The locum tenens industry in the United States was, quite literally, born of necessity. Shortly after I finished medical school in 1976, I joined the Health Systems Research Institute, Inc., a nonprofit organization formed by the University of Utah, the Intermountain Regional Medical Program, and the Robert Wood Johnson Foundation. Our objective was to develop innovative solutions to rural health care issues. I ran a team that managed 22 clinics and five hospitals in nine western states and was team leader for Yellowstone National Park Medical Services.

We very quickly realized there was a dire need for physicians to fill in for geographically isolated practitioners so they could take vacations, attend CME events, or recover from illness or injury without leaving their communities at risk. In response, I established the first locum tenens company in the United States in 1979.

The locum tenens industry in the United States was, quite literally, born of necessity. Shortly after I finished medical school in 1976, I joined the Health Systems Research Institute, Inc., a nonprofit organization formed by the University of Utah, the Intermountain Regional Medical Program, and the Robert Wood Johnson Foundation. Our objective was to develop innovative solutions to rural health care issues. I ran a team that managed 22 clinics and five hospitals in nine western states and was team leader for Yellowstone National Park Medical Services.

We very quickly realized there was a dire need for physicians to fill in for geographically isolated practitioners so they could take vacations, attend CME events, or recover from illness or injury without leaving their communities at risk. In response, I established the first locum tenens company in the United States in 1979.
MARCH 2010 Volume XXIII, No. 12

FEATURES

Pack your bags! 1
The who, why, and how of locum tenens work
By Therus C. Kolff, MD, MPH

Ongoing, systemic changes to prevent chronic disease 1
The Statewide Health Improvement Program
By Cara McNulty, MS, and Rachel Cohen, MPH

Community Caregivers 2010 28
Making a difference in Minnesota and the world
By Scott Wooldridge

DEPARTMENTS

CAPSULES 4

PROFESSIONAL UPDATE: RADIOLOGY 14
Behind the scenes
By Scott Nielsen, MD

MEDICUS 7

INTERVIEW 8

SPECIAL FOCUS: CHRONIC ILLNESS

Cancer as a chronic disease 16
By Noel Laudi, MD, MRCP (UK)

COPD 20
By Ken Kanisaki, MD

Migraine 22
By Frederick R. Taylor, MD, FAHS

Diabetes 18
By Richard M. Bergensdal, MD, and Jim McGowan

Arthritis 26
By Pamela Van Zyl York, MPH, PhD, RD, LN

TREATING CHRONIC ILLNESS

Great strides have been made and yet the number of people with chronic illness is growing exponentially. The best hopes for success will lie in collaborative, multidisciplinary approaches.

Objectives:

We will explore the history of treating chronic disease and what fundamental problems may lie in our most basic approach to the topic. We will examine the programs that have been most successful with everything from diabetes to COPD to asthma and more. We will study ways cross-platform treatment solutions are developing and look at what the future may hold. We will discuss how quality of patient care may improve while new collaborative approaches lower costs.

Panelists include:

◆ Charles Horowitz, MD, Minneapolis Clinic of Neurology
◆ Thomas Huntley, PhD, Minnesota House of Representatives, Chair, Health and Human Services Finance Committee
◆ Ronald Schwartz, MD, Minnesota Gastroenterology, PA
◆ Dennis Urbanik, VP, U.S. Diabetes Business Unit, Sanofi-Aventis

Sponsored by: Pfizer and Sanofi-Aventis

MINNESOTA HEALTH CARE ROUNDTABLE

THIRTY-THIRD SESSION

Treating chronic illness
Exploring collaborative approaches

Thursday, April 29, 2010
1:00 – 4:00 PM • Duluth Room, Downtown Mpls. Hilton and Towers

Background & focus: For many years health care economists have documented that treating chronic illness accounts for by far the greatest percentage of all health care costs. This knowledge has focused initiatives aimed at improving quality and reducing cost across a number of diseases and methodologies. Everything from health plan-sponsored practice guidelines and provider reimbursement strategies, to improved medications, to employer and even government involvement, to enhancing personal responsibility and much more has been utilized.

