SUMMER 2017 • VOL.1 • NO.3

MFP

MINNESOTA FAMILY PHYSICIAN

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PALLIATIVE CARE IN PRIMARY CARE 16

PADDLEBOARD FOR WELLBEING 22

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Photo at top: A handful of MAFP Past Presidents gather at the House of Delegates on April 19, 2017. Front row: ***Nicholas Bernier, MD, FAAFP; Jerry Rogers, MD, FAAFP; Patricia Fontaine, MD, FAAFP; Lynne M. Lillie, MD, FAAFP; Carol Featherstone, MD, FAAFP; Dania Kamp, MD, FAAFP; M. Tariq Fareed, MD, FAAFP;*** *and* ***Nancy Baker, MD****. Back row:* ***Terrence Cahill, MD; Kurt Angstman, MD, FAAFP;*** *and* ***Daron Gersch, MD, FAAFP****.*

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

By David Bucher, MD, FAAFP,
MAFP President

ARE YOU ACTIVATED?

Summer in Minnesota – for many, it's our favorite season, filled with activities with our family and friends.

Often it can seem overwhelming, trying to keep up with the running, swimming, boating, chauffeuring of kids and trips to the lake cabin. Many of us find time to improve and increase our physical activity this time of year – which is great for our physical health and well-being – but I'd like to reflect on how we're doing in our professional activation.

Most of us in family medicine are quite aware of the legislative changes proceeding at the federal level. Whatever perspective you have on these changes, I strongly encourage you to become involved and speak out on behalf of primary care and family physicians, as well as the interests of our patients. Our state Academy (MAFP) and the American Academy of Family Physicians (AAFP) offer easy ways to do this on an ongoing basis.

In this edition of the *Minnesota Family Physician*, please enjoy some motivating articles about your colleagues who have found their "activation" for family medicine.

Particularly inspiring is the large number of resolutions that came through the House of Delegates in April: a total of 22 with eight put forward by our family medicine residents and medical students. Our colleague Mac Baird, completing his role as the chair for the U of M Department of Family Medicine and Community Health, shares his experience with advocating for graduate medical education funding at the state legislature…a substantial success! And PGY-2 resident Peter Meyers and medical student Paul Stadem explain their enthusiasm for being newly "activated" leaders in family medicine.

We are also excited for the candidacy of MAFP Past President Lynne Lillie, who has been active on the AAFP Board, and now is seeking the role of AAFP President. The MAFP is strongly supporting her to help her succeed in taking on this top leadership position.

Are you feeling activated yet?

If there are ways the MAFP could help you better engage in your community, please reach out to us at **952.542.0130** or **office@mafp.org**.

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 3

MINNESOTA IS PROUD TO SUPPORT LYNNE M. LILLIE, MD, FAAFP FOR AAFP PRESIDENT-ELECT

A Conversation with the Candidate

Early in her career Lynne Lillie began to see how external factors could affect what transpired between her and a patient in the exam room. Insurance companies were just beginning to talk about "quality withholds," telling physicians they could get fully reimbursed if they could only prove they were good doctors.

Her clinic then didn't have systems in place to measure the care they provided and had to hire new staff to figure out their quality metrics and do their reporting. That, of course, took away from their bottom line, and doctors were asked to see more and more patients to make ends meet.

"People were running to the point of exhaustion," she says. She noticed physicians around her were discouraged. Some cut their hours. A few gave up medicine altogether.

> *"It's not just about cutting back dollars spent on health care, it's about spending dollars in the right place."*

Lillie has been working ever since to make things better for doctors and patients both in her practice and through the Academy.

"You can either set out and feel victimized in the situation, or you can set out and say, 'I'm going to work on finding and creating solutions because there's got to be a better way.'"

This year, the family physician, who has trained in Duluth and practiced in St. Paul, Red Wing and Rochester, is running for President-Elect of the AAFP.

If elected, she'll spend a year doing behind-the-scenes work as President-Elect before stepping into the presidential role, serving as the AAFP's spokesperson in 2018. As past-president the following year, she'll serve as the AAFP's board chair. The three-year commitment is a big one, requiring as much as 200 days a year of travel and a nearly full-time work schedule.

We asked her about her decision to enter the race and what she hopes to accomplish.

SERVING AS THE AAFP'S PRESIDENT IS A DEMANDING JOB THAT WILL TAKE YOU AWAY FROM SEEING PATIENTS. WHY ARE YOU WILLING TO DO THIS WORK?

There are so many reasons. Most important, my journey has gone from caring for patients to caring for communities to caring for our profession. Too many of our family medicine colleagues these days are struggling and need to be empowered to do the work they do best. I find it an important calling to be out front, to represent our members and their interests in Washington. I want to empower family physicians, to give them the tools, regulatory support and payment reform they need so they can care for America.

WHAT PREVENTS FAMILY PHYSICIANS FROM EFFECTIVELY DOING THEIR JOBS?

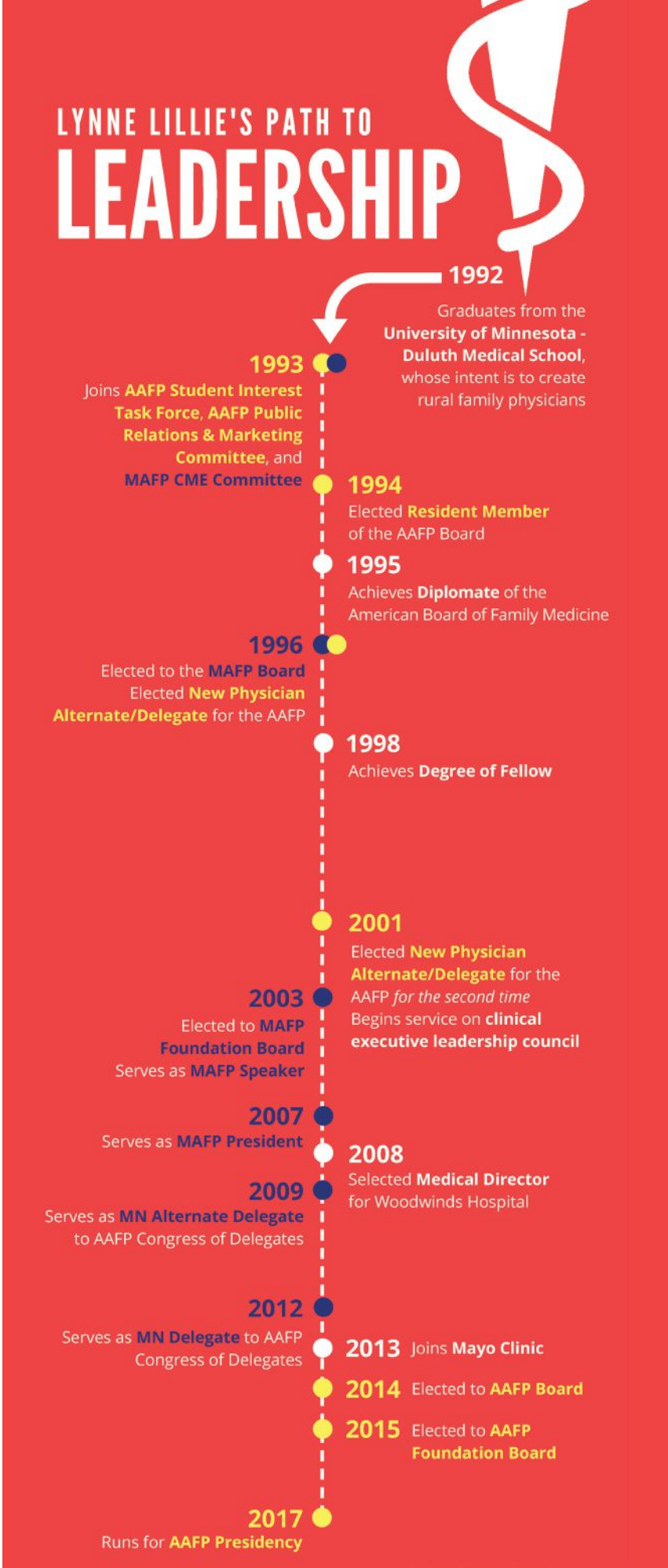
Many external influences come between physicians and patients: third-party payers, government regulations, quality metrics, hospital bylaws, clinical administration and technology. All of these things impact the ability of family physicians to provide effective, quality care for their patients.

