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Continuing Medical Education Committee Members (left to right): Tony Nguyen, MD; Pamela Dumke, MD; Sandra Stover, MD; Michele Hanson, MD; Kimberly Lundeen; and George Smith, MD

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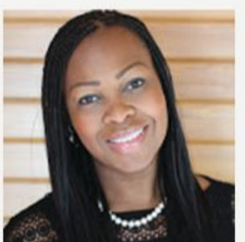

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Minnesota Academy of Family Physicians members took part in MMA Day at the Capitol on February 13. Photo Credit: MMA

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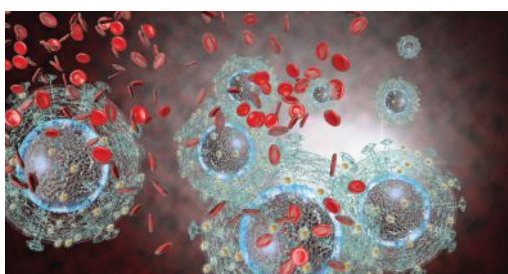

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MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

By Glenn Nemec, MD
MAFP President

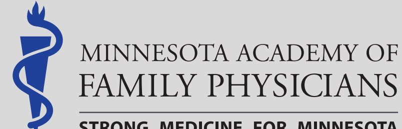
JACKS AND JILLS OF ALL TRADES

One of my "other" positions outside of being MAFP president is sitting on the U of M Medical School Admissions Committee. At the U, one of our biggest priorities is to find students that have diverse viewpoints, backgrounds and experiences. We are convinced that this improves the profession. I am personally certain that diversity improves our specialty.

One of the comments that I often hear about family medicine from colleagues, residents and students is "you can do so much and go so many different directions." Indeed, just about any special medical interest can be integrated into a family medicine practice. Dr. Chaisson's extensive integration of women's reproductive medicine chronicled in the fall 2018 issue of *Minnesota Family Physician* is one example. In my own practice, I am the "vasectomy guy," but I also do plastic repairs of earlobe tears (from kids grabbing their mother's earrings). I happen to like surgery, so I find ways to integrate that. Many of us are the sideline docs at sporting events. Some of us do C-sections, EGDs and colonoscopies or work with chronic pain patients prescribing Suboxone or certifying patients for medical cannabis. I could go on for a while here, but you are the "choir"—you all get this. Many of you are doing this.

The rest of medicine and society (not to mention insurers and legislators) are somewhat slower on the uptake. Our diversity is an incredibly valuable tool for providing medical care to our patients. It often gets viewed by these other parties as more of a potential danger, as some of the credentialing battles have demonstrated. I view our diversity as yet another way to emphasize to all these other groups how different we are than the rest of the physicians. Limited specialists are pretty much, well, limited by their specialty in what they do. When we're talking with students about career choices, diversity is a trump card we should bring up. When we're talking with third party payers, it's an asset we should emphasize. When we're talking with legislators, we need to mention it. Slowly and surely, we need to bring them all around to recognizing how badly American medicine needs so many more of us. And in the meantime, until they get around to that, they need to see why it's so important to make things as easy on us as possible.

At the MAFP, we are hard at work for you on all these messages every day. Keep these ideas in the front on your own brain, because we need every opportunity we can get to keep sending the message. We are different (diverse!), and that makes us better for patients' health. Diversity is a trump card.



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 131,000 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 the MAFP at 952-224-3875 or Lisa Regehr, lisa@mafp.org.

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By Maria Huntley, CAE, MAM
MAFP Executive Vice President

THE FUTURE OF CME AND MAFP

Identified year after year as THE top membership benefit from AAFP is the support and offerings of CME. Historically, this has been true in Minnesota, as well. We proudly offer two in-person CME events annually that are planned for family physicians by family physicians. As a matter of fact, our Spring Refresher has been touted as the largest family physician focused live CME in the region. We also offer opportunities throughout the year for members to come together to partner with their peers on KSAs for American Board of Family Medicine Recertification.

