WINTER 2018 • VOL.2 • NO.1

MFP

MINNESOTA FAMILY PHYSICIAN

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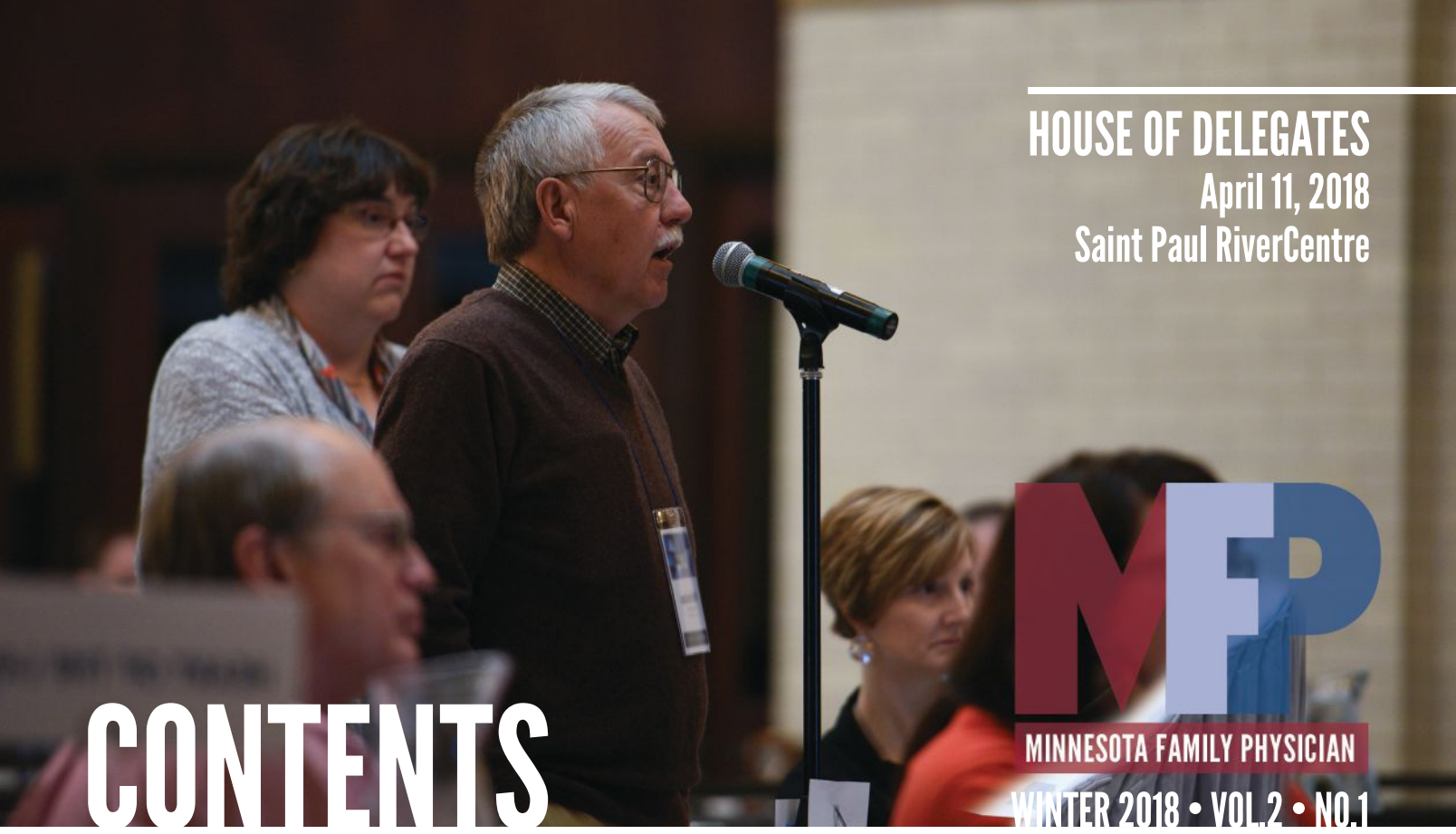

HOUSE OF DELEGATES
April 11, 2018
Saint Paul RiverCentre

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WINTER 2018 • VOL.2 • NO.1

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

By David Bucher, MD, FAAFP,
MAFP President

ENCOURAGEMENT... DO YOU NEED SOME? CAN YOU GIVE SOME?

Last spring I spoke about a goal to support and be encouraging to one another as family medicine colleagues. Our cover story this month features the Rural Physician Associate Program (RPAP). This unique endeavor has allowed many medical students to experience first-hand what it is to care for patients in primary care settings. The variety of preceptors, communities and medical settings has given direction in career choice for our students, many of whom are now our partners in practice. It is the encouragement they receive AND GIVE to their preceptors that underlie the strength of RPAP.

Also in this edition you can read about how four of our members are representing our concerns on state and national committees. For instance, Dr. Bradley Johnson is participating on the Minnesota state workgroup on opioid care. We can all understand how important this can be to the challenges we face in caring for and providing pain management for our patients. Dr. Daron Gersch represented AAFP at a fall conference of the CDC's PROTECT Initiative on reducing accidental medication overdose in children.

In this issue, you'll find information about the Academy's efforts to support Tobacco 21 legislation throughout the state. There have been several successes to celebrate, and there is opportunity to do even more in our communities to improve health.

At the times we can only offer comfort to our patients, we turn to our palliative care partners. Dr. Cory Ingram provides prognostication tools and frameworks — and much insight — for this third article in a four-part series.

Resilience in the face of increased demands of practice relies on encouragement we give and receive form one another. My practice partners Dr. Tim Rumsey and Dr. Jerry Montie explain how music, and their participation in the band "Rhythm Pups" enriches them, and helps them balance work with life outside.

Your leadership group at the MAFP recently approved an update to our strategic plan and part of this involves how you are represented within the organization. I encourage you to add your ideas, perspectives and voice to the process being led by our chief executive officer, Maria Huntley. Any of your chapter directors or board members would like to hear from you.

As we head into the Minnesota winter, consider how you can reach out to the young learners and to your co-workers to lift them up, and provide encouragement.

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.

The *Minnesota Family Physician* (MFP) is the official publication of the MAFP. Contact MAPF at 952-224-3873 or Renee McGivern, renee@mafp.org.

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Edition 5

By Emie Buege, a Twin Cities freelance writer

NEW DIRECTOR KIRBY CLARK, MD TALKS ABOUT WHAT'S NEW WITH RPAP/METROPAP PROGRAMS

Kirby Clark, MD, became director of RPAP and MetroPAP in August 2017 and is now responsible for the leadership, direction, and operational oversight of both programs. He is a family physician and assistant professor at the University of Minnesota.

The Rural Physician Associate Program (RPAP) at the University of Minnesota Medical School was founded in 1971 in response to a shortage of physicians practicing in rural areas. The program encourages students to go on to rural practice by involving them in all aspects of rural community life, while building a strong foundation in clinical and communication skills. The program was expanded to include urban medical care in 2010.

Previously, Clark was the associate program director and director of medical student education at the University of Minnesota St. John's Hospital Family Medicine Residency. He has experience in longitudinal curriculum design, implementation, and assessment.

Clark shared thoughts about his new role and vision for both programs, the changes in RPAP and MetroPAP curriculum, the need for community preceptors, and more.

What drew you to the director position for RPAP and MetroPAP?

Training and learning from resident physicians and medical students has brought so much life and fulfillment to my career.

I spent the last 12 years teaching in a family medicine residency program in East St. Paul. I was practicing in an urban, underserved community with a rural heart. Many of my Hmong patients were displaced rural farmers, and about a third of the program's residency graduates went on to practice in rural areas.

Over the years, I have become more intrigued with the science of medical learning and the design of learning experiences.

Kirby Clark, MD is leading the RPAP and MetroPAP programs that together, have graduated 1,589 alumni since their inception. RPAP is considered a pioneer in longitudinal integrated medical curriculum and has been replicated by medical schools across the U.S. and beyond.

Leading RPAP and MetroPAP seemed like a great opportunity to contribute to the efforts to align our medical training through the continuum—from undergraduate through residency and continuing medical education.

What's new with RPAP and MetroPAP? Any curricular changes?

Each year, the RPAP and MetroPAP curriculum advances to match evolving patient needs and the changing landscape of healthcare delivery. Changes in scope of practice, healthcare facilities, and administrative tasks are ubiquitous—and a reality our students need to experience.

