Physicians Bulletin

VOL. 41
NO. 1

JANUARY/FEBRUARY **2020**

USA $1.95

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Maintaining the 'GOOD' IN MEDICINE

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A PUBLICATION OF THE

Metro Omaha Medical Society

METRO OMAHA MEDICAL SOCIETY
7906 Davenport St. | Omaha, NE 68114
(402) 393-1415 | www.omahamedical.com

Physicians Bulletin is published bi-monthly by Omaha Magazine, LTD, P.O. Box 461208, Omaha NE 68046-1208.

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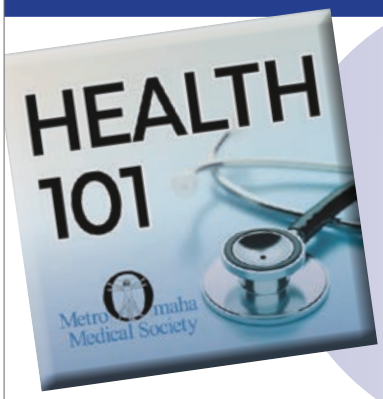

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Jan 6: Gut Health
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Jan 20: Depression
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Feb 10: Plastic Surgery

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FEB 05

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WEDNESDAY, FEBRUARY 5
7:00 A.M. - 8:30 A.M.
LOLA'S CAFE - 4952 DODGE ST.

FEB 27

TRIVIA NIGHT - EARLY CAREER PHYSICIANS

THURSDAY, FEBRUARY 27
5:30 P.M. - 7:30 P.M.
KAUFMANN ROOM IN BLACKSTONE
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MAR 05

MOMS/OBA MEDICAL LEGAL DINNER

THURSDAY, MARCH 5
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10220 REGENCY CIRCLE
5:30 P.M. RECEPTION (CASH BAR);
6:30 P.M. DINNER/PROGRAM

APR 02

POP-UP PHYSICIANS' LOUNGE (COCKTAILS)

THURSDAY, APRIL 2
5:00 P.M. - 7:00 P.M.
MARKET BASKET - 2501 S. 90TH ST.

APR 17-18

DOCBUILD - HOME BUILDING EVENT

FRIDAY, APRIL 17 & SATURDAY, APRIL 18
SEE AD ON PAGE 8.

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A CALL FOR OUR OWN NARRATIVE

AUDREY PAULMAN, M.D.
Editor
Physicians Bulletin

We had already blocked our calendars so that we could go visit our daughter and her family overseas. The full itinerary had not yet been set, but Paul and I had requested those days off, and the request was approved. It was almost as if work had come to own all of days, and we had to petition to use some of our days for travel and relaxation. And so, the days had been requested and they were now held in our own personal time bank, just for us to use.

The Smithsonian magazine arrived in the mail that same day the vacation request was submitted. It was too much of a coincidence to be ignored.

With a cover photo of the Dome of the Rock, the lead story touted a different way to see the Holy Land. The experience advertised was a "dual narrative" tour. Here is what the story promised: TWO TOUR GUIDES—ONE ISRAELI, ONE PALESTINIAN—OFFER A NEW WAY TO SEE THE HOLY LAND.

We had been to Jerusalem once before, and I was interested in repeating the experience—to again see the places I learned about in Bible stories and have seen on the evening news. And so, just like that, we had a planned itinerary for our family vacation.

With a few clicks on a website, I was in contact with the tour operator, and the day-long, dual narrative tour of Jerusalem and Bethlehem was booked. It seemed like it would be a good use of those personal days—we could visit family and spend time to learn a little about Jerusalem before returning to Omaha.

Plane tickets were booked. We were ready to go.

The day began in a tourist class hotel, with busloads of people sitting at large tables eating breakfast. The groups were identified by their religious garb and seated by their country of origin. I didn't recognize some of the countries identified, many having been established since my world history class in high school. We were the Americans in the room.

We walked the short distance to meet with the guides, who identified themselves. Lara introduced herself as a Moscow-born Jewish Israeli citizen, and Noor, a Palestinian. Over the next five hours, at every stop on the walking tour, each would explain the significance of the site in their culture. Rather than following a prescribed text, questions from the tour group were allowed and the guides provided the dual narrative responses. The discussion allowed us to look beneath the surface into the very personal and sensitive issues regarding the current reality of living in Jerusalem.

We got a different understanding of the area. Even though the area is filled with sites of historical significance, it is the people who live there that are important. The individuals have a personal narrative, and the people, collectively, have a narrative as well.

We listened and we learned.

Narratives have been used in health care as well.

A few years ago, health care reform developed a platform of putting a face with a story to show the impact of medical errors. This included important stories of individuals that suffered harm from the existing health care system, such as the story of Josie King. The process of developing and sharing a personal narrative has been used to help initiate changes to a system that can cause harm.

"In addition to the narratives of patients, and the narratives of healthcare systems, there needs to be a third narrative, the narrative of us."
— AUDREY PAULMAN, M.D.

I ask, where is the dual narrative? What if the harm the system causes is to the physician? Is that story being heard? What about the successes? Are those being shared?

We need to develop our own narrative, both as individuals, and collectively as professionals.

In this edition of the Physicians Bulletin, we have individual physician narratives and an invitation to be a member and work toward developing a collective narrative.

This includes physicians who actively participate in the change of the process of health care, whether it is through the use of innovative synchronous telehealth or the use of a scribe. There is a narrative about a physician who is active in philanthropy because of his own personal experiences with receiving. There is a mention of a MOMS event surrounding storytelling where physicians began developing telling their personal narratives.

Max Lydiatt, a fourth-year medical student, writes a strong narrative, titled "My Blood on the Floor." I recommend reading it.

And then, in this edition, the featured story is about Dr. John Peters, the incoming president of MOMS. He shares thoughts on the strengths of physicians working together.

The story of being a physician should not be written or told by others. It should be developed and told by us. In addition to the narratives of patients, and the narratives of health care systems, there needs to be a third narrative, the narrative of us.

'E PLURIBUS UNUM'— POWERFUL WORDS FOR THE MEDICAL COMMUNITY

JOHN PETERS, M.D.
President
Metro Omaha Medical Society

ONE.

The message is all around us. The power of unity.

The natural world abounds with examples. Perhaps we take these for granted. Schools of fish, flocks of birds, hives of bees, herds of various animals. Why? Defense. Security. A collective finding, developing and sharing of resources. A mutually beneficial community that helps the individuals...and the group, to achieve more together. To not only survive, but to thrive. Generally speaking, human civilization has followed suit. Families, teams, business colleagues, towns, countries, groups of countries. It works.

"As individuals with more clinical training and real-world patient experience than any other medical professionals, I would argue that what we are facing is not a choice, but rather a responsibility. A responsibility to our patients and our profession. It is time to unify, organize, adapt and execute together."

— JOHN PETERS, M.D.

Reach in your pocket and pull out a coin. You will see the inscription "e pluribus unum." From many one. Our founding fathers thought the concept to be so important, it is forged on the back of each and every coin that passes through our fingers each day. A reminder.

In the arts, musicians of various talents coalesce in orchestras and bands. Though each excels playing a different instrument as an individual, together they produce music through harmony and cooperation that is often a grande and unique expression that the soloist is unable to generate.

A painter uses colors, textures and shading that contrast and complement, to develop the overall aesthetic of the entire piece. Many colors. One painting.

Unity makes our world more functional, and more beautiful. Why does this matter?

We find ourselves, as physicians, in an era of increasing regulation, oversight, and ever-changing and seemingly unending "metrics" to purportedly improve medical care. Simultaneously, entities other than the physician and patient community, have substantial or complete control of crucial issues such as reimbursement, financing for medical training, and constructs for the provision of care. As one might expect, physician burnout and suicide have increased at an alarming rate. Early retirement and practice sales to private equity firms have been chosen by some physicians.

It is obvious. The environment and the rules in the medical arena are changing. It is very likely they will continue to change. How shall we choose to respond? As individuals with more clinical training and real-world patient experience than any other medical professionals, I would argue that what we are facing is not a choice, but rather a responsibility. A responsibility to our patients and our profession. It is time to unify, organize, adapt and execute together.

