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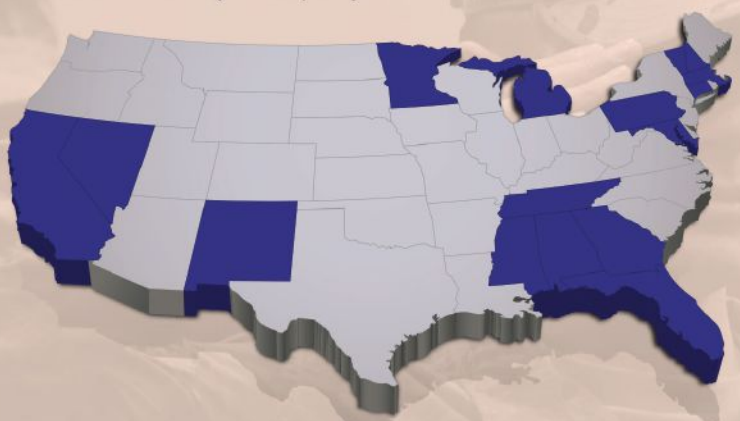

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Dr. John Lay, MD
LTC(R), US Army
Regional Medical Director
Centurion of Florida

Correctional Medicine, similar to Military Medicine, provides evidenced based medicine to a unique population within a policy focused framework. My experience as a military physician provided for a smooth transition into a challenging and rewarding second career as a correctional health care physician.

Correctional Medicine allows me to continue the mission of serving an underserved population. It has given me the opportunity to use the leadership skills that were developed during my military career while continuing to uphold the core values that were engrained in me. I also found that it was a great transition as I was moving from military to civilian life.

Dr. Clayton Ramsue, MD
Retired Lt. Col. US Air Force
Statewide Medical Director
Centurion of Mississippi

The Giving Voice Chorus performs with Jon Hallberg, MD in the presentation *More than a Song: Reawakening Hope for Persons with Alzheimer's* at the Spring Refresher.

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MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

By Glenn Nemec, MD, MAFP President

WE'RE A LITTLE DIFFERENT... SPREAD THE WORD!

You have all heard the statistics somewhere in a journal or at a conference: The U.S. has the most expensive medical care system in the world and yet, among first world nations we have the worst overall patient outcomes. However, nestled in the middle of that system are family physicians, who get much better overall patient outcomes at way less cost. This is not an accident. It is because our training is significantly different than any other specialty. We get taught to simultaneously evaluate multiple "ologies", and then we apply that evaluation to the entire bio-psycho-social existence of our patients. Of course we will get a better overall outcome! Given the crisis state of medical care costs, you would think that every person with any influence anywhere in our system would be working like crazy to make more of us, encourage patients to see us and make it easier for us to see them. Not happening, as we all know. Eventually getting to a family medicine centered medical care system in the U.S. is a large beast to move, but move it we must. And we all can play a part.

Amazingly, there are a lot of people with influence who don't have a clue that we are already doing what they would like to see: better outcomes for less money. Many of you have interactions with hospital, clinic and medical system administrators. They need to hear the message. Some of you sit on advisory boards for insurance companies, large businesses, health care delivery systems or physician education systems. They need to hear the message, too. All of you have the ability to contact your state and national legislators. Send them the message. However, just like the patient that needs to hear a strong definitive message about stopping smoking at every visit in order to be likely to try it and succeed, all these people that we can educate also need to hear it over and over again in order to get them to eventually do something.

We ARE different than the rest of the doctors. That's a good thing for the medical care system in the US, and people need to hear about it—often. Let's all get to work on that. Our patients are counting on us.

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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KENNEDY NAMED 2018 FAMILY PHYSICIAN OF THE YEAR

The Minnesota Academy of Family Physicians (MAFP) named Diane Kennedy, MD, of Luverne, Minnesota, the 2018 Family Physician of the Year.

This award is presented annually to a family doctor who personifies the highest ideals of family medicine: compassionate, comprehensive patient care AND commitment to the community.

Kennedy is a rural family doctor at Sanford Luverne Clinic in southwest Minnesota. She has served the community of Luverne (population 4,658) for nearly 25 years.

She practices full spectrum family medicine—care for ALL ages and conditions—including outpatient, inpatient, emergency and obstetrics care.

AN ADVOCATE, A LISTENER, A SERVANT LEADER

Kat Dahl, Kennedy's daughter and soon to be family medicine resident, said, "My mom is the first one to arrive at the clinic in the morning and the last one to leave at night. Seeing over 25 patients in one day is not an anomaly for her; it's just a normal Tuesday. She is always willing to see patients who need to be seen."

Kennedy's patients and colleagues describe her as an advocate, a listener and a servant leader. She goes above and beyond to remove barriers that may be impacting her patients' ability to receive care. She regularly comes alongside patients in crisis to provide support and additional resources in their time of need.

"Compassion is a necessity," said Kennedy, "You have to be able to understand the perspective of the patient and empathize with their situation in order to develop a treatment plan that will result in a better outcome."

In addition to valuing her patients, Kennedy places a high value on her clinical team. Kennedy said, "I don't know how to be anything but a team player. I truly value everyone who is part of the patient experience. It is absolutely impossible for me to do any of this on my own. I have the luxury of working with the best group of family physicians as well as exceptional nurses."

Kennedy largely credits her incredible team for receiving this honor. She said, "We work together for a common goal. We have our own practice styles but, at the same time, we hold each other to a greater standard."

A TEACHER AND MENTOR TO THE NEXT GENERATION OF DOCTORS

In addition to her clinical responsibilities, Kennedy serves as a mentor and educator to medical students via the internationally renowned University of Minnesota Rural Physician Associate Program and Rural Medical Scholars Program.

Alexis Quade, MD, who was mentored by Kennedy, said, "Kennedy instilled in me a passion for primary care and rural

medicine. She is a physician who is making a difference in the lives of her patients and community."

Kennedy feels it's important to teach and mentor the next generation of doctors. She said, "I believe in paying it forward. We all remember the preceptors that we were exposed to during our training and how much their presence, knowledge and feedback influenced how we practice medicine. It is important to me to make an attempt to be that person. It is demanding on my time, but I receive so much in return. Hopefully, I have provided students with a practical clinical experience that helps them better understand family medicine and why it is critical to either be a family doc or respect a family doc."

A ROLE MODEL FOR STRONG, HEALTHY FAMILIES

Kennedy believes in the importance of caring for her patients outside clinic walls. She sees patients at the local nursing home, Veterans Home and Hospice Cottage. She provides sideline coverage at local sporting events and is an active member of her church and the local 4-H chapter.

Over the years, Kennedy has been actively involved in the community of Luverne. She remarks, "It was probably more as a mom than as a family physician. I think the role of an active, involved parent is important for patients to witness and important for strong, healthy families in a rural community."

Kennedy and her husband, Mark, of 31 years have three daughters: their oldest, Jessa, is pursuing her doctorate in Asian history; their middle daughter, Kat, graduated from the University of Minnesota Medical School in May and will begin family medicine residency training in Sioux Falls in June; and their youngest, Ellen, graduated in December with an undergraduate degree in business.

"My family is a still a priority," said Kennedy, "and I travel to where my kids are whenever I get the chance."

A WELL-DESERVED HONOR

When asked what she loves most about family medicine, Kennedy said, "That is difficult to answer! I love the relationships I have with my patients, but I also love the intellectual challenge of diagnosing and caring for difficult conditions. I enjoy the different roles I have with my patients: teacher, coach, mentor, parent and friend. My job gives me the opportunity to use a variety of different tools to impact the lives of others while developing strong intergenerational relationships. Many days, I seem to learn more from my patients than they learn from me."

Kennedy embodies family medicine: providing comprehensive, compassionate, collaborative care to ALL ages and conditions. She is committed to her community and committed to growing our specialty.

Congratulations to our 2018 Family Physician of the Year Diane Kennedy, MD. Thank you for all you do for your patients, your community and family medicine!

