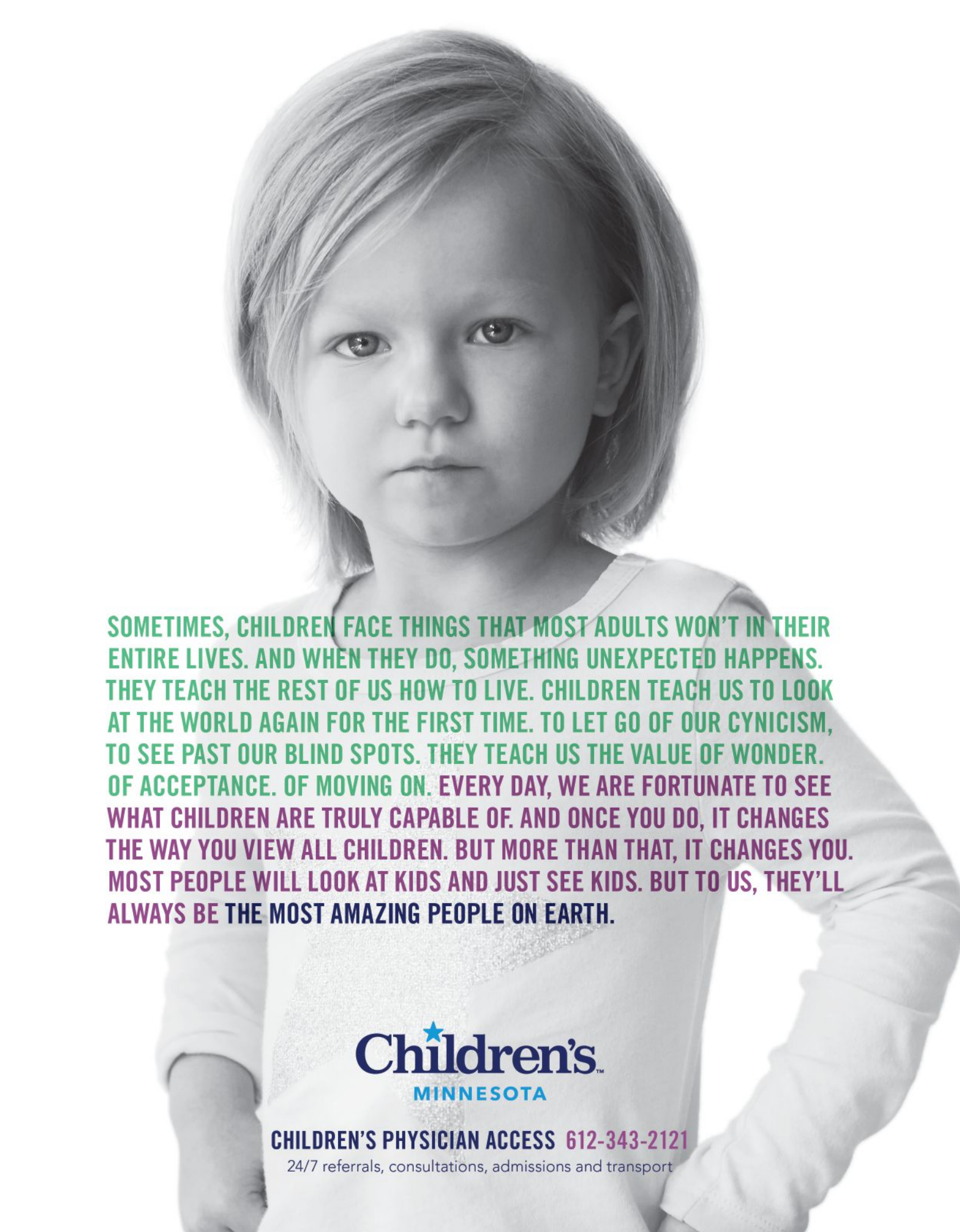
SPRING 2017 • VOL.1 • NO.2

MFP

MINNESOTA FAMILY PHYSICIAN

JULIE MAYERS BENSON, MD, FAAFP IS FAMILY PHYSICIAN OF THE YEAR 22


SOMETIMES, CHILDREN FACE THINGS THAT MOST ADULTS WON'T IN THEIR ENTIRE LIVES. AND WHEN THEY DO, SOMETHING UNEXPECTED HAPPENS. THEY TEACH THE REST OF US HOW TO LIVE. CHILDREN TEACH US TO LOOK AT THE WORLD AGAIN FOR THE FIRST TIME. TO LET GO OF OUR CYNICISM, TO SEE PAST OUR BLIND SPOTS. THEY TEACH US THE VALUE OF WONDER. OF ACCEPTANCE. OF MOVING ON. EVERY DAY, WE ARE FORTUNATE TO SEE WHAT CHILDREN ARE TRULY CAPABLE OF. AND ONCE YOU DO, IT CHANGES THE WAY YOU VIEW ALL CHILDREN. BUT MORE THAN THAT, IT CHANGES YOU. MOST PEOPLE WILL LOOK AT KIDS AND JUST SEE KIDS. BUT TO US, THEY'LL ALWAYS BE THE MOST AMAZING PEOPLE ON EARTH.
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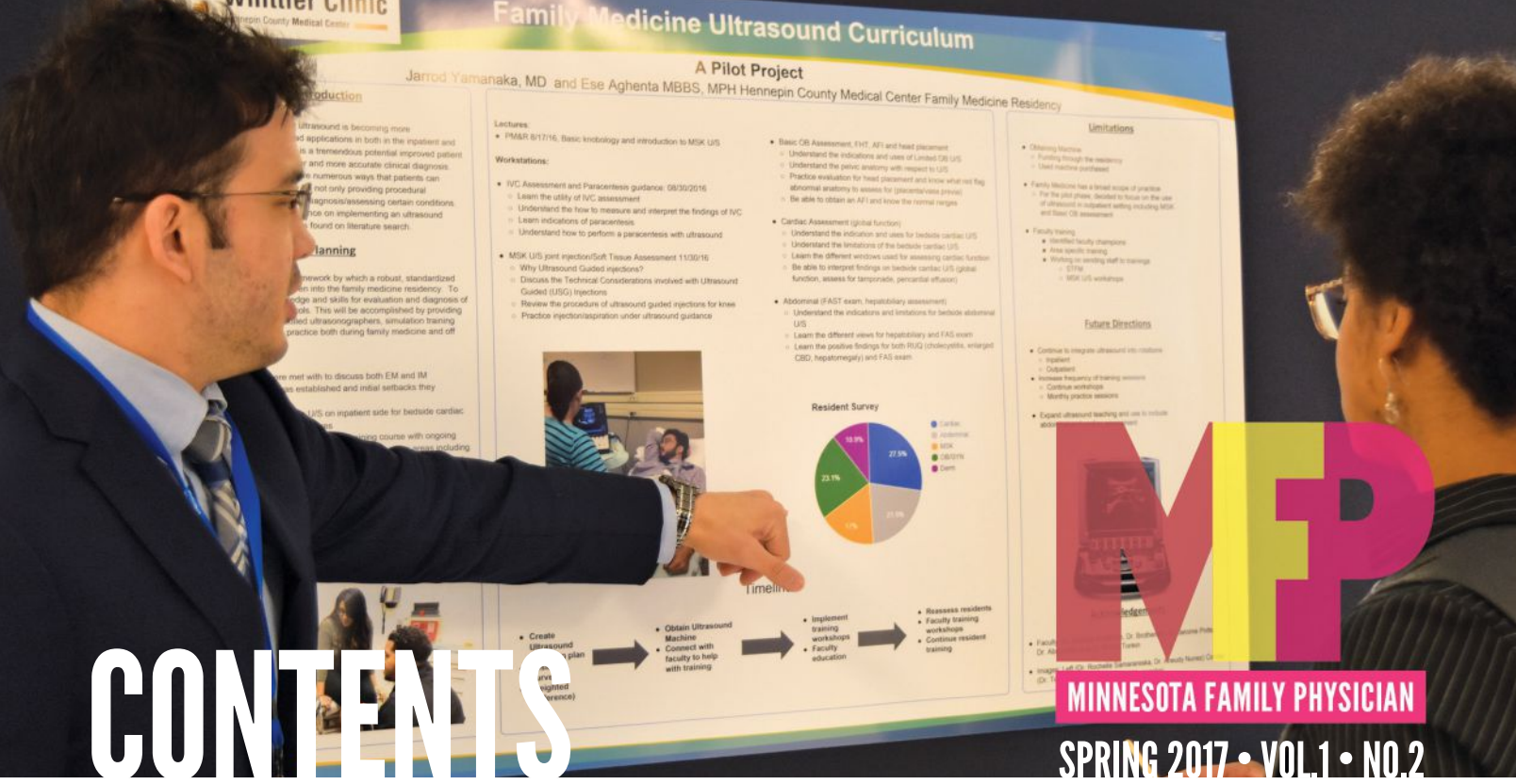

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MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

By David Bucher, MD, FAAFP,
MAFP President

Are You Awake?

As in, not placated, not anesthetized…

Years ago, when I had the privilege of taking leadership training, mentors spoke about Medicine's state of "permanent whitewater."

Well, we're moving even faster now, like at the speed of Instagram and Snapchat. Every day is a "Twitter storm" and many of us struggle to keep up with the pace of change and the volume of knowledge. Our lives are overflowing with hyperbole; everything is "amazing," "awesome," and HUGE is the new super-hyperbolic adjective.

Your MAFP leadership believes part of moderating the pace and volume of our work lives is to seek balance, but we need more pragmatic and dedicated efforts to change the healthcare system in support of more rational and appropriate patient care.

I'd like to invite you to add your considerable experience, wisdom and perspective to our growing advocacy work on behalf of ourselves and our future colleagues. Engagement with our MAFP Foundation supports and nurtures the future family physicians of our state. And taking time out to gather together and nourish ourselves at the Spring Refresher can help curb some of the craziness. I am hopeful many of you were able to attend and celebrate our Academy Award winners like Dr. Julie Mayers Benson, our family doc of the year, who is featured on the cover of this issue.

Also in this issue: Dr. Chris Stuart describes his group's experiences remaining independent in practice; Dr. Todd Leonard shares what his work caring for incarcerated persons entails, and Dr. Shailey Prasad describes the "tribe" he and colleague Dr. Cora Walsh found in Kochi, India, earlier this year.

What a great chronicle of the diverse ways we care for patients as family physicians.