Please send me tickets at $95.00 per ticket. Mail orders to Minnesota Physician Publishing, 2812 East 26th Street, Minneapolis, MN 55406. Tickets may also be ordered by phone (612) 728-8600 or fax (612) 728-8601.

Name ____________________________
Company __________________________
Address __________________________
City, State, Zip ______________________
Telephone/FAX ____________________ Exp. Date _______________
Card # ____________________________
☐ Check enclosed ☐ Bill me ☐ Credit card (Visa, Mastercard, American Express, or Discover)

Signature _________________________
Email ______________________________

Please mail, call in or fax your registration by 4/22/2010
Pack your bags from cover

The industry quickly outgrew its rural roots and now serves hospitals, community-based practices, clinics, academic institutions, government agencies—you name it—in every state. Locum tenens providers help organizations ensure access to and continuity of care, preserve their referral networks, and maintain financial stability. And while locum tenens work is more common in some specialties—primary care, emergency medicine, hospitalists—physicians from just about every medical specialty are in demand. This includes surgical subspecialists, internal medicine subspecialists, maternal-fetal medicine specialists, behavioral health specialists, and more. Staffing Industry Analysts, Inc., pegged the industry at $1.8 billion in revenue for 2009.

This flexible lifestyle lets new physicians try out a variety of practice settings and geographic locations.

Who and why

The obvious question is, “Who works as a locum tenens, and why?” The

Locum tenens pushes Minnesota hospitalist around the world, into cultural and clinical learning

Rebecca Zadroga, MD, grew up and attended medical school in Costa Rica, then opted into an exchange program with Hennepin County Medical Center in Minneapolis, where she also subsequently completed a three-year residency in internal medicine. With dual citizenship, she traveled back and forth, comparing and contrasting the countries and their health care systems.

As she completed her training, unsure of exactly what she wanted to do and where she wanted to do it, she decided to investigate locum tenens. She was initially drawn to the idea of international locums, so she connected with a recruiter at a locum tenens company that provides both U.S. and international placements. “The rest,” she says, “is history.”

In the following three-plus years, Zadroga worked on the Navajo Indian Reservation, in a clinic serving migrant workers in Washington State, and in a small hospital on New Zealand’s North Island.

“Every place I worked was essentially a medically underserved community,” she says. “They had similarities and differences. But people are people are people. People have the same pains and medical problems everywhere you go. It was fascinating to learn how these universal problems were handled in each cultural context.” For Zadroga, locum tenens provided more than a job; it gave her the chance to develop an understanding of the impact of history and culture on a community and its health care.

On the Navajo reservation she was struck by dichotomy. “The older generation is struggling to hang on to their language, their history, their traditional healing,” she says, “while the younger generation is more interested in assimilating, finding jobs, starting new lives.” She fears this schism is fracturing the community, maybe irreparably.

In New Zealand she found very practical people, endearingly loyal to their colonial past, fond of the Queen, accepting of the limitations of socialized medicine, but also extremely grateful that their care is free. Medicine is simpler and people are self-reliant, “probably because it is still an agriculture-based society,” she says. “Even in the cities, people are still tied to the land. Everyone has a grandma on a chicken farm.”

Locum tenens a “must do”

About locum tenens, Zadroga says, “If you can afford it, it is a must do. I was extremely fortunate to graduate without any medical school debt, and to miss an opportunity like this would have been criminal.

“I did it right after residency,” she continues. “I was kind of wet behind the ears. Locum tenens got me into the learning curve quickly. I say, don’t be scared. Go outside of your comfort level. That’s when your best life lessons are learned.

“Locum tenens let me decide where and when to work. It also gave me free time, because I wanted to do other things in life besides work,” she says. In her free time she took a four-month tour around Asia, tasted wine in Germany, climbed mountains in Mongolia, rafted rivers in the tropics, and pursued further training in tropical medicine.