WHAT ADMINISTRATIVE BURDENS ARE PARTICULARLY IN YOUR SIGHTS?

Prior authorization is one I face every day. It's not just for medications, it's for diabetic shoes, for Depends. In the last couple of weeks, I've seen paperwork four times on one patient because the insurance company wasn't happy with the ICD codes we used. I don't think dealing with that was a good use of my medical license.

YOU'VE SAID YOU WANT TO EDUCATE LEGISLATORS, BUSINESS LEADERS AND THE PUBLIC ABOUT PRIMARY CARE. WHAT DON'T THEY UNDERSTAND?

For legislators, the biggest thing to understand is that increasing spending on primary care will result in total lower cost of care, if we do it right. There's a huge ROI for investing in primary care. Right now, people in government are talking about cutting back on spending in health care, but they talk about it indiscriminately.



Lynne engaging with emerging physician leaders at the AAFP National Conference of Constituency Leaders in Kansas City.

It's not just about cutting back dollars spent on health care, it's about spending dollars in the right place. Spending dollars on primary care and public health leads to prevention, which would absolutely decrease the total government spend on health care in the country. We need to spend dollars on preventing disease, not just fixing disease.

For business leaders, it's that providing preventive care services would reduce their total spend on health care. Some businesses out there really get that, even hiring primary care practices to take care of their employees.

For the general public, it's understanding exactly what family physicians can do, and that there's a significant difference between the number of training hours required for family physicians and that of other health care providers. Nurse practitioners, for example, get 2,800 to 5,350 hours while family physicians have anywhere from 20,700 to 21,700. It's a huge difference! The point is family physicians are highly skilled and the public should understand that value.

YOU'VE SAID YOU WANT TO "INVERT THE HEALTH CARE PYRAMID" IN THE UNITED STATES. WHAT DOES THAT MEAN?

Most all other industrialized countries in the world have a health care system where about 50 percent of spend is on primary care. In the U.S., it's inverted: only 6 to 10 percent of our health care spend goes to primary care, while the rest goes to specialty care. If we really want to reduce the overall cost in the country, we have to put more into primary care and prevention; to do that, we have to have the workforce available to deliver that care; and to do that, we need to do a better job of promoting primary care in our medical schools, have payment reform for our primary care workforce and reduce the administrative burden that falls disproportionately on primary care physicians.

YOU'VE SUGGESTED HAVING PRACTICES AND RESIDENCY PROGRAMS REPORT ON PHYSICIAN WELLBEING AS THEY DO PATIENT EXPERIENCE. WHAT WOULD THIS ACCOMPLISH?

The idea is from the AMA's Christine Sinsky, MD. Wouldn't it be interesting if there were physician wellness indicators that were publicly reported, so when residents were looking for places to train or patients were looking for a clinic, they'd look for places that had high physician wellbeing scores? I think we should strive to live in that world in medicine.

WHAT HAVE YOU LEARNED ABOUT LEADERSHIP DURING YOUR CAREER?

I've learned that you first have to listen, then learn, in order to lead. Leadership is about empowering others to be their best. You need to have a vision for your organization and be aware of threats. You should always be looking five years down the road and wondering, 'Where do we need to be to be relevant?' The first thing leaders need to do is listen. You have to sit back and try to understand what the true issues are—the "why" of the problem.

HOW DO YOU UNDERSTAND THE ROLE OF THE AAFP PRESIDENT?

The work that the Academy does on behalf of patients is really village work. In 2015, the AAFP president got to stand in the Rose Garden with President Obama as MACRA was signed into law. He was the spokesperson, but our Academy had spent 15 years on Capitol Hill advocating for repeal of the SGR. It was a village of people and leaders.

To me, the primary role of the president is to continue to influence external leaders to appreciate the scope of family medicine and support primary care in our country. And then, secondarily, to be motivational and empowering to our membership so they know that we're doing everything we can to help them be the best they can be on the front lines.

An AAFP board member since 2014, Lynne is used to a rigorous schedule. Here she is catching quality time with grandson Wally between AAFP commitments in Minneapolis and Kansas City.

Lynne and running mates John Cullen, MD of Alaska and Mott Blair, MD, FAAFP of North Carolina

IF YOU COULD ADDRESS ONLY ONE ISSUE AS AAFP PRESIDENT, WHAT WOULD IT BE?

I'd take on the administrative burdens that are strangling physicians' ability to be successful in caring for America. That's why I'm running for president. The burden that our front-line physicians face is intolerable. And we need action.

WHAT ARE FAMILY PHYSICIANS IN OTHER PARTS OF THE COUNTRY CONCERNED ABOUT?

Of course, each region or state is going to have unique circumstances, but in general, I hear doctors across the country are talking about the same things: They're struggling with workforce issues, having medical schools that are promoting family medicine as a residency choice, recruiting primary care doctors in rural areas, ensuring family physicians maintain a full scope of practice and have adequate hospital privileges; and ensuring the survivability of independent practices.

HOW DOES BEING FROM MINNESOTA INFORM YOUR DISCUSSIONS AT THE NATIONAL LEVEL?

When I talk about being from Minnesota, I talk about the state being a strong producer of primary care physicians and the fact that we have strong support for primary care here. Also, many of our family physicians are doing full-scope practice. We also have been national leaders in developing concepts such as the patient-center medical home, which started with complex pediatric patients. We're very progressive and fortunate to have high quality primary care. Having "grown up" in Minnesota, I've been able to take advantage of some of our learnings, and I like to be able to share them.

ARE YOU READY FOR THIS?

Yes. For 25 years I've been developing the tools to be an effective leader—visionary thinking, strategic planning and intentional action. I'm ready to listen, learn and lead, as together with our membership, we will transform our health care system to develop, support and grow family medicine. MP

You can read more about Dr. Lillie's candidacy at www.lillie4aafp.com. Election of AAFP officers happens at the Congress of Delegates, held September 10-13, 2017, in San Antonio.

CONNECT WITH LYNNE

@LynneLillie • www.lillie4aafp.com

DYNAMIC DUO ELECTED BY STUDENTS & RESIDENTS

Paul Stadem, MAFP Student Director
MS4 Mayo Clinic School of Medicine, Rochester
@PaulStadem

Peter Meyers, MD, MPH, MAFP Resident Director
PGY-3 United Family Medicine Residency, St. Paul
@peterjmeyers

WHAT DOES BEING INVOLVED MEAN TO YOU?

