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- Fitting into the Medical Community

Care-A-Van Keeps Cancer Patients on The Road  
PAGE 8

WMS 2016 Physician of The Year  
PAGE 12

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### ABOUT THE COVER

Cheyenne Pediatrician Joseph Horam, MD has been a long-term member of the US military and more recently, as a member of the Wyoming National Guard.

## Contents

THIS MAGAZINE ISSUE IS DEDICATED TO THOSE WYOMING MEDICAL SOCIETY MEMBERS WHO HAVE SERVED IN OUR NATION'S ARMED FORCES.



Care-A-Van Keeps Cancer Patients on The Road	8
Dr. Mike Tracy is the WMS 2016 Physician of The Year	12

### ON THE COVER WYOMING PHYSICIANS WHO SERVE

Taking Care of a Dictator	16
Wyoming Physicians Who Have Served in the Military	24
Wanted: Good Docs to Serve in the Military	30
Fitting into the Medical Community	32

Casper Residency Profiles	38
---------------------------	----

### PARTNER MESSAGES

Good Health for Wyoming, Together	40
Child Health Champions: Healthier Kids through Public Policy	41
CANDOR Toolkit: Physicians Now Have the Right Tools to Do the Right Thing After an Adverse Event	42
Tough Conversations: Talking to Your Patients and Their Families About Advance Directives	43
Beware of the Patch!	44

WMS Member List	48
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## IHS Pharmacies to Benefit from Rules Changes

BY ROBERT MONGER, MD



The two pharmacies on the Wind River Indian Reservation function as independent pharmacies that do not participate in prescription reporting databases such as the Prescription Drug Monitoring Program (the PDMP), and historically the pharmacies have been reluctant to make any changes. Starting in early 2017, however, both pharmacies will enroll with Wyoming Medicaid and will participate in the point-of-sale system for tracking medications, and additionally tribal members' prescriptions will be regulated through the Wyoming Medicaid prescription program. What prompted the tribal pharmacies to agree to make this change? One reason is that they've negotiated a deal to collect an extra \$5 million per year from the federal government by participating.

It's not uncommon for tribal members to see physicians both on the reservation at Indian Health Service (IHS) clinics and to also sometimes see physicians off the reservation in places like Riverton and Lander, and likewise they often use pharmacies both on and off the reservation to fill prescriptions. But because the IHS pharmacies don't report to databases such as the PDMP it's currently not possible for physicians to track what prescriptions patients fill at IHS pharmacies. So, for example, if a tribal member receives a prescription from an IHS clinic and fills it at an IHS pharmacy, and then later receives a prescription from a provider off the reservation and fills it at a pharmacy off the reservation, then neither the prescribers nor the pharmacies involved know about both prescriptions. This has implications not just because of the potential for abuse of prescription medications but also for monitoring for drug interactions.

When the two IHS pharmacies enroll with Wyoming Medicaid in 2017 their prescriptions will be entered into the Medicaid point of sale system, which means that it will be possible to track them. The pharmacies will also switch from the IHS formulary to the Wyoming Medicaid prescription program including the use of the preferred drug list and the prior authorization process for medications that are not normally covered. One likely result is that a number of tribal members will need to switch some of their current medications to medications that are covered by Medicaid.

So how will the two Wind River IHS pharmacies make an extra \$5 million per year from the federal government under the new program? It has to do with the very complicated and confusing way that IHS is funded.

When a tribal member is seen at an IHS clinic by a health-care provider such as a physician or dentist the clinic bills for


an "encounter." The billing is administered by Medicaid but is a pass through and is paid entirely by the federal government. For 2016 the clinics are paid \$368 per encounter, and there is a limit of two encounters per tribal member per day.

Strangely enough the IHS pharmacies also bill an encounter to fill prescriptions, and the encounter fee covers both the pharmacist's time and also the medication cost. For example, under the current system if a tribal member goes to an IHS pharmacy with three prescriptions the pharmacy will fill all three and then be reimbursed \$382 for the encounter, regardless of the cost of providing the medications. If medication costs exceed the encounter fee then tribal members are commonly referred to pharmacies off the reservation where the medication can be billed through Medicaid or private insurance.

The new reimbursement schedule that the Wind River IHS pharmacies have negotiated changes the encounter billing such that each individual prescription filled will now count as an encounter, and there won't be a cap on billing for pharmacy encounters. So when the new system takes effect and a tribal member presents their three prescriptions to be filled the pharmacy will bill 3 x \$368 and be reimbursed \$1,104 regardless of the cost to the pharmacy of providing the medications.

IHS pharmacies obtain their medications wholesale using the federal supply schedule, and many generic medications can be obtained for pennies per pill. Because each prescription filled under the new system will now be reimbursed \$382 it is estimated that the net result will be an increased reimbursement from the federal government to the two pharmacies a combined total of \$5 million per year.

Money aside, enrolling the two pharmacies on the reservation in the Wyoming Medicaid program is a change for the better that will help ensure appropriate use of prescription medications. Once prescriptions are entered into the Medicaid point-of-sale system, they will populate into the Medicaid Total Health Record (THR) that can be reviewed by providers. Unfortunately, because the PDMP is a separate database run by the Wyoming Board of Pharmacy, the IHS pharmacy data won't automatically populate into that system even after the pharmacies enroll with Medicaid unless the two pharmacies register directly with the Board of Pharmacy. Wouldn't it be nice if the THR and the PDMP communicated with each other?

The pharmacies are scheduled to enroll with Wyoming Medicaid in January 2017 and look for the changes to go into effect on the go-live date that is currently set for March 20, 2017. 





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## Partnerships Making WMS and Its Members Stronger

BY SHEILA BUSH



It was seven years ago this September that my predecessor, Dennis Ellis, announced his departure from the Wyoming Medical Society resulting in the WMS Board searching for a new executive director.

Deciding to apply for the job proved difficult as I was good at convincing myself I hadn't yet had enough experience, or been given enough opportunities to work under the leadership of great people that I so deeply respected and who had so adeptly led WMS up until that point. I knew I had so much more to learn from my mentors like Wendy Curran, Susie Pouliot and Dennis Ellis.

I was right in thinking I still had so much more to learn, and still believe I have mountains to climb. One thing I knew to be true and have only confirmed since then is that everything in life, work, home, and play is solely based on relationships.

I ended my interview with the WMS hiring committee in 2009 by telling them that I was certain they had more qualified individuals hoping to be given the responsibility of leading WMS, but what I lacked in credentials I would make up for with an unending dedication to make lasting relationships on behalf of WMS with our own members, policy leaders, hospitals and partners.

I can't talk about meaningful partnerships at WMS without immediately thinking of The Doctors Company (TDC). TDC and WMS have a rich history dating back to the days when TDC was a much smaller company and WMS handled all of their in-state premium billing.

The relationship has grown and strengthened through the years with generous grants supporting tort reform efforts, and TDC's 5 percent discount on medical malpractice insurance premiums to WMS members. It's because of this partnership that WMS has done so much including building websites, hosting its annual meeting, and conducting a patient safety summit.

I know I speak for all of the WMS leadership team when I tip a hat and give a heartfelt thanks to the commitment and dedication TDC has shown to WMS, our mission and our physicians. WMS is proud to continue our exclusive endorsement of TDC in recognition of all they do for Wyoming doctors.


It is with that same thankful heart that I announce a new partnership with medical malpractice insurer UMIA. Starting Jan. 1, 2017, any WMS member who was an active member in 2016 and renews for 2017, or who joins as a new member, will

be offered an additional 5 percent discount on their medical malpractice premium with UMIA. This is something long in the making that our board has been eager to share with our members. It is finally official and we couldn't be happier about what the future may hold for this partnership.

My voice was probably shaking with nerves in that interview so many years ago, but I know my words were firm. Everything comes down to relationships, and that has never been truer than it is now.

We owe a deep thanks to TDC for supporting WMS all these years and for understanding our desire to further strengthen partnerships with other organizations in our

unending efforts to create the best member value we can for Wyoming doctors. Thank you to UMIA for taking a chance and standing with WMS as we embark on this new partnership that we hope will be beneficial for all involved.

WMS is passionate about remaining a membership-driven organization and in order to do so we must keep membership recruitment and retention at the forefront of everything we do. If you are not currently a member of WMS, please consider joining us to support your colleagues and the work WMS does on your behalf to protect and further the practice of medicine in Wyoming. Who knows, with these new developments we might even save you a little bit of money. 

**WMS is passionate about remaining a membership-driven organization and in order to do so we must keep membership recruitment and retention at the forefront of everything we do.**



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# Care-A-Van Keeps Cancer Patients on The Road

## Free Van Services Helps Cancer Patients Go From The Big Horn Basin to Cody for Treatment

BY BOB VINES  
Wyoming Medical Society



The Big Horn Basin Radiology Center's Care-A-Van heads west Wyoming Highway 14 toward Cody, with the Absaroka Range in the background. The van transports radiology patients from across Wyoming's Big Horn Basin on a daily basis to receive treatment in Cody. The route is 425 miles.

**K**evin Johnson has every available restroom along a 425-mile route through Wyoming's Big Horn Basin flagged in the GPS system of the white Honda minivan affectionately known as the Care-A-Van.

"So I can tell them exactly how many miles and how many minutes it's going to take to get there. It's for my own benefit too," he laughs.

It is a job requirement, especially when treating patients undergoing the not-so-pleasant inexact science of proper bladder fullness in order to receive radiation treatment for prostate cancer.

Twice a week, Johnson leaves the parking lot of Big Horn Basin Radiology Center in Cody before the sun rises. He picks up his first passengers in Thermopolis at 6:30 a.m. and turns north, stopping in Worland, Basin and Greybull before heading back to the clinic. Once each passenger meets their appointment, Johnson loads them back up and takes them home.

"I have learned a lot about everything from beekeeping to how to raise the right amount of grass in the right spots," he says. "It becomes real personal real quick in a small vehicle, and everybody has a good time. It's usually pretty lively. It gets hard to concentrate on driving sometimes because I'm laugh-

ing so hard."

Although Johnson only makes this trip on Thursdays and Fridays (he has a partner that drives the other three days of the work week), the passengers make this trip five days a week for up to nine weeks. By noon, they are back to their respective daily routines after receiving radiation treatment for a wide range of cancers.

One of those passengers, Marcus Arthun, 71, operates a small ranch south of Worland and is preparing for calving season, which begins before he receives his final radiation treatment for prostate cancer. He has completed 15-of-45 treatments and admits his energy level is affected by the radiation, but it doesn't slow him down.

"I'm better off going (rather than not getting treatment)," he says. "I have to keep doing stuff."

Arthun was apprehensive when he first learned that his treatment plan would require daily radiation treatments in Cody. But the Care-A-Van not only allows him an option that was less invasive to his ranching operation, it also allows him time with others who understand what he is going through. And in the case of his chauffeurs, he gains insight from survivors since both Care-A-Van drivers have beaten their own cancers.



“They have compassion for it,” Arthun says. “They share their frustrations and experiences. All that helps. No question.”

“I was lucky with my cancer,” says Johnson, who was diagnosed with colon cancer that was resolved through surgery. “The shock of being told you have cancer for the first time hits you like a truck. But I must live a charmed life because I never had to go through what they are going through. I’m learning every day what it’s like to go through what they’re going through and I feel so fortunate.”

