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THE POLK COUNTY MEDICAL SOCIETY

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SEPT/OCT 2016

Bulletin

MEMBER MAGAZINE FOR THE POLK COUNTY MEDICAL SOCIETY

Inside This Issue

Feature Articles

Monthly Articles

COVER PHOTO: Members of the Polk County Medical Society Executive Council gather on the steps of the United States Capitol during the 2016 Washington, D.C. Fly-in to advocate on federal issues on behalf of PCMS Members.

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ADVOCACY *in* *Washington, D.C.*

The Polk County Medical Society held their annual Washington, D.C. Fly-In September 13th-14th, 2016, while both the Senate and House were in session.

PCMS Board Members, Executive Director and staff advocated personally with the Iowa Congressional Delegation, on behalf of PCMS members.

L-R: Dr. Susan Jacobi, Paula Noonan, Administrative Director, Drs. Nancy Kane, Kaaren Olesen, Matthew Rauen, Kathie Lyman, Executive Director, Senator Joni Ernst, Drs. Joel From, Janie Hendricks, Philip Colletier and Steve Cahalan.

The PCMS Delegation is welcomed by Senator Joni Ernst to kick off the Washington, D.C. Fly-In visits with our Iowa U.S. Delegation.

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Advocacy and Physician Leadership

By: Matthew Rauen, M.D.

Physicians have an opportunity to serve as advocates multiple times each day. With every patient encounter, we are entrusted by patients and families to assist in choosing a care plan that is in the patient's best interest. When making challenging treatment decisions, we often attempt to view our patients as family members. We believe this approach to patient care ensures our patients receive the best possible care. With this approach and thought process impacting our clinical encounters, every physician can quickly recount episodes when we have gone above and beyond for our individual patients.

While physicians have consistently served as advocates for their patients, in recent decades our professional societies have found it more important to focus on advocacy efforts in a much more organized way. Not unlike other professional groups, physicians are now encouraged to reach out to state and federal policy makers as well as other local groups and organizations that influence healthcare delivery.

Physicians are uniquely positioned to serve as public advocates. We are a trusted source of knowledge and experience in the medical field, and we serve in the front lines of patient care. When issues arise, we are often the first to identify them, and we can provide direct feedback to lawmakers on the impact of changes in healthcare policy. This has been particularly true recently as physicians and healthcare organizations have been forced to devote greater resources to prove compliance.

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In September, members of the Polk County Medical Society (PCMS) made their annual pilgrimage to Washington, D.C. We were very fortunate to have wide representation from members of large practices and small practices, both hospital based and private practice. There was representation from numerous specialties. Having such a diverse group come together with some common issues really spoke to our concern for all people in central Iowa and their ability to receive healthcare. It also enabled the group to provide accurate and pertinent information to our representatives.

Collectively, we shared with our members of Congress our ideas, suggestions, and frustrations regarding the practice of medicine in central Iowa. Senators Grassley and Ernst and Congressman Young are very aware of many of the issues we are facing as physicians in the Des Moines area. Our ability to clarify the issues and answer questions from the lawmakers further develops the relationships between PCMS members and the lawmakers. These relationships will serve us moving forward as the lawmakers and their staff seek out advice from PCMS members on healthcare topics in the future. Our access and personal attention we receive from the three Iowa lawmakers year after year is the direct result of the tremendous efforts of PCMS executives Kathie Lyman and Paula Noonan.

Ultimately, physicians posses the ability to identify the social, educational, and economic barriers that impact an individual's access to healthcare. Viewing many of the same issues in a broader sense and working toward potential solutions is at the heart of physician advocacy.

Contemplating policy changes that improve public health, improve access to care, and improve the delivery of care can all benefit patients in central Iowa. Furthermore, when new policies - sometimes with unintended consequences - impact a physician's ability to deliver care effectively, we speak on behalf of both patients and other members of our profession.

In summary, advocacy beyond the individual patient before us is important. Trips to the Iowa Statehouse and Washington, D.C., should be encouraged. I truly believe every physician should participate in these sorts of activities at least once in their career. We are fortunate in central Iowa that there are so many opportunities in our local environment where we can serve as advocates, and that the PCMS leadership has established solid relationships with our national policy makers as well. I challenge each of you to consider your role as an advocate in the coming year.

ADVOCACY, Volunteerism *and YOU!*

By: Kathie J. Lyman

Your board members and your staff participated in the Washington, D. C. Fly in September 13th and 14th. We met with our Iowa Congressional Delegation on several key areas of concern for Iowa doctors and their patients. The personal meetings with each of our Congressional Delegation were outstanding. You can read about the meetings in the President's article in this issue of **The Bulletin**.

