TIDINGS!

Newsletter of the Catholic Health Association of Minnesota February 2013

Believing in the worth and dignity of the human person made in the image and likeness of God, the Catholic Health Association-Minnesota assists its members to fulfill the healing mission of the Church.

Mark Your Calendar

February 21, 2013
JRLC Day on the Hill
State Capitol, St. Paul
FFI: www.jrlc.org

June 2-4, 2013
CHA-USA 2013 Assembly
Anaheim Marriot Hotel, CA
FFI: www.chausa.org

Collaborations with the Bishops

"The common belief of seeing suffering, pain and death as needless or wasted is a challenge to the mission of Catholic healthcare" stated Fr. Stephen J. LaCanne, Director of St. Joseph's Hospital Spiritual Care. This recognition of the lost value of suffering within our modern culture was identified as one of the many challenges facing Catholic healthcare during a presentation with CHA-MN leadership and the Minnesota Catholic Bishops this past December.

Reaffirming the mission of Catholic healthcare, and recognizing the current challenges, were the core themes of this important gathering with the local bishops at the Chancery in St. Paul. Reflecting upon statements from the Ethical and Religious Directives, 'The Church has always sought to embody our Savior's concern for the sick… In faithful imitation of Jesus Christ, the Church has served the sick, suffering, and dying in various ways throughout history… The Church seeks to ensure that the service offered in the past will be continued in the future.'

After a review of how local Catholic health organizations embrace the Church's social mission, LaCanne identified the Catholic Identity Matrix (CIM), developed out of the University of St. Thomas, as a helpful tool for clarifying mission and identity. "The CIM does not provide a 'quick fix' to the challenge of Catholic institutional identity. However, periodic use of the CIM enables Catholic health care organizations to establish a discipline of sustained, ongoing improvement in response to the challenge of mission integration."

The common belief of seeing suffering, pain and death as needless or wasted is a challenge to the mission of Catholic healthcare

An overview of the sponsorship model was presented to the bishops by Sr. Mary Heinen. Recognizing the role of the bishop in the oversight of the 'healing mission' within their respective diocese; the religious order as 'sponsor' is responsible for the asset, the facility and the system of healthcare. The two roles work collaboratively together and overlap in fulfilling the mission of Catholic healthcare.

Of particular note was addressing misconceptions that sponsorship was somehow the sole result of religious backing away from their responsibilities in healthcare. Rather it was acknowledged as a movement driven by several factors including an increased role of laity, specialization and increased technology within healthcare, demographics within religious orders – and perhaps most importantly, the call of Vatican II for religious to revisit their founding purposes, their roots.

BISHOPS *cont. on page 3*

MINNESOTA BISHOPS WITH CHA-MN LEADERSHIP

Shaping Healthcare Reform

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane." - Dr. Martin Luther King, Jr.

Minnesota continues to move forward with a State Based health care exchange and CHA Minnesota remains optimistic about the prospects for state level reform and is committed to leading and participating in the dialogue on this critical issue.

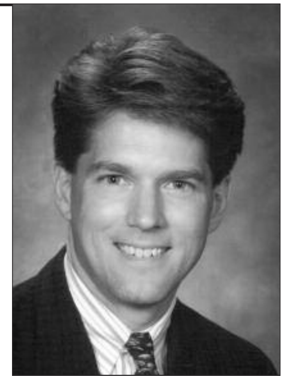
As our ministry tradition conveys, 'Our mission, in accordance with Catholic social teaching and values, calls us to serve as advocates for all, particularly the poor and other vulnerable populations. We believe that health care is a basic human right. To that end, health care should be considered an essential building block for a just and free society, just as education is. As the Catholic health ministry, we are committed to moving toward a more just and equitable health care system that ensures health care for everyone.'

In response, CHA-Minnesota will continue to advocate for the following specific healthcare coverage expansions:

- Covering All Children – *CHA Minnesota supports the state ensuring that all children have health care.*
- Low-income Individuals – *CHA Minnesota supports the early expansion of the Medicaid program to include all low-income individuals.*
- Strengthening the Safety Net – *CHA Minnesota supports initiatives that recognize the full spectrum of care for the uninsured provided by integrated health care systems. Because of our belief in the dignity of all, this system should not discriminate based upon immigration status.*
- Other Measures for Expansion – *CHA Minnesota welcomes other proposals to ensure that all currently uninsured individuals would have access to coverage, including measures to allow buy-ins to public health programs; refundable and advanceable tax credits for the purchase of private insurance; federal grants to states to provide coverage for high-risk populations; and encouragement of a Basic Health Plan and other innovative ideas.*

CHA-Minnesota has also consistently supported principled health care reform derived from our core values: human dignity; concern for the poor and vulnerable; justice; common good; stewardship; and pluralism.