FUN FACTS ABOUT DIANE KENNEDY, MD

Hometown: Pipestone, MN

Current residence: A small farm in Luverne, MN, with a cow/calf operation

Family: Husband, Mark Dahl; adult daughters, Jessa, Kat and Ellen

Medical school: University of Minnesota

Residency: Family medicine in Sioux Falls, South Dakota

How she spends her free time: "I am a fair weather farmer. I help my husband when it is not 30 below and blowing snow. I try to garden, but I have issues with follow through when the weeds start growing. We have a small cabin on a lake. That has been a new development in the last couple of years, and I have learned the art of getting away. I also try to stay fit. After 20+ years of jogging, I have recently switched to lap swimming and the elliptical to be a little nicer to my joints. My family is still my priority, and I travel to where my kids are whenever I get the chance."

Why she chose family medicine: "I grew up wanting to be the hometown doctor, and my husband and I wanted to stay in a rural community. Family medicine seemed the best fit for those goals. I now have more reasons why I continue to choose family medicine; probably the most important one is the generational relationships that have developed over time."

ABOUT THE AWARDS

Since 1981, the MAFP has recognized its members for their hard work and dedication to family medicine via its own Academy Awards. Honors include Family Physician of the Year, Educator of the Year, Resident of the Year, Medical Student Leadership Award and Innovation & Research Award.

Family physicians from across Minnesota are nominated for awards by patients, community members, learners and colleagues. Nominees must be members of the MAFP.

The MAFP Board of Directors selects awardees after reviewing nomination letters and credentials. Awards are formally presented at the annual MAFP Spring Refresher in April.

Twenty-eight MAFP members were nominated for Family Physician of the Year, the Academy's top honor. Finalists included **Kurt Devine, MD** (Little Falls), **Alice Mann, MD** (Lakeville) and **Kimberly Tjaden, MD** (St. Cloud).

WHY I BECAME A FAMILY PHYSICIAN

My mother is a family physician in Luverne, where she takes care of patients in the clinic, hospital and emergency department. I spent a lot of time in the hospital growing up, and I remember having sleepovers in the call room. I realized I was committed to pursuing a career in medicine after one event during college. I was driving with my mom and we approached the scene of a large accident. There were fire trucks, ambulances, and police cars blocking our way. My mom called the dispatch to see if her help was needed and they informed her that a pregnant woman was involved in the accident. Instead of pulling behind the long line of cars, my mom sped ahead toward the scene and jumped out of the car to provide what care she could. I remember sitting in the car, incredibly proud of my mother as a helicopter landed in the middle of the interstate. In that moment, I knew that I wanted to be the type of physician that can help people when it is most needed, regardless of the situation, which is why I chose family medicine.

I want to be able to help as many different kinds of people with as many different kinds of issues as I can. I want to help the young and old, the rich and poor, the big and small, the healthy and chronically ill. Every person deserves access to high quality healthcare and, thanks to observing my mother's work, I know I can provide that care as a family physician.

Kat Dahl, MD, will begin her family medicine residency at Center for Family Medicine – South Dakota in June. She is Dr. Kennedy's daughter.

2018 FAMILY PHYSICIAN OF THE YEAR NOMINEES

Sofia Ali, MD
Julie Anderson, MD, FAAFP
Heather Bell, MD
Jennifer Boelter, MD
Karen Borchert, MD
Dave Bucher, MD, FAAFP
Jesse Coenen, MD
Kurt Devine, MD*
Ryan Dick, MD
Roli Dwivedi, MD
Annie Ideker, MD
Sue Inoue, MD
Ryan Kelly, MD
Diane Kennedy, MD*
Ryan Kray, MD
Steven Long, MD
Alice Mann, MD*
Greg McNamara, MD
Michael Mercer, MD
Gerald Montie, MD
Matthew Penning, MD
Deanna Plant, MD
Jennifer Smith-Kristensen, MD
Kimberly Spaulding, MD
Mark Steinhauser, MD
Kimberly Tjaden, MD*
Garret Trobec, MD
Anne Whitworth, MD

*denotes finalist

HOUSE OF DELEGATES 2018 REPORT

22 Resolutions Heard at this Year's House of Delegates

This year was another for the record books with 22 resolutions submitted by members and local chapters and heard at the House of Delegates on April 11, 2018, at the Saint Paul RiverCentre in St. Paul. (Last year, we also had 22 resolutions; the year before that, we had five.) We continue to be a healthy and highly-engaged Academy!

Under the guidance of Speaker of the House Renée Crichlow, MD, FAAFP, Vice Speaker Andrew Slattengren, DO, and reference committee chairs Nicole Chaisson, MD, and Pat Fontaine, MD, FAAFP, your 2018 House of Delegates took the following actions:

1. The Unique Role of Family Physicians – The MAFP will work to educate policy makers and the public on the unique role of family physicians and that we are different and bring a unique value and cost savings to the healthcare system while achieving better patient outcomes.

2. Crisis of Neglect and Abuse in the Assisted Living and Nursing Home Facilities in Minnesota – The MAFP board will develop a letter addressed to the involved state legislators and appropriate legislative committees to express our urgent concern about the issue of elder abuse and neglect in assisted living and nursing home facilities, recommending that an MAFP selected family physician with geriatric care skills serve on any state governmental workgroup addressing this issue. The MAFP will also forward a resolution to the Minnesota Medical Association to review and support appropriate remedies to address elder abuse and neglect in the MMA's policy development process and will identify resources to assist in educating and empowering family physicians to identify and address elder abuse and neglect in the ambulatory care setting.

3. Petitioning – The Board of Directors was directed to file for information that the MAFP will no longer uses passive "opt out" membership lists on petitions.

4. *A resolution on free market pharmacy reform was not adopted.*

5. Health Care Payment Reform – This resolution was referred to the Board of Directors: The MAFP and the AAFP will ask the government to give a medical tax credit for U.S. citizens buying direct primary care to transform American medical care into a more efficient primary care based personal health care system.

6. Office-based Treatment of Opioid Use Disorder – The MAFP will provide a clinical education session at the 2018 Destination CME and the 2019 Spring Refresher that addresses office-based treatment of opioid use disorder and will provide members with information about the eight-hour buprenorphine waiver training courses that are required for physicians to prescribe buprenorphine.

7. Prior Authorization Alternative Medication Ranking – The MAFP will join with other interested parties and bring forward a resolution to the AAFP Congress of Delegates to create legislation in Minnesota requiring insurance companies and pharmacy benefit managers (PBMs) to provide the following information that must accompany the notice that a requested medication is not covered by the patient's insurance: 1. the exact reason that the medication is not covered or requires a prior authorization; 2. a list of medications of the same class or type that are covered or do not require a prior authorization, preferably ranked from least out of pocket expense to most out of pocket expense.

8A. Protect the Future of Family Physicians and Our Patients — The MAFP will develop and bring forward to the AAFP a policy to promote the appropriate compensation of physicians for oversight of nurse practitioners and physician assistants.

8B. Portions of the resolution to protect the future of family physicians and our patients that were related to lobbying the Minnesota legislature were not adopted.

8C. Protect the Future of Family Physicians and Our Patients — The MAFP will support and request that the AAFP support state legislation that ensures patients receive accurate healthcare information by prohibiting misleading and deceptive advertising or representation in the provision of health care services.

9. MAFP Support to Expand the Number of Refills Allowable in the State of Minnesota to Allow Synchronized Prescription Renewal as a Means to Improve Family Physician Efficiency and Resilience in Outpatient Practice — The MAFP will work with the Minnesota Board of Pharmacy to change the Administrative Rule that limits chronic, non-controlled prescriptions to 365 days and expand the Minnesota refill rules to 15 months.

10. Insuring Access to Long Term Primary Care Physicians and Providers that Are Certified Health Care Homes — This resolution was referred to the Board of Directors: The MAFP will make it a priority to support legislation that will NOT ALLOW a health plan to deny a primary care provider/clinic the right to contract with the health plan company as an in-network provider (part of the narrow network) if the primary care provider/clinic is certified as a Health Care Home (HCH) by the Minnesota Department of Health (MDH) or in the process of certifying to become an HCH through the MDH.