PS: That I get to be around some of the most energized, enthusiastic and brilliant family physicians in the country. It was the ability to learn from these physicians as leaders within the Academy that helped to convince me that family medicine was the specialty for me.

PM: Several opportunities for leadership development and civic engagement, which is really important for primary care doctors (in my opinion). It's also fun! And a great way to meet other residents, attend conferences and stay up-to-date on innovative ideas and projects around the country.

WHAT'S THE SONG YOU HAVE STUCK IN YOUR HEAD?

PS: "Something Just Like This" by the Chainsmokers and Coldplay

PM: "Rollercoaster" by Bleachers

WHAT COULD WE DO TO CONVINCE MORE STUDENTS TO GO INTO FAMILY MEDICINE?

PS: I think that it starts before students even enter medical school with how pre-med students learn about what it means to be a physician and how we can help our patients live a healthier life. In medical school, it requires getting medical students around family medicine faculty and residents regularly to showcase the breadth, depth and compassion of family docs. With breadth, we also must showcase the feasibility of family medicine, as I often hear that family medicine is too broad for many students' comfort.

PM:

- Highlight the outstanding mentoring and leadership opportunities across the country.
- We're also the most in-demand specialty (for the last 10+ consecutive years).
- AND we're at the core of our future health system, so there's a lot of exciting clinical innovation taking place!

NEXT PLACE ON YOUR TRAVEL BUCKET LIST?

PS: Hawaii. Someday my fiancé and I will make it there!

PM: Maldives

TWEET THAT CAPTURES YOUR LIFE RIGHT NOW?

PS: It took me three years, but I finally don't have to spell check "auscultation" every time I write a patient note. #Progress #ReadyFor4thYear

PM: I can always tell I'm tired when an emotionally manipulative TD Ameritrade ad on the hospital lounge TV makes me cry. #newdad

The MAFP Student and Resident Directors were elected by our first-ever electronic vote which allows all of our resident and student members to choose their representatives. They serve on our Board of Directors, represent our chapter at the AAFP Resident and Student Congresses, and help plan relevant programming.

22 RESOLUTIONS HEARD AT THIS YEAR'S HOUSE OF DELEGATES

This year was one for the record books with 22 resolutions submitted by members and local chapters and heard at the House of Delegates on April 19, 2017, at The Depot in downtown Minneapolis. (Last year we had five resolutions, and the year before that, eight.) Eight resolutions were crafted by resident and medical student members as a result of an Advocacy 101 training held in January. All signs of a healthy and highly-engaged Academy!

Under the guidance of Speaker of the House **Glenn Nemec, MD**, Vice Speaker **Renee Crichlow, MD, FAAFP**, and reference committee chairs (and past MAFP presidents) **Randy Rice, MD, FAAFP** and **Julie Anderson, MD, FAAFP**, your 2017 House of Delegates took the following actions:

1. **Military Tobacco 21** – The MAFP will ask the AAFP to adopt a policy position and lobby the United States congress to pass a law that makes it illegal for military commissaries to sell tobacco products to those under 21.

2. **Support employed physicians involvement in the MAFP and AAFP** – The MAFP work with the AAFP to create tools that employed member physicians can use to demonstrate the return on investment that MAFP/AAFP dues provide. The MAFP will also work with the AAFP to create documents that members can use to demonstrate the value of involvement in leadership roles at the MAFP and AAFP.

3. **Replace the Foundation's dues allocation with an annual gift and matching grant** – The MAFP will discontinue allocating $20 of active members' dues starting in fiscal year 2017, and provide the Foundation with an up to $20,000 Annual Matching Grant to encourage individual giving in 2017 with the amount to be adjusted annually during the budgeting process; the MAFP will also provide an additional $25,000 Annual Gift to the Foundation with the amount to be adjusted annually during the budgeting process.

4. *A resolution to update the bylaws with language that would give the board of directors the power to adopt, amend or repeal provisions in the Bylaws or Articles of Incorporation (as opposed to the House of Delegates as it is now) was not adopted.*

5. **Request for strengthening Minnesota environmental regulations to require the completion of a Health Impact Assessment (HIA) for all projects requiring an environmental assessment worksheet (EAW) or Environmental Impact Statement (EIS)** – The MAFP will support the completion of a Health Impact Assessment (HIA) for all projects proposed in Minnesota which require the completion of an environmental assessment worksheet (EAW) or an environmental impact statement (EIS) and will propose this to the MN (Environmental Quality Board) EQB or appropriate Minnesota State Authority. The MAFP will also support the requirement that all federal environmental impact statements be required to include a comprehensive and independently produced Health Impact Assessment. The MAFP will also submit this to the AAFP for its consideration.

6. **Support placement and coverage of Long-Acting Reversible Contraceptives (LARC) in the early postpartum period** – The MAFP will support a policy that LARC methods be a recommended option for postpartum women prior to hospital discharge, and a policy assuring coverage of LARC device and placement prior to hospital discharge, separate

MAFP FOUNDATION LAUNCHES KEY SHIFT JULY 1ST

As a result of resolution #3 passing at House of Delegates, beginning July 1, 2017, the MAFP will match dollar-for-dollar every individual donation to the Foundation (up to $20,000). The shift from the dues allocation to intentional, individual giving is meant to strengthen the connection between each MAFP member and the Foundation's mission. Increased individual donating will make the Foundation more sustainable over time and unlock further grant opportunities that will support future family physicians in Minnesota. Members are encouraged to give throughout the year at **mafp.org/donate** and tweet your support using the hashtag **#nexgenFM**.

from the global fee, for all women who select these methods. The MAFP will also advocate for Minnesota State Medicaid reform to allow for coverage and reimbursement of LARC device and placement prior to hospital discharge, separate from the global fee, for women who select these methods.

7. **Advocating for healthy communities –** The MAFP will perpetuate our current Medicaid and MNSure coverage levels for our communities and support the continued expansion of Medicaid and MNSure coverage levels for our communities.

8. **Support community health workers to improve refugee/immigrant health –** The MAFP will explore ways to increase sustainable funding avenues to support and expand community health care workers in underserved communities. The MAFP will also write a letter to Minnesota colleges to advocate for expanding community health worker training programs and to encourage increasing diversity among enrollees in the programs, and develop educational materials/resource guide to assist with the integration of community health workers into healthcare homes.

9. **Climate change –** The MAFP will facilitate efforts to educate family physicians about climate change's health effects and to provide guidance on the reduction or mitigation of such effects. The MAFP will support efforts to communicate with local, state and national legislators about the need to take action to adapt to and mitigate the adverse health effects of climate change. The MAFP will encourage health care institutions to review, report and improve their carbon footprint and that of their supply chain and also encourage them to prepare for climate impacts.

10. **Increasing Minnesota immunization rates through physician education and routine reassessment of patient vaccination status –** The MAFP will recommend that members utilize the MIIC reporting system to document all vaccinations administered and verify new patient immunization status. The MAFP will also implement an immunization curriculum regarding best practices for discussing vaccines with hesitant patients at the MAFP 2018 Spring Refresher. The MAFP will also recommend that our MAFP members utilize best practices to repeatedly engage vaccine hesitant patients and guardians for the health of our patients and the wider health of the community.