During the next 12 months, I challenge you to be "awake" in your persistent interactions in your community, with our Academy and with your colleagues in the House of Medicine. I look forward to serving you and our Academy this year.

David Bucher, MD, FAAFP, took the oath to become the new MAFP President on April 20, 2017. The installation ceremony was performed by AAFP Board Member and MAFP Past-President Lynne M. Lillie, MD, FAAFP.

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

Representing more than 3,100 family physicians, family medicine residents and medical students, the Minnesota Academy of Family Physicians (MAFP) is the largest medical specialty organization in Minnesota. It is the state chapter of the American Academy of Family Physicians (AAFP), one of the largest national medical organizations in the United States, with more than 124,900 members.

The MAFP promotes the specialty of family medicine in Minnesota and supports family physicians as they provide high quality, comprehensive and continuous medical care for patients of all ages.

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Edition 2

By Shailey Prasad, MD, MPH, and Cora Walsh, MD

REPORT FROM KOCHI

Two members travel to India to grow their tribe

It is a unique time in family medicine worldwide with the discipline growing significantly in many countries. One such place is India.

In January of this year, Dr. Walsh and I had the unique opportunity to participate in the third annual conference of the Academy of Family Physicians of India's (AFPI) Family Medicine and Primary Care Conference in Kochi, in the southern Indian state of Kerala. Besides attendees from India, the conference also attracted family physicians from the UK, Canada, South Africa and Bangladesh.

I delivered the keynote address on "Comprehensiveness of Family Medicine — the Models" and conducted a session on peer consultations together with Dr. Walsh. Dr. Walsh also gave a talk on the importance of qualitative studies in family medicine.

Dr. Prasad with Dr. Raman Kumar, president of the Academy of Family Physicians of India

We were highly energized by the conference. The growth of family medicine in India seems to be in good hands with a very active professional organization of AFPI.

"It was fascinating to hear the conversations [happening at the conference]," Dr. Walsh commented. "I felt like I was witnessing the early phase of a movement. I am thrilled to see the energy and hope we continue to have some long-term partnerships with folks on the ground in India."

The energy is indeed palpable, and after collaborating with family physicians in India for a few years now, I anticipate what is happening right now in India is probably a similar moment to how family medicine was in the US in the early 1970s. There is also a large potential for growth in academic family medicine in India. We noticed that our physician counterparts at the conference were acutely aware of the need to develop training and guidelines that are relevant to local circumstances rather than import a model from outside.

One of the interesting challenges to health care in India is the rapid growth of the private sector in the past 30 years. This has led to many high-end hospitals being built that cater to a very small section of society and to "medical tourists." Increasingly, young physicians and students in India want to provide care to larger sections of society and be more comprehensive in addressing the social determinants of health.

Young physicians and students in India are finding the tenets of Family Medicine very attractive. They seem to be strongly attracted to family medicine as a discipline because of its commitment to health justice, while providing comprehensive care to families and communities. They are looking for — and discovering — their tribe. MP

Dr. Prasad MD, MPH, is Executive Director for the Center for Global Health and Social Responsibility at the University of Minnesota. Dr. Walsh is a board-certified family physician at North Memorial Camden Physicians in Minneapolis with special interests in women's health, prenatal care — including deliveries, dermatology and mental health.

My tribe is made up of those who "think different," the squares pegs in round holes, the misfit toys who don't feel comfortable doing things the way they've always been done.

Jon Hallberg, MD
Associate Professor
University of Minnesota
Department of Family Medicine and Community Health

I found my tribe my intern year by taking a chance and reaching out to a renowned pediatric endocrinologist at Mayo, Dr. Seema Kumar, to see if she had any research opportunities for combating pediatric obesity. Now, almost three years later, I'm part of a passionate group of pediatricians, family physicians, nurse practitioners, study coordinators and statisticians who all have a passion about pediatric obesity and we share the responsibility on each project, making things more manageable.

Natalie Gentile, MD
PGY-3 Mayo Clinic Family Medicine Program

I don't shy away from issues that I am passionate about. The MAFP and AAFP have been great places to share new ideas with like-minded people who get the importance of family medicine. Be bold, be brave, don't be afraid to speak your mind — there are others who agree with you!

Julie Anderson, MD, FAAFP
St. Cloud Medical Group — South
MAFP Past President

HOW DO YOU FIND YOUR TRIBE?

At a recent FMIG talk at the University of Minnesota, Dr. Shailey Prasad said, "...to work in health justice, find your tribe." What does this mean? Six MAFP members weigh in.

There's no template for finding your tribe! I think it's pretty simple: you have to organize your people. Twitter has been a nice shortcut for me, personally.

Peter Meyers, MD
PGY-2 Allina United FMRP
MAFP Alternate Resident Director

Sometimes I lead advocacy projects on my own, trying to find out the where, with whom and how, but I was able to do it because MY TRIBE, my Latino Community, showed me the Why, and then, it became imperative to me. I am privileged to have an MD title that opens doors they don't have access to, so I feel part of my obligation as a caregiver is to shape how they are going to receive care, the access, the quality, the outcomes — their voices reflected on all of those things. That is also part of my job. It is my privilege, in all its meaning!

Maria Veronica Svetaz, MD, MPH, FSAHM, FAAFP, MOM
Faculty, Department of Community and Family Medicine, HCMC

My community is made up of people who are younger, older, men, women, non-binary, people who often look different from me, come from different places, and believe different things. What they share, and what draws me to them is their capacity to see possibilities for what this world could be and offer their talent and their passion to will that vision into reality.

Nathan Ratner, MS2
University of Minnesota — Duluth

By Alexandra Gits, MD

A CHAMPION FOR TOBACCO 21: *A Resident Discovers Advocacy*

Advocacy is a powerful, underrated tool that acts as a bridge between the social determinants of health and health promotion. It demands addressing the educational, economic, and environmental factors that contribute to the suffering of our patients and allows us to be socially accountable to the populations that grant us professional status.

MY PASSION FOR ADVOCACY

In my circumstances, advocacy became a saving grace to withstand my waning idealism about medicine as a path to changing lives. As my years in medical school came to a close, I began to realize that although I was starting to provide effective care within the clinic walls, my patients were affected much more by circumstances beyond my reach or control. Serendipitously, towards the end of medical school I began working with Family Medicine for America's Health, an organization built on the principle of demonstrating to the public and lawmakers the importance of primary care in achieving the Quadruple Aim. I quickly realized advocacy work, coupled with my duties as a physician, was a means to increase my professional satisfaction and act as a conduit to create social change.

Now firmly established in my family medicine residency at the University of Minnesota North Memorial program, the Minnesota Academy of Family Physicians and my faculty have graciously allowed me to continue to grow and refine my skills in advocacy through financial and moral support (thank you in particular to Lisa Regehr with the MAFP and Dr. Renee Crichlow). I have had the privilege to travel around the state in the last year advocating to community and professional audiences about Tobacco 21 (T21) legislation and attempt to motivate others to become involved.

TOBACCO 21 ("T21")

T21 will raise the legal minimum age to purchase tobacco and nicotine products from 18 to 21. It is supported by the fact that over 90% of regular tobacco users start before the age of 21 and 95% before 18 years of age. If we remove the young adult cohort that are able to purchase tobacco products and expose younger peers to the addictive properties of nicotine with the peer pressure that comes with smoking, we may curb the next generation of smokers. Tobacco also is an issue of disparity and injustice.

In Minnesota, patients that come from lower socioeconomic backgrounds or are of an ethnic minority are more susceptible to the harms of tobacco, are targets of big tobacco marketing (along with our youth) and smoke at higher rates. Family physicians thoroughly know the role tobacco plays in the health not just of the individual but of the family unit and beyond. We have a responsibility to educate the patients we see on tobacco use and support policies that reduce tobacco consumption. Even as a young resident physician with a busy schedule, it was an easy ask to advocate on behalf of this legislation.

As family physicians, we are acutely aware and sensitive to the impact political changes have on the health of our patients. We are able to speak with validity to those who can enact change both in the legislature and our institutional leaders because of our privileged look into patient's lives and position as physicians on the ground level of the Minnesota healthcare system.

I urge all family physicians to become involved in advocacy, support Tobacco 21, and embrace your public role in order to honor our patients by eliminating the disparity created by the social determinants of health. If you have further questions or comments on Tobacco 21 legislation or advocacy, please feel free to contact me. MP

Alex Gits, MD, is a PGY-1 at University of Minnesota, North Memorial Family Medicine Residency; she can be reached via email at alexgits@umn.edu.

TOP 3 QUESTIONS ABOUT T21

HOW WILL IT BE ENFORCED?

T21 has passed in California and Hawaii and over 200 communities across the United States. It has been successfully enforced through a number of mechanisms, some communities have a public reporting website where constituents in a community can anonymously report violating businesses, others have trained decoys to approach businesses and attempt to buy nicotine products. Enforcement has been paid for by increasing tobacco licensing fees and having penalty fees.

WHAT EVIDENCE DO WE HAVE THAT T21 REDUCES SMOKING RATES?

I preface this answer by saying that T21 legislation is only five years old and preliminary data is still being collected. We do know that research by the Institute of Medicine has predicted that T21 would reduce the number of 15- to 17-year-olds that smoke by 25% and prevent over 220,000 premature deaths. Early passers of T21 legislation have reported that the rate of high school smoking was cut in half within five years.

HOW DO I GET INVOLVED?

So many ways! Write a letter to your local newspaper, call your representatives in the State legislature or raise awareness by giving a community talk on the subject. Contact the MAFP for help getting started.

5 TIPS FOR MAKING A STRONG VACCINE RECOMMENDATION

There's no shortage of information to discuss with a parent during a well-child visit. It can be overwhelming to cram everything in—for both the parent and the provider. Here are some tips for how to make a strong vaccine recommendation that won't take up too much time.

1. USE THE PRESUMPTIVE APPROACH.

How you start a conversation about vaccines matters when it comes to parents' acceptance of or resistance to vaccines. Research suggests that starting vaccine conversations by presuming a parent is planning to vaccinate rather than asking the parent if they would like to vaccinate leads to less resistance to vaccination.[1,2] Say, "It's time for a few vaccines. Today we'll give shots to protect against diseases like whooping cough, diphtheria, pneumococcal, polio and more."

