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MFP

MINNESOTA FAMILY PHYSICIAN

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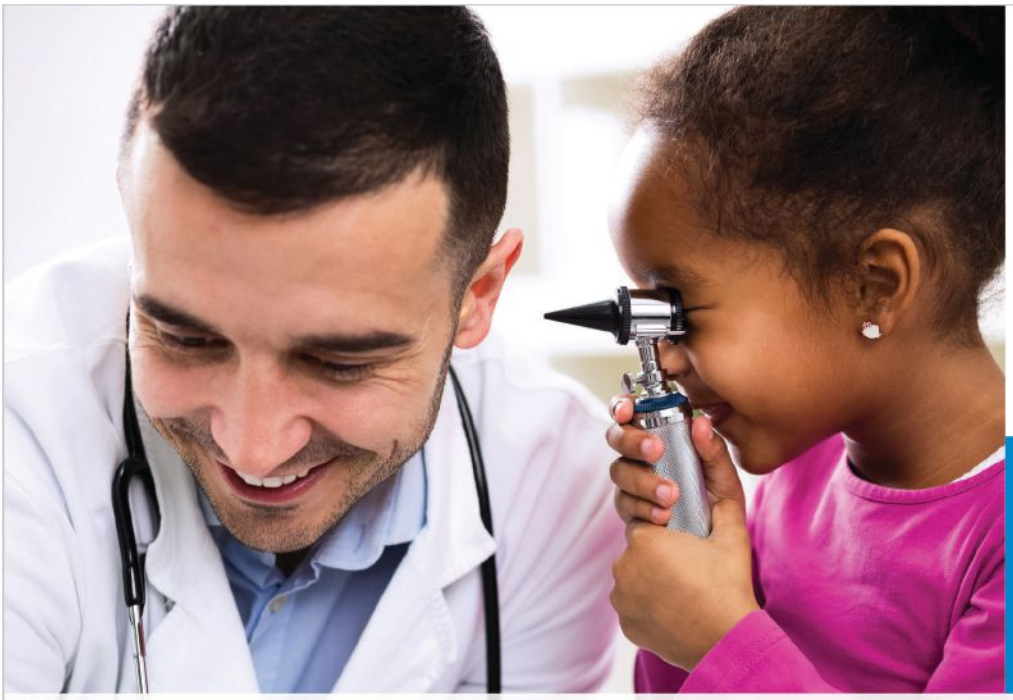

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10 lucky residents received $1,000 scholarships provided by the Arden Anderson Scholarship Fund at the Welcome to Minnesota event on June 24 at the Science Museum of Minnesota.

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MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

By Glenn Nemec, MD, MAFP President

ISLAND LIFE

In our last issue, I wrote about the "Family Medicine Difference"—how we are trained differently than any other specialty and how that difference produces better overall patient results for less money. Keep preaching that message. Our patients need us to do that. But we also need to think about ourselves, which is a skill that many of us are not so good at. As family medicine physicians, we are often "out there on an island;" not only with respect to our different training (which is not well understood by medicine in general), but also with respect to our location (how many nephrologists live and practice in Paynesville?) and our daily routine (how many of us still frequent the doctors' lounge at the hospital?).

Islands can be beautiful places, but they can get a little isolated, too. We need to remember and appreciate the value of reconnecting with our family medicine colleagues. This brings me to the MAFP Spring Refresher and the Destination CME event. Over the past few years, we have seen declining attendance, which was expected given the CME offerings that are so readily available on the internet. I want to encourage each of you to "get off the island" at least once a year and attend one or both of these events—not just because it's great CME designed and often delivered by your own colleagues (who DO understand that we are "different"), but because of the value these events bring in just being around, talking to and sharing with other family medicine docs who "get it."

Think of attending these events as another part of improving your personal resilience and preventing burnout. I understand that there is expense and time and travel involved, but there is real therapeutic value in connections with family medicine colleagues. (And if you do not come away from one of these events re-energized for our specialty and our work, then you really should be taking one of those burnout questionnaires and thinking about getting some structured help.) You might even get motivated to become active in one of the many specialty-wide issues that the MAFP or AAFP are working on. There are few things better for burnout than contributing to the improvement of your profession and, in doing so, you will help raise the visibility of what we do to the people who can help us make it easier to help our patients.

You are not Tom Hanks, "stuck" on your island. But if you find yourself having conversations with "Wilson," it's time to build your raft and set sail for Minneapolis for the Spring Refresher conference in March. I look forward to the opportunity to interact with you and hope we can fan each other's flames for our practice of family medicine.

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 MAFP at 952-224-3875 or Lisa Regehr, lisa@mafp.org.

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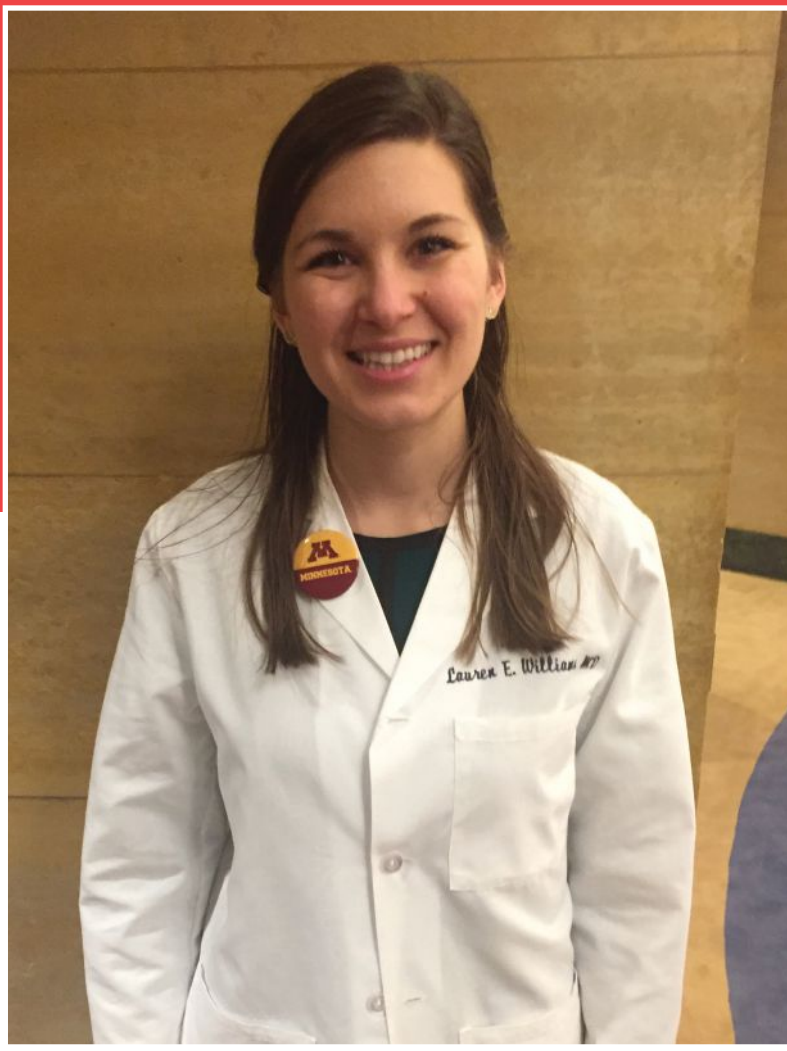
LEARNING TO LEAD

New-to-Practice Physician Lauren Williams, MD, Talks to MAFP Director of Advocacy & Engagement Jami Burbidge about her Leadership Journey.



WHAT DOES LEADERSHIP MEAN TO YOU?