Zadroga began a three-year fellowship in infectious disease in Minneapolis this year and “won’t be able to go gallivanting around the world” until she finishes it, she says. When that time comes, she may combine her love of travel and culture and tackle neglected tropical diseases, “the nonsexy diseases that impact lots and lots of very poor people.”

This flexible lifestyle lets new physicians try out a variety of practice settings and geographic locations.

Who and why

The obvious question is, “Who works as a locum tenens, and why?” The

Locum tenens pushes Minnesota hospitalist around the world, into cultural and clinical learning

Rebecca Zadroga, MD, grew up and attended medical school in Costa Rica, then opted into an exchange program with Hennepin County Medical Center in Minneapolis, where she also subsequently completed a three-year residency in internal medicine. With dual citizenship, she traveled back and forth, comparing and contrasting the countries and their health care systems.

As she completed her training, unsure of exactly what she wanted to do and where she wanted to do it, she decided to investigate locum tenens. She was initially drawn to the idea of international locums, so she connected with a recruiter at a locum tenens company that provides both U.S. and international placements. “The rest,” she says, “is history.”

In the following three-plus years, Zadroga worked on the Navajo Indian Reservation, in a clinic serving migrant workers in Washington State, and in a small hospital on New Zealand’s North Island.

“Every place I worked was essentially a medically underserved community,” she says. “They had similarities and differences. But people are people are people. People have the same pains and medical problems everywhere you go. It was fascinating to learn how these universal problems were handled in each cultural context.” For Zadroga, locum tenens provided more than a job; it gave her the chance to develop an understanding of the impact of history and culture on a community and its health care.

On the Navajo reservation she was struck by dichotomy. “The older generation is struggling to hang on to their language, their history, their traditional healing,” she says, “while the younger generation is more interested in assimilating, finding jobs, starting new lives.” She fears this schism is fracturing the community, maybe irreparably.

In New Zealand she found very practical people, endearingly loyal to their colonial past, fond of the Queen, accepting of the limitations of socialized medicine, but also extremely grateful that their care is free. Medicine is simpler and people are self-reliant, “probably because it is still an agriculture-based society,” she says. “Even in the cities, people are still tied to the land. Everyone has a grandma on a chicken farm.”

Locum tenens a “must do”

About locum tenens, Zadroga says, “If you can afford it, it is a must do. I was extremely fortunate to graduate without any medical school debt, and to miss an opportunity like this would have been criminal.

“I did it right after residency,” she continues. “I was kind of wet behind the ears. Locum tenens got me into the learning curve quickly. I say, don’t be scared. Go outside of your comfort level. That’s when your best life lessons are learned.

“Locum tenens let me decide where and when to work. It also gave me free time, because I wanted to do other things in life besides work,” she says. In her free time she took a four-month tour around Asia, tasted wine in Germany, climbed mountains in Mongolia, rafted rivers in the tropics, and pursued further training in tropical medicine.

Zadroga began a three-year fellowship in infectious disease in Minneapolis this year and “won’t be able to go gallivanting around the world” until she finishes it, she says. When that time comes, she may combine her love of travel and culture and tackle neglected tropical diseases, “the nonsexy diseases that impact lots and lots of very poor people.”
Emergency medicine physician finds balance through locum tenens practice

Jay DeSilva, MD, believes locum tenens gives a physician the opportunity to find the right fit, earn fair compensation, and practice pure medicine with integrity. The board-certified emergency medicine physician has been doing just that since 2003. “I finally got the system worked out,” he says. He works 10 days per month, with four days for travel to and from assignments. “So for 15 days each month, I can be 100 percent there with my family.” It’s a welcome change from his first, more traditional practice, which included three hours of commute time each day.

DeSilva prefers assignments where he can spend more time with patients and strike a balance between fixing and preventing. “Medicine is a noble profession,” he says. “Locum tenens gives you the opportunity to take what you know, look at the challenges people are facing every day, and help children and parents discover what it takes to make their dreams a reality.”