These CME offerings have been the core of our MAFP identity. Our membership numbers in Minnesota continue to climb year after year. Our Destination CME event this past summer doubled in size over 2017 (its inaugural year).

Why, then, is our attendance at the Spring Refresher declining year after year? Looking back over the past ten years, our peak attendance at this event had 14% of our members in attendance, declining slowly to only 9% last year. Of those in attendance, 80% were active physicians and 10% were residents.

So, one must ask: What gives? We're certain it isn't just one thing. We've heard that there needs to be more clinical topics and we've heard there needs to be more offerings on non-clinical topics that impact patients and communities. We've heard it's too difficult to take two days away from clinic when there are so many other opportunities to earn CME. We've heard feedback about locations. And our really honest members have told us they would rather get their CME in a warm climate during our long, cold winters. Who can blame them?

On the other side of the coin, we've heard from members about how important the Spring Refresher is for their training, as well as being an opportunity to connect with their colleagues from across the state. We've heard about how unique our event is compared to any other CME offerings.

All of this has led us to the re-imagination of how we are going to think about our CME offerings in the future. The first step was to develop a CME Faculty that has met (and will continue to meet) in strategic sessions to look at the role the MAFP plays in CME offerings from a strategic perspective. We are working hard to have important perspectives at the table as this conversation evolves: rural and urban, retired and students/residents, practicing physicians and academic.

Now we need you. We're looking to add some additional perspectives to the conversation. Two areas identified specifically are **new to practice (in practice for 7 years or less)** and what I would call truly **rural** practicing physicians. If you fit that role or know someone who does, or if you are personally interested in being part of the CME Faculty, please stand up. Email maria@mafp.org to get involved. I promise to work hard to make your participation smooth and your experience meaningful.

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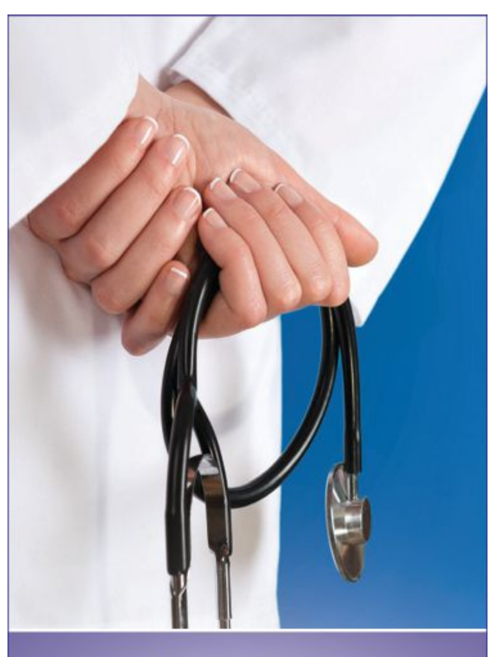

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ADVOCATING FOR GUN VIOLENCE PREVENTION

Physicians have been pushing for action to address the gun violence epidemic in the United States. At the insistence of members, state and national physician professional organizations have adopted policies aimed at identifying and addressing the causes of gun violence. The Minnesota Medical Association took a bold stance last year when it identified gun violence as a public health crisis and called on policymakers at the state and national levels to step up and protect our health and safety.

At the 2018 MAFP House of Delegates (HOD), three resolutions on gun reform were brought forward and debated. With their passage, the MAFP was directed to advocate for legislation that would address universal background checks and "red flag" or extreme risk protection orders, ban military-style assault firearms and high-capacity magazines and champion the authorization of research on the cause and impact of gun violence on the health and well-being of children and adults in this country. At HOD, hunter and gun owner members expressed concerns about MAFP involvement in this issue. However, the majority of those present felt strongly that meaningful steps could be taken to address gun violence while preserving the rights of responsible gun owners, and the resolutions were adopted.