This is a great question. Leadership has looked very different for me at different times of my life and is actually quite difficult for me to define. I have consistently been told of—and recognized—the importance of leadership in personal growth and affecting positive change in my community. Initially, for me, this meant diving in and taking on specific titles or positions that identified me as a "leader": team captain, chapter president, small group leader, board member, etc. Though I grew personally and was able to accomplish certain tasks within each of these roles, I still found myself unsure of what leadership truly meant.

Fortunately, I have been able to learn from many mentors and colleagues who have modeled excellent leadership. Many of the individuals whom I have seen lead most effectively first step back rather than immediately diving in. By gaining an understanding of the assets, challenges and overall trajectory of the organization or group, they develop a comprehensive vision for how to move forward with intention and clear direction. Often, this means harnessing others' unique abilities and placing them in positions where they can most effectively work towards shared goals.

Leadership is about influence. At times, this means charging ahead at the front of the pack, but it can also mean providing gentle encouragement from the background. Leadership, as I see it now, is not a static role; rather, it's a process of cultivating an environment in which those around you within your community are able to thrive and become the best versions of themselves. As time goes on, I am sure that my understanding of leadership will continue to evolve, and I look forward to continuing to learn from the many examples and mentors around me.

HOW AND WHERE HAVE YOU FOUND OPPORTUNITIES TO LEAD?

As I alluded to above, I think any community that one is a part of is an opportunity to lead and cultivate a positive environment. I have tried to pay close attention and keep this mindset within my residency, North Minneapolis, and the broader community of family medicine and healthcare in our state and country. I have been fortunate to connect with opportunities on each of those levels, both in traditional leadership roles and through more abstract participation and engagement. I fortunately was connected with the MAFP early in my residency and found opportunities there to participate as the resident representative to the MAFP board, the MMA policy council and multiple AAFP commissions. Through these roles, I have seen how intertwined the roles of physician and advocate truly are and have come to appreciate the role of organized medicine in supporting physicians and our patients in the midst of major changes in medicine and the healthcare system. I was also able to gain a better understanding of residency education as chief resident in our program, a role that pushed me to understand how I could best help support the incredible, passionate energy of my colleagues and allow them to truly thrive within the program. Each of these experiences has been an incredible avenue for growth, self-discovery and development of my own resiliency, and I am so grateful to have been a part of them.

HOW DID YOU FIT THESE ACTIVITIES IN DURING YOUR RESIDENCY?

My program was, fortunately, very supportive in giving me the flexibility and time needed to participate. One of my colleagues, Alex Gits (also the current MAFP resident director!), created an advocacy elective in which I was able to participate, using that time to attend conferences and meetings over the last year. While it has been a significant time commitment with both local meetings and national travel, the activities have given me great perspective into the healthcare system and learning opportunities that I would not have had access to otherwise. I also had the chance to connect with exceptional mentors and colleagues from around the country who shared their passion for family medicine and fostered my resiliency and enthusiasm for the specialty.

WHERE DO YOU GO FROM HERE?

First, I'm going on vacation. Come September, I will be joining North Clinic in Maple Grove practicing outpatient family medicine and OB. I plan to continue my involvement in the MAFP through working with Dr. Jeremy Springer and Jami Burbidge to co-chair the legislative committee. Thinking long-term, my biggest goals are to continue to support my family medicine community and to advocate for an equitable healthcare system for all. What exactly this will look like, I have no idea, but I look forward to finding out.

WHAT ADVICE DO YOU OFFER OTHERS LOOKING FOR WAYS TO LEAD?

Start where you are! Family medicine doctors are all leaders in our own ways and our role as a physician carries more weight than many of us realize. Be grateful for this privilege and use it well. Look around at your sphere of influence and consider a vision for what you would like to see happen in the community around you. From there, be open to any opportunities to connect with and learn from those around you and find how your unique talents can play a role. Don't be afraid to try something new, push yourself, and HAVE FUN! If you're not enjoying yourself, it is easy to feel discouraged, but maintaining a positive outlook even in the face of major challenges will take you far.

FROM VOLUNTEER TO FAMILY DOCTOR TO ADVOCATE

Alice Mann, MD, MPH, Is Running for the Minnesota House of Representatives

By Emie Buege, Freelance Writer

Alice Mann, MD, MPH, says that volunteering has made her a better doctor—more compassionate and patient. Volunteering is also what led her down the path to becoming a family physician.

During a college mission trip to Tanzania, Mann had the opportunity to help at a "clinic." But, she remarks, "It was more than a clinic. They had a room for deliveries, a room with four beds for inpatient care and an area for outpatient care—all managed by one doctor. I quickly learned that, in order for me to work in a clinic setting like this, I needed to be able to do a little bit of everything: set a broken bone, pull out an infected tooth, deliver a baby, diagnose and treat malaria. I knew then and there that family medicine was the only specialty that could do ALL of that."

Following that experience, Mann wholeheartedly pursued family medicine. She completed medical school at Meharry Medical College in Nashville, Tennessee, and a family medicine residency at Mayo Clinic Health System in La Crosse, Wisconsin. Mann also earned her MPH from Johns Hopkins Bloomberg School of Public Health.

Mann has since been practicing family medicine for a decade. She currently sees patients at Northfield Hospital's Lakeville Family Health Clinic and Northfield Hospital's Emergency Room.

She is passionate about volunteering and providing medical care to underserved populations around the world. Mann has served in Brazil, Haiti, Mali, Nicaragua, Puerto Rico, Tanzania, Zimbabwe and a Syrian refugee camp.

Mann lives with her husband Elliot; their three sons: Max (5), Alex (3) and Marcelo (1); and their 95-pound Argentinian Mastiff named Pepper.

Her experiences both as a family physician and a volunteer have recently led her down a new path: running for the Minnesota House of Representatives.

We talked with Mann about her run for office—why she's running and why she thinks it's important for family medicine to have a voice at the legislature.

WHY DID YOU DECIDE TO RUN FOR THE MINNESOTA HOUSE OF REPRESENTATIVES?

I noticed that my patients were having an increasingly harder time getting to me (because of costs), and medications were getting more and more expensive.

I have had to spend countless hours on the phone with insurance companies arguing about what they will or won't cover. I've had asthmatic patients who cannot afford lifesaving inhalers and diabetic patients who cannot afford their life-sustaining insulin. I don't think that's the way healthcare should be.

I have also had the privilege of getting to know my patients on a more personal level. Over the years, I have heard stories of choosing between paying for childcare versus staying in a job; getting fired for taking time off to take care of a sick family member; having to work two jobs just to pay the rent and put food on the table. I have seen how these stories negatively impact my patients' health.

WHY IS IT IMPORTANT FOR FAMILY MEDICINE TO HAVE A VOICE AT THE LEGISLATURE?

I think that family physicians are in a very unique and privileged position in that we have often heard both sides of every story. We take care of patients who have been hurt by gun violence, and we take care of patients who are responsible gun owners. We take care of people who work for big businesses and don't have adequate health insurance, and we also take care of people who own small businesses and have a hard time affording health insurance for their employees.

Because we have heard several sides of the issues, we understand that solutions aren't one-sided and that compromise is required.

WHAT DO YOU THINK ARE THE MAIN ISSUES FACING FAMILY PHYSICIANS AND THEIR PATIENTS?

Our patients are facing increasing healthcare costs, which have become a significant barrier to receiving the care they need. They are also facing—as are physicians—the erosion of the patient-doctor relationship, due in part to the increasingly shorter amounts of time allowed between doctor and patient during visits.