2. KEEP THE CONVERSATION GOING.

Even with the presumptive approach, parents may still have questions or concerns. One systematic review showed that lower vaccine uptake was associated with parents feeling their discussion with a provider was inadequate in length and depth or dismissive.[3] One communication strategy to try is, "Ask, acknowledge and advise":

- Ask questions to get to the root of the parent's concerns so that you can more effectively address them. "Why do you want to skip the MMR vaccine today?"
- Acknowledge their concerns to show you are listening and build trust. "That's a common concern that I've heard from other parents."
- Advise the parent on why vaccines are important based on your experience and knowledge. "I've read the studies showing this vaccine is safe and effective. I gave it to my own kids and I would recommend we vaccinate your baby today, too."

3. BE FAMILIAR WITH COMMON QUESTIONS AND RESOURCES.

Make sure you have a good understanding of the most common vaccine questions and issues parents have, such as number of vaccines, whether vaccines cause autism, vaccine ingredients, and frequent side effects. Parents are reassured when their provider can speak knowledgeably about vaccine issues. If issues arise that you are unfamiliar with, ask the parent to provide you with their information source so you can evaluate the information with them.

4. GUIDE PARENTS THROUGH THE PROCESS.

While immunization is an everyday occurrence in a primary care clinic, the experience for a new parent can feel overwhelming. Even parents amenable to vaccination need to understand what to expect. Briefly review the Vaccine Information Statement and what they can do if their baby has pain or fever. Make sure they know who to call if they have additional questions. If possible, give them a print-out of the vaccines their child received.

5. REMIND PARENTS THAT VACCINATION IS THE NORM.

The vast majority of Minnesota parents vaccinate their children. Talking about vaccines as a normal part of the well-child visit, similar to measuring length or weighing a child, can go a long way.

Contributed by Malini DeSilva, MD, MPH. Dr. DeSilva is a Medical Specialist with the Infectious Disease Epidemiology, Prevention and Control Division at the Minnesota Department of Health.

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NORTHWEST FAMILY PHYSICIANS AND THE DYAD LEADERSHIP MODEL

The experience of a metro-area independent family practice

Dr. Chris Stuart, left, meets with his dyad partner Dr. Gregory Frane at Northwest Family Physicians' Rogers clinic

Chris Stuart, MD, at Northwest Family Physicians (NWFP), which is based in Crystal, Minnesota, is deeply committed to being an independent family medicine doctor. He wears two hats as he moves through each workday.

One minute he's the beloved doctor interacting with patients, grateful for the opportunity to be a resource for their healing and a witness to their lives. He talks about his love for family medicine, which was kindled in Sioux Falls where he grew up under the care of family docs and further explored during his residency.

"I just knew I wanted to be that kind of physician who knows people and they know me, providing guidance and healing as needed, and offering the reassurance that comes with that," said Stuart.

The next minute, he wears a physician-manager hat as the president and chief medical officer of NWFP, overseeing the operations of the three clinics in Crystal, Plymouth and

Rogers, Minnesota. There are 12 physicians, one nurse practitioner, and five physician-assistants who work at NWFP.

DYAD LEADERSHIP MODEL

In his dual role, Stuart is as conversant about their physician-led, professionally-managed dyad model as he is about the colonoscopies he performs. The dyad leadership model pairs a clinical leader with an administrative leader to facilitate partnership and cooperation.

Every facet of the NWFP operation is the responsibility of more than 20 dyads: there's a dyad for marketing, another for urgent care, a third for staff resiliency and so on. A dyad often is formed when a manager identifies an operational need and makes the case with the physician-owners for a dyad to address it.

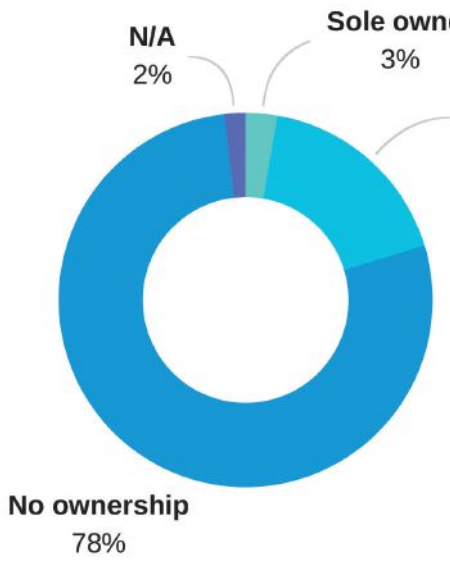
Brenda McNeill, the administrator of clinic operations, started working for NWFP in 1998. At that time, committee chairs ran the practice. There was a pharmacy committee that addressed prescribing, a utilization review committee that addressed referrals, etc. As the practice became more complex, administrators and managers took on more responsibility, and it became difficult to keep the physicians engaged. Dyads became the solution.

"We wondered how we could get that physician involvement back to support management in the work we're doing," said McNeill. "It's so much easier for a manager to generate an idea and have one of the physicians be a champion for it."

She described the "team care" dyad she's assigned to with Dr. Scott Reichel, who practices in the Crystal clinic. It arose because she wanted to change NWFP's care model when she became the administrator. The standard care model they were using was one provider and one medical assistant working together during the clinic day. Any care that was not addressed at the visit, or any follow-up from that visit, was addressed by a group of triage nurses.

Instead McNeill proposed a team care model that brings triage functions and care management activities out on the floor with the doctors and medical assistants. The focus is on pre-visit planning and maximizing the visit for the patients while they're at the clinic.

Dr. Reichel liked the concept and joined her to form the dyad. They tested the model at one station, tweaked a few things, and are now implementing the care model clinic-wide. They've learned the importance of the principles of understanding and communicating, so there is clarity and flexibility about duties and expectations as roles overlap.



OWNERSHIP STATS FOR MN FAMILY DOCS

Source: AAFP Member Census as of March 2017

McNeill has worked in different health systems but feels most at home in a nimble, small independent practice.

"You tend to make change quickly," she said. "My staff feels like if they have an idea and present it well, they'll be told to go for it."

"Good communication is vital," Stuart affirms. "It entails team members being able to share honestly about what's working and what's not working in a secure, respectful and appreciative environment."

"Don't think of me as a Proctologist. Think of me as Colon Tech Support."

BEING AN INDEPENDENT PRACTICE

Stuart reflected on the growth and history of NWFP from the time it was founded in 1954 by Dr. Harry St. Cyr and Dr. Dick Williams; merged with Crystal Doctors Park in 1984; and opened the Plymouth and Rogers clinics in 1986 and 1995, respectively.

"We have a rich, rich heritage and strong connections to families here," said Stuart. "We want to preserve that relationship with those patients and communities."

As the chief medical officer, Stuart is very thoughtful about how the entire team — and the dyad approach — are in service of what he describes as the three pillars of success:

- Unity refers to being aligned on what they value and to focus on it: individualized medical care
- Productivity/profitability describes the mindfulness everyone has about what things will cost the practice and patients
- Growth is about learning, growing and getting better as individuals and an organization

> *"My staff feels like if they have an idea and present it well, they'll be told to go for it."*

"We believe that excellent family physicians committed to helping their patients be as well as they can via individualized care will attract more patients who want that type of attentive, effective care," said Stuart. "We'd love to have so many physicians that we need to have more space."

Stuart's efforts aren't going unnoticed. NWFP won an award for excellence in primary care by the Peterson Institute of Health Care and Stanford University Clinic Research Center in 2012. It was one of only 11 out of 15,000-plus organizations that applied for the award.

"We're really proud of that," said Stuart. "We were recognized for high quality, low-cost care, and good patient experience. Bigger is not necessarily better." MP

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By Carmen Peota

MINDING THE GAP

A new look at preventive care for adolescents and young adults

For the first time in her life, 17-year-old Grace (not her real name) had a boyfriend. Wanting to be responsible, she went to the clinic in her high school for contraception, opting for a Depo-Provera shot. The shot may or may not have been the choice her primary care physician would have recommended. But Grace hadn't been seeing her for that kind of guidance in recent years.

In fact, Grace's mother can't recall when her daughter last went in for a well visit. She recalls bringing her in for sports physicals so she could play soccer and for a concussion, upper respiratory illnesses, and back and digestive problems. But a physical? "That's a good question," she says, "I'd have to look at my old calendars."

Grace is a pretty typical teen as far as health care goes. She went regularly to her pediatrician during her early years. But once she was past the age when she needed immunizations, preventive care took a back seat.

It takes a back seat for many youth and young adults. An analysis of several studies published in the *American Journal of Preventive Medicine* in 2015 found that the percentage of adolescents who have had preventive care in the past year was between 43 and 81 percent. It was between 26 and 58 percent for young adults.

Too old to need many immunizations and too young to have many chronic health problems, they drift away from preventive care starting around age 10 and don't return until well into their 20s. "We've got this in-between age where we just don't see them routinely," observes Kacey Justesen, MD, medical director at Broadway Family Medicine Clinic in Minneapolis.

The problem is there's much that could be addressed if they did. "This age group faces a lot of challenges," Justesen notes, "a lot of changes in their developmental, emotional and mental health."

A well visit is a chance to offer counsel about nutrition, exercise, and safety, she notes. It's also a chance to have confidential discussion about sensitive topics such as drugs, alcohol, contraception and sexual orientation, "It's [a chance to have] a critical conversation."

WHAT QUALITY PREVENTIVE CARE CAN LOOK LIKE

"Most of an adolescent [preventive care] visit, in my view, is counseling and talking," says LeAnn Hutchison, MD, a family physician at Park Nicollet's Burnsville Clinic and its Diamondhead Clinic, which offers free care to children and teens. "It's trying to gain a little rapport with patients and parents, trying to figure out where they are, what they need, what they will need to hear."

Hutchison, who has done fellowship training in adolescent medicine, says she genuinely enjoys that challenge. "I like to hear what they have to say. I like to be supportive and let them know that if things are rough now, they can get better," she says, admitting her own adolescence wasn't a happy period for her.

In addition to talking to them about physical issues such as healthy weight, she lets them know it's important to "really try" in school because that will open doors for them. She talks about peer pressure and substance use and sexual choices, including how to prevent pregnancy and sexually transmitted disease—abstinence and contraception included. She reminds them that they're responsible for their choices.

She explains Minnesota's confidentiality laws to parents, telling them, "I want the adolescent to have another trusted adult to go to and get reliable advice." And to teens, she explains she won't tell their parents if they talk about contraception or smoking but will if they talk about suicide or being abused.

All that, of course, takes time, something not easily found during the course of a busy day in the clinic.