This fall we are busy planning for the **2017 Iowa Legislature and PCMS priorities** for the practice of medicine and their patients. One of the main priorities will be the continued funding of the PCMS Volunteer Physician Network (VPN) to care for Iowans in need. Last year, through funding granted by the Iowa Legislature, the PCMS VPN program donated over $5.2 million dollars in free specialty care to Iowans in need. This was over 2,000% ROI for the state. Many Iowans received the specialty care they needed and could not receive without the VPN.

The reason the VPN funding is so important is that the VPN is still needed in Iowa. The patients served are 200% below the federal poverty level and do not qualify for any other state or federal programs. The 458 PCMS specialists volunteer their time, and staffs' time, to care for these patients without recognition, through the VPN. The program is now in our 13th year. Even though the new healthcare laws cover more lives, we continue to see an increase in the number of patient referrals from the 59 free referring clinics in Iowa. Many of these patients are working, often with 2 jobs, but are not able to pay for insurance, or have insurance, but cannot meet the large deductibles on their insurance plans.

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These patients used to go to the ER when the acuity level was very high and the cost of care was much higher. Today your PCMS specialty colleagues and Des Moines hospitals provide through the VPN that care to patients in their office with dignity.

The PCMS Government Relations Committee will meet on **Wednesday, November 30th** to review the priorities the PCMS focused on last year. They will determine the priorities for the PCMS to advocate for physicians and their patients in the 2017 Iowa Legislature.

This truly is the time for the PCMS members to become engaged in advocating together on the laws at the state and national level that will be passed in 2017.

They will have an impact on your practices. The PCMS has 2 lobbyists at the state level. At the national level, the PCMS board, members, and your staff, advocate on a regular basis with the Iowa Congressional Delegation on the issues members identify in your PCMS Government Relations Committee each year.

The time is now! Those who need to be involved are YOU! Please let your staff at the PCMS offices know that you are interested in joining the PCMS Government Relations Committee November 30th. **WE HOPE TO SEE YOU THERE!!!**

Allergy/Immunology: *How We Can Help*

By: Vuong Nayima, D.O.

Allergy/Immunology is a growing subspecialty affecting many patients in ways that the medical community is only starting to understand. Even in large medical centers, inpatient consulting work in this field can be lacking. This absence diminishes awareness of the diseases we treat and services we provide. While hardly exhaustive, this article seeks to summarize just a few issues that may warrant involvement of a clinical allergist/immunologist.

Allergic rhinitis affects 50 million Americans, and providers know allergists are adept at treating it. However, not everyone knows that treating allergic rhinitis may drastically improve other atopic conditions (asthma and eczema) and chronic sinusitis. In children, for example, up to 80% of asthmatics have an allergic component. Other recent advances in the treatment of atopic diseases include new biologics (mepolizumab and the upcoming dupilumab), and older biologics like omalizumab have a relatively new indication for chronic urticaria.

Drug allergy is also common, with 25% of patients self-reporting an allergy to an antimicrobial and 10% of patients reporting at least a penicillin allergy. Although the vast majority of these cases are not true allergies but rather adverse reactions or effects of concomitant

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viral/bacterial infections, they ultimately stay on a patient's chart unless action is taken to disprove them. Additionally, many patients with a true penicillin allergy outgrow it, but require testing to confirm.

Patients previously labeled penicillin allergic more frequently receive broad-spectrum antibiotics, which are associated with higher healthcare costs, increased resistance, and suboptimal antibiotic therapy. Therefore, the CDC recommends skin testing and physician-observed challenges to confirm the allergy.

Immunology may be a lesser known field within the medical community, but our awareness and understanding of various deficiencies is rapidly expanding. Common variable immune deficiency, for example, is rarely recognized in a timely fashion, resulting in unnecessary mortality/morbidity for patients despite well-defined treatments.

In children, diagnostic delay from time of symptom onset to diagnosis is around 5 years, even with classical presentations. Adults fare worse, as average diagnosis can take 10 years or more. Patients with recurrent infections, severe or unusual infections, or abnormalities on immune screening labs would benefit from earlier involvement of an allergist/immunologist.

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L-R: Dr. Philip Colletier, U.S. Senator Chuck Grassley and Dr. Matthew Rauen have lively discussion about current support for PCMS Legislative priorities this session.

Members of the PCMS Executive Council visits with U.S. Representative David Young in his office on issues regarding V.A. Hospital residency caps.

L-R: Drs. Steve Cahalan, Susan Jacobi and Philip Colletier discuss mental health access and program funding issues with U.S. Senator Joni Ernst.