A gun violence prevention workgroup was subsequently established within the MAFP legislative committee. The three members of the workgroup, Nancy Baker, MD, Emily Benzie, MD and Pat Fontaine, MD, recently shared their experiences and involvement in the issue of gun violence prevention. These examples highlight ways in which family physicians are using their voices and platforms to advocate on behalf of their patients and communities. The following are excerpts from that conversation.

WHAT LED TO YOUR INTEREST IN THIS ISSUE?

EMILY BENZIE, MD: I have been interested in this issue for a long time but, after the Marjorie Stoneman Douglas High School shooting in Parkland, FL, I was moved to turn my interest into action. I was very inspired by the leadership shown by the

young survivors and, frankly, I felt guilty and embarrassed that the adults in our country (myself included) hadn't already done all we could to prevent the tragedy those students lived through. Being a strong believer in prevention as a family physician and wanting to do what I can to leave our country a safer place to grow up in for my beloved nieces and nephews, I decided to become engaged on the issue of gun violence prevention.

NANCY BAKER, MD: I did my family medicine residency training at St. Paul Ramsey Medical Center (now Regions Hospital) and certainly cared for several young gunshot victims in the emergency department and on my surgery rotation. In the mid 1990s, I was impressed when one of the Regions ED doctors first explicitly named gun violence as a public health issue. However, the reason that I now feel compelled to speak out for sensible gun control laws is because of the astounding rise in US mass shootings in the last few years. They have become commonplace.

PAT FONTAINE, MD: The impact of gun violence hit me personally one evening as I was attending a birth at our community teaching hospital. The young mother-to-be was surrounded by her family, including her own mother, who was actively giving her encouragement throughout a tough labor. Abruptly, a nurse came into the room and whispered something into the older woman's ear. Confused, the resident and I watched as the recipient of the whispered message broke into a chilling, keening wail followed by wracking sobs. Her son, the patient's brother, had just been brought into the emergency department and died from a gunshot wound. Chaos prevailed in those last minutes before the baby was born, and I felt such sadness and anger. Sadness that a life was senselessly lost and a family tragically disrupted at a time that should have been a joyous celebration of a new life. Anger fueled the conviction that this should never happen again.

A LOT OF PHYSICIANS ARE FINDING THEIR VOICES AROUND THIS ISSUE AND ARE NOT COMFORTABLE BEING TOLD THIS IS NOT "THEIR LANE." WHAT DO YOU SEE AS THE ROLE OF FAMILY PHYSICIANS IN GUN VIOLENCE PREVENTION?

EMILY BENZIE, MD: As family physicians, prevention of harm and maintaining the health and safety of our patients, families and communities are of utmost importance and what we aim to do every day. It is our job to help educate our patients so they can make their healthiest decisions and live their healthiest lives. There is certainly a role for prevention here by educating about safe gun storage and identifying patients who may be at risk of harming themselves or others and trying to mitigate those risks, especially if they have access to firearms. Just like how we try to decrease morbidity and mortality from illnesses like diabetes and cancer, working to lessen the effects of the public health crisis of gun violence is also right "in our lane."

NANCY BAKER, MD: I've spent the majority of my career practicing full spectrum family medicine and have worked with parents, grandparents and children who, in today's world, are all vulnerable to gun violence. There are profound adverse physical and mental health consequences to gun misuse to which we can speak with credibility. Not only do primary victims carry memories and consequences of injury, those who see repeated images or hear stories of gun violence are at risk for secondary victimization.

PAT FONTAINE, MD: Gun violence is a public health issue, and physicians who deal with the effects are justified in becoming advocates. I'm personally motivated to ensure that women and children are free from gun violence. If background checks and red flag laws could prevent even one school shooting, it would be worth it. In our homes, children become the victims of accidental shootings when adults keep guns loaded and accessible for personal protection (and one survey showed that 67% of gun owners now cite personal protection as the primary reason they own a gun). Women living in homes with guns are five times more likely to be killed in a domestic dispute than when a gun is not present.

HOW HAVE YOU BEEN INVOLVED IN THIS ISSUE?

