highlight the need for ongoing visible public education that must be provided through multiple modes to reach new parents and those who provide care to infants.

These “State of South Dakota’s Child” articles, for the past 26 years of their publication, have continually identified the racial disparities in infant mortality in South Dakota. Data presented in the most previous publication demonstrated a gradual closing of the gap in mortality for the white and minority infants. Unfortunately, 2012 data require that attention be focused upon the racial inequity in infant deaths. Consistently the disparity in mortality is greatest after the 27th day of life when social factors increasingly contribute to the well being of infants.

As an outcome of the 2012 Task Force on Infant Mortality convened by First Lady Daugaard, efforts are currently being taken to provide individualized reviews of infant deaths. These reviews should help focus efforts on specific dynamics associated with tragic loss of new life. Governmental public health strategies are vital to...
Communities, but will never supplant the critical role of personal responsibilities. All those whose personal and professional lives touch those of pregnant women and infants must recognize how their supportive care of families can protect infants whose risk of death this first year of life will not be surpassed until the sixth decade of life.

REFERENCES


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Remember...AA&R Ask. Advise. Refer.
Building a Whole New Mind: An Interprofessional Experience in Patient Safety and Quality Improvement Education Using the IHI Open School

By Ryan Miller, MSIV; Tessa Winterton, MSIV; and Wendell W. Hoffman, MD, FACP

Abstract

Introduction
Throughout the last decade, there has been a significant move toward integrating patient safety and quality improvement concepts into health professions education, essentially building a whole new mind in terms of medical knowledge. While existing literature has suggested possible means of implementation, little research has described outcomes and specific examples of integration. The Institute for Healthcare Improvement (IHI) Open School offers a curriculum that could be incorporated in most health professions training. This project serves to study implementation of Open School courses, garner student feedback and guide the implementation of quality and safety curricula across health disciplines in South Dakota.

Methods
First-year medical and allied health students at the University of South Dakota completed surveys before and after having one introductory lecture and finishing two of the Open School courses in interprofessional teams within an existing health professions course.

Results
Medical student means showed significant differences in 16 of 16 (p=0.05) primary teaching points related to Open School course objectives, while allied health students showed significant differences in 13 of 16 (p=0.05) points. Students valued an introductory lecture and thought their educational experience was enhanced by the addition of the Open School courses.

Conclusion
Our results demonstrate that the Open School courses chosen for this sample of interprofessional students provide a simple, inexpensive and effective method to implement quality and patient safety concepts within existing health professions curricula.

Introduction
Teaching patient safety (PS) and quality improvement (QI) to health professions students is a relatively new concept but has been recognized as vital to the future of health care. The Institute of Medicine’s landmark report in 2001, Crossing the Quality Chasm, recommended a restructuring of clinical education consistent with principles of 21st century health systems.¹ Fundamentally, the way forward will require a whole new way of thinking about knowledge, which is to turn the “art of medicine” into the new science of medicine, what one of the authors (WWH) has coined as “health care in its right mind.”²⁻⁴⁻⁵

Despite the need for change, the response of our educational apparatus has been lacking. Into this void has stepped the Institute for Healthcare Improvement (IHI). IHI is an international leader in transforming health care delivery and an independent not-for-profit organization based in Cambridge, Mass. At its core, IHI affirms that “everyone should get the best care and health possible.”⁶ Founded more than 25 years ago by Dr. Donald Berwick, IHI’s work is focused in five key areas: improvement capability; person- and family-centered care; patient safety; quality, cost and value. To educate and equip the medical industry regarding these crucial pillars, the IHI Open School for Health Professions (hereafter termed Open School) emerged in 2008. In a mere five years, 580 health
professions schools and hospitals in 46 states and 60 countries have established chapters of the Open School. The Open School has accelerated the incorporation of PS and QI topics into health professions education and serves to “…fill the current gap in the professional preparation of improvement leaders while the educational institutions catch up with the need.” The establishment of Open School chapters provides students, residents and faculty with free online courses and resources from world-renowned faculty, such as Lucian Leape, Don Berwick, Lloyd Provost and Jim Reinertsen, as well as a forum to facilitate interprofessional dialogue. The Open School online courses are completely revised and updated by an internal editorial team of Open School team members and physician advisors on an ongoing basis, making this knowledge continually new to the learner. Funding is via professional subscriptions to the courses as well as grants and donations. In addition, continuing medical education credit is offered for each course. Lastly, a basic certificate is available upon completion of core content modules, which cover PS, QI, leadership, person- and family-centered care and value. The most current information about the Open School can be accessed at www.ihi.org/offerings/IHIOpenSchool/overview.

The South Dakota Open School chapter was founded in the spring of 2011 with the goal of unifying health disciplines across the state to collaborate on important issues such as QI, PS, teamwork, communication, and patient-centeredness. The chapter now includes eight schools, and over 600 medical, nursing, pharmacy, occupational therapy, physical therapy, physician assistant, health service administration, health sciences, respiratory therapy, and health information management students are members who are participating in chapter events, online activities and QI projects.

This project was created as a part of a Scholarship Pathways project (a student-designed longitudinal scholarly project within the school of medicine) and represents the first attempt within the chapter to demonstrate the legitimacy of the Open School online modules within a curriculum. The project introduced basic concepts of PS and QI into first-year medical and allied health curriculum using an introductory lecture and Open School courses in small interprofessional teams.

Methods
A one-hour introductory lecture discussing general PS and QI topics was given by one of the authors (WWH). Students completed two courses, PS 106: Introduction to the Culture of Safety and PS 103: Teamwork and Communication, chosen because of their topic relevance and potential for group discussion. An existing interprofessional Gross Anatomy course at the University of South Dakota (USD) provided an ideal framework for the pilot project because students were already divided into interprofessional teams, and the project objectives coincided with existing Gross Anatomy objectives. The Gross Anatomy course included first-year medical, physical therapy, occupational therapy and physician assistant students, and all students enrolled in Gross Anatomy in the fall of 2011 were given the opportunity to participate. Students completed the courses in groups of four on the afternoon that their group was not in anatomy lab. One student per group was assigned as the facilitator, and he or she was provided a handout to help guide the group and foster discussion. The timeline for the project is shown in Figure 1.

Students completed a pre-project survey prior to the initial introductory lecture and a post-project survey following the completion of the two Open School courses. For most of the survey questions, students were presented with a statement and responded using a 5-point Likert scale: 1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree. The full list of survey items can be found in Appendix 1. The 16 primary items on the investigator-developed surveys were adopted from the Open School course objectives. Other survey items were included to obtain feedback regarding the introductory lecture, the small group setting and the overall educational experience. The mean student ratings were compared using mixed model repeated measures in PROC MIXED in SAS. Clearance for the project was provided by the USD

<table>
<thead>
<tr>
<th>Table 1. Means for responses related to overall Anatomy educational experience with QI and PS project added (Scale 1-5 with 5=strongly agree).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Anatomy Educational Experience with QI and PS concepts added</strong></td>
</tr>
<tr>
<td>My exposure to the larger context of medicine as taught by including patient safety and quality improvement topics such as culture of safety, teamwork and communication in medicine, and patient centered care enhanced my educational experience in Anatomy.</td>
</tr>
</tbody>
</table>
Table 2. Student preferences for individual versus group completion of the IHI Open School courses and whether they thought the courses were beneficial at this early point of their education.

<table>
<thead>
<tr>
<th></th>
<th>Allied Health Students</th>
<th>Medical Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefer individual work</td>
<td>23 (45%)</td>
<td>24 (69%)</td>
</tr>
<tr>
<td>Prefer work group</td>
<td>28 (55%)</td>
<td>11 (31%)</td>
</tr>
<tr>
<td>Beneficial at this time</td>
<td>23 (50%)</td>
<td>18 (53%)</td>
</tr>
<tr>
<td>Not beneficial at this time</td>
<td>23 (50%)</td>
<td>16 (47%)</td>
</tr>
</tbody>
</table>

Results

Pre- and post-project surveys were completed by 110 students, representing 87 percent of all students enrolled in the Gross Anatomy course. Figures 2 and 3 show mean student ratings for 16 primary items for medical students and allied health students, respectively; statistically significant differences are noted in each figure. The medical student means showed significant difference in all items (p=0.05), while allied health students showed differences on 13 of 16 items (p=0.05). When evaluating medical and allied health students as a whole, the overall group showed a difference in all cases except item 16.