I can think of no better way to do this than active participation in the Metropolitan Omaha Medical Society, my state and national specialty societies, and the Nebraska Medical Association.

I am honored to be the president of MOMS for 2020, and an active member of the Omaha physician comm*unity*.

I urge each of you to reach out to your physician colleagues (including me), and develop, rekindle and maintain the bond we share as healers. "E pluribus unum."

We are many. We are one.

MUCH TO DO IN A SHORT LEGISLATIVE SESSION

AMY REYNOLDSON
Executive Vice President
Nebraska Medical Association

As we enter into the 2020 Legislative session, we know that it is going to be a busy one, in particular with the Health and Human Services Committee (HHS). In this short session of the biennium, legislators will be faced with complex situations facing the Department of Health and Human Services, such as the youth rehabilitation treatment facility issues and Medicaid Expansion implementation. They will also be challenged to find time to address the bill still in committee as well as new bills introduced.

The 2020 legislative session began Jan. 8 and new bills were introduced the first 10 days of session, commencing on Jan. 23. We will introduce a bill to clean up the physician delegation language to allow physicians the ability to delegate or assign tasks to unlicensed professionals, such as medical assistants. The NMA has also been engaged in the conversation on surprise billing legislation. State Sen. Morfeld introduced LB569, Out-of-Network Consumer Protection, Transparency, and Accountability Act and is circling back to amend this language. Lastly, the physician assistants recently competed their 407 technical review process and are introducing language to modernize statutes related to their profession without expanding scope of practice.

NMA has continued to monitor and work bills that are still in the HHS committee from the 2019 session. Two specific bills that impact public health are LB140 and LB378. LB140 would prohibit those under age of 18 from using indoor tanning beds. The NMA supports this bill as data indicate the increase of young people being diagnosed with malignant melanoma. LB378 would require the use of eye protection and repeal the requirement for the use of helmets while riding a motorcycle or moped for anyone over the age of 21. The NMA has had a long-standing position of opposition on the helmet repeal bill.

The NMA has also been specifically tracking two scope expansion bills still in HHS committee. LB528 was introduced by State Sen. Hilkemann and if passed it would change provisions relating to use of pharmaceutical agents and use of certain treatments and procedures by optometrists. This bill would give the Board of Optometry authority to determine optometric scope of practice in the future. It also allows optometrists to perform laser, surgery, and injections on the eye or lids without restriction. The NMA opposes this bill and will continue to educate senators about the patient safety issues of expanding the scope of practice for optometrists. The second scope expansion bill we continue to monitor is LB730. This bill was introduced by State Sen. Walz and it would change, transfer, and eliminate provisions related to APRNs. This bill would eliminate the requirement that nurse midwifes have a practice agreement with a physician. It also eliminates the separate Nurse Practitioner, Nurse Midwifery, Nurse Anesthetist, Clinical Nurse Specialist, and Practical Nurse practice acts and consolidates them into the APRN Act.

The NMA continues to track LB110, medical marijuana legislation that would allow patients to use marijuana if recommended by a physician for specific health reasons outlined in the bill. This bill had three hours of debate on the floor of the Legislature in the 2019 session. The NMA has strong concerns about the public health impact of using medical marijuana to treat health issues when the research on marijuana has been insufficient and inconclusive. The NMA would like to see the DEA reclassify cannabis to Schedule II to allow for clinical testing, including peer reviewed and evidenced-based scientific testing. For these reasons the NMA opposed the bill in its final format.

"We encourage all members to engage in the legislative conversation and can do so by following the NMA legislative updates in the weekly STAT as well as on the NMA website."
— AMY REYNOLDSON

In November 2020, there will be 25 out of the 49 seats up for election in which eight of those senators are term-limited. The NMA will participate in senator roundtable discussions with other health care organizations in the summer of 2020 to meet the candidates for those 25 seats. This is a great opportunity to learn about their focus, position on health care related items, and get a better understanding of their political interests.

We encourage all members to engage in the legislative conversation and can do so by following the NMA legislative updates in the weekly STAT as well as on the NMA website. It is also important to connect with your local state senator and education them about your profession.

ON THE MOVE

The NMA has moved their office and is now located at 1045 Lincoln Mall, Suite 200, Lincoln. We are located just three blocks to the west of the State Capitol down the beautiful Lincoln Mall. We invite you to stop by if you are in the area to check out the new space.

I WANT A WHOLE-BODY MRI: WHEN PATIENTS DEMAND UNNECESSARY TESTS

ERIC ZACHARIAS, M.D.

COPIC Department of Patient Safety and Risk Management

A 63-year-old patient was at his primary care physician's office for an annual physical exam. The patient told the physician that he wanted "a whole-body MRI to make sure I don't have any treatable cancer before it's too late." The patient noted he had recently seen cancers in several of his friends and colleagues.

The patient noted that he was in excellent physical health, felt great and didn't want to die of a curable cancer that could be caught early by an MRI. When the PCP attempted to explain that he would not order the requested imaging because there was no scientific evidence that a routine screening MRI is of any benefit to asymptomatic individuals and may actually be harmful due to false positive findings, the patient became visibly frustrated and said, "Tell that to all my friends with cancer!"

The patient also told the doctor that if he did not order the MRI, then he would report the physician to the state medical board for incompetence and find another physician "more interested in preventing disease than treating it." This was upsetting to the PCP because he thought he had an excellent relationship with the patient, believed he had been sensitive to the patient's concerns, and done a good job of explaining pre-test probability and the risks of false positives in screening imaging. The PCP had never been reported to the medical board and didn't know what the risks of that were.

This case illustrates several of the issues that may arise when patients demand unnecessary tests. A list of common questions and general advice follows:

WHAT AM I OBLIGATED TO DO FOR A PATIENT WHO DEMANDS A TEST THAT I THINK IS UNNECESSARY? A simple answer to this question is that, in any given scenario, physicians are held to the medical standard of care. This is defined as "what a reasonable and prudent physician with the same or similar training in similar circumstances would be expected to do." As experienced physicians may know, each situation can have myriad complicating factors so that when there is a judgment call regarding a cognitive medical decision, there actually is a "range of acceptable practices." However, in a situation where a patient demands an unnecessary test, the physician is held to the standard of care.

WHAT IF THE PATIENT IS PERSISTENTLY DEMANDING AND WILL NOT ACCEPT MY REFUSAL TO ORDER A REQUESTED TEST? Although it is next to impossible to reduce the complexities of how to handle such an encounter to a single piece of advice or a simple algorithm, a physician should understand that, foremost, he or she is an advocate for the best care for patients. Sometimes, the best care is not necessarily what the patient is demanding. It is important to understand the patient's underlying reasoning for wanting the study in the first place since addressing this may put the patient at ease. For instance, a discussion in the above case where you acknowledge that seeing three closely occurring cases of cancer in friends would be unsettling and prompt most people to ask if they should be doing more to screen themselves. If, the patient persists despite reasonable efforts to educate a patient as to why you decline to order a requested test, then it may be reasonable to refer the patient to another physician for a second opinion.

WHAT IF, DESPITE MY BEST EFFORTS TO CONVINCE A PATIENT THAT HE OR SHE DOES NOT NEED A TEST, I GIVE IN AND ORDER A TEST THAT I BELIEVE IS UNNECESSARY? If it is not obviously harmful and could reasonably be justified that in a particular scenario it is within the "range of acceptable medical practices" to order a particular test, then that might be considered within the standard of care. In such a case, it would be useful to outline your thought process as to why you are ordering the test despite believing it is unnecessary such as "…although I discussed the risks with Mr. Jones of ordering an MRI, including incidental and benign findings that might lead to more and risky testing and that the best science tells us that the test is not valuable and may be harmful, I think he has significant and ongoing anxiety about not being tested which is having adverse effects on his health, and in this case, it is reasonable to order the MRI since he clearly understands why I recommend against it."