As we match our curriculum to these changes, we are increasing our focus on team communication, leadership, and navigation of electronic healthcare tools (like the electronic health record). We are moving toward an education model with more active versus passive learning, i.e., more engagement, less lecturing.

We are also working to develop assessment tools that are more effective in providing formative feedback to students and more

efficient for preceptors. We are moving away from the idea of only occasionally "grading" students by comparing them to their peers, and focusing more on tools to coach all students to excellence in defined competencies.

All that said, what has brought so much success to our programs is our commitment to authentic relationships with our patients and the communities we serve. Keeping experiences that center students on their patients and community will always be at the forefront of our curriculum, and that needs no remodeling.

What is your vision for RPAP and MetroPAP?
I hope to continue to align these programs with Minnesota's workforce needs. Rural Minnesotans depend on programs like RPAP to train their physicians to have the necessary competencies for practice, and to pipeline them back to rural areas. The same is true for our urban underserved communities.

In the coming years, I expect we will be using more robust online-learning modules, rapid-cycle assessment tools, and technology allowing RPAP and MetroPAP students to meet in groups more often.

Our goal is to build the capacity to place every student who qualifies and desires to participate in RPAP or MetroPAP at a training site. We also want to cluster more training sites, so students going through RPAP and MetroPAP can have the added support of a peer learning community.

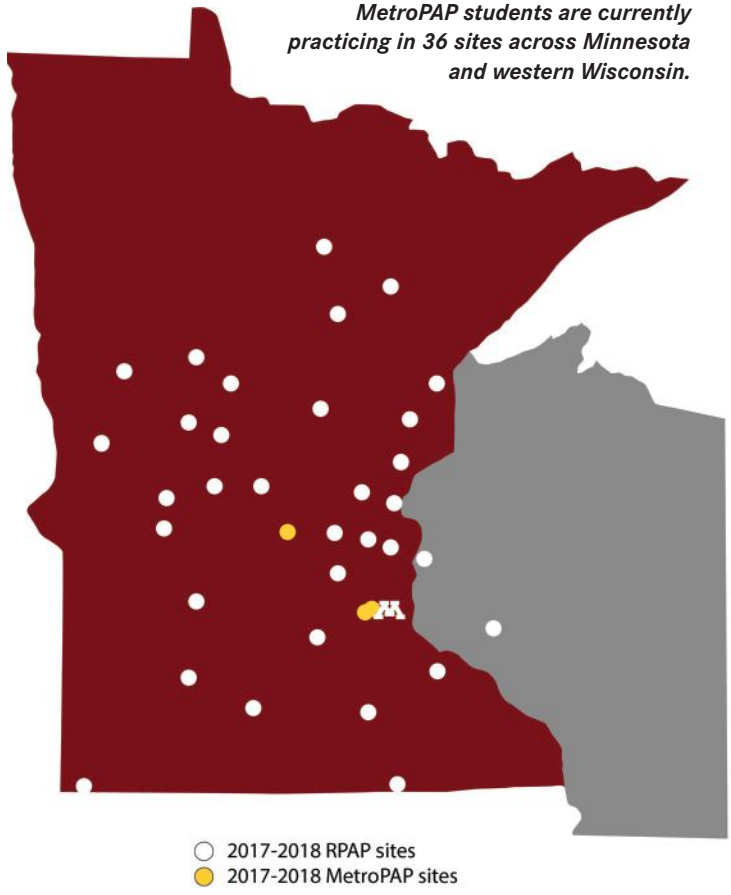
What do you think makes RPAP and MetroPAP stand out from other longitudinal clerkships?
There is increasing interest and data to support medical student learning in longitudinal integrated clerkships (LICs).

LICs are student-learning experiences that involve the comprehensive care of patients over time, and allow for continuous relationships with mentors within the context of a community. While RPAP was, for many years, the only LIC at the University of Minnesota Medical School, we now have a number of LIC options, each with a different focus.

RPAP is unique in its focus on rural medicine and rural community engagement and advocacy. MetroPAP is focused on urban underserved medicine, population health, and urban community engagement and advocacy. These programs have a history of providing robust training in comprehensive, resource-wise healthcare.

What makes both programs stand out, however, is the passion and commitment preceptors and communities have for supporting our students.

From Big Fork to the north; Fergus Falls to the west; Menomonie to the east, and Austin, to the south, 36 RPAP and 5 MetroPAP students are currently practicing in 36 sites across Minnesota and western Wisconsin.



Is there a need for community preceptors?
Yes, it takes a large community of providers to educate RPAP and MetroPAP students. We're always looking for community physicians—and training sites—to participate.

A primary focus of RPAP and MetroPAP is continuity with a community of patients, so primary care physicians serve as "primary preceptors." Preceptors from all areas of the state, with varied scopes of practice and medical interest, serve as primary preceptors to RPAP and MetroPAP students.

While we're looking for preceptors from across the state, we have a specific need in northwest and southwest Minnesota.

Community physicians interested in precepting can visit our website at rpap.umn.edu to learn more about the role of an RPAP or MetroPAP preceptor and download application materials.

Are there benefits to being a community preceptor?
Community physicians who precept for RPAP or MetroPAP receive a clinical faculty appointment at the University of

Minnesota, a University email account, and access to the University's Bio-Medical Library and other online educational resources.

Beyond that, preceptors find that having a student helps keep their medical knowledge current and brings a new level of joy and excitement to their practice. Patients are typically thrilled and impressed to see their doctor serving in this role.

As the students are asked to carry out a significant community health project, the community at large also benefits from the program. And, some practices find it's a great recruitment tool, giving students an opportunity to immerse themselves in a community they may want to return to for their future career.

Learn more about RPAP and MetroPAP, the roles of community preceptors and training sites, and the medical student application timeline and process at http://rpap.umn.edu.

MORE ABOUT RPAP AND METROPAP

Since their inception, these two programs have graduated 1,589 alumni in total: 1,569 from RPAP and 20 from MetroPAP. The 2017-2018 class has 36 students in RPAP and five in MetroPAP, practicing at 36 sites across Minnesota and western Wisconsin.

RPAP is now an internationally recognized, nine-month elective, immersing third-year medical students into full-spectrum rural medical care. Students see patients of all ages and all healthcare concerns in clinical, hospital, and community settings. They practice continuity of care and gain exposure to the disciplines of primary care, surgery, emergency medicine, psychiatry, pediatrics, obstetrics, gynecology, and community health.

Considered a pioneer in longitudinal integrated medical curriculum, RPAP has been replicated by medical schools across the U.S. and beyond.

RPAP Preceptor Americo D. Fraboni, MD – Fairview Northland Medical Center

Having been an RPAP student myself, I remember how unprepared and unsettled I felt as a student moving to a rural area to "live" for nine months and learn how to be a doctor. Many times over the past 17 years, I have thought of that "unsettled" feeling. Each time a new student starts in October, I try to make them feel as welcomed and as excited about learning as I possibly can. It's hard to believe that I have been a preceptor for that many years, but I think that I get from the students as much as they get from me. Honestly, I continue to learn on a daily basis when I work with them. I truly have to know what I am talking about, because these students have technology at their fingertips and can fact-check me at any time! They keep me on my toes, and we continue to grow and increase our knowledge together. It takes a lot of time and effort, but I love it!

RPAP Participant McKenzie DeKam, MS3 University of Minnesota

My participation in the RPAP program has been, without a doubt, one of the most influential and positive experiences of my medical training thus far. The program has greatly enriched my education by enabling me to work closely with preceptors and patients over a long period of time. This gift of time helps to establish trust and allows me to gain hands-on experience in patient care in a way that challenges me daily and has increased my skill and confidence as a medical student. The self-directed learning model allows me to tailor my schedule to best support my interests. Working in a rural hospital has helped me to gain a better understanding of the unique opportunities, responsibilities, and challenges that go along with being a rural physician.

RPAP Participant McKenzie DeKam, left, is an MS3 student at the University of Minnesota. Americo Fraboni, MD is her preceptor and a former RPAP participant. He is a family physician in Princeton, Minn.

By Maria Huntley, CAE, MAM
MAFP Executive Vice President

MAFP LEADERSHIP ENERGIZED BY UPDATED STRATEGIC PLAN

ENERGIZED FOR THE NEXT THREE YEARS

The Leadership of MAFP recently reviewed the 2015-2017 strategic plan, and updated and approved the specific goals we intend to achieve over the next three years. The plan will continue to help us prioritize our time, energy and resources.

We have accomplished much and are excited to continue the hard work through 2020.

The strategic plan defines four pillars, or areas, of focus: Governance, Membership, Advocacy and Identity. Each area has at least two goals as described below.