Students felt that the short introductory lecture was beneficial and relevant to their education, and mean values were 3.9 and 4.4 (5=strongly agree) for allied health and medical students, respectively. Additionally, students were asked to respond on how the courses related to their overall educational experience. The students generally agreed with the statement that these courses enhanced their educational experience in Anatomy. When asked about the setting in which they preferred taking the courses, 55 percent of allied health students preferred small groups, while only 31 percent of medical students preferred the small group setting. Finally, students were asked about their impressions of the Open School courses as they relate to their educational experience. The students generally agreed that the content was beneficial and timely. These post-survey questions were not subjected to statistical analysis but were used for future course improvement.
Help Shape the Future of Medicine in South Dakota

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

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

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

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PO Box 7406
Sioux Falls, SD 57117-7406
www.sdsma.org

South Dakota State Medical Association Foundation
Shaping the Future of Medicine in South Dakota
Discussion

Our results show that significant learning took place in most categories. Some differences between allied health and medical student groups were noted (Figures 2 and 3). These differences may be attributed to prior clinical experience in the allied health students who are often required to have a number of patient contact hours prior to entering their programs. Response bias could also account for some of the pre- to post-survey changes, as students may have “expected to learn the material” and ranked the post-survey items higher. Additionally, how the courses are implemented and the enthusiasm of the instructor or facilitator is important for course success. For example, simply placing the Open School courses as an “add-on” in an already busy basic science course may not seem relevant to students, unless faculty advocate how the Open School can bring the basic science courses to life. Nonetheless, this method of integrating the Open School in an existing interprofessional Gross Anatomy course was effective in teaching students important quality and safety concepts early in their education.

As noted, there were mixed responses in terms of whether to take the courses individually or in groups. Allied health students tended to prefer groups, while medical students tended to prefer taking the courses individually. These responses were based on apparent perceptions of time constraints, group dynamics, or other aspects more related to the culture of each particular discipline. It would be interesting to study the best setting for student learning: small groups, individual study, or courses taken individually with subsequent discussion in small groups using related case studies. Since both small group and individual study seem acceptable to students, either could be implemented based on the needs of a particular course or curriculum.

We are encouraged that students generally appreciated the content of the courses, and this speaks highly of the quality of the Open School courses. On average, students believed the courses enhanced their educational experience in Gross Anatomy. This finding, while only slightly above neutral in terms of mean ratings, suggests that these PS and QI concepts are applicable in courses other than specifically designated quality/safety or clinical medicine courses.
courses. In addition, while the responses were mixed, approximately half of students felt that the content was beneficial for first-year students just beginning their formal health care training. Of the students who did not feel that the courses were beneficial at this time, nearly all stated that placement closer to their clinical experiences would be more appropriate.

The study has several limitations. First, some key health care disciplines such as nursing and pharmacy were not included. Second, the Open School courses were studied in the context of a Gross Anatomy course and completed in a way that added additional work to an already busy course; had the Open School courses been implemented in a course that focused specifically on these topics, the responses may have been quite different. Third, student rather than faculty facilitation of the courses during the small group time may have influenced the perception of the courses. Finally, we are using one sample of students from a first-year class at a single university.

Overall, the responses from students were compelling enough that we feel confident in suggesting that the Open School be used as the foundational quality curriculum in a wide range of health professional programs. For students to have even a small amount of interest in the concepts within a required, student-developed pilot project is impressive and speaks to the importance which students place on these topics. Significant improvement was demonstrated in all disciplines in nearly all categories, suggesting that Open School courses are beneficial for multiple health disciplines.

Conclusion

Health care is in the midst of a knowledge revolution, and educationally will demand a new paradigm to build a whole new mind, one that admits that we can no longer teach just to the patient, but must also teach to the context of the patient. Our overriding goal is to integrate Open School courses and QI projects into health professions curriculum at all South Dakota health professions schools. We plan to create a community where students and health care providers in all disciplines use the same quality and safety language to work effectively in interprofessional teams, with a focus on patients and their safety. Open School courses prove to be a simple, inexpensive and effective way to quickly implement PS and QI concepts within health professions curricula. The tools are out there for us to make momentous change, and so we must start together to build that whole new mind.

Acknowledgements

The authors would like to acknowledge Ann Settles, Jane Gavin, and Robert Mocraft for allowing implementation of quality and safety into their Gross Anatomy course, Beth Hahn for assistance in data collection, Paul Thompson for statistical analysis, Matt Bien for guidance in developing the project and critically editing the manuscript, and Susan Anderson for support in project development.

REFERENCES


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Wendell W. Hoffman, MD, FACP, Clinical Professor of Medicine, Sanford School of Medicine of the University of South Dakota, Sanford Clinic – Infectious Disease; Faculty Advisor, South Dakota IHI Open School Chapter.
### Appendix 1. Items on Pre- and Post-project Surveys.

#### General Items

- **With which program are you affiliated?**
- **Have you worked or volunteered in a health care setting in the past?**
  - If you answered YES to the previous question, for how long and what was your role?
- **In your experiences with healthcare settings, what things have you observed that you think could or should be improved?**
- **Had you heard of the Institute for Healthcare Improvement (IHI) before coming to medical school?**
  - If you answered “yes” to the previous question, when or how did you hear about the Institute for Health Care Improvement?
- **In your own words, describe what the field of “Patient Safety” involves.**
- **Give specific example of something that could be considered “quality improvement” in a health care setting.**

#### Sixteen Items related to IHI Open School course objectives (1-5 scale from strongly disagree to strongly agree)

1. You are able to explain the basic concepts of patient safety and quality improvement and their role in health care.
2. You are able to explain the importance of health care professionals attaining competency in patient safety and quality improvement.
3. You are able to explain how you as a student can contribute to improvement of patient safety in the setting that you train in.
4. You are able to identify patient safety issues in a clinical setting.
5. You are able to define the role of each member of a health care team and when to call on another member for his or her expertise.
6. You are able to explain the characteristics of a culture of safety.
7. You are able to list ways in which the prevailing culture of health care makes it hard for caregivers to voice their own concerns.
8. You are able to give examples of ways in which a culture of safety can help improve the care you provide.
9. You are able to describe several specific behaviors you can practice (even as a health professions student or new health care provider) to foster a culture of safety in your workplace.
10. You are able to list several questions you can ask an organization’s staff to determine whether the organization is “safe.”
11. You are able to describe the characteristics of an effective team.
12. You are able to explain the reasons why teamwork is important for patient safety.
13. You can precisely identify the steps of the SBAR technique.
14. You are able to describe how to conduct an effective briefing.
15. You can successfully explain how communication and teamwork are related to developing an effective plan.
16. You are able to explain the role of leadership in fostering effective teamwork.

#### Introductory Lecture (1-5 scale from strongly disagree to strongly agree)

- Having a short introductory lecture to patient safety and quality improvement and its relevance to my health professions education was beneficial.

#### Overall Anatomy Educational Experience with QI and PS concepts added (1-5 scale from strongly disagree to strongly agree)

- My exposure to the larger context of medicine as taught by including patient safety and quality improvement topics such as culture of safety, teamwork and communication in medicine, and patient centered care enhanced my educational experience in Anatomy.

#### Additional Questions

- Were the IHI Open School courses beneficial for you in this point of our education? Explain how you will benefit or not benefit from these courses in the near future.
- Did you find it helpful to take the IHI Open School courses in small group (interdisciplinary) setting helpful, or would you rather have completed the courses individually?
- What were your overall impressions of the 2 courses that you took?
Congratulations, Valerie Stephens MD

On being named Rapid City Regional Hospital’s Physician of the Quarter for Customer Service Excellence

Rapid City Regional Hospital is honored to recognize Dr. Valerie D. Stephens for continually providing her patients with compassionate, comprehensive, and caring medicine. Dr. Stephens is a champion and leader in initiatives that result in improved outcomes for patient care. She serves as a credible role model professionally and personally for patients, colleagues and other health professionals. Dr. Stephens consistently exceeds expectations, while demonstrating a greater commitment in the understanding of and responsiveness to the physical, spiritual, emotional, and intellectual needs of her patients.

Valerie D. Stephens, MD
Board Certified: Gastroenterology
Rapid City Medical Center

Hypertension is one of the most serious health problems in the country. Fortunately, it’s also one of the easiest to diagnose and treat.

You know the classifications and risks. Don’t assume your patients do. Talk to them about their BP and do it often. Breaking the silence is one of the best ways to fight this silent killer.
Introduction

The use of tobacco can have devastating effects on health including heart attack, respiratory disease, cancer and stroke. In addition to these health effects, tobacco use has tremendous mortality and financial impacts. The Centers for Disease Control and Prevention (CDC) estimates that over 1,200 people in the U.S. die every day from tobacco use, and health care costs related to tobacco use are over $190 billion per year. It is estimated that health care expenditures from smoking in South Dakota cost $276 million every year. People who smoke cigarettes not only risk their own health, but also, they expose other people to the detrimental effects of secondary exposure. Recent surveillance data shows that 23 percent of South Dakota residents report the use of cigarettes, with segments of the population showing even greater prevalence. Young adults in South Dakota (age 18 to 24) have the highest smoking rate at over 34 percent. Smokeless tobacco use in South Dakota is among the highest in the nation (6.2 percent), particularly for males (11.9 percent). In 2008, the rate of non-ceremonial tobacco use among American Indians in South Dakota was 44 percent compared to 16 percent of the white population.