With the closest treatment center an hour and a half away for patients like Arthun, just getting there can be a challenge. This is where the Care-A-Van comes in. The free service, which is funded through St. Vincent Healthcare and private donations, is necessary for rural patients to receive treatment and provide as little intrusion into their lives as possible.

As St. Vincent Healthcare Director of Satellite Operations

Kendra Eaton says, it isn’t financially feasible to provide such care any other way.

“It takes many resources and a relatively high patient volume to be able to support high quality care in a small community. For example, radiation oncology programs are typically only present in communities that have a population of 100,000 or greater,” she said.

That is more than ten times greater than Cody’s current population. The entire Big Horn Basin’s population is less than 50,000.

Big Horn Basin Radiation Center radiologist Dr. Michael Smith says, “The actual (radiology) machine costs \$3 to \$5 million, then you have to

have a vault with 8-10 feet of concrete walls with the rest of the clinic. When all is said and done, to build a radiation center is anywhere from \$10 to \$15 million.”

He says the clinic currently treats around ten patients daily, although that fluctuates considerably at times.

“It becomes real personal real quick in a small vehicle, and everybody has a good time. It’s usually pretty lively. It gets hard to concentrate on driving sometimes because I’m laughing so hard.”

KEVIN JOHNSON  
Cody, WY



Worland-area rancher Marcus Arthun sits in the waiting room of the Big Horn Basin Radiology Center after receiving treatment for prostate cancer.





Kevin Johnson of Cody drives a 425-mile route through Wyoming's Big Horn Basin to transport radiology patients for treatment at the Big Horn Radiology and Oncology Center in Cody.

Smith credits the transportation program with making difficult decisions easier for cancer patients.

"I think without the van, there are a fair number of people that would not be treated because logistics would be impossible. Transportation issues are huge – getting people to and from appointments. Especially with radiation where we have six to eight weeks Monday through Friday - that can be daunting for someone who lives an hour-plus from a treatment center. A lot of these people are elderly and could be facing some real grim choices."

Smith uses breast cancer patients as an example. There are typically two paths of treatment – mastectomy or lumpectomy. With a lumpectomy, the patient has the tumor removed followed by a sampling of the lymph nodes then six and a half weeks of radiation. He said that some doctors report that many patients choose the mastectomy over the lumpectomy simply because a lot of the women logistically can't do the follow-up radiation treatment.

"You might have an older lady who cannot drive well. If she has breast cancer she might be forced to do a mastectomy rather than keeping her breast simply because transportation is an issue," he says. "But if they have the van to ride then it's a different story."


The Care-A-Van has operated out of the same parking lot since before the clinic's construction. The current location used to be a parking lot for West Park Hospital. Patients would meet there to be transported to a cancer center in Billings, Mont. That was 18 years ago when dosimetrist Blake Smith first began working for the clinic.

Blake Smith says the Care-A-Van program has gone through some changes over the years, but the idea remains the same.

"Our treatment deliveries have changed but as far as transportation, that doesn't change much, although it is much more comfortable (these days)," Smith says.

Previous buses were big and clunky, with turned odometers and finicky temperature controls. That issue has been resolved with yearly leases. The new Care-A-Van may lack certain personality; however, its drivers and passengers appreciate the sleek style and technologies such as GPS.

After receiving his fifteenth treatment, Arthun was back at the ranch in the early afternoon just in time to move hay.

"It is better than I thought it would be," he says. "When I first heard (I had cancer) – well, nobody wants to face up to it. I knew I was going to go ahead and do it (traveling to receive treatment), but I anticipated it to be more difficult than it is. It has been a positive experience." 



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Physician, Entrepreneur, Advocate  
**Dr. Mike Tracy**  
 is the WMS  
 2016 Physician  
 of The Year

BY BOB VINES  
 Wyoming Medical Society



Powell's Michael Tracy, MD is the 2016 Wyoming Medical Society Physician of The Year.

“I got a really good tip for a house call the other night  
 — a piece of hot, fresh apple pie.”

MICHAEL TRACY, MD, POWELL, WY

**T**he Cowboy Code of the West holds a prominent space on the wall behind the reception desk at 307Health in Powell. Although all the other walls of the modern Direct Primary Care clinic are adorned with art and photographs from patients and local artists, Wyoming's iconic Cowboy Code has its reserved spot in direct eye-line of all who walk through the clinic's door.

Michael Tracy, MD, refers to it often – as a moral guideline and a mission statement for the clinic he shares with partner Robert Chandler, MD. Most of all, it is a reminder of his commitment to the 600 or so patients that have the number to the cell phone that is attached to his waist and the Bluetooth device that could possibly be surgically implanted in his ear.

Tracy, 51, is professional, easy-going and amiable. He is professional enough to easily discuss his visions of the future of healthcare with quiet reason and confidence, void of hyperbole and unfair criticism. He is easy-going enough to take business

calls while “getting some line wet” in Northwest Wyoming's trout-rich waterways. And you have to like a guy who proudly displays an old Powell Panther-signed football along with his copy of Paula Abdul's Greatest Hits on his bookshelf with a small library of medical and business books.

The Wyoming Medical Society has chosen Tracy as 2016's Physician of the Year. His willingness to try a new business model and his patient safety advocacy were among the reasons for his nomination.

In a Direct Primary Care (DPC) system, the patient pays a monthly fee directly to the physician and can see their doctor as often as they need. The system bypasses insurance, co-pays and the traditional fee-for-service system. It also includes housecalls and the benefits they may bring.

“I got a really good tip for a house call the other night -- a piece of hot, fresh apple pie,” Tracy says.

The doctor was supposed to be mowing the back lawn when





Michael Tracy, MD, practices with Bob Chandler, MD at 307Health in Powell, a Direct Primary Care practice.

he received the call that one of his patients had been stung by several bees.

“I thought it was better to just see him,” he says. “I was able to go, spend some time with him and make sure he was going to be okay and didn’t need to go into the emergency room.”

And have some pie.

Not only does the system simplify healthcare access for many patients, it also simplifies the paperwork flow for the physician. Tracy and Chandler employ a full-time receptionist and a full-time nurse, and both of their spouses work part-time. Tracy says that if they were to operate a fee-for-service system, they would probably have to employ two more full-time employees to manage insurance claims.

Tracy and Chandler left their long-term employment with Powell Valley Healthcare to start 307Health last summer. The new direction seemed a natural progression for the physician ready to start a new chapter in his career.

“The fee-for-service system is cause for such stress for patients and providers. If you really start looking at physician burnout, a big reason is a loss of control over a lot of things that really impact you. I felt that I would rather explore a new model that might invigorate people like me entering their 50s,” Tracy says.

If he needed confirmation that this was the right decision for

him, he received it recently when a residency classmate suddenly died at the age of 49.

“Life is short, it really is,” Tracy says. “And you want to make the most of it. So if you find that you are not happy doing what you are doing and you can find a different way to use your skill set, then definitely do it.”

After getting an undergraduate degree from the University of Colorado, he took a couple years off before going to medical school. He worked two years in Aspen as a carpenter’s apprentice and traveled through Australia with a backpack and no itinerary for six months.

He doesn’t regret the time he spent between college and medical school. He said that many of his medical school classmates struggled during their first year directly out of college.

“For me, I just thought about some of the construction work and ranch work I had done and it seemed pretty easy to just sit around, drink coffee and study hard,” Tracy says. “I wasn’t banging nails in 20 degrees and snow.”

After earning his medical degree from CU and completing his residency in Internal Medicine and Pediatrics at the University of Rochester (New York), he worked as a physician in rural Missouri as part of a student-loan repayment program. He and his young family moved to Powell in 2002 when his contract ended.



They quickly acclimated to their new community and he began to build a strong practice at Powell Valley Healthcare, serving on the hospital's board of directors. He is a past president of the Wyoming Medical Society, serves as the Governor of the Wyoming Chapter of the American College of Physicians and has organized patient safety summits in Wyoming.

His wife, Karrie, works at the clinic as a services representative. They have three children. Daughter Anja, 22, will begin post-graduate studies at the University of Wyoming this fall. Son Nicolas, 20, also attends UW. Their youngest daughter Amanda, 18, recently graduated from Powell High School and will attend UW with her older siblings.

The new practice also gives Tracy an opportunity to focus on something as his nest empties.

"I've spent so much of my recent life working hard and trying to catch up with my family after work," Tracy says. "Now, you aren't catching up with the kids anymore. It has been an adjustment."

Tracy and Chandler share an office. Tracy likes it. He says it gives him and his partner plenty of opportunities to consult each other. His bookcase features books about biodiversity in the Amazon, the Black Plague and even "Atlas Shrugged." The aforementioned football was a relic destined for the landfill when Tracy saved it, hoping to eventually find a member of that year's team to whom he might present the ball.

He draws inspiration from the book "Creativity, Inc." by Pixar co-founder Ed Catmull which focuses on creativity in business and leadership. He also has a copy of Eric Topol's "The Patient Will See You Now," and quotes from both books as easily as he quotes the Cowboy Code of Ethics. Whether talking about patient safety, transparency, or the future of American healthcare, he has considered all angles and can easily strengthen his position with an appropriate anecdote or Donald Berwick quote.

He feels the DPC system is the best system to deliver services with the Institute for Healthcare Improvement's Triple Aim approach in mind. The Triple Aim is a framework developed to describe an approach to optimizing health system performance that simultaneously pursues three dimensions: improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care which is directly addressed in the Affordable Care Act.

The clinic had to convince the Wyoming State Legislature to pass a bill that prevents defining DPC as any form of insurance. With assistance from Wyoming House Labor, Health and Social Services Committee Chair, Rep. Elaine Harvey, R-Lovell, the bill passed unanimously in both the State House and Senate. The new statute allows the clinic to practice without being regulated by the state's insurance code.

"The time is ripe for people to try and figure out a more cost-effective way to deliver healthcare to better the experience for the patient," he says.

Both Tracy and Chandler have been to Washington, D.C., to discuss the direct primary care model with members of Congress and found strong support and interest from both sides of

the political spectrum, which is unusual these days.

The clinic resides in a building they own with a local orthodontist. Their patient-friendly focus is apparent in their exam rooms, equipped with height-adjustable exam tables and cushioned chairs. The rooms are large and friendly. Large-screen 4D television sets are hooked through the doctor's iPhones and iPads. They use the technology to access informational videos on the Internet and can pull up medication information and patient charts across 47 inches.

307Health is a combination of modern office amenities and a more traditional form of physician access that is reminiscent of a day when doctors

made house calls. But Tracy is quick to point out that although he sees the similarities with the frontier doctor, there are some major differences with the DPC model.

"It really is a step back in time with the caveat being that a step back in time used to be a pay-for-service system" he says.

When a patient signs up for care with 307Health, they pay a monthly fee on a sliding scale based on age from \$30 for patients under the age of 20 to \$75 for patients over 65, along with a one-time registration fee of \$25 per individual or \$50 for a family. In return, patients see their physicians as needed without office co-pays. They also have Tracy's cell phone number which they are encouraged to use and have options of using other technology such as Skype.

"By doing this with a finite number of people we'll be able to have the time to be able to take care of these people in the way that we need to," he says. "The interesting thing about fee-for-service is you have to keep signing people up for your practice

**"The fee-for-service system is cause for such stress for patients and providers. If you really start looking at physician burnout, a big reason is a loss of control over a lot of things that really impact you."**

MICHAEL TRACY, MD  
WMS Physician of the Year  
Powell, WY

because you have to have enough volume to make sure your schedule is full every day. That means you're going to sign up more people than you can take care of on the high-demand days. And that is why it sometimes takes months to get a doctor's appointment."