There are very few neutral positions when it comes to healthcare reform, and quite often extremely polar opinions, of which our recent election most clearly highlighted. There is a tremendous opportunity for positive reform right now, but we need guiding principles for the practical implementation of such reform. CHA-Minnesota provides the voice of Catholic healthcare to this important discussion.



As I See It

Toby Pearson
CHA-MN Executive Director

GUIDING PRINCIPLES FOR HEALTHCARE REFORM

CHA-Minnesota supports healthcare reform guided by the following principles:

- Available and accessible to everyone, paying special attention to the poor and vulnerable;
- Health and prevention oriented, with the goal of enhancing the health status of communities;
- Sufficiently and fairly financed;
- Transparent and consensus-driven, in allocation of resources, and organized for cost-effective care and administration;
- Patient centered, and designed to address health needs at all stages of life, from conception to natural death; and
- Safe, effective and designed to deliver the greatest possible quality.

WORLD DAY OF THE SICK

Since 1992, the Catholic Church has celebrated World Day of the Sick on Feb. 11 — the day on which the church commemorates the feast of Our Lady of Lourdes — under the sponsorship of the Pontifical Council for Health Pastoral Care. World Day of the Sick has three consistent themes. First, it reminds the faithful to pray intensely and sincerely for those who are sick. Second, the celebration invites Christians to reflect on and respond to human suffering. And third, this day recognizes and honors all persons who work in health care and serve as caregivers.

In a message for the 2013 World Day of the Sick, Pope Benedict XVI calls on everyone to be a good Samaritan and concretely help those in need. Thanking those who care for the sick and elderly, the pope underlines the church's fundamental role in "lovingly and generously accepting every human being, especially those who are weak and sick."

To help Catholic health care observe this important event, CHA USA has resources and related links to share (www.chausa.org) ■

BISHOPS *cont. from page 1*

In response to the election results and the advancement of the Affordable Care Act, the bishops and leadership discussed current issues surrounding Health Care Exchanges. Operating from the social teachings of the Church which guide health care reform, CHA-MN is making two practical recommendations at this time: (1) Expand Medicaid coverage to 138% FPL in 2014, in addition to (2) Provide Coverage for Adults 138-200% FPL. These recommendations stem from a concern that commercial exchange plans with tax credits may result in a move backwards from MinnesotaCare coverage levels. There is also concern regarding 'undocumented' and their lack of coverage, in addition to cash flow issues and basic affordability for the these focused populations.

CHA-MN will continue to monitor what will be covered by the plans and how it will be covered; much will be determined by how the Obama administration deals with the mandate. Specific challenges continue to be contraceptives and abortion. CHA-MN affirmed its commitment to work with the Minnesota Catholic Conference of Catholic Bishops and other like-minded groups to ensure we are speaking with one voice on these important issues. ■

CHA-MN DIRECTOR BRET REUTER WITH ARCHBISHOP NIENSTEDT

A Shared Statement of Identity for the Catholic Health Ministry

We are the people of Catholic health care, continuing Jesus' mission of love and healing today. As provider, employer, advocate, citizen – bringing together people of diverse faiths and backgrounds – our ministry is an enduring sign of health care rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind and spirit.

Foundation of Catholic Healthcare Leadership

An Online Course for Formation & Development

Six Consecutive Fridays:
February 8 – March 15, 2013

Understanding the foundations of Catholic health care ministry is an essential competency for today's leaders. Executives, directors and managers who work in Catholic health settings are leaders of a ministry. For this reason, an understanding of the church's theological roots, social justice tradition and ethical framework is essential for the successful leader.

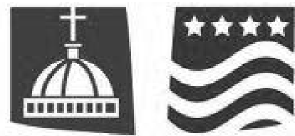
CHA is pleased to offer the Foundations of Catholic Health Care Leadership Program in an online format. In doing so, we hope to make the program more accessible and affordable to a broader audience.