There is little room for debate on the premise that prevention and cessation of tobacco use has a positive impact on health. Health care providers have both an opportunity and a critical responsibility to intervene in curbing tobacco use and secondary exposure in their patient

Abstract

Background

Tobacco use is a burden in terms of mortality, chronic disease, and economic impact. Effective treatments exist to aid tobacco users who are motivated to quit. The South Dakota QuitLine provides coaching to all participants and the option of a cessation product (nicotine replacement therapy [NRT], or the prescription medications, varenicline or bupropion) at no cost. This study describes the types of services requested by South Dakota QuitLine participants and the associated cessation outcomes across service types.

Methods

Data from South Dakota QuitLine enrollees during a four year period (2008 to 2011) were included. Enrollment data (demographics and tobacco use) and outcome evaluation data (30 day point prevalence – abstinence) collected seven months later were accessed (N = 11,603/26,876 enrollees, 43.2 percent response). The frequency of requests for each type of cessation service and associated cessation outcomes are reported. Abstinence at seven months was compared for the different services.

Results

Frequencies of cessation services requested were coaching/varenicline (64.6 percent), coaching/bupropion (5 percent), coaching/NRT (22.6 percent), and coaching only (5.4 percent). Overall abstinence at seven months was 47.2 percent. Abstinence rates for service types were the following: coaching/varenicline (49.8 percent), coaching/bupropion (47.3 percent), coaching/NRT (42.9 percent), and coaching only (40.3 percent). Chi-square analysis and confidence interval comparisons identified significantly higher abstinence (p < .05) for varenicline/coaching in comparison to coaching only or coaching/NRT.

Conclusions

All service options available from the South Dakota QuitLine result in cessation rates of 40 percent or greater. Providers should assess tobacco use, advise users to quit, and refer to the South Dakota QuitLine.

Tobacco Quitline Outcomes by Service Type

By Jennifer L. Kerkvliet, MA, LPC; and Nancy L. Fahrenwald, PhD, RN, APHN-BC
populations. Provider encouragement can motivate tobacco users to quit. A recent meta-analysis of eleven studies concluded that health care provider advice to quit smoking for medical reasons can increase abstinence by 47 percent. Offering additional support beyond advice, either through behavioral counseling and/or cessation products, results in an additional 40-60 percent of patients making a quit attempt. Clinical practice guidelines for tobacco cessation developed by the U.S. Preventive Services Task Force recommend that health care providers follow the five A’s (i.e., Ask, Advise, Assess, Assist and Arrange) at every health service appointment for every patient who uses tobacco.8

Numerous effective treatment options for tobacco cessation exist. Behavioral coaching was found to be more effective at achieving cessation than no treatment and brief advice.9 Medications can also increase the odds of a successful tobacco cessation attempt. A meta-analysis of 70 randomized controlled trials identified that the use of nicotine replacement therapy (NRT) was superior to no NRT (odds ratio 1.98).10 Two prescription cessation medications, varenicline and bupropion, were each identified as superior to no treatment in a meta-analysis of 69 studies, and varenicline was nearly twice as effective as bupropion.11 Counseling and cessation medications used together have been shown as the most effective treatment method.9 Randomized, controlled trials indicate that any type of tobacco treatment is superior to no treatment control.

Cessation treatment is widely accessible in the U.S. through quitlines, which provide telephonic cessation counseling services in every state. Data from quitline programs provide an opportunity to explore tobacco cessation outcomes by the type of cessation services requested in a population-based sample of tobacco users seeking cessation assistance. In South Dakota, callers to the South Dakota QuitLine choose which service they want to utilize – coaching alone, or coaching plus a cessation product. All who enroll in the service are provided up to five individual telephone-based coaching sessions. Trained health coaches assist clients with setting goals, determining a quit date, and overcoming barriers to quitting. Education on withdrawal and development of coping strategies to help prepare clients for success in the attempt is also provided. Callers who request coaching plus a cessation product choose one of three options – NRT in the form of patches, gum or lozenges, or the cessation medications bupropion or varenicline. The South Dakota QuitLine is one of only two state quitlines that offer a choice among a variety of cessation products, all at no cost to clients.12 Cessation products are offered free of charge for eight weeks, provided a prescription is obtained for the medications (varenicline and bupropion require prescription). Cessation products are mailed directly to the participant’s home in staggered increments following completion of specified coaching calls. Cessation products are not provided without coaching.

Tobacco dependence is a chronic disorder; hence, multiple attempts are often needed before the quit is maintained. Therefore, callers are eligible to enroll in South Dakota QuitLine services on a yearly basis as needed to quit. Priority populations, including pregnant women, youth callers, spit tobacco users, Medicaid recipients, and American Indian participants, are eligible to re-enroll every three months.

**Purpose**

Few population-based studies exist which directly compare the outcomes of different types of cessation treatment.11 Therefore, the purpose of this study was to examine tobacco cessation outcomes by the types of cessation services requested from the South Dakota QuitLine (coaching, coaching and NRT, coaching and bupropion or coaching and varenicline). The specific aim was to describe the frequency of requests for different cessation services and compare associated seven-month cessation outcomes based on service type.

**Methods**

**Design and Sample**

This longitudinal cohort study examined South Dakota QuitLine intake data that was available for 26,876 participants who requested coaching services between Jan. 1, 2008 and Dec. 31, 2011. A total of 11,603 completed the seven-month follow-up survey, resulting in a response rate of 43.2 percent.

**Measures and Procedures**

Intake data and seven-month outcome evaluation questions are based on standardized assessments referred to as the Minimal Data Set (MDS) as established by the North American Quitline Consortium (NAQC).13-15 The MDS provides a consistent method of evaluating quitlines nationwide. At the time of requesting South Dakota QuitLine services, MDS demographic and tobacco use data is collected by South Dakota QuitLine staff. An external evaluator collects MDS data on the seven-month cessation outcomes. Participants contacted at seven-month follow-up are asked, “Have you used any tobacco, even a puff or a pinch, in the past 30 days?”, referred to as the 30-day point prevalence abstinence rate of respondents (30 dpp).11 The percentage of respondents answering no to this question is the primary cessation outcome. Items on the evaluation survey also inquire about current tobacco use, type and extent of tobacco use, quit attempts, motivation to quit, cessation product use, and other types of assistance used in
the quit attempt (Table 1). The outcome evaluation survey was administered over the phone by trained university-based research staff. Seven attempts to contact participants were made at varying times and days before the participant was considered lost to follow-up. The data collection procedures were approved by the South Dakota State University Institutional Review Board.

Analysis
Data analysis was performed using the Statistical Package for the Social Sciences (SPSS) software, version 20.0 (International Business Machines Corp., Armonk, NY). Descriptive statistics were used to describe the sample and address the specific aim. Chi-square analysis was used to examine whether there were significant differences in 30 dpp (abstinence) across the different categories of services requested.

Results
Description of the Sample
Characteristics of South Dakota QuitLine callers included in this study are outlined in Table 2. Most callers were female (55 percent), white (91 percent), and had been using tobacco for 10 years or longer (83 percent).

Cessation Services Requested and Associated Seven-Month Outcome (30 dpp – abstinence)
Of the South Dakota QuitLine callers who provided seven-month data on both cessation medication and current tobacco use (N = 11,056), nearly two-thirds reported use of coaching plus varenicline (64.6 percent), followed by coaching and NRT (22.6 percent). There were 5.4 percent of participants who reported coaching only as their choice of service and 5 percent reported coaching and bupropion (Figure 1). A small number of participants (n=267) reported

Table 1. Minimal Data Set of the North American Quitline Consortium15

<table>
<thead>
<tr>
<th>Required Intake Questions Regarding Tobacco Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How can I help you?</td>
</tr>
<tr>
<td>2. Just to confirm, are you calling for yourself, or calling on behalf of or to help someone else?</td>
</tr>
<tr>
<td>3. How did you hear about the quitline?</td>
</tr>
<tr>
<td>4. Is this your first call to the quitline in the past 12 months?</td>
</tr>
<tr>
<td>5. What types of tobacco have you used in the past 30 days? A) Cigarettes, B) Cigars, cigarillos, or little cigars, C) A pipe, D) Chewing tobacco, snuff, or dip, E) Any other type of tobacco?</td>
</tr>
<tr>
<td>6. For each type of tobacco used: Do you currently smoke/use [type of tobacco] every day, some days or not at all?</td>
</tr>
<tr>
<td>7. For each type of tobacco used: How many/much [type of tobacco] do you smoke/use on the days that you smoke/use? [Time frame is week instead of day for cigars, pipe, chewing tobacco, and other tobacco products.]</td>
</tr>
<tr>
<td>8. For each type of tobacco used: When was the last time you smoked/used [type of tobacco]?</td>
</tr>
<tr>
<td>9. Cigarette smokers only: How soon after you wake up do you smoke your first cigarette?</td>
</tr>
<tr>
<td>10. For each type of tobacco used: Do you intend to quit using [type of tobacco] within the next 30 days?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Follow-up Questions (administered 7-months after intake)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall how satisfied were you with the service you received from the quitline?</td>
</tr>
<tr>
<td>2. Have you smoked any cigarettes or used other tobacco, even a puff or a pinch, in the last 30 days?</td>
</tr>
<tr>
<td>3. What types of tobacco have you used in the past 30 days?</td>
</tr>
<tr>
<td>4. For each type of tobacco used: Do you currently smoke/use [type of tobacco] every day, some days or not at all?</td>
</tr>
<tr>
<td>5. For each type of tobacco used: How many [type of tobacco] do you smoke/use on the days that you smoke/use? [Time frame is week instead of day for cigars, pipe, chewing tobacco, and other tobacco products.]</td>
</tr>
<tr>
<td>6. Cigarette smokers only: How soon after you wake up do you smoke your first cigarette?</td>
</tr>
<tr>
<td>7. For each type of tobacco used: Do you intend to quit using [type of tobacco] within the next 30 days?</td>
</tr>
<tr>
<td>8. Since first calling the quitline, seven months ago, did you stop using tobacco for 24 hours or longer because you were trying to quit?</td>
</tr>
<tr>
<td>9. Since first calling the quitline seven months ago, have you used any of the following products or medications to help you quit?</td>
</tr>
<tr>
<td>10. Other than the quitline or medications, did you use any other kinds of assistance to help you quit over the past seven months, such as advice from a health professional, or other kinds of quitting assistance?</td>
</tr>
</tbody>
</table>
multiple product use (e.g., coaching plus bupropion and NRT) and they were excluded from this analysis since the additional service was independently accessed outside of South Dakota QuitLine services.