Six hundred patients seems to be a good number for Tracy right now and he's hesitant to increase that number until he gets a good feeling about how he can deliver his brand of personalized care.

One challenge that Tracy said faces new DPC clinics is convincing hospitals to view such clinics as partners rather than competition. He points out the need to work in conjunction with hospitals because physicians need access to the hospital's resources.

"If (hospitals) can view us as a referral source instead of competition it would probably be better for both sides," Tracy says. "That is how it is evolving. I think there were people that initially viewed us as competition but now they see us sending our patients to them."

Tracy acknowledges that reforming the current healthcare system is a marathon rather than a sprint, and the key to DPC's sustainability will fall into the hands of the next generation of physicians – not an easy feat with interest in primary care fading with young medical students who hear job satisfaction is low.

"These guys are thinking about surgery, orthopedic surgery – a lot of things besides primary care," he says. "Then they find out there's a model where you might be able to have the relationship with that patient be the focal point of the practice."

Along with continued promotion of the model, Tracy sees the next step as developing relationships with insurance companies in order to allow the services patients receive from DPC clinics to count toward their deductible.

Over the past year, Tracy has found himself wearing more hats than the letters behind his name would indicate. He is a physician, entrepreneur and a patient advocate. He considers this for a few seconds before saying,

"I like the word 'advocate,'" he says. "I view it as a partnership with patients. I feel that advocating for patients is something I can do better now than I could as an employed physician partly because I'm really looking out for patients' best interests along all lines."

Those lines for Tracy include transparency in cost and service, patient safety, easy and affordable access to healthcare and open, honest communication with their physician.

He refers to the Cowboy Code of the West once more.

"There's no question that all of those simple principles are so important but they get chucked to the wayside because people are so worried that they are going to get sued," Tracy says.

Then his phone rings and he politely puts his patient first. 

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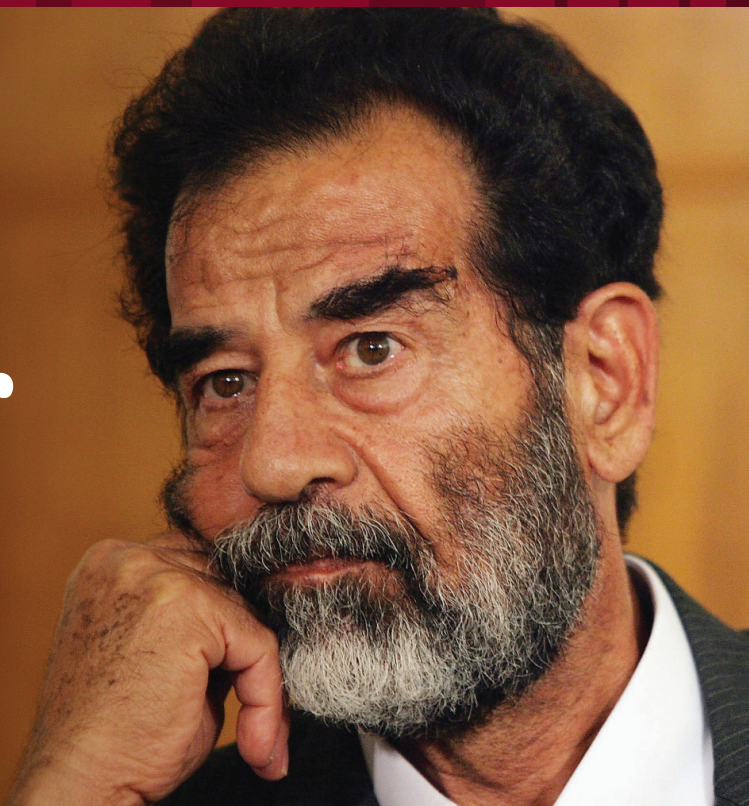
## Taking Care of a Dictator

# Taking Care of a Dictator



BY TOM LACOCK &  
ROB MONGER, MD  
Wyoming Medical Society

Former President of Iraq, Saddam Hussein, contemplates during his initial interview by a special tribunal, where he is informed of his alleged crimes and his legal rights. (Public Domain: Department of Defense photo).  
INSET PHOTO – Joseph Horam, MD poses in the Courthouse used in the Dujail trial of Saddam Hussein.



**M**ilitary deployments were nothing new for Joseph Horam, MD -- he had been deployed six times before. However, this deployment to Iraq, scheduled for May 2006, started off much differently than previous tours.

Horam, a colonel in the Wyoming Army National Guard and former State Surgeon received a call from Col. David Wilmont, State Surgeon of Indiana in March 2006. The request was simple: Could he come a month early? We have a special mission.

“Usually you come into the theatre and you meet with the local unit commander who says, ‘Here is your villa and your gear, let’s get to work,’” Horam says. “Instead, I am told to meet with Maj. Gen. John D. Gardner and he presents me with the mission to provide the medical care to Saddam Hussein. With the admonition that you will keep him alive so justice will prevail.

“That was a sobering way for the meeting to start. And then Gen. Gardner says, ‘Let’s go meet your patient.’”

### Caring for a Dictator

He had many nicknames among the military physician community -- HVD1 (High Value Detainee No. 1); VIC (Very Important Criminal) and the Ace of Spades -- but most of the world knew him simply as Saddam. Hussein was one of eight patients

Horam was responsible for while in Iraq, with the other seven high-ranking members of Hussein’s cabinet who were also co-defendants in Hussein’s crimes against humanity.

Horam says a typical day involved morning rounds, a directed physical on Hussein followed by medical reporting, lab testing, medication review and arranging consultations as needed. Just as important as the medicine being practiced was the need to establish trust with his new patient. (During the courthouse activity he similarly made rounds on all the defendants at least twice daily.) When not involved with the detainees Horam was assigned to the Golby Troop Medical Clinic providing primary care to U.S. and coalition soldiers.

“Social visits were important as it related to the trust,” says Horam. “It wasn’t every night, but a lot of evenings we would have dinner together, not just me but some of the higher-ups. We would have dinner and we would chat about everything. He actually had a lot of candor. It seemed like a lot of times we got together and had very interesting discussions. Saddam would get really engaged in our American culture.”

Through much of his career in the National Guard, Horam worked with friend, neighbor and fellow Cheyenne physician, Col. David Lind, MD, who says it was Horam’s ability to see the





Where there is one there is often the other. David Lind, MD (left) and Joseph Horam, MD have been through several deployments together as part of the Wyoming Army National Guard. In this 2006 photo, Lind and Horam are shown at Camp Liberty outside of Baghdad, Iraq.

big picture while respecting the local values of a culture that made him the perfect person to take care of the dictator.

“He actually got to know Saddam really pretty well as an individual,” says Lind. “He spent a lot of time with him and I think struck up almost a friendship with him. I know Saddam would invite Joe and the others he valued back in the evening for cigars. I think that made Joe one of the assets for that situation and that time.”

“He had his cigars and these were Cubans,” Horam says. “That was the social thing. I had never smoked anything before and here we were smoking a Romeo and Juliet. I learned quickly not to inhale because those things are tough on you.”

Engrained in Horam’s mission to take care of the Iraqi dictator was a 10-year gag order, which forbade him to speak of Hussein until this summer. It was an agreement Horam took seriously enough not to mention his patient to his wife, Carol. Horam laughs when he says Carol has been very supportive through his military career -- but in 2006 there were questions why, despite being in the same deployment and facility as Lind, he didn’t call his wife as often as Lind called his. Horam says Carol found out about his mission during an event at West Point six years after he returned from the Middle East when

some of the wives of the physicians who took care of Hussein mentioned it to her.

“We signed a 10-year non-disclosure agreement,” Horam says. “The whole thing was about security. All of the various activities where we traveled about were very covert, and the judicial actions were a very high-secure operation.”

### The Health of a Dictator

Taking care of Hussein offered its challenges, mostly due to his age (around age 67) and a life lived hard. Hussein’s military medical record folder was nearly a foot tall by the time Horam received it and included a difficult case of hypertension with adrenal adenoma. Horam says on a daily basis he logged the status and plan for 15-20 various ailments, and asked for consultations with cardiology, dental, psychiatry, and urology for Hussein.

“We had him on every anti-hypertensive,” Horam says. “He had a lot of stuff for his age, but one time he kept complaining about his leg. I checked him out and said, ‘It looks okay, but let’s give it a basic x-ray.’ He had shrapnel all over his leg. I showed it to him and he was like, ‘Oh yeah, that was from a shoot-out many years ago.’”





## Taking Care of a Dictator

Horam says Hussein was generally a good patient, reasonable and compliant. However the relationship was not without its fiery moments.

“He tried to fire me at least three times, generally related to the perception that I was not doing enough to mediate a pardon agreement with higher authorities, and allow him to have some renewal of leadership management of his Iraqi people,” Horam says.

Much of Horam’s time with Hussein was spent during the initial legal proceedings against Hussein. The trials meant moving the high-value detainee to a jail in the basement of the courthouse where the prisoners were housed

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JOSEPH HORAM, MD  
Speaking about Saddam Hussein

during hours out of court for up to two weeks at a time. As the physician for the trial, Horam had his own cell in the basement along with the “Elite Eight” defendants.

Hussein was indicted in a total of 12 consecutive trials, with the first being the trial of Dujail, a small agricultural community in Iraq. During a visit to the community in the 1990s, there was an attempt on Hussein’s life. His alleged response was to have the Iraqi military kill 148 residents of the community. Although Iraq was attempting to become a democracy at this time, Horam says the trial exposed some of the growing pains involved in moving



Joseph Horam, MD tends to a patient while working out of the 31st Combat Support Hospital at LSA Anaconda, Balad, Iraq in 2004. Horam is shown here attending to one of several Iraqi policemen caught in an ambushed firefight.





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## Taking Care of a Dictator



Joseph Horam, MD sits on a personnel carrier as part of a convoy preparing to cross the Tigris River in Iraq. Horam was on his way to negotiate medical logistical supplies for a special community of Iranian exiles

away from a dictatorship made up of three separate Muslim sects, including assassinations of multiple defense attorneys, the replacement of the Chief Justice of the Tribunal and issues with witness integrity.

Making medical care during trial more difficult was a 19-day hunger strike during which Hussein lost 11 pounds, and Horam says he felt the dictator's mental faculties were slipping as the strike continued. Horam reports some of the other detainees were cheaters and actually gained weight. Horam performed some psychiatry in hopes of gauging his patient's faculties after Hussein refused a military specialist. Horam would ask questions suggested to him by psychiatrists, who then analyzed the answers.

After day 19, Horam was called to meet with the chief justice, who asked if Hussein was ready for the trial's closing arguments. Horam says he told the judge Hussein was not.

"I told the generals this is potentially a disaster," Horam

says. "At this point ... the trust came in. I said, 'What we have to do is take care of his health, and we were going to take care of Saddam in the hospital.' Saddam didn't mind. He was saving face because we didn't force him to eat as he agreed to a feeding tube."

After five days of bringing him back up slowly Hussein began to get back to his old self again. (Which meant a defiant dictator attitude during the "world stage" of court testimony. Eventually, the Tribunal convicted the entire group of eight defendants. Hussein was executed Dec. 30, 2006. His cabinet and co-defendants were executed in 2007.