An informed consent discussion with a patient where you outline why the test is being done, the potential risks to the patient, your reasons for advising against it, and your reasons for ordering the test anyway might be helpful to have in the patient's chart in the event of adverse downstream events.

DO ANY MEDICAL ORGANIZATIONS HAVE STATEMENTS REGARDING UNNECESSARY TESTS? The AMA's Code of Medical Ethics states that "Physicians should not recommend, provide, or charge for unnecessary medical services."

MY BLOOD ON THE FLOOR

MAX LYDIATT
Fourth-Year Medical Student
University of Nebraska Medical Center

Each time I visit the Red Cross, I surrender two units of packed red blood cells and am met with the assurance that with each donation, lives are saved. The cynic in me had pictured a freezer-burned bag of my cells tossed in a biohazard garbage, but despite my pessimism, or perhaps directly because of it, the Red Cross accepts each unit with much fanfare. T-shirts, gift cards and trinkets are presented as rewards, but faced with a critical shortage, they seem to have focused in on the notion of confronting the cynics like me with the reality of the need.

In late October, as a part of this initiative, the Red Cross sent a notification via email of the arrival of my blood at the same hospital where the rest of my cells were recently employed as a medical student on trauma surgery. At first I thought little of it—I had donated with the hopes that it would be used, and I told myself that I would treat it with the same indifference that I would give to any other medication—but on rounds that day when one of my patient's CBC revealed an asymptomatic anemia, a unit of blood was to be ordered and I suddenly felt uncomfortable.

The moment passed and the blood was ordered, but as the hours and days wore on, I viewed each infusion with an increasingly profound significance. With each unit I felt a sudden ownership that was thrust upon me. A degree of responsibility that I seldom felt as a medical student. That was my blood that hung at the bedpost of a hemophiliac, my blood that was slammed through a rapid transfuser in the heat of a trauma activation, and my blood on the floor as I surveyed the wreckage of a cold body.

Over the coming days, I acutely felt the haunting dread that followed each decision I recommended. How would I feel if one of these patients had an adverse reaction to my blood—to the piece of myself that I gave only in good faith. I had tacitly relinquished the control of the blood I donated, but when it came to the final act, I was unsure of the implications. This was far from my norm where I would put in my time and blithely fulfil my duties. In the space of an infusion, I would cede a piece of myself and gain a tangible stake in the fate of another that would transcend duty hours and receive no tangible recompence.

To be responsible for their fate in ways more direct than any I had yet experienced tormented me at first, but in the eye of this storm I realized that it was not a sensation that was totally foreign to me. This was the same sensation I felt when I woke up in the middle of the night worrying about how a patient was faring post-operatively, or returned to a bedside long after my shift had ended. As I grew as a student-doctor I saw past the tangible part of myself I had given, and began to see the ever more substantial stains of blood that invisibly covered the hearts of so many in that hospital.

"I see clearly now how continuously tapping this reservoir can leave one immobilized by compassion fatigue, but I also begin to appreciate the true nobility of building a body of work that exists solely of the pieces that you give of yourself."

— MAX LYDIATT

I looked around at the physicians I was with and finally realized that my pain was also their pain. I saw for the first time the reality of their continuous sacrifice. I saw in that moment, the emotional scars they bore from the pieces they had given of themselves. Some were as old as their medical school training, and many more were fresher still. Since that experience, not a day has gone by where I don't try to recapture the essence of that feeling. For each patient I try to heal, there is a cost to be borne, but with that comes an incomparable connection. I see clearly now how continuously tapping this reservoir can leave one immobilized by compassion fatigue, but I also begin to appreciate the true nobility of building a body of work that exists solely of the pieces that you give of yourself. There is meaning in this pain, and with the appreciation of connection my blood brought me, I have begun to believe that the tragic beauty of medicine is measured not in the volume of care that we give, but the pain we feel for each drop of blood that we leave on the floor.

TEN CONSIDERATIONS WHEN SELLING YOUR PRIVATE MEDICAL PRACTICE

MICHAEL C. PALLESEN
Cline Williams Wright Johnson & Oldfather

The decision to sell a medical practice should not be taken lightly. This article addresses in a "Top 10 List" some of the basic considerations that should be taken into account when selling a medical practice.

1. RETAIN AN ATTORNEY: Engaging legal counsel experienced in physician practice sales transactions early in the process may seem rather obvious. However, when many transactions of this type involve two anxious parties who have had discussions prior to consulting attorneys until it's time to "paper the deal." In this case one (or both) of the parties may feel that a binding agreement was reached and thus hard to alter after the lawyer(s) get involved.

2. FIND A BUYER: Once a physician has made the decision to sell his or her practice, the physician is faced with the challenge of locating a buyer. In order to effect a smooth transition, the selling physician should locate a buyer that shares the selling physician's skills, specialties and philosophies, such that the buyer will be able to retain as many of the selling physician's patients as possible.

3. ENTER INTO A CONFIDENTIALITY AGREEMENT AND LETTER OF INTENT: The desire to discuss a possible transaction is initially articulated in a confidentiality agreement. The letter of intent, while non-binding as to material terms of the transaction, generally sets the parameters of the negotiations and in a sense commits the parties mentally to the agreement. After signing the letter of intent, the buyer will conduct a "due diligence" investigation to confirm that the practice is worth the consideration being paid and does not carry unknown liabilities.

4. STRUCTURE OF THE SALE TRANSACTION: The sale/purchase transaction itself may be structured as either an asset or stock purchase (or in the case of a limited liability company the purchase of the membership interests). In an asset purchase transaction, the buyer buys only the practice's assets and does not inherit any liabilities unless specifically agreed. In a stock purchase agreement the buyer acquires both assets and liabilities. The more typical arrangement the context of a physician practice sale transaction is an asset purchase.

5. DETERMINE THE SALE PRICE: The purchase price agreed upon by the parties should account for both the practice's tangible and intangible assets, in order to reflect the fair market value of the practice. It is important to note that under federal law, valuation of the practice must not include the value of existing or future referrals. However, payment for goodwill, which is based on the practice's reputation, location, and profitability, is appropriate, subject to certain restrictions.

6. REPRESENTATIONS AND WARRANTIES: Beyond the purchase price, other terms in a typical transaction include representations and warranties. The seller will represent as to ownership of assets, compliance of the practice with legal and regulatory requirements, and any liabilities that could affect the value of the assets or practice being sold. Likewise the buyer will represent his or her ability to consummate the transaction, that he/she is a licensed physician in good standing and is not subject to pending or threatened disciplinary proceedings.

7. NONCOMPETITION CLAUSE: A covenant not to compete is another likely provision in the purchase agreement as the buyer will want to ensure that the selling physician cannot become quickly dissatisfied with his or her decision and significantly reduce the value of the purchased practice by establishing a competing practice shortly following the sale.

8. NOTICE TO PATIENTS: A selling physician must also provide adequate notice of the impending sale to the practice's patients to ensure continuity of medical care. Careful planning is important here because what constitutes adequate notice varies with each patient's individual treatment and failure to provide such notice could result in exposure for professional negligence.

9. MALPRACTICE TAIL COVERAGE: If the selling physician is retiring upon completion of the transaction, the physician may wish to cancel his or her malpractice insurance, but should first take a close look at what type of policy he or she has in order to ensure that he or she is protected against future claims, despite cancellation of the policy (e.g., a so-called "tail").

10. TRANSFERABILITY OF THIRD PARTY CONTRACTS: Agreements that are deemed to be personal to the selling physician terminate upon the transfer of the practice, while other agreements are assumable by the buying physician or group and thus, add value to the transaction. Leases for office space and equipment are examples of agreements that may not be immediately terminable or that the purchaser may want to assume as part of the transaction.

Maintaining the **‘GOOD’ IN MEDICINE**

John Peters, M.D., has a direct response to why membership in MOMS is critical. "To help maintain what is good about medicine and try to change what is not."