11. **Point of Care Physician Input on Governmental Health Care Committees –** This resolution was referred to the Board of Directors: The MAFP will adopt the legislative policy of continuously using any available opportunity to advise the State Government on the wisdom and efficiency of having a Point of Care (preferably Family Physician) Provider on the committee roster for any governmental committees making decisions affecting health care delivery. The MAFP will also forward a companion resolution to the AAFP for application on the national level.

12. *A resolution to exclude first degree family members from HIPAA requirements was not adopted.*

13. **Meatless Mondays –** The MAFP will educate family physicians statewide about the health benefits of a plant-based diet (such as the Meatless Mondays program developed in conjunction with Johns Hopkins School of Public Health, www.meatlessmonday.com) and encourage physicians to recommend a plant-based diet to patients to improve patients' overall health and help manage chronic disease.

14. **Transfer of jurisdiction over required clinical skills examinations to U.S. medical schools –** The MAFP Board of Directors was directed to file the following resolution for information: The MAFP will advocate for the Minnesota Board of Medical Practice to eliminate the Step 2 CS Exam requirement for U.S. medical graduates who have passed a school-administrated clinical skills examination.

15. **Prior authorization –** The MAFP will work through non-legislative means toward moving insurance companies and PBM's to always include in their "non-coverage notices" the specific reason a drug is not approved, AND list formulary medications in the same class.

16. **Request for increasing emphasis on end of life care planning –** The MAFP will become a non-profit partner of the Twin Cities Medical Society – Honoring Choices campaign (as listed on the Honoring Choices website), which is a no-cost action that emphasizes the importance the MAFP realizes in end of life care planning. The MAFP will incorporate end of life care planning into topics at the Spring Refresher or other appropriate MAFP-sponsored continued medical educational activities.

17. **Minor consent for HPV vaccination –** The MAFP will support legislation giving minors the ability to consent for the human papillomavirus vaccination.

18. **Support for the Direct Primary Care (DPC) bill –** The Board of Directors was directed to file for information that the MAFP will support state and national legislation that would ensure that DPC options are available to consumers buying coverage in health care exchanges, that DPC's be defined as a healthcare service outside the scope

of state insurance regulations, that payments to DPC physicians be allowed as a "qualified medical expense" by the IRS that would allow HSA's monies to be used for DPC's, and that would allow Medicare and Medicaid beneficiaries to participate in DPC's with their government benefits.

19. **Pregnant women civil commitment –** The Board of Directors was directed to file for information that the MAFP will study the risks of opioid withdrawal on maternal health and fetal health in the context of civil commitment procedures and accompanying wait times in the local jail system for "chemically-dependent" pregnant girls and women.

20. **Oppose legislative restrictions on health centers receiving Title X and Medicaid funding –** The MAFP will lobby the State Congress to oppose legislation that diminishes funding and/or access to preventive and reproductive health services for women and men, and, as a matter of policy, the MAFP will support maintaining Medicaid and Title X funding of all providers or clinics that otherwise meet usual standards for eligibility.

21. **Make birth control pills an over-the-counter drug –** The MAFP will ask the AAFP to appeal to the FDA to approve oral contraceptives for over-the-counter use.

22. **Request for policy supporting access for all women to scientifically based reproductive care –** The MAFP will develop a policy statement supporting all women's access to facilities that provide scientifically based information about contraception, reproductive health and safety regardless of a woman's insurance or ability to pay.

Authored by a medical student or resident member

Will graduate to national level, heard at AAFP Congress of Delegates in September

HOUSE OF DELEGATES 101

WHAT IS THE HOUSE OF DELEGATES ANYWAY?

House of Delegates is the MAFP's annual business session to deliberate on resolutions, hear updates from AAFP leadership and elect MAFP officers. Resolutions are the way members bring forward changes and/or issues that affect the specialty of family medicine in Minnesota. Resolutions are collected January – March each year, following meetings of MAFP's 11 local chapters, and the House of Delegates convenes in April, one day ahead of the Spring Refresher. Resolutions can be submitted by local chapters or individual members.

All members are invited to attend House of Delegates, however voting is done by the delegates from the local chapters. Unsure which local chapter you're in? Contact missy@mafp.org.

WHY SHOULD I PARTAKE AS A MEMBER?

Participating in the policy making process is a powerful benefit of your membership.

Resolutions not only help to guide the policy decisions of the Academy, but can also raise awareness of issues of importance to family medicine. A strong resolution may also make its way through our House of Delegates and be carried forward to the AAFP Congress of Delegates to become national policy.

Student members listening to testimony at House of Delegates

"Authoring a resolution is also an excellent way to get involved in the Academy and enjoy the satisfaction of being a change agent for the improved health of Minnesotans and of healthcare in our state."

– Speaker of the House Glenn Nemec, MD

By Macaran A. Baird, MD, MS

FAMILY MEDICINE EDUCATION AND FUNDING VALIDATED IN 2017 LEGISLATIVE SESSION

I am immensely pleased to announce that on May 30, 2017, Governor Mark Dayton signed the Minnesota Legislature's higher education bill which included $6.24 million funding for the University of Minnesota Department of Family Medicine and Community Health.

The funds are designated to restore the department's continued administration of eight residency programs which, collectively, graduate 55 family physicians and train other interdisciplinary professionals annually.

On behalf of the Department of Family Medicine and Community Health at the University of Minnesota Medical School, I want to thank you for your unwavering support for us during the past few months. You have been instrumental in our success.

WHY IT MATTERS

Approximately 70% of our graduating residents remain in Minnesota, providing a significant contribution to the primary care workforce for the state. The state funds allow the department to continue its related academic programs and applied research activities. In addition, the funding is imperative in light of the loss of funding from UCare on which the department relied when other sources of revenue decreased during the last decade.

HIGHLIGHTS FROM THE ADVOCACY CAMPAIGN

- Family physicians turned out in white coats to fill the hearing room when Dean Brooks Jackson and I spoke to the House and Senate committees
- Advocates of family medicine like MAFP resident Lauren Williams, MD, wrote op-eds explaining how critical family medicine was to their communities

- More than 200 supporters called and e-mailed their legislators
- Our friends at the MAFP, Minnesota Medical Association, and the Rural Physicians Associate Program sent a "call to action" to their members on our behalf
- More than 223 tweets used the hashtag #MN4FamMed to express support

> *"A lot of people worked together to gain this funding, MAFP and its members were critical. Family physicians from across Minnesota mobilized, acted and made a difference."*
> *– Renee Crichlow, MD, FAAFP*

THOSE WHO MADE A DIFFERENCE

A special thank you goes to all who made a difference, including:

- Mark Dayton, Governor, State of Minnesota
- Eric Kaler, PhD, President, University of Minnesota
- Brooks Jackson, MD, MBA, University of Minnesota Vice President, Academic Health Center; Dean, Medical School
- Regents, University of Minnesota
- State of Minnesota Legislators
- Leadership, MAFP
  - **Renee Crichlow, MD, FAAFP**
  - **Lauren Williams, MD**
- Leadership, Minnesota Medical Association
  - **David Agerter, MD**
  - **David Thorson, MD**
- Kenneth D. Holmen, MD, President and Chief Executive Officer, CentraCare Health
- Faculty, residents, alumni, University of Minnesota Department of Family Medicine and Community Health
- And others too numerous to mention

Your advocacy efforts have made it possible for our department to continue training the next generation of providers to deliver on the promise of family medicine. I am truly grateful to each of you for your dedication, passion, and continued support.