"Saddam and I often spoke of his impending execution, which he discounted as a lost opportunity to return him to the leadership of Iraq," Horam says. "His narcissism served him to the end."

Horam said on the way out of Iraq he had a chance to say goodbye to his famous patient and the meeting was not without

some emotion. Horam said Hussein also thanked him for taking care of him and for looking at him as more of a patient than a prisoner of war.

“I was not a sympathizer and kept it professional, but the last day, yeah, it was personal,” Horam says. “I had no admiration for the individual. He has a charisma that you step into a room and there was something about a person like that. His ability to be a cruel, brutal dictator was always there.”

### Tidbits about Hussein

Horam says from his time with Hussein, it was clear that the dictator believed his legacy as president was someone who cared for his people and excelled in the areas of infrastructure, education, medical, and military development. He also prided himself in selecting a cabinet of Sunni, Shiite, Kurds and Christians.

While many of the other defendants in Hussein’s cabinet wore traditional Arab clothing, Hussein spent much of the time during his trial in Western-style suits. Horam says he thought Hussein felt more sophisticated than the other defendants and wanted to set himself apart as the leader. He said Hussein did wear the Arab clothing, but during social events with others from the middle east.

Horam said there was only one evening when Hussein requested any real sort of entertainment. After a conversation about the movie “The Passion of The Christ,” Hussein expressed an interest in watching the movie. Horam said, though Hussein was a Muslim, he had a general curiosity about the Christian faith. Horam, Hussein and other high-ranking officials watched “The Passion of The Christ,” together and afterwards, Hussein said only, “Jesus suffered.”

“We would talk a lot about religion,” Horam says. “He could show he had a religious side to him, but I thought it was more for show - superficial. He had a curiosity about different religions. He would acknowledge Christianity and

the faith concept.”

Outside of the movie, Horam says he feels Hussein spent his off-hours trying to remain focused on the trial, as well as writing some poetry, which Horam compared to Psalms in the bible. Hussein also read Hemmingway and would talk about “The Old Man and The Sea.”

“If you wanted to get him angry, talk U.S. policy,” says Horam. “He would say, ‘Get me and Bush in a room and we will work it out.’ There was a time when Bush was a quarter-mile away and they never met. He was okay with American people but very much hated President Bush. He would go on tirades about President Bush. That was his focus.

“I think he regretted underestimating the will of the United States. We talked about that and asked why he went into Kuwait. He said it was (Iraq’s) sovereign right; ‘The land belongs to us and we wanted it back.’ They went through the Iran-Iraq war for seven years and there were funding issues and a sense of getting back the people’s trust in his military might. That was an easy opportunity to jump in there, take all that land and oil-developing areas. Who is going to complain?”

Horam was a veteran of Operation Desert Storm, during which he was stationed in Riyadh, Saudi Arabia, with the 50th

General Hospital. He says in 1991 his staff was briefed to expect chemical casualties in the hundreds. That meant physicians would live at the hospital to treat the wounded. After three days and nights it never happened.

“I personally asked Saddam (about that),” Horam said. “I said, in the time of Desert Storm I remember that we were to expect large scud missile attacks and we were prepared to take care of chemical injuries. He looked at me and said, ‘Yes, but too much consequences.’”

### Reflections

Ten years after his mission, Horam has had time to reflect on his time in the Middle East and the detainee he worked so hard to keep healthy until his execution. He admits that

“The military medical environment can expand your horizons and from the civilian standard of care may seem screwy, but it works as you develop skills and apply them as a team in the combat environment. I enjoyed the vast exposure to providing primary care, emergency medicine, first-assist surgery, flight medicine, and detainee care.”

JOSEPH HORAM, MD





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concept, in and of itself, was an interesting philosophical issue to consider as a physician.

“Having had some background taking care of detainees in the war environment, you do have to address the personal respect to other individuals regardless of their criminal of war status,” Horam says. “You have your professional perspective. You have to provide a standard of medical care you personally feel comfortable with.”

Horam says he was disappointed with the way the Iraqi authorities chose to execute Hussein.

“I felt terrible about the way his execution was set up. He was brought in and there was this shouting between him and those who were in the gallows area, and they were basically ridiculing him. They showed the execution on TV, and then he was buried in a private area so they couldn’t create a martyred remembrance of that for the country. I didn’t feel like it was handled very well.”

### A Retirement from the Military

Horam, whose father was active duty Army for 27 years, earned his medical degree through the Army, including University of Colorado School of Medicine and a pediatric residency at Tripler Army Medical Center in Hawaii. Horam was then stationed at Fort Knox, Kentucky, for four years. After his active duty military career, he joined the Wyoming Army National Guard, worked as a flight surgeon, and rose to the level of state surgeon during his 20 years with the Guard. Horam regards providing the unit leadership that maintained combat readiness for over 1800 Wyoming Guardsman as his most important military accomplishment.

His deployment to take care of Hussein was his third tour in the Middle East. He says he also worked with a group of Iranian exiles, many with terrorist backgrounds that weren’t known about until the U.S. occupied Iraq. The Iranian community of more than 4,000 people featured 10 doctors whom he worked with to provide medical logistics, such as pharmacy and durable medical equipment. He later assisted with a NATO Peacekeeping mission in Kosovo in 2009 where he and six other physicians were in charge of the health of around 5,000 U.S. soldiers and consultants to more than 20 other countries. (Humanitarian missions were provided on a frequent basis with Albanians and Serbs from various communities throughout Kosovo.)

“The military medical environment can expand your horizons and from the civilian standard of care may seem screwy, but it works as you develop skills and apply them as a team in the combat environment,” Horam said. “I enjoyed the vast exposure to providing primary care, emergency medicine, first-



Joseph Horam, MD poses near a HMMWV Ambulance during a field medicine training in 2004.

assist surgery, flight medicine and detainee care.”

Horam retired in 2013 with 27 years of military service including more than two years on deployment, the same month as his friend, Lind.

“My confidant, David Lind, provided an important reality base of support,” Horam says. “I thought of Dave as sort of my go-to guy and I think he felt likewise.”

For his part, Lind agreed.

“He understands what he has to do and what I have to do, and we always worked really well together,” adds Lind. “If there were ways to support each other we would. He is just a phenomenal guy to be with, a good battle buddy and a good partner.”

***Dr. Joseph Horam has been a resident of Cheyenne, Wyoming since 1994, a pediatrician at Cheyenne Regional Medical Center and the Medical Director for Blue Cross Blue Shield of Wyoming.***

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## Wyoming Physicians Who Have Served

### Wyoming Physicians Who Have Served in the Military



**CHERYL VARNER, MD**

**Rank:** Commander  
**Branch of Military and Position:** Navy Reserves - Expeditionary Medical Facility Great Lakes  
**Years of Service:** 1987 - Present  
**Current Civilian Practice:** Currently an Otolaryngologist at Big Horn ENT with Sheridan Memorial Hospital.



**HART JACOBSON, MD**

**Rank:** Commander, Colonel  
**Years of Service:** 1969-77, US Navy; 1983-97, US Army; 1997-2004, US Air Force  
**Branch of the Military:** Navy, Army, and Air Force  
**Current Civilian Practice:** Retired



**JOHN MANSELL, MD**

**Rank:** Colonel  
**Years of Service:** 1988-2011  
**Branch of Military and position:** Army National Guard  
**Current Civilian Practice:** A Wyoming Pain Clinic, PC in Gillette.



**DEAN W. BARTHOLOMEW, MD**

**Rank:** Major  
**Years of Service:** 2001-2008  
**Branch of Military and Position:** Active duty Air Force, commander of aerospace flight at FE Warren Air Force Base in Cheyenne.  
**Current Civilian Practice:** Platte Valley Medical Clinic, P.C., Saratoga, WY



**MAJOR JEFFREY JAKE BEHRINGER, MD**

**Rank:** Major  
**Years of Service:** 2013-Present  
**Branch of Military and Position:** Wyoming Army National Guard - Flight Surgeon  
**Current Civilian Practice:** Niobrara Community Hospital, Cheyenne Regional Medical Center, and Cheyenne VA.



**SARA HARTSAW, MD**

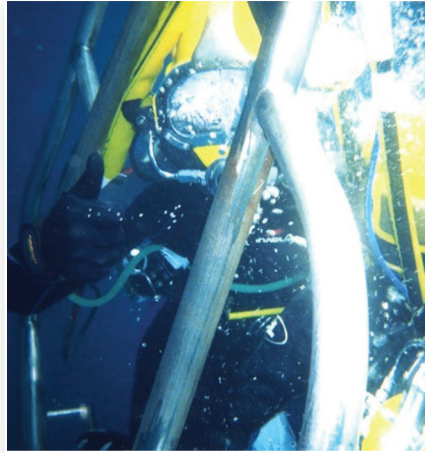
**Rank:** Lt. Commander  
**Years of Service and position:** 2013-Present; general surgeon  
**Branch of Military and Position:** Navy Reserves  
**Current Civilian practice:** High Plains Surgical Associates, PC.





**WILL SMITH, MD**

**Rank:** Lt. Colonel MC  
**Branch of Military and Position:** US Army Reserve - 62A (Emergency Medicine) - Branch Chief of Disaster Medicine, US ARMY MEDCOM HQ - G34, San Antonio, TX.  
**Years of Service:** 2001-Present  
**Current Civilian Practice:** Medical Director, Grand Teton National Park, Teton County Search and Rescue, Jackson Hole Fire/EMS; Emergency Medicine, St. John's Medical Center, Jackson, WY.



**DUSTIN ROBERTS, MD**

**Rank:** Lt. Commander  
**Years of service:** 2000-2015  
**Branch of Military and Position:** Navy - undersea medical officer on Ohio class submarine, staff anesthesiologist, residency attending  
**Current Civilian Practice:** Central Wyoming Anesthesiology; Wyoming Medical Center, Wyoming Surgical Center and Casper Surgical Center.



**SAM T. SCALING, MD**

**Rank:** Major  
**Years of Service:** Active Duty: 1970-71 and 1972-75; Reserves: 1975-77.  
**Branch of Military and Position:** USAF Senior Medical Student Program; Department of OBGYN and Family Medicine; USAF reserves.  
**Current Civilian Practice:** Womens Health Associates of Wyoming in Casper



**DANIEL W. WHITE, MD**

**Rank:** Colonel  
**Years of Service:** 25 Years of Service  
**Branch of Military and Position:** US Army. Retired as Chief of Orthopedic Surgery, Evans Army Hospital, Fort Carson, CO  
**Current Civilian Practice:** Orthopedic Sports Medicine Surgeon, Casper Orthopedics Associates



**ROBERT NAGY, MD**

**Rank:** Lt. Colonel  
**Years of Service:** 1969-2002  
**Branch of Military and Position:** 1969-1976, Active duty Navy in Oakland; 1983-90, Army in Salt Lake City; 1990-91, Army active duty in Saudi Arabia; 1991-2002 Army reserves at Salt Lake City.  
**Current Civilian Practice:** Short-term missionary ENT surgeon in Kenya



**GEORGE M.A. FORTIER IV, MD**

**Rank:** Major  
**Year of Service:** 13 - Reserve, four Active duty  
**Branch of Military and Position:** Air Force Minot APB Regional Hospital; Chief surgical Svcs; Medical Director ICU  
**Current Civilian Practice:** Banner Health Clinic in Torrington and Platte County Memorial Hospital





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## Wyoming Physicians Who Have Served



**DAVID LIND, MD**

**Rank:** Colonel  
**Years of Service:** 1972-1985; 1988-91; 2001-2012  
**Branch of the Military:** Army  
**Current Civilian Practice:** Cheyenne Obstetrics and Gynecology



**CHRIS HILLS, MD**

**Rank:** Major  
**Years of Service:** 2004-2013  
**Branch of the Military and Position:** Deployment with 31st and 115th Combat Support Hospitals in Helmand Province, Afghanistan Sept 2009 - Feb 2010.  
**Current Civilian Practice:** Orthopedic Spine Surgeon in Jackson.