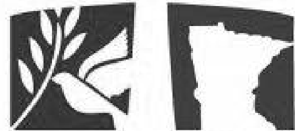
The online course is organized into six sessions lasting up to two hours each. Each session will include up to two presentations, as well as opportunities for interaction via online chat, voice contact and electronic small group discussions. Registrants are expected to participate in all sessions. Assignments and reading materials will be available for download prior to each session. For more information, visit http://www.chausa.org/onlinefoundations ■

Stewards of the Gift of Life

A Pastoral Statement on Physician Orders for Life-Sustaining Treatment (POLST) from the Catholic Bishops of Minnesota

A Pastoral Statement on Physician Orders for Life-Sustaining Treatment (POLST)





MINNESOTA CATHOLIC CONFERENCE

INTRODUCTION

All human life is sacred. Created in God's image and likeness, each human life possesses immeasurable worth and inviolable dignity. At the moment of conception, a new and unique person comes into being, and the love of God accompanies each moment of life. Death in this world marks the conclusion of our earthly pilgrimage, but not the end of our lives, for we are also called to eternal life.

In our time, advances in medical technology have given us many blessings and the hope of extended lifespan. Surgical procedures, medical devices, drugs, and therapies have improved the quality of life for many. But this progress challenges us to stay informed regarding the many choices and ethical challenges it has created.

Our Catholic faith teaches us that our life and our health are gifts of God. *As stewards of these gifts, we are obligated to take reasonable care of ourselves. We exercise that stewardship when we make thoughtful use of the resources medicine affords to maintain our health and recover from illness.*

Our faith also teaches us, however, that we do not need to use any and all possible means to preserve our lives in this world. Although "a person has a moral obligation to use ordinary or proportionate means to preserve his or her life" (*Ethical and Religious Directives for Catholic Health Care Services, dir. 56*; hereafter "*ERD*"), we may forgo extraordinary or disproportionate means of preserving life: those which "do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community." (*ERD* dir. 57.)

Furthermore, in principle, there is an obligation to provide food and water (including medically assisted nutrition and hydration for those who cannot take food orally) to all patients, including those in chronic and presumably irreversible conditions. Medically assisted nutrition and hydration, however, become morally optional when they cannot reasonably be expected to prolong life, when they would be excessively burdensome for the patient, or when they would cause significant physical discomfort (ERD dir. 58).

Determining which life-preserving medical interventions are ordinary and which are extraordinary is often difficult. This is as it should be, given the immeasurable worth of a person's life. It requires careful deliberation, informed by accurate and timely medical information regarding the person's condition, prognosis, and options; the risks and benefits accompanying these options; and the person's own preferences and values. While medicine today is highly scientific, we humbly accept a degree of uncertainty about predictions and expectations for how a person may respond to specific treatments.

We strive to make prudential decisions that both respect the value of each life and accept the limitations of our human condition.

Among the most difficult of these decisions are those that must be made when a patient is no longer capable of speaking for himself or herself. Over the years, different forms of "advance directives" have allowed patients to make their wishes regarding medical treatment known ahead of time. The most common are the "living will" and the "Durable Power of Attorney for Health Care Decisions." Of these two the Durable Power of Attorney is far preferable, for experience has shown that the most informed decisions are made by a duly appointed health care agent, a person legally appointed by the patient to speak on his or her behalf, who can speak directly with a patient's health care professionals about the patient's preferences and best interests in light of all the relevant medical information.

Yet even when the agent's guidance is given, it must still be implemented by health care professionals. Disagreements, delays, and confusion about the patient's actual intentions and specific wishes still remain problematic in some cases.

POLST *cont. on page 5*

POLST *cont. from page 4*

POLST ("PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT")

As part of recent efforts intended to improve care at the end of life, POLST forms (in Minnesota, "Provider Orders for Life-Sustaining Treatment") are becoming increasingly discussed in our state and nationwide, particularly for patients in long-term care settings or with terminal illnesses. Like advance directives for health care, the purpose of a POLST form is to help ensure that a patient's wishes for medical care and treatment in the final stages of life are understood and carried out.

POLST forms, however, differ from advance directives in a significant way. While an advance directive is a patient statement of treatment preferences, POLST forms constitute standing medical orders signed by a physician or other health care professional with legal authority to issue medical orders (in Minnesota, this includes nurse practitioners and physician assistants). As designed, the intention of a POLST form is to assure that the preferences and choices of each patient are honored when decisions are needed.