NANCY BAKER, MD: Several years ago, I realized that I had a responsibility to speak on behalf of my patients who are at risk for the adverse effects of violence. I became involved with a number of educational initiatives to train physicians to recognize and intervene appropriately when working with victims of interpersonal violence. I was asked to speak at the MAFP, MMA, AAFP and several other state chapters about ways to support victims and assist with safety plans. While serving on the AAFP Commission on Special Issues & Clinical Interests, I helped draft the original AAFP white paper on intimate interpersonal violence in the 1990s. This experience affirmed the importance of family physicians speaking out on issues of importance.

PAT FONTAINE, MD: I wrote a resolution and chaired the conference committee at the MAFP House of Delegates last year, where we passed resolutions supporting gun safety measures to take to the state legislature. Also, I have worked with Protect Minnesota through a Gun Sense Team at the church I attend, Unity Unitarian.

EMILY BENZIE, MD: I attended the March for Our Lives in St. Paul in March 2018 and the Wear Orange event at the Minnesota State Capitol in June 2018. I also joined Moms Demand Action and recently took on a position as co-leader for the St. Paul local chapter.

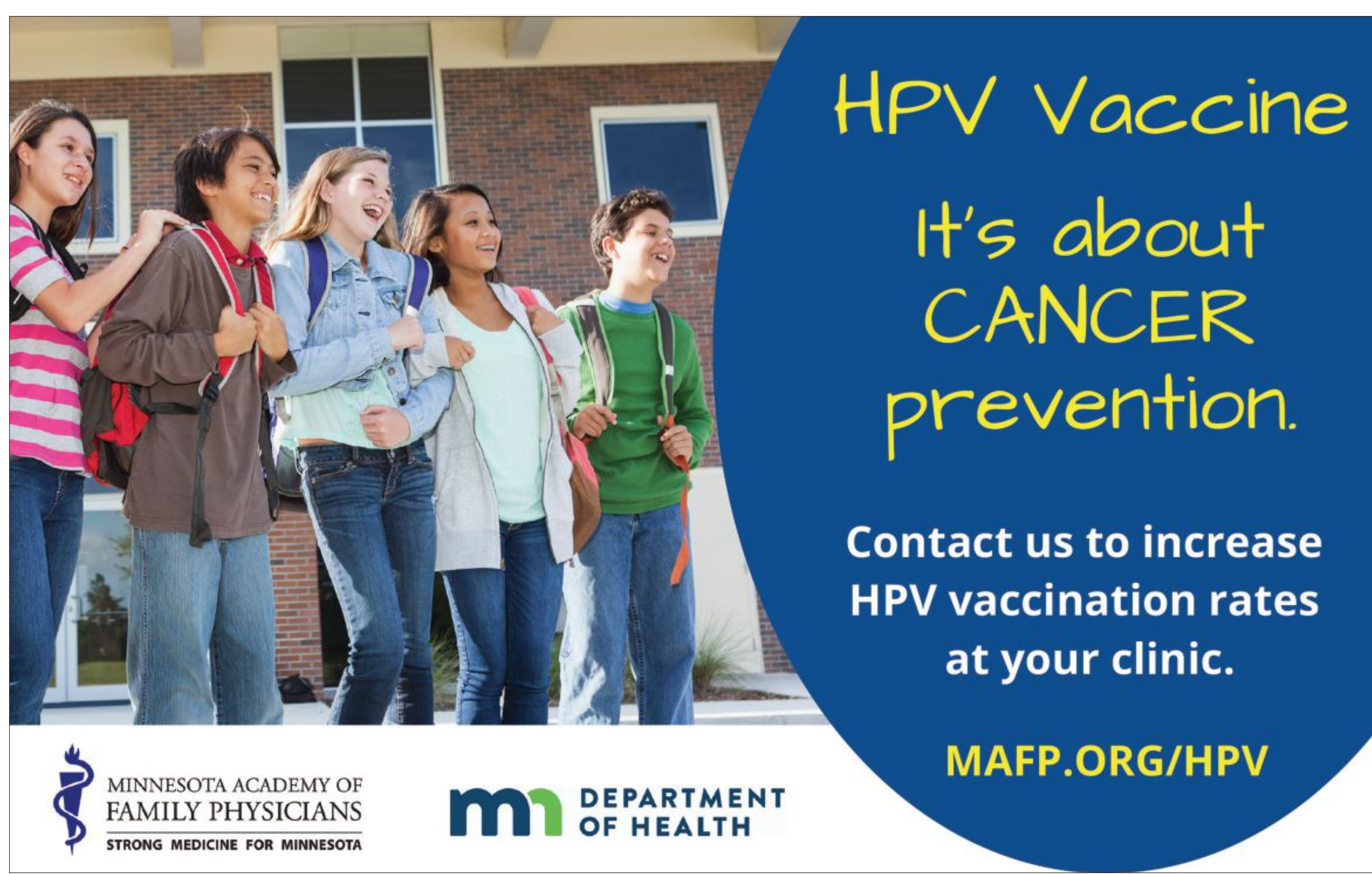
KNOWING THAT YOU ARE ALL AT DIFFERENT PLACES IN YOUR CAREERS, HOW HAVE YOU FIT THIS INTO YOUR LIVES? WHAT LESSONS HAVE YOU LEARNED IN YOUR JOURNEY?