**MATT MITCHELL, MD**

**Rank:** Lt. Colonel  
**Years of Service:** 1997-2006  
**Branch of Military and Position:** Air Force - orthopedic surgeon  
**Current Civilian Practice:** Casper Orthopedic Specialists



**WILLARD M. WOODS, JR.**

**Rank:** Major  
**Years of Service:** 1968-79  
**Branch of Military and Position:** US Army



**GREGORY H CROSS, JR, MD**

**Rank:** Commander  
**Years of Service:** 1983-2001  
**Branch of Military and Position:** Navy - Radiologist  
**Current Civilian Practice:** Yellowstone Radiology in Cody



**CAROL SCHIEL, MD**

**Rank:** Major  
**Years of Service:** 1981-87  
**Branch of Military and Position:** Residency at Madigan Army Medical Center in Tacoma, Wash. and Army Medical Corps at Munson Hospital in Ft. Leavenworth, Kans.  
**Current Civilian Practice:** Cheyenne Children's Clinic



**MICHAEL D. EISENHAUER, MD, MBA**

**Rank:** Colonel

**Years of Service:** 1985-2010

**Branch of Military and Position:** US Army - Primary responsibilities were administrative in nature, involving healthcare policy and implementation in Theater. Clinical duties included responsibilities as personal physician to the General Staff with offices at Al Faw Palace complex, Camp Victory and US Embassy, Baghdad.

**Current Civilian Practice:** Locums' Interventional Cardiology Services; employed by Weatherby Cardiology, with duties in WY, KS, NE, MT, and AK.



**PHILLIP SCHIEL, MD**

**Rank:** Major

**Years of Service:** 1981-87

**Branch of Military and Position:** Residency at Madigan Army Medical Center in Tacoma, Wash. and Army Medical Corps at Munson Hospital in Ft. Leavenworth, Kans.



**ROBERT PRENTICE, MD**

**Rank:** Major

**Years of Service:** three

**Branch of Military and Position:** Air Force Pediatrician

**Station:** Kadena AB, Okinawa, Japan

**Current Civilian Practice:** Cheyenne Children's Clinic



**ERIC WEDELL, MD**

**Rank:** Captain

**Branch of the Military:** Air Force

**Years of Service:** 1971-73

**Location of Service:** Richards-Gebauer AFB



**JEFF STOREY, MD**

**Rank:** Colonel in Air National Guard  
**Station:** 153rd Air Wing in Cheyenne Wyoming

**Years of Service:** 24

**Branch:** Air National Guard

**Current Civilian Practice:** Cheyenne Women's Clinic

**Current Military Position:** Commander 153rd Medical Group Cheyenne Wyoming



**WESLEY W. HISER, MD**

**Rank:** Major

**Branch of the Military:** Army, U.S. Special Forces 7th, 5th, 10th

**Years of Service:** Three years active duty, three years reserves

**Location of Service and Job:** Ft. Bragg, Walter Reed, Vietnam, Ft. Devens, MA.

**Current Civilian Practice:** Casper, WY, Cardiology 40 years.





## Serve in the Military

# Wanted: Good Docs to Serve in the Military

BY TOM LACOCK

Wyoming Medical Society

**W**hile many Wyoming physicians have previously served in the US Armed Forces, opportunities abound for doctors interested in being a part of the military.

Most days Jeff Storey, MD, is a physician at Cheyenne Women's Clinic, but at least one weekend a month and two weeks a year he is the Group Commander for the 153rd Medical Group of the Wyoming Air National Guard. He says the Guard is always looking for physicians and is tasked with maintaining the health and care of 1,100 members of the air wing in Cheyenne. He says the 153rd has several opportunities, including acting as flight surgeons (caring for aircrew members with flying duties), critical care air transport teams and more.

He says the National Guard has less stringent requirements than active duty military requires for entry into the service. While the Guard prefers physicians age 45 and under, it will admit older doctors with a waiver. Storey says doctors interested in serving should be in generally good health, cannot be considered morbidly obese and will have to pass an annual physical fitness test, which includes requirements of sit-ups, push-ups, a waistline measurement and a 1.5-mile run.

Storey says the requirements of doctors in the Guard include one weekend a month and two weeks a year. While the pay isn't necessarily high, he says the opportunity to see the world and significantly-reduced healthcare coverage through Tricare make it worthwhile. He adds that although there is always a risk of deployment, in the past 10 years the 153rd has not deployed anyone involuntarily.

Hospitalman Chief Matt Birchall of Navy Health Professions in Denver says the Naval Reserve is in need of physicians in all specialties. The Navy requires a three-year commitment with physicians serving one weekend per month and two weeks a year at a local Naval Reserve Center (likely Cheyenne, though some might be able to drill in Billings or Salt Lake). For those more than 50 miles from drill, the Navy includes travel pay and low-cost health and dental coverage through Tricare.

The two-week training is conducted at an alternate location -- most likely a Naval Treatment Facility. The Navy offers signing bonuses of up to \$75,000, which varies depending on specialty. Doctors interested in serving must be under the age of 58 (though they will consider all ages for critical specialties), pass a physical exam and must be licensed to practice in the U.S.



Lt. Col. Luis Otero, MD, the Chief of Medical Staff at F.E. Warren.

The Army Medical Corps seeks physicians to conduct and supervise direct patient care, and plan and execute disease prevention and health promotion programs. Additionally, physicians may conduct medical research on diseases of military importance and more. Army-provided data credits Army medicine with overseeing \$1.4 billion in research and development each year and manages 148 graduate medical education programs.

To take part in the Army's Medical Corps, a physician must be between the ages of 21-42, be licensed in the U.S. or Puerto Rico, be eligible for board certification, and complete an approved graduate medical education internship in family medicine. Among the benefits of doing so listed by the Army are no need for malpractice insurance, paid continuing education, 30 days of paid vacation, retirement, and no-cost or low-cost medical and dental care.

### Why Do It?

Lt. Col. Luis Otero, MD, the Chief of Medical Staff at F.E. Warren, says many things about practicing medicine in the Air Force are similar to doing so in private practice. Advantages include not dealing with as much insurance paperwork, but there is the added obligation of letting commanders know if




their personnel can perform deployed missions.

Captain Jim Caruso, MD, works with Naval Medical Recruiting out of Denver after joining the Navy in 1984. He says he got into military medicine as a way to pay for medical school. He was assigned positions all around the world including nine months in support of Operation Desert Shield and Desert Storm with additional deployments in Somalia and Panama. He later served as a pathologist, a flight surgeon and a forensic pathologist working several high-profile missions such as the 2003 Space Shuttle Columbia disaster. He is the chief medical examiner for the City of Denver while taking retirement pay and healthcare, in addition to tapping his unused GI Bill benefits to send his oldest daughter to college.

“A career in Navy Medicine set me up well for the next chapter. I obtained excellent training, honed my leadership skills much earlier than most physicians ever will, and gained notoriety in my field.”

Storey says it's commonplace to say no one joins the military for the money, but mentioned the travel opportunities he has


experienced, as well as the opportunity for training as reasons he has stayed in the military.

“I do it because of the benefit of feeling like you are contributing to both your community and country,” Storey says. “It sounds somewhat trite, but it is the meaning of patriotism to commit to the military and serve the country.” 

**For more information on joining the Naval Reserve, contact Chief Matt Birchall at 303-746-3107 or [matthew.birchal@navy.mil](mailto:matthew.birchal@navy.mil).**

**To discuss service through the Air National Guard, contact Jeff Storey, MD, at 307-637-7700.**

**For more information on military careers in the Army, contact Lyndie S. Corder: [usarmy.knox.usarec.list.9e1a2@mail.mil](mailto:usarmy.knox.usarec.list.9e1a2@mail.mil)**



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## Wyoming Military Medical Facilities

# Fitting into the Medical Community

BY TOM LACOCK  
Wyoming Medical Society



Completed in 1932, the Cheyenne VA Hospital and surrounding complex features 17 buildings on 50.88 acres. The facility itself is a full-service hospital campus with a total staff of 950, which serves 24,500 veterans in a three-state region.

Colonel Cherron R. Galluzzo is the Commander of the 90th Medical Group at F. E. Warren AFB in Cheyenne, having come to town in mid-July -- her 16th move for the Air Force since 1993. So far it is safe to say her welcome to Wyoming seems to be going well, as illustrated by a recent unexpected greeting from Cheyenne Mayor Rick Kaysen.

“My mom and I were out for dinner downtown and Mayor Kaysen and his wife came over to ask how we were doing,” Galluzzo says. “That simple gesture is a testament to what Cheyenne is all about. The warm reception we have received since we’ve been here makes me excited to be part of such a great community.”

While Kaysen and Cheyenne understand how the 90th Medical Group at F.E. Warren fits into the community at large, few understand the role the medical facilities at the base -- and the other two military medical facilities in Wyoming -- play in the state’s medical community. Between F.E. Warren and VA Hospitals in Sheridan and Cheyenne, military healthcare facilities

take care of roughly 45,000 residents of Wyoming, Montana, as well as parts of Colorado and Nebraska.

### F.E. Warren

Galluzzo leads 228 personnel and manages a \$9.8 million budget at F.E. Warren, working under a dual mission -- to maintain the health of warfighters, as well as the families of the airmen based in Cheyenne.

Galluzzo is a nurse by training, earning her BS in Nursing from the University of Akron. After earning a Masters in Human Resource Development and two more Masters at Maxwell Air Force Base in Alabama, she came to Cheyenne in July. She is a Senior Flight Nurse with more than 600 hours flown and has been deployed in direct support of major operations including Operation New Dawn, Operation Enduring Freedom, and Iraqi Freedom.

Serving with Galluzzo is Lt. Col. Luis Otero, MD, the Chief of Medical Staff at F.E. Warren, who arrived in Cheyenne this

summer after time in Ohio, Japan, California, South Carolina and the Air War College in Alabama. Awarded the Bronze Star for developing public health procedures during a deployment to Afghanistan, Otero oversees all clinical care on the base. That includes a patient roster of 9,600 and another 11,000 who have access to ancillary services on the base such as use of the pharmacy, or x-ray equipment. Despite the administrative duties he carries, Otero still maintains a day a week in-clinic.

“I love clinic,” says Otero, who attended medical school at University of Miami in Florida. “I went into family medicine because I love seeing patients and I love the variety I get to see. It re-energizes me and I have a passion for it.”

The clinics at F.E. Warren operate under the Air Force Medical Home framework - the military’s version of a Patient Centered Medical Home - and the clinic is NCQA Level 3 certified. The clinic is open to all military members and their families carrying the TriCare Insurance product. TriCare is the military’s health care program for uniformed service members, including active duty and retired members of the military and is managed by United HealthCare. TriCare Plus members - TriCare’s military supplement - also have access to base clinics and pharmacies.