11. Incorporating Information on Physician Wellbeing in the MAFP Website — The MAFP will dedicate a section of its website to information about physician wellbeing, including but not limited to links to available state and national resources for promotion of physician wellbeing and prevention of burnout as well as recommendations of where to seek immediate help for physicians already struggling with burnout.

12. Increase Percentage of Women's Reproductive Health Topics at MAFP Conferences, AAFP FMX and at the National Conference for Residents and Students — The MAFP will seek to increase the number of women's reproductive health topics at future MAFP conferences. The MAFP will also advocate through the AAFP to the

Family Medicine Experience (FMX) Curriculum Advisory Panel (CAP) to increase the percentage of women's reproductive health topics at future FMX events and, via its delegation, submit a resolution to the AAFP calling on the AAFP to increase the representation of women's reproductive health topics among future AAFP CME events.

13. Preventing Gun Violence in Minnesota — The MAFP will support proposed legislation in Minnesota that requires the following: 1. Universal background checks and licensing restrictions for all gun sales, not just those purchased from a federally licensed gun dealer but including those sold at gun shows, at flea markets or purchased online; 2. Allows law enforcement and family members to keep guns out of the hands of individuals who are under protective orders and who are considered a danger to others, or themselves; 3. Renewing and strengthening bans on the sale of military-style assault firearms and high-capacity magazines; 4. Renewing and strengthening bans on the manufacture and sale of bump stocks, or other mechanisms that allow a semi-automatic firearm to fire like an automatic firearm. In addition, the MAFP delegation to the AAFP Congress of Delegates will continue to support the AAFP leadership's efforts to champion the federal re-authorization of research on the causes and impact of gun violence on the health and well-being of children and adults in this country.

14. Gun Violence — The MAFP will continue to work with the Minnesota Medical Association on its Call to Action on Gun Violence (March 2018) and join other professional and community organizations in educating and advocating to implement the Call to Action. The MAFP will also continue to speak out and advocate on this important public effort to protect our citizens.

15. Gun Violence Safety — This resolution was referred to the Board of Directors: The MAFP will commit to saving lives by supporting common sense gun violence prevention measures, including but not limited to: passing Universal Criminal Background Check and Gun Violence Protection Order bills; making state funds available for trauma-informed gun violence prevention programs; and supporting full epidemiologic research of gun-related data within the state of Minnesota for public health purposes. The MAFP will also commit to blocking attempts to weaken Minnesota's gun laws and stand opposed to gun bills, including but not limited to Stand Your Ground, Permitless Carry, Lifetime Permit to Carry, Campus Carry, and the repeal of gun-free school zones.

16. MAFP Bylaws Update — The MAFP Bylaws were amended to reflect some administrative changes and an updated board governance structure.

17. Access to Dental Care for All — The MAFP will work together with the state legislature and state dental associations to make dental care more universally available to the uninsured and underinsured as for those with insurance and the ability to pay for service. The MAFP will also assist the legislature and dental organizations with policy reform to improve access to dental providers by identifying barriers and subsequently proposing solutions.

18. Support Legislation in Minnesota that Protects Access to Contraception — The MAFP will support legislative action in Minnesota to require all insurers that cover prescription drugs to also provide coverage of FDA-approved prescription contraceptive drugs and devices. The MAFP will also advocate for and support access to no-cost birth control coverage in Minnesota.

19. Health Equity — The MAFP will establish a Minnesota Health Equity Task Force to work with our national colleagues and to collaborate with our local professional and community organizations to advance health equity in primary care and in our communities and that the MAFP will engage students, residents, practicing and retired family physicians to do the ongoing work of this task force for health equity. The MAFP will also offer Health Equity & Advocacy learning opportunities at our educational forums such as the Spring Refresher.

20. MAFP Support of Opiate Stewardship Program Established, Report Required and Money Appropriated — The MAFP will work to identify funding streams to support family physicians in addressing the opioid crisis.

21. MAFP to Join in Support of an Organization Working on Establishing Minnesota's First Breast Milk Bank — The MAFP will provide a letter of support to the organization Breast Milk for Babies (soon to be Minnesota Milk Bank for Babies), which is working on establishing a human breast milk bank in Minnesota.

22. Resolution to Fortify Immunization Administration in Minnesota — The MAFP will, in partnership with our primary care colleagues, work vigorously with our government officials in the executive and legislative branches in the state to fortify and strengthen the universality of childhood immunizations, including stricter state law and limitations on ability of parents and care-givers to decline childhood immunizations.

By Kimberly Becher, MD

JUMPING THROUGH HOOPS WASTES MY TIME, WORSENS OUTCOMES

Every day, I get denial notifications for tests or treatments I've ordered. I can't remember the last time an entire day passed without something I thought a patient needed being denied. Often, these are treatments that, if delayed, might result in bad outcomes or hospitalizations, the very things insurance companies say they want to avoid. But in my experience, and through conversations with other primary care physicians, it doesn't feel like the insurance companies are truly committed to avoiding emergency visits and hospital admissions.

It's hard enough to survive a day in a busy primary care office when the orders I place go smoothly. But my stress and frustration build to intolerable levels as each order I place bounces back due to insurance denial. I joke that sometimes I feel like I'm on that Ashton Kutcher show Punk'd because some of the denials for prior authorization requests are so ridiculous.

Even as I started to ponder writing this post, I heard pushback. People who don't practice medicine suggested that maybe I'm doing something wrong. Maybe I'm not using the right criteria for ordering tests, or maybe I'm using the wrong diagnosis codes. But every one of you in outpatient primary care knows this reality, and you likely have seen it increase in the past two months.

The concept of first-line treatment—that is, using the medication that is most appropriate for the patient, is solidly evidence-based and is most likely to treat a condition with the least adverse effects—is evidently not something insurance companies consider when crafting their formularies. No first-line treatment in well-established medical literature should require a prior authorization, and such treatments certainly should not be completely ruled out as options. Yet it happens every time a patient presents with an acute deep venous thrombosis or pulmonary embolism.

Last week, I ordered a six-month followup MRI to monitor growth of a known brain mass. The lab value associated with that mass was trending upward, the symptoms caused by the mass were worsening, and the plan from the entire team of doctors caring for this patient (family medicine, endocrinology, neurosurgery and ophthalmology) agreed on the six-month followup.

Denied. Appealed. Denied again.

Now the patient will have to first see one of the subspecialists, who will then order the MRI, which will hopefully then be approved. Then the patient will have to reschedule the followup visit with that subspecialist, instead of having the MRI data before seeing the whole team. Meanwhile, the patient becomes more debilitated.

Influenza has been terrible this year, and I have had the antiemetics ondansetron (Zofran) and promethazine (Phenergan) denied without a prior authorization. Diagnosis codes used: vomiting, dehydration and influenza.

The absurd prior authorization process has previously been featured in this blog, and it is by far one of the more frustrating and unproductive things we deal with as physicians. Typically, we get a prior authorization request, we submit all the information the insurance company requests, then the payer gets what, in my opinion, is an unacceptable window of time to think about its next move—somewhere between 24 hours and five days, depending on the company. This is how patients end up in the ER for IV fluids.

On Jan. 1 each year, many payers change their preferred inhaler, insulin and glucometer regimens for the year. That means that for

the first couple months of any calendar year, every inhaler I try to refill or glucometer supply I prescribe is rejected, often with no guidance from the payer as to what its new preferred option is. We play this game every year, and by April we might have it all figured out. It is a huge waste of time. It also causes significant lapses in patients' access to their medications and supplies. As a result, people completely run out of insulin and albuterol.

In West Virginia, we have only one payer participating in our health care exchange. If one of their customers comes to my office and has chest pain along with all the risk factors for coronary artery disease (high cholesterol, tobacco use, diabetes, high blood pressure, a strong family history of heart attacks in first-degree relatives at young ages), they will not be able to get a stress test. I have fought to get a stress test approved in every way imaginable. I have written letters, I have gone through the multiple prior authorization steps and even done the dreaded peer-to-peer phone calls where I literally plead my patient's case and need for a cardiac stress test.