To cover more ground faster, Hutchison looks at the results of a teen screen before she sees the patient. Youth at the Diamondhead Clinic complete a questionnaire about issues including bike helmet and seatbelt use, their access to guns, sexual health, substance use, exercise and diet, and how they feel they're doing in school. "It's a nice jumping off point," Hutchison says of the teen screen, which is also used at a number of other Park Nicollet clinics. She explains that none of the information they share on it goes into their health record. "It's a way to open up conversations and get a little background."

TOOLS FOR THE JOB

Shannon Neale, MD, director of family medicine for Park Nicollet who practices at Park Nicollet Clinic- Creekside, says tools like the teen screen can help physicians more easily do their job. "[Doctors] often say, well I don't have time to do all these different things in my practice. But if you're using the right tools, it helps you to make your visit more efficient and of higher quality." The Creekside clinic has long used the teen screen, and HealthPartners is considering using it system-wide.

Neale says all youth 12 and older are offered the teen screen whenever they come to Creekside. They are told that if they've already filled one out within the last three months, they don't need

Kacey Justesen, MD

LeAnn Hutchison, MD

Shannon Neale, MD

to do it again. "It's targeting them when they do come in and looking for opportunities," Neale says.

Like Hutchison, she looks at the responses before she enters the exam room to learn what's most pertinent that day, for example, problems at school. "Probably that's on the parents' list, but we're addressing it right away. It's bringing the concerns about social and emotional development to the forefront of the visit instead of a side note at the end," Neale says.

Elsa Keeler, MD, MPH, FAAP, a pediatrician who sees patients at HealthPartners White Bear Lake Clinic, says the goal when seeing adolescents and young adults is getting them to take charge of their own health. Keeler says that's a long process that begins around age 12, with the teen starting to speak to the doctor alone, and culminates between 18 and 21, when the young adult is making not only their own appointments but also their own decisions.

Keeler has had a hand in HealthPartners' efforts to ease that process, developing a number of tools. One is a readiness questionnaire. Youths are asked to respond to statements such as "I know how to refill prescriptions and can make medical appointments" or "I know how to access my medical records." There are also letters that a physician can send to a teen or young adult who might need help finding a family physician or other adult primary care provider.

NEW COLLABORATIVE EFFORT

Neale and Keeler will be bringing their ideas to a new multi-state collaborative focused on preventive care for adolescents and young adults starting this spring. Clinicians, public health experts, insurance industry representatives and others from four states, including Minnesota, will be taking part in an Adolescent and Young Adult Health Collaborative Improvement and Innovation Network (CoIIN). CoIINs are multidisciplinary teams supported by Health Resources and Services Administration that work to find solutions to a common problem.

"It's a way for health care providers, public health and health insurers to address policies around youth-centered care and

look at what can be done," says Katy Schalla Lesiak, APRN, CPNP, a child health consultant in the Minnesota Department of Health's Maternal and Child Health Section who is co-leading Minnesota's team.

Schalla Lesiak especially hopes the CoIIN can identify ways to solve a problem identified by a previous collaborative. "Basically what they found in focus groups," she says, "was that neither young people nor parents knew preventive care was even a thing that needed to happen after age 10."

The CoIIN will attempt to come up with strategies for increasing the rate of young people using preventive health services (likely focusing on ways to market to and communicate with them) and improving the quality of visits with use of evidence-based practices. They'll also be looking at state and federal policy changes that would support these goals.

Pediatrician Elsa Keeler notes there's long been awareness of the importance of high-quality adolescent care in Minnesota. She credits that in part to the fact that so many physicians in the state trained under then-University of Minnesota professor Robert Blum, MD, a leading authority on adolescent medicine.

She's optimistic with this new effort, awareness will grow and further progress can be made. As she reminds, preventive care in adolescence and young adulthood sets a health trajectory for a lifetime. "What happens then predicts the future." MP

PATIENTS HAVE PLENTY TO TEACH A NEW ATTENDING PHYSICIAN

By Luis Garcia, MD

With all due respect to my mentors, I've discovered that my greatest teachers are my patients.

When I was asked to present to my residency program what life was like during my first few years as an attending, I immediately began digging through my list of interesting patients (yes, I keep a list!) for the most bizarre and provocative diagnoses I had encountered.

In doing so, I realized that each one of those patients had taught me something greater than simply deeper medical knowledge. My patients have taught me to be a better doctor. They've given me lessons on communication, compassion, dedication and more. We've all had these lessons, but perhaps we haven't taken the time to deeply reflect on them. Although the lessons I've received are too numerous to count, here are a handful that may be helpful to all of us.

KEEP A POKER FACE

I'd like to think I have a pretty good poker face. I'm known in my office for having a serious affect. (I prefer "focused.") When I crack a joke, I keep a straight face, leading my staff to wonder if I was joking or not.

This wasn't the case with a recent patient interaction. I had seen Joe about his weight several times, so I thought we had a good rapport. However, on one visit he casually made reference to his boyfriend, and I turned to him with what must have been a surprised look on my face, said, "Oh, I didn't know you were in a relationship! That's great!" and continued the conversation about his obesity. A few weeks later, my practice manager received a complaint that Joe felt I had judged him for being gay based on that one reply and my nonverbal communication.

Although my reaction was simply the general surprise of discovering he was in a relationship, the complaint was a reminder for me to keep my facial expressions, posture and tone of voice in check. Patients expect us to be understanding, accepting and nonjudgmental when they share their lives with us. With this small event, I learned that it's our responsibility to make sure our words and expressions help create a welcoming environment that can strengthen our relationship with patients.

BUT DON'T BE AFRAID TO CRY

A few weeks later, a young woman presented with a genitourinary problem. She was anxious and trembling. She looked as if

she hadn't slept for days, with dark rings around her eyes and a look of desperation. She began to share how depressed she had been feeling during the past month since this problem emerged. Her speech was pressured, and I quickly realized I needed to stop typing, face her directly and look her in the eyes.

Within a few minutes of her sharing her stresses and struggles, I realized something deeper than the chief complaint was distressing her. I asked her, "What happened?" to which she revealed a sexual assault that happened when she was 11.

She said she was up all night and couldn't sleep because she was so nervous to tell someone about her trauma for the first time ever. Tears then flowed down both of our faces. It was a moment of sadness but also relief. She had held onto this torturous event for nearly a decade, and now 40 minutes into a 15-minute "acute" visit we were sharing a hug and developing a care plan to address her posttraumatic stress disorder and her (thankfully) unrelated genitourinary problem.

Many times our patients need to see that we are human, too, and we shouldn't be afraid to show those emotions that help strengthen the physician-patient bond.

EMBRACE A SENSE OF OWNERSHIP

Our patients entrust their health and their lives to us, which gives us a huge responsibility we must own. This ownership takes different forms, such as reading about diseases we're not familiar with, getting on the phone with specialists to discuss difficult cases and sometimes even trusting our gut instinct to seek out the best care for patients.

This became most evident with one of my 16-year-old patients who began losing weight. Her workup revealed she had an autoimmune condition, but despite being evaluated by various local specialists, she continued to deteriorate. One day in my office, I watched as she struggled to lift her 85-pound body out of the chair, and her gait made me nervous that she would collapse. It was clear at that moment that we needed to take some drastic measures.

Her mother and I knew she couldn't continue like this. I immediately got on the phone with a tertiary care children's hospital several hours away, printed out her entire medical record and soon had her on her way to find answers. It was one of the best "ownership" decisions I've made. During her two-week stay in the hospital she not only regained weight but was seen by some of the nation's most renowned pediatric rheumatologists, who have helped slow the progression of her disease. Who knows what would have happened had we not embraced that opportunity for her? Seeing results like this has encouraged me to continue owning a deeper responsibility to all my patients.

So what have all these lessons added up to? I've learned that my greatest joy in medicine is my relationship with my patients. It's easy to get overwhelmed. I've had my share of moments where I've felt frustrated that my patients' health isn't improving or burdened by the seemingly endless "tasks" that appear in the electronic health record. But relationship is what family medicine is all about.

Family medicine is not just continuity of care, or taking care of patients throughout their life spectrum. True family medicine means genuinely caring for our patients, which can come through when we challenge ourselves to communicate better, when we look a patient in the eyes and ask him or her a question that we know will make us run behind, and when we own our responsibility to patients and stretch ourselves to care for them.

When we strengthen those relationships, we can have better outcomes, happier patients, greater job satisfaction and, ultimately, joy.

These are just a few of the lessons that my patients have taught me.

Dr. Garcia is a family physician in York, PA, working at Family First Health, a federally qualified health center. He focuses on caring for the Spanish-speaking community and is an avid photographer.

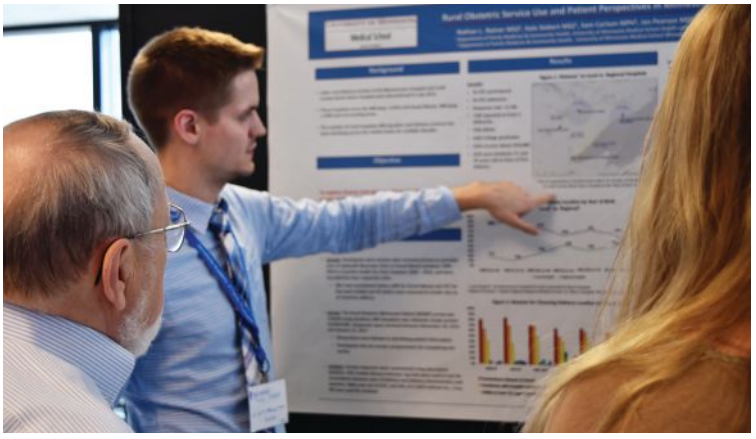
From AAFP: Fresh Perspectives, February 2017, © AAFP

CONVERSATION STARTER

What have your patients taught you?

Share your comments on the MAFP Facebook page or email tara@mafp.org and we will continue the conversation in the next issue of this magazine.

FORUM HOSTS 65+ INNOVATORS ON MARCH 4TH



An inspirational talk from **Mac Baird, MD, MS**, kicked off the 2017 MAFP Innovation & Research Forum, held in March at HealthPartners in Bloomington. The Forum is Minnesota's only venue that brings together family medicine innovators from across the state. This year's event featured 15 project presentations, 17 posters and presentation of the 2017 Innovation & Research Award to Dr. Baird. Many projects were funded by the MAFP Foundation, which raised $1,145 during the daylong event.