Dr. Baird is Professor and Head of the Department of Family Medicine and Community Health at the University of Minnesota.

by Julie Mayers Benson, MD, FAAFP

PALLIATIVE CARE IN PRIMARY CARE

Palliative Care for Family Physicians — A Four-Part Series

The purpose of this series is to offer the family physician, the provider in the inner circle of patient-centered care, the necessary tools to integrate primary palliative care into their practice.

Family medicine, for many, is the only way to practice medicine.

Caring for others regardless of age, sex or disease brings intrigue and challenge, as well as a deep sense of fulfillment. And over the years as medicine has changed, so has the art and practice of medicine. People are living longer and better with more and multiple chronic diseases. And with that, the complexity of caring for these patients has increased significantly.

Only about 15% of our patients will die suddenly, while nearly 85% will decline slowly over many months or years, living with significant symptom burden for a much longer time than their parents did. This prolonged trajectory can be fraught with repeated health crises and exert a significant emotional toll on patients and families.

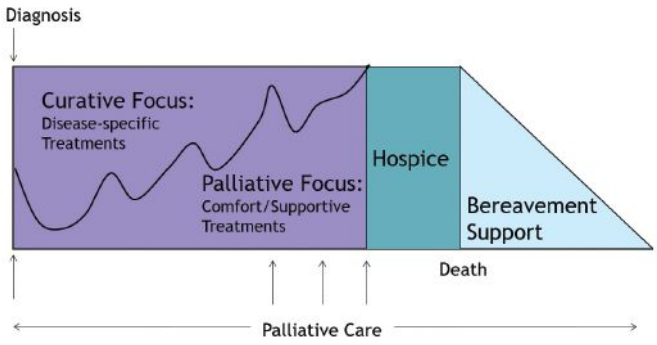
Family physicians are uniquely qualified and positioned to walk this journey with patients. This type of comprehensive patient-centered care is palliative care. However, one of the greatest obstacles for practitioners is knowing what it is, when to offer it and when to refer.

WHAT PALLIATIVE CARE IS (AND ISN'T)

Because palliative care is a relatively new specialty, gaining approval just 11 years ago by the American Board of Medical Specialties, many practicing physicians were not indoctrinated in its core principles.

Palliative care is "specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve the quality of life for both the patient and the family. It is provided by a team of palliative care doctors, nurses, social workers and others who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment."[3]

WHAT PALLIATIVE CARE LOOKS LIKE



Palliative care can start at the time of diagnosis of a serious potentially life-threatening illness. And as the trajectory of the illness progresses, the amount of services and support increases proportionately. It can be the predecessor to hospice.
Hospice is both a philosophy of care as well as a specific Medicare insurance benefit. The philosophy of care is about tending to patients and their families at the end of life irrespective of age, sex, race or disease process.

The founder of modern hospice, Dame Cecily Saunders said, "You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die."

The Medicare benefit was permanently enacted by Congress in 1986. It specifically allows for access of high-quality end of life care for all beneficiaries. There are several requirements:

1. Patients must have a terminal illness with a likely prognosis of less than six months as determined by two physicians; and
2. Patients must elect palliative rather than curative therapies.

Primary palliative care is the basic competencies necessary for primary providers to care for the chronically or terminally ill that include having advanced care planning conversations with shared decision making, basic symptom management and knowledge of when to refer for more complex case management.

CORE PRINCIPLES & WHEN TO OFFER AND REFER

A 2013 survey of more than 10,000 family physicians taking boards found that nearly two-thirds do not provide any end of life services.[1] One concern is that family physicians may feel ill-prepared to care for patients with serious and life-threatening illnesses at the end of life.

This is not necessarily surprising. According to the Accreditation Council for Graduate Medical Education (ACGME), the only mention of related curricula is "residents must demonstrate competence to independently: …provide end of life care".[2] But there is no stipulation for number of hours, content or core competencies. In contrast, the ACGME requires a minimum of 200 hours "dedicated to participating in deliveries and providing prenatal and postnatal care." That is in addition to the "at least 100 hours dedicated to the care of women with gynecologic issues, including well-woman care, family planning, contraception, and options counseling for unintended pregnancy."
We can correct this imbalance by understanding a few core principles…

- Palliative care requires taking care of the whole patient—medically, socially, emotionally, culturally, spiritually and ethically. This interdisciplinary approach requires a team of professionals to provide care. But members of this team can be accessed on an as-needed basis and do not need to be under one roof at all times.
- Palliative care requires comprehensive symptom assessment and management, not just disease treatment. This includes but is not limited to pain, depression, anxiety, shortness of breath, fatigue, nausea and constipation. Many symptoms may be the result of treatments and need careful discussion on risk versus benefit of these treatments.
- Palliative care requires patient-centered advance care planning and goals of care documentation for all care team members to be able to access to guide future therapies. Medical students and residents need to be taught when and how to have these types of conversations, the same way they are taught procedures.

Much too often patients ask, "Why didn't my oncologist tell me this chemo wasn't likely to work or why didn't my cardiologist tell me that I will die from my congestive heart failure?"

As primary providers it is our responsibility to start having these conversations earlier. But knowing when to have them is hard. Providers often feel as if they are "taking away hope." Most experts feel that one of the best ways to know when to start having these difficult conversations is known as the Surprise Question: "Would you be surprised if your patient

died in the next year?" Even if the clinician is wrong and the patient doesn't die in the year, there is rarely any harm to preparing a patient and family for what is likely to come.

When a practitioner is unable to determine IF the patient needs this conversation, then the patient should be referred to specialty level palliative care. Complex pain and symptom management are other common reasons to refer for specialty level care.

A WORKFORCE NEED

The aging population in the U.S. is expected to number 79 million Medicare beneficiaries by 2030. There are simply not enough specialty palliative care providers to accommodate this impending bubble; therefore it is imperative that the medical community unites to meet this workforce need.

This is where family medicine is uniquely positioned, already embedded in the lives of patients and community, to walk alongside for the duration of their lives. Family medicine supports many core principles promoted by palliative care:

- Both focus on and treat the whole person, not just the disease or health condition.
- Both recognize that physical, psychological, social and spiritual issues and concerns, and primary relationships (family and community) impact health and well-being.
- Both educate, support and advocate for patients, families and caregivers across all health care settings.[4]

Primary Palliative Care is the perfect example of interdisciplinary comprehensive patient-centered care that will transform the future of medicine. By recognizing and identifying the need for palliative care, creating curiosity and instilling confidence in practitioners to guide patients effectively, the goal of improving quality and providing compassion is achieved. This is why we became family practitioners in the first place.

Dr. Benson is a family physician at Lakewood Health System in Staples, MN, where she practices full scope family medicine. She is the MAFP's 2017 Family Physician of the Year. She is board certified in Hospice and Palliative Medicine and currently serves as President of the Minnesota Network of Hospice & Palliative Care.

Subsequent articles will outline the procedure to have difficult conversations, proceed with shared decision making and offer a review of common symptom management.