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PHYSICIAN LEADERS PICTURED: From left to right: Dr. Michael McCubbin, Sleep Medicine/Allergy; Dr. Tim Rankin, Orthopaedics; Dr. Scott Neff, Orthopaedics; Dr. Daniel McGuire, Orthopaedics; Dr. Stephen Quinlan, Urology; Dr. John Tentinger, Imaging; Dr. Brad Lair, Oncology/Hematology; Dr. Kendall Reed, Gastroenterology.

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6th Annual PCMS/Kathie J. Lyman *Scholarship Golf Tournament*

Over 100 PCMS members, guests, and sponsors enjoyed a beautiful day at the 6th Annual Kathie J. Lyman Scholarship Golf tournament, September 28th at the Hyperion Field Club in Urbandale. Everyone had a great time.

The PCMS Golf tournament proceeds provide financial scholarships annually to medical students from the Des Moines University, University of Iowa and Global Medical Service trips for students.

The awards program and silent auction were fun with great food and camaraderie. The beautiful evening for golfers and reception guests made the perfect ending of a successful golf fundraiser.

L-R: Dr. Janie Hendricks volunteers to kick off the 6th Annual PCMS/KJL Charity Golf Tournament with scholarship namesake Kathie Lyman, long time Executive Director of PCMS.

L-R: Wesley Life Organization sponsors and volunteers, Peggy Luciano and Karie Kesterson-Gibson lead the way to Golfer Registration.

PCMS Staff and volunteers prepare to greet the golfers!

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Golfers load up their clubs and get ready for the fun to begin!

Drs. Matt Raeker and Josh Rosebrook get ready to rumble on the golf course.

L-R Golfer Dale Schroeder assesses the swing of Dr. Richard Holt.

L-R: Golfers Julie Stewart, Elaine Castelline, Drs. Brett Ripley and Mindi Feilmeier enjoy the sun and fun to raise money for medical student scholarships.

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L-R: Drs. Jason Stecker. Ryan Bakke, Don Junge and Mark Sundet reclaim their First Place win!

L-R: Drs. Adam Secory, Dan Pelzer and Rob Lee sportingly scrutinize a putt from Dr. Danny Drewry.

L-R: Drs. Matt Raeker, Josh Rosebrook, Andrew Steffensmeier and Teresa LaMasters look like pros on tour, at the 2016 golf tournament.

L-R: Kevin Ward, Lane Danielson, Dr. Craig Mahoney and Tom Joensen survey the competition.

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L-R: Sam Ayers, Tim Nelson, Drs. Mark Tannenbaum and Magdi Ghali try to decide who is driving this golf cart!

Sponsor team, R & M Rehab sports a striking pose at the 2016 golf tournament.

L-R: Dr. Mindi Feilmeier, Mike Collins, Dave Ellis and Thadeus Franklin enjoy the gorgeous weather and golf competition.

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L-R: Dr. Craig Mahoney presents the 2nd place prize to team members, Dr. Todd Peterson, Kyle Hougham and Dr. Joe Eaton.

L-R: Dr. Craig Mahoney present Dr. Valerie Kounkel with numerous Women's top prizes for the event . . . it was a sweep!

Golfers come in from a beautiful day of competition and fun on the course!

The Awards ceremony wraps up another great year of golf to raise funds for future physicians in Iowa!

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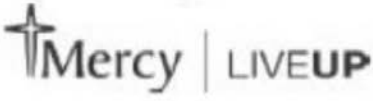
The PCMS members help celebrate long time PCMS friend and supporter, Senator Chuck Grassley's birthday while in Washington, D.C.

The PCMS Delegation wrap up a successful visit of advocacy, on behalf of PCMS members, in Washington, D.C. with U.S. Representative David Young.

Thank You to all Sponsors of the 6th Annual PCMS/Kathie J. Lyman Golf Tournament

We appreciate your support



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THE OPIOID EPIDEMIC: IT'S STILL A PROBLEM

Guidelines from the CDC

By: Daniel Rosenquist MD, FAAFP
COPIC Department of Patient Safety and Risk Management

Drug overdoses are the No. 1 cause of accidental deaths in the U.S., surpassing deaths by motor vehicle accidents. Many drug overdose deaths involve prescription medications, predominantly opioids. Even greater by orders of magnitude are those patients and their families affected by opioid dependence and addiction.

Strategies to combat this epidemic are now being endorsed by many large public agencies, and the following information is guidance released from the Centers for Disease Control and Prevention (CDC) this year.