The overall seven-month quit rate (30 dpp abstinence) was 47.2 percent and the corresponding 95 percent confidence interval (CI) was 46.3 percent to 48.1 percent. Quit rates (95 percent CI) by types of services requested are reported in Table 3. Chi-square analysis identified that there were significant differences across categories of services requested, \( \chi^2(3, N = 10,789) = 48.42, p = .00 \). Quit rates and corresponding confidence intervals were compared across categories to identify significant differences between services requested. Participants who requested coaching services and varenicline had the highest quit rate of 49.8 percent (95 percent CI [48.6, 51.0]) but this rate was not significantly different from the quit rate for coaching plus bupropion, which was 47.3 percent (95 percent CI [43.1, 51.5]). The quit rate for coaching and varenicline was significantly higher than coaching plus NRT, 42.9 percent (95 percent CI [41.0, 44.9]) and coaching only, 40.3 percent (95 percent CI [36.4, 44.4]). There were no other significant differences in quit rates across categories.

**Discussion**

Cessation coaching is the common element across all service options available from the South Dakota QuitLine and cessation outcomes are strong regardless of the service options selected to augment coaching. Nearly all of the callers to the South Dakota QuitLine requested a cessation product in addition to coaching (95 percent). The most commonly requested type of cessation service was coaching plus varenicline (65 percent). Coaching plus varenicline was first introduced in 2008 as one of the service options available to South Dakota QuitLine callers, which may have impacted utilization rates of the various service options. Quit rates (30 dpp – abstinence) are strong over the four year period assessed, with 46.3 percent to 48.1 percent of clients reporting no tobacco use seven months after enrolling in the cessation service. These relatively short-term quit rates (seven months) are higher than the reported outcomes of other state quitlines, which report quit rates ranging from 19.7 percent to 41 percent.\(^{16-19}\) The inclusion of varenicline and bupropion at no cost likely contributes to at least a portion of the increase in quit rate, as comparison quitlines did not include these two medications as service options. However, it is pertinent to note that for tobacco users who will not or cannot utilize cessation products, outcomes among participants who

![Figure 1. Types of Services Reported by South Dakota QuitLine Callers at Seven-month Follow-up (N = 11,056)](image)

**Table 2. Characteristics of Available Data on Callers to the South Dakota QuitLine Service (N = 26,876)**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (SD) or %</th>
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<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>% Female</td>
<td>54.6%</td>
</tr>
<tr>
<td>% Male</td>
<td>45.4%</td>
</tr>
<tr>
<td>Age (range 13 to 90)</td>
<td>41.5 (14.0)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>90.9%</td>
</tr>
<tr>
<td>American Indian</td>
<td>5.8%</td>
</tr>
<tr>
<td>Other</td>
<td>3.3%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>11.1%</td>
</tr>
<tr>
<td>High school diploma/GED</td>
<td>38.6%</td>
</tr>
<tr>
<td>Some college or higher</td>
<td>50.2%</td>
</tr>
<tr>
<td>Duration of tobacco use</td>
<td></td>
</tr>
<tr>
<td>0 to 5 years</td>
<td>6.6%</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>10.6%</td>
</tr>
<tr>
<td>10 or more years</td>
<td>82.7%</td>
</tr>
<tr>
<td>Type of tobacco use</td>
<td></td>
</tr>
<tr>
<td>Cigarettes only</td>
<td>93.1%</td>
</tr>
<tr>
<td>Spit Tobacco only</td>
<td>3.4%</td>
</tr>
<tr>
<td>Other</td>
<td>0.8%</td>
</tr>
<tr>
<td>Polytobacco use</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

**Table 3. Cessation Outcome by South Dakota QuitLine Services Requested, 2008-2011**

<table>
<thead>
<tr>
<th>Service Requested</th>
<th>N</th>
<th>Quit Rate (7-mo 30 dpp)*</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coaching plus varenicline*</td>
<td>7,138</td>
<td>49.8%</td>
<td>48.6% – 51.0%</td>
</tr>
<tr>
<td>Coaching plus bupropion</td>
<td>552</td>
<td>47.3%</td>
<td>43.1% – 51.5%</td>
</tr>
<tr>
<td>Coaching plus NRT*</td>
<td>2,499</td>
<td>42.9%</td>
<td>41.0% – 44.9%</td>
</tr>
<tr>
<td>Coaching only**</td>
<td>600</td>
<td>40.3%</td>
<td>36.4% – 44.4%</td>
</tr>
</tbody>
</table>

*Statistically significant differences (p < .05)

*Seven-month 30 dpp: Thirty-day point prevalence abstinence, “Have you used any tobacco, even a puff or a pinch, in the past 30 days? Table shows percentage of respondents at seven-month follow-up who responded “no” to the question.
requested coaching only were still positive at a reported quit rate of 40.3 percent. This study contributes new evidence about the effectiveness of population-based interventions aimed at reducing tobacco use.

Accessible and effective treatment options exist to address tobacco use and dependence, and most tobacco users (68.8 percent) report wanting to quit.\textsuperscript{19} Despite its effectiveness, few providers have the availability, expertise, or resources to provide cessation counseling. Partnerships between health care providers and state quitlines can ensure that patients receive the necessary assistance to quit, at little cost to the provider, and in South Dakota, at no cost to the patient. A comparative study out of Australia found that patients referred to quitline services by their physician were nearly three times more likely to be quit a year later than those who receive standard care.\textsuperscript{20} Providers at all levels can: a) ASK about tobacco use, b) ADVISE patients to quit, and for patients who are interested, c) REFER to the South Dakota QuitLine. Integration of these steps into electronic health record has been found to be feasible and cost effective.\textsuperscript{21} Three health systems in the state have, or are in the process of, adding these steps into the electronic health record.

Several limitations to this study are recognized, most notably, self-selection bias. In the study population, 97 percent of clients self-initiated the contact with the South Dakota QuitLine. These clients are likely more motivated to quit, and this increase in motivation may result in higher quit rates. To assess quit rates, we relied on respondents to self-report tobacco use. Although this is standard methodology, social desirability bias must be considered. The study population selected type of service, and all types were provided at no cost to the participant. The economics of replicating this level of service provision in other areas may not be feasible. Finally, data on the amount of cessation medication used in the quit was not assessed. Future studies should investigate a comparative dose-response relationship within and between service options in a population-based study.

**Implications for Practice**

All types of cessation services available at the South Dakota QuitLine result in cessation rates of 40 percent or greater. The findings of this study build on prior research demonstrating that counseling plus medication results in the highest rates of tobacco cessation. The results of this study identified that there are strong outcomes across service options. The resources required to provide both cessation counseling and medication to tobacco users within health care settings are considerable. Providers should assess tobacco use, advise users to quit, and refer to the South Dakota QuitLine.

**South Dakota QuitLine Service**

Individuals can enroll with the South Dakota QuitLine telephone cessation service directly by calling 1.866.SDQUITS (866.737.8487). Provider referral forms and supportive educational information is also available through the South Dakota QuitLine web service at www.sqquitline.com.

**Acknowledgements**

This project was supported through a contract with the South Dakota Department of Health (SDDOH), including limited flow-through funding from the Centers for Disease Control and Prevention. The team acknowledges the SDDOH Tobacco Control and Prevention Staff, particularly Linda Ahrendt, Chronic Disease Director, and Scarlett Bierne, Tobacco Program Director, for ongoing support and guidance; and Avera Corporate Health Services, vendor of the South Dakota QuitLine, for providing data for the project. The content is solely the responsibility of the authors and does not necessarily represent the official views of the SDDOH. We also thank numerous undergraduate research assistants in the SDSU Office of Nursing Research for their assistance with data collection.