In Minnesota, POLST forms were developed over the course of several years of consultation and endorsed by the Minnesota Medical Association in December 2009. Many hospitals, long-term care facilities, and healthcare systems are using POLST, including Catholic health care providers. For this reason, the Bishops of Minnesota believe it important to comment upon POLST.

POLST forms tend to oversimplify the medical decision-making process

ETHICAL CONCERNS WITH POLST

While we understand the rationale for POLST, and though the Minnesota form is preferable to that in some other states, we believe that there are sufficient and significant ethical concerns that argue against its use for advance care planning. Those concerns are both substantive and procedural. That is, the POLST model itself raises important concerns, as does the way in which these forms are constructed and are being used. We summarize these concerns below.

The POLST Paradigm is Flawed

Though the typical default instruction for any particular intervention on a POLST form is "aggressive treatment," the form implies that potential medical interventions are in themselves morally neutral. The form does not reflect the patient's underlying rationale for weighing treatment options that would inform real-time decisions in changing circumstances.

Because we cannot foretell the future, one cannot truly give informed consent for health care treatments when variables such as ability to communicate, the absence or presence of a terminal illness, and actual medical conditions are unknown. From a Catholic perspective, making a morally sound decision regarding end-of-life care calls for informed consent based on information related to the actual circumstances and medical conditions at a particular moment. For both patients and providers, it is difficult to determine in advance whether specific medical treatments will be absolutely necessary or optional. Though we have some ability to determine a person's course of illness, we do not have absolute certainty. Therefore, any tool created to guide medical management must take these predictive limitations into consideration.

Further, POLST forms tend to oversimplify the medical decision-making process. Decisions depending upon factors such as the benefits, expected outcomes, and the risks or burdens of the treatment are oversimplified by "one-size-fits-all" checkboxes, without the benefit of clinical context. As a result, using POLST bears the risk that an indication may be made to withhold treatment that, under certain unforeseen circumstances, the patient would want to receive. Another grave concern is whether these forms might be used for patients who are not terminally ill, as a form of assisted suicide or euthanasia. Despite the possible benefits of these documents, this risk is too great to be acceptable.

Problems with the POLST Forms and Procedures

In addition to the fact that the POLST paradigm itself cannot be fully reconciled with a Catholic framework for end-of-life decisions, there are a number of specific concerns related to the way in which POLST forms may be utilized:

1) Because the form permits but does not require the signature of a patient (or the patient's legally designated agent), assuring the necessary true informed consent for such important decisions is problematic.
2) As standing medical orders that (per the POLST form) are to be followed before consulting with the primary care professional or the health care agent, the use of POLST does not assure that the treatment decisions it orders are appropriate to the current condition, prognosis, and needs of the patient.
3) POLST lacks a conscience clause for the health care professionals who may have ethical concerns with the medical orders they are asked to fulfill.
4) As a relatively new tool, the procedures for a patient to revoke or change preferences on a POLST, once signed, are not clear or reliable.

POLST *cont. on page 6*

POLST *cont. from page 5*

5) POLST forms may conflict with other advance care directives or durable power of attorney. Because there is no requirement that Advance Health Care Directives (AHCDs) be cross-checked with POLST forms for consistency, a POLST form without a patient's signature could be implemented rather than the patient's wishes expressed in a (non-consulted) AHCD.
6) The signature of a physician (or, in Minnesota, of a nurse practitioner or physician assistant) creates an actionable medical order which is operative upon its signing and which could then legally bind Catholic health care professionals and institutions to follow POLST-form designated treatments that may be contrary to Catholic moral teaching.
7) There is no requirement that the health care professional who signs the POLST form is the one who prepared it with the patient, which, unfortunately, can be the case in a busy practice.

We understand and support the need for advance care planning, and we thank those who so generously provide care and compassion to those who are sick. *However, the problems noted above lead us to discourage the use of POLST by Catholics and Catholic health care providers in light of the better alternatives that are available.*

The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death."