Physicians are facing burnout at skyrocketing rates. In my opinion, this is due to several things, including being over-worked, the stress of unrealistic scoring systems and unrealistic expectations (both from administrators and patients), the lack of autonomy and under-appreciation.

YOUR FAMILY MOVED TO AMERICA FROM BRAZIL WHEN YOU WERE EIGHT YEARS OLD. DO YOU THINK COMING HERE AS AN IMMIGRANT HELPED SHAPE EITHER OR BOTH OF THESE PATHS (AS A FAMILY DOCTOR AND AN ADVOCATE)?

Yes, I think so. At the age of eight, I received the most powerful gift one can give a child: opportunity. My parents uprooted our family from Brazil and moved us to Richfield, Minnesota, in search of a better future.

I had also been exposed to international health at a young age. When I started my training here in the U.S., I knew that other places were not as fortunate as we are here. My last trip to Puerto Rico, in the wake of Hurricane Maria, was really the impetus for running for office—when I saw an entire island of American citizens suffering.

YOU HAVE BEEN AN ACTIVE VOLUNTEER, CARING FOR POPULATIONS AROUND THE WORLD. WHY IS VOLUNTEERING IMPORTANT TO YOU?

One of my passions is volunteering and providing medical care to populations in need across the globe. I have served in Tanzania, Mali, Nicaragua, Haiti and Brazil. I spent five months living and working in rural Zimbabwe. More recently, I provided medical care at a Syrian refugee camp and took care of people affected by Hurricane Maria in Puerto Rico.

The bottom line is that volunteering is a selfish act for me. It makes me feel good. When I provide care for a population who really needs it, I feel like I'm doing what I'm supposed to be doing.

WHICH DISTRICT ARE YOU RUNNING TO REPRESENT?

I'm running for the Minnesota House of Representatives District 56B, representing Lakeville and Burnsville.

HOW CAN FAMILY DOCS GET INVOLVED IN ADVOCACY?

Mann says, "There are a multitude of avenues to explore when it comes to advocacy. You can find a group who advocates for just about anything."

A FEW SUGGESTIONS FOLLOW TO GET YOU STARTED ON ADVOCATING FOR FAMILY MEDICINE:

NATIONAL // FIGHTING FOR FAMILY MEDICINE

In June, the American Academy of Family Physicians (AAFP) launched a new advocacy brand, Fighting for Family Medicine. The brand is not just a rally cry for family physicians; it's designed to raise awareness concerning legislative issues that impact family medicine, physicians and patients and communicate to members about the AAFP's advocacy work on both the federal and state level.

The Fighting for Family Medicine brand offers members several tools, including a new bi-weekly, all-member email feature and new advocacy web-page (www.aafp.org/advocacy). The page features real-time updates, bite-sized features highlighting current efforts and clear language on how to engage/participate in legislative discussions.

You can also follow the conversation on Twitter by using the #FightingforFamilyMedicine hashtag.

STATE // MAFP COMMITTEE, TASK FORCE

Interested in serving on the MAFP Legislative Committee OR Health Equity Task Force? Want to advocate for patients, colleagues and the specialty of family medicine? Contact Jami Burbidge, MAM, MAFP Director of Advocacy and Engagement, at jami@mafp.org.

You can also follow our advocacy related tweets (@MNFamilyDocs) and use the hashtag #MAFPAdvocacy.

STATE // MINNESOTA MEDICAL ASSOCIATION

The Minnesota Medical Association (MMA) is an active voice at the legislature, working to advocate for all Minnesota physicians and often partnering with physician organizations like the MAFP.

The MMA influences national and state healthcare reform efforts and advances professionalism by placing physicians on influential boards, task forces and committees. They also offer a variety of advocacy events, groups/committees and tools.

Visit their website to learn more: www.mnmed.org/advocacy.

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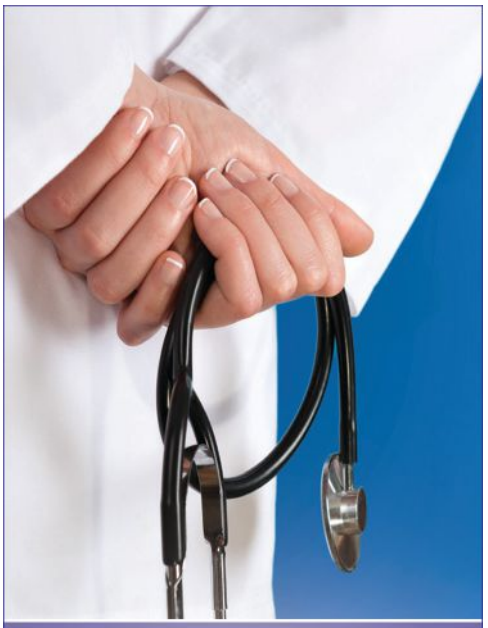

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XANAX IS NOT THE ANSWER TO XENOPHOBIA

Fear... the great motivator.

For years, I found the level of anxiety rising in my patient panel. There were those we thought were simply looking for Xanax, but I believe there was something underlying all that anxiety.

It really began around 9/11. The attack on our country prompted the most basic of instincts: the fight-or-flight response. That made sense. People felt threatened, and I saw a steady rise in patients with anxiety.

What causes anxiety? Fear. We live in a country where fear rules the day. We seem to be afraid of everything. Fear of another terrorist attack. Fear of death. Fear of injury. Fear of illness. Fear of fear.

Fear is a great motivator because it engages the most basic, primal parts of our brains. When the fight-or-flight response kicks in, your body gets ready for you to either run or defend yourself. Basically, your thalamus gets input from your senses and sends a signal to your amygdala. Your amygdala tells your hypothalamus to pump up the adrenals, which rush blood to your muscles so you can get yourself out of danger. In a slower response, the amygdala alerts the prefrontal sensory cortex, which compares the threat to previous memories of threats to gauge the severity of the situation. All of this happens in milliseconds.

When we have an overwhelming emotional response out of proportion to the stimulus presented that shuts down that sensory cortex, we call it an amygdala hijack. In other words, we don't apply reason to a situation. We just react.

WE ALL NEED TO RECOGNIZE THE MOTIVATION OF FEAR. WE NEED TO RETRAIN OURSELVES TO NOT GET HIJACKED. WE NEED TO THINK RATIONALLY AGAIN.

Why is fear a motivator? We see what it does internally, but it goes one step further. If someone presents you with a solution—a way out of a problematic situation—you are likely to buy into that solution. That is why commercials that offer us solutions do so well. It doesn't matter if the marketing agents are selling cars, medicine or home security systems; the products are presented as the answers we need.

Fear is used to sell most anything. Potential solutions make us feel good—safe—for a moment. Then we move on to feeling fearful of something else and seek the solution for that next worry.

For centuries, fear has been used to take advantage of situations. It has repeatedly led to armed conflict. The fear of the other is certainly a motivator.

What makes us feel better in these situations?

One strategy is to demonize other people. We have done that many times in our past. We did it to Native Americans, the Irish and African-Americans, just to name a few.

As a result, many people in our country now fear immigrants of any kind. Why? Because we have been told to fear them. That indoctrinated fear is a great motivator.

In such instances, we find comfort in surrounding ourselves with others who believe as we do. Watching certain TV networks or listening to certain radio programs that support our point of view reinforces our fears. This simply paves the way for those neurons that trigger the amygdala hijack.

This may not seem rational and, indeed, that amygdala hijack blocks out reasoning. We all are guilty of experiencing this reaction, but there is hope. Once we recognize this amygdala hijack and the feeling of fear and the need to lash out, we can force ourselves to realize what is happening and then retrain our brain to think before we speak.