Then, he goes a step further when discussing what needs to change and how his agenda for his year as president of the Metro Omaha Medical Society will address that shortcoming: "The main thing I want to do is help unify the physician community. I see separation and fracturing. A loss of interaction is part of it."

Back in the day, Dr. Peters said, physicians routinely saw one another during time spent at local hospitals. They spent some time in the hospital physician lounge, doing rounds—talking about their cases and their personal lives. These days, primary care physicians spend less time in hospitals and specialists often perform surgery at ambulatory surgical centers. "I have colleagues whom I haven't seen in several years. I don't go to the meetings they do, and they don't go to the meetings I attend."

As an ophthalmologist in a solo practice, Dr. Peters said, one can become further isolated. "It takes away some of the joy of practicing medicine."

The solution, he said, isn't simple. "Personally, I think it's important to be in someone's presence" meaning creating spaces and places where physicians can gather. Emphasis on hosting social events for the physician community is helpful, and much of this is already in progress.

His other priority for his time as MOMS' president is to create greater awareness about the value the medical society brings to the physician community, specifically, and to the greater community, in general. He would like MOMS to accentuate its advocacy for quality patient care and public health. He knows both priorities aren't easy fixes.

"The main thing I want to do is help unify the physician community. I see separation and fracturing. A loss of interaction is part of it."

— JOHN PETERS, M.D.

"That's what I would like to promote."

Dr. Peters, a Lincoln native, said he didn't think long before joining MOMS as a new medical resident. Education and advocacy are key, he said. "You need an organization to have a voice—to help your specialty, your practice, and therefore, your patients."

He increased his involvement in MOMS when asked to serve as MOMS' delegate to the Nebraska Medical Association. He said he especially enjoys attending the sessions, hosted by MOMS, with state lawmakers and legislative candidates.

Prior to his increased involvement in MOMS, Dr. Peters had become active in the Nebraska Academy of Eye Physicians and Surgeons, serving on its Executive Committee since 1996, and as its president in 2002. Involvement at the state level led to involvement in the American Academy of Ophthalmology, initially serving as a Councilor for six years, then as a regional representative in charge of advocacy and organization in a four-state area. Dr. Peters now serves as the Associate Secretary for State Affairs for the academy.

CONT. PAGE 20

The **Peters** File

Hometown
Lincoln, Nebraska

Undergraduate Degree
Creighton University in biology

Medical Degree
Creighton University Medical Center

Residency
University of Nebraska Medical Center in ophthalmology

Specialty
Ophthalmology

Titles
Assistant Professor, Hospitalist

Clinic
Omaha Center for Sight

Hobbies
Physical fitness, cycling, hiking, landscaping and reading

Why He Joined MOMS
"I joined MOMS for the purpose of being in an organization that facilitates advocacy, education and cooperation."

FROM PAGE 19

While beginning his tenure as Secretary for State Affairs, MOMS leadership asked him to serve as 2020 president. He hesitated. "I needed to see if I could do both—and run my solo practice—and keep everything rolling along."

After checking previous commitments for the upcoming year, he decided he could make it work. Supporting his profession is important. He considers it part of being a physician.

What initiated his entry into medicine was, of all things, time spent working in the basement file room at Lincoln General Hospital. His mother worked in the Radiology Department and got her teenage son a job reading radiology reports. In a large storage room, he removed each collection of X-rays from the file bins, then read every report. "If it didn't meet the criteria, we could destroy the files and make more room for storage. I learned a lot of medical terminology."

He later worked as an orderly and in the department's dark room. He watched physicians in action—"their level of skill and knowledge intrigued me."

His parents would ask him if he liked the work and wanted to pursue medicine as a career. He did. Undergraduate degree in biology. A year of graduate school in genetics. Medical degree. Residency and fellowship. As far as teaching and conducting research—"I knew I didn't want to go down those two paths full-time. I wanted to go into the clinical side of life sciences. I appreciate the combination of art and science—and medicine has both."

He credits opportune timing for his introduction to ophthalmology and the late Ira Priluck, M.D., who would serve as a mentor. Dr. Peters was working through his surgical specialty rotations, crossing specialties off his list when they did not interest him. One day, the program coordinators at Creighton couldn't find any med student willing to attend an ophthalmology surgical case. Dr. Peters volunteered.

His task that day was to watch as Dr. Priluck performed surgery. He arrived and introduced himself as the student assigned to the case is expected to do. Dr. Priluck's response: "Great. My scrub tech is sick today. Scrub in. You're going to assist me."

"I knew I didn't want to go down those two paths full-time. I wanted to go into the clinical side of life sciences. I appreciate the combination of art and science—and medicine has both."

— JOHN PETERS, M.D.

"I told him I had never done this before. He said 'no problem.'"

Dr. Priluck took a sterile magic marker and identified each instrument on the Mayo stand cover. "When I ask for the instrument, hand it to me. You'll sit next to me and look through the microscope."

Dr. Peters said he was hooked. He realized ophthalmology was a demanding and detail-oriented surgical specialty that could have a big impact on patients' lives.

During his career, he worked at Creighton for several years, and then went into solo practice for 13 years. He then joined a group practice, but nearly five years later decided to re-start his own office. His practice, Omaha Center for Sight, is situated near 88th Street and West Center Road.

When he's not seeing patients or in surgery, Dr. Peters often can be found exercising. He wakes each morning at 5:00, is at the gym by 5:30 and spends an hour or so working out. He also enjoys everything outdoors—cycling, hiking and camping.

He also loves to landscape. He smiles and says "I have a number of projects on my list." Yet another enjoyable combination, he will tell you, of art and science.

SCRIBES: LESSENING THE DOCUMENTATION BURDEN FOR PHYSICIANS

Dr. Meera Dewan began using a medical scribe, who joins her in the examination room with her patients, when she brought her practice to Think.

"I was excited," she said. "I had heard it made such a positive impact on patient care." She estimates that using a scribe saves her at least two hours a day, which allows her to spend more time with patients and less time completing her electronic health records.

Medical scribes, also called documentation assistants, are professionals who transcribe information during clinical visits in real time into electronic health records under physician supervision. Scribing, or "team documentation," frees physicians from note documentation and entering orders or referrals, wrote Andis Robeznieks, senior news writer for the American Medical Association.

The use of scribes results in lower physician documentation burden and improved efficiency, workflow and patient-physician interaction, according to a study conducted by researchers from the Kaiser Permanente integrated health care organization. The study, "Association of Medical Scribes in Primary Care With Physician Workflow and Patient Experience," was published in JAMA Internal Medicine.

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Meera Dewan, M.D. (right) is assisted by a scribe during a patient visit.

The **Schooff** File

Hometown
San Francisco

Undergraduate Degree
Brigham Young University in Provo, Utah, in microbiology

Medical Degree
Uniformed Services University of the Health Sciences in Bethesda, Maryland

Residency
Fort Bragg, North Carolina, in family medicine

Military Service
Six years in the U.S. Army with rank of captain

Specialty
Family medicine

Location
CHI Health Clinic in LaVista

Hobbies
Community and church service

Family
Wife, Cathy Schooff; four grown children, Matthew Schooff, Stephanie Gubler, Brian Schooff and Jenna Larsen

Why He Joined MOMS
"To connect with and help support medicine in Omaha."

Some physicians utilize "Angel Scribes" that listen from another eoom.

FROM PAGE 23

The researchers studied the impact scribes had on 18 primary care physicians in the Kaiser system for over a year. They concluded that the scribes led to significant improvements in productivity and job satisfaction.

Michael Schooff, M.D., estimates he saves two to three hours a day by using a medical scribe, which has helped him regain balance in his life.

"I was getting burned out," he said. "I would spend all day in clinic, then come home and spend my evenings charting those visits. I was in a bad place."

No more. "With that time savings, it gave me time and then energy to do other things. I started having more balance in my life," Dr. Schooff said.

With more time for exercise, Dr. Schooff lost 100 pounds. "I largely attribute Augmedix with saving my medical career—and my life."