He works in a small Minnesota hospital on a regular basis and appreciates the state and its people. “Minnesota is a pioneering state,” he says. “It could be an example for the nation. People take responsibility for staying healthy. It’s progressive and family-oriented.”

Family, balance, and adventure are important themes in DeSilva’s life. He earned his first-degree black belt in martial arts while completing his emergency medicine residency at Albert Einstein Medical Center in Philadelphia. Some of his peers counseled him to focus just on medicine, but he is convinced that doing both gave him a greater sense of balance and made him a better husband, father, and doctor. He’s now a fourth-degree black belt and a Master in a traditional martial art. In one location he covers often (a “return engagement”), he teaches martial arts to kids in the lobby of the hospital.

During his medical training, DeSilva participated with NASA in several research projects that focused on finding creative solutions to ordinary problems in medicine. After residency, he joined the Air Force Reserves and served as chief of professional services to ordinary problems in medicine. After residency, he joined the Air Force Reserves and served as chief of professional services to the PJs (pararescue jump specialists) and their tasks included global aeromedical evacuation.

Locum tenens runs deep in the DeSilva family. DeSilva and his wife, Lori, met while he was on a flight from a locum tenens assignment. Now, Lori and their 2½-year-old son Troy, travel with him whenever they choose.

Jay DeSilva takes a picture of his wife and son with him on every locum tenens assignment because when he has to make hard decisions—fighting prescription abuse in the ED, for example—he knows he is doing it for the right reason. “I believe in locum tenens,” he says. “It’s the best way a physician can keep a sense of balance and practice responsibly, while maintaining integrity. The full measure of what we have accomplished is not what we take with us, but rather what we leave behind.”

“Who” generally breaks into three categories: physicians completing training, physicians in mid-career transition, and physicians who want to slow down without losing their clinical skills or ability to practice. Here are the “whys” behind the “whos”:

Just out of residency:
Locum tenens lets new doctors work as much as they like, when the objective is paying off student loans, or scale back when they need to study for their boards. This flexible lifestyle also lets new physicians try out a variety of practice settings and geographic locations before making a permanent commitment. One young psychiatrist I talked to refers to his tenure in locum tenens as “my working fellowship.” And, he says, it pays better.

Looking for the next great job:
Changing jobs mid-career; no matter what the circumstances, is stressful. Whether a physician is relocating to be closer to family, looking for a different lifestyle, seeking professional advancement, or leaving a position that didn’t work out as planned, locum tenens is a great way to test the fit of a new situation. It’s a no-strings-attached way to get to know the location, team, and medical community. Then, if both parties think it’s a great fit, there is a good chance the locum tenens doctor will be offered a full-time position.

Semi-retirement or part-time work:
I believe that every physician who is able should use locum tenens to transition into retirement. We are a valuable resource in this nation (and in the world, as the recent tragedy in Haiti reminds us). As the physician shortage intensifies, the country will need every hour a physician is willing to work. Locum tenens gives us the ability to work on our own terms—two weeks a month, three to six months a year, 12 months overseas, long weekends. The options are limitless. Some physicians travel with their spouses. Many accept assignments near their grown children or grandchildren. Others favor places that let them pursue a passion, like medical volunteer work, plein air painting, or Cajun cooking. Still others use locum tenens assignments to try new adventures, like fly fishing in Montana or tramping in New Zealand.

(If it sounds like I’m still hooked on the cachet of locum tenens, it’s true. I still hold active licenses in Georgia, Indiana, Kentucky, Maryland, Nevada, New Jersey, New Mexico, New York, and Pennsylvania.)

One potential downside to medicine-on-the-go is being
away from home, so locum tenens work may suit some physicians better than others. However, don’t assume children are a deal-breaker. Lots of physicians travel with a spouse and very young children. And I have talked with several physicians who have relocated their school-age children for one- or two-year placements in New Zealand and Australia.

Getting started
If locum tenens interests you, I recommend contacting an experienced locum tenens placement agency. The National Association of Locum Tenens Organizations (www.nalto.org) holds its members to strict standards for ethics and business practices. Make sure any agency you work with is a member.