The medical facilities on the base include a family health clinic with two physicians and three PAs; a Personnel Reliability clinic - dedicated to service members who are a part of the Intercontinental Ballistic Missile mission - featuring three PAs; a Flight Medicine clinic with three physicians; and a mental health clinic with one psychiatrist, two psychologists, and three licensed clinical social workers. An optometrist, a physical therapy clinic, and an alcohol and drug treatment clinic are also housed on the base.

The one piece of the medical puzzle lacking at F.E. Warren is specialists. Capt. Lauren Rodgers is the practice manager for the clinics at F.E. Warren and says the base makes 100 referrals a day to specialists in Cheyenne and Northern Colorado. That has led to some strong relationships within the medical community.

“Because most of our clinics are set up to have primary care

with very little specialists, we end up interacting quite a bit with the physicians we are referring to,” Otero says. “Part of my job is to refer members out and get referral reports back. This community does extremely well with those. We have great relationships where information is being passed back to us.”

Otero says specialists interested in joining the mission are encouraged to speak with the United HealthCare representative about getting into the TriCare network.

Military providers tend to be transferred roughly every four years, as do enlisted personnel. Rodgers says thanks to the PCMH model, electronic health records and programs such as the Exceptional Family Member program, which helps the military track family members with special needs, the transition tends to be seamless.

“You have families coming and going so every time they arrive at a new place, they have to set up a relationship with the providers,” Otero says. “As providers we get moved as well. Both sides have a lot of transition, but luckily our military population is very resilient and tend to respond to that well.”

Two other areas unique to the Air Force at F.E. Warren are a public health department, which trends on-base, such as occurrence of injuries or event illness/STD’s and an environmental de-

partment charged with making sure buildings and facilities are up to code and healthy.

The clinic at F.E. Warren is currently overtaken by workers in hardhats and is in the process of an \$18.3 million facelift. Rodgers says the plan is to update the 30-year-old clinic which was originally built to be a small, community hospital. The hope is to make patient flow easier.

“My job is all about access,” Rodgers says. “Are we meeting our access numbers? The Air Force has set goals for us, so urgent needs should be seen in 24 hours, future appointments in seven days. I work to see that we are meeting those. What is our population asking for?”

Otero says one of the next steps for his group is to begin to build on the relationships it has developed in the Cheyenne area and look to do the same in Northern Colorado where a large number of airmen who serve at F.E. Warren reside.

“I went into family medicine because I love seeing patients and I love the variety I get to see. It re-energizes me and I have a passion for it.”

LT. COL. LUIS OTERO, MD  
Chief of Medical Staff at F.E. Warren AFB





## Wyoming Military Medical Facilities



The medical clinic on the FE Warren base includes areas for dental, and vision exams as well as a pharmacy.

### VA Facilities in Cheyenne and Sheridan

In addition to F.E. Warren's active-duty mission, the state has two Veterans Affairs hospitals -- in Cheyenne and Sheridan -- to serve Wyoming's veterans. Samuel House, public affairs officer for the Cheyenne VA, says any veteran who served either stateside or in the combat theatre during time of war is eligible for services at the VA. He said if an individual suffered an injury which was service-related and is compensable is also eligible for services.

Completed in 1932, the Cheyenne VA hospital and surrounding complex features 17 buildings on 50.88 acres. The facility itself is a full-service hospital campus with a total staff of 950, which serves 24,500 veterans in a three-state region. The Cheyenne VA serves patients north from Wheatland/Torrington south to Fort Collins/Greeley, from Rawlins east to Sidney, Nebraska. The VA offers clinics in Fort Collins, Greeley, Sidney, Nebraska, and Rawlins, which feed into the Cheyenne facility. Mobile telehealth through use of a recreational vehicle serves veterans in Wheatland, Torrington, Sterling, Colorado, and Laramie.

"We have 75 beds in our hospital, a 24-7 emergency room, and did 25 surgeries last week," House says.

Of those 75 beds, five are in the hospital's ICU, 10 are in the VA's residential rehab treatment facility for post-traumatic stress disorder, as well as alcohol and substance abuse. It is a residential setting in which the doors are always open. The facility's Community Living Center offers 35 beds for short-term rehab and long-term veteran stays. The facility also houses a hospice. Service-connected veterans can also get prescriptions

at \$8 per-month per-prescription while non-service connected vets pay \$9 per-prescription per-month.

Like its sister to the south in Cheyenne, the Sheridan VA also serves a large area of the map with responsibilities for over 11,000 patients spread over nearly 70,000 square miles. The Sheridan VA has 68 licensed independent providers at its facility including 31 physicians serving the 171-bed facility. The Sheridan facility features primary care, as well as physical rehabilitation, neurology, podiatry, dentistry, mental health and audiology. Sheridan VA also provides long-term and skilled care. A new community transition program in support of serious mental illness will kick off this December.

Acting public affairs officer for the Sheridan VA, Terry Parsley said the Sheridan VA is a tertiary care mental health referral center for veterans throughout Colorado, Montana, Oklahoma, Utah and Wyoming. The new Community Transition Program will provide a comprehensive, evidence-based approach to treatment and rehabilitation of Veterans with serious mental illnesses such as schizophrenia, schizoaffective and bipolar disorders, and other psychosis spectrum disorders. The goal is to provide integrated, recovery-oriented care through an interdisciplinary team that will assist the individual in acquiring new skills to reduce psychiatric relapse, enable him or her to attain the highest level of functioning possible, and to integrate into the community of his or her choice.

"We strive to incorporate medical providers into the mental health treatment teams to facilitate co-management of the Veterans' physical health conditions while they are actively engaged in the mental health treatment programs," says Parsley.





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## Wyoming Military Medical Facilities



Jim Gray, MD, FACP practices at the Cheyenne VA as a gastroenterologist and says the medicine is nearly the exact same as it is in private practice. The biggest difference is there is admittedly more paperwork and more bureaucracy.

### Practicing in a VA

Jim Gray, MD, FACP, practices at the Cheyenne VA as a gastroenterologist and says the medicine is nearly exactly the same as it is in private practice. The biggest difference is there is admittedly more paperwork and more bureaucracy. However, he said he has worked at VAs in Cheyenne and Amarillo, Texas, and the focus on the patient is one he appreciates.

“The VA, unlike most of my experience in the private sector, is very focused on the patient, and in this case the veteran,” Gray says. “In the VA and in the military the administrators meet every morning and talk about what is happening with patients. You tend not to do that in the private sector.

“It is a great place to work, it really is. We hire an awful lot of doctors on a fee-based basis. Instead of them having a full or part-time job, they are out there and available. If we need them and they are available, we put them to work and pay them on the rate that has been agreed upon.

House says the VA has a history of paying about the median of market rate or a little below and admits the hiring process for any position at the VA can be arduous. He says sometimes a physician who has applied for a position with the VA will take another position because of the time involved in the hiring process. While there are several available positions for physicians at the Cheyenne VA, he says getting through the process is worth the effort.

“Although benefits are comparable, physicians from certain disciplines do not earn the same pay as in the private sector,” Gray says. “However, they also do not typically have the same workload and call requirements.”

### VA Battles a National Reputation

News media reports over the past two years have documented issues with veterans being asked to wait long periods for an appointment at a VA facility. House said it is the goal of the VA to get every veteran calling for an appointment seen within 14 days of the call.


He said the Veterans Choice Act of 2014 allows vets who have been determined eligible and who live 40 miles or more from a VA facility to seek care outside the VA system. The program offered \$7 billion for more healthcare staff nationwide and another \$10 billion for veteran health care visits within the community. However, he says the performance by the third-party administrator for taking the calls from vets and setting appointments, Healthnet, has been disappointing.

“Many times it would take 45 minutes to an hour and a half to get through on that number,” House says. “It still happens today. (Vets) would be verified, then they would be told by the individual on the phone they would need to wait 72 hours to receive another phone call telling them when they appointment would be. Many times the appointment would be in a different state. Sometimes the appointment would be for a provider that they know is not good, and sometimes they would not get the call.”

A report by the Department of Veterans Affairs released July 6 panned the Veterans Choice program. According to the Associated Press The report recommends replacing the program with community-based delivery networks that it said should improve access, quality and cost-effectiveness.

The report does offer kudos for recent changes in the VA system as a whole, pointing out that in March the VA health system set a record for completed appointments: 5.3 million in VA hospitals and clinics, 730,000 more than in March 2014. The VA also issued twice as many authorizations for government-paid, private care than in a comparable period two years ago. The report adds nearly 97 percent of appointments are now completed within 30 days of the veteran’s preferred date.

House says getting the area’s vets seen quickly has been a priority and is happy with the efforts being made at the Cheyenne office.

“When they call here they are seen quickly,” House says. “Our former director and current director saw the writing on the wall, and they used some of that money to hire additional providers as well as additional schedulers.” 

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# Wyoming Family Practice Residency - Casper Profiles

## Wyoming Medicine Questions

1. Where are you from originally and where did you attend medical school?
2. What made you consider Wyoming for your residency?
3. What makes Wyoming a unique place to practice?
4. If you were recruiting medical students to UW Family Medicine Residency Program in Casper, what would you tell them?
5. What are your plans for practice after graduation?

### Eric Larsen, DO West Texas



1. I grew up in a small town in rural West Texas. I went to medical school at the University of North Texas College of Osteopathic Medicine in Fort Worth.
2. I love adventure, exploring, and I yearned for the mountains. I wanted a residency program that focused on teaching and full-spectrum medicine. After rotating through large, hectic hospital systems during medical school, I realized the value of an unopposed residency program.
3. Wyoming has the lowest population and the highest miles driven per capita per year in the United States. Translation: wide open spaces. It is one of the few places left where family medicine physicians truly practice it all. These are just some of the reasons why being a doctor in Wyoming is always exciting and continually challenging.
4. Our residency program is perfect for medical students who want to learn full-spectrum care. As a team member in an unopposed program, our residents have every learning opportunity at their fingertips. If you want to learn central lines, joint injections, cesarean sections, etc., this is the place for you. If you are interested in learning something there is someone interested in teaching you. Most of our residents are not originally from Wyoming, but many of us choose to stay. We treat our residency team like family.
5. I have not yet decided on an exact career path. I recently married the lady of my dreams and we are excited to have the world at our fingertips. We both fell in love with Wyoming and the West — I just don't think we could ever leave.

### Jaime Hajjari, MD Oklahoma



1. I am from Norman, Oklahoma and attended medical school at Ross University.
2. The Rockies were calling me, and I chose Wyoming for residency because I was looking for a place with positive people who cared about teaching and making me a great doctor.
3. Wyoming is unique because of a rural feel with all the amenities of big city medical care and experience. We also happen to have the advantage of proximity to ski areas, Platte River, Alcova and Fremont, which is a dream for anyone that loves outdoor adventures.
4. I would tell them to read above, or just come hang out for a month like I did and fall in love with our program and area.
5. I hope to be doing either full time ER or part time ER and outpatient. I would love to stay in Wyoming and am currently looking at some local job opportunities.