Denied. I explain that these patients will end up dying of a heart attack without the appropriate testing at the appropriate time. Still denied.

This insurer will pay for the stress test if the patient is seen by cardiology—sometimes. I had one patient's stress test denied even when ordered by cardiology. These patients end up in the ER the next time they have a worsening episode of chest pain, some with elevated troponins and having the heart attack that we were trying to prevent months ago.

Opiates are a hot topic, especially here in West Virginia. One of the preferred options that payers will cover rather than topical lidocaine gel for pain is oxycodone. The rationale is because it's cheaper, not because it is safer and not because it is the right treatment for the patient.

I have had similar alternative treatment suggestions from insurance companies for chronic migraines. I had extended-release propranolol denied for migraine prophylaxis, but dilaudid was listed as preferred. That is nowhere near appropriate care for migraines.

I don't do inpatient medicine, so I can't speak firsthand to the denials or the process those physicians endure. But I can tell you my patients are often denied coverage for admissions. Patients are furious when they come in for their hospital followup appointments because they were notified in the hospital that their insurance had decided the stay wasn't covered. I see the documentation in the admission history and physical and cannot understand how the ICU isn't covered for conditions such as sepsis, heart failure exacerbations with elevated troponins and diabetic ketoacidosis. A physician colleague told me that one of her patients had an ICU stay denied because the patient improved so quickly that they were discharged in less than 72 hours, so surely, they had not actually been sick enough to warrant ICU-level care.

I want patients to know the truth. The denial letters insurance companies send often say things like, "This test was denied because your doctor failed to submit necessary information." In reality, I've sent every detail from the entire chart, all of which every physician would agree warrants approval. I want patients to know how hard we fight and how upset we become when what we think is in their best interest is denied by payers. These are burdens we feel, burdens that come home with us and cause some of us to eat too much ice cream after work. These are burdens that our spouses have to listen to us complain about night after night. I don't stop worrying about the patient when the insurance company throws a roadblock between them and what I think they need — I worry more. I worry about how much worse their problem will get when a diagnosis is delayed or a treatment isn't accessible. And I don't worry from a legal malpractice standpoint, I worry because our health care system is failing our patients, and it is driving good, compassionate doctors out of primary care. We can only carry so much, and payers have realized that they can push us to the breaking point with all the administrative hoop-jumping they have created.

I am not writing this because I have answers, I'm writing because I'm desperate for change. I'm tired of being angry all day. I'm tired of losing.

We all have the power to make change. We all have a duty to stand up, to dive in deep to make policy changes at whatever level is accessible to each of us individually. My state chapter recently utilized the AAFP's Speak Out tool to make it easier for us to email our state legislators about a prior authorization streamlining bill. The tool is often used for federal legislation, but it is sometimes aimed at state issues, as well.

Until more patients take up this cause with insurance companies themselves, it is up to us to raise awareness that they often aren't making the right choices for patients.

Kimberly Becher, MD, practices at a rural federally qualified health center in Clay County, West Virginia.

From AAFP: Fresh Perspectives: New Docs in Practice, March 2018, ©AAFP

By Patrick Lalley, MD
& Paula Lindhorst, MD

SYMPTOM MANAGEMENT IN PRIMARY PALLIATIVE CARE

How do you manage symptoms in a patient with a serious or life-threatening illness? Previous articles in this journal on the topic of palliative care have discussed the definition and need for palliative care, how to have the difficult conversations with patients and families and what tools and signs are helpful in determining prognosis. Family physicians are in the ideal position to identify and treat patients with serious illness, including the symptoms associated with these illnesses. This article will outline an approach to care with an emphasis on specific symptom management.

Let's begin with Mrs. J, an 86 y/o female who comes to her primary care provider (PCP) for a follow-up visit. She has severe chronic obstructive pulmonary disease (COPD) with bronchiectasis and a history of recurrent pulmonary emboli. She has been hospitalized for shortness of breath twice in the past six weeks and was seen last week in the urgent care center for similar symptoms. She is followed by primary care and pulmonary medicine and is currently receiving maximal therapy for her COPD, including bronchodilators, inhaled steroids, oxygen at night, and she recently completed a course of oral antibiotics without appreciable benefit. She lives at home with her husband, who also has significant health issues. She understands that her illness is getting worse but is not ready to "give up" and would like to get stronger and get back to exercising.

Using a disease model approach to this visit, her PCP might spend time trying to adjust her medications and treatments for her COPD with the goal of keeping her out of the hospital. In Mrs. J's case, however, there is not a lot to adjust. With a palliative care approach, the focus would be on her comfort—including physical, psychosocial and spiritual aspects, her wishes and goals of care, as well as ensuring that she is getting optimal care for her COPD. Effective symptom and comfort management is an important tool for building trusting relationships with patients and families, allowing the PCP to subsequently support them as they face difficult health care decisions.[1]

In review of the 2015 data for the leading causes of death in the United States, cancer deaths account for only 30% of the total. Most of these patients are managed by oncology at the end of life. For the other 70% of deaths, family medicine plays a central role in caring for these patients over the years of their serious chronic diseases, and primary palliative care is considered best practice of care for these patients near the end of life.

NUMBER OF DEATHS FOR LEADING CAUSES OF DEATH

- Heart disease: 633,842
- Cancer: 595,930
- Chronic lower respiratory diseases: 155,041
- Accidents (unintentional injuries): 146,571
- Stroke (cerebrovascular diseases): 140,323
- Alzheimer's disease: 110,561
- Diabetes: 79,535
- Influenza and pneumonia: 57,062
- Nephritis, nephrotic syndrome and nephrosis: 49,959
- Intentional self-harm (suicide): 44,193

Death Rates for the Leading Causes of Death: United States, 2015, www.cdc.gov.

Patients with serious illness commonly report a myriad of symptoms, including: pain, dyspnea, fatigue, irritability, dry mouth, lack of appetite, nausea, constipation, drowsiness, anxiety and depression. The Edmonton Symptom Assessment Scale (see page 17) is a validated tool that is easy to use and tracks symptoms over time, providing an objective assessment of a patient's comfort.[2]

BACK TO THE CASE

Mrs. J is asked about her current symptoms and she replies, "I am short of breath all the time and feel better when using my oxygen." She was off her oxygen for 40 minutes from her home to the office and her oxygen saturation is 80% on room air and improves to 96% with 2L nasal cannula. Her shortness of breath is worse when she is worried and stressed and better when she uses lorazepam 0.125 mg three times daily as needed. She also complains of being tired, and it takes a lot of energy and time to do her nebulizer treatments.