Here’s what you should expect:
• Carefully screened worksites that match your skills, experience, and interests
• Paid professional liability insurance
• Paid travel, housing, and local transportation
• Help with licensure, credentialing, and securing privileges
• Compensation based on your specialty and the demands of the position
• No placement fees

Also pay attention to the service you receive from the agency recruiter and/or scheduling director. You want to work with someone who listens well and respects your preferences, but isn’t afraid to present a job if it seems like a good fit for you.

Life in the fishbowl
Bear in mind that poor-quality physicians don’t make it in locum tenens. Credentials are scrutinized before every assignment, current references are checked, and post-assignment evaluations are gathered after every job. We call it “life in the fishbowl,” but frankly, wouldn’t have it any other way.

The other side of the coin
If your practice or facility is short-staffed or a member of your group anticipates needing some time off (for maternity leave or military deployment, for example) a locum tenens physician can preserve your patient base and referral networks while protecting your staff from burnout. All revenue generated by a locum tenens physician stays with the facility or practice, so the service generally pays for itself. The same rules apply—contact an agency that upholds NALTO standards and work with a customer service representative who understands the clinical demands of your practice.

It’s been a thrill to see the locum tenens industry grow and change along with the U.S. health care system. I encourage you to become part of it when—not if—it makes sense in the arc of your career and life.

Therus C. Kolff, MD, MPH, is a medical director for VISTA Staffing Solutions, one of the oldest and largest full-service locum tenens and physician placement companies in the nation, offering both U.S. and international placements.
Chronic disease from cover partnership with health care provider groups, health plans, and community organizations, is striving to improve the health of Minnesotans and contain the ever-increasing costs of health care. Through health care homes, we are working to improve care coordination and the patient experience, especially for those with chronic and complex conditions. But we are also looking beyond health care delivery and moving upstream—to prevent the chronic diseases that bring people into the health care system in the first place.

An integral component of Minnesota’s Vision is the Statewide Health Improvement Program, or SHIP. The goal of this program is to address the three leading causes of preventable illness and death: tobacco, physical inactivity, and poor nutrition. SHIP aims to reduce chronic disease, and moving upstream—to prevent the chronic diseases that bring people into the health care system in the first place.

Policy, systems, and environmental changes are sustainable and make it inherently easier for individuals to choose healthier options so they can incorporate healthy behaviors into their daily lives.

Policy interventions may be laws, resolutions, mandates, regulations, or rules. Examples are laws and regulations that restrict smoking in public buildings and organizational rules that promote healthy food choices at a worksite. Systems interventions are changes that affect all elements of an organization, institution, or system; they may include a policy or environmental change strategy. An example is a clinic adopting a referral process to connect at-risk patients with appropriate community resources.

Environmental interventions involve physical or material changes to the economic, social, or physical environment. Examples are incorporating sidewalks, walking paths, and recreation areas into community development design or a high school making healthy snacks and beverages available in all of its vending machines.

To support the program requirement that these interventions be evidence-based, grantees must choose from a newly created Menu of Interventions. Each intervention in the menu:

- Addresses at least one SHIP risk factor (tobacco, physical activity, or nutrition)
- Occurs in at least one SHIP setting (school, community, worksite, or health care)
- Is population-based (versus individual-based)
- Emphasizes prevention (versus individual treatment)
- Addresses policy, systems, or environmental change
- Is evidence-based or practice-based
- Has associated evaluation outcomes

All interventions in the menu underwent a rigorous review process conducted by MDH and multiple other parties, such as representatives from the Centers for Disease Control and Prevention (CDC), health care providers, nonprofit organizations, legal organizations, various cultural groups, University of Minnesota and Extension Services, local public health agencies, tribal governments, and other state government agencies.