AN ALTERNATIVE

We call for renewed efforts to educate the Catholic community and other interested persons in the rich tradition of our Catholic teaching on end-of-life care. In particular, we invite those with experience and expertise to work with us in fostering the important conversations about the use of medical interventions that best take place between patients, their designated health care agents, and providers. We repeat our strong support for the appointment of a health care agent who can speak for a patient in the actual circumstances, acting in the patient's best interest consistent with the principles of Catholic teaching, rather than relying on often vague prior written instructions for unforeseeable situations.

At the same time, we recognize that some persons and facilities have already been using POLST. Their evident interest in improving end-of-life care can benefit the development of the education and alternatives noted above. We encourage those with current POLST forms to revisit the directions given and update them, if necessary, to ensure that they are signed by the patients in question to assure that they are consistent with patient wishes and with Catholic teaching. We further encourage that Catholic facilities phase-out the use of POLST forms and provide alternative forms of advance care planning that avoid the ethical concerns we noted above.

The Minnesota Catholic Health Care Directive, and its accompanying Guide, is an excellent alternative that can assist in this transition. The thoughtfully designated health care agent and his or her knowledge concerning the patient's wishes during end-of-life scenarios, along with knowledge of related Catholic moral teaching, are imperative in upholding the dignity of human life and the integrity of the decision-making process.

CONCLUSION

The resources of medicine and technology are our servants, not our masters. Their tremendous potential to prolong life must always be judged in light of the purpose and value of human life itself. As stated in the *Ethical and Religious Directives for Catholic Health Care Services*:

Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death (Part Five, Introduction).

We believe that this "true moral judgment" requires dialogue that involves the patient, family members and loved ones, and health care professionals, based on the facts of the situation and a realistic appraisal of morally-acceptable options. But above all, it requires a context of prayerful discernment, compassionate support, and our Christian hope for eternal life as revealed in the Risen Christ. ■

The Most Rev. John C. Nienstedt, *Archbishop of Saint Paul and Minneapolis*
The Most Rev. John F. Kinney, *Bishop of St. Cloud*
The Most Rev. John M. LeVoir, *Bishop of New Ulm*
The Most Rev. John M. Quinn, *Bishop of Winona*
The Most Rev. Paul D. Sirba, *Bishop of Duluth*
The Most Rev. Michael J. Hoeppner, *Bishop of Crookston*
The Most Rev. Lee A. Piché, *Auxiliary Bishop of St. Paul and Minneapolis*

Recommendations of the Minnesota Health Reform Task Force

Recognizing the urgency and scope of the challenges facing Minnesota, Governor Dayton appointed the Health Care Reform Task Force in November 2011 to provide leadership and advice on implementation of the federal Affordable Care Act and state reform initiatives. The recommendations in this Roadmap to a Healthier Minnesota (December 2012) acknowledge that all Minnesotans have an essential role to play in transforming our health care system in order to get more health for the dollar.

The Task Force recommends eight overarching, interconnected strategies, listed below:

- Strategy I: Pay for Value.
- Strategy II: Support Patient-Centered, Coordinated Care
- Strategy III: Prepare and Support the Health Provider Workforce.
- Strategy IV: Improve Health for Specific At-Risk Populations.
- Strategy V: Engage Communities.
- Strategy VI: Measure Performance and Ensure System Stability
- Strategy VII: Design Benefits to Enhance Personal Responsibility
- Strategy VIII: Increase Access and Support Consumer Navigation

The recommendations in the Roadmap are interconnected strategies designed to transform health care and improve health in Minnesota. While the report does not include a specific implementation timeframe for each recommendation, the Task Force does envision implementation over the next five years, in conjunction with other reform efforts underway across the state. The landscape of health care is constantly evolving and these recommendations have been developed as a result of Minnesota's collaborative culture and as a significant step in our continuous process of improvement. It is in this spirit that the Health Care Reform Task Force offers the Roadmap to a Healthier Minnesota accessible at http://mn.gov/health-reform/images/TaskForce-2012-12-14-Roadmap-Final.pdf. ■

Governor's budget proposes increase in spending for Health and Human Services

(MHA Newsline, January 28, 2013)

Gov. Dayton recently released his recommendations for the state's 2014-15 biennial budget, beginning July 1, 2013. The governor's budget is based on the November forecast, which forecast a $1.1 billion projected shortfall. For the first time in nearly 10 years the governor's budget includes an increase in spending for the Health and Human Services budget. It also includes spending for several of MHA's top priorities, including restoration of Medical Education and Research Costs (MERC) to FY2011 levels and expansion of Medicaid eligibility to 138 percent of federal poverty guidelines.