PAT FONTAINE, MD: I have learned the complexities of the issue. There are people I've worked with for years and whose opinions I respect who see things differently than I do. Many have very different emotional responses to the gun safety debate—all legitimate, all based in their own experiences and upbringing. I have no problem with that. We must find common ground.

NANCY BAKER, MD: I'm semi-retired and now working part time as a hospice physician. I have more flexibility in my work schedule, so am eager to provide whatever leadership and energy that I can. I'm grateful for having had significant leadership and media and public speaking training during my medical career, so am eager to now share my skills with colleagues and others in positions of power.

EMILY BENZIE, MD: I have been attending in-person and online meetings for Moms Demand Action and the MAFP legislative committee whenever I can. Technology helps in that I have been able to join some meetings online from home. One challenge has been the realization that there is so much work to be done and so many great opportunities available for participation, so I am working on trying to determine how much I can take on while still balancing my other commitments to work and family. A lesson learned has been that, with so many opportunities for engagement and so much need, there is a role for everyone with time and interest. Many different skillsets and voices are needed to work toward common goals that will benefit our patients and communities.

Are you interested in getting involved? Check out the MAFP's website (mafp.org) or advocacy blog (mafpadvocacy.org) to learn more about this and other issues and get ideas for how you might use your voice to advocate. Get in touch with the MAFP to connect with the legislative committee and the gun violence prevention workgroup or to help brainstorm your next steps at jami@mafp.org.



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HIV PrEP

By Michael Stiffman, MD, MSPH; Family Physician and Clinic Medical Director, HealthPartners Inver Grove Heights

By Patricia Adam, MD, MSPH; Vice Chair for Clinical Affairs Department of Family Medicine and Community Health, University of Minnesota

HIV is now a preventable infection. There is strong evidence that a simple prescription can keep almost any patient at risk from getting it.[3,4] This article will explain how and why we can help prevent HIV.

THE PATIENT PERSPECTIVE

"I came to see you because I couldn't find a doctor to give me PrEP. Doesn't [name of health system] require doctors to keep up with medical science? Everyone knows that PrEP is how you prevent HIV!"

"Why did my doctor refer me to infectious disease for PrEP? I was offended. I don't have an infectious disease!"

Direct-to-customer ads on TV are encouraging our patients to ask for PrEP. Our patients expect to be treated. As family doctors, we are the guardians of our patients' health and can and should be at the vanguard of this important approach to HIV prevention.