The amygdala hijack causes us to do things that will make us say, "Wow, I really should not have done that," when we look back later.

For me, I know it is happening when I sense several things happening. My heart begins to race because the adrenals kick in. I feel my muscles start to tense up, getting ready for that fight or flight. I also feel like the focus is on me. After all, I am the one being threatened, right?

Fear may tell you another person is dangerous. The rational self would say, "OK, that person doesn't have a gun or a knife, so I am in no immediate danger." The other person may be perceived as scary, but thinking rationally, we would know that our fear comes from our own personal biases. Rationally, we can think our way through the situation.

The bottom line is that this frenzy of activity in our brain in response to frightening stimuli is not good for us or society. This is what is at the heart of post-traumatic stress disorder. This overstimulation leads to short circuits in the fear pathway that make that fight-or-flight amygdala hijack the predominant response. This leads to violent outbursts and violent acts.

We all need to recognize the motivation of fear. We need to retrain ourselves to not get hijacked.

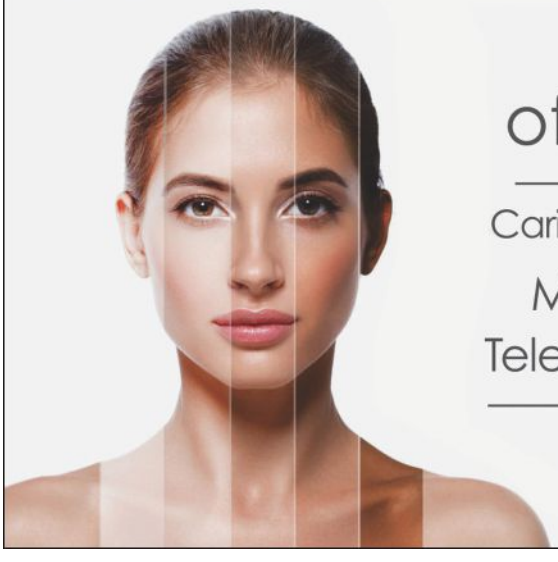
We need to think rationally again.

Leonard Reeves, MD, is a member of the AAFP Board of Directors.

This post is reprinted with permission from the AAFP Leader Voices Blog originally published July 16, 2018 at 1:48 pm.

Twin Cities Dermatology Center

Margareth Pierre-Louis, MD, MBA
Medical Director



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By Jason Ricco, MD, MPH
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and Community Health

PARTNERING WITH COMMUNITY HEALTH WORKERS

Family medicine continues to evolve from the era of individual physicians in solo practice to a continually expanding interprofessional team with the end goal of providing more comprehensive and patient-centered primary care. To this end, the Patient-Centered Medical Home (PCMH) has been identified as a model for achieving such holistic and effective care and, in many ways, it has been successful. However, there is ample evidence that the PCMH model is falling short of the Triple Aim of improved quality, lowered cost and improved health for patients who need it the most: psychosocially-complex, underserved populations.[1-5] This is partially a function of the limitations imposed by services that do not extend past the brick and mortar of the clinic itself. Effective health promotion requires relationships with community resources and organizations that help to address social determinants of health.

WHY COMMUNITY HEALTH WORKERS?

Increasingly, community health workers (CHW) are being utilized within primary care to bridge underserved communities and health services to overcome logistical, financial and cultural barriers to health care.[6] The CHW model is inherently designed as a multi-tiered community approach at the individual, organizational, and social network levels.[6] As such, there is real potential for an expanded focus on multilevel health determinants by incorporating CHWs into PCMH care coordination programs that traditionally revolve around synchronization of multiple disease-specific treatment plans and specialist referrals. In prior studies, CHWs have been shown to be effective in improving both health outcomes and the patient experience in the management of chronic diseases.[6-9] Additionally, CHW programs have demonstrated cost-effectiveness in reducing emergency room visits and increasing primary care visits in high-risk Medicaid patients, as well as significant practice-level cost savings in simulations with more moderate-risk populations.[10-12]

WHO IS A COMMUNITY HEALTH WORKER?

Community health workers inherently possess natural helper instincts as family members, friends and community members. It is less a job description than a set of characteristics certain individuals accumulate through assisting and supporting loved ones and neighbors. They are connectors through their network of personal interactions and relationships. They are problem solvers who create innovative solutions to problems not adequately addressed by current policies. In many under-resourced

countries, health agencies have harnessed the power of volunteer CHWs for precisely the reason that they are already doing the work anyway. CHWs are not traditional care coordinators in that they may not necessarily have backgrounds in social work or nursing. As such, their strength lies not in expertise in medical interventions or navigating referrals but in working with patients to address social determinant barriers through linkage with community resources. Their role can be flexible based on the needs of the patients with whom they work. CHWs can increase the capacity and self-efficacy for patients to take on the work of engaging the health care system through social support, education and outreach.

CHWS IN MINNESOTA

Minnesota has been at the forefront of recognizing the value of CHWs as frontline public health workers. Minnesota is the first state to create and offer a statewide CHW training program housed within post-secondary education. The standardized curriculum is a competency-based, 14-credit certificate course with a flexible pathway for a wide variety of health care and social service settings. Currently, seven technical and community colleges across the state offer the certificate program. To enter, applicants must have a high school diploma or GED.

According to Minnesota statute, the state's Medical Assistance (MA) program covers care coordination and patient education services provided by a CHW as long as the CHW is trained by one of the recognized CHW certificate programs. Since 2009, Minnesota's Medicaid plan has covered CHW services provided under an authorized supervising provider. In Minnesota, many provider types can authorize CHW services, including physicians, nurse practitioners and mental health professionals. Currently, CHWs can bill for services in 30-minute units for providing "diagnosis-specific health education" under a supervising provider.[13]

According to the Department of Human Services, Minnesota Medicaid does not cover CHW provision of "social services" such as resource provision or advocacy.[13] This represents a major limitation in capturing the true value added by CHWs in addressing social determinant barriers to health. Getting to this point, a randomized clinical trial in a high-poverty population in Philadelphia compared chronic disease management goal-setting by a physician with goal-setting supported by a multifaceted and flexible CHW intervention. The results demonstrated improved clinical outcomes in the CHW group despite the fact that the CHWs did not provide disease education or clinical care.[14] The authors argue that this suggests that "flexible interventions focused on patient-identified social and behavioral factors appear to have removed barriers to chronic disease control."[14]

FLIPPED MEDICAL HOME: A CHW PROGRAM TARGETING SOCIAL DETERMINANTS OF HEALTH

In 2015, the UCare Foundation funded a research study investigating the feasibility and effectiveness of integrating a CHW into our PCMH in Minneapolis with existing care coordination provided by RNs and social workers. In this pilot program, we enrolled 30 patients with uncontrolled diabetes to work with a CHW in developing a patient-centered action plan addressing patient-identified barriers and goals. The 12-month intervention consisted of regular in-person encounters either in clinic, during home visits, or in the community. In between, the CHW maintained close follow-up with phone calls and texts. We evaluated the program using a mixed methods approach framed by the Health Care Triple Aim. We compared the study participants to matched controls receiving usual care, including traditional care coordination. While we did not see a positive impact on specific health outcomes like Hgb A1C levels in this small study sample, we did see a significant increase in both primary care and behavioral health visits among patients working with the CHW. Patients in the CHW group also had higher satisfaction, particularly with the interpersonal manner of their health care.