## Tyler Merchant, DO

Missouri

1. I was born and raised in Marshall, MO. I earned my Doctor of Osteopathic Medicine degree from Lake Erie College of Osteopathic Medicine in Greensburg, Pennsylvania.
2. Wyoming offers great broad-spectrum family medicine opportunities. This together with excellent OB training, including opportunities for C sections, led me to Wyoming.
3. Wyoming is unique in its variety. Though it is mostly rural, Casper is large enough to offer much of what a big city does: plenty of places to eat and many choices of activities for fun. The geography is also really cool, with everything from rivers to fish in, mountains to hike, and big open fields full of game to hunt.
4. Family medicine training here is rich. We are unopposed, so you will have dibs on new procedures and management of complex patients. We interact directly with community attending physicians and those from outside facilities. We have several tracks, including OB, hospitalist, and others that offer more intense training in those areas. Finally, our dual accreditation means that all residents here are exposed to longitudinal osteopathic principles and practice.
5. I am hoping to complete a one-year fellowship in surgical and high-risk obstetrics after residency. My wife and I love it here and are strongly considering staying in Wyoming to practice.



## Brian Iutzi, MD

Alaska

1. I am from Alaska and completed medical school at the University of Washington.
2. This part of the WWAMI region is a great area in which to train for full scope family medicine, including OB care.
3. This residency is an unopposed family medicine program in a rural state with large coverage areas. Wyoming residents love the outdoor life and there are plenty of summer and winter activities throughout the year.
4. I would tell medical students they will receive good procedure training, amazing full scope training from the ER to the ICU, and from the clinic to nursing homes with plenty of OB experience as well.
5. I plan to practice in a rural setting in Alaska with a possible return to Wyoming in the future.



## Alex Ukleja, MD

Connecticut

1. I am from Connecticut and I went to Ross University for medical school.
2. I wanted to come to Wyoming for its amazing exposure and education in the primary care setting. I loved the autonomy the Casper program provided.
3. I would tell medical students how inclusive the residency is and how much learning is available in this setting, most importantly, exposure to the patients.
4. I plan to practice in North Carolina as a hospitalist.







# Good Health for Wyoming, Together

BY DR. MARK LAITOS

**H**ealth care is changing so much – and so quickly – that the system we know today is hardly recognizable from the one we all knew just a few years ago. And I think it's very likely I will be saying the same thing a few years from now.

What hasn't changed is that affordability, access and quality are complex problems, and no single good idea or innovation will be the “cure all” that solves for all three. Yet we know significant progress will come from the physician community and organizations that pay for care working together and collaborating in new ways – together – to make a collective impact.

After 30 years as a practicing physician, and as a past president of the Colorado Medical Society, I have an enduring respect and appreciation – gained first hand and on the front lines – of the pressures doctors face in the modern-day practice of medicine.

Now I'm a physician medical executive for a leading health service company and have the privilege of working with doctors in four states, including Wyoming. In this role, I have an equal appreciation – also gained first hand and on the front lines – of how important it is to focus on population health and to empower systems of care: Systems that support both the way doctors want to practice and the way their patients want to be treated, systems that place an emphasis on the outcomes generated, rather than simply on the services provided.

At Cigna, we believe that there is a single – but not simple – concept at the heart of our work together. It is that good health, in all of its dimensions, is the path to a sustainable health

care system.

Collectively, we're working to shift our emphasis from “sick care” to health care, helping to prevent people from becoming ill in the first place, with better incentives for healthy behaviors. The question is how do we get there? A large part of the answer: We get there together.

We know doctors direct patients' recovery from illness or injury, help them manage a chronic condition, promote their emotional/behavioral well-being and encourage healthy behaviors that will help their patients have the best chance for a healthy future. The doctor-patient relationship is a very special and unique one.

Companies like Cigna play an important role, too. We can amplify the impact in ways that a single doctor or practice may not be able to. In my decades of practice, I often didn't know what happened to my patient when he or she left my office – until perhaps the next time I saw them in our office. But behind the scenes, companies like mine can use our data to flag when an individual isn't getting preventive or follow-up care, or to supplement a preventive office visit with help from a qualified health coach or a worksite wellness program. These efforts can help people succeed in ways large and small – from taking that first step toward a daily walking habit, to quitting tobacco or eating better. At the systemic level, we can also help connect the common interests of health care professionals, patients and their employers who pay for care so that we are working in tandem to achieve common goals.

There are ample problems for us to solve together to give people a better future – one where health is an enabler, not a barrier, to a fulfilling life. Doctors across the country know that the percentage of overweight and obese adults and children in the U.S. has soared over the last several decades. They also know that too few people make the connection between excess



Dr. Mark Laitos

...companies like mine can use our data to flag when an individual isn't getting preventive or follow-up care, or to supplement a preventive office visit with help from a qualified health coach or a worksite wellness program.

CONTINUED ON PAGE 46 >



# Child Health Champions: Healthier Kids through Public Policy

**L**andon Noble, 10 years old, is one of 1,300 residents of Basin, Wyoming. He's also one of only six kids in the entire US with a particularly rare chromosomal deletion disorder—but he isn't the only child in Wyoming diagnosed with a complex and chronic medical condition, and there are things all of us can do to help the families who face this experience.

In Landon's case, his family didn't know what to expect upon diagnosis. With a more common condition like Down's Syndrome, doctors can provide a sort of roadmap for parents that tells them what their child's prognosis is and what symptoms they can expect to develop as the child ages. Landon's condition didn't come with any of that. Because it is so rare, it didn't even have a name. The Noble family continues to figure it out as they go. As Landon grew, it became clear that he would have cognitive delays, as well as heart and lung problems and a multitude of feeding issues.

Today, Landon's care is spread out across a vast geographic region. He sees a pediatrician in Cody for regular checkups, and sees a genetics doctor out of Salt Lake City for some of his appointments, while most of his care is provided at Children's Hospital Colorado. As a result of this fragmented and sometimes unpredictable care, Landon's mom had to quit her job just to help with the care coordination that keeping him stable requires. But there is a better way. There is a proposal that would help families like this. And there are things you can do to help Landon and kids like him, as well as future efforts to improve the health and wellbeing of kids in Wyoming.

The ACE Kids Act, which recently had its first hearing in U.S. Congress, would help states create tailored, intensive, pediatric-focused networks of providers that can reach across state lines to ensure that kids on Medicaid who live with chronic medical complexity receive the best care possible, while reducing unnecessary costs. By establishing regional networks of care for these children, it would be easier to coordinate care

for families who need to seek care both locally and regionally to meet their needs.

There are nearly 70,000 kids on Medicaid or CHIP in Wyoming. Nationally, about six percent of kids with Medicaid coverage are considered medically complex, so if that average holds in Wyoming, approximately 4,000 kids would benefit from provisions in the ACE Kids Act. When one contemplates that many kids in wheelchairs and with feeding tubes, etc., it's easy to understand the vast impact this bill could have on families' lives.

In the context of the current budget cuts in Wyoming, the ACE Kids Act will also save the state money. Each Medicaid-eligible child costs Wyoming about \$2,700 annually, on average. However, 6 percent of the kids on Medicaid—those who have

medical complexity—account for 40 percent of all costs for Medicaid kids. That's why designing a system that provides better and more cost-effective care for that small population will produce meaningful savings for the whole system.

Wyoming Medical Society readers can learn more and speak up in support of this legislation and other public policies to benefit kids in Wyoming by joining the Children's

Colorado Child Health Champions network.

Kids can't always speak up for themselves, but healthcare leaders in Wyoming can speak up on their behalf, and the Child Health Champions network makes it easy. The Champs network is a group of more than 5,000 people, including hundreds of Wyoming citizens, who care about kids' health and wellbeing and want to make a difference. The network joins the voices of physicians and other healthcare professionals, patients and families, business leaders and community members to speak up clearly and powerfully for kids when public policy decisions are made. Champions write letters, make phone calls, tweet at legislators and share information when needed to influence public policies in Wyoming, Colorado, and in Washington, D.C. Please become a Child Health Champion today by visiting [www.childrenscolorado.org/advocacy](http://www.childrenscolorado.org/advocacy).

**Kids can't always speak up for themselves, but healthcare leaders in Wyoming can speak up on their behalf, and the Child Health Champions network makes it easy.**





# CANDOR Toolkit: Physicians Now Have the Right Tools to Do the Right Thing After an Adverse Event

BY ROBIN DIAMOND, MSN, JD, RN

Senior Vice President of Patient Safety and Risk Management, The Doctors Company

In the past, hospitals and physicians could appear cold and distant after adverse events. The fear of malpractice lawsuits created a culture in which physicians were expected to avoid most contact with a patient or family who might have reason to sue—and physicians certainly weren't supposed to accept blame.

The actual effect of this way of thinking was just the opposite of what hospitals and doctors desired. Rather than shielding them from liability, patients and family members perceived this culture of silence as callous and uncaring, in some cases encouraging them to file lawsuits.

That was then. Over the past decade the healthcare community has embraced the idea that saying "I'm sorry this happened," or at least acknowledging that an unanticipated adverse event occurred with genuine sympathy and concern, can go a long way toward healing the relationship between the healthcare provider and patient. Physicians have moved progressively toward a culture that expects an adverse event—a medication error, for instance, or a death during routine surgery—to be followed by a full disclosure of the facts to the patient and family.

This is not just the right thing to do; it also helps the hospital and physicians avoid malpractice litigation, especially the lawsuits motivated not by actual errors or substandard care but by patients and family members who were left angry and abandoned.

The Agency for Healthcare Research and Quality (AHRQ) developed the Communication and Optimal Resolution (CANDOR) Toolkit with the input of healthcare professionals who studied the different tools, policies, and procedures in use at various hospitals, including the disclosure resources offered by The Doctors Company. David B. Troxel, MD, medical director at The Doctors Company, served on the oversight commit-

tee, and I served on the technical advisory committee, which assessed expert input and lessons learned from AHRQ's \$23 million Patient Safety and Medical Liability grant initiative launched in 2009.

CANDOR calls for a prompt response and specific actions after an adverse event. Within one hour, specially trained hospital staff should:

1. Explain the facts, and what might still be unknown, to patients and family members.
2. Contact the clinicians involved and offer assistance, because the stress and grief of the healthcare professionals can easily be overlooked in these incidents.

3. Immediately freeze the billing process to avoid further stressing the patient with a bill for the services that may have caused harm.

CANDOR calls for the hospital to complete a thorough investigation within two months, keeping patients and relatives fully informed along the way. When the investigation is complete, the patient and family are provided with the findings and engaged in a

discussion of how the healthcare organization will try to prevent similar adverse events in the future.

The investigation will not always find that the physician or other clinicians failed to meet the standard of care, and in those cases the patient and family members can still benefit from understanding what happened. In many cases, they will not sue despite their loss because they are satisfied that the hospital and physicians did their best and were forthcoming with information.

**The actual effect of this way of thinking was just the opposite of what hospitals and doctors desired. Rather than shielding them from liability, patients and family members perceived this culture of silence as callous and uncaring, in some cases encouraging them to file lawsuits**

*Contributed by The Doctors Company.  
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# Tough Conversations: Talking to Your Patients and Their Families About Advance Directives

BY EMILY CLEGG, JD, MBA, CPHRM

Senior Risk and Patient Safety Consultant, UMIA Insurance, Inc.

**M**ost people don't want to think about the end of life, much less talk about it. With advancing technologies, however, the end of life can be a conscious decision as opposed to a predestined moment in time. Not talking about that decision before it arrives can cause unbearable distress for a family—distress medical professionals can mitigate by starting that tough conversation.