BUT SURELY THAT'S NOT A PROBLEM *HERE*

In 2017, there were almost 9,000 people living with HIV in Minnesota; 284 were newly diagnosed with HIV. **Twenty percent of new cases overall and approximately 25% of new cases in women were in greater Minnesota.** Men having sex with men is still the primary risk factor for men born in the US, whereas heterosexual sex is the leading risk factor for women and most foreign born men.[1]

FAMILY PHYSICIANS ARE EXPERTS IN PREVENTION

As family physicians, we are the experts in prevention, so why are we not all offering our patients full HIV prevention? This is squarely within our scope of practice. We can and should all start implementing for our at-risk patients. PrEP for HIV is as relevant and important as prescribing a statin, immunizing our

children against hepatitis B or giving anti-malarial medications for travel. None of us would say to a patient, "You need to see a cardiologist to get your cholesterol treated for heart prevention."

EVIDENCE

There is now a large body of evidence that PrEP works for HIV prevention, including seven large, randomized, controlled trials and many published reports of real-world case series that show that virtually all patients taking PrEP consistently are protected against HIV.[3,4] Guidelines by the US Preventive Services Task Force (USPSTF), the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) all strongly and affirmatively recommend PrEP.

Here is what we know about HIV prevention in 2019:[2]

- Condoms reduce the chance of getting HIV.
- Treating pregnant women who have HIV effectively prevents their children from getting it. *(Perinatal prevention)*
- Treating a person who has HIV to full suppression of the virus virtually eliminates the risk of infecting others, prompting the international and US health agency slogan "U=U" (undetectable = untransmittable). *(Treatment as prevention)*
- Treating a person who is HIV negative with HIV medications after they are exposed reduces their risk of infection. *(Post exposure prophylaxis; PEP)*
- Treating a person who is HIV negative and at risk for HIV exposure reduces their risk of contracting HIV. *(Pre-exposure prophylaxis; PrEP)*
- Treating 50 people without HIV with PrEP prevents 1 case of HIV (NNT=50). In comparison, we need to treat 104 people without heart disease with atorvastatin to prevent a heart attack. In other words, HIV PrEP is approximately twice as effective as a highly prescribed preventive medication. (TheNNT.com)

PRACTICAL NUTS AND BOLTS: HOW TO PRESCRIBE PrEP

What is PrEP and how is it prescribed?

Prescribing PrEP is quite simple: TRUVADA® (tenofovir disoproxil fumarate + emtricitabine, or TDF/FTC), one pill once daily. That's it. Studies of other dosing regimens, including intermittent dosing, are underway but are currently not recommended.

Who should be considered a candidate for PrEP?

- People with a recent or current sexually transmitted infection (STI). An STI diagnosis should trigger, in addition to treatment, an assessment for high-risk sexual behavior. Does this mean that every 17-year-old who tests positive for chlamydia should be given PrEP? Of course not. But it is a great opportunity to assess for HIV risk, educate on prevention and, if appropriate, treat with PrEP.
- Anyone with more than one sexual partner.
- Anyone who meets sexual partners online or has other anonymous sexual partners.
- Anyone who has transactional sex (for money or drugs or other goods).
- Anyone who is HIV negative but has a partner who is HIV positive.
- Injection drug users.

HOW TO COUNSEL PrEP PATIENTS

When starting patients on PrEP, we generally counsel them as follows: We highly recommend using condoms for all sexual intercourse both to prevent most STIs and because all PrEP trials advised patients to use them. Tissue data suggests that there is good protection from HIV approximately a week after starting TRUVADA. The highest risk of getting HIV is from receptive anal intercourse (bottoming) followed by receptive vaginal intercourse. Insertive intercourse confers half that risk. There is very low risk (but not zero) from oral sex. PrEP effectively reduces HIV risk regardless of method of exposure. Guidelines recommend taking TRUVADA daily, although there is some evidence that intermittent use also affords some protection.

HOW TO MONITOR SOMEONE ON PrEP

Patients on PrEP need to be seen every three months for ongoing risk assessment, HIV testing and any additional STI screening. TRUVADA has a low risk of renal toxicity, so creatinine should be checked every six months. Quarterly HIV testing is particularly important since TRUVADA, while very effective at preventing HIV, is not sufficient as a single agent to treat HIV. The rare individual who contracts HIV while on PrEP will need referral to an HIV specialist for full HIV treatment.