Qualitative analysis of participant interviews revealed four major roles fulfilled by the CHW:

- **Coach:** Participants discussed how the CHW motivated them to seek out medical care when needed, and stay on track and focused on their disease management.
- **Advocate:** Participants overwhelmingly described the CHW as being an advocate for them, both within their care team and in linking them with community resources.
- **Teacher:** Participants discussed gaining a deeper understanding of diabetes and how to manage it from the CHW, including explaining things in everyday language.
- **Confidant:** Participants identified the CHW as a major source of support, comfort, inspiration and motivation.

Among the many powerful stories that we heard was one of a woman who was unable to afford the co-pay for her insulin after the unexpected death of her daughter. With her family struggling to cover the funeral expenses, she was forced to prioritize burying her daughter over getting insulin to treat her diabetes. When our CHW learned of this, she reached out to several existing contacts in the community, including local faith leaders. She ultimately talked with a pastor who knew the involved funeral home owner and, through this connection, the funeral home owner agreed to a significantly discounted payment plan for the family. It's extremely unlikely that a provider or traditional care coordinator could have come up with a comparable

solution for this patient without the CHW's vast social network of community relationships.

LESSONS LEARNED FROM PARTNERING WITH A CHW

It became exceedingly clear early on in this pilot program that we were remarkably lucky in finding a CHW with over 40 years of personal and professional ties to the surrounding community. Based on this reflection, I would argue that the single most important qualification for a CHW is that they be an expert in the community. Minimal education requirements, prior health care experience and other desired skills are secondary to a grounding in the community and shared experiences with the target population. It is certainly possible that the real intervention is not the specific tasks and roles of a CHW, but the persons themselves. Success depends on fostering a trusting, therapeutic relationship with patients in order to bridge the gap between underserved communities and the health care system.

There is growing evidence that social isolation or loneliness is a major determinant of health outcomes. Being socially connected is associated with a 50% reduction in risk of early death, and the magnitude of effect of social isolation on mortality is at least as strong as, if not stronger than, many other well-known risk factors, such as smoking and obesity.[15] Given that a CHW program is primarily a relational intervention, CHWs are uniquely qualified to address social isolation in addition to other social determinants of health within primary care. In partnership with PCMHs, they can provide a flexible and cost-effective way to provide social support in addition to traditional care coordination needs for patients that need it the most.

ACKNOWLEDGMENTS

Thanks to our CHW, Ms. Ora Hokes, for teaching us about the importance of community relationships and shared personal experiences in effectively engaging patients to overcome barriers to achieving health.

DEDICATION

This article is dedicated to the memory of Ellen Dodds, who worked as a tireless champion for our CHW program as research coordinator and behind-the-scenes mastermind. This work would not have been possible without her.

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MINNESOTA FAMILY MEDICINE

FAMILY MEDICINE PHYSICIAN JOB DETAILS:

The practice is General Family Medicine with a full-time clinic practice, as well as attending to hospitalized patients.

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Ad Council

Phalen Village Family Medicine Clinic in the White Bear Avenue Parade.

Past MAFP President **Julie Anderson, MD, FAAFP**, a direct primary care trailblazer, recently opened a direct primary clinic in St. Cloud, called Simplicity Health.

Congrats to MAFP Resident Director **Alex Gits, MD**, who was named a recipient of the 2018 American Academy of Family Physicians (AAFP) Award for Excellence in Graduate Medical Education. Of the 3,500 eligible family medicine residents, only 12 are selected. Residents are selected for their leadership, civic involvement, exemplary patient care, and aptitude for and interest in family medicine.

Lisa Regehr, MAFP staff to the Research and Quality Improvement Committee and the Research Network, has been appointed to the AAFP National Research Network Advisory Group for a two-year term.

Several of our members were recently honored by the University of Minnesota Medical School for excellence in scholarship, practice, and/or teaching. Congrats to Drs. **Colbenson**, **Angelos**, **Kashem**, **Ea** (University of Minnesota St. Joseph's Hospital Family Medicine Residency), **Knopp** (University of Minnesota/ Methodist Hospital Family Medicine Residency Program), **Kristin Helvig** and **Byron Holth**.

Renée Crichlow, MD, FAAFP, MAFP President-Elect, is starting a new position as Director of Advocacy and Policy at the University of Minnesota Department of Family and Community Medicine.

Phalen Village Family Medicine Clinic took part in the White Bear Avenue Parade. Go, Family Medicine!

BURNSVILLE FAMILY PHYSICIANS

An independent primary care division of Twin Cities Orthopedics, is seeking a family physician to join our group. We are a healthy practice which values independence and flexibility, in order to provide excellent patient-centered care that is driven by the providers. Independence is important! If you are an established physician looking for a change or a new graduate who has not considered independent practice before, we invite you to take a closer look. Please contact **Michelle Turner, Clinic Manager** at **952-435-0304** to learn more about this unique practice opportunity.

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COMING UP NEXT

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

Medical Cannabis in Minnesota — An Update
October 24, 2018
6 - 8:00 PM
Pinstripes, Edina, MN

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 (formerly SAM).

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

Innovation & Research Grant Deadline
December 1, 2018

HEALTH CAREER MENTORSHIP PROGRAM TEACHES RESILIENCE

By Emie Buege, Freelance Writer

The Ladder is a unique mentorship program/club in North Minneapolis for kids who are interested in health careers. It incorporates service learning, leadership development and progressive mentorship.

Renée Crichlow, MD, FAAFP, MAFP president-elect, founded The Ladder six years ago. Crichlow holds a faculty appointment at the University of Minnesota, serves as associate program director of the University of Minnesota North Memorial Family Medicine Residency and chairs the Society of Teachers of Family Medicine Emerging Leaders Fellowship.

The Ladder brings together scholars ages 9-99. Participants learn from each other in a cascading mentorship model. Elementary school students learn from high school students, who learn from undergraduate students, who learn from medical students and so on.

Meetings are held the second Saturday of every month, 12:30-2:30 pm, at the Urban Research and Outreach-Engagement Center in Minneapolis. Each session focuses on a different health career/topic and includes hands-on learning, mentorship and a free lunch.

*We asked 2018 family medicine resident graduate **Melissa Pavek, MD**, who has been a member of The Ladder for more than four years, to share about her experience with the program and its impact on her career path.*

WHAT DREW YOU TO THE LADDER?

I was a medical student, moving back to Minneapolis from Willmar, Minnesota. I had just completed the University of Minnesota Rural Physician Associate Program and was looking for a way to reconnect with the community.

I was also interested in The Ladder because North Minneapolis is under-represented in medicine, and I really believe in the work The Ladder is doing to change this.

I grew up with a mother who is a nurse. I had plenty of access to mentorship and resources on how to pursue a career in healthcare. Many of the kids who come to The Ladder don't have access to those same resources. They might be the first

generation in their families to think about college.

Having a community of individuals—from different backgrounds, all at different stages of their careers—consistently show up to be mentors, learners and scholars is a good start to closing that gap.

HOW HAS THE LADDER IMPACTED YOUR CAREER PATH?

I never saw myself as a leader before medical school, and what I learned from The Ladder gave me the courage to pursue leadership positions in residency.

The biggest lessons I've learned are about what good can come from looking for the strengths of others, the benefits of helping others grow and how finding the positives in challenging situations can help individuals and communities find the strength to move forward.

These lessons have changed my views on what it means to be a leader, and I'll continue to build on my leadership skills throughout my career.

WHAT HAS IT BEEN LIKE TO BE BOTH A MENTOR AND A MENTEE?

It's been wonderful! At The Ladder, we're all there to teach and we're all there to learn. Each of us has wisdom from our own lives to share and each of us benefit from the experiences of others.