SOURCES

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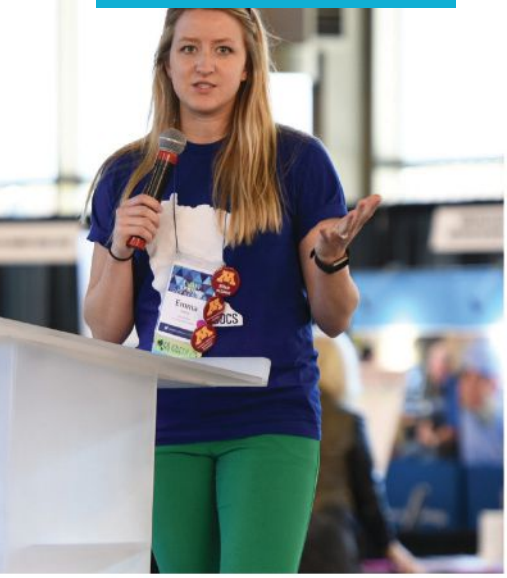
2. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120_family_medicine_2016.pdf
3. CAPC
4. E. McCormick, E. Chai, and D. Meier, "Integrating Palliative Care into Primary Care," Mount Sinai Journal of Medicine 79 (2012): 579-85, doi:10.1002/msj.21338.
5. http://www.jpsmjournal.com/article/S0885-3924(15)00816-7/abstract

ONLINE RESOURCES FOR PALLIATIVE CARE:

- www.getpalliativecare.org
- www.capc.org
- www.MNHPC.org
- www.honoringchoices.org
- www.theconversationproject.org




SPRING
REFRESHER


@MNFamilyDocs

COMING UP NEXT

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

The Congress is live streamed, so watch MAFP social media for the link to see policy-making and our own Dr. Lynne Lillie in action this year!

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

Family Medicine Resident Experience (for Medical Students)
September 23, 2017
9:00 AM – 12:00 PM
Pinstripes, Edina, MN

Dairy Farm Tour for Family Docs
September 30, 2017
9:00 – 11:00 AM
Wolf Creek Dairy
Dundas, MN (near Northfield)

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

Virtual KSA – Cerebrovascular Disease
October 29, 2017, 5:00 PM
Your home or office

This is a virtual, ABFM-approved, Knowledge Self-Assessment (KSA) session (formerly SAM) focused on cerebrovascular disease.

SUP: TRY PADDLEBOARDING FOR WELLBEING

More than the casual-greeting-with-head-nod, "SUP" is short-hand for Stand Up Paddleboarding, the latest paddling craze to hit the land of 10,000 lakes and perhaps the newest way to fill up your cup!

Warning: you may never be the same.

Paddleboarding offers a full-body workout for you and your patients, and since you stand at your full height, you can enjoy unique views of everything from Lake Superior agates to sunsets on Lake Shetek.

PADDLEBOARDING PRIMER

To get started, you just need some basic SUP gear and techniques:

- the board itself
- a long paddle
- a life jacket (required)
- a leash (highly recommended)

Beginners should start on a smaller lake, or a quiet bay on a larger lake. As your skills improve you can try larger lakes and slow-moving rivers.

MINNESOTA'S WATER TRAILS

Minnesota has 35 designated state water trails for your paddling pleasure. Each has designated accesses, rest areas and campsites. When currents are slow, flat water portions of the Mississippi, Minnesota and St. Croix Rivers are suitable for intermediate paddlers or beginners with a guide.

These Minnesota State Parks rent stand-up paddleboards ($10/hour):

- Bear Head Lake State Park
- Big Bog State Recreation Area
- Camden State Park
- Glacial Lakes State Park
- Glendalough State Park
- Itasca State Park
- Lake Shetek State Park
- McCarthy Beach State Park
- Myre Big Island State Park
- Sakatah Lake State Park
- Scenic State Park
- Split Rock Creek State Park
- William O'Brien State Park MP

Member Who SUPs: Suzy Human, MD – Bemidji

Paddleboarding for me is a break from talking and work and family and everything. I prefer to go alone, it's time for me only, watching turtles swim underneath me, or fish, or seeing otters on the shore if I'm lucky. I sometimes go in the evening, especially after a rough day so I won't bring home my frustrations. I also love the mornings as the wildlife is more active and it starts my day so well. I can smile or frown or cry or laugh, depending on the day, and no one knows but me. Paddleboarding is my secret, quiet space and allows me to keep being an effective doctor, mom, wife, friend, daughter, sister, person.

I enjoy the flexibility in my schedule to see my New York grandchildren and look forward to the arrival of #3 this October. I indulged my sense of curiosity to travel, rekindle friendships, complete ESL teacher training, take cooking classes, learn mah jongg, and use a Fitbit to track more exercise. I enjoy precepting at Broadway Family Medicine, facilitating a first-year medical school class and a family medicine interest group book club.

Kathy Brooks, MD – Edina
Member since 1983

Retirement is a great opportunity to reassess and refocus – maybe several times. We moved to be closer to grandchildren and really enjoy picking them up from school and daycare a couple of times a week and listening to the excited chatter about friends, math, soccer and climbing on the playground. Between times I continue rewarding and stimulating work with others around the country on their research projects in asthma, COPD and shingles. My husband and I travel to places like Japan and Croatia where you need to stay longer than the one week we felt we could while in practice.

Barbara Yawn, MD, MSC, FAAFP – Blaine
Member since 1978

Since retiring in 2014, I have been precepting one day a week at St. Joseph's residency clinic. Retirement has given us a chance to spend January and February in Hawaii, and we've taken driving and Road Scholar vacations a couple of times per year. I still play golf or go to the gym most days, read more, sit on more church committees and just hang out with my wife. Also, I'm no longer sleep-deprived.

David Hunter, MD – Woodbury
Member since 1977

HOW ARE YOU KEEPING BUSY IN RETIREMENT?

We asked a few life members to share...

HAVE YOU BEEN A MEMBER FOR 25+ YEARS?

Consider becoming a life member with a one-time dues fee.

Members who have held Active membership for a minimum of 25 years and who are either totally retired or age 70 or older are eligible. Contact the MAFP office for assistance!

I keep busy working one or two half-days per week as an Associate Medical Director for a health insurance company. I now attend many grandchildren's activities, exercise at a health club and sing in our church choir. I also go on a week-long disaster relief trip several times a year, rebuilding homes and lives for those affected by tornadoes, floods and hurricanes. (I also help with chores around the house including laundry, but failed cooking!!)

Gerald Jensen, MD – Blaine
Member since 1976; Past President of the MAFP Foundation

Retirement has meant more time with organizations I care about, including our church, the North Star Museum of Boy Scouting and Girl Scouting and Rotary. Also more freedom to travel as we have enjoyed Road Scholar trips to Europe and South America, winter trips to Mexico, hiking trips to Sedona and the North Shore, cabin camping with family in state parks and trips to Disney World and Branson. Most importantly, retirement has given me more time with my wife, our three kids, and seven grandchildren, especially valuable as we help our daughter and family cope with a serious illness over the past year.

George Smith, MD, FAAFP – St. Paul
Member since 1976

I retired from practice in 2008 and became a part-time residency teacher. At first I missed my patients, but as time passed, I observed remarkable learning and I got to witness the positive effect of my teaching first-hand. My new work has become an adventure that has gone along well, with more time for our grandchildren, travel and gardening.

Donald Pine, FAAFP – Minneapolis
Member since 1974

Your Minnesota delegation at the AAFP Family Medicine Advocacy Summit, May 22-23 in Washington, DC.