GOVERNANCE PILLAR – FOUR GOALS

The Governance Pillar will be focused on four guiding goals. First, we will explore the opportunity to improve the local chapter experience so it is relevant, efficient and purposeful. Improvements begin when we identify and focus on local issues to drive engagement and reach out intentionally to chapters to encourage meetings.

The next three goals represent continued work from the 2015 strategic plan. We will continue to evaluate and streamline the Academy's governance structure. We will simultaneously align the MAFP Foundation's governance structure and further enhance fundraising. Lastly, we will continue efforts to evolve our sustainable business model by diversifying new potential revenue sources and increasing revenue from existing sources.

MEMBERSHIP PILLAR – TWO GOALS

The Membership Pillar will be laser-focused on two goals: increasing member advocacy and engagement, and enhancing relationships between students, residents and practicing family physicians. We are excited to add a new staff position in 2018 that is dedicated to working with our members and collaborative partners on advocacy goals, so watch for new opportunities to engage with the Academy.

ADVOCACY PILLAR – THREE GOALS

These goals complement those identified in our original Advocacy Pillar. First, we will work with medical schools and residency programs to enhance advocacy training for students and residents. Second, as a complement to our traditional lobbying, we plan to explore opportunities to increase grassroots efforts around issues important to our members. Third, to address the workforce crisis that we face, we will be fierce advocates for increasing family medicine residency slots in Minnesota.

IDENTITY PILLAR – TWO GOALS

Some have suggested that this pillar might be difficult for nice, humble Minnesotans, but we will not be deterred! We will increase our outreach to high-quality students, encouraging them to choose family medicine as their specialty. We will also promote the central role of family physicians to two audiences: the public and our members.

FROM A PRESIDENTIAL SPARK...

Dr. Bucher's goal for his year as MAFP president was to get members ignited. I am here to tell you that we are starting to feel the heat! I, too, encourage and challenge our members to keep pushing the Academy to provide meaningful and relevant experiences.

I get to tell people that I have the best job in the world, and I mean it. I am privileged to go to work each day and support family physicians—physicians who just want to take care of their patients and the communities they live in. Thank you for that honor.

By Jami Burbidge, MAFP Advocacy Director

DULUTH DOCTOR SAYS PATIENTS RECEPTIVE TO MEATLESS MONDAY MESSAGE

Dr. Nayasha Spears introduced a resolution at the House of Delegates in 2017 encouraging MAFP to educate family physicians about the benefits of a plant-based diet and reducing meat consumption.

MAFP Member Nyasha Spears found a renewed interest in advocacy after the 2016 presidential election. Like many in the U.S., she was surprised by the results and felt compelled to take action for a cause she believed in.

Dr. Spears practices at the P.S. Rudie Medical Clinic in downtown Duluth.

Around that time, she received an email from the Lake Superior Chapter about a House of Delegates resolution on climate change. Dr. Spears thought about the role of family docs in climate change and where they could really have an impact. She found herself more and more interested in the environmental impact of our food production and consumption, and specifically, the vast amount of meat that Americans consume.

"Family docs are in a perfect position to educate our patients about both the health and environmental benefits of eating less meat," said Dr. Spears. "We are in the business of habit change and have influence over the decisions our patients make."

"And if we educate our patients about how decreasing their meat consumption provides health benefits and environmental benefits, that's a win/win," says Dr. Spears.

Her research on the best way to advocate for less meat in patients' diets led her to the Meatless Monday initiative. It was started by Sid Lerner, a former advertising executive, and the Center for a Livable Future at the Johns Hopkins Bloomberg School of Public Health.

The initiative focuses on Monday because in our culture, Monday

is viewed as the beginning of the week and a day to reset our attitudes and behavior.

Meatless Monday identifies three benefits of going meatless to discuss with patients:

- **Health:** Doctors can cite evidence that reducing meat consumption and increasing plant-based eating reduces heart disease, stroke, diabetes, obesity and cancer.
- **Wallet:** We can talk about how healthcare and out-of-pocket spending for chronic illnesses could be reduced, as could our grocery bills, because meat is more expensive than plant-based protein.
- **Environment:** For patients who are passionate about the environment, doctors can share that, according to the Meatless Monday website, animal agriculture has a particularly high climate impact. It accounts for approximately 14.5 percent of the global greenhouse gas emissions that stem from human activity. That figure is astounding, and larger than the amount attributed to the entire transportation sector.

Dr. Spears' patients are receptive to Meatless Monday. She writes them prescriptions to eat less meat and get 30 minutes of exercise daily. Her approach starts a conversation about Meatless Monday and how small behavior changes affect patients' health and the health of the planet.

"I believe family physicians in Minnesota can play a leading role in this important behavior change because they trust us and look to us to provide them resources to lead healthy lives," said Dr. Spears.

"We should be talking to the schools, hospitals and other institutions in our communities about taking part in this easy initiative to help make our world healthier."

Dr. Spears' passion led to the following resolution, which was adopted at the 2017 MAFP House of Delegates:

> BE IT RESOLVED that the MAFP will educate family physicians statewide about the health benefits of a plant-based diet (such as 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.

Are you interested in bringing Meatless Mondays into your practice? To begin the conversation, check out the resources at http://www.meatlessmonday.com.

By Renee McGivern, MAFP marketing and communications director

WHAT WE'RE LEARNING ABOUT ADVOCATING FOR TOBACCO 21

Family and other physicians in Minnesota are playing a valuable role in advocating for policy changes in their communities that would raise the minimum legal sale age for tobacco products to 21.

Their local advocacy in the Tobacco 21 campaign along with other residents and representatives from community-based organizations is gaining ground. Tobacco 21 is one focus of Minnesotans for a Smoke-Free Generation, a coalition of Minnesota organizations that share a common goal of saving Minnesota youth from a lifetime of addiction to tobacco. MAFP is a member of the coalition.

The cities of Bloomington, Edina, Plymouth and St. Louis Park passed Tobacco 21 policies in 2017. The St. Cloud City Council also approved it, but the mayor later vetoed it.

MAFP Member Jamie Peters, MD testified at the Bloomington hearing on the evening the city council voted to raise the tobacco age to 21. He said the city council chamber was filled with advocates and opponents, and that the council was well-informed before the meeting started.

"Coalition members and MAFP had done their homework and provided the council with excellent background," said Peters. "So really, my job in providing testimony was to help the council focus on the most salient aspects of why the Tobacco 21 proposal should be passed."

Tobacco 21 advocates give a thumbs-up for their victory after the Bloomington City Council approved raising tobacco sales to age 21. Dr. Jamie Peters is in the front row to the left. MAFP's Lynn Balfour is kneeling next to him.

He said one of the points that resonated most with the council was how raising the tobacco age would drive down use among 15- to 17-year olds; it decreases their ability to get tobacco at school through older friends. Limiting early exposure to nicotine helps prevent a lifetime of addiction.

"Being involved at the local government level which results in improving patients' lives is very consistent with our overall values as family physicians and very rewarding," said Peters.

"And being able to tell the council that I represented 3,000 MAFP members was powerful," said Peters.

He also said he enjoyed reading the material ahead of time and testifying, and that it didn't take a lot of time to participate.

Members of Minnesotans for a Smoke-Free Generation help bring people together in a community, like parents, coaches, health professionals and people impacted by tobacco. They provide background material and data to the decision makers and advocates.

"What works is a community-driven effort in which residents of the city are leading the effort, and speaking one-on-one with policymakers before and at council meetings," said Molly Moilanen, Director of Public Affairs at ClearWay Minnesota and co-chair of Minnesotans for a Smoke-Free Generation.

"What's so important about doctors' testimony is how they can say to a council, 'I can only help one person at a time, but you have the power to help an entire population,' " said Moilanen.

Dr. Julie Anderson, who practices family medicine in St. Cloud, spoke at her city council's hearing on Tobacco 21 last October and said the council members were very interested in the effort.

"Speaking in front of a city council could be intimidating for some, but it helps to remind yourself that you are an expert in health care and that, as a family physician, you are respected member in the

community who takes care of patients on the frontlines," said Anderson.

She discovered that being an advocate can be easy and fun if you find others who share your vision and can leverage their experience and resources to create a strong voice.

"The MAFP and AAFP have many resources to help you be an effective advocate for change in your community," said Anderson. "While the ultimate goal would be a statewide Tobacco 21 policy, we know from experience that these changes start locally," said Anderson.

In 2016, the MAFP House of Delegates (HOD) voted to focus advocacy efforts on raising the age of nicotine sales to age 21 in cities and counties.