Every scholar at The Ladder—from elementary school students through attending physicians—chooses one quote and tells a story about why that quote is meaningful to them.

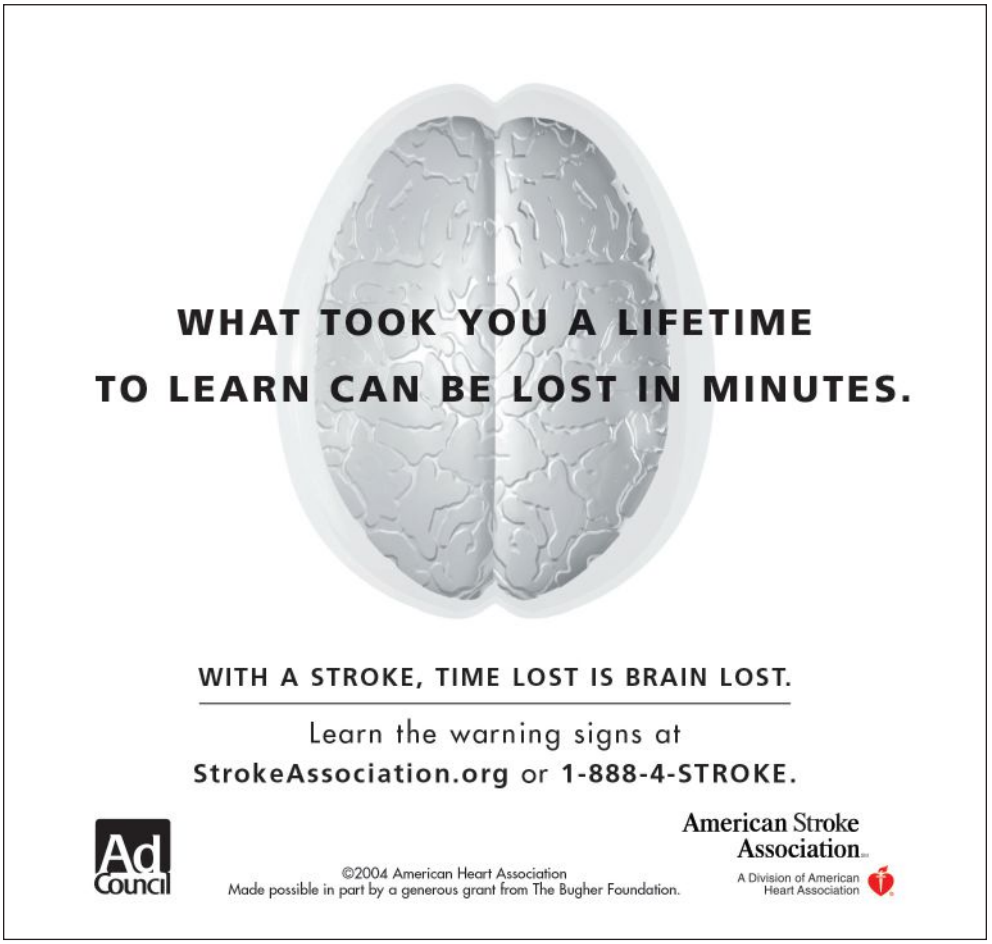
Each scholar is able to give examples from their lives of challenging situations they've been through and how they persevered and learned from those situations.

I think one of the most important parts of mentorship is passing along stories of

THE LADDER PLEDGE, THE TWELVE RUNGS

1. **We believe our true self is wise and compassionate and seek to know this self.**
2. **We take full responsibility for our choices.**
3. **We take full responsibility for our actions.**
4. **We strive each day to appreciate the good in ourselves, our community and our lives.**
5. **We are determined to correct any mistake that we may have made and determined to take right action now and in the future.**
6. **We embrace the truth that each day we can be the right person and do the right thing, starting now.**
7. **We seek to see the best parts of others and speak directly to that being.**
8. **We seek to see the good in our communities.**
9. **We seek to serve the positive works in our communities.**
10. **We seek knowledge and desire to act from wisdom.**
11. **We will spread—by our actions and our lives—the principles of a successful community: Lift as you climb; build as you grow.**
12. **We know we will succeed, because we will never give up!**

THIS, I PLEDGE.



resilience: how people have found strength and what actions they've taken to overcome. It's fuel for perseverance!

As adults, we often forget about the wisdom and insight young people have to share. Giving even our youngest scholars a platform to tell about their experiences enriches all of our lives.

Coming to The Ladder reminds me that I'll always be a teacher AND I'll always be a learner.

DESCRIBE A TYPICAL SESSION OF THE LADDER.

We start each session with an introduction to our topic of the month. Topics have included infectious diseases, food as medicine, the mind-body connection and more.

During the topic introduction, we also introduce two quotes, and the leader of the day explains what those quotes mean to them.

We then line up in order of age and education level, starting with the youngest elementary school students through high school, college, medical school, residency and beyond.

We break into three smaller groups, have lunch and introduce/reintroduce ourselves. We then discuss how the quotes resonate with us; usually, this leads to talking about a challenge we've overcome.

Then we go with our small groups to various fun activities to teach our younger scholars about the field of medicine.

Lastly, we rejoin together as a large group, talk about what we learned and read The Ladder Pledge.

DEFINE THE LADDER IN THREE WORDS.

Inspiring. Community. Overcoming.

To learn more about The Ladder or start a chapter in your area, visit theladdermn.org.

WELCOME TO MINNESOTA!

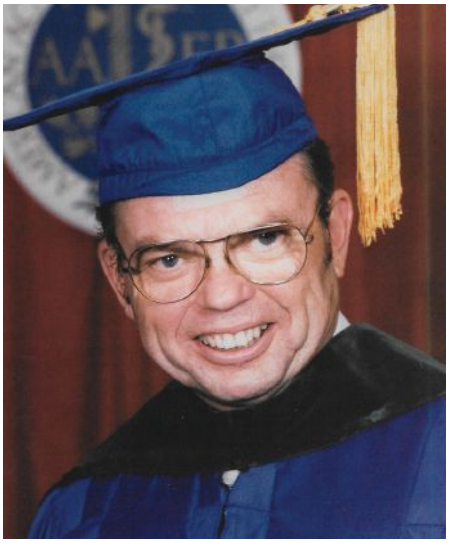
52 First year residents turned up at the Science Museum of Minnesota to connect with Academy leaders, network with colleagues and meet physician recruiters.

10 Lucky interns won $1,000 scholarships provided through a gift from the Arden Anderson, MD, Scholarship Fund.

15 **Sponsors** — Thank you for making this event possible

- American Academy of Family Physicians Foundation/ Family Medicine Philanthropic Consortium
- Avera Marshall Regional Medical Center
- CentraCare Health
- Essentia Health
- Fairview Health Services and HealthEast
- HealthCare Associates Credit Union
- HealthPartners
- Lakewood Health System
- Medi-Sota Recruitment
- Minnesota Medical Solutions
- North Clinic
- Sanford Health Physician Recruiting Office
- Scenic Rivers Health Services
- Tri-County Health Care
- U.S. Army Health Care

1 **Amazing doc inspiring the next generation of family medicine.**



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

IN-PERSON TRAINING IS AVAILABLE AT YOUR CLINIC FOR CHILD AND TEEN CHECKUPS!

To request free in-person training, customized for your clinic's needs, submit a C&TC Training Request form online www.health.state.mn.us/divs/cfh/program/ctc/training.cfm. MDH C&TC health consultants can provide an overview of C&TC updates—including practical resources for implementation and efficient clinic flow—or focus on specific screening components.

