Mayo Unveils Destination Medical Center Plan

At a time when health care in general is shrinking, Mayo Clinic is expanding. Last spring, it announced a 20-year, $5.6 billion economic development plan aimed at making Mayo Clinic and, by extension, Rochester, Minn., one of the leading medical destinations in the world.

In addition to doubling the size of the Minnesota campus, the plan calls for turning Rochester into a vibrant destination city — a thriving intellectual and cultural community with high-end hotels, restaurants and sports facilities.

Each year, Mayo Clinic attracts more than 1,650,000 outpatients from all 50 states and 150 countries. Bradley J. Narr, M.D., chair of anesthesiology and director of the new Destination Medical Center initiative, says expanding Mayo Clinic’s highly successful practice model and medical assets will help ensure its status as a global medical community for decades to come.

Mark A. Frye, M.D., chair of the Department of Psychiatry and Psychology, says the expansion presents “a wonderful opportunity for the department to broaden its ability to provide the best possible care to patients worldwide. Our three flagship programs — Mayo Clinic Depression Center, Pain Rehabilitation Center and Addiction Services — are exemplary models of integrated care with the goal of providing the best care every day to every patient who struggles with depression, pain and addiction.”

Pain Rehabilitation Center Improves Pain and Function Without Opioids

In 2011, doctors wrote more than 131 million prescriptions for hydrocodone, making it the most widely prescribed drug in the United States. Along with oxycodone, it is also the most abused. Both opioids have fueled an epidemic of addiction and fatal overdoses that outpace those from heroin and cocaine combined.

The problem is not just that opioid prescriptions for chronic noncancer pain have doubled in the last decade. It is also the drugs’ lack of long-term efficacy. Patients need higher doses over time to achieve the same level of pain control, leading to an increased risk of dependence, addiction and overdose and to reduced quality of life,
In September 2013, Mayo Clinic held its fifth Frontiers of Addiction Treatment conference in Rochester, Minn. The two-day meeting, which highlighted advances and current issues in the field, coincided with the Clinic’s 40th anniversary of addiction treatment.

More than 200 people attended the anniversary celebration, including Robert M. Morse, M.D., an emeritus professor of psychiatry and founding director of Mayo Clinic Addiction Services, who was honored for his groundbreaking work in the treatment of alcoholism and other addictive disorders.

“Dr. Morse developed a therapeutic model that addressed the psychiatric and medical disorders that often co-occur with substance abuse,” says psychiatrist Terry D. Schneekloth, M.D. “It’s a model that is increasingly emulated today, but 40 years ago it was a profoundly novel approach.” Dr. Morse and longtime colleague, Joseph Davis, according to Larissa L. Loukianova, M.D., Ph.D., an addiction psychiatrist at Mayo Clinic in Minnesota.

Barbara K. Bruce, Ph.D., L.P., clinical director of Mayo Clinic Comprehensive Pain Rehabilitation Center adds, “Sixty-five percent of adults admitted into our program have experienced chronic pain for an average of 10 years and are on daily opioids, with an average morphine equivalent of 130 milligrams. Yet despite high doses of these medications, their functioning is poor and their pain levels are very high.”

Mayo Clinic has one of the largest adult and pediatric pain rehabilitation programs in the country, treating more than 700 patients a year. It also has one of the most skilled and experienced programs for safe and effective tapering of low- and high-dose opioids. “Our adult pain rehabilitation program has been in operation since 1974. One of the goals has always been to taper narcotics completely over the course of the program,” Dr. Bruce says. “But we don’t just taper medications, we taper them in the context of many other strategies for pain management, including physical and occupational therapy, stress management and relaxation techniques, biofeedback, and cognitive behavioral therapy.”

Most pain center patients enter a three-week, hospital-based outpatient program, though a two-day program also is available. In addition to treating a broad range of pain types, the programs address co-occurring medical and mental health disorders.

Dr. Bruce says the primary aim is functional restoration and improved quality of life — “the ability to work, volunteer, be a productive parent and spouse.”

Eighty-four percent of patients who complete the three-week program report better pain control despite discontinuing pain medications, 93 percent note an increase in aerobic activity and more than 80 percent report fewer depressive symptoms. Longitudinal data show that the majority continue to experience significant and sustained improvements in pain severity and functioning six months after treatment.

**Pediatric pain program**

In 2010, Mayo created a pediatric pain rehabilitation program co-led by Tracy E. Harrison, M.D., a pediatric anesthesiologist and pain physician, and Karen E. Weiss, Ph.D., L.P., a pediatric psychologist.

The pediatric and adult programs have similar structures, but the issues and stressors teens face are very different. “By the time children enter our program, they have often been out of school for two or three years, have seen multiple physicians, and are on all kinds of pain medications — about 20 percent on opioids,” Dr. Harrison explains. “We taper them off their medications and work with families and educators to get them back into school, into sports, into their lives. We give them hope and a very clear trajectory.”