THANK YOU TO OUR GRANTORS

- Allina Health United Family Medicine Residency Program
- Department of Family Medicine Mayo Clinic Rochester
- Essentia Health
- HealthPartners Institute
- Park Nicollet Foundation/ University of Minnesota Family Medicine Residency Program
- UCare
- UMN Department of Family Medicine and Community Health

> ***"THE FORUM UNITES VISIONARIES AND RESEARCHERS TO DISSEMINATE THEIR IDEAS AND ENTHUSIASM."***
>
> *— Angela L.H. Buffington, Ph.D, Forum Co-chair*

Forum Co-chairs Laura Miller, MD and Angela L.H. Buffington, Ph.D., with 2017 Innovation & Research Award recipient Mac Baird, MD, MS

MARK YOUR CALENDAR

AAFP Family Medicine Advocacy Summit
May 22-23, 2017
Washington Court Hotel, Washington, DC

Kickoff & Social for 1st-Year Residents*
June 11, 2017
Location TBD

AAFP National Conference of Family Medicine Residents and Students
July 27-29, 2017
Kansas City Convention Center, Kansas City, MO

MAFP Summer Destination CME*
August 18-19, 2017
Arrowwood Resort & Conference Center, Alexandria, MN

AAFP Congress of Delegates
September 11-13, 2017
Grand Hyatt, San Antonio, TX

AAFP Family Medicine Experience (FMX)
September 12-16, 2017
Grand Hyatt, San Antonio, TX

Residency Opportunities & Procedure Workshops*
September 24, 2017
Location TBD

Family Medicine Midwest Conference
October 6-8, 2017
Hilton O'Hare, Rosemont, IL

**For more details and to register, visit www.mafp.org/events*

BENSON RECEIVES MINNESOTA FAMILY PHYSICIAN OF THE YEAR AWARD

Julie Mayers Benson, MD, FAAFP, a family physician at Lakewood Health System in Staples, Minnesota, has been named the 2017 Family Physician of the Year by the MAFP.

Benson's patients describe her care as top notch, heartfelt and "above and beyond."

"She is always so genuine with her patients," wrote Lakewood colleague Molly Mertens. "I see her interact with her hospice patients on one side of the floor, and then celebrate new life with labor and delivery on the other side. She is truly passionate about her patients — from the very beginning of life to the very end."

When asked about what it's like to participate in two such significant human experiences, often in the same day, Benson said, "I actually experience the exact same emotions whether I'm delivering a baby or attending to a patient in their final hours. It's just different ends of the life cycle."

Benson is on call 24/7 for Lakewood's hospice care.

When asked how she handles stress, she smiles immediately and says with confidence that she gets way more out of her role as a family doc than it causes her stress.

Knowing this may prompt eyebrow raises, she goes on to explain, "When I get to be in a room with someone, I lose myself. I'm so grateful that people let me into their lives, that they let me see their vulnerability. I really have the greatest job in the world."

Benson didn't always know she wanted to be a doctor. She credits the experience of watching an expert physician coordinate her father's complex health situation in the eighth grade as her inspiration for medicine. Years later, when she first experienced family medicine as a med student, she was hooked.

"From that point on, it was a no-brainer," she says.

Many are grateful it was such an easy decision for Benson.

"Over the past 20 years that I have known her, she has always placed patient care first and foremost," commented Lakewood colleague David Freeman, MD. "She is also a sought-after preceptor for medical students, college and high school students who are interested in pursuing medicine careers."

"She started our palliative care/hospice program and made it one of the best in the country for a rural hospital system," added colleague Christine Albrecht, MD, FAAFP.

Benson is recognized as an expert in Minnesota's palliative care community. She currently serves as the Board President for the Minnesota Network of Hospice and Palliative Care.

Congratulations to Dr. Benson on this top award!

As the Minnesota Family Physician of the Year, Benson will become Minnesota's nominee to the American Academy of Family Physicians for the 2017 National Family Physician of the Year. MP

GET TO KNOW JULIE

HOMETOWN
St. Anthony Park, MN

CURRENTLY LIVES IN
Staples, MN

FAMILY
Husband Steve; Daughter Katie, 18; Son Jack, 15

FIRST JOB
Hostess at Denny's (in Roseville)

FAVORITE TREAT
Anything chocolate or Bailey's

FAVORITE MN SPORTS TEAM
Pickleball in our barn on Saturday mornings with Bailey's & coffee. I invite my neighbors and colleagues!

IF YOU COULD HAVE DINNER 'WITH ANYONE ALIVE OR DEAD, WHO WOULD IT BE?
My dad. He died last April. He was an amazing small-business man. He survived a massive heart attack at age 45 and continued to be an amazing business man. I miss him.

WHAT PIECE OF ADVICE WOULD YOU OFFER MAFP MEMBERS?
Do what gives you joy.

IT'S A GOOD DAY WHEN...
I can deliver a baby and get home in daylight hours.

CLAIM TO FAME
I am an RPAP success story! I was the first RPAP student in Staples in 1992. After completing the program I went back to Minneapolis to finish medical school, then returned to Staples and have been here ever since!

ABOUT THE ACADEMY'S TOP AWARD

The Family Physician of the Year award has been given annually by the Academy since 1981. It is presented to a family physician who represents the highest ideals of the specialty of family medicine, including caring, comprehensive medical service, community involvement and service as a role model.

It is also the only Academy Award available for patients to submit nominations, which they do in December and January each year. This year, 78% of nominations were by patients while 22% came from employees or colleagues.

2017 FAMILY PHYSICIAN OF THE YEAR NOMINEES

Libby Brever, MD
Nathan Brever, MD
Douglas Brew, MD
Jimmie Browning, MD
Kirby Clark, MD*
Mark DePaolis, MD
Joel Dunn, DO
Roli Dwivedi, MD*
Margaret Gill, MD
Ryan Harden, MD
Dania Kamp, MD
Elizabeth Kennedy, DO
Robert Koshnick, MD, FAAFP
Amanda Lovold, DO
Mohamed Maray, MD
Julie Mayers Benson, MD, FAAFP*
Bartley Mueller, MD
Mark Paulson, MD
Dennis Peterson, MD
Scott Rahm, MD
Deborah Rasmussen, MD
Thomas Satre, MD
Thomas Seaworth, MD
Rebecca Stepan, MD
Lynn Stottler, MD
Johanna Toninato, MD
Arne Vainio, MD*
Erin Westfall, DO
Julie Youngs, MD
Randy Zimmerman, MD
Patrick Zook, MD

**denotes finalist*

More to come on all 2017 Academy Awards in our next issue!

***Like the MAFP Facebook page** to see more about these nominees in your news feed in the months ahead!*

Photo by the *Duluth News Tribune*

Todd Leonard, MD

TODD LEONARD, MD TALKS CORRECTIONAL CARE

MAFP member **Todd Leonard, MD**, of Waite Park, is a correctional medicine physician and president of MEnD Correctional Care, PLLC, a company he founded in 2008 to provide health care services to correctional facilities. MEnD serves 31 county facilities within Minnesota, Wisconsin and Iowa.

WHY DID YOU CHOOSE TO BECOME A CORRECTIONAL MEDICINE PROVIDER?

I actually had the opportunity arise from my hometown area, in Sherburne county. In 2006, they had a unique opportunity — and challenges — that required an improved way to manage and care for detainees in the Sherburne county jail. The jail houses not only county inmates, but also federal inmates from the U.S. Marshals Service and Immigration and Customs Enforcement. The sheriff at that time was someone I knew since childhood, and he turned to me for consultation and consideration of becoming the medical director at the jail. Although I had never thought about working in corrections before, and had never set foot in a county jail, I agreed to help part-time in managing the clinic, and caring for the 600 or so inmates there. I soon realized this was a very stimulating and challenging environment, and it played to my strengths as a medical provider. I began talking with other counties in Minnesota, and realized that there was a void that needed to be filled with better systems to care for this patient population, and that there was a business opportunity to provide correctional health care in the upper Midwest. For this reason I decided to leave community practice, and I formed MEnD Correctional Care in 2008. We began operations in 2009, with two employees (myself and one registered nurse) and have worked very hard to grow the business ever since.

HOW CAN SOMEONE BECOME A CORRECTIONAL MEDICINE PROVIDER?

There are recruiting and advertising opportunities almost every day for position openings in this industry. All you have to do is reach out to companies like MEnD, and discuss the opportunities available. It really becomes a career decision regarding scope of practice and work/life balance.

WHAT CERTIFICATION DO YOU NEED?

There are so many intricacies in the merging of law enforcement and medical care, along with judicial and other legal issues

arising out of daily care and situations involving our patients. As of 2017, we don't have board certification in correctional healthcare, however we have advanced certifications as practitioners (with the gold standard being through the National Commission on Correctional Healthcare — NCCHC) and we now have partnerships developing between such agencies as the AAFP and the NCCHC, and other medical oversight agencies and law enforcement agencies.

WHAT ARE GOOD HEALTH HABITS FOR PRISONERS?

Unfortunately, jails are riddled with temptations for poor health choices. Many inmates don't participate enough in the recreational activities available to them, and their vending or commissary food choices are typically unhealthy. Therefore, good habits would include staying as active as possible within the confines of the correctional system, and limiting snacking to a minimum. These issues provide great challenges for us in treating diabetic patients.

WHAT ARE OTHER CONTRIBUTING FACTORS TO PRISONER HEALTH?

With so many people confined in close quarters, communicable diseases can pose serious issues. The factors stated previously surrounding activity and diet choices can certainly affect their health. Ownership and participation from inmates in their own illness and overall health can greatly affect prognosis and outcomes. The ongoing threat of violence from other inmates can certainly affect health on occasion. Lastly, patients' mental health and chemical abuse issues can greatly affect their health, and we can typically help these patients stabilize, improve their health while incarcerated with treatment and avoidance of chemicals.

HOW DO YOU HANDLE STRESS?

After 10+ years in correctional healthcare, you develop strategies to prevent overstressing or burning out. One major lesson I've learned over this time is to not escalate discussions with patients, and to build rapport and respect with them. I call it my "place of zen." Too often I see medical professionals in this industry verbally sparring with patients, and it never ends well for either party. At MEnD we preach the mantra of helping the patients who will cooperate, respecting patients and colleagues, and de-escalating volatile situations and always trying to take the high road. Outside of work, it's important to have hobbies and interests that have no relationship to correctional healthcare. In that way it's like any other specialty in medicine. What's most important is that you leave work at work as much as possible, and engage in activities that take you away from work-related stress.