Dr. Robert Koshnick of Detroit Lakes introduced the tobacco sales resolutions to the HOD. He is passionate about reducing smoking and sees an obvious benefit for making tobacco unavailable to young people, most of whom start smoking before they reach 21.

The Detroit Lakes City Council considered but did not approve the Tobacco 21 proposal last fall.

"We were really organized and had a lot of people there, but it wasn't enough," said Koshnick. "There were two groups of opponents: the business owners who sell tobacco and e-cigarettes and defend the local ordinance, and libertarians who don't like government interference in personal lives."

People with a vested interest in selling tobacco and e-cigarettes swayed the council, he said.

Koshnick shared that if he had to do it all over again, he'd reach out to MAFP members who'd been successful with their Tobacco 21 efforts in their cities. And he would not limit himself to speaking on behalf of MAFP but also share his personal point of view.

MINNESOTANS FOR A SMOKE-FREE GENERATION

"This is a public health issue that's killing people," said Koshnick. "Does the city council value generating profits or a better quality of life for young people who aren't mature enough to know the impact of smoking?"

Drs. Peters, Anderson and Koshnick are willing to talk to MAFP members about their experiences.

For more information about being a Tobacco 21 advocate, contact Jami Burbidge, MAFP Director of Advocacy: jami@mafp.org

Shawn Martin, Senior Vice President, Advocacy Practice Advancement and Policy, AAFP

VALUE-BASED PAYMENT? SURVEY SAYS...

> **"Charlie, here comes the deuce. And when you speak of me, speak well."**
>
> *— Kevin Costner as Crash Davis in Bull Durham*

During the past decade, there has been a sustained effort to transform the health care delivery system to better align payments with quality and performance. Although some aspects of practice transformation have always been a part of our health care system and policy environment, there certainly has been an increase in activity since the early 2000s.

The current approach towards quality and performance improvement began in the early 2000s with what was initially known as the Physician Quality Reporting Initiative (PQRI). In the past 10 to 12 years, we have seen quality improvement and practice transformation concepts such as PQRS, value-based modifier, meaningful use, patient-centered medical homes, accountable care organizations and several others that have been implemented by insurance companies. Despite some variations, today, we have largely coalesced around the concept of value-based payments (VBP).

I recognize that terms like transform, better align, quality, and performance tend to kickstart a healthy debate among family physicians, and few phrases cause the elevation of blood pressure quite like "value-based payments," but I still think it is important to share some thoughts on this subject.

Providing high-quality health care in the most efficient manner possible is a goal that is easily supportable and without question one that our members strive to achieve each day. How you go about achieving that goal within your individual practices is a question that lends itself to analysis, so we decided to do some analyzing.

This summer, the AAFP partnered with Humana to survey family physicians regarding their engagement with, and attitudes toward, value-based payment models. This is the second time the two organizations have partnered on such a project. In 2015, shortly after the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), the two organizations conducted a similar survey. The results are interesting both in the progress that has been made among family physicians, but also in the fact that the barriers identified in 2015 persist today.

My colleague, Amy Mullins, M.D., summarized the findings this way during a congressional briefing on Nov. 29: "Progress continues toward value-based payment, but major barriers still stand in the way." The survey was comprehensive, but I have pulled some key findings that demonstrate where progress has been made and the barriers that continue to exist. The following questions are taken directly from the survey.

How familiar are you with the concept of value-based payment?

Sixty percent of respondents said they were extremely and/or moderately familiar with the concept of value-based payments. This is a slight increase from 2015. What is most interesting is the number of family physicians who responded that they were "not familiar at all" dropped from 12 percent to 7 percent.

What is your current status or strategy towards value-based payment?

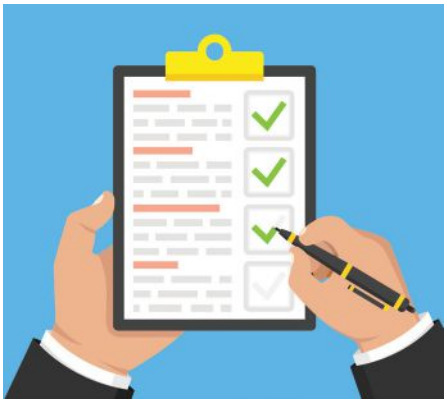
Forty-seven percent responded that they were actively pursuing VBP opportunities in their practice. Twenty-one percent responded that they were developing capabilities, but are waiting until results are better known. All told, more than 65 percent of family physician are either participating in a VBP model or preparing to do so in the near future.

What changes to your practice are you making or have been made to participate in value-based payments?

- Fifty-four percent responded that they are updating or adding health IT infrastructure.
- Forty-three have hired or are hiring care coordinators.
- Twenty-two percent have hired or are hiring behavioral health support.
- Fourteen percent are not making any changes.

What are the major barriers to value-based payment models?

- Ninety percent stated the lack of staff



time to implement care functions that support VBP.

- Seventy-five percent responded that the lack of uniformity across payers was a major barrier to VBP.
- Seventy-eight percent stated that the lack of standardized performance measures and metrics was a major barrier.
- Seventy-six percent said the unpredictability of revenue was a major barrier.

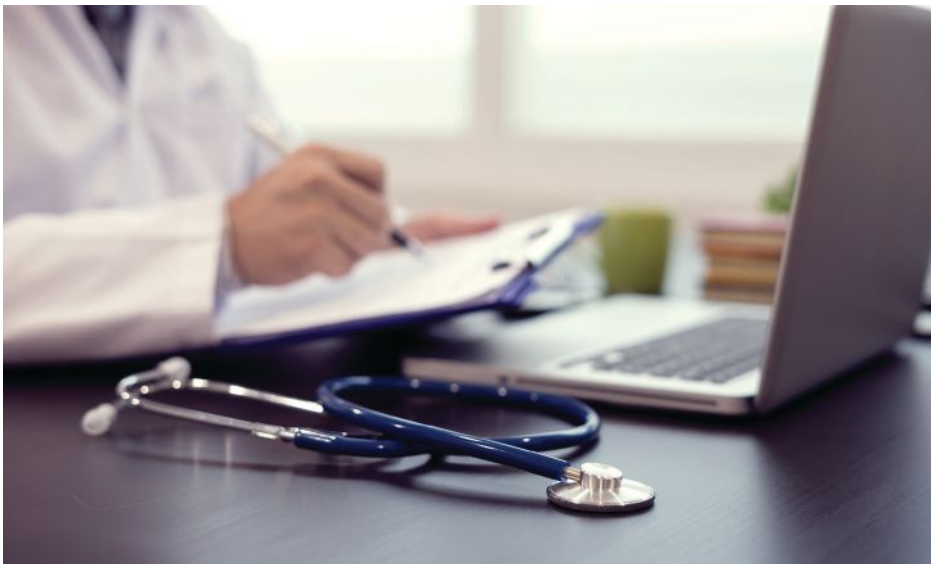
As part of the survey, the AAFP took a deeper look at the payer mix of family medicine practices, which is illustrative of the concerns raised regarding the lack of uniformity across payers and the lack of standardized performance measures and metrics. Thirty-seven percent of respondents have contracts with 10 or more payers. Almost 60 percent have contracts with seven or more payers. Clearly, the variation amongst payers is a major barrier to VBP and a major source of frustration.

One of the more interesting findings of the survey is the high level of skepticism that continues to exist regarding the value of value-based payment models. Sixty-two percent of respondents stated that there is a lack of evidence that using performance measures results in better patient care, and 58 percent think VBP will increase the work for family physicians without benefiting the patient.

My final observation is the continued frustration with the functionality of electronic health records, data registries, and clinical data repositories. These items continue to be prominent barriers identified by those physicians seeking to implement VBP models in their practice—their EHR and other technology platforms simply do not help them.

The findings of the survey are interesting. We have produced an infographic (220 KB PDF) and press release on the findings.

This post was originally published in the AAFP's In The Trenches blog: http://bit.ly/2EZ6pEn



By Cory Ingram, MD, MS, FAAHPM

PROVIDING ANTICIPATORY GUIDANCE AND RESPONDING TO THE NEXT CRISIS

Palliative Care for Family Physicians: Part 3 of a Four-Part Series

Family physicians are essential in providing palliative care to their patients and their patients' loved ones. As previously highlighted in this series, most people will decline slowly over many months or years.[1] The intention of this article is to provide objective prognostication tools and frameworks to augment the family physician's clinical gestalt so that they may provide their patients and their patients' loved ones and caregivers with anticipatory guidance about where a clinical situation may be heading. These prognostication tools are imperfect and require the clinical context and assessment of clinicians who know the patient well.