**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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Nancy L. Fahrenwald, PhD, RN, APHN-BC, College of Nursing, South Dakota State University.
Antimicrobial resistance is serious global threat; a consequence in part due to agent overutilization and inaction despite recognition of the problem. Given there are few novel antimicrobial agents in the current drug pipeline, treatment options are likely to become severely limited as resistance development advances. In fact, if progress is not made soon in curtailing inappropriate antimicrobial use and resistance, some have suggested we may be approaching a situation equivalent to the “pre-antimicrobial” era.1

The Infectious Diseases Society of America (IDSA) published guidelines for the development of institutional antimicrobial stewardship programs (ASPs) in 2007.2 These guidelines have provided valuable advice on how to successfully implement ASPs, including recommendations for resources, strategies and financial justification, albeit with a hospital-based focus. The IDSA is currently developing a guideline for ASP development in different types of health care settings, with projected publication in spring 2015. The Centers for Disease Control and Prevention (CDC) has also assisted in efforts to reduce antimicrobial resistance. The Get Smart: Know When Antibiotics Work campaign developed by the CDC promotes awareness of antimicrobial resistance among both healthcare professionals and the general public. This campaign’s main message is that antibiotics aren’t always the answer, with guidance provided to the public regarding issues such as appropriate symptomatic treatment of the common cold. The Get Smart campaign materials may be freely accessed on the CDC website, www.cdc.gov/drugresistance/campaigns.html.3

For the first time, a recent publication by the CDC prioritizes current antimicrobial resistance threats, categorizing them as “urgent,” “serious”, or “concerning”.4 This report further discusses four “core actions” recommended by the CDC to address these threats, including: 1) prevention of infection/prevention of spread of resistant organisms, 2) tracking resistant bacteria, 3) improving antimicrobial use, and 4) promotion of the development of new diagnostics and antimicrobials to identify and treat resistant bacteria. The final section of this CDC document summarizes information on each organism in the report, including recommendations for infection detection and management, as well as public health implications. The entire report may be accessed on the CDC website, www.cdc.gov/drugresistance/threat-report-2013/index.html.

The “urgent” treats described by the CDC include Clostridium difficile infection, carbapenem-resistant Enterobacteriaceae (CRE), and drug-resistant Neisseria gonorrhoeae. These three “urgent” threats will be discussed further in this column. Twelve threats were classified as “serious” according to the CDC, with extended spectrum beta-lactamase producing Enterobacteriaceae (ESBLs), Vancomycin-resistant Enterococcus (VRE), multidrug-resistant Pseudomonas aeruginosa, and Methicillin-resistant Staphylococcus aureus (MRSA) listed among them. The final category, “Concerning” includes the less common but worrisome threats of vancomycin-resistant Staphylococcus aureus (VRSA), Erythromycin-resistant Group A Streptococcus, and Clindamycin-resistant Group B Streptococcus.

The CDC estimates 250,000 C. difficile infections per year in the U.S. with approximately 14,000 deaths. Improved C. difficile infection prevention and detection, as well as prudent antimicrobial prescribing are cited by the CDC as ways to contain this threat. CRE is a rapidly developing problem, particularly among patients with health care exposure. The CDC estimates 9,000 CRE infections per year in the U.S. with an associated 600 deaths. Invasive forms of CRE infection are associated with high mortality, with half of all patients with CRE bloodstream infections succumbing to their illness. CRE is commonly resistant to nearly all antimicrobials, including carbapenems, agents commonly thought of as the antimicrobials of “last resort.” While several potential options remain for the treatment of CRE infection (colistin, polymyxin B, tigecycline, fosfomycin), resistance and/or treatment failure has already been described with these agents.5-7 As with C. difficile, CRE infection prevention/detection, as well as prudent antimicrobial prescribing is paramount in containing this important threat. Sexually transmitted infections caused by N. gonorrhoeae now represent the second most common notifiable infection in the U.S., with 820,000 infections reported per year, of which 246,000 are classified as “drug
resistant” according to the CDC. Of particular concern with this organism, drug resistance to cephalosporins has emerged, and N. gonorrhoeae strains resistant to cephalosporins are often resistant to other antimicrobial classes. The CDC now recommends only parenteral ceftriaxone plus either azithromycin or doxycycline as first line treatment for gonorrhea. If cephalosporin-resistant N. gonorrhoeae becomes widespread, it may have serious public health implications, resulting in an increase in conditions such as pelvic inflammatory disease, epididymitis or other sexually transmitted infections. The CDC is working with the World Health Organization, as well as local and state STD programs to combat this threat through surveillance and awareness/preparedness initiatives.

What about South Dakota? Should we be concerned? While C. difficile infection is not new to our communities, CRE is, and it has become an emerging threat. According to the South Dakota Department of Health, there have been eight confirmed cases of CRE since becoming legally reportable in South Dakota on July 1, 2013 (L. Kightlinger, written communication, Dec. 3, 2013). To this point, most CRE infections in South Dakota are believed to have been acquired in health care facilities (long-term care or hospitals). While most of these patients have been geographically located in northeastern South Dakota, one case was identified in Sioux Falls.

Antimicrobial resistance is serious and we are not isolated from it in South Dakota. The CDC has provided useful information to educate and promote awareness of this growing problem. Practitioners are encouraged to review these important tools and use them where possible to promote efforts that may reduce antimicrobial resistance and infection caused by resistant pathogens.

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.

About the Authors:
By Brad R. Laible, PharmD, BCPS, Professor, Department of Pharmacy Practice, SDSU College of Pharmacy.

A reputation is like trust. It takes years to grow, but can be ruined in seconds. Make sure your reputation is protected with medical malpractice insurance coverage from PSIC.
Medical Record Maintenance

Quality medical record documentation is a critical factor in a health care organization’s efforts to prevent and control patient injuries and malpractice losses.

**Transferring Charts to Satellite Offices**

Transferring charts between facility locations requires special systems and precise record management. Regardless of how many sites a patient might visit, ideally just one chart should be maintained for that patient, and should contain all information about the patient, no matter where they have been seen. As more clinics and health care systems adopt electronic medical records (EMR), the concerns with managing multiple charts become less of an issue. However, medical record timeliness is of utmost importance. While some EMR systems have the capacity to accommodate multiple satellite facilities, many do not have the ability to instantaneously push out newly captured information – which results in a lag in the system – and so it may take 12 to 24 hours after a patient is seen in one facility before his or her information is available in another (satellite facility).

**After-Hours Telephone Calls**

To ensure completeness and accuracy of a patient’s medical record and to provide continuity of patient care, after-hours telephone calls must be documented in a patient’s record in a timely manner. The documentation of a telephone call must include:

- Date and time of the call;
- Patient’s concern(s);
- Advice given to the patient;
- Action taken;
- Name of the health care provider.

After-hours telephone call information must be placed into the patient’s medical record in a manner consistent with the timeline and the procedures for processing other documentation.

**Medication Refills**

Providing safe and appropriate prescribing standards for medication refill authorization or denial should be a goal of the organization. Requests for medication refills are received into the clinic in several ways: by phone call, email or fax from a patient or pharmacist, or during a clinic visit. A designated person at a clinic can take information from any of the above sources. All medication refill requests must be authorized or denied by the physician or authorized practitioner after checking the medical record. The refill authorization or denial must be documented in the medical record and should include:

- Date and time;
- Medication given or denied;
- Authorized dose and amount;
- Patient instructions;
- Ordering practitioner.

If the refill request is denied, the patient and/or pharmacy should be informed of the denial and the reason. The physician may authorize a qualified staff member to communicate the refill authorization or denial to the pharmacy and document such disposition in the medical record. Patients should be informed at the time of treatment about the need for periodic exams and/or lab requirements for medication refills.

**Monitoring Medical Record Completeness**

Lastly, medical records should be reviewed regularly to ensure their accuracy and completeness. Medical records can be reviewed for timeliness and completeness during the abstraction and coding functions by the medical records staff, and findings should be forwarded to the medical staff committee.

In addition, the medical staff committee should conduct a clinical pertinence review monthly on a representative sample of all practitioners’ records. Recommended changes are then communicated either to the specific health care provider or to all medical staff, as appropriate. Recommended changes should be adopted by either the specific health care provider or by all medical staff.

In the next issue, we’ll take a closer look at medical record handling.
When you hear the words “charitable giving,” something very specific may come to mind. Maybe you think of an annual donation you make at the office, or a faith-based initiative to which you’ve contributed. And while the focus used to be on giving money to large causes, changes have been taking place in how and why we give, changes that are broadening our understanding. In fact, the way many of us look at our charitable giving – even the words we use to describe it – are changing. The focus used to be on giving money to large causes. Increasingly, donors want to invest their money or skills to create opportunities for others.

Those with charitable intent have been asked to write checks for a long time – it is truly the standard of giving. However, as donors have become more knowledgeable, the following questions have emerged: “Who am I giving this money to, what impact will it have, and who will hold the recipient accountable for positive results?”