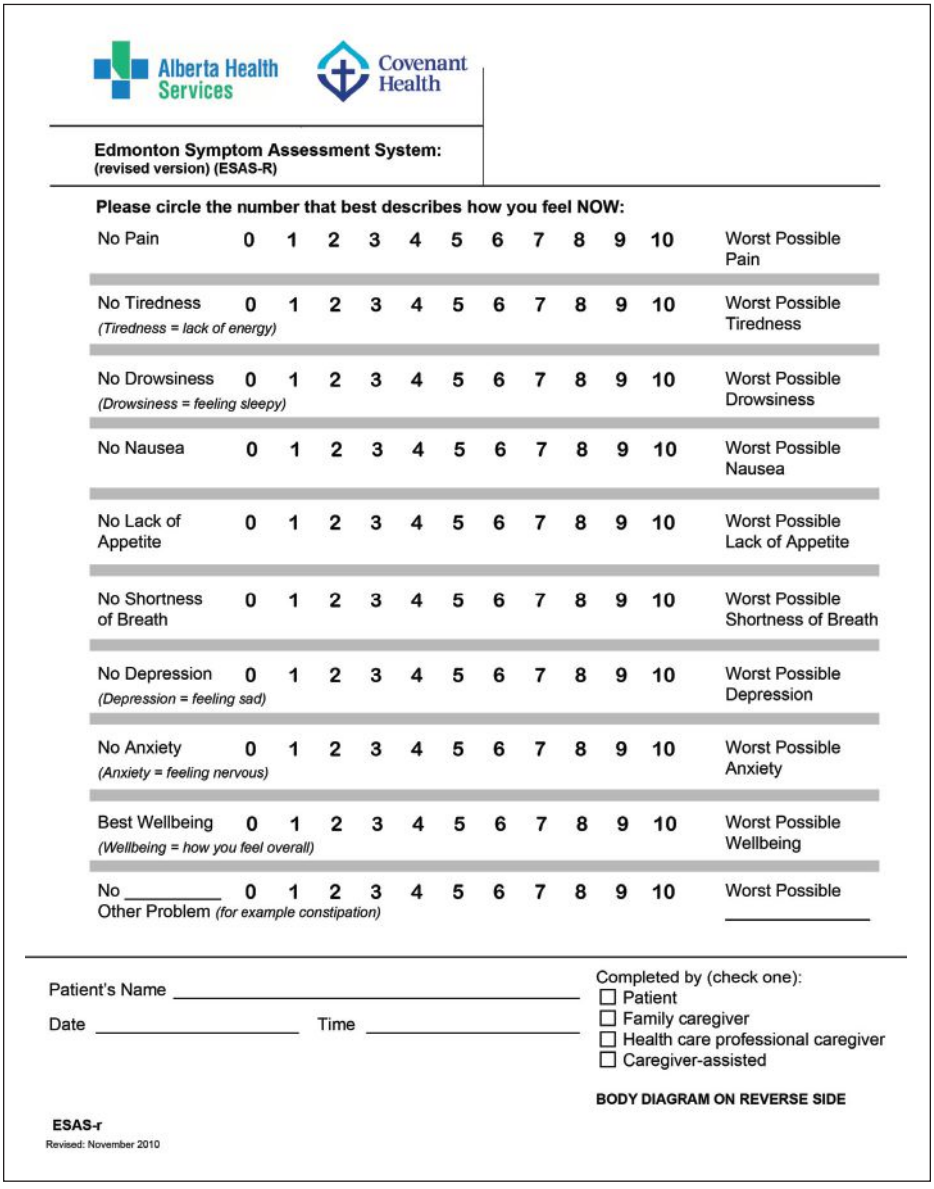
SHORTNESS OF BREATH – Fifty percent of patients with serious illness will complain of air hunger, shortness of breath,

and chest tightness. In advanced terminal cancer, dyspnea is associated with < 30-day survival.[3] The physiological mechanisms include a decrease in ventilatory capacity, an increase in ventilatory demand, a decrease in lung compliance or an increase in airway resistance. In evaluating a patient with dyspnea, think of the mechanisms and possible diagnoses, and then treat any reversible causes.

Non-pharmacologic interventions – Dyspnea is associated with anxiety, fear and panic; therefore, psychosocial evaluation is important. Management includes: relaxation techniques, psychosocial support, use of a fan or cool air on the face,[4] modification of activity, pulmonary rehabilitation and acupuncture.[5] Oxygen may be useful in hypoxemic patients, but there is no proven benefit in non-hypoxemic patients.[6] Noninvasive positive pressure ventilation (NPPV) may benefit patients with acute respiratory failure with acidosis, hypoxia with cardiopulmonary edema or chronic hypoventilation with neuromuscular disorders (e.g. amyotrophic lateral sclerosis). In dying patients, NPPV may reduce the work of breathing and conserve energy and reduce the dosing of opioids and their side effects. It can decrease air hunger associated with hypoxia and somnolence associated with hypercapnia. NPPV can be used to prolong life to meet short term goals.[7]

Pharmacological interventions – Opioids are first line therapy for shortness of breath after other treatments are opti-mized.[8] In contrast to pain symptoms, start with lower doses (1-2 mg of morphine every four hours as needed), and titrate slowly for effect. In clinical trials, this approach to opioid dosing has not been correlated with increased mortality.[9] The effectiveness of nebulized morphine has not been proven.[10] When starting opioids, it is always important to include a bowel program to treat the common side effect of constipation. A follow-up phone call within two days of starting a patient on opioids is beneficial in assessing for effectiveness and adverse reactions. Benzodiazepines can be used as second line therapy for shortness of breath, but use with caution when combining with opioids due to potential for increased sedation and respiratory depression.[11] Other medications that may be beneficial for shortness of breath include bronchodilators, diuretics and glucocorticoids.

FATIGUE – Fatigue is a subjective feeling of tiredness and a perception of decreased



Alberta Health Services | Covenant Health

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient's Name _____

Date _____ Time _____

Completed by (check one):
☐ Patient
☐ Family caregiver
☐ Health care professional caregiver
☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

ESAS-r
Revised: November 2010

1. Watanabe SM, Nekolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multi-centre comparison of two numerical versions of the Edmonton Symptom Assessment System in palliative care patients J Pain Symptom Manage 2011; 41:456-468.
2. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991; 7:6-9

capacity for physical and mental work. It is highly prevalent in end stage cancer, heart failure and COPD. It is multifactorial due to pain, sleep issues, anemia, dyspnea, depression or medication side effects. As with dyspnea, treatments should be directed toward correcting reversible causes. Based on limited evidence, a 2014 Cochrane Review does not recommend a specific drug for the treatment of fatigue in palliative care patients.[12] Several medications have been used with some success, including: glucocorticoids (dexamethasone starting dose 2-4 mg per day), methamphetamines (methylphenidate 2.5-5 mg at 8 am and noon), megestrol acetate, testosterone for hypogonadism, and complementary therapies (American ginseng 2000 mg/day).[13] Non-pharmacological approaches include energy conservation strategies, moderate exercise, yoga, sleep hygiene, cognitive behavioral therapy and mindfulness-based stress reduction.

CASE STUDY CONCLUSION

Summary of Mrs. J's visit – 86 y/o with chronic respiratory failure and recently increasing symptoms. Her goals are to continue to pursue treatment for her lung condition, which includes going to the hospital and emergency room if needed. With a focus on her symptoms of shortness of breath and fatigue, and a plan to manage her better at home, the following suggestions are made: more frequent levalbuterol nebulizer/inhaler use every four hours as needed, a trial of morphine (liquid 10mg/5 ml for ease of dose titration and administration) 1-2 mg every 4 hours as needed for shortness of breath, and continue use of low dose lorazepam for anxiety related shortness of breath. Because of Mrs. J's wish to resume exercising, arrange pulmonary rehabilitation and schedule a home oxygen evaluation for daytime oxygen use. Arrange for a nurse call back in two days to check on her response to the morphine and schedule a routine follow-up visit in one month.

A palliative approach in primary care can improve the comfort and quality of life for patients and families dealing with serious illness. It is imperative to address the symptom issues initially to relieve suffering and gain trust. The other tasks of discussing goals and directives and wishes and fears for these patients will then become easier even in a single office visit.

RESOURCES

1. www.mypcnow.org/fast-facts – Palliative Care Network of Wisconsin—includes 350+ practical, concise, point-of-care, regularly updated topics. Free app for iPhone & Android.
2. www.aahpm.org – American Academy of Hospice and Palliative Medicine pocket-size Primer of Palliative Care, 6th edition 2014.

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3. Maltoni M, Pirovano M, Scarpi E, et al. Prediction of survival of patients terminally ill with cancer: Results of an Italian prospective multicentric study. Cancer. 1995; 75(10):2613-2622.
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13. Barton DL, Liu H, Dakhil SR, et al. Wisconsin Ginseng (Panax quinquefolius) to improve cancer-related fatigue: A randomized, double-blind trial, N07C2. J Nat Cancer Inst. 2013; 105(16):1230-1238.

ADDITIONAL RESOURCES

- Dudgeon D, Shadd J. Assessment and management of dyspnea in palliative care. UpToDate, 1/11/2018.
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- Bruera E, Yennurajalingam S. Palliative care: Overview of fatigue, weakness, and asthenia. UpToDate, 9/14/2017.
- Oechsle K, Goerth K, Bokemeyer C, Mehnert A. Symptom burden in palliative care patients: Perspectives of patients, their family caregivers, and their attending physicians. Support Care Cancer. 2013; 21(7):1955-1962.