While Think Whole Person Healthcare uses its own team of medical scribes (some who are stationed in the examination room, while others—called "angel scribes"—listen in while stationed elsewhere in the Think building), Dr. Schooff uses Augmedix at his CHI Health Clinic in La Vista. Augmedix, founded in 2012, provides its customers with a device—either a Google Glass or smartphone—to support its real-time service.

Dr. Schooff said his clinic manager at CHI asked him about four years if he was willing to try Augmedix. Dr. Schooff said he was skeptical, and tempted to decline, because he had high expectations for how he wanted his medical records to be written.

"A little voice told me that if I don't try it, I lose all my privileges to complain. I asked my manager how long I would have to try it? 'One day.'"

— MICHAEL SCHOOFF, M.D.

"A little voice told me that if I don't try it, I lose all my privileges to complain," he said. "I asked my manager how long I would have to try it? 'One day.'"

So he did. The first day was a struggle, he said, but left him with hope that using the service could positively impact his life. He now wears the Google Glass, which incorporate his eye prescription, is fitted with a hearing piece and comes in two colors. (The other, more recent available option, uses a device similar to a cell phone in size that is docked and stationed so the scribe can see the patient and hear the conversation.)

Patients must agree each time they are treated to allow Dr. Schooff to use the scribe service. He noted that some have declined, typically when they seek to discuss a matter they consider private or embarrassing. Their conversations are not recorded—so the scribe, on occasion, asks Dr. Schooff to repeat himself or clarify what he said. He reviews the record of the patient visits and it becomes a legal document when he approves it.

Dr. Dewan estimates that using a scribe saves her at least two hours a day, which allows her to spend more time with patients and less time completing her electronic health records.

"Privacy can be a concern at times" Dr. Dewan said, "and the other issue is accuracy of the transcription." She reviews the record carefully each time she signs off the document.

Dr. Dewan also noted that she calls her scribe by her first name when she enters the examination room. She stated that the scribes at Think often are pre-health professionals who are young, highly motivated and eager to learn.

The **Dewan** File

Hometown
Nagpur, India

Undergraduate Degree
Bachelor of Science at Government Medical College in Nagpur, India

Medical Degree
Nagpur Government Medical College, India

Residency
Creighton University Medical Center in family medicine

Specialty
Family medicine, with interest in sleep disorders and Healthy living

Location
Think Whole Person Healthcare

Hobbies
Travel and family

Family
Husband, Naresh Dewan, M.D., a daughter, Tina Dewan-Mahajan, M.D.; and a son, Vinay Dewan, M.D.

Why She Joined MOMS
"I think I found my voice with MOMS."

FEATURE

THE LINDERS' APPROACH

TO PHILANTHROPY AND ANGEL INVESTING

CONT. PAGE 28

"If you're able to attend school—or know someone who is able to attend—because of the generosity of others, you quickly realize the importance of giving. It can change a life."

— JAMES LINDER, M.D.

A handwritten, personalized thank-you note goes a long way with Dr. James and Karen Linder.

"We appreciate the fact that students who received our support (in the form of a scholarship or research support) have taken the time to write a personal letter talking about their goals—and how the support has helped them in their lives," James Linder, M.D., said.

The Linders—he's CEO of Nebraska Medicine, she's CEO of Tethon 3D (a company that provides materials and hardware for additive manufacturing)—have made philanthropy part of their lives. They also, as angel investors, provide financial support to start-up companies seeking capital. The Linders first talked about their motivation as philanthropists and then as angel investors, and offered advice for those looking to get involved in either—or both.

For Karen Linder, charity—which evolved to philanthropy—has been a part of her life since she was a child.

"I don't recall a point when in life where philanthropy became an issue because before that we called it 'charity' and charity was part of my family's culture." Attending worship services, she said, always meant putting something in the collection basket. "You gave no matter what your capacity."

For her husband, philanthropy became engrained in his life a bit later. Yes, he witnessed his parents giving to their church—but didn't understand the impact their giving made. His introduction began when he experienced firsthand the impact scholarships have on students without the means to cover the cost of their schooling. "If you're able to attend school—or know someone who is able to attend—because of the generosity of others, you quickly realize the importance of giving. It can change a life."

"We appreciate the fact that students who received our support (in the form of a scholarship or research support) have taken the time to write a personal letter talking about their goals—and how the support has helped them in their lives."

— JAMES LINDER, M.D.

The Linders offered their definition of charity and philanthropy: the former meant giving in multiple forms, including time and service. "Helping people." Philanthropy generally connotes giving financially.

The Linders each received financial support to attend college—she at Nebraska Wesleyan; he at Iowa State and then UNMC. "We benefitted from the generosity of others. We want to extend that to the next generation," Karen Linder said.

Over time, the Linders have seen their giving directed to what they describe as three buckets: the arts, education and entrepreneurship. They direct much of their giving to these areas, especially their alma maters, but not entirely.

Their ongoing support of Film Streams in Omaha led to the creation of the 25-seat Linder Microcinema, which features more experimental and challenging art films and serves as the home for Film Streams Courses. Patrons often seek out the Linders to thank them for funding the Microcinema.

"We both love movies," Karen Linder said. "That's a personal interest of ours."

As nonprofits become more sophisticated in their fundraising, philanthropists find they no longer can remain anonymous in their giving. This means the Linders receive more requests for support than they can fulfill. The growing number of requests, they said, means they must decline requests.

They have yet to establish a threshold for their annual giving, but realize they probably should. "If we have an unexpected financial return from an investment we will typically earmark one-third for philanthropy, one-third for re-investment and one-third for other purposes" said Dr. Linder.

The Linders introduced their children to philanthropy by establishing donor-directed accounts for each, as a test of sorts. They allowed their children to decide where to direct their giving, and hope they eventually will add to their funds.

They asked their children to "find where your interests are get a feel for how you feel about getting involved in this activity," Dr. Linder said. "As you can imagine, it's different from child to child. They're getting a taste for it while they're younger."

Karen Linder added: "The goal is that they earn their living throughout their lives so they can do this on their own."

The discussion with the Linders then turned to angel investing, which they do through Linseed Capital LLC, a company they formed over 10 years ago. Investing in companies typically comes at three levels, seed, angel and venture.

They described angel investing as supporting companies valued at between $1.5 million and $5 million that are looking to raise between $250,000 and $1.5 million. They choose this category because they want to work with already established businesses—which may not yet be producing revenue—yet have some type of value or intellectual property associated with it.

"We like the good these companies are doing and the people involved—but we don't necessarily expect a return on our investment."

— KAREN LINDER

"It means the company has gone beyond the stage of just being a good idea," Karen Linder said.

Before investing, they do their homework. Who does the research may be determined by who has the most time or passion for the company. They look at such things as the company's management team and the skills its members have, market size, competition and what advantage this company may have over that competition. "We ask what problem are they solving. Just because you can do something, doesn't mean people want it. You have to have a problem to solve," Karen Linder said.

In the end, both must agree to support a project.

Their goal in their angel investments is a return on their investment. "We're excited about the ones that achieve a successful 'exit'— which typically means being acquired by a larger company. The goal is to have them return more than the initial investment."

In angel investing, Dr. Linder said, "the expectation is that one in 10 will be a home run, while two or three will be a modest return. Some will become an ongoing businesses, some will break even and others go out of business." The Linders joked that some investments are "venture philanthropy"—meaning they invest in a company without high business expectations. "We like the good these companies are doing and the people involved—but we don't necessarily expect a return on our investment," Karen Linder said.

"The home runs and those with modest returns make up the difference of the others," Karen Linder said.

The Linders were the first investors in Flywheel, which was a home run for the community. (Flywheel's specialty is helping freelance and smaller agencies expand their business on WordPress. WordPress is a free, open-source content management system often associated with blogging but also involves other web content.)

"The founders of the company and employees have gone on to do their own investing and start other companies. Flywheel's three co-founders are now angel investors," Dr. Linder said.

The Linders said businesses sometimes approach them for angel investments individually or through Nebraska Angels, a network of 60 active, local *angel investors*.

Either way, the Linders said, they derive satisfaction that extends beyond the hope for a positive return on their investments. "We live vicariously through the younger people we invest in," Dr. Linder said.