While the days of writing a check are by no means gone, this new approach better answers those questions on what can be achieved, and how “generosity” can create “social capital.” This new perspective on giving is life-changing, and with this approach, you can actually create opportunities with lasting impact.

Micro-lending, for instance, and similar projects that create sustainable businesses, are on the rise. Donors and entrepreneurs who fund such work want to create something sustainable, with a lasting impact. They don’t want the gift to be an end in itself.

Creating social capital opens doors to people who may not have thought about the impact of their giving. Jerry Foster, founder of Foster Group, a wealth management and investment advisory firm, says, “Generosity can be a tool for changing the way people view the world, while also transforming their hearts. People don’t often view generosity in a transformative way. But when generosity is seen differently, as life changing and transformational, it liberates those who give and those who receive. This can multiply the effect of the gift.”

People love to give to all sorts of causes and for very different reasons. Some are intrigued by creating opportunities with social capital, while others give to minimize tax implications. Whatever the case is for you, remember that when you give it can become an expression of your individual passion. Your giving can provide opportunities for others that can transform their lives.

As things have changed and people are becoming more intentional, they think more about ways to give and the change they can create, rather than simply reacting to an appeal. In general, donors today want to make a bigger difference, and the return on investment they seek is not merely financial in nature. Instead, they’re looking for a meaningful return on their generosity, and the social capital it creates.
On Nov. 18, 2013, the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Council released the CMS Quality Strategy for 2013 and beyond to improve meaningful quality measurements and to align the private and public health care sectors. This Quality Strategy supports the three broad aims of the National Quality Strategy, which are also the aims of SDFMC’s current contract with CMS, referred to as the 10th Statement of Work (SOW):

- **Better Care:** Improve the overall quality of care by making health care more patient-centered, reliable, accessible and safe.
- **Healthy People, Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers and government.

In its ongoing efforts to advance these three aims, the National Quality Strategy has identified the following six priorities (or goals) and objectives:

**Goal 1:** Make care safer by reducing harm caused in the delivery of care.
- Improve support for a culture of safety.
- Reduce inappropriate and unnecessary care.
- Prevent or minimize harm in all settings.

**Goal 2:** Strengthen person and family engagement as partners in their care.
- Ensure all care delivery incorporates patient and caregiver preferences.
- Improve experience of care for patients, caregivers, and families.
- Promote patient self-management.

**Goal 3:** Promote effective communication and coordination of care.
- Reduce admissions and readmissions.
- Embed best practices to manage transitions to all practice settings.
- Enable effective health care system navigation.

**Goal 4:** Promote effective prevention and treatment of chronic disease.
- Increase appropriate use of screening and prevention services.
- Strengthen interventions to prevent heart attacks and strokes.
- Improve quality of care for patients with multiple chronic conditions.
- Improve behavioral health access and quality care.
- Improve perinatal outcomes.

**Goal 5:** Work with communities to promote best practices of healthy living.
- Partner with and support federal, state and local public health improvement efforts.
- Improve access within communities to best practices of healthy living.
- Promote evidence-based community interventions to prevent and treat chronic disease.
- Increase use of community-based social services support.

**Goal 6:** Make care affordable.
- Develop and implement payment systems that reward value over volume.
- Use cost analysis data to inform payment policies.

The full implementation of these six goals and objectives is currently being developed by the CMS Quality Improvement Council.

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- Attention difficulties
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January 2014
Trouble, trouble, trouble,
Oh! we got trouble,
Right here in River City!
With a capital "T"
That rhymes with "P"
And that stands for Prescription Drugs.

Proof of this trouble comes from South Dakota's new Prescription Drug Monitoring Program or PDMP established by the South Dakota legislature in 2010. This tool is there to help prescribers and pharmacies know when a drug seeker is at the door claiming pain or medical trouble in order to obtain drugs to sell or abuse.

We know so far this year in South Dakota, 162 people have received prescriptions of abusable drugs from more than ten physicians, and 55 have had at least six prescribers of such meds coming from six or more different pharmacies.

We also know that since 2004, poisoning deaths in South Dakota from abuse or wrongful use of certain prescription drugs have averaged at 19 per year, mostly due to narcotics and opioids, and that number appears to be on the rise.

Still, appropriate prescribing of narcotic pain medicine provides for many an escape from suffering. Rest assured that physicians and care providers will and should prescribe pain relievers without hesitation when such medicines are needed to help people in trouble.

But with all that compassionate care comes excessive prescribing. In fact, the PDMP tells us that in the first eight months of this year in South Dakota there has been dispensed more than 11 million tabs of the specific medication hydrocodone with acetaminophen or Vicodin.

That is 13 tabs for every South Dakotan. Other prescriptions for potentially abused medications commonly sold on the streets include zolpidem or Ambien, lorazepam or Ativan, methylphenidate or Ritalin/Concerta, and oxycodone with acetaminophen or Percocet, to name a few.

The harms from drug and alcohol abuse extend beyond the illicit user to those living nearby. The surrounding community so exposed has increased crime and violence, child and spouse abuse, motor vehicle accidents, sexually spread diseases, fetal alcohol syndrome in children, and deaths due to accidental and intentional overdose.

We've got trouble, trouble, trouble right here in South Dakota. This is a call to all physicians and pharmacies out there who are targeted by drug seekers. Do not fall for it. Use the PDMP, be aware of the danger to patients and society, and just say no when you should. And to those who are seeking illicit drugs, know that we are watching you.
The South Dakota Board of Medical and Osteopathic Examiners (SDBMOE) is requesting additional data with licensure renewal applications this year. This effort is part of a state and nationwide effort to identify information about health care professionals including academic training history, where and what services are provided to patients as well as other demographic information. Gov. Dennis Daugaard made improving the availability of health care providers in rural South Dakota a key provision of his South Dakota Workforce Initiative (SD WINS).1 This effort has been approved by the South Dakota Legislature.2

A recent Associated Press story also highlights the problem in South Dakota. Nineteen of South Dakota’s 66 counties lack a primary care physician.3 Information gathered by the SDBMOE from the new questions on the renewal applications may provide assistance in determining how effective the rural recruitment efforts have been, and how to adjust those efforts to meet anticipated needs. The SDBMOE will ask the questions of all their regulated professions to provide a more detailed look at which health care personnel are available to serve the needs of South Dakotans.

Frequently Asked Questions (FAQ) that the Board Staff is fielding this year:

Q: You already have my medical school information. Why do you need it again?
A: The academic training information is not yet available in an electronic format; therefore, for this year, licensees will need to provide the month and year of completion for medical school and post graduate training.

Q: How do I answer the “how many weeks worked” question?
A: Use the actual number of weeks worked. For example, if you took two weeks of vacation, the answer would be 50 weeks.

Q: The “Please provide more details…” box comes up after one of my answers. If I made a mistake, can I type: “I hit the incorrect answer” in the explanation field?
A: Yes, that would be an appropriate response. If more details are needed for this or any other explanation, you will be contacted.

Q: The individuals that I supervise are not correctly listed. What do I do to change this?
A: Please send an email with the necessary corrections and the board staff will assist you. You can see who you are supervising at any time by doing a Licensee Look-Up on the Board website.

Q: Why are you only asking about the American Board of Medical Specialties (ABMS) board certification? Shouldn’t the American Osteopathic Board (AOA) certification be asked as well?
A: At this time, only the ABMS is being requested as it is the only board certification organization mentioned in the South Dakota medical practices act. Also, this question was already part of the information technology (IT) system so it was relatively easy to include in the renewal application. Next year the ability to ask about AOA certification may be available.

For assistance, contact the Board Office, preferably when you are at a computer so staff can guide you.

REFERENCES
2. SDCL 34-12G.
In Memoriam 2013
Honoring physician members of the SDSMA who passed away in 2013

Robert D. Bloemendaal, MD
Douglas E. Cameron, MD
Paul F. Dzintars, MD
Gary A. Halma, MD

Earl G. Nelson, MD
Winston B. Odland, MD
Duane Reaney, MD

James A. Rud, MD
Richard G. Sample, MD
Kudzai Vengesa, MD
At this point in the year, many of us are focused on the new year – identifying projects and defining tasks for completion in the upcoming months, having put the busy holiday season behind us. While 2013 brought DAKOTACARE great challenges yet great success, the launch of the most significant piece of the Affordable Care Act (ACA) in 2014 promises to make it a busy and challenging year.

Unquestionably, our work over the past year has been greatly affected by the many provisions of the ACA, and this will continue to be the case throughout 2014 and beyond as major portions of the law take effect. One of the major components of the ACA was the creation of the Health Insurance Marketplace (exchange) to assist individuals and families who do not have employer-based coverage, government-sponsored health care (such as Medicaid), or existing individual coverage, to shop for coverage and potentially qualify for prepaid tax credits to help pay for that coverage. The “SHOP” Exchange was also created to provide opportunities for small employers to shop for group coverage as well. By means of background, South Dakota was one of 35 states that did not create a state-based exchange, and instead, allowed the federal government to establish a federally facilitated exchange in our state. Three of South Dakota’s four domestic health insurers (including DAKOTACARE) chose to participate in both the individual exchange and the SHOP Exchange in South Dakota in 2014. In addition, South Dakota has opted, to date, to forego the Medicaid expansion prescribed by the ACA. While this decision will affect the initial ACA enrollment numbers, this topic is sure to be discussed during the upcoming legislative session.