SPRING REFRESHER

COMING UP NEXT

Welcome to Minnesota: An Event for Incoming First-year Residents
June 24, 2018 1:00 – 3:00 pm
Science Museum of Minnesota,
St. Paul, MN

AAFP Family Centered Maternity Care Conference
July 25 – 28, 2018
Minneapolis Marriott City Center,
Minneapolis, MN

National Conference of Family Medicine Residents & Medical Students
August 2 - 4, 2018
Kansas City Convention Center,
Kansas City, MO

MAFP Destination CME
Friday & Saturday,
August 17 - 18, 2018
The Inn on Lake Superior, Duluth, MN

Made for Medical Students: Family Medicine Resident Experience
September 15, 2018
9:00 AM – 2:00 PM
Pinstripes, Edina, MN

AAFP Congress of Delegates
October 7 – 10, 2018
Ernest N. Morial Convention Center,
New Orleans, LA

AAFP FMX
October 9 - 11, 2018
Ernest N. Morial Convention Center,
New Orleans, LA

Virtual KSA – Coronary Artery Disease
October 28, 2018 5:00 PM
Your home or office
This is a virtual, ABFM-approved, Knowledge Self-Assessment (KSA) session

Family Medicine Midwest Conference
November 9 - 11, 2018
University of Wisconsin,
Madison, WI

RESILIENCE THROUGH PROFESSIONAL DEVELOPMENT

Dr. Peter Meyers Shares His Experience as a Visiting Scholar to the Robert Graham Center

HOW DID YOU FIRST GET INVOLVED WITH THE ORGANIZATION?

I had followed the work of the Robert Graham Center (RGC) for several years and had heard the director, Andrew Bazemore, speak at several conferences while I was in medical school. I didn't realize the RGC had a visiting scholars program, however, until I had already started residency. I submitted an application for the Larry A. Green Visiting Scholars Program in August 2016 (during my PGY-2 year). In March or April of 2017, I was notified that I had received a spot in the rotating program. Then I completed my month as a visiting scholar in January 2018.

WHAT WAS YOUR FIRST IMPRESSION?

The staff at the RGC are incredibly supportive, welcoming and approachable. They love working with students and residents.

WHAT SURPRISED YOU MOST?

I am an admirer of the work produced by the RGC, so I was surprised to discover that the staff is mainly comprised of 10 (or so) employees. They work very hard and efficiently with their time (and their resources).

WHAT TYPES OF PROJECTS DID YOU WORK ON?

My main project focused on the rates at which graduates from Teaching Health Centers (THCs) enter medically underserved areas after residency. We used existing databases at the RGC to map allopathic (and some osteopathic) graduates from THCs to geographic regions of the country using multiple markers for determining the degree to which a region was medically underserved. Our plan was to use that data to inform advocacy efforts from the Society of Teachers of Family Medicine (STFM) and the American Academy of Family Physicians to stabilize or increase funding for THCs. Ultimately, additional funding was included in the February 2018 omnibus budget bill before I could complete the final paper (great!). This

Peter Meyers, MD, MPH & Vivian Jiang, MD

funding question will undoubtedly arise again, so we are keeping our work moving forward for the next round of budget negotiations in 2020. It has been an interesting project that happens to combine several interest areas of mine (primary care workforce development, underserved medicine, legislative advocacy), so I am very grateful for the opportunity to work with the RGC and the STFM.

WHAT DID YOU FIND MOST CHALLENGING?

I really enjoyed my time with the RGC. I felt like I hit my stride about three weeks into the month and then had to head home, just as I was getting comfortable. Transitioning back to residency was a bit challenging. I missed having the time to dive into interesting non-clinical topics and the direct support from economists, statisticians and clinician-investigators to pursue that work. That said, I started to miss my clinical practice towards the end (not to mention my family!).

WHAT ADVICE DO YOU HAVE FOR OTHERS WANTING TO EXPLORE THIS TYPE OF PROFESSIONAL DEVELOPMENT?

Go for it! The future (and present) of our profession *needs* more of us to speak out and advocate for our patients and our colleagues. When interviewing residency programs, ask questions about how the program supports residents and see if any former residents have pursued these types of experiences. There are lots of ways to enhance your education outside the clinic during and after residency. If you're interested in health policy or advocacy opportunities, email me! I'd be happy to talk about some of the options I've come across.

Peter Meyers, MD, MPH, is completing his residency at United Family Medicine and will begin practice at East Side Family Clinic in St. Paul.

2018 INNOVATION & RESEARCH FORUM – SATURDAY, MARCH 3

106 Medical students, residents, physicians and researchers took part

24 Podium Presentations

24 Posters

6 Sponsors

- Department of Family Medicine Mayo Clinic Rochester
- Department of Family Medicine and Community Health, University of Minnesota
- HealthPartners
- Park Nicollet Foundation/University of Minnesota Methodist Hospital Family Medicine Residency Program
- UCare
- United Family Medicine Residency Program — Allina Health

1 Opening presentation by Innovation & Research Award Recipient Michele Allen, MD, on *Patients, Clinics, Communities and Beyond: Engagement within Population Health Research for Equity*

Today — Do More of What You Love

At Mercy Clinic, we span across four states with a team of more than 2,100 Mercy primary care and specialty care physicians, and 600 advanced practitioners. Mercy was named one of the top five largest U.S. Health Systems in 2017 by Truven, an IBM Watson Health Company and we serve millions annually. Mercy includes 44 acute care and specialty (heart, children's, orthopedic, and rehab) hospitals, more than 700 physicians and outpatient facilities, more than 40,000 co-workers and more than 2,000 Mercy Clinic physicians in Arkansas, Kansas, Missouri, and Oklahoma. Mercy also has outreach ministries in Louisiana, Mississippi, and Texas.

Go to http://www.mercy.net/careers to search for your specialty opportunities.

Mercy

Family Medicine Opportunities:

To find out about physician and Advance Practitioner openings across the Mercy System, please contact:

Joan Humphries, Director of Physician Recruitment (East)
Joan.Humphries@mercy.net | 314-364-3821
SE Missouri & Columbia, Illinois

Arnold	Barnhart	DeSoto	Farmington
Fenton	Festus	Gerald	Hazelwood
Highridge	Hillsboro	Imperial	O'Fallen
Potosi	St. Clair	St. Louis South County	
St. Louis West County		Warrenton	Columbia, IL

Jessica Williams, Director of Physicain Recruitment (West)
Jessica.Williams@mercy.net | 405-752-3334
Oklahoma

Ada	Ardmore	Edmond	El Reno
Guthrie	Healdton	Holdenville	Moore
Norman	Oklahoma City	S. OKC	

Tammy D. Hager, Director of Physician Recruitment (Central)
Tammy.Hager@mercy.net | 417-820-6650
SW Missouri – Fort Smith & Rogers, Arkansas

Fort Smith, AR	Rogers, AR	Branson, MO
Joplin, MO	Lebanon, MO	Rolla, MO
Springfield, MO		

MAFP FOUNDATION NOW FUNDED THROUGH ANNUAL GIFT, INDIVIDUAL DONATIONS AND MATCHING GRANT

The Minnesota Academy of Family Physicians (MAFP) Foundation is now funded through an annual gift of $25K, individual donations and a matching grant of up to $20K. Previously, the Foundation was supported through a dues allocation.

This change in funding means individual member donations are critical to the Foundation's ability to carry out its mission: supporting educational and scientific initiatives that improve the health of *all* Minnesotans.

WHY THE CHANGE IN FUNDING?

In 2015, the MAFP approved a three-year strategic plan. The plan included a goal to develop a comprehensive, coordinated fundraising and charitable contributions strategy to support the work of the MAFP Foundation. This strategy was designed to help the Foundation become financially self-sustaining.

Members of both the Academy and Foundation boards, as well as the finance committee, determined this change in funding would better move the Foundation in that direction.