WHAT UNIQUE ISSUES DO YOU ENCOUNTER?

As a physician who has practiced in both the community and in corrections, I've seen both sides. Most community medical providers have very little idea as to the extent of issues we face in corrections, and the information we are able to obtain regarding their patients. I would say probably the most surprising fact I've learned over this time is just how rampant the abuse is in the community involving prescription and illegal drugs. It is at an epidemic level, and when we work together with community providers, we can break the cycle of this type of abuse, and set our patients up for a much higher probability of success upon re-entry into the community. Conversely, one of the biggest advantages of practicing correctional healthcare is the ability to actually observe your patients 24/7 and determine exactly how well they are functioning. This comes into play significantly with chronic pain conditions. We are able to determine if a patient is functioning at a high level, or if they need additional treatment to curb their painful symptoms. This is in stark contrast to community practice, where we may be able to observe our patients for maybe 30 minutes, while having little idea as to their true level of function for the remaining 23 1/2 hours of the day.

HOW ARE REFERRALS HANDLED?

All correctional healthcare starts with a comprehensive health assessment early in their incarceration, identifying all mental and medical health issues that are present or could arise soon Then, depending on these screenings and triage, patients may need urgent or routine referrals to our medical providers and mental health professionals. If we feel patients warrant further medical care outside of our scope, we refer them to community specialists. It really is a true primary care-centric system, with the primary care medical provider acting as the quarterback of the medical team caring for each patient. However, in correctional healthcare, the registered nurse is often at the center of medical care efforts, and plays a larger role in patient care compared to many community settings.

DO YOU FIND YOURSELF PRACTICING OUTSIDE THE SCOPE OF FAMILY MEDICINE?

I aggressively maintain my scope of practice boundaries. However, I will say that my skill in psychotropic medication prescribing has improved dramatically since entering correctional healthcare. With the massive shortage of psychiatric prescribing providers in the community, correctional medical providers are challenged with managing mental health conditions a bit farther than we were accustomed to in the community. Other than that, chemical detoxification and withdrawal treatment is another aspect of care that many primary care providers are not exposed to on a regular basis in the community. In correctional healthcare, it is a daily exercise, with many patients requiring aggressive treatment for benzodiazepine, opiate, and alcohol withdrawal. MP

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For more information contact

Travis Weyant at tweyant@unmc.edu or 402.559.3964

University of Nebraska Medical Center

unmc.edu/intmed/geriatrics

58 MAFP members attended Day at the Capitol on February 15, 2017. *Photo by Kathryn Forss, reprinted with permission from the MMA.*

IN THE NEWS

Meredith Sax Bourne, MD, PGY-3 at U of M North Memorial, received the 2017 Arnold P. Gold Humanism and Excellence in Teaching – Resident Instructor Award for being a "scientifically excellent and compassionate physician." Congratulations Meredith!

Alexandra Gits, MD, received a scholarship to attend the AAFP Family Medicine Advocacy Summit May 22-23 in Washington, DC. The purpose of the summit is to educate participants on family medicine's legislative priorities and how to advocate for those issues.

The UM Family Medicine / RPAP Department has selected the UM/Centracare St Cloud Family Medicine Residency program as an additional MetroPAP site. They will start their inaugural year in the fall of 2017. **Anna Krieger, MS3** has been accepted as their first UM medical student.

RECENTLY PUBLISHED

Jason Huikko, MD, St. Cloud, and **Thomas Satre, MD**, Sauk Rapids: "Are the Vanderbilt ADHD scales helpful in ruling out comorbid conditions in children with ADHD?" Evidence Based Practice. 2016;20(3):11-12

Noah Retka, MD, St. Cloud, and **Thomas Satre, MD**, Sauk Rapids: "Does clinic-based teaching on inhaler technique improve asthma outcomes?" Evidence Based Practice. 2016;19(12):7-8

NEW STUDENT MEMBERS

MAYO CLINIC SCHOOL OF MEDICINE
Sarasa Kim, Rochester
Ajdin Kobic, Rochester
John Lee, Rochester
Andrea Lyke, Rochester
Janice Ma, Rochester
Allyson Palmer, Rochester

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL — DULUTH CAMPUS
Stephanie Aldrin, Minneapolis
Benjamin Eidenschink, St. Louis Park
Breeanna Lorenzen, Minneapolis
Nathan Ratner, Duluth
Erica Sanders, Minneapolis
Abigail Solom, Plymouth
Risa Visina, Minneapolis
Christina Warner, Minneapolis

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL — TWIN CITIES CAMPUS
Gretchen Colbenson, St. Paul
Rachit Gupta, Apple Valley
Sakeen Kashem, Minneapolis
Joshua Warneke, St. Paul

NEW TO MINNESOTA

Michael Butner, MD, St. Cloud, has transferred from Tennessee.
Victoria Chiou, MD, St. Paul, has transferred from Illinois.
Vanessa Gil, MD, Mahnomen, has transferred from Ohio.
Teresa McCarthy, MD, Plymouth, a faculty geriatrician at the University of Minnesota, joined as a supporting member.
Rebecca Stroklund, DO, Alexandria, has transferred from Wyoming.
Josie Syverson, MD, Clontarf, has transferred from Idaho.
Chameng Vang, DO, Minneapolis, has transferred from Wisconsin.
William Watson, DO, Minneapolis, has transferred from Wisconsin.
Katrina Wherry, MD, Clearwater, has transferred from the Uniform Services AFP.
Cheryl White, MD, Erskine, has transferred from Pennyslvania.
Linnea Will, MD, Plymouth, has transferred from Hawaii.

GRANT RECIPIENTS

The following residents received Innovation Grants from the MAFP Foundation in Q1 2017:
Katherine Howard, MD & **Rebecca Zimmerman, MD** and **Jeffrey Sachs, MD**.

IN MEMORIAM

Anthony Jaspers, MD, of Mankato, passed away January 15, 2017, after a long illness. He is survived by his wife of 47 years, Mary; and his children, Christine in St. Paul, Jeremy in Mankato, Fr. Andrew in St. Paul; and his granddaughters, Emilia, Claire, & Lucienne. Born and raised in Shakopee, he enjoyed his education at Benilde High School, Marquette University and the University of Minnesota Medical School.

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"Now I can only make it halfway up before I have to catch my breath."

ACC/AHA/HFSA GUIDELINE RECOMMENDED CLASS I[3] LEVEL OF EVIDENCE B-R

Your patient is telling you about her heart failure symptoms, a sign of increased risk of HF hospitalization and death.[1,2]

Entresto®
(sacubitril/valsartan) tablets
24/26mg • 49/51mg • 97/103mg

ENTRESTO® reduced the risk of CV death or HF hospitalization as first event vs enalapril[4]

When you see symptoms, there's risk, so
it's time for ENTRESTO.

INDICATION

ENTRESTO is indicated to reduce the risk of cardiovascular death and hospitalization for heart failure in patients with chronic heart failure (NYHA Class II-IV) and reduced ejection fraction.

ENTRESTO is usually administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB.

IMPORTANT SAFETY INFORMATION

WARNING: FETAL TOXICITY

- **When pregnancy is detected, discontinue ENTRESTO as soon as possible**
- **Drugs that act directly on the renin-angiotensin system can cause injury and death to the developing fetus**

ENTRESTO is contraindicated in patients with hypersensitivity to any component. ENTRESTO is contraindicated in patients with a history of angioedema related to previous angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy.

ENTRESTO is contraindicated with concomitant use of ACE inhibitors. Do not administer within 36 hours of switching from or to an ACE inhibitor. ENTRESTO is contraindicated with concomitant use of aliskiren in patients with diabetes.

Angioedema: ENTRESTO may cause angioedema. Angioedema associated with laryngeal edema may be fatal. ENTRESTO has been associated with a higher rate of angioedema in Black patients and in patients with a prior history of angioedema. If angioedema occurs, discontinue ENTRESTO immediately, provide appropriate therapy, and monitor for airway compromise. ENTRESTO must not be re-administered.

Hypotension: ENTRESTO lowers blood pressure and may cause symptomatic hypotension. Patients with an activated renin-angiotensin system, such as volume- and/or salt-depleted patients (e.g., those being treated with high doses of diuretics), are at greater risk. Correct volume or salt depletion prior to administration of ENTRESTO or start at a lower dose. If hypotension persists despite dose adjustment of diuretics, concomitant antihypertensive drugs, and treatment of other causes of hypotension (e.g., hypovolemia) reduce the dosage or temporarily discontinue ENTRESTO. Permanent discontinuation of therapy is usually not required.

Impaired Renal Function: Decreases in renal function may be anticipated in susceptible individuals treated with ENTRESTO. In patients whose renal function depends upon the activity of the renin-angiotensin-aldosterone system (e.g., patients with severe congestive heart failure), treatment with ACE inhibitors and angiotensin receptor antagonists has been associated with oliguria, progressive azotemia and, rarely, acute renal failure and death. Closely monitor serum creatinine, and down-titrate or interrupt ENTRESTO in patients who develop a clinically significant decrease in renal function.

ENTRESTO may increase blood urea and serum creatinine levels in patients with bilateral or unilateral renal artery stenosis. In patients with renal artery stenosis, monitor renal function. Avoid use with aliskiren in patients with renal impairment (eGFR <60 mL/min/1.73 m^2).

In patients who are elderly, volume-depleted (including those on diuretic therapy), or with compromised renal function, concomitant use of non-steroidal anti-inflammatory drugs (NSAIDs), including COX-2 inhibitors, with ENTRESTO may result in worsening of renal function, including possible acute renal failure. These effects are usually reversible. Monitor renal function periodically.

Hyperkalemia: Hyperkalemia may occur with ENTRESTO. Monitor serum potassium periodically and treat appropriately, especially in patients with risk factors for hyperkalemia such as severe renal impairment, diabetes, hypoaldosteronism, or a high potassium diet. Dosage reduction or interruption of ENTRESTO may be required.

Concomitant use of potassium-sparing diuretics (e.g., spironolactone, triamterene, amiloride), potassium supplements, or salt substitutes containing potassium may lead to increases in serum potassium.

ARBs: Avoid use of ENTRESTO with an ARB, because ENTRESTO contains the angiotensin II receptor blocker valsartan.

Lithium: Increases in serum lithium concentrations and lithium toxicity have been reported during concomitant administration of lithium with angiotensin II receptor antagonists. Monitor serum lithium levels during concomitant use with ENTRESTO.