Family physicians have the opportunity to talk with a patient or caregiver about a chronic worsening irreversible clinical condition and establish practical care plans.[2]

These clinical conditions, and even the associated treatments are often sources of increasing suffering, with minimal or temporary clinical benefits.[3] Clinical work in these settings is very challenging. When the approaching end-of-life is not recognized in a timely fashion, the physician must balance the uncertainty of prognostication with the long-lasting and devastating effects of overtreatment.[4]

Providing excellent care through the end of life requires more than dedication to the medical aspects—the personal and spiritual aspects of care must also be considered. Family physicians can do this well.[5,6]

Because many of the individual disease states co-exist, I want first to address the goals of medicine and unveil the unasked question in relation to responding to crisis.

THE UNASKED QUESTION:

Often a person with an advanced illness reaches a point where the benefits of treating each itemized disease are not making the person better, and medical care may cause more suffering and shorten survival.[7] The focus on the quality of a person's life is blurred by all the medical comings and goings. In times like these, family physicians can help their patients to regain control of the possible goals of medical care.

The possible goals of medicine can include cure, physiological restoration, life prolongation, symptom management and attention to the quality of life, and preparation for a good death.[8] Often, only the last three goals are possible in advanced illness. When the goal of life prolongation is questionable, and the burdens of medical treatments to achieve life prolongation are eroding the patient's fleeting quality of life, a sole focus on quality of life and preparation for death are likely the only achievable goals.[3]

The unasked question recognizes that we can always push a frail person's physiology further. We can make them die from something other than what they were already dying from, like pneumonia at home or discontinuing ventilator support in the hospital days later. **The unasked question then, is this: If the person is not allowed to die from what they are already dying from, what are they going to be allowed to die from?**

It is not asked literally, but the conversation ideally would address the elephant in the family physician's office, nursing home, or hospital. And the next question is this: If the patient is aware of this question, this choice, how would they choose to live during this precious time?[9]

EVALUATING FRAILTY AND CONSIDERING A CONSERVATIVE APPROACH TO CARE

Frailty is the geriatric syndrome that diminishes the potential for functional recovery following a pathologic or iatrogenic stressor, due to aging-related impairments. Frail people are typically dying with a constellation of problems and not from one problem. This complexity is important to keep in mind when considering procedures or treatments for just one of the problems in the constellation. The patient may simply be too frail to survive or recover from that one intervention. Death and disability may approach faster when we intervene regarding a frail person, rather than simply leaving well enough alone.[7] Family physicians see people with frailty regularly and can easily evaluate for the common clinical features: loss of strength, unintentional weight loss, low activity level and increased sleep, poor endurance or fatiguing easily, and slowed performance and unsteady gait. Often people with frailty are unable to withstand surgical and procedural interventions and may live better and longer with a more conservative approach to their care.[7]

There are other various frailty evaluation scales.[10] Each parameter followed over time adds to the prognostic evaluation.

PALLIATIVE PERFORMANCE SCALE (V2, PPSV2) TOOL FOLLOWS DISEASE TRAJECTORY

The PPS is a valid and reliable tool that emerged from the oncology literature and is used by family physicians in evaluating their patients. The five domains that determine PPS are ambulation, activity and evidence of disease, self-care, intake, and level of consciousness. The scale moves in ten-degree increments, ranging from 100%, which is normal, to 0%, at death. It can be particularly useful in objectively following a patient's disease trajectory: additional palliative care needs are indicated as the PPS declines.[11]

PPS can be helpful in objectively conveying a patient's past and present clinical status to others. For example, when communicating with adult children of a patient, the family physician can use the PPS to help objectively identify the parent's decline and the associated elements causing the decline. Additionally, the PPS can be particularly helpful in assisting a patient interested in hospice care if the patient has many comorbidities and no single hospice-qualifying diagnosis. The PPS is included in the hospice narrative to accurately support a patient's ongoing hospice needs.

CARING FOR PEOPLE LIVING WITH DEMENTIA USING SEVEN STAGES

Dr. Barry Reisberg defined seven stages common to dementia, which he called Functional Assessment Staging, or FAST staging.[12] Stages V-VII typically are stages where more anticipatory guidance is needed, and thus our focus will be on those stages. Each stage is progressively more challenging to manage in the home. Disease progression also increases caregiver exhaustion. End-of-life care in dementia can be thought of as traversing Stages V, VI and VII over the course of months to years.[9]

Staging evaluates a person's daily functioning as related to ADL and iADL. A simple approach to remembering the various Activities of Daily Living (ADLs) is to think of them as everything you do in the morning to prepare yourself for the day. ADLs would include bathing, dressing, transferring, toileting, grooming, and feeding yourself. Everything you do next, things to navigate the world after you are ready for the day, is identified as Instrumental Activities of Daily Living (iADLs), such as managing finances, transportation, medication, communications, laundry, housework, shopping, and cooking.[9]

Family physicians will recognize in their practice those dementia patients who are "all dressed up and have nowhere to go." This is Stage V. People in Stage V appear well dressed and ready for the day. However, they are disoriented and unable to perform most iADLs. Often practical issues arise around dressing for the appropriate season, driving, and managing finances. It is often challenging to balance safety, which is important to the family, with independence, which is important to the patient. Often people in Stage V live at home.[9]

Stage VI is marked by incontinence, an inability to recognize loved ones, and wandering. It can be thought of as the "Velcro" stage because in this stage people tend to cling to others when wandering and wear incontinence materials. People in Stage VI live in a care facility or have a caregiving system at home that mimics an institutionalized setting.[9]

Stage VII is the end-of-life stage attributed solely to dementia. Family physicians should feel comfortable and confident in referring to this part of life as a time of life called dying. In Stage VII, a person is dependent in ADLs and can speak only a few words. The patient is dependent on others for all caring. Most time is spent in bed. This is a time when the patient is eligible for hospice care. It is difficult to identify benefit without harm in providing artificial nutrition and hydration to patients in Stage VII. Generally, aspiration risks remain elevated despite medical interventions, and can lead to poor quality of life and shortened length of life.

Time devoted to developing care plans for predictable crisis, is time well spent to ensure that the care matches the patient's values, preferences and priorities near the end of life.[9]

CARING FOR PEOPLE LIVING WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

COPD presents a great deal of difficulty for prognostication. Many factors affect prognostication in COPD: age, functional status, co-morbidities, hypoxia and hypercarbia. Thus the view of the whole patient from the perspective of the family physician becomes very important.

In ambulatory patients with COPD, family physicians can evaluate their forced expiratory volume in one second (FEV1), distance walked in 6 minutes, MMRC dyspnea scale, and body mass index. These measurements can be used to calculate the BODE Index.[13] (See **Figure 1**.) The calculated point total then lends insight into prognostication. (See **Figure 2**.)

In hospitalized COPD patients with PaCO2 > 50, the mortality risk is 10% during that index hospitalization, 33% during the next 6 months and 43% that following year. If a COPD patient requires mechanical ventilation, their in-hospital mortality rate is 25%.[14]

Hospice admission criteria for patients with COPD include cor pulmonale and pO2 <55mmHg while on oxygen, albumin <2.5gm/dl, unintentional weight loss of >10%, progression of disease, and poor functional status that can be referenced with the PPS and a frailty evaluation.[15]

CARING FOR PEOPLE LIVING WITH HEART FAILURE (HF)

The prognostication and care of people with HF continue to change and, thankfully, options for treatments have increased in the last years. This increase has led to longer life spans, difficulty prognosticating and the always-present risk for acute death for HF patients. The last three goals of medicine are usually at play until very near the end of life.[8]

FIGURE 1: BODE Index Table

Summary - The BODE Index Table

Variable	Points on BODE Index			
	0	1	2	3
FEV1 (% predicted)	≥65	50-64	36-49	≤35
6-Minute Walk Test (meters)	≥350	250-349	150-249	≤149
MMRC Dyspnea Scale	0-1	2	3	4
Body Mass Index	>21	≤21		

FIGURE 2: Survival Rates Based on BODE Index Point Total

BODE Index Survival Rates

Approximate 4-year survival rates are then calculated as:

- 0-2 points - 80%
- 3-4 points - 67%
- 5-6 points - 57%
- 7-10 points - 18%

Patients with NYHA Class IV heart failure, characterized by symptoms at rest, have a 30-40% estimated 1-year mortality compared to 10-15% for Class III, who are comfortable at rest but highly restricted with activity.[16]

Perhaps the most important predictors of a poor prognosis are additional signs and symptoms that a family physician can easily monitor in clinic. Often multiple signs and symptoms may coexist: Hospitalization for HF, intolerance to beta-blockers or ACE-inhibitors, elevated BUN, systolic blood pressure less than 100 and/or pulse greater than 100, decreased ejection fraction, treatment resistant ventricular dysrhythmias, anemia, hyponatremia, cachexia, orthopnea, and other common comorbidities like diabetes, COPD, cirrhosis, stroke, and cancer. Frailty and PPS can also factor into prognostication.[16]

SUMMARY

In summary, family physicians play an important role in caring for people throughout their lives, including through the end of life. Family physicians often have a broader, more whole-person view regarding patient care; they can factor in many aspects of a person's clinical, prognostic, and personal attributes to talk about next steps in care. Frailty and PPS may lend the best augmentation to prognostication in difficult-to-prognosticate situations like COPD and HF. Iterative and careful attention to disease-specific and personal criteria are important in providing anticipatory guidance and practical care-planning as patients and families transition through the stages of life, including the stage of life known as dying.