In this first year of ACA-compliant coverage, individuals and families are only guaranteed access to coverage if application is made during the open enrollment period, which began on Oct. 15 and runs through March 31, 2014. After that date, unless a special enrollment occurs, the next open enrollment window does not open until Nov. 15, 2014 to Jan. 15, 2015. Individuals and small groups may also purchase ACA-compliant plans “outside” the exchanges, and have a broader choice of plans, by working directly with insurers, but prepaid tax credits are only available to individuals for plans purchased through the exchange.

Individuals and families who wished to have ACA-compliant plans in place by Jan. 1, 2014 needed to have their application accepted and initial premium paid by Dec. 23, 2013. Coverage effective dates are available through May 1, 2014 and are based upon the date applications are accepted and premiums paid.

The failure of the federal government’s healthcare.gov website, scheduled to open on Oct. 1, 2013, and its continued troubles garnered much public notice and concern. While improvements have been made, the federal government still has a great deal of work to do to make the exchanges fully functional. Besides the initial enrollment process, tools must be in place to send enrollment data to insurers daily, to coordinate the payment of premium and application of prepaid tax credits, and to facilitate risk adjustment. Early attempts resulted in much incomplete and garbled data, potentially jeopardizing access to care on Jan. 1, 2014. At the time of this writing, the federal government reported that 30 to 40 percent of the “back end” infrastructure still remains to be built, and the completion of that work will undoubtedly be a primary focus in upcoming weeks.

Federal government benchmarks for federal exchange enrollment were to have 500,000 enrolled by Oct. 31 (actual enrollment was ≈26,000), and 7 million by March 31, 2014 (leaving over 40 million uninsured in 2014). While success was declared for modifications to the healthcare.gov website by the promised Nov. 30 date, enrollment activity will need to be brisk through March 31 in order to meet targets that will maintain actuarially sound insurance markets, and assure the ongoing viability of the ACA.

Delays in planned ACA roll-out dates, a multitude of changes, continuing legal challenges to the law, and early problems encountered by the federal government assure that we will spend much of the next 12 to 18 months “stress testing” the ACA, but it is safe to say that the major issues will inevitably be corrected and some measure of operational success will eventually be achieved. These necessary “repairs” and how quickly they can be made will be one important determining factor, along with consumer reaction to plan costs and coverage and the effectiveness of the individual mandate, in measuring the initial success of the ACA in expanding coverage to the uninsured.
2014 South Dakota Legislative Directory

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Phone (605) 773-3212 • Fax (605) 773-5844

SOUTH DAKOTA LIEUTENANT GOVERNOR
MATT MICHELS
Office: State Capitol; 500 E. Capitol Avenue; Pierre, SD 57501
Phone (605) 773-3661 • Fax (605) 773-4711

SOUTH DAKOTA SENATE
State Capitol, 500 E Capitol Ave, Pierre, SD 57501

President Pro Tempore
Sen. Corey Brown (R) ......................769-0540

Majority Leader
Sen. Timothy Rave (R) ....................360-7190

Asst. Majority Leader
Sen. Dan Lederman (R) ....................232-0050

Majority Whips
Sen. Ried Holien (R) ......................886-4330
Sen. Ryan Maher (R) ......................466-2371
Sen. Larry Rhoden (R) ....................985-5461

Minority Leader
Sen. Jason Freichs (D) ...................949-2204

Asst. Minority Leader
Sen. Billie Sutton (D) .....................775-2110

Minority Whips
Sen. Jim Bradford (D) ....................685-4241
Sen. Angie Buhl-O’Donnell (D) ..........376-2512

SOUTH DAKOTA REPRESENTATIVES
State Capitol, 500 E Capitol, Pierre, SD 57501

All representatives can be reached during the Legislative Session by calling the house lobby at 773-3851. Fax messages addressed to a specific legislator may be sent to 773-6806.

Speaker of the House
Rep. Brian Gosch (R) .....................719-3365

Speaker Pro Tempore
Rep. Dean Wink (R) ......................985-5240

Majority Leader
Rep. David Lust (R) ......................343-8261

All senators can be reached during the Legislative Session by calling the senate lobby at 773-3821. Fax messages addressed to a specific legislator may be sent to 773-6806.

Senator
Adelstein, Stanford
Begalka, Tim
Bradford, Jim
Brown, Corey
Buhl-O’Donnell, Angie
Curd, Blake
Ewing, Bob
Freichs, Jason
Heineman, Phyllis
Holien, Ried
Hunhoff, Jean
Jensen, Phil
Jones, Chuck
Jones, Tom
Kirkey, Mark
Krebs, Shantel
Lederman, Dan
Lucas, Larry
Maher, Ryan
Monroe, Jeff
Novstrup, Al
Omdahl, David
Otten, Ernie
Peters, Deb
Rampelberg, Bruce
Rave, Timothy
Rhoden, Larry
Soholt, Deb
Sutton, Billie
Tidemann, Larry
Tieszen, Craig
Van Gerpen, Bill
Vehle, Mike
Welke, Chuck
White, Jim

Home Telephone

Home Telephone
### 2014 South Dakota Legislative Directory

<table>
<thead>
<tr>
<th>Representative</th>
<th>Home</th>
<th>Dist.</th>
<th>Telephone</th>
</tr>
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<tbody>
<tr>
<td>Anderson, David</td>
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<td>Bartling, Julie</td>
<td>Gregory</td>
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<td>605-835-8120</td>
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<td>Bolin, Jim</td>
<td>Canton</td>
<td>16</td>
<td>605-987-2630</td>
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<td>Union Center</td>
<td>29</td>
<td>605-985-5488</td>
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<td>Campbell, Blaine</td>
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<td>605-393-1645</td>
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<td>Greenfield, Brock</td>
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<td>605-692-9716</td>
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<td>Flandreau</td>
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<td>Heinert, Troy</td>
<td>Mission</td>
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**Asst. Majority Leader**

<table>
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<tr>
<th>Representative</th>
<th>Home</th>
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<tr>
<td>Rep. Justin Cronin (R)</td>
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**Majority Whips**

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<td>Rep. Jacqueline Sly (R)</td>
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**Minority Leader**

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**Asst. Minority Leader**

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<td>Rep. Julie Bartling (D)</td>
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**Minority Whips**

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Listed below are the SDSMA District Medical Societies and the state legislative districts contained within each medical society.

**SDSMA District**

<table>
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<th>Legislative Districts</th>
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<td>11, 23, 28A, 28B</td>
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</table>
The American Medical Association (AMA) Economic Impact Study, completed in conjunction with the South Dakota State Medical Association (SDSMA), demonstrates how office-based physicians in South Dakota boost the state’s economy by contributing:

- $1.8 billion in sales revenue
- $1.2 billion in wages and benefits
- Almost 9,000 jobs
- $54 million in state and local tax revenue

For more information, please visit ama-assn.org/go/eis.

Your membership matters.

The AMA and SDSMA are using studies like the AMA’s Economic Impact Study to educate lawmakers on issues that matter to you—medical liability reform, unfair payer practices and more.

It’s only through the support of our members that this work is possible. Please join or renew your 2014 AMA and SDSMA memberships by calling SDSMA at (605) 336-1965 today.
For Your Benefit:

SDSMA Is Your Legislative Advocate

SDSMA’s legislative staff is your eyes, ears and voice in Pierre and Washington. We track hundreds of pieces of legislation that affect you, as well as coordinate opportunities for you to get involved in the process. Want to be the Doctor of the Day during the South Dakota legislative session? How about a Physician Lobbyist? You can, and we can make it possible.

There are more SDSMA benefits to tell you about and you’ll hear about them in the months to come. In the meantime, if you’d like more information about our legislative services and advocacy programs, give us a call at 605.336.1965, visit the SDSMA website at www.sdsmoa.org, or email Mark East at meast@sdsmoa.org.

“For Your Benefit” is the SDSMA’s monthly update on programs and services available to physicians through their affiliation with the SDSMA.

A Physician’s Guide to Charitable Giving

The SDSMA Center for Physician Resources brings you a live event and webinar titled, “A Physician’s Guide to Charitable Giving.” The presentations will outline reasons to give and proven strategies for evaluating and making charitable donations, ways to gift and models of giving.

The live event is scheduled for 7 p.m. Jan. 16 at CJ Callaway’s in Sioux Falls; please register by emailing Mark East at meast@sdsmoa.org. The webinar on the same topic is at 7 p.m. on Jan. 21. Find a link to register for the webinar at www.sdsmoa.org.

Source: SDSMA staff

Medical Record Privacy – Disclosure With Patient Consent

For the release of protected health information, valid written authorization of the release of records is necessary.