Common Adverse Events: In a clinical trial, the most commonly observed adverse events with ENTRESTO vs enalapril, occurring at a frequency of at least 5% in either group, were hypotension (18%, 12%), hyperkalemia (12%, 14%), cough (9%, 13%) dizziness (6%, 5%) and renal failure/acute renal failure (5%, 5%).

Please see Brief Summary of Prescribing Information, including Boxed WARNING, on following pages.

STUDY DESIGN: PARADIGM-HF was a multinational, randomized, double-blind trial comparing ENTRESTO to enalapril in symptomatic (NYHA class II–IV) adult HF*r*EF patients (left ventricular ejection fraction ≤40%). After discontinuing their existing ACEi or ARB therapy, patients entered sequential single-blind run-in periods during which they received enalapril 10 mg twice daily, followed by ENTRESTO 100 mg (49/51 mg) twice daily, increasing to 200 mg (97/103 mg) twice daily. Patients were then randomized to receive either ENTRESTO 200 mg (97/103 mg) (n=4209) twice daily or enalapril 10 mg (n=4233) twice daily. The median follow-up duration was 27 months, and patients were treated for up to 4.3 years. At the primary end point, the first event in the composite of CV death or first HF hospitalization, ENTRESTO was superior to enalapril, $P<0.0001$.[4]

ACC=American College of Cardiology; AHA=American Heart Association; HFSA=Heart Failure Society of America; B-R=Class of Recommendation B, randomized trial; CV=cardiovascular; HF=heart failure; NYHA=New York Heart Association; HF*r*EF=heart failure with reduced ejection fraction; ACEi=angiotensin-converting enzyme inhibitor; ARB=angiotensin II receptor blocker.

For more information, visit **EntrestoHCP.com**

References: 1. Ekman I, Cleland JGF, Swedberg K, et al. Symptoms in patients with heart failure are prognostic predictors: insights from COMET. *J Card Fail.* 2005;11(4):288-292. **2.** Wong M, Staszewsky L, Carretta E, et al. Signs and symptoms in chronic heart failure: relevance of clinical trial results to point of care—data from Val-HeFT. *Eur J Heart Fail.* 2006;8(5):502-508. **3.** Yancy CW, Jessup M, Bozkurt B, et al. 2016 ACC/AHA/HFSA focused update on new pharmacological therapy for heart failure: an update of the 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America [published online ahead of print May 20, 2016]. *Circulation.* doi: 10.1161/CIR.0000000000000435. **4.** ENTRESTO [prescribing Information]. East Hanover, NJ: Novartis Pharmaceuticals Corp; August 2015.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080 10/16 ETR-1337101

ENTRESTO™ (sacubitril and valsartan) tablets, for oral use
Initial U.S. Approval: 2015

BRIEF SUMMARY: Please see package insert for full prescribing information.

WARNING: FETAL TOXICITY
- **When pregnancy is detected, discontinue ENTRESTO as soon as possible (5.1)**
- **Drugs that act directly on the renin-angiotensin system can cause injury and death to the developing fetus (5.1)**

1 INDICATIONS AND USAGE

1.1 Heart Failure

ENTRESTO is indicated to reduce the risk of cardiovascular death and hospitalization for heart failure in patients with chronic heart failure (NYHA Class II-IV) and reduced ejection fraction.

ENTRESTO is usually administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB.

4 CONTRAINDICATIONS

ENTRESTO is contraindicated:
- in patients with hypersensitivity to any component
- in patients with a history of angioedema related to previous ACE inhibitor or ARB therapy *[see Warnings and Precautions (5.2)]*
- with concomitant use of ACE inhibitors. Do not administer within 36 hours of switching from or to an ACE inhibitor *[see Drug Interactions (7.1)]*
- with concomitant use of aliskiren in patients with diabetes *[see Drug Interactions (7.1)]*.

5 WARNINGS AND PRECAUTIONS

5.1 Fetal Toxicity

ENTRESTO can cause fetal harm when administered to a pregnant woman. Use of drugs that act on the renin-angiotensin system during the second and third trimesters of pregnancy reduces fetal renal function and increases fetal and neonatal morbidity and death. When pregnancy is detected, consider alternative drug treatment and discontinue ENTRESTO. However, if there is no appropriate alternative to therapy with drugs affecting the renin-angiotensin system, and if the drug is considered lifesaving for the mother, advise a pregnant woman of the potential risk to the fetus *[see Use in Specific Populations (8.1)]*.

5.2 Angioedema

ENTRESTO may cause angioedema. In the double-blind period of PARADIGM-HF, 0.5% of patients treated with ENTRESTO and 0.2% of patients treated with enalapril had angioedema *[see Adverse Reactions (6.1)]*. If angioedema occurs, discontinue ENTRESTO immediately, provide appropriate therapy, and monitor for airway compromise. ENTRESTO must not be re-administered. In cases of confirmed angioedema where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms.

Angioedema associated with laryngeal edema may be fatal. Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, administer appropriate therapy, e.g., subcutaneous epinephrine/adrenaline solution 1:1000 (0.3 mL to 0.5 mL) and take measures necessary to ensure maintenance of a patent airway.

ENTRESTO has been associated with a higher rate of angioedema in Black than in non-Black patients.

Patients with a prior history of angioedema may be at increased risk of angioedema with ENTRESTO *[see Adverse Reactions (6.1)]*. ENTRESTO should not be used in patients with a known history of angioedema related to previous ACE inhibitor or ARB therapy *[see Contraindications (4)]*.

5.3 Hypotension

ENTRESTO lowers blood pressure and may cause symptomatic hypotension. Patients with an activated renin-angiotensin system, such as volume- and/or salt-depleted patients (e.g., those being treated with high doses of diuretics), are at greater risk. In the double-blind period of PARADIGM-HF, 18% of patients treated with ENTRESTO and 12% of patients treated with enalapril reported hypotension as an adverse event *[see Adverse Reactions (6.1)]*, with hypotension reported as a serious adverse event in approximately 1.5% of patients in both treatment arms. Correct volume or salt depletion prior to administration of ENTRESTO or start at a lower dose. If hypotension occurs, consider dose adjustment of diuretics, concomitant antihypertensive drugs, and treatment of other causes of hypotension (e.g., hypovolemia). If hypotension persists despite such measures, reduce the dosage or temporarily discontinue ENTRESTO. Permanent discontinuation of therapy is usually not required.

5.4 Impaired Renal Function

As a consequence of inhibiting the renin-angiotensin-aldosterone system (RAAS), decreases in renal function may be anticipated in susceptible individuals treated with ENTRESTO. In the double-blind period of PARADIGM-HF, 5% of patients in both the ENTRESTO and enalapril groups reported renal failure as an adverse event *[see Adverse Reactions (6.1)]*. In patients whose renal function depends upon the activity of the renin-angiotensin-aldosterone system (e.g., patients with severe congestive heart failure), treatment with ACE inhibitors and angiotensin receptor antagonists has been associated with oliguria, progressive azotemia and, rarely, acute renal failure and death. Closely monitor serum creatinine, and down-titrate or interrupt ENTRESTO in patients who develop a clinically significant decrease in renal function *[see Use in Specific Populations (8.7) and Clinical Pharmacology (12.3) in the full prescribing information]*.

As with all drugs that affect the RAAS, ENTRESTO may increase blood urea and serum creatinine levels in patients with bilateral or unilateral renal artery stenosis. In patients with renal artery stenosis, monitor renal function.

5.5 Hyperkalemia

Through its actions on the RAAS, hyperkalemia may occur with ENTRESTO. In the double-blind period of PARADIGM-HF, 12% of patients treated with ENTRESTO and 14% of patients treated with enalapril reported hyperkalemia as an adverse event *[see Adverse Reactions (6.1)]*. Monitor serum potassium periodically and treat appropriately, especially in patients with risk factors for hyperkalemia such as severe renal impairment, diabetes, hypoaldosteronism, or a high potassium diet. Dosage reduction or interruption of ENTRESTO may be required *[see Dosage and Administration (2.1) in the full prescribing information]*.

6 ADVERSE REACTIONS

Clinically significant adverse reactions that appear in other sections of the labeling include:
- Angioedema *[see Warnings and Precautions (5.2)]*
- Hypotension *[see Warnings and Precautions (5.3)]*
- Impaired Renal Function *[see Warnings and Precautions (5.4)]*
- Hyperkalemia *[see Warnings and Precautions (5.5)]*

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In the PARADIGM-HF trial, subjects were required to complete sequential enalapril and ENTRESTO run-in periods of (median) 15 and 29 days, respectively, prior to entering the randomized double-blind period comparing ENTRESTO and enalapril. During the enalapril run-in period, 1,102 patients (10.5%) were permanently discontinued from the study, 5.6% because of an adverse event, most commonly renal dysfunction (1.7%), hyperkalemia (1.7%) and hypotension (1.4%). During the ENTRESTO run-in period, an additional 10.4% of patients permanently discontinued treatment, 5.9% because of an adverse event, most commonly renal dysfunction (1.8%), hypotension (1.7%) and hyperkalemia (1.3%). Because of this run-in design, the adverse reaction rates described below are lower than expected in practice.

In the double-blind period, safety was evaluated in 4,203 patients treated with ENTRESTO and 4,229 treated with enalapril. In PARADIGM-HF, patients randomized to ENTRESTO received treatment for up to 4.3 years, with a median duration of exposure of 24 months; 3,271 patients were treated for more than one year. Discontinuation of therapy because of an adverse event during the double-blind period occurred in 450 (10.7%) of ENTRESTO treated patients and 516 (12.2%) of patients receiving enalapril.

Adverse reactions occurring at an incidence of ≥5% in patients who were treated with ENTRESTO in the double-blind period are shown in Table 1.

Table 1: Adverse Reactions Reported in ≥5% of Patients Treated with ENTRESTO in the Double-Blind Period

	ENTRESTO (n = 4,203) %	Enalapril (n = 4,229) %
Hypotension	18	12
Hyperkalemia	12	14
Cough	9	13
Dizziness	6	5
Renal failure/acute renal failure	5	5

In the PARADIGM-HF trial, the incidence of angioedema was 0.1% in both the enalapril and ENTRESTO run-in periods. In the double-blind period, the incidence of angioedema was higher in patients treated with ENTRESTO than enalapril (0.5% and 0.2%, respectively). The incidence of angioedema in Black patients was 2.4% with ENTRESTO and 0.5% with enalapril *[see Warnings and Precautions (5.2)]*.