Clinicians, nursing staff, clinic administrators including coders are encouraged to attend. These brief, interactive trainings can be customized for the intended audience, and done at routine provider meetings, all-staff meetings, grand rounds, or whenever is convenient.

County/tribal C&TC Coordinators and health plan representatives are also available to provide information about local resources, addressing basic needs, incentives for well visits, and more.

Meanwhile, the following resources are available online:

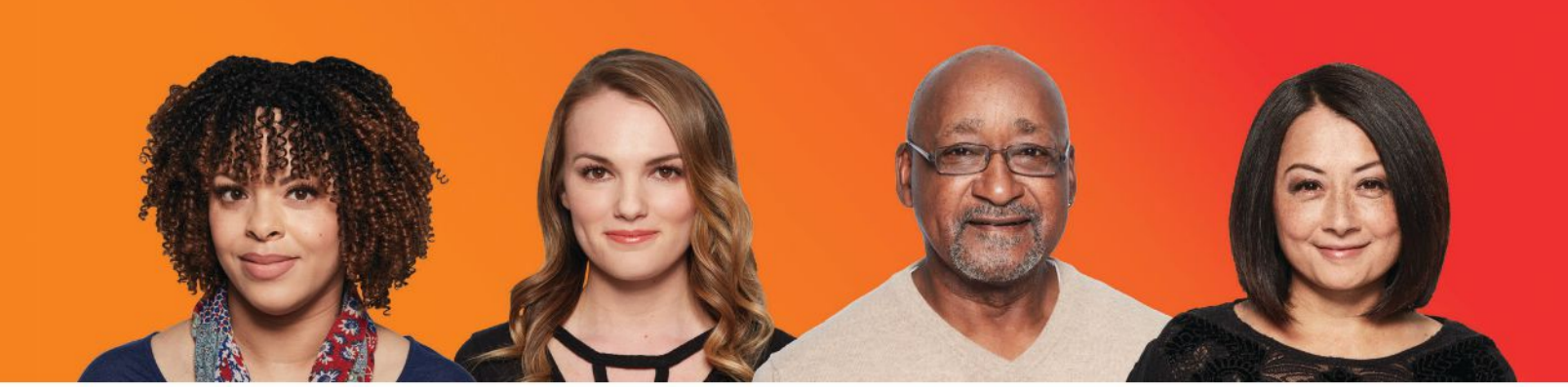
1. Minnesota Health Care Programs Provider Manual, C&TC section (www.dhs.state.mn.us) – This policy manual outlines C&TC visit requirements, coding, and screening exceptions to ensure reimbursement with the enhanced bundled rate for a complete C&TC visit.

2. Provider Call Center – 651-431-2700 or 800-366-5411 for billing questions.

3. C&TC Coordinator list (www.dhs.state.mn.us) – Every county health board and four tribes have C&TC staff that provide outreach to local families to promote well visits (including help to schedule an appointment, get transportation or an interpreter) and provide in-person outreach and support to clinics and providers.

4. The Minnesota Department of Health C&TC Provider page (www.health.state.mn.us/ctc) has clinical information and resources for each of the C&TC screening and service components.

For more information, contact: health.childteencheckups@state.mn.us.



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Clinical trials bring us closer to the day when all cancer patients can become survivors.

Clinical trials are an essential path to progress and the brightest torch researchers have to light their way to better treatments. That's because clinical trials allow researchers to test cutting-edge and potentially life-saving treatments while giving participants access to the best options available.

If you're interested in exploring new treatment options that may also light the path to better treatments for other patients, a clinical trial may be the right option for you. **Speak with your doctor and visit StandUpToCancer.org/ClinicalTrials to learn more.**

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HPV VACCINE: MAKING A STRONG RECOMMENDATION — PROJECT UPDATE

Get free CME at your clinic on improving HPV vaccination rates and cancer prevention! About 625 HPV-associated cancer cases were reported in Minnesota each year from 2010-2014. Of those cases, 78 percent were HPV-attributable and about 92 percent could have been prevented with the 9-valent HPV vaccine. The Minnesota Department of Health has teamed up with the Minnesota Academy of Family Physicians to work on increasing HPV vaccination rates across the state. Together, we're offering a free, 30-minute CME accredited presentation on evidence-based strategies for increasing on-time HPV vaccination. The presentation is followed by a brief discussion with the physician presenter and a public health professional to review your clinic's adolescent vaccination rates and create an action plan to improve your HPV vaccination rates. Family Physicians are the key to increasing HPV vaccination rates and protecting more Minnesotans from cancer! To set up a visit, send an email to lynn@mafp.org.

This project's success is due in large part to the following members, who are trained to present the CME program at clinics throughout Minnesota:

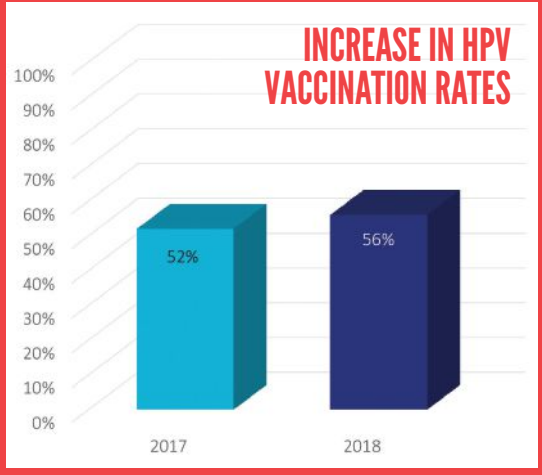
HPV Vaccine Physician Champions

- Christine Hult, MD, FAAFP
- Kathy MacLaughlin, MD
- Jennifer Mader, MD
- Shelley Overholt-Thiesen, MD, FAAFP
- Barbara Yawn, MD, MSC, FAAFP

Organizations and providers throughout Minnesota are working on improving HPV vaccination rates. The statewide HPV vaccine initiation rate for adolescents aged 13 to 17 years increased from 52% in 2017 to 56% in 2018. There is still work to be done as Minnesota's HPV vaccination completion rate remains low, with only 38% of adolescents aged 13 to 17 years completing the vaccine series.

Data source:

These data come from the Minnesota Immunization Information Connection (MIIC). HPV vaccine initiation and completion rates were calculated annually as of April 2017 and April 2018. The HPV vaccine initiation rates include adolescents aged 13 to 17 years who received at least one dose of HPV vaccine. The HPV vaccine completion rates reflect adolescents in this age group who completed either the 2-dose or 3-dose HPV series depending on the age they received their first dose per CDC immunization recommendations.



Per end-of-month AAFP reports for the following months:

- May 2018
- June 2018
- July 2018

NEW TO THE LAND OF 3,100 FAMILY DOCS

Jeffrey Lipke, MD, FAAFP, Osakis, has transferred from Colorado.
Roy Klossner, MD, Thief River Falls, has transferred from Florida.
Adrianne Westmoreland, DO, Estherville, IA, has transferred from Iowa.
Ekenesenarienrien Omokaro, MD, MPH, Fosston, has transferred from Maryland.