ADOLESCENTS

The FDA just approved TRUVADA for PrEP for anyone over 35 kg (77 lbs), which includes adolescents. In Minnesota, the minor consent laws apply only for diagnosing and treating sexually transmitted infections, not for preventing them. As a result, we currently must obtain parental consent in order to prescribe TRUVADA for PrEP to adolescents.

COST

One month of TRUVADA costs approximately $1,600. Most insurers (commercial and government) cover the cost in Minnesota. For patients with high out-of-pocket costs, there are online resources, including a copay card from the manufacturer. Preventing HIV is much less expensive than treating it and is a key part of the strategy for eliminating HIV.

TOOLS TO HELP US

The CDC has an excellent HIV risk calculator that graphs (for you and your patients) patients' risk. This can help your patients understand how much PrEP will lower their risk of getting HIV (www.CDC.gov/HIVrisk). The CDC also has (on their website) complete guidelines for PrEP and information for patients about assistance programs for paying for TRUVADA.

HIV, as we all know, has profound effects on our patients' health and their lives. As family physicians, we are uniquely positioned to know and understand their HIV risk factors. In 2019, PrEP is the evidence-based standard of care for preventing HIV. We all need to step up and do our part.

One pill once a day. Blood tests every three months. Highly effective prevention. What could be simpler to implement in our practice?

FAMILY MEDICINE PRACTICE

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FOR YOUR CONSIDERATION: 24-year, stable, family medicine practice. Solo physician desires to slow down or retire completely mid year 2019. Will stay to help provider(s) assimilate to practice.

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About the practice: 90+% insurance, most medicare is Health Spring. AR lower than average, computerized appts and billing (capable of more-Doctor's Access software-272.03/mo), COMCAST. Call group quite reasonable, 1:5, no inpt or ER coverage.

About the patients: I like to say most of my elderly patients are playing golf, not chronically ill on mega meds and oxygen. Many have become friends of my family.

About the staff: Nurse for 20+ years, office manager 18 years, office help 3 mornings a week. All will need replaced.

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REMEMBER: *Tennessee has no state income tax, Hall investment tax fully repealed by Jan 2021 (2% in 2019 and 1% in 2020), and hardly EVER snows appreciably in central Tennessee!*

SELECTED REFERENCES

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Knowing if you have HPV—especially the most dangerous strains, HPV types 16 and 18—can help protect you from developing cervical cancer.

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This resource was created with support from Roche Diagnostics Corporation.

FAMILY OF FAMILY MEDICINE IS WORKING TO EXPAND THE WORKFORCE

The specialty of family medicine is celebrating its 50th anniversary this year. During the past half century, there have been many changes in medical education, health care financing and care delivery. Changes continue to occur at a rapid pace. Family medicine needs broad initiatives to stay abreast and help lead this transformation.

Large-scale projects require a team approach, and family medicine is blessed to have a great team. Twice a year, the "family" of family medicine meets in person to address the broad issues facing the discipline. Known as the Family Medicine Working Party, (www.aafpfoundation.org) the event provides a venue for communication and collaborative work. The family is comprised of the eight organizations that represent the breadth of the specialty and aim to address its needs regarding education, certification, research, philanthropy and more:

- the AAFP,
- the AAFP Foundation,
- the American Board of Family Medicine (ABFM),
- the American College of Osteopathic Family Physicians (ACOFP),
- the Association of Departments of Family Medicine (ADFM),
- the Association of Family Medicine Residency Directors (AFMRD),
- the North American Primary Care Research Group, and
- the Society of Teachers of Family Medicine (STFM).