Dr. Ingram is Associate Medical Director for Palliative Medicine — Community Division; Director of Palliative Medicine in Population Health; Associate Medical Director Mayo Clinic Hospice; Assistant Professor Palliative Medicine; Assistant Professor Family Medicine, Mayo Clinic, Rochester MN

WEBSITES AND RESOURCES

1. The Center to Advance Palliative Care (CAPC): http://www.capc.org
2. Fast Facts at PC Now: https://www.mypcnow.org/fast-facts
3. PPSv2 pdf available at: http://palliative.info/resource_material/PPSv2.pdf

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Andrew Slattengren DO, faculty at North Memorial Family Medicine Residency; member of the MAFP board is the Chair of the FMM Foundation

Family Medicine Midwest

Family Medicine Midwest was held October 6-8, 2017 in Rosemont, Illinois. This event combined scholarly work and research presentations; community-based practice and best practice sharing, and promoted cooperative and collaborative health care innovation.

More than 350 physicians, residents and medical students — 18 of whom traveled on scholarships provided by the Minnesota Academy of Family Physicians, the University of Minnesota Department of Family Medicine and Community Health, the Department of Family Medicine at Mayo, and individual family physicians.

Minnesota physicians, residents and students presented a total of 11 educational sessions during the conference, including an emotional and motivating plenary talk "The #FMRevolution of Today" by MAFP executive board member Dr. Renee Crichlow.

Here's what one student had to say about the event:

"Thank you so much for the opportunity to attend the conference, it was both an educational and inspiring experience. Given my interest in women's health, I specifically enjoyed lectures on abortion care, water births, contraception and perineal suturing techniques. I also attended a lecture on behavioral interviewing which will be helpful as I begin the interview process for residency. I was selected to present a poster on my Advance Care Planning project that I worked on for 9 months as a student in the Rural Physicians' Associate Program. It was really amazing to share my work with students from across the midwest and hear them voice their interest in doing something similar in their own area."
— Danielle Francen, MS 4, University of Minnesota.

The Family Medicine Midwest (FMM) Foundation launched in 2012 with a core mission of identifying and supporting students interested in Family Medicine. It is committed to communicating the value of Family Medicine to practicing colleagues, future colleagues and the public.

COMING UP NEXT

Research Network Dinner
Friday, March 2
University Club • St. Paul, MN

Innovation & Research Forum
Saturday, March 3
HealthPartners • Bloomington, MN

Day at the Capitol
Wednesday, March 14
Minnesota State Capitol • St. Paul, MN

MAFP House of Delegates
Wednesday, April 11
Saint Paul RiverCentre
St. Paul, MN

MAFP Spring Refresher
Thursday & Friday, April 12 & 13
Saint Paul RiverCentre
St. Paul, MN

AAFP Leadership Conference/Annual Chapter Leader Forum/ National Conference of Constituency Leaders
Thursday – Saturday, April 26–28
Sheraton Kansas City Hotel at Crown Center • Kansas City, MO

AAFP Family Medicine Advocacy Summit
Monday & Tuesday, May 21 & 22
Washington Court Hotel
Washington, DC

Welcome to Minnesota for 1st-year Residents
Sunday, June 24
Minnesota Science Museum
St. Paul, MN

AAFP National Conference of Family Medicine Residents and Medical Students
Thursday – Saturday, August 2–4
Kansas City Convention Center
Kansas City, MO

MAFP Destination CME
Friday & Saturday, August 17 & 18
Inn on Lake Superior • Duluth, MN

Medical Student-Family Medicine Resident Experience
Saturday, September 15
Pinstripes, Edina, MN

AAFP Congress of Delegates
Monday – Wednesday,
October 8–10
Hilton New Orleans Riverside
New Orleans, LA

AAFP Family Medicine Experience (FMX)
Tuesday – Saturday, October 9–13
Ernest N. Morial Convention Center
New Orleans, LA

Family Medicine Midwest Conference
November 9–11
Madison, WI

Julie Mayers Benson, MD, FAAFP of Staples, Minn. was the 2017 Minnesota Family Physician of the Year

MOST VALUABLE PHYSICIAN AWARD EVENT SET FOR APRIL 12

Join us the evening of April 12, 2018 to honor the 2018 Minnesota Family Physician of the Year recipient. This delightful event will be held at Saint Paul River-Centre and starts with a 5:15 p.m. reception.

The award recognizes a family physician member who personifies the highest ideals of the specialty of family medicine. The winner is nominated by the general public, clinic administrators, MAFP members and non-member family medicine colleagues.

You can register separately for this event, which follows the first day of CME sessions at the Spring Refresher.

Visit http://mafp.org/page/awards to learn more about the MAFP Academy Awards.

By Renee McGivern, MAFP Marketing and Communications Director

MUSIC IS SOUNDTRACK OF LIFE FOR TWO UNITED FAMILY MEDICINE DOCTORS

What does resilience look like? If a new patient was a fly on your clinic wall, what would she observe as everyone interacts throughout the day?

At United Family Medicine on West 7th Street in St. Paul, she'd notice musical instruments in a meeting room and maybe hear a patient plunking out a tune on the piano in the entryway. She'd see how everyone flows in and out, playing an essential part in what seems like an energetic, high-performing band.

Dr. Tim Rumsey has been practicing family medicine since 1975 in the same neighborhood. He founded Helping Hand Health Center there, a free storefront clinic. Over decades, that has evolved into a large community health clinic with a residency program and long-time staff serving a diverse population.

"We have a wonderful team and a challenging clinic with mentally ill, underserved and marginalized folks, but also musicians, politicians, and judges," said Tim. "We have quite a lot of longevity with the staff and it's a tribute to how we are taking care of each other and ourselves."

In 1995, he recruited Dr. Jerry Montie, who'd been practicing at a migrant health clinic in rural Washington.

"It's been an amazing place to be with an environment of young physicians, medical students and family medicine residents," said Montie. "It's an exciting dynamic place to work and that's probably the biggest protection we've had against burnout."

Dr. Jerry Montie plays several instruments and writes music as well. Sometimes, he plays with Rumsey's band, Rhythm Pups. Here, he plays and sings with his niece at the 2016 Healthy West 7th Block Party.

Dr. Tim Rumsey enjoys performing with his band, Rhythm Pups. Here, they're playing at the 2016 Healthy West 7th Block Party. You can follow the band's schedule on Facebook.

Outside the clinic, Montie writes and plays music as his way of defending against burnout and building resiliency. When he was the medical director at United Family Medicine, he'd sometimes start meetings with his guitar and a song.

His enthusiasm for music struck a chord with Rumsey, who then pulled out his guitar and started playing again more than a decade after setting it aside. Rumsey hung guitars and rock and roll photos on his office wall when he was the medical director.

"Music is a pursuit that has nothing to do with medicine," said Rumsey. "I play my guitar or mandolin before I go to bed so I can relax. I look forward to it."

Dr. Tim Rumsey and Dr. Jerry Montie believe that music is a way to use a different part of the brain and shift gears from the intensity of medicine. Here, they show off their new guitars.

He also started performing in a band—Rhythm Pups—and sometimes, Jerry plays with them.

"Jerry and I both have performed, and it's an exhilarating experience of connecting with an audience," said Rumsey. "Music is the soundtrack of our lives, and I listen to it every day."

Both doctors have a lot to say about family medicine today. They say that resilience is an issue for primary care physicians because of the increased pace of family medicine, the limited time with patients and computerization.