IN THE NEWS

The University of Minnesota Medical School named **Kirby Clark, MD**, the new Director of Rural Physician Associate Program (RPAP) and Metropolitan Physician Associate Program (MetroPAP) — two flagship and internationally-recognized longitudinal integrated clerkship programs. Clark will be responsible for the leadership, strategic direction, organization and operations of all aspects of RPAP and MetroPAP and replaces **Kathy Brooks, MD**, who retired in November 2016.

Minnesota Business magazine named **MAFP EVP Maria Huntley, CAE, MAM** one of the winners of its 2017 (Real) Power 50 Awards. The award recognizes remarkable players in the Minnesota business community. Winners were honored at an awards gala on April 27.

Anna Larson, DO, PGY-3 at U of M Medical Center, was selected as an AAFP Emerging Leader. She will be presenting her project titled *"Developing a Toolbox: To Improve Resident Education with Transgender and Gender Nonconforming (TGNC) Patients"* at the Family Medicine Leads Emerging Leaders Institute Project Awards Showcase and Networking Reception during the AAFP National Conference July 27-29 in Kansas City, MO. Congratulations Anna!

Lauren Williams, MD, PGY-3 at U of M North Memorial, will run for Resident Member of the AAFP Board of Directors at the AAFP National Conference July 27-29 in Kansas City. Currently Williams serves on the AAFP's Commission on Quality and Practice.

LEADERSHIP NOTES

The MAFP elected new officers during their annual meeting on April 19, 2017. 2017-2018 MAFP Officers include:

- President-Elect **Glenn Nemec, MD**
- Speaker **Renee Crichlow, MD, FAAFP**
- Vice Speaker **Andrew Slattengren, DO**
- Board Chair **Sam Hanson Willis, MD**
- Officer-at-Large **Roli Dwivedi, MD**
- Treasurer **Kurt Angstman, MD, FAAFP**
- AAFP Senior Delegate **David Hutchinson, MD**
- AAFP Junior Delegate **Julie Anderson, MD, FAAFP**
- AAFP Senior Alternate Delegate **Daron Gersch, MD, FAAFP**
- AAFP Junior Alternate Delegate **Dania Kamp, MD, FAAFP**

Elected at last year's House of Delegates, **David Bucher, MD, FAAFP** was installed as 2017-2018 MAFP President on April 20, 2017.

The following members will serve as local Chapter Directors, liaisons to the MAFP Board of Directors: Central Chapter: **Christine Albrecht, MD, FAAFP** – Staples; East Metro Chapter: **Alex Vosooney, MD** – St. Paul; Heart of the Lakes Chapter: **Julie Pazdernik, MD** – Detroit Lakes; Lake Superior Chapter: **Deb Allert, MD** – Two Harbors; Park Region Chapter: **Deb Dittberner, MD** – Alexandria; Southeast Chapter: **Scott Pauley, MD** – Rochester; Southern Chapter: **Kim Wernsing, MD** – St. Peter; and West Metro Chapter: **Sam Hanson Willis, MD** – Minneapolis.
Dave Goodman, MD, Minneapolis, was named special constituency director to the MAFP Board of Directors.

Resident & Student Leaders include:

- Resident Director **Peter Meyers, MD**
- Resident Alternate Director **Alexandra Gits, MD**
- Student Director **Paul Stadem**, Mayo Clinic School of Medicine
- Student Alternate Director **Sam Stokes Cerkvenik**, University of Minnesota Duluth
- Student Alternate Director **Kate Chamberlain**, University of Minnesota Twin Cities

The MAFP Board of Directors provides strategic direction for the MAFP and implement policy.

7 members attended the AAFP National Conference of Constituency Leaders (NCCL) and Annual Chapter Leadership Forum (ACLF) April 27-29 in Kansas City: **David Bucher, MD, FAAFP; Bushra Dar, MD; Betsy Gilbertson, MD; Dave Goodman, MD; Karen Jankowski, MD; Lynne Lillie, MD, FAAFP**; and **Glenn Nemec, MD**. NCCL is AAFP's forum to address member issues specific to women, minorities, new physicians, international medical graduates (IMG) and GLBT physicians or physician allies. The conference is an opportunity for members of these underrepresented constituencies to voice their individual and group perspectives. ACLF serves as an orientation for emerging leaders who serve, or who are interested in serving, on chapter boards.

12 members spoke at the Society of Teachers in Family Medicine Annual Spring Conference May 5-9 in San Diego: **Ese Aghenta, MD; Randolph Borrero, MD; Allyson Brotherson, MD, FAAFP; Renee Crichlow, MD, FAAFP; Roli Dwivedi, MD; Alexandra Gits, MD; Minelva Nanton, MD; Tanner Nissly, DO; Shailendra Prasad, MD; Chris Reif, MD, MPH; Veronica Svetaz, MD** and **Michael Wootten, MD**.

8 members attended the AAFP Family Medicine Advocacy Summit May 22-23 in Washington, DC: **Julie Anderson, MD, FAAFP; David Bucher, MD, FAAFP; Renee Crichlow, MD, FAAFP; Katie Freeman, MD; Alexandra Gits, MD; Christine Hult, MD, FAAFP; Lynne Lillie, MD, FAAFP**; and **Michael Stiffman, MD**. During the two-day conference they were educated on family medicine's key legislative issues, received training on how to lobby on Capitol Hill and visited Congressional leaders.


2017 Fellows

DEGREE OF FELLOW

Three members received the FAAFP Degree of Fellow on April 20: **Julie Mayers Benson, MD**, FAAFP of Staples, **Christine Albrecht, MD, FAAFP** also of Staples, and **David Johnson, MD, FAAFP** of Eden Prairie. Established in 1971, the Degree of Fellow is a special honor bestowed upon AAFP members who have distinguished themselves by their service to family medicine and their commitment to professional development through medical education and research.

HPV VACCINATION CHAMPIONS

Six members have volunteered to serve as HPV vaccination champions in Minnesota: **Kathy Brooks, MD** of Edina; **Christine Hult, MD, FAAFP** of St. Paul; **Jennifer Mader, MD** of Cokato; **Kathy McLaughlin, MD** of Rochester; **Shelley Overhold-Thiesen, MD, FAAFP** of Brainerd and **Barbara Yawn, MD, MSC, FAAFP** of Blaine. Champions are trained by the Minnesota Department of Health's HPV experts and asked to deliver 5 to 10 webinars to members in 2018.

STUDENT EXTERNSHIP RECIPIENTS

The Foundation accepted the following medical students to the David Mersy Student Externship in Family Medicine Program. Each student will receive a $2,000 stipend as part of this family medicine experience program. Congratulations!

Dureeti Foge, MS2 Project: *Identifying barriers to papanicolaou (pap) test screening among East African women*
Family Physician Mentor:
Roli Dwivedi, MD

Katherine Crist, MS1 Project: *Differences in mood and smoking-related symptomatology between pregnant and non-pregnant smokers*
Family Physician Mentor:
Sharon Allen, MD

Michael Tradewell, MS3 Project: *Expanding naloxone distribution to American Indian communities in Hennepin County*
Family Physician Mentor:
Roli Dwivedi, MD

NEW TO THE LAND OF 3,100 FAMILY DOCS

Edward Ciriacy, MD, FAAFP, Ely, has transferred from Nevada.

Jonathan Harvey, MD, St. Paul, has transferred from Florida.

Sriveer Kaasam, MD, Park Rapids, and **Ward McCracken, DO**, Minneapolis, have transferred from Illinois.