Statewide reach and collaboration

The Minnesota Legislature invested $47 million in SHIP for two years (2009–2011). This amount is based on CDC’s minimum recommendation of $3.89 per person for comprehensive health prevention interventions. The vast majority of these funds are distributed through MDH to local community health boards and tribal governments throughout the state. These local governmental agencies are charged with broadly engaging their communities and resources to implement selected strategies.

In July 2009 MDH awarded funds through a competitive grant process to 40 grantees, covering all 87 counties and eight of 11 tribal governments in Minnesota. (The sidebar describes four representative grant projects.) Grantees received funds for either an assessment phase or an implementation phase. Assessment grantees are required to transition to implementation within nine months.

To date, grantees have accomplished important early work, including:

- Capacity-building to conduct policy, systems, and environmental change work
- Development of community commitment through partnerships with a wide variety of community organizations
- Assessment of community needs and assets to create policy, systems, and environmental change related to tobacco and obesity
- Selection of interventions from the menu of interventions based on results of their community assessments
- Development of action plans to implement policy, systems, and environmental change strategies in their schools, communities, worksites, and health care settings
- Completion of evaluation plans, identification of outcomes measures, and designation of key benchmarks to measure progress toward goals
Types of interventions
SHIP interventions address tobacco use and exposure, healthy eating, and active living in order to reduce the number of Minnesotans who use or are exposed to tobacco, increase physical activity, and improve nutrition.

For example, SHIP includes a focus on creating tobacco-free sites, leading to reduced exposure to secondhand smoke for individuals using these spaces. SHIP interventions also aim to connect students, employees, and patients to cessation services that help smokers stop using tobacco.

Active living allows people to integrate physical activity into their daily routines. Active schools, communities, and worksites are created by increasing opportunities for non-motorized transportation, such as walking or biking; increasing opportunities for individuals to access recreational facilities; and increasing the quality and time that children spend in physical activity in schools and in child-care settings.

Because lack of access to affordable, healthy foods is linked to obesity, diabetes, and other related health problems, SHIP interventions offer a variety of ways to improve access to nutritious foods in schools, communities, and worksites. Examples include implementing healthy lunch and snack policies in schools, increasing the number of and access to farmers markets, and providing information about the nutrition content of foods.

The importance of the health care setting
To improve the health of Minnesotans and reduce health care costs, it is critical that Minnesota’s health care systems make reducing obesity and tobacco use a top priority. Health care providers can promote the development and maintenance of healthy lifestyle behaviors by encouraging patients to maintain healthy eating habits, participate in physical activity on a regular basis, avoid the use of tobacco products, and limit exposure to secondhand smoke. Health care professionals can also advocate for change in their communities and enhance government, media, and industry efforts.

SHIP interventions in the health care setting include implementing tobacco-free grounds policies for hospitals and other health care facilities and connecting individuals with existing effective cessation services; implementing maternity care practices that encourage breastfeeding through prenatal, birth, and postpartum services; supporting implementation of the Institute for Clinical Systems Improvement (ICSI) guidelines “Prevention and Management of Obesity” and “Primary Prevention of Chronic Disease Risk Factors” for adults and children where applicable; building partnerships to facilitate active referral of patients to local resources that increase access to high-quality nutritious foods, opportunities for physical activity, and cessation of tobacco use; and implementing support strategies to motivate and aid patients in making daily decisions to improve their behaviors relating to eating, physical activity, and abstinence from tobacco use.

Investment in the future health of Minnesotans
In many ways, SHIP grantees have only just started their work, yet the results they have already achieved show tremendous promise for future success. It will take time and sustained efforts throughout our communities to achieve the reductions in tobacco use and exposure and obesity that can lessen the burden of chronic disease in Minnesota, but SHIP is on the path to reaching those goals—by making the healthy choice the easier choice for all of us.

For more information about the Statewide Health Improvement Program, a list of grantees, and a list of interventions, visit www.health.state.mn.us/health reform/ship.

Cara McNulty, MS, is manager and Rachel Cohen, MPH, is supervisor and communications coordinator of the Statewide Health Improvement Program at the Minnesota Department of Health.