"What we really are looking for is not resiliency training but support from the health system," said Montie. "What we need to sustain our resiliency is the time to do the right things for patients, lead a balanced life, and participate in things like music."

Rumsey agrees.

"We got through med school, internships and residencies, which shows family medicine doctors are resilient," he said. "But the system has to give us room to do what we're supposed to do instead of tasks that can drive us crazy."

For both physicans, music is a way to use a different part of the brain and shift gears from the illness of the health system and intensity of medicine. Montie says that music translates over to family medicine.

"There is beauty and aesthetics in music as well as in taking care of the precious families we see," observed Montie. "There's beauty in art and in life, and they kind of anchor each other."

Primum non nocere. We must face the fact that it is by our collective hands that we face a prescription opioid crisis. In Minnesota, family medicine accounts for roughly three times more opioid prescribers than any other specialty group. Of the family medicine physicians that do prescribe opioids, the top 25% write high dose opioid prescriptions (i.e. > 700 cumulative morphine milligram equivalence) 15 times more frequently than the lowest 25% of opioid prescribers.

The charge of the **Minnesota DHS Opioid Prescribing Work Group** was to thoughtfully draft opioid prescribing recommendations intended to 1) reduce progression toward new chronic opioid use, 2) reduce variation in opioid prescribing behavior and 3) provide educational resources for prescribers.

The recommendations released on Dec. 1st can be found at https://mn.gov/dhs/assets/draft-complete-set-of-recommendations_tcm1053-319378.pdf.

— Bradley Johnson, MD South County Health Alliance, Owatonna

I represented AAFP at the fall 2017 **CDC's PROTECT Initiative: Advancing Children's Medication Safety** conference. The focus is on reducing accidental medication overdose in children, especially children under five.

I had a unique role there as a family doctor. There were only three clinical physicians including myself in a group of about 40 people. I was able to offer practical ideas and feedback from a clinician's standpoint to everyone's ideas about safer packaging, dosing and storage.

It was impressive to be surrounded by people from drug companies, universities, public health agencies, and consumer advocates all working towards the same goal of childhood safety. This CDC initiative has made significant changes that has helped decrease the morbidity and mortality of children secondary to accidental overdosing. Examples include safe packaging of medications, proper measurement of medications, and public health campaigns for safe storage of medication.

— Daron Gersch, MD, FAAFP CentraCare, Albany, Minnesota

FAMILY MEDICINE INFLUENCERS

I am involved with the **Minnesota Coalition for Quality Payment Program Excellence**. It is a large group of representatives from Minnesota healthcare systems and provider professional associations, convened by Stratis Health. The Coalition's purpose is to assure successful participation (defined as 90% of providers) in Merit-based Incentive Payment Systems (MIPS/QPP) now mandated by the federal government.

The first year that data from physician practices are being used to create adjustment to Medicare payments in 2019 was 2017. While many large group practices have QI departments and registries that can be used for reporting, the requirements can present a challenge for smaller groups

It is important for MAFP members to be represented, stay informed, and have a voice in this process. Questions can be directed to QPPHelp@stratishealth.org.

— Patricia Fontaine, MD, MS Health services, Faribault State Prisons

I serve on the **MDH Child and Teen Checkup Work Group**. Improving the services we provide to children and adolescents in Minnesota is something I care deeply about. Participating on this MDH Child and Teen Workgroup has been a wonderful opportunity to be an advocate for children and to point out the important role of family medicine. This collaboration brings all stakeholders together to discuss the impact of decisions MDH makes on providers and care groups as well as allowing the Academy to have an influence on policy.

Shannon Neale, MD Park Nicollet Creekside Clinic, St. Louis Park


IT'S BEEN NEARLY SIX MONTHS WITHOUT ANY BIG SMILES. FOR EITHER OF YOU.
No big, joyful smiles is one early sign of autism.
Learn the others today at autismspeaks.org/signs.
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IN THE NEWS

Alexis Vosooney, MD has been appointed to the AAFP Commission of Health of the Public and Science for a four-year term. She practices at the Allina Health West St. Paul Clinic.

Maria Huntley, CAE, MAM, MAFP executive vice president, was appointed to the AAFP Commission on Continuing Professional Development and will serve four-year terms starting this month.

James Pacala, MD, MS was appointed head of the University of Minnesota Department of Family Medicine and Community Health in December 2017.

Macaran Baird, MD, MS was appointed CEO of the University of Minnesota Physicians late in 2017. He is a professor and retired department head at the University of Minnesota Department of Family Medicine and Community Health.

Leif Solberg, MD was recently elected to the National Academy of Medicine. Dr. Solberg is a HealthPartners researcher.

Deborah Dittberner, MD is the new MAFP Board Chair. She replaces Sam Hanson Willis, MD in that role. She practices in Alexandria, Minn.

Arden Virnig, MD from Mille Lacs Health System in Onamia, raised $13,699.15 for the Children's Cancer Research Fund by riding in the Great Cycle Challenge. His fundraising ranked first in Minnesota and fourth in the nation.

Lauren Williams, MD, PGY3 was named Advocate of the Year by the University of Minnesota Alumni Association.

Michelle Moran, MS2 University of Minnesota-Duluth, is the recipient of the 2017 Peter and Virginia Torreano Scholarship. The scholarship supports students interested in rural family practice. In addition to her studies, Moran is building a database to track youth concussions.

Daron Gersch, MD, FAAFP was recently elected as chair of the AAFP subcommittee on public health issues of the AAFP Health of the Public and Science Commission, which he serves on.

GRANT RECIPIENTS

The MAFP Foundation recently awarded innovation and research grants to these MAFP members.

Here are the recipients:

Jay-Sheree Allen, MD, PGY3 Mayo Family Medicine Residency Program

Lucas Boyle, MD, PGY1 North Memorial Family Medicine Residency Program

Anne Doering, MD, PGY1 and **Lonzale Ramsey, MD, PGY2** North Memorial Family Medicine Residency Program

Shannon Fleming, MD, PGY2 and **Dane Nimako, PGY2** United Family Medicine Residency Program

Zia Okocha, MD, PGY3 North Memorial Family Medicine Residency Program

Rose Olson, MS4 University of Minnesota Medical School, Twin Cities Campus

Lisa Prusak, MD Duluth Family Medicine Residency Program

Nathan Ratner, MS3 University of Minnesota Medical School, Duluth Campus

Ben Rosentein, PGY1 St. John's Family Medicine Residency Program

Thomas Schmidt, MS2 University of Minnesota Medical School, Twin Cities Campus

Jesse Susa, PGY2 Duluth Family Medicine Residency Program

NEW TO THE LAND OF 3,100 FAMILY DOCS

Michael MacIntire, MD, Minneapolis, has transferred from Georgia.

Julia Welle Forberg, MD, Red Wing, has transferred from Idaho.

Kristin Eide, DO, Minneapolis

Jeanne Gambucci, DO, Stillwater and **Tenille Ottley-Sharpe, MD**, Albert Lea, have transferred from Illinois.

Stephen Holmes, MD, Rochester, has transferred from Iowa.

Justin Golden, MD, Edina, has transferred from Massachusetts.

Isaac Adediran, MD, Minneapolis and **Ethan Morrical, MD**, Duluth, have transferred from Michigan.

Stephanie Erickson, MD, Red Wing, has transferred from Nebraska.
Ethan Berke, MD, MPH, Minneapolis, has transferred from New Hampshire.
Robyn Knutson Bueling, MD, St. Paul; **Francis Moraleda, MD**, Bemidji; and **Jill Olson, MD**, Bemidji, have transferred from North Dakota.
Sandeep Pagali, MD, MPH, Rochester, has transferred from Pennsylvania.

Branden Pfefferkorn, MD, MPH, St. **Paul and Jennifer Robinson, MD**, St. Paul, have transferred from Washington.
Albert Chiu, DO, Minneapolis; **Sarah Karalus, DO**, Inver Grove Heights; **Anne Lovell, DO**, St. Paul; **Barret Myers Wolfson, MD**, Bigfork; **Sakina Rashida Sachak, MD**, Faribault; and **Yer Xiong, MD**, Stillwater, have transferred from Wisconsin.