"Some unintended challenges that the dues allocation created included some members not being aware of the donation to the Foundation and other members not considering a donation because it was automatically done for them. At the same time, the Foundation is incorporated into all the programs the Academy offers, which has reduced the Foundation's operating expenses by more than 50%," said Maria Huntley, CAE, MAM, Executive Vice President of the MAFP.

WHEN WAS THE CHANGE PUT INTO EFFECT?

This funding change went into effect on July 1, 2017.

WHY SUPPORT THE FOUNDATION?

Donations to the MAFP Foundation, the philanthropic arm of MAFP, support the future of family medicine.

When you donate to the Foundation, you are helping fund:

- Family medicine research and innovation led by resident and medical student leaders.
- Programs that support family physicians and the patients they serve.
- Leadership development opportunities for family physicians.

Huntley said, "Past funding has not only supported the development of new and future family docs, it has also had a profound impact on Minnesota communities and patients."

HOW CAN YOU DONATE?

The MAFP Foundation is a registered 501(c)3 organization. Donations are 100% tax deductible. You can donate online, safely and securely, at mafp.org/give. To make an offline donation, contact Lynn Balfour, MBA, Deputy Executive Vice President of the MAFP, at lynn@mafp.org, 952-224-3872.

FIRST PRESIDENTIAL GIFT RECEIVED

We're excited to recognize David Bucher, MD, FAAFP, Immediate Past President of the MAFP, for his steadfast commitment to the MAFP Foundation and its programs that serve student and resident members of the Academy. Recently, Dr. Bucher donated a portion of his presidential honorarium to the MAFP Foundation. Through his leadership, he "walks the talk" and demonstrates the importance of supporting our Foundation throughout the year. Thank you, Dr. Bucher, for your financial support that makes a difference to future family physicians.

I enjoy the work that I do with our young learners—both medical students and residents—and want to help support them in their training experiences. There is a large group of my peers and our colleagues who are nearing retirement, and I wonder, "Who is coming along to take our place; Who will provide the great quality primary care for the next generation of our country's citizens?" The MAFP Foundation provides a tangible way to support the "pipeline" to family medicine in Minnesota, with grants and financial support to allow students and residents to be curious, and explore their social and research interests as well as stimulate their excitement for family medicine. That's why I give to the MAFP Foundation.

– **David Bucher, MD, FAAFP,** MAFP Immediate-Past President, United Family Medicine

It is such a joy to see the students or residents who were reached through your efforts doing creative work and innovative research. I was able to mentor and sponsor two students this year and seeing their completed work at the Innovation and Research Forum reflected the potential of future generations of health care professionals. My giving is just not a donation; it is a small effort towards making a big difference.

– **Roli Dwivedi, MD**, Medical Director & Assistant Professor, University of Minnesota/Community-University Health Care Center

I happily contribute to the Minnesota Academy of Family Physicians Foundation because of its mission to raise funds and award research and innovation grants to Minnesota's future family physicians, especially Minnesota medical students who are interested in family medicine.

– **David Mersy, MD**, Life Member

WHY I GIVE | WHAT WE'RE WORKING ON

Social determinants of health, including structural racism, significantly impact patient wellbeing and our work as family physicians. This is especially evident in the disparate maternal mortality and birth outcomes of Black patients compared to their White counterparts. Our project seeks to understand how police violence impacts the reproductive health choices of Black women. Our multidisciplinary team is taking a qualitative approach this work through focus groups held in the North Minneapolis community.

– **Anne Doering, MD** & **Lonzale Ramsey, Jr, MD**
UM – North Memorial Family Medicine Residency

Churches United in Ministry (CHUM) is a homeless shelter in downtown Duluth that has welcomed Duluth Family Medicine Residents to provide on-site primary care. Our efforts to connect patrons of CHUM to a lasting medical home begins by forming human relationships and providing simple necessities like hygiene products and clothing. The MAFP endorsed these efforts by sponsoring our "Sock Exchange," which has streamlined the delivery of clean socks to the patrons of our on-site health office.

– **Jesse Susa, MD**
UM – Duluth Family Medicine Residency

I worked on a research project with the purpose of identifying major barriers faced by East African women in the Twin Cities regarding early screening for cervical cancer, more specifically the pap test. And gaining an understanding of their knowledge about the importance of cervical cancer screening. We plan to use the findings to develop culturally tailored educational materials that will seek to mitigate these barriers.

– **Dureeti Foge, MS 3**, UM – Twin Cities

University of Minnesota medical students take part in the Polar Plunge. Photo credit: Nick Cooper, Townsquare Media Duluth.

IN THE NEWS

Duluth student members participated in the annual Polar Plunge hosted by Mix 180. Their 17-member team of students and medical school staff and faculty raised over $2,500.

HCMC Family Medicine Residency has successfully completed its first year of Group Well Baby Care, completing 48 group medical visits encompassing 222 well child checks, and celebrated first birthdays for babies whose moms went through their Centering Pregnancy groups for their prenatal care.

Dr. Jay-Sheree Allen has been presented the Barbara Bush Distinguished Fellowship Award by the Mayo Clinic School of Graduate Medical Education. This award is based on the qualities associated with the founders, Drs. William and Charles W. Mayo, including outstanding clinical performance and scholarly activity, with a particular emphasis on humanitarianism. It is named in honor of the contributions of Mrs. Barbara Bush, former First Lady of the United States and former trustee of Mayo Clinic. Dr. Allen was recognized for her contributions to the health of individuals and communities both locally and internationally through her volunteer work among underserved communities at Center Clinic in Dodge Center and in Apam and Accra, Ghana, as well as her prospective commitment as a National Health Service Corps scholar.

Renée Crichlow, MD, FAAFP, MAFP President-Elect, was featured by the American Academy of Family Physicians for her work encouraging the next generation of doctors. Through her efforts with the STFM Emerging Leaders Fellowship and The Ladder, a leadership program with a tiered mentorship model for young people interested in health careers.

LEADERSHIP NOTES

The MAFP elected new officers at the Annual Meeting on April 11, 2018. The 2018–2019 officers include:

- President-Elect **Renée Crichlow, MD, FAAFP**
- Speaker **Andrew Slattengren, DO**
- Vice Speaker **Deborah Dittberner, MD**
- Officer-at-Large **David Goodman, MD**
- AAFP Delegate **Daron Gersch, MD, FAAFP**
- AAFP Alternate Delegate **Renée Crichlow, MD, FAAFP**

Elected at last year's House of Delegates President **Glenn Nemec, MD,** was installed as President on April 12, 2018.

Resident & Student Leaders include:

- Resident Director **Alexandra Gits, MD**
- Resident Alternate Director **Benjamin Meyerink, MD**
- Student Director **Christopher Hughes**, University of Minnesota Twin Cities
- Student Alternate Director **Emily Sirek** University of Minnesota Duluth
- Student Alternate Director **Nathan Rockey**, Mayo Clinic School of Medicine

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

DEGREE OF FELLOW

Two members received the AAFP Degree of Fellow on April 12: **Jennifer Pecina, MD, FAAFP,** of Rochester, and **Jon Hallberg, MD, FAAFP,** of Minneapolis. 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.

2018 AWARD RECIPIENTS

- Educator of the Year **Robert Levy, MD,** of Minneapolis
- Family Medicine Resident of the Year **Lauren Williams, MD,** of Minneapolis
- Medical Student Leadership Award **Paul Stadem** of Eden Prairie
- Innovation & Research Award **Michele Allen, MD,** of Minneapolis

11 members attended the AAFP National Conference of Constituency Leaders and the Annual Chapter Leadership Forum in April 26 Kansas City, MO. ACLF **Glenn Nemec, MD**; **Renée Crichlow, MD, FAAFP**; **Maria Huntley, CAE, MAM,** and **Jami Burbidge, MAM**. NCCL — **Betsy Gilbertson, MD**; **Amanda Meegan, DO**; **Kristina Lelcu, MD**; **Shanda Dorff, MD, FAAFP**; **Nicole Chaisson, MD, MPH**; and **Lauren Williams, MD**.