Kyle Kircher, MD, Stillwater, has transferred from Wisconsin.

NEW RESIDENT MEMBERS

Luke Albares, MD, Duluth
Julie Amaon, MD, Minneapolis
Katherine Baillon, DO, Minnetonka
Darby BeDell, MD, Minneapolis
Cameron Blegen, MD, BA, St. Paul
Mark Bostrom, MD, Mora
Abbie Bruning, DO, St. Paul
Sarah Carlson, MD, Minneapolis
Nailah Cash-O'Bannon, MD, Minneapolis
Temur Chowdhury, MD, Farmingville
Alysse Cruz, MD, Minneapolis
Christopher Culhane, MD, St. Paul
Elizabeth Curry, DO, Rochester
Anne Doering, MD, Minneapolis
Mara Edison, DO, Rochester
James Erickson, DO, Warroad
Jeremiah Fairbanks, DO, Hastings
Camdin Gray, MD, Minneapolis
Jade Grimm, MD, Rochester
Lee Haggenjos, MD, Minneapolis
Matthew Haugen, MD, Minneapolis
Marlen Henning, MD, Lake Park
Carrie Inejick, MD, St. Paul
James Ircink, MD, Madison, WI
Charles Kelly, MD, Minneapolis
Lee Kenyon, DO, Rochester
Thomas Krumme, MD, Roseville
Mindi Kvaal Anderson, MD, Moose Lake
Tyler Lacey, MD, St. Paul
Luke LeBlanc, MD, Lakeville
Alison Liewen, MD, Duluth
Joe MacDonald, MD, St. Paul
Nathan Manthey, DO, Rochester
Benjamin Meyerink, MD, Rochester
Justin Meyers, MD, St. Paul
Laura Murphy, MD, Minneapolis
Nadjeschda Nordquist, DO, St. Paul
Daniel O'Connor, Cold Spring
Ebiere Okah, MD, Minneapolis
Benjamin Paul, DO, Eagle Lake
Justin Penny, MD, Minneapolis
Ngoc Pham, MD, St. Paul
Brianna Pilling, DO, Rochester
Laura Robitschek, DO, Minneapolis
Ben Rosenstein, MD, Minneapolis
Elizabeth (Betsy) Rowe, DO, MA, Minneapolis
Jordan Schild, MD, St. Peter
Betlehem Semahge, MD, St. Paul
Adei Shaqra, DO, Sartell
Siri Shaqra, DO, Sartell
Radhika Snyder, MD, Minneapolis
Haley Stewart, DO, Blaine
Katherine Swanson, DO, Minneapolis
Chip Tabor, MD, Duluth
Jessica Taylor, MD, St. Paul
Stephanie Vilendrer, MD, Minneapolis
Christina Werman, DO, St. Paul
Jenny Zhang, MD, Minneapolis
Katie Zurek, MD, Howell, MI

NEW STUDENT MEMBERS

MAYO CLINIC SCHOOL OF MEDICINE
Rohin Aggarwal, Rochester
Claire Cambron, Rochester
Priyal Fadadu, Rochester
Catherine Gao, Rochester
Hannah Gilder, Medford, OR
David Ivanov, Rochester
Alexis Johnson, Rochester
Grace Kim, Rochester
Joshua Labott, Rochester
James Lee, Rochester
Anna Najor, Rochester
Benjamin Mundell, Rochester
Payal Patel, Rochester
Elias Saba, Rochester
Maximilian Staebler, Rochester
C. Thew, BS, Rochester

U OF M MEDICAL SCHOOL – DULUTH CAMPUS
Maddie Grosland, Duluth
Emily Sirek, New Richmond

U OF M MEDICAL SCHOOL – TWIN CITIES CAMPUS
Femi Akinnagbe, MS, Minneapolis
Ashleigh Burt, Chicago, IL
Cynthia Chweya, Minneapolis
Katherine Crist, Minneapolis
Sarah Cook, Cold Spring
Collin Cousins, Edina
Elizabeth Fronek, Minneapolis
Burton Hendrickson, St. Paul
Rebecca Kortum, Wayzata
Jennifer Lee, Minneapolis
Rose Marie Leslie, Minneapolis
Mike Rose, St. Paul
Jia-Shyuan Su, MS, BA, Minneapolis
Thomas Schmidt, MHS, St. Paul
Taylor Thomas, Custer, WI
Michael Tradewell, Minneapolis
Ahren Wippermann, Minneapolis
Zareen Zaka, MBBS, Minneapolis

IN MEMORIAM

Gregory Gepner, MD, of St. Paul, passed away March 12, 2017 at the age of 69. He attended the Stanford University School of Medicine and did his family medicine residency at the U of M. After residency, he and his wife moved to Redmond, OR, an area without much access to medical care, where he and another physician started a clinic. After seven years in Redmond, the Gepners returned to Minnesota with their family and Gepner started a practice at the Nokomis Clinic in Minneapolis. He became known for a program that helped patients quit smoking through goal setting and daily support from clinic staff. He went on to join the faculty at the University of Minnesota Physicians Smiley's Family Medicine Clinic, where he taught medical students and residents. Gepner is survived by his wife Rebecca; son Josh of Portland, OR; daughter Rachel of San Francisco, and granddaughter Clara.

Jack T. Kelly, MD, formerly of Robbinsdale and Delano, passed away May 10, 2017 at the age of 90. He graduated from the University of Minnesota and later entered the U of M Medical School, graduating in 1956. He was a family physician and co-founder at Northeast Medical Clinic in Minneapolis and chief of staff at St. Mary's Hospital. In 1968 he returned to the U of M for a residency in Psychiatry and joined the Department of Family Medicine, and eventually became the associate head of the department until his retirement in 1996. He is survived by his wife, daughter, two grandchildren and two great-grandchildren.

"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.

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East Hanover, New Jersey 07936

T2015-100

Issued: July/2015

First-year resident scholarship recipients and the family of Arden Anderson, MD

MAFP FOUNDATION PRESENTS TEN $1,000 SCHOLARSHIPS

Ten first-year residents received a $1,000 scholarship at the MAFP's Kickoff & Social for Incoming Residents on June 11, 2017, at the Science Museum of Minnesota in St. Paul. The event was an opportunity for new residents to learn more about the Academy and Minnesota's Family Medicine community.

SCHOLARSHIP RECIPIENTS

- **Nneka Agujiobi, MBBS** – HCMC
- **Lee Kenyon, DO** – Mayo
- **Rebecca McDougle MD** – HCMC
- **Ben Meyerink, MD** – Mayo
- **Nadia Nordquist, DO** – UM St. Joe's
- **Radhika Snyder, MD** – HCMC
- **Elizabeth "Betsy" Rowe, DO** – UM Medical Center
- **Becki Siffring, MD** – UM Methodist
- **Stephanie Vilendrer, MD** – UM St. Joe's
- **Carrie Wojick, MD** – Allina

EVENT PARTNERS

- Cuyuna Regional Medical Center
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- HealthEast
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The scholarships are possible thanks to the late Arden Anderson, MD (1926-2004) a family physician from Brainerd, MN, who served as MAFP President from 1972-1973 as well as Board Chair of the AAFP. Dr. Anderson left a generous legacy gift to the MAFP Foundation to be used to support scholarships for future family physicians, specifically those intending to practice in Minnesota.

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