NEW RESIDENT MEMBERS

Nneka Agujiobi, MD, Minneapolis
Courtney Black, MD, Minot
Adrianne Chesser, MD, St. Paul
Dennis Ea, St. Paul
Kelsey Finn, DO, Minneapolis
Kayla Harris, DO, St. Paul
David Henry, MD, Minneapolis
Daniel Johnson, DO, Rogers
Rebecca McDougle, MD, Minneapolis
Lauren McPherson, MD, Minneapolis
Daniel Olson, MD, Mankato
Rebecca Siffring, MD, St. Louis Park

NEW STUDENT MEMBERS

University of Minnesota Medical School — Duluth Campus
Anna Ayers Looby, Duluth
Whitney Bertram, BSN, Duluth
Katrina Christian, Le Center
Sylvia Frazier, Duluth
Jenna Nypan, Duluth
Chandni Patel, Duluth
Michelle Patregnani, Duluth
Karen Riley, Hermantown
Payton Schultz, Duluth
Tenaya Siva, Duluth
Marissa Wheeler, Duluth
Ashley Wittrock, Hermantown

University of Minnesota Medical School — Twin Cities Campus
David Bergstrand, BS, New Ulm
Catherine Bledsoe, Coon Rapids
Rachel Busko, Fergus Falls
McKenzie DeKam, Leota
Anya Dmytrenko, Minneapolis
Rachel Husmann, Plymouth
Charles Kotulski, Madelia
Samantha Lorentz, St. Louis Park
Kimberly Lundeen, St. Paul
Andre Scarlato, Minneapolis
Hayley Sharma, Minneapolis
Lisa Skarbakka, Minneapolis
Jessica Stowe, Rochester
Nathan Stratton, Lauderdale
Thomas Walsh, St. Paul
Georgianna Whiteley, Wayzata

ANDREW PATTOCK, MS2, UNIVERSITY OF MINNESOTA MEDICAL SCHOOL, TWIN CITIES CAMPUS

Medical student Andrew Pattock, left, worked on the Pay for Performance website under the guidance of his family physician mentor, David Satin, MD.

In 2016, Andrew applied to and was selected to participate in the David Mersy, MD Student Externship Program offered by the MAFP Foundation.

The title of Andrew's project was P4P (Pay for Performance) Research and his family physician mentor was David Satin, MD.

Q: WHAT IS THE MOST IMPORTANT TAKEAWAY FROM YOUR WORK ON THIS P4P PROJECT?

Our project showed that an online compilation and summary of the most recent and important research on physician payment reform is broadly desired. In addition to users across the state and country, nearly half of users have been from countries outside the United States.

Q: HOW CAN OUR MEMBERS USE THIS WEBSITE?

You can access the website at either p4presearch.org.

Q: WHAT WAS YOUR BIGGEST CHALLENGE WITH THIS PROJECT?

The most significant challenge was time. The rate of evidence being published regarding P4P and payment reform is rapid. With our busy schedules, finding availability to review the latest articles and discuss the significance to the overall literature has been an ongoing challenge.

Q: HOW DID YOU FEEL WHEN YOU HEARD YOU GOT FUNDING FROM THE MAFP FOUNDATION?

We were honored to receive funding from the MAFP Foundation. Family physicians are truly the target audience of the project as they are currently most impacted by P4P and physician payment reform.

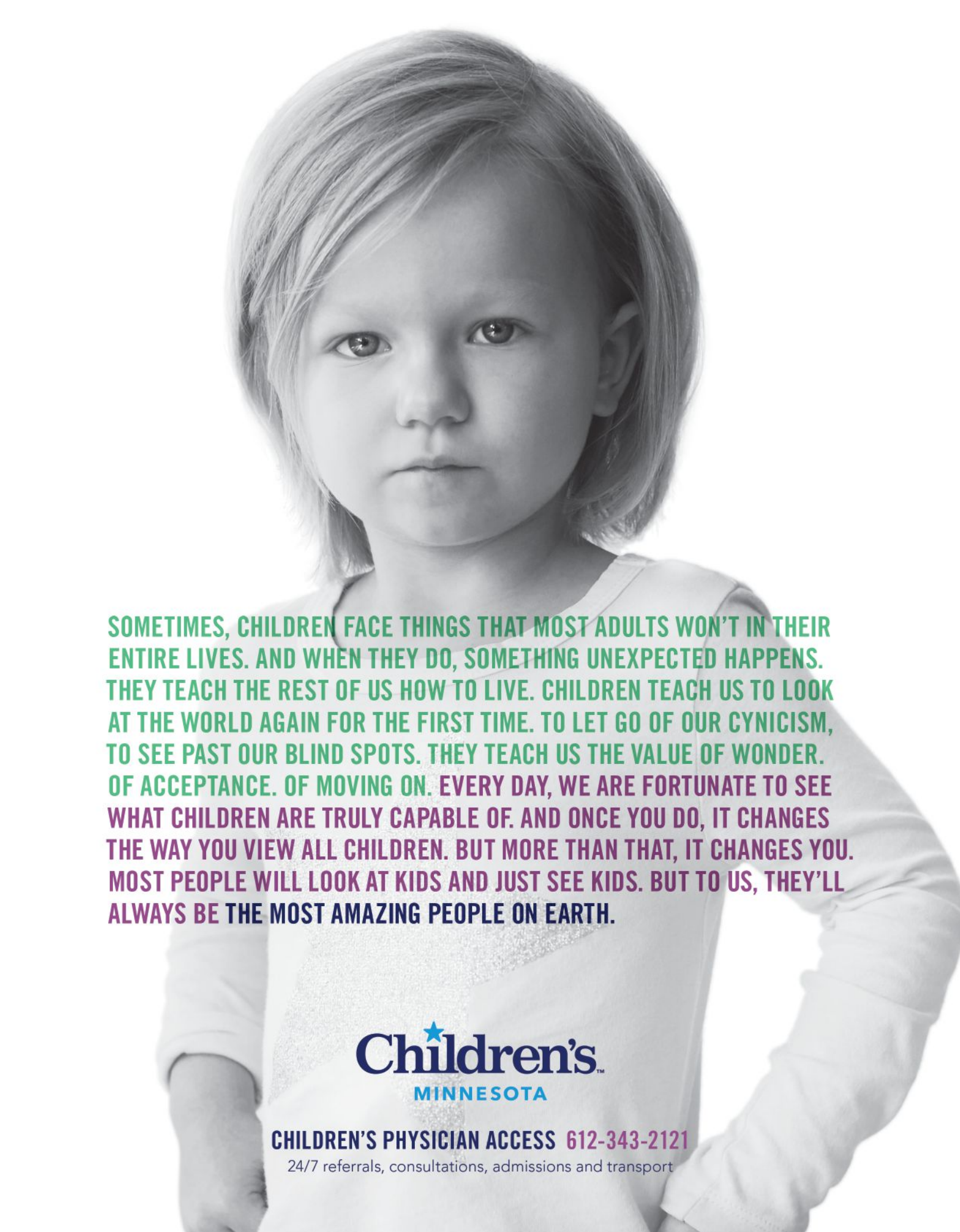
GRANT APPLICATIONS ARE DUE MAY 1, 2018

Innovation Grants
- Open to students, residents and family physicians
- $1,000 grants to fund family medicine projects

Resident Research Grants
- Open to residents only
- $3,000 grants to fund family medicine research

David Mersy, MD Student Externship Program
- Open to students only
- $2,000 stipends to fund a family medicine experience

Applicants must be members of the AAFP and MAFP. Learn more at ***www.mafp.org****.*


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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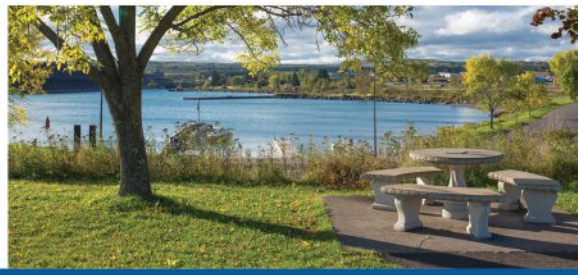

Work Where You Vacation

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Full-time Family Practice Physician at Lake View Medical Clinic
Join an established team of seven providers. Full-time practice includes four days per week in the clinic with inpatient care at the adjacent Lake View Hospital. Patients range from newborn to geriatric; practice does not include obstetrics.

The practice model offers:

- Opportunity for balanced exposure to hospital and clinic medical care
- Collaborative team environment
- High priority on quality and patient/staff satisfaction
- Competitive salary with additional productivity incentives available

Lake View Hospital is a 25-bed Critical Access Hospital, a Level 4 Trauma Center and an Acute Stroke Ready Hospital. Lake View is part of St. Luke's Health System in Duluth, MN, which offers a variety of specialty outreach services to Two Harbors.

Contact us to learn more.

BC/BE Opportunities
St. Luke's is an Equal Opportunity Employer

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