Orthostasis was reported in 2.1% of patients treated with ENTRESTO compared to 1.1% of patients treated with enalapril during the double-blind period of PARADIGM-HF. Falls were reported in 1.9% of patients treated with ENTRESTO compared to 1.3% of patients treated with enalapril.

Laboratory Abnormalities

Hemoglobin and Hematocrit

Decreases in hemoglobin/hematocrit of >20% were observed in approximately 5% of both ENTRESTO- and enalapril-treated patients in the double-blind period in PARADIGM-HF.

Serum Creatinine

Increases in serum creatinine of >50% were observed in 1.4% of patients in the enalapril run-in period and 2.2% of patients in the ENTRESTO run-in period. During the double-blind period, approximately 16% of both ENTRESTO- and enalapril-treated patients had increases in serum creatinine of >50%.

Serum Potassium

Potassium concentrations >5.5 mEq/L were observed in approximately 4% of patients in both the enalapril and ENTRESTO run-in periods. During the double-blind period, approximately 16% of both ENTRESTO- and enalapril-treated patients had potassium concentrations >5.5 mEq/L.

7 DRUG INTERACTIONS

7.1 Dual Blockade of the Renin-Angiotensin-Aldosterone System

Concomitant use of ENTRESTO with an ACE inhibitor is contraindicated because of the increased risk of angioedema *[see Contraindications (4)]*.

Avoid use of ENTRESTO with an ARB, because ENTRESTO contains the angiotensin II receptor blocker valsartan.

The concomitant use of ENTRESTO with aliskiren is contraindicated in patients with diabetes *[see Contraindications (4)]*. Avoid use with aliskiren in patients with renal impairment (eGFR <60 mL/min/1.73 m^2).

7.2 Potassium-Sparing Diuretics

As with other drugs that block angiotensin II or its effects, concomitant use of potassium-sparing diuretics (e.g., spironolactone, triamterene, amiloride), potassium supplements, or salt substitutes containing potassium may lead to increases in serum potassium *[see Warnings and Precautions (5.5)]*.

7.3 Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) Including Selective Cyclooxygenase-2 Inhibitors (COX-2 Inhibitors)

In patients who are elderly, volume-depleted (including those on diuretic therapy), or with compromised renal function, concomitant use of NSAIDs, including COX-2 inhibitors, with ENTRESTO may result in worsening of renal function, including possible acute renal failure. These effects are usually reversible. Monitor renal function periodically.

7.4 Lithium

Increases in serum lithium concentrations and lithium toxicity have been reported during concomitant administration of lithium with angiotensin II receptor antagonists. Monitor serum lithium levels during concomitant use with ENTRESTO.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

ENTRESTO can cause fetal harm when administered to a pregnant woman. Use of drugs that act on the renin-angiotensin system during the second and third trimesters of pregnancy reduces fetal renal function and increases fetal and neonatal morbidity and death. Most epidemiologic studies examining fetal abnormalities after exposure to antihypertensive use in the first trimester have not distinguished drugs affecting the renin-angiotensin system from other antihypertensive agents. In animal reproduction studies, ENTRESTO treatment during organogenesis resulted in increased embryo-fetal lethality in rats and rabbits and teratogenicity in rabbits. When pregnancy is detected, consider alternative drug treatment and discontinue ENTRESTO. However, if there is no appropriate alternative to therapy with drugs affecting the renin-angiotensin system, and if the drug is considered lifesaving for the mother, advise a pregnant woman of the potential risk to the fetus.

The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

Clinical Considerations

Fetal/Neonatal Adverse Reactions

Oligohydramnios in pregnant women who use drugs affecting the renin-angiotensin system in the second and third trimesters of pregnancy can result in the following: reduced fetal renal function leading to anuria and renal failure, fetal lung hypoplasia, skeletal deformations, including skull hypoplasia, hypotension, and death.

Perform serial ultrasound examinations to assess the intra-amniotic environment. Fetal testing may be appropriate, based on the week of gestation. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury. If oligohydramnios is observed, consider alternative drug treatment. Closely observe neonates with histories of *in utero* exposure to ENTRESTO for hypotension, oliguria, and hyperkalemia. In neonates with a history of *in utero* exposure to ENTRESTO, if oliguria or hypotension occurs, support blood pressure and renal perfusion. Exchange transfusions or dialysis may be required as a means of reversing hypotension and replacing renal function.

Data

Animal Data

ENTRESTO treatment during organogenesis resulted in increased embryo-fetal lethality in rats at doses ≥ 49 mg sacubitril/51 mg valsartan/kg/day (≤ 0.14 [LBQ657, the active metabolite] and 1.5 [valsartan]-fold the maximum recommended human dose [MRHD] of 97/103 mg twice-daily on the basis of the area under the plasma drug concentration-time curve [AUC]) and rabbits at doses ≥ 5 mg sacubitril/5 mg valsartan/kg/day (4-fold and 0.06-fold the MRHD on the basis of valsartan and LBQ657 AUC, respectively). ENTRESTO is teratogenic based on a low incidence of fetal hydrocephaly, associated with maternally toxic doses, which was observed in rabbits at an ENTRESTO dose of ≥ 5 mg sacubitril/5 mg valsartan/kg/day. The adverse embryo-fetal effects of ENTRESTO are attributed to the angiotensin receptor antagonist activity.

Pre- and postnatal development studies in rats at sacubitril doses up to 750 mg/kg/day (4.5-fold the MRHD on the basis of LBQ657 AUC) and valsartan at doses up to 600 mg/kg/day (0.86-fold the MRHD on the basis of AUC) indicate that treatment with ENTRESTO during organogenesis, gestation and lactation may affect pup development and survival.

8.2 Lactation

Risk Summary

There is no information regarding the presence of sacubitril/valsartan in human milk, the effects on the breastfed infant, or the effects on milk production. Sacubitril/valsartan is present in rat milk. Because of the potential for serious adverse reactions in breastfed infants from exposure to sacubitril/valsartan, advise a nursing woman that breastfeeding is not recommended during treatment with ENTRESTO.

Data

Following an oral dose (15 mg sacubitril/15 mg valsartan/kg) of [^{14}C] ENTRESTO to lactating rats, transfer of LBQ657 into milk was observed. After a single oral administration of 3 mg/kg [^{14}C] valsartan to lactating rats, transfer of valsartan into milk was observed.

8.4 Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

8.5 Geriatric Use

No relevant pharmacokinetic differences have been observed in elderly (≥65 years) or very elderly (≥75 years) patients compared to the overall population *[see Clinical Pharmacology (12.3) in the full prescribing information]*.

8.6 Hepatic Impairment

No dose adjustment is required when administering ENTRESTO to patients with mild hepatic impairment (Child-Pugh A classification). The recommended starting dose in patients with moderate hepatic impairment (Child-Pugh B classification) is 24/26 mg twice daily. The use of ENTRESTO in patients with severe hepatic impairment (Child-Pugh C classification) is not recommended, as no studies have been conducted in these patients *[see Dosage and Administration (2.4) in the full prescribing information, Clinical Pharmacology (12.3) in the full prescribing information]*.

8.7 Renal Impairment

No dose adjustment is required in patients with mild (eGFR 60 to 90 mL/min/1.73 m^2) to moderate (eGFR 30 to 60 mL/min/1.73 m^2) renal impairment. The recommended starting dose in patients with severe renal impairment (eGFR <30 mL/min/1.73 m^2) is 24/26 mg twice daily *[see Dosage and Administration (2.3) in the full prescribing information, Warnings and Precautions (5.4) and Clinical Pharmacology (12.3) in the full prescribing information]*.

10 OVERDOSAGE

Limited data are available with regard to overdosage in human subjects with ENTRESTO. In healthy volunteers, a single dose of ENTRESTO 583 mg sacubitril/617 mg valsartan, and multiple doses of 437 mg sacubitril/463 mg valsartan (14 days) have been studied and were well tolerated.

Hypotension is the most likely result of overdosage due to the blood pressure lowering effects of ENTRESTO. Symptomatic treatment should be provided.

ENTRESTO is unlikely to be removed by hemodialysis because of high protein binding.

Distributed by: Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936

T2015-100

Issued: July/2015

WORKING TO BUILD THE FOUNDATION OF FAMILY MEDICINE IN MINNESOTA

The MAFP Foundation funds creative and ambitious projects that lead to innovative solutions to challenges faced by patients and family physicians. Each issue we feature a winning project. Grants are offered quarterly. Apply at **www.mafp.org/grants**.

In February 2016 the Foundation awarded medical student **Robin Sautter** a $1,000 Innovation Grant to fund a Somali women-only fitness class in Willmar, Minnesota. Willmar has seen a tremendous influx of Somali refugees over the past several years and Kandiyohi County had identified physical inactivity as a major health issue in their 2014 Community Health Assessment.

MORE ABOUT THE PROJECT

How did you come up with the idea?

After speaking with several healthcare providers and members of the Somali community, I learned of several barriers that limited the Somali women's ability to stay physically active, particularly in the winter months. I wanted to work together with all members of the community to create a space where the women could exercise without worrying about cost, safety, or equipment.

Barriers breached

A "safe space." The women stated they did not feel comfortable when exercising with men present. To address this concern, I created a women's only class where the women could feel at ease and even remove their headscarves if they wanted to. This would only be possible in a women's-only setting.

Location. Most of the class participants could not drive and public transportation is very limited in Willmar. Thus, it was incredibly difficult for them to go to the local gym. For this reason I found an empty classroom down the hall from their English class so that any woman could participate.

Cost. The women had concerns about the cost of paying for a gym membership or for proper exercise attire. This was eliminated by the class being free and modifying activities so that they wouldn't need any new exercise apparel, plus the MAFP grant gave us the opportunity to purchase exercise equipment!

Where are you at right now and what's next?

We held group fitness classes for 30 minutes twice a week and averaged about 20 women per class. One of the participants stated that since she started the class she has been able to get down on the floor to pray again. She hadn't been able to do that in years. Currently two of the next RPAP students are continuing the project and next steps include motivating the women to continue to exercise as a group without the guidance of medical students.

Robin Sautter, MS4 University of Minnesota Medical School – Duluth, Class of 2017

What was it like when you heard you got funding from the MAFP Foundation?

I was elated! Although we can always find ways to exercise without equipment, the MAFP grant allowed the women to explore new and fun ways to stay active.

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