NEW TO THE LAND OF 3,100 FAMILY DOCS

Laura Huggins, MD, Glenwood, and **Adam Van Dijk, MD**, Wayzata, have transferred from Colorado.
Jared Szymanski, DO, Minneapolis, has transferred from Florida.
Yasser Chebli, MD, Blaine, and **Fardows Salim, MD**, Edina, have transferred from Illinois.
Rachel Agneberg, DO, Minnetonka, and **Elizabeth Siitari, MD**, Northfield, have transferred from Iowa.
Jessica Whelan, MD, St. Paul, and **Mark Steffen, MD, MPH**, St. Paul, have transferred from Kentucky.
Martha Ording, MD, St. Paul, has transferred from Michigan.
Danielle Wang, MD, St. Paul, has transferred from Montana.
Daniel Wheeler, MD, Bemidji, has transferred from New Jersey.
Aimee Pearce, MD, Minneapolis, has transferred from New York.
Karin Lokensgard Pierce, MD, Grand Forks, ND, and **Promil Bhutani, MD**, East Grand Forks, have transferred from North Dakota.
Maleeha Faisal, MBBS, Blaine, has transferred from Ohio.
Heidi Malling, MD, Pillager, has transferred from Oklahoma.
Carl Rasmussen, MD, Sisseton, SD, has transferred from Oregon.
Zachary Taylor, MD, Minneapolis, has transferred from Texas.
Chelsea Mann, MD, Bigfork, **Andrew Mayo, MD**, Stillwater, and **Frances Truitt, MD**, Rochester, have transferred from Wisconsin.

NEW RESIDENT MEMBERS

Courtney Black, MD, Minot, ND
Adrianne Chesser, MD, St. Paul
Kelsey Finn, DO, Minneapolis
Kayla Harris, DO, St. Paul
Daniel Johnson, DO, Rogers
Daniel Olson, MD, Mankato
Rebecca Siffring, MD, St. Louis Park
Lucas Boyle, MD, Minneapolis
Joshua Ostrue, DO, St. Peter
Eric Valder, DO, Mankato

NEW STUDENT MEMBERS

MAYO MEDICAL SCHOOL
Kylie Andersen, Rochester
Merit George, Medford, NY
Mykhaylo Krushelnytskyy, Rochester
Gohar Manzar, PhD, Rochester
Amanda Porter, Rochester
Nathan Rockey, Rochester
David Rollins, Rochester
Aradhana Sahoo, Rochester
Sarah Tawfic, Rochester
Rachel Weigel, Chanhassen
Timothy Xu, Rochester

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
Asma Adam, Fridley
Anya Dmytrenko, Minneapolis
Margaret Flint, Minneapolis
Jane Goodson, St. Paul
Jiaochen Ke, Minneapolis
Luis Ortega, BS, Brooklyn Park

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL DULUTH
Jill Golobich, Hibbing
Henry Lossen, Winona
Dakota Lundstrom, Embarrass
Nicholas Reiners, Cambridge

IN MEMORIAM

Francis Joseph Boyle, MD, Springfield
Steven P. Kulenkamp, MD, St. Paul

MAKING A DIFFERENCE IN ROCHESTER MINNESOTA

Jay-Sheree Allen, MD, is one of many family medicine residents at Mayo Family Medicine Residency Program who volunteer at The Center Clinic, which provides low cost family planning services to low income, uninsured and underinsured women and their partners in Dodge County Minnesota.

Recently, Dr. Allen received an innovation grant from the MAFP Foundation to fund a new initiative at The Center Clinic aimed at increasing the screening, addressing risk factors and reinforcing prevention of HIV. Dr. Allen took time to talk with us about this important patient project in the Rochester community.

What impact has this project had on the patients at The Center Clinic?
As of April 2018, this project reached 75 patients and of those 40 patients have been tested for HIV and another ten indicated that they would like the test done at a later date. Twenty-five patients declined the HIV test because they were being tested elsewhere or feeling they did not need to be tested. We're excited about these early findings because, in 2016, only six patients were tested for HIV at The Center Clinic. This project is already making a difference.

What did you learn from patients who completed the patient survey?
Interestingly, patients shared that the most common HIV risk factors were multiple partners and inconsistent condom use but, while most patients are aware of the risk factors, they unfortunately do not regularly use protection.

What advice do you have for other family medicine residents about taking on an extra project like this?
It can be difficult with our exhaustive clinic duties in residency but I would still encourage my peers to not ignore a healthcare gap in the community if they are reasonably able to contribute. I'm grateful to the MAFP Foundation for supporting this project.

MEET DULUTH'S STUDENT INNOVATORS

What do students at the University of Minnesota Medical School –Duluth Campus, Lake County Ambulance Service and Lake County Public Health have in common? Community paramedicine of course! Leif Olson, Natasha Gallett and Logan Smestad received a grant from the MAFP Foundation for their project titled "Physician, Emergency Medical Service (EMS) and Community Perceptions in Rural Community Paramedicine Program Planning." Dr. Emily Onello was their mentor.

This student-led collaborative project focused on surveying more than 250 community stakeholders to solicit input into planning a community paramedicine program. Olson was not surprised to learn that physicians and EMSs are equally concerned with finding the right solutions to most effectively address the needs of patients and an openness to developing new services that reduce barriers to care.

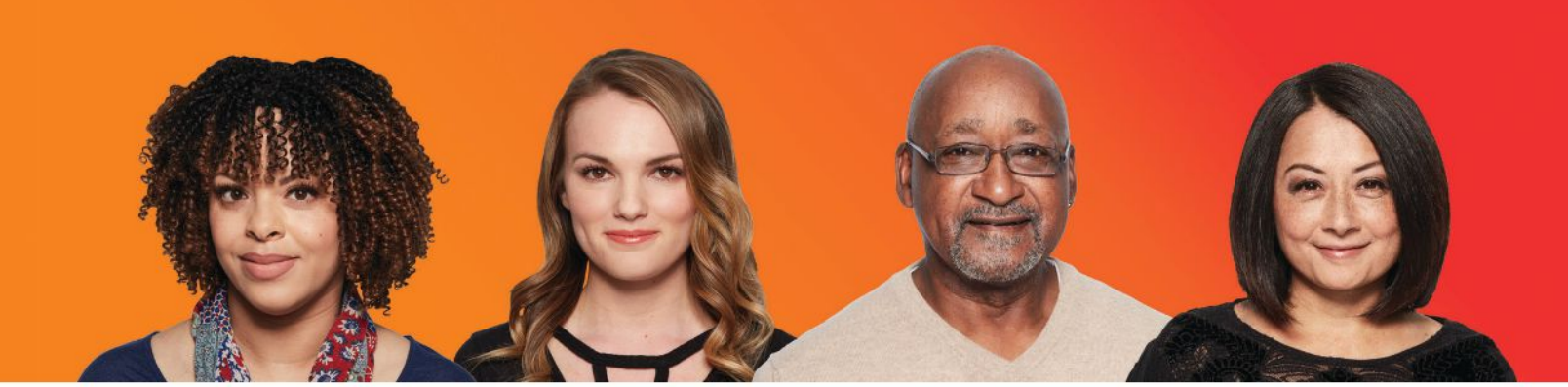
We asked Gallett how medical students should approach extra-curricular activities like this project and she said, "In managing my curiosity and appetite for scientific inquiry, I've learned to work closely with mentors and be especially selective before pursuing any of the numerous available, compelling, experiential learning to become the individual family physicians we want to be. As young medical students, we have ambition and passion for diverse topics that are shaped by many of our pre-medical school lives."

The MAFP Foundation was proud to fund this student innovation project aimed at improving care for rural Minnesotans.

UPCOMING GRANT APPLICATION DEADLINES

Medical students, family medicine residents and practicing family physicians are invited to apply for a grant. Grants are a member benefit offered exclusively to members of the MAFP. Grants are funded by charitable gifts to the MAFP Foundation.

September 1, 2018 • December 1, 2018 • May 1, 2019



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