**40 Years of Addiction Treatment**

Barbara K. Bruce, Ph.D., L.P.
The World Health Organization estimates that depression will be the world’s second most common health problem by 2020. To meet the growing need for effective care, Mayo Clinic Depression Center, under the direction of Mark A. Frye, M.D., offers four innovative, evidence-based programs for people with bipolar disorder or major depression.

• The Mood Clinic provides comprehensive outpatient assessment for adults with depressive symptoms.
• A 16-bed inpatient unit serves people whose depression significantly affects their safety, functioning or quality of life. More than 600 patients a year receive intensive individualized treatment, which may include cognitive behavioral therapy, medications, and family or group therapy.
• A 10-day, outpatient group psychotherapy program helps patients manage interpersonal issues using interpersonal social rhythm therapy, mindfulness-based cognitive therapy and behavioral activation.
• A comprehensive consultation service addresses issues specifically related to mood disorders in women, especially initiation and maintenance of pharmacologic therapy during and after pregnancy.

Each Depression Center program is comprehensive and highly individualized. “Medicine doesn’t get more personalized than this,” says William V. Bobo, M.D., a psychiatrist specializing in the evaluation and treatment of depression at Mayo Clinic in Minnesota. “For one thing, we have the luxury of time. Because we have much longer appointment times than most, patients can tell their whole story and we have a chance to ascertain as many relevant factors as possible.”

The Depression Center is also fully integrated with Mayo Clinic, allowing for the simultaneous evaluation and treatment of mental health and co-occurring medical disorders. “If a Depression Center patient needs to see a cardiologist, for example, we coordinate the entirety of care, and the efficiency with which that is accomplished is stunning,” Dr. Bobo says.

He adds, “Patient care is our foremost mission, but as an integrated practice, we are also committed to research. Our investigations span the translational spectrum from basic bench science work to population health studies and include epigenetic, pharmacogenetic and brain-imaging studies as well as clinical trials.”

For instance, Mayo researchers recently reported in the Journal of Psychopharmacology that low-dose intravenous ketamine can rapidly reduce depressive symptoms and suicidal ideation. Dr. Frye, senior study author, says outstanding clinicians and investigators, such as Dr. Bobo, Osama A. Abulseoud, M.D., Susannah J. Tye, Ph.D., and Marin Veldic, M.D., enable the Depression Center to combine the highest quality patient care with clinically relevant research and education.

For more information
Transitions Program Reduces Psychiatric Hospital Admissions, Fills Gaps in Care

In Minnesota, as elsewhere, mental health services are strained. Escalating demand and dwindling resources have led to a shortage of psychiatric beds and overburdened emergency departments, leaving acute care patients waiting days or weeks for treatment. Patients discharged from acute hospitalization often endure equally long waits to see a new therapist or enter a program.

Mayo Clinic Psychiatric Hospital in Rochester, Minn., under medical director Timothy W. Lineberry, M.D., is finding innovative ways to address these problems. One is the new Transitions program, an intensive outpatient program for adults leaving acute hospitalization or needing additional care after an emergency department visit.

Bruce Sutor, M.D., program founder and chair of the clinical practice committee in the Department of Psychiatry and Psychology at Mayo Clinic in Minnesota, explains, “Transitions is a structured, multidisciplinary program designed to meet the different needs of different patients. The main populations we want to serve are people who have chemical dependency issues along with psychiatric issues and those with parasuicidality or significant life stressors. These patients have the greatest need for services when they leave the hospital.”

Dr. Sutor says the idea for Transitions was prompted by the suicides of two young men awaiting treatment for chemical dependency. “There was a long gap from the time they left the hospital until they successfully completed suicide, and that really struck a chord,” he explains. “I realized that people’s lives were on the line and we needed to do something.”

Transitions has two main goals. One is to get patients out of the hospital sooner — typically two to three days earlier than normal — and provide them with immediate outpatient treatment. The other is to prevent unnecessary hospitalizations by diverting ED patients who don’t require inpatient care into the program. In both cases, hospital beds become available for people experiencing significant mental health crises and all patients receive seamless and appropriate care.

Dr. Sutor tells the story of a young woman contemplating suicide who called for help late one evening. “Normally she would have been admitted to the hospital,” he says. “But because she asked for help, had structure and support at home, and could do an intake with Transitions in the morning, we let her spend the night with her family. That would not have been possible if she had to wait weeks to get an appointment with a therapist. But I felt comfortable knowing she would be seeing experienced clinicians the next morning.”

Transitions operates five days a week, with two sessions running simultaneously in the early and late afternoon. Patients can participate in various groups, including skills building, stress management and dialectical behavioral therapy for those in significant distress. A psychiatric nurse practitioner, licensed alcohol and drug counselor, registered nurse and other staff provide treatment under the medical direction of Brian A. Palmer, M.D.