Protected health information may be released by the patient, and must include written authorization that contains certain provisions in order to be valid. Personal representatives and parents of minors may execute such an authorization as well.

The authorization must be in writing and contain the following:

• A description of the information to be used or disclosed.
• The person, or class of persons, authorized to make the requested use or disclosure.
• The name or other specific identification of the person, or class of persons, to whom the covered entity may make the requested disclosure.
• A description of each purpose of the requested use or disclosure. The statement, “at the request of the individual” is a sufficient description when an individual initiates the authorization and does not provide a statement of the purpose.
• An expiration that relates to the individual or the purpose of the use or disclosure. The statement “end of the research study,” “none,” or similar language is sufficient if the authorization is for the use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository. “End of case” or “end of lawsuit” is also acceptable.
• The signature of the individual and date. If the authorization is signed by a personal representative, a description of his or her authority to act for the individual must also be provided.

For more about medical records privacy, download the SDSMA legal brief Medical Record Privacy – Disclosure With Patient Consent at www.sdsmoa.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.

Credentialing Timeframe Being Developed

In response to a problem brought forth by members about the length of time it has taken for providers to be credentialed for health plan participation, the SDSMA is working to develop a bill to be introduced in the upcoming legislative session.

The bill would require health plans to credential providers within a certain period of time – 60 or 90 days. While the bill draft is currently under development, the SDSMA is in the process of obtaining support for this effort.

Source: SDSMA staff
The South Dakota Board of Medical and Osteopathic Examiners (SDBMOE) adopted two new rules on Nov. 13 regarding physician licensure by expediting the process and creating a provision for reciprocity.

So that waiver-eligible applicants who have exceeded the licensing examination timeframe don’t need to wait between quarterly SDBMOE meetings, the board adopted an administrative rule to give provisional license status upon completion of the applicant’s file. The rule would apply to American Board of Medical Specialties-certified applicants. The individuals can then begin practice instead of having to wait for the next board meeting.

In addition, the board adopted a reciprocity rule. Applicants who hold a valid medical license issued by another state may be licensed by reciprocity in South Dakota if they have completed a residency program in the U.S. or Canada and if they pass the appropriate licensure examinations within the proper timeframe, provided they have not had any allegations of misconduct and complete a criminal background check.

Source: SDBMOE

The deadline for award nominations is February 1, 2014. Complete your Nomination Form today and help your colleagues get the recognition they deserve!

Source: SDSMA staff

SGR Not the Only Factor Influencing 2014 Fee Schedule Conversion

Reports about the 2014 fee schedule conversion factor announced in the final fee schedule rule on Wednesday, Nov. 27, are confusing and sometimes conflict. That is because the SGR-induced payment cut is not the only factor influencing the 2014 conversion factor.

The fee schedule payment cut due to the SGR is, in fact, approximately 24 percent. However, at the same time, changes were made in the weights assigned to the three fee schedule components – physician work, practice expense, and malpractice expense – to more closely match their assigned weights in the Medicare Economic Index. To offset the aggregate impact of this “rescaling” of the three fee schedule components, a positive 4.72 percent adjustment was made to the fee schedule conversion factor. The net impact of these changes produced a conversion factor that is 20.1 percent lower than the 2013 conversion factor.

Nonetheless, the SGR-induced payment cut is about 24 percent, and despite the higher-than-expected conversion factor, a review of the actual payments that will be made using the new “rescaled” relative value units reveals that most services will, in fact, be reduced by about 24 percent because of the SGR.

Because the regulation was issued nearly four weeks late, the Centers for Medicare and Medicaid Services (CMS) has agreed to extend until the end of January 2014, the period in which doctors can change their Medicare participation status.

Source: AMA staff
Report of the AMA Delegate and Alternate Delegate on the 2014 AMA Interim Meeting

By Mary S. Carpenter, MD, SDSMA delegate to the AMA, and Herbert Saloum, MD, SDSMA alternate delegate to the AMA.

AMA 2013 Interim Meeting
In November, the SDSMA delegation of Mary Carpenter, MD, Herbert Saloum, MD, Daniel Heinemann, MD and CEO Barb Smith joined hundreds of our fellow physicians and medical students at the AMA interim meeting just outside the nation’s capital in National Harbor, Maryland. SDSMA Medical Student Section President Jeremy Pepin along with medical students George Ceremuga, Eammon Grosek, Teresa Maas, Benjamin Meyer, Collin Michels and Ashley Osenga attended the Medical Student Section of the meeting. Ms. Maas was elected as an alternate delegate to the AMA House of Delegates.

Repeal the SGR and Allow Balanced Billing
The House of Delegates (HOD) voted to continue its support of a Congressional proposal to repeal the SGR, Medicare’s flawed payment formula, while continuing to work to enhance potential legislation in alignment with AMA policy. AMA President Ardis Dee Hoven, MD, said the AMA is “pulling out all the stops to get Congress to act.” The AMA will continue to advocate for payment options that are consistent with quality care and lowering costs. The challenge for Congress will be to find the “pay-fors” in a budget-neutral environment. We encourage each of you to contact our Congressional delegation to encourage them to take this opportunity to eliminate the SGR at a time when the cost is at an all-time low.

Improvements to the ACA
A resolution from Indiana discussed at the SDSMA’s November Council meeting that would have the AMA recommend several changes to the ACA was referred by the House of Delegates to the Board of Trustees to report back at the 2014 Annual Meeting. The resolution, “Improving the Affordable Care Act,” called for replacing the individual mandate with a refundable tax credit to purchase individual health insurance, repealing the employer mandate, and allowing health insurance to be sold across state lines. The resolution also calls for a delay of at least a year in implementation of the ACA. The resolution had 19 resolves, some of which conflicted with each other, and some were already AMA policy. Some would require a change in AMA policy.

Delay or Cancel ICD-10
Delegates reiterated their concerns about the implementation of ICD-10, calling for a delay. The coding system is set to launch on Oct. 1, 2014. The AMA estimates it will cost from $83,290 to $2.7 million per practice, depending on size, to implement ICD-10.

DME
A resolution introduced by South Dakota and Nebraska, which passed in the House of Delegates, calls for updates to AMA policy on requirements for prescription of durable medical equipment (DME) to be consistent with emerging patient care models. The resolution will create new language stating that any member of a physician-led care team can complete a certificate of medical necessity, but the prescription for the DME ultimately is the responsibility of the physician.

Rural Track for Primary Care
Delegates passed a resolution to change rural training track requirements in order to encourage interest in rural residency programs. Rural training tracks are proven to positively impact recruitment efforts. This resolution changes the way residents receive credit for rural experiences so patient encounters during this experience may count toward the continuity requirements for the completion of a residency, and would expand rural tracks to internal medicine, general surgery, pediatrics and OB/GYN, in addition to family medicine.

DEA Licenses
A resolution was passed to limit the increase in the cost of DEA licenses to the inflation rate. Unchecked, license fees could be $700 in four years under the current increase rate.

Cannabis
The AMA reaffirmed its opposition to marijuana legalization. Delegates passed a resolution recognizing that cannabis is a dangerous drug and should not be legalized.
CME Events

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

<table>
<thead>
<tr>
<th>January 2014</th>
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<tbody>
<tr>
<td>Jan. 17</td>
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<tr>
<td>“Educating Medical Providers about the Clinical Care of Transgender and Intersex People”</td>
</tr>
<tr>
<td>Leighton Auditorium, Siebens Building, Mayo Clinic, Rochester</td>
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<tr>
<td>AMA PRA Category 1Credit(s)” available</td>
</tr>
<tr>
<td>Register online: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<td>Jan. 27-31</td>
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<td>26th Annual Selected Topics in Internal Medicine</td>
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<tr>
<td>Grand Hyatt Resort and Spa, Koloa, Kauai, Hawaii</td>
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<tr>
<td>Mayo School of Continuous Professional Development, Rochester</td>
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<td>Register online: <a href="http://www.mayo.edu/cme">www.mayo.edu/cme</a></td>
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<td>Feb. 26-March 1</td>
</tr>
<tr>
<td>Mayo Clinic 17th Annual Endocrine Update</td>
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<td>Westin Kierland Resort, Scottsdale</td>
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<td>March 5-8</td>
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<tr>
<td>Internal Medicine Recertification Course</td>
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<tr>
<td>The Westin Gaslamp Quarter, San Diego</td>
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<tr>
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<tr>
<td>March 19-22</td>
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<tr>
<td>“Pain Medicine for the Non-Pain Specialist”</td>
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<tr>
<td>Mayo School of Continuing Medical Education, Rochester</td>
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<tr>
<td>April 24-25</td>
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<tr>
<td>“Ethics Problem Solving and Consultation: The Mayo Approach”</td>
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<tr>
<td>Leighton Auditorium, Siebens Building, Mayo Clinic, Rochester</td>
</tr>
<tr>
<td>AMA PRA Category 1Credit(s)” available</td>
</tr>
<tr>
<td>Register online: <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?

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