The governor's proposal calls for $37.892 billion in General Fund expenditures for the 2014-15 biennium. Health and Human Services spending is allocated at $11.5 billion, about 30.5 percent of the budget. The governor's budget includes various tax increases, raising approximately $2.1 billion in net new revenues. (This addresses the $1.1 billion shortfall and adds revenues for various spending priorities.) Raise income taxes on top 2 percent of wage earners Tobacco tax increase of $0.94 per pack Expand sales tax base to include services and clothing greater than $100; reduce the rate to 5.5 percent Property tax refunds of $500

Health and Human Services is slated for an increase of $128 million; $93 million for "health care eligibility and accessibility," $29 million for IT system modernization and $12.8 million for MERC. This is great news and our collective advocacy efforts have helped. While it is not full restoration, it restores spending to FY11 levels.

The Legislature will begin work on its budget proposals, which will be based on the February Budget Forecast to be released on Feb. 28. ■

We Have Moved!

Please note a change in the official address for The Catholic Health Association of Minnesota.

CHA-MN
1890 Randolph Ave., Suite 300
St. Paul, MN 55105

Catholic Health Association of Minnesota
1890 Randolph Ave., Suite 300
St. Paul, MN 55105

Updates from our membership...

What's happening in your organization? Please send your news to Toby Pearson, CHA-MN executive director. Telephone: (651) 503-2163; e-mail: tpearson@chamn.org. Ask your public relations or communications director to put us on the news release list: CHA-MN, 1890 Randolph Ave., Suite 300, St. Paul, MN 55105. ■

News & Notes

- **CentraCare Health System** has named Mary Ellen Wells as the transitional leader for New River Medical Center in Monticello. Family Medicine physician Michael Schmitz, has also been named the CentraCare's Total Cost of Care Medical Director.

* The Minnesota Health Insurance Exchange has established a new website: http://mn.gov/hix/

- **Mayo Clinic Health System – Franciscan Healthcare** announced that it has reached a definitive agreement with the Benedictine Health System (BHS), Duluth, Minn., to transfer operations of Arcadia Nursing Home to Catholic Residential Services, a BHS Member Organization based in La Crosse, Wis., effective January 1, 2013

- The **Benedictine Health System** recently announced the name of the Red Wing's new senior living facility, St. Crispin, the patron saint of shoemakers, tanners and saddlers.

- **St. Joseph's Hospital** is one of the 50 Top Cardiovascular Hospitals in the country, according to Truven Health Analytics (formerly Thomson Reuters). ■

CATHOLIC HEALTH ASSOCIATION OF MINNESOTA BOARD OF DIRECTORS

Mr. David Nelson, President
St. Francis Medical Center, Breckenridge
(218) 643-3000; davidnelson@catholichealth.net

Mr. Lee Larson, President-Elect
St. Gertrude's Health Center, Shakopee
(952) 233-4408; lee.larson@bhshealth.org

Sr. Mary Heinen, Secretary
St. Mary's Health Clinics, St. Paul
(651) 690-7028

Ms. Colleen Hegranes, Treasurer
St. Catherine University, St. Paul
(651) 690-6501; cahegranes@stkates.edu

Mr. Bret Reuter, Past-President
St. Cloud Hospital/St. Benedict's Senior Community
(320) 251-2700; ReuterB@centracare.com

Mr. Jason Adkins, Ex-officio
Minnesota Catholic Conference, St. Paul
(651) 227-8777; jadkins@mncc.org

Mr. Thomas Crowley
St. Elizabeth's Hospital, Wabasha
(651) 565-5559; Tom.Crowley@ministryhealth.org

Rev. Steve LaCanne
St. Joseph's Hospital, St. Paul
(651)232-3000; sjlacanne@healtheast.org

Mr. Daniel McGinty
Essentia Health, Duluth
(218) 786-2630; Dan.McGinty@essentiahealth.org

Ms. Kathy Tomlin
Catholic Charities – St. Paul/Minneapolis
(651) 647-2588; Kathleen.tomlin@cctwincities.org

Sr. Tierney Trueman
Saint Mary Hospital, Rochester
(507) 255-3125; Trueman.Tierney@mayo.edu