The Linders said philanthropy and angel investing are connected. "We believe you can impact the community by investing in young companies—which is equal to or more impactful than philanthropy."

Then, the Linders extended a challenge and an invitation to the medical community.

"I encourage all physicians—once you've cleared your medical school debt—to experience the enjoyment of philanthropy—making something happen that otherwise would not happen," Dr. Linder said.

Then, if angel investing sounds interesting, attend a Nebraska Angel meeting—"as our guests."

The **Linder** File

Hometown
Omaha

Undergraduate Degree
Iowa State University in biochemistry and microbiology

Medical Degree
University of Nebraska Medical Center

Residency
Duke University and UNMC in pathology

Specialty
Pathology

Title
Chief Executive Officer

Institution
Nebraska Medicine

Hobbies
Playing golf with his wife

Family
Wife, Karen; five children

Why He Joined MOMS
"My involvement in Nebraska Medicine and UNMC leadership made participating in MOMS essential."

THEIR PERSPECTIVE ON TELEMEDICINE

When Ralph Hauke, M.D., lists the primary advantages he sees provided by telemedicine, one is a matter of convenience and the other, economics.

Convenience means his cancer patients in rural Nebraska don't have to travel to Omaha for their chemotherapy treatments. Elderly patients don't have to worry about securing transportation. Patients with youngsters don't have to worry about finding babysitters, and farmers may not have to miss an entire day working their crops because of longer drive times to and from their treatment sites.

Economics refers to access and rural hospitals that may be struggling financially. Local hospitals provide the care with consultation from specialists in Omaha, such as Dr. Hauke. "Hospitals in rural areas are struggling to remain open. This is something we can offer them."

Dr. Hauke and Deanna Larson, M.D., a hospitalist with CHI Health Mercy Council Bluffs, discussed how telemedicine impacts the way they practice medicine, the safeguards in place, and its ramifications for billing.

Telemedicine allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications technology. *Telemedicine* allows patients in remote locations to access medical expertise quickly, efficiently and without travel.

Modern telemedicine began in the early 1900s in the Netherlands with the transmission of heart rhythms over the telephone, according to a 2018 article in the Cleveland Clinic Journal of Medicine, which was followed by transmissions to radio consultation centers in Europe in the 1920s. In the 1940s, radiographic images were transmitted by telephone between cities in Pennsylvania.

"The revenue for the chemotherapy stays with the local hospital. That's OK. It's about helping patients."

— RALPH HAUKE, M.D.

Today, telemedicine is used in a variety of specialties including radiology, neurology, and pathology. There are two types of telemedicine programs:

Synchronous programs occur in real time and are a live two-way interaction between the patient and health care provider. This includes virtual appointments that are conducted using the patient's smartphone, tablet, or computer with a camera. When using a smartphone or tablet, patients must first download an app that connects them with a provider.

Asynchronous programs are not live and involve the transfer of images, videos and other clinical information that a health care provider views and responds to at a later time.

Drs. Hauke and Larson provide synchronous telemedicine: Dr. Hauke to his cancer patients throughout Nebraska, but especially at hospitals in McCook and Columbus. Dr. Larson conducts virtual visits in hospitals in such communities at Plainview, Schuyler and Kearney, in Nebraska, and Corning and Missouri Valley in Iowa.

"We can see patients in underserved areas that often times don't have access to a hospitalist," Dr. Larson said. In such cases, she said, a patient is seen in the emergency room, and the attending ER physician thinks he or she may need to be admitted. "We coordinate a time with the patient's nurse to do the medical history and physical through the virtual computer."

The attending nurse assists with the examination. The nurse, for example, uses an oscultatory device and places it on the patient's chest so Dr. Larson can listen.

CONT. PAGE 32

The **Hauke** File

Hometown
Colón, Panama

Medical Degree
University of Panama Medical School

Residency
University of Nebraska Medical Center in internal medicine

Fellowship
UNMC in medical oncology

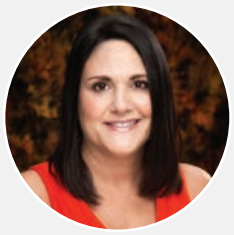
Specialty
Oncology

Institution
Nebraska Cancer Specialists

Hobbies
Collecting stamps, playing chess and watching soccer

Family
Wife, Yasmin Hauke, M.D.; a son, Ralph Hauke III

Why He Joined MOMS
"It's a community, and I wanted to join forces to preserve the practice of medicine."



The **Larson** File

Hometown
Tekamah, Nebraska

Undergraduate Degree
University of Nebraska-Lincoln in psychology

Medical Degree
University of Nebraska Medical Center

Residency
UNMC in internal medicine

Position
Hospitalist

Location
CHI Health Mercy Council Bluffs

Family
A daughter, Morgan

Why She Joined MOMS
"I like that MOMS is able to help people and do things that are not based solely on an institution. MOMS is independent. I feel MOMS can be objective. I also want to give back to the community I've worked in my entire life."

"We can see patients in underserved areas that often times don't have access to a hospitalist. We coordinate a time with the patient's nurse to do the medical history and physical through the virtual computer."

— DEANNA LARSON, M.D.

FROM PAGE 31

"Technology has come a long way and will only continue to get better," she said.

The patient-physician relationship was among the concerns cited in a 2014 article in the American Medical Association Journal of Ethics: "We are taught as physicians about the importance of the patient-doctor relationship as a basis for fostering mutual trust and empathy."

Dr. Hauke, who first practiced telemedicine during his time with the Veterans Administration, said he requires his patients to periodically come to Omaha—"for a face-to-face"—for restaging studies. During treatments, he said, he sends orders earlier so the local hospital can order the needed drugs. Local care providers wait to prepare the drug treatments until the day of the patient visit. "Everything is set up and ready for the patient. It works pretty smoothly."

Neither listed patient nor physician security as a concern. Both go through a two-part sign-in process before they treat a patient through telemedicine. "It's safer than your average website," Dr. Larson said.

Dr. Larson said billing insurance for telemedicine, provided it is administered for patients in underserved areas, follows Medicare's lead. "The key to billing is having someone understand the rules and guidelines," she said. "They are very complicated and they change every year."

An institution may reimburse a physician for consultation services outside of what is covered by insurance for many reasons. Sometimes it is not efficient for a specialist to spend their time traveling to a hospital within city limits to only see one or two patients. This care would not be covered under traditional Insurance billing because it is not in an underserved area but it is still beneficial to an organization as a whole to be able to offer comprehensive services to provide the care, Dr. Larson said.

Dr. Hauke said telemedicine is time-driven when it comes to billing and he is careful to document the time he spends treating these patients. He realizes that, as a private practice oncologist, he's losing money when providing consultation via telemedicine. "The revenue for the chemotherapy stays with the local hospital. That's OK. It's about helping patients."

While telemedicine through technology can cross state lines, Dr. Hauke said, licensing has yet to make the transition. He's heard about conversations for creating reciprocity between bordering states, but still waits for those discussions to turn into policy and guidelines. He speculates that Nebraska's limit on malpractice claims may be a stumbling block for other states without the limits.

He also described a situation where telemedicine may create a professional conundrum: A large nationwide corporation partners with a health care institution to provide oncology consultation via telemedicine for its employees. An employee then seeks care from a local hospital and its staff.

"What if you find yourself with a patient who is simply following the instructions from someone in Boston? The patient sees him and tells you this is what he says we should do."

"What if I disagree with the other physician's recommendations?"

"The insertion of non-local medical care through telemedicine, while with great potential benefit for patients, could also create disruptions in the local flow of care. These issues will need to be worked out as they become appreciated."