Shawn McGarry, a Utah attorney, has been through conversations about advance directives with clients and with his own family.

"The fact that people create a will without advance directives is shocking to me," he says. "How can we care more about how our belongings are distributed than alleviating the burden of end-of-life decisions on our loved ones?"

George Schoepfoerster, MD, a family practitioner and geriatrician, engages in end-of-life discussions on a daily basis in nursing homes across central Minnesota. Dr. Schoepfoerster describes an advance directive as a conversation about what a patient values and feels was the meaning of his or her life. This leads to decisions about when life is worth living and when to let go.

Whatever your approach, the conversation starts with some basic terminology:

## Advance Directive

An advance directive or health care directive is a document expressing a patient's wishes concerning life-sustaining care if he or she becomes unable to make decisions. Any competent adult can and should complete a directive, not just those facing a terminal illness. A directive is where a patient expresses — while still able to think clearly — two important issues: first, what life-saving treatment he or she would choose (also covered by a living will); and second, who can make decisions on his or her behalf (also covered by a power of attorney or proxy). Patients can address either of these separately, but the advance directive usually encompasses both.

A patient can complete an advance directive on his or her own, and with or without help from a provider or an attorney. McGarry agrees that an attorney is not necessary.

"The critical issue is the communication between and among family members," he says.

As for a physician's involvement, Dr. Schoepfoerster feels a

provider can help tailor the conversation to the medical realities.

## Living Will

In a living will (sometimes called "Instructions for Health Care" in Wyoming), a patient specifies what life-sustaining interventions he or she wants or does not want if certain events become a reality. This may include wishes

about care, resuscitation, hospitalization and under what circumstances the patient wants to live or to let go.

McGarry describes how his father's living will came from jokes about whether he wanted to live if he could only eat tofu. Funny scenarios led to serious scenarios and then to a written document. When his father's health deteriorated, "it alleviated the burden of having to face those questions," both for the family and for the providers involved. Knowing his father's wishes preempted any disagreement between family members and gave them peace.

Without a living will, McGarry says he believes the burden on his mother to make decisions would have been too much to bear. To illustrate, the living will directed that his father wanted extubation when it was clear he would not recover. When the tube was removed, however, his father seemed to struggle.

"If my mom had been saddled with the decision to let him die, then for her to see him struggling to breathe... It would have been horrific for her," he says. "But we had a directive in place that said, 'If these certain things are present, then I don't want to live.'"

## Power of Attorney or Health Care Proxy

A power of attorney, also called a proxy or health care agent, designates a loved one to manage a medical crisis, to communicate with providers, and to speak on a patient's behalf should



Emily Clegg, JD, MBA, CPHRM



# Beware of the Patch!

BY LAWRENCE A. JENKINS, MD  
Premiere Bone and Joint

Despite warnings from the FDA, drug manufacturers and patient safety agencies, fentanyl transdermal patches (Duragesic) continue to be prescribed inappropriately to treat acute pain in opioid-naïve patients, sometimes in large doses or in combination with oral or intravenous (IV) opioids. Some of these prescribing errors have occurred in hospitals; other mistakes have originated in physicians' offices or ambulatory surgery centers, where well-meaning but misinformed primary care physicians or surgeons have prescribed the drug for opioid-naïve patients with contraindications such as acute postoperative pain.

Several tragic deaths have occurred in Wyoming from the use of these patches indicating that there is still not adequate awareness of their potential danger amongst physicians and pharmacists in our state. Even when used appropriately, there are so many variables that affect the transdermal absorption of fentanyl, that providers should really consider an alternative delivery system for their narcotic dependent patients.

The fentanyl patch is only indicated for use in patients with persistent, moderate to severe chronic pain who have been taking a regular, daily, around-the-clock narcotic pain medicine for longer than a week and are considered to be opioid tolerant. Patients must avoid exposing the patch to excessive heat as this promotes the release of fentanyl from the patch and increases the absorption of fentanyl through the skin which can result in fatal overdose.

The directions for prescribing and using the fentanyl patch must be followed exactly to prevent death or other serious side effects from fentanyl overdose. Any provider planning on using this system should be intimately familiar with the full prescribing indications and precautions. This includes the several FDA mandated Black Box Warnings issued over the last several years summarized below:

Fentanyl patches should not be used to treat short-term pain, pain that is not constant or for pain after an operation. Fentanyl patches should only be used by patients who are already taking other narcotic painkillers (opioid tolerant), and who have chronic pain that is not well controlled with shorter-acting painkillers.

Patients who are using the fentanyl patch and their caregivers should be told about the directions for safe use of the patch and should follow the directions exactly. These directions are provided in the patient package insert.

Patients who are using the fentanyl patch and their caregivers should be told about safe methods for storage and disposal of used, unneeded or defective fentanyl patches. Fentanyl patches should be stored in a safe place and kept out of the reach of children. Safely dispose of used, unneeded or defective fentanyl skin patches by folding the sticky side of the patch together (until it sticks to itself) and flushing it down the toilet.

Health care professionals who prescribe the fentanyl patch and patients who use the fentanyl patch and their caregivers should be aware of the signs of fentanyl overdose. Signs of fentanyl overdose include trouble breathing or shallow breathing; tiredness, extreme sleepiness or sedation; inability to think, talk or walk normally; and feeling faint, dizzy or confused. If these signs occur, patients or their caregivers should get medical attention right away.

A patient using the fentanyl patch may have a sudden and possible dangerous rise in their body level of fentanyl or have a stronger effect from fentanyl if they: use other medicines that affect brain function; drink alcohol (beer, wine or distilled spirits); have an increase in body temperature or are exposed to heat; or use other medicines that affect how fentanyl is broken down in the body. These factors are described further in

**The fentanyl patch is only indicated for use in patients with persistent, moderate to severe chronic pain who have been taking a regular, daily, around-the-clock narcotic pain medicine for longer than a week and are considered to be opioid tolerant**

the product label. Even when patients use the patch correctly, there are still risks associated with their use. If the patches are not disposed of properly, children, and pets, can come in contact with these patches, sometimes with tragic consequences.

The FDA has warned that children, being naturally curious, could have fatal contact with fentanyl patches, including placing them in their mouth or even having accidental exposure when hugging someone wearing a patch. The FDA announced in 2012 that since 1997, there have been 26 cases of accidental exposure to fentanyl. Most of these cases involved children under the age of two. Of the 26 cases, 10 resulted in the death of the child while another 12 required hospitalization.

The concomitant use of fentanyl transdermal system with a CYP3A4 inhibitors (such as ritonavir, ketoconazole, itraconazole, troleandomycin, clarithromycin, nelfinavir, nefazadone, amiodarone, amprenavir, aprepitant, diltiazem, erythromycin, fluconazole, fosamprenavir, verapamil) may result in an increase in fentanyl plasma concentrations, which could increase or prolong adverse drug effects and may cause potentially fatal respiratory depression.

Carefully monitor patients receiving fentanyl transdermal system and any CYP3A4 inhibitor for signs of sedation and respiratory depression for an extended period of time, and make dosage adjustments if warranted.

Given the multitude of problems associated with their use, I would encourage all Wyoming providers to seriously think twice before prescribing these transdermal pain patches.

Even when used exactly as intended, the potential for accidental overdose, drug interactions or tragic consequences due to improper disposal outweigh, in my opinion, any ben-

efit derived from their use. There are many alternatives available to providers who care for acute and chronic pain patients. Do yourselves and your patients a favor and avoid this system whenever possible.

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## Good Health for Wyoming, Together

CONTINUED FROM PAGE 40

weight and other serious medical conditions, such as heart disease and stroke, high blood pressure, diabetes and cancer, among others.

Beyond working one-on-one with people who are enrolled in our plans, we are also working alongside the Wyoming Medical Society in our communities, including through the Cigna Foundation, which is funding programs with the American Diabetes Association and American Cancer Society that focus on the health needs of Wyoming residents.

In May, Cigna announced a new initiative to work with the country's doctors to curb the country's opioid crisis, starting with cutting the use of those drugs among our own customers by 25 percent over three years. We have also provided de-identified customer claims data to the American Society of Addiction Medicine (ASAM) to test and validate performance measures related to addiction treatment. We support ASAM's goal to verify what works in the treatment of patients with substance use disorders, make the medical community aware of proven strategies, and hasten the adoption of these successful methods.

Working with physician practices, we continue to lead the industry in adopting value-based models of care that reward prevention, coordination of care and better outcomes over the old fee-for-service world of the past. We have more than 150 of these arrangements in place with large physician groups all around the country and recently created a new service company, CareAllies, to help physicians and other providers be successful in this new model regardless of the payer they are working with.

We believe that ongoing collaboration among all parts of the health care system will be the path that delivers the best quality at the most affordable cost. We congratulate the doctors being recognized in this issue for the work they have done. We also know that almost all the readers of Wyoming Medicine have their stories of successful patient care that won't appear in print, but which are still very much seen in the lives of patients and in our communities. Cigna thanks you for the good care you give your patients every day. We will continue to look for opportunities to work together to help you continue to deliver good care.



The intersection of health care and law is a puzzling place. We can help put those pieces together.

Health care is a constantly and quickly changing field, and health care law is no exception. Over 30 years, we have developed significant experience advising physicians on the impact of the myriad laws affecting their practices, and we spend a great deal of time and energy staying on top of current developments in health care law to better serve Wyoming's physicians.

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## Tough Conversations

CONTINUED FROM PAGE 43

he or she become incompetent. Instead of addressing interventions, a proxy gives authority for someone else to decide in the moment.

Dr. Schoephoerster argues that a proxy is the most critical piece of any advance directive because there is less room for interpretation and argument. A living will might request “no heroic measures,” which may apply differently in a real-life scenario. A proxy, on the other hand, can see the changing scenario day to day and say, “now this is what I think the person would want.”

Dr. Schoephoerster explains that a proxy can also take the provider out of the middle of feuding family members. The patient already selected one representative to speak on his or her behalf, and that person speaks for the whole family.

## Physician Order for Life-Sustaining Treatment

Wyoming recently adopted a new advance directive called the physician order for life-sustaining treatment (POLST). The POLST is a standing and transferrable medical order completed by a physician that directs treatment in specific scenarios. The POLST functions as a do not resuscitate (DNR) order that can transfer between facilities, sometimes even between states.

Unlike other directives, the POLST becomes appropriate at the end of life because it is effective immediately, not when some hypothetical circumstance arrives. It is used for patients with mental capacity, but who face life-threatening illnesses; patients with very specific, perhaps religious, preferences about end-of-life; and patients who want a DNR order outside of a health facility.

Dr. Schoephoerster explains that the POLST form has two advantages over other advance directives. First, it is an order from a physician. The physician involved with the patient is involved in the decision-making. Second, it is specific. The POLST is completed when medical realities are present, not hypothetical, and it addresses specifics of chronic disease management, resuscitation, hospitalization and other real scenarios.

## Start the conversation

Providers hold enormous power to break down intimidation and start the conversation. Sharing talking points about options can lead families to face the harder part — talking about values in life, spiritual beliefs and their feelings about their humanity that will lead to decisions about end-of-life care.

**Resources:** *WyoPOLST*, [www.wyomed.org/wyopolst](http://www.wyomed.org/wyopolst)  
**Wyoming Aging Division**, <http://health.wyo.gov/aging>  
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