NEW RESIDENT MEMBERS

John Anderson, DO, St. Cloud
Maria Arciniegas Calle, MD, Minneapolis
Stefania Baccino, MD, Edina
Blake Chapman, DO, St. Cloud
Toni Dick, MD, Crystal
Brandon Edlund, MD, Minneapolis
Andrew Glogoza, DO, Minneapolis
Anderson John, DO, St. Cloud
Ramla Kasozi, MD, St. Paul
Catherine Kress, DO, Hopkins
Olaoluwa Lediju, MBBS, Minneapolis
Ramneet Manhas, MD, Minneapolis
Jessica Miller, MD, Minneapolis
Caitlin Mullins, MD, MPH, Minneapolis
Brandon Porten, MD, Arden Hills
Joseph Renier, MD, Minneapolis
Jacan Simon, DO, Mankato
Michael Symanietz, MD, Sartell
Frances Tepolt, MD, St. Paul
Paola Terán Rodriguez, MD, St. Cloud

NEW STUDENT MEMBERS

MAYO MEDICAL SCHOOL
Joseph Gottwald, PharmD, Rochester
Jennifer Grauberger, Rochester
Marc Greenberg, Rochester
Editt Nikoyan, Rochester
Jeremie Oliver, Rochester
Kekoa Taparra, Rochester

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
Corey Babcock, Minneapolis
Dieter Brandner, Minneapolis
Joshua Brandon, Minneapolis
Lorenzo Castanon, Oak Grove
Elizabeth Kim, Minneapolis
Anna Krieger, Minneapolis
Emily Kvasnicka Friedrichsen, St. Paul
Joseph Novak, Minneapolis
Kale Siebert, Minneapolis
Meera Sury, St. Paul
Kenzie Tolan, Rosemount
Alex Vo, Minneapolis
Caleb Vogt, St. Paul

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL – DULUTH
Claire Donovan, Alexandria
Courtney Semotink, Hermantown

IN MEMORIAM

Ellen Dodds, Researcher
Joseph C. Von Drasek, MD
Marilyn "Susie" Nanney, PhD, MPH, RD, Researcher
Bradley Warren Peterson, MD

The Laundry Love initiative consists of regular opportunities to help people who are struggling financially by assisting them with doing their laundry.

LAUNDRY LOVE

Danny Wells and Erin Anderson, Fourth Year Medical Students at the University of Minnesota, received an Innovation Grant from the MAFP Foundation to help fund this initiative. Foundation Executive Director, Lynn Baflour, talked with them about their project.

WHAT WAS THE MOST SURPRISING MOMENT FOR YOU AS A VOLUNTEER WHEN INTERACTING WITH PEOPLE AT THE LAUNDROMAT?

How much a load of laundry can help a family. One community member said, "I come here every week. This week was a rough week for me because I have to pay my rent and so I only washed one load but you all really helped me out. Thank you. God bless you all!"

HOW MANY QUARTERS HAVE BEEN HANDED OUT AND HOW MANY PEOPLE HAVE YOU IMPACTED?

The average number of families we helped each month is 25; that's about 300 over the year. Each family gets $10 in quarters (40 quarters), so each month we give out about $250 (1,000 quarters) and each year about $3,000 (12,000 quarters).

To learn more about this initiative, contact Danny Wells wells329@umn.edu or Erin Anderson ande9239@umn.edu.

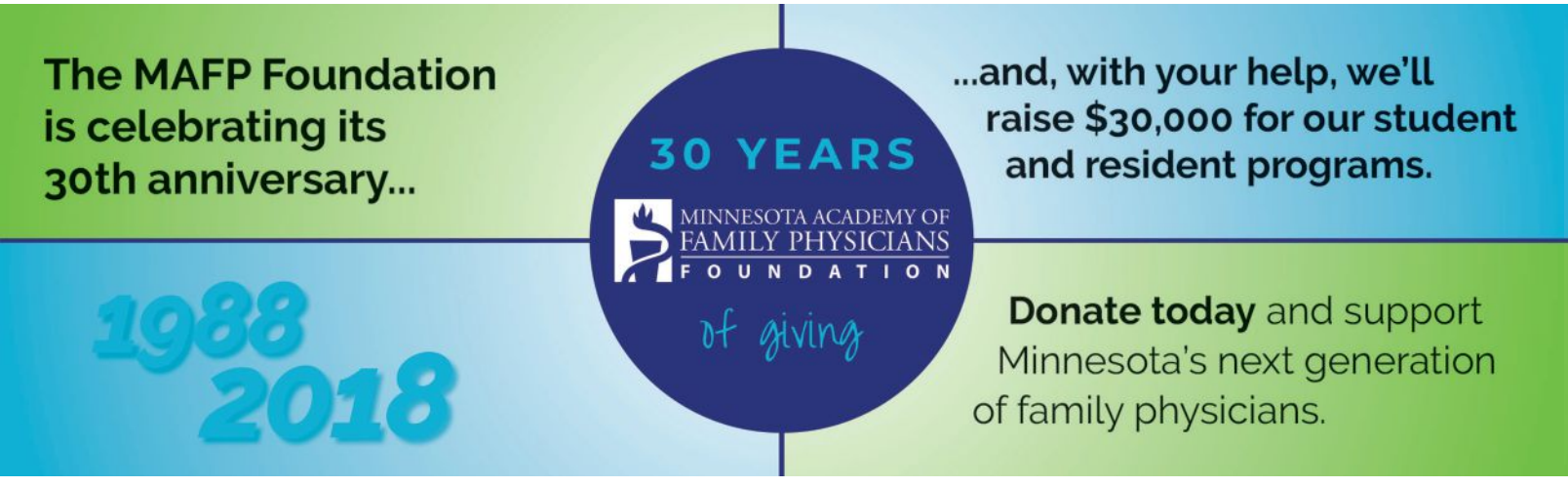
HAVE PEOPLE BEEN RECEPTIVE TO YOUR PRESENCE AT THE LAUNDROMAT? DO YOU THINK THEY KNOW ABOUT YOUR PROJECT AND EXPECT TO SEE VOLUNTEERS THERE? IS THE RESPONSE FROM ADULTS DIFFERENT THAN THE RESPONSE FROM CHILDREN?

The Gold Humanism Honors Society has been organizing Laundry Love since 2015. The community has been very receptive to having us at the laundromat; they know us well and look forward to us coming each third Tuesday of the month. Volunteers are from all years at the University of Minnesota Medical School. We've tailored our event to fit the needs of the laundromat and of the community, so it is always an evolving process. The children love to read books (in Spanish and English) with the volunteers and we always have a group of children that gather to read with us. We also bring educational worksheets covering arithmetic, grammar and fun games to play. The adults relax as we help financially with the cost of laundry and provide entertainment for their children at the laundromat—which can be a boring place for a kid!

www.laundrylove.org

WHAT'S THE BIGGEST IMPACT THIS PROJECT IS HAVING ON YOU AS A VOLUNTEER AND FUTURE PHYSICIAN?

It has instilled in us the importance of taking time to share in community. In medical school, you can easily get swept up with studying and taking tests and forget the reason you went into medicine in the first place: to establish relationships with people and support them on their path to wellness. This community project is a great way to help communities and remind us, as medical students, that our education is bigger than us and test scores. It's about gaining the skills and knowledge to one day be able to be there for people and assist them with their health goals. This project is a direct reflection of the Gold Humanism Honor Society's mission, as it provides a basic service that gives dignity to those who are struggling financially. By washing laundry, we engage with our community members in a way that emphasizes humility and empathy. The opportunity to connect with people personally can be especially lacking during the first two years of medical school, when classroom time is heavy; therefore, events like Laundry Love are important factors in increasing our recognition of each other's humanity—especially those with very different life experiences and opportunities.



Moving is the best medicine.
Keeping active and losing weight are just two of the ways that you can fight osteoarthritis pain. In fact, for every pound you lose, that's four pounds less pressure on each knee. For information on managing pain, go to fightarthritispain.org.

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Interested and qualified candidates may contact Hilary Wade at wadeh@bronsonhg.org or 269.341.7596

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