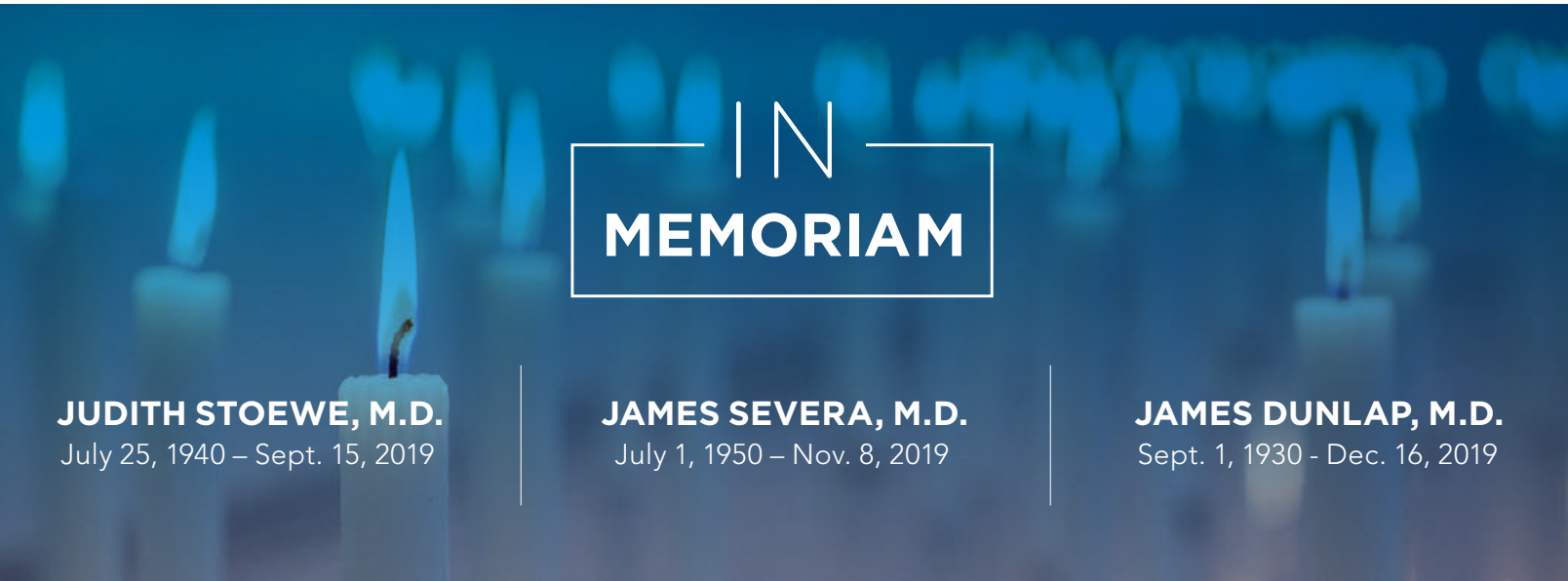
NEW MEMBERS

Nicholas Basalay, M.D.
Psychiatry
Boys Town Residential Treatment Center

Sean Figy, M.D.
Plastic Surgery
UNMC/Nebraska Medical Center

Jordan Holmes, M.D.
Gastroenterology
Midwest Gastrointestinal Associates, P.C.

Andrew Troia, M.D.
Pediatric Ophthalmology
Pediatric Ophthalmology Associates, P.C.



IN MEMORIAM

JUDITH STOEWE, M.D.
July 25, 1940 – Sept. 15, 2019

JAMES SEVERA, M.D.
July 1, 1950 – Nov. 8, 2019

JAMES DUNLAP, M.D.
Sept. 1, 1930 - Dec. 16, 2019

PHYSICIAN STORYTELLING WORKSHOP AND PERFORMANCE

The Metro Omaha Medical Society hosted a storytelling workshop and performance event for physicians at Hardy Coffee Company in Benson. Modeled after the popular 'story slam' events, attendees were encouraged to come with a short 5 to 8 minute story to share, based on their own experiences. Before the performances, Jen Castello with Nebraska Writers Collective led a brief storytelling workshop. She then performed a story of her own.

1. Jen Castello reviews a basic outline of writing and telling a story.
2. Dr. Richard Lund shares his story.

This event was sponsored by the Metro Omaha Medical Society Foundation and the COPIC Foundation.

PEDIATRIC WEIGHT MANAGEMENT CLINIC SEEKS TO SERVE A COMMUNITY NEED

Boys Town National Research Hospital is responding to a critical community health care service need with the opening of its Pediatric Weight Management Clinic.

According to the 2018 Community Health Needs Assessment, an Omaha-area health survey, nearly 30% of children in our community have excess body weight, making pediatric obesity a top concern of physicians and parents.

"Diabetes, elevated cholesterol and liver conditions at a young age can lead to serious life-long complications for a developing child," said Kelly McCarthy, M.D., Boys Town pediatrician and clinic director. "The clinic will bring together not only the medical aspects, but will also focus on the individual social and emotional needs of every child and family to help guide impactful change."

The Pediatric Weight Management Clinic is designed to meet children and families where they are on their health journey, focusing on four key areas:

- Medical management addressing and treating medical conditions due to weight.
- Nutrition knowledge through counseling and meal planning to teach healthy eating.
- Activity and exercise training in a variety of settings to encourage participation.
- Behavioral and mental health care to identify and replace unhealthy habits.

Patients and families will work directly with a pediatrician, child psychologist, dietician and physical therapist to create a unique plan for their needs. The multidisciplinary team will meet with families monthly to coordinate care and services, including nutrition education, cooking classes, age-appropriate fitness classes and to provide motivation and support to keep them on track.

For some children, bariatric surgery may be an option. If surgery is indicated, a Boys Town board-certified pediatric surgeon experienced in bariatric surgery will perform it.

The Pediatric Weight Management Clinic is located at Boys Town National Research Hospital, 555 N 30th St. in Omaha.

PULMONARY FIBROSIS CARE CENTER IS FIRST IN NEBRASKA

CHI Health Creighton University Medical Center—Bergan Mercy has joined the Pulmonary Fibrosis Foundation's Care Center Network. This means patients with idiopathic pulmonary fibrosis now have a place near home to turn for care.

Sixty-eight medical centers nationwide offer this kind of expertise in diagnosing and treating people with pulmonary fibrosis. CUMC-BM is the only care center in Nebraska with the designation.

Pulmonary fibrosis can be a devastating disease that causes progressive scarring in the lungs; more than 200,000 people in the United States are living with it.

CHI Health's goal is to provide comprehensive care and expertise to those living with this life-threatening condition. Patients with pulmonary fibrosis become progressively shorter and shorter of breath. Life expectancy can be three to five years. As the condition progresses, a person's risk of heart attack, stroke and other serious health issues increases.

While there is no cure currently for pulmonary fibrosis, therapies and treatments are constantly improving. If caught early, treatment can slow the progression of pulmonary fibrosis. At the care center, patients receive a comprehensive evaluation and diagnosis, assistance with social services and opportunities to take part in research. They also learn about treatments, breathing techniques and exercise programs.

PARTNERSHIP STRENGTHENED WITH AFFILIATION AGREEMENT

Children's Hospital & Medical Center and the University of Nebraska Medical Center recently announced the signing of a new Master Affiliation Agreement to further strengthen their long-standing partnership and enhance pediatric care, education and research in Nebraska and beyond.

The Master Affiliation Agreement creates a path forward to broaden and enhance collaborations between Children's and various UNMC entities. It serves as an "umbrella" over Children's current Institutional Affiliation Agreement with the UNMC College of Medicine. It also is intended to provide a framework under which new individual affiliation agreements between other UNMC academic units and Children's will be developed.

"When independent, freestanding children's hospitals like ours and academic medical centers like UNMC team up, it makes pediatric care stronger and it makes communities stronger," said Rodrigo López, Children's interim president and CEO. "We are pleased to broaden and build upon this tremendous partnership because we know it will make life better for children."

"We are pleased to expand the UNMC agreement with Children's Hospital & Medical Center," said Jeffrey P. Gold, M.D., UNMC chancellor. "For more than a decade, the UNMC-Children's partnership has flourished. The new agreement is a win-win for both institutions, but more than that, it's a win-win for children and families in the region.