Published in March 2016, the "CDC Guideline for Prescribing Opioids for Chronic Pain" report is directed at primary care physicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. However, the report has recommendations relevant to all prescribers of opioids with extensive analysis of the evidence related to:

- When to initiate or continue opioids for chronic pain
- Opioids selection, dosage, duration follow-up and/or discontinuation
- Assessing risk and addressing harms of opioids use

It is recommended that all opioid prescribers review the entirety of the report, with an emphasis on the following 12 recommendations (note that items 4, 6, and 11 apply to all prescribers of opioids, even short-term):

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain, and clinicians should consider opioid therapy only if benefits for pain and function outweigh risks.

2. Before starting opioids therapy for chronic pain, clinicians should establish treatment goals, including realistic goals for pain and function, and consider how opioids therapy will be discontinued.

3. Before starting and periodically during opioids therapy, clinicians should discuss with patients known risks and realistic benefits of opioids therapy, and patient and clinician responsibilities for managing therapy.

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4. When starting opioids therapy, clinicians should prescribe immediate-release opioids instead of extended-release/longacting opioids.

5. Clinicians should prescribe the lowest effective dosage, and should carefully reassess evidence of benefits and risks when increasing to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day.

6. Long-term opioids use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms within one to four weeks of starting opioids therapy or escalating dose, and should evaluate benefits and harms of continued therapy with patients every three months or more frequently.

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms, such as sleep apnea, pregnancy, renal or hepatic insufficiency, patients over the age of 65, mental health conditions, substance use disorder and/or prior overdose. Risk mitigation includes offering naloxone especially when there is a history of overdose, history of substance use disorder, opioid dosages ≥50 MME/day, or concurrent benzodiazepine use.

9. Clinicians should review the prescription drug monitoring program (PDMP), if available, when starting opioid therapy and periodically, ranging from every prescription to every three months.

10. Clinicians should use urine drug testing (UDT) before starting opioid therapy and consider UDT at least annually.

11. Clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for opioid use disorder.

Link for the full CDC report: http://goo.gl/l629u9

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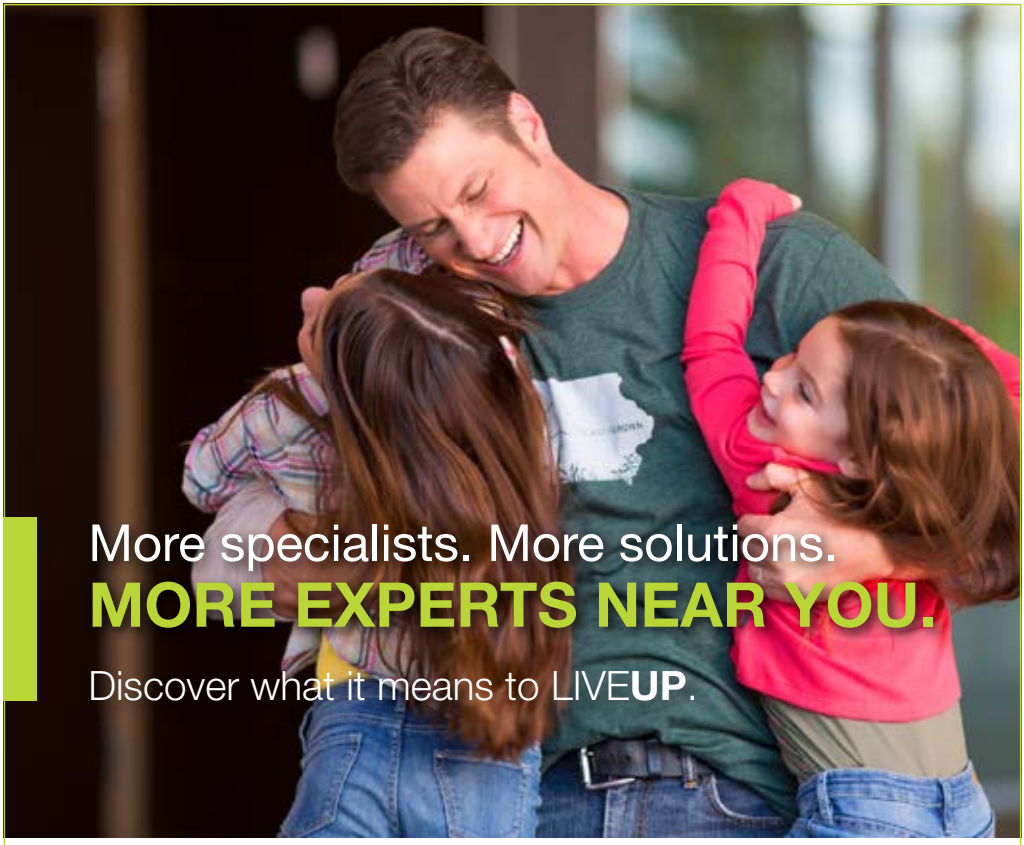

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