"It will pay dividends by improving patient care, while providing more research and educational opportunities for our faculty and students. It will truly put our pediatric care on par with the best programs in the country. We are very grateful to the Children's leadership and look forward to continued collaboration in the future."

TODERO NAMED VICE PROVOST OF HEALTH SCIENCES CAMPUSES

Catherine Todero, Ph.D., professor and dean of the College of Nursing, was named vice provost of Health Sciences Campuses for Creighton University. In addition to her new responsibilities, she will continue to serve as dean of the College of Nursing.

In her new role, Todero will exercise general executive responsibility for the broad educational, clinical and community engagement programs of Creighton's health sciences colleges and schools. She will provide leadership, oversight and stewardship to all aspects of the University's health sciences academic programs and facilities at both the Omaha and Phoenix campuses.

She has been instrumental in developing the Creighton University Health Sciences - Phoenix Campus. Todero also led the establishment of the College of Nursing's accelerated BSN degree program in Phoenix, and served as program lead in planning for the new $100 million, 180,000-square-foot building in midtown Phoenix, which is scheduled for completion by 2021.

As vice provost, Todero will serve as the senior administrative Creighton University leader in Phoenix; oversee accreditation for the various academic programs; and establish and develop relationships with community and civic leaders, academic institutions, health system partners, local governing bodies and philanthropic organizations.

As the senior health sciences leader, Todero will chair a Creighton University Health Science Governing Council that will include the Omaha health sciences deans and Phoenix associate deans; assist in the development and coordination of academic programs on the two campuses; and join leadership on Creighton's President's Cabinet, the Creighton University Arizona Health Education Alliance and the affiliation council with CHI Health.

FREMONT CLINICS JOIN SYSTEM

Two long-standing private medical practices in the Fremont commu-nit—Prairie Fields Family Medicine and 23rd Family Med—are now part of Methodist Health System.

The practices merged and became Methodist Physicians Clinic Prairie Fields on Jan. 1. Both practices have been serving area patients and families for more than 30 years and are located in the same building at 350 W. 23rd St. in Fremont.

"The physicians, advanced practice providers and staff at Prairie Fields and 23rd Family Med have been active members of our medical staff and tremendous supporters for many years," said Brett Richmond, president and chief executive officer of Methodist Fremont Health. "We are very excited about the opportunity to more closely align with these practices in collectively serving our region."

Providers who have been practicing at the 23rd Family Med location include Monty Sellon, M.D.; Paul Glowacki, M.D.; RaeAnn Meyer, PA-C; Bryce Exstrom, PA-C; Lisa Stenvers, PA-C; Cherl Mues, APRN; and Kasee Wiesen, APRN.

"As I looked at the future of my medical practice, I realized that although I have no immediate plans to retire, that day will eventually come," Dr. Sellon said. "I wanted to make sure my patients would continue to have access to the same high-quality health care well into the future. An affiliation with Methodist Physicians Clinic also ensured that our staff would continue to be a part of a practice that truly puts patients first."

Providers who have called the Prairie Fields Family Medicine location home include Thomas McKnight, M.D.; Thomas Wolf, M.D.; Andrea VerMaas, M.D.; Lynnda Schiermann, PA-C; Jenny Belitz, PA-C; and Jessica Francis, PA-C.

"We have had a great relationship with Methodist for many years and look forward to continuing to build upon that," Dr. McKnight said. "This affiliation should be good for our patients and for patient continuity, and I think there will be very little change for them because of that existing close relationship."

NEW FACILITY TOUTED TO BE CORNERSTONE OF NEBRASKA'S FUTURE ECONOMY

Leaders at Nebraska Medicine and the University of Nebraska Medical Center unveiled early plans to propel the medical center campus and the state of Nebraska to the highest levels of clinical care and research with the construction of a new, state-of-the-art facility, scheduled to take shape over the next decade.

This public/private partnership will have goals of: improving the quality of life for all Nebraskans and laying the groundwork for the state's 21st-century economy and create a new future of health care, research and education for the region, nation and the world.

The project, which is in such an early phase it currently doesn't have an official name, could consist of several new buildings, to be constructed on the northwest corner of the current medical center campus. Buildings in the complex could include one or more new towers for research and inpatient care, which would consolidate care in one location and replace older facilities, some of which are more than 70 years old. Strategic investments would also allow this facility to be a hub for expanding clinical trials and enrollment, new educational technologies and to become a magnet for medical tourists.

The public-private partnership between the medical center, the public sector and the private sector may lead to new opportunities to collaborate with the federal government which could expand UNMC/Nebraska Medicine's reputation in treating highly infectious diseases and national readiness and training of federal and civilian employees.

As the project is still in its infancy, specific costs will be established as it takes shape. Early estimates project that costs could be in the range of $1 billion to $2 billion, depending on scope, a figure that is in line with other prominent academic medical center projects nationally.

University of Nebraska Medical Center

DRS. MANNON TO TAKE LEAD ROLES IN INTERNAL MEDICINE

Peter Mannon, M.D., and Roslyn Mannon, M.D., will join the University of Nebraska Medical Center Department of Internal Medicine in leadership roles in February. Both currently hold positions at the University of Alabama at Birmingham.

Dr. Peter Mannon has been named chief of the Division of Gastroenterology/Hepatology in the UNMC Department of Internal Medicine. He also will direct the Paustian Inflammatory Bowel Disease Center.

Dr. Roslyn Mannon will join the UNMC Department of Internal Medicine as associate chief for research in the Division of Nephrology and as vice chair of research mentoring and academic development for the department. Her clinical and research expertise is kidney transplantation.

Both held titles at Duke University Medical Center in North Carolina; Veteran's Administration Medical Center in Durham, North Carolina; National Institutes of Health in Bethesda, Maryland: and Uniformed Services University of the Health Sciences, also in Bethesda.

An accomplished clinician and inflammatory bowel disease researcher, Dr. Peter Mannon is a professor of microbiology and director of the Inflammatory Bowel Disease Center and Gastroenterology/Hepatology Clinical Research Program at UAB.

"Dr. Peter Mannon is an ideal person to lead our Division of Gastroenterology and Hepatology forward," said Deb Romberger, M.D., chair of the UNMC Department of Internal Medicine.

Dr. Roz Mannon, currently professor of medicine and surgery and section chief for transplant nephrology at UAB, said she is delighted to join UNMC to be part of an amazing institution.

Troy Plumb, M.D., chief of the UNMC Division of Nephrology, said Dr. Roz Mannon is a national leader in kidney transplantation and her expertise as a researcher and mentor make her ideal for the position.

APPLICATION FOR MEMBERSHIP

This application serves as my request for membership in the Metro Omaha Medical Society (MOMS) and the Nebraska Medical Association (NMA). I understand that my membership will not be activated until this application is approved by the MOMS Membership Committee and I have submitted my membership dues.

PERSONAL INFORMATION

Last Name:_____ First Name:_____Middle Initial:_____

Birthdate:_____Gender: ☐ Male ☐ Female

Clinic/Group:_____

Office Address:_____Zip:_____

Office Phone:_____ Office Fax:_____Email:_____

Office Manager:_____Office Mgr. Email:_____

Home Address:_____Zip:_____

Home Phone:_____Name of Spouse:_____

Preferred Mailing Address:

Annual Dues Invoice: ☐ Office ☐ Home ☐ Other:_____

Event Notices & Bulletin Magazine: ☐ Office ☐ Home ☐ Other:_____

EDUCATIONAL AND PROFESSIONAL INFORMATION

Medical School Graduated From:_____

Medical School Graduation Date:_____Official Medical Degree: (*M.D., D.O., M.B.B.S, etc.*)_____

Residency Location:_____Inclusive Dates:_____

Fellowship Location:_____Inclusive Dates:_____

Primary Specialty:_____

I certify that the information provided in this application is accurate and complete to the best of my knowledge.

_____ _____

Signature *Date*

FAX APPLICATION TO:
402-393-3216

MAIL APPLICATION TO:
Metro Omaha Medical Society
7906 Davenport Street
Omaha, NE 68114

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