The first step toward a Working Party was an ad hoc planning committee in 1977 comprised of the AAFP, the American Board of Family Practice (now ABFM), STFM and the Family Health Foundation of America (now the AAFP Foundation). The first official Working Party happened two years later with representatives from those four organizations. The stated objectives of the conference were to improve communication, delineate areas of responsibilities both common and unique to each organization, enhance cooperation and avoid duplication of effort. One of the

earliest work products of the meetings was a position paper on the medical education accreditation system.

The groups began meeting biannually in 1981 and eventually expanded to include the other organizations.

Family medicine organizations, working together, created the Future of Family Medicine Project in 2002 and, more recently, Family Medicine for America's Health (fmahealth.org) (FMA Health) in 2013.

During the past five years, the major focus of Working Party has been the tremendous work of FMA Health. As that project is winding to a close, the initiatives born from its tactic teams are being handed off to the various organizations to continue their progress. During this process, the organizations are working together in a collaborative and coordinated fashion.

For example, the AAFP has taken a lead role on the ambitious America Needs More Family Doctors: 25 x 2030 collaborative. ACOFP, ADFM, AFMRD and STFM are working on various aspects of the initiative, which aims to ensure that by 2030, 25 percent of U.S. allopathic and osteopathic medical students select family medicine as their specialty choice.

Obviously, there must be a multifaceted approach. Interventions must begin before a student enters medical school, impact the process of medical education, and assure ample graduate medical education training opportunities. The current practice of medicine and the outlook for the specialty's future have a significant impact on students, underscoring the importance of reducing administrative burden, achieving meaningful payment reform, and providing practical and meaningful ongoing professional self-regulation. This is more than one organization can accomplish alone.

The 25 x 2030 project was a focus of the Working Party meeting earlier this month. All eight organizations worked together to develop ideas and direction for moving this project forward. The collaborative spirit during the meeting was amazing, and the communication between the groups was incredible. The family worked together as a cohesive team, just as it has done since the inception of this important meeting.

Each of the organizations has committed staff and members/diplomates to a steering committee for the collaborative. The committee will meet in March to set an agenda. As priorities are defined and projects initiated, other members of these organizations — and allies from outside family medicine and even outside medicine — also will be engaged. Achieving this workforce reform will take each of us — where we stand, in our communities, clinics, institutions and health systems — advocating for change.

The 25 x 2030 project is just one example of how we must continue to work together for the specialty. The structure put in place in the late 1970s will continue to lend itself to large-scope initiatives that will affect family physicians in all practice settings.

Michael Munger, MD, is Board Chair of the AAFP.

Originally posted at 09:37AM Jan 23, 2019 by Michael Munger, MD on the AAFP Leader Voices Blog.

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Family Medicine

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Thank you to our FAMILY DOC NIGHT OUT sponsors Leafline Labs and Minnesota Medical Solutions (A Vireo Health Company) and our expert panelists, moderator and guests for joining us at Pinstripes in Edina on Wednesday, October 24. What a great night of education on medical cannabis and connection with Minnesota family docs!

INTRO TO ADVOCACY

SATURDAY, JANUARY 19, 2019

Thank you to all the Minnesota medical students and family medicine residents (as well as MAFP officers and leaders) who joined us for Intro to Advocacy at Surly Brewing Company. Sessions covered building an advocacy tool kit, leveraging social media and utilizing the press, and tips on meeting with legislators. If you missed the event, here are some ideas to get you started on your advocacy journey:

- Sign up to receive updates from our NEW advocacy blog at mafpadvocacy.org.
- Check out the advocacy resources on our website at mafp.org/advocacy-resources.
- Follow the #MAFPAdvocacy hashtag on Twitter (@MNFamilyDocs).

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Carris Health is an innovative health care system committed to reinventing rural health care in West Central and Southwest Minnesota. Carris Health was formed in January 2018 and is part of CentraCare Health. Visit **www.carrishealth.com** for more information.

Jay Sheree-Allen, MD, new-to-practice physician and Mayo FMRP alumni, was appointed as an at-large trustee to the AAFP Foundation Board of Directors.

Emily Anderson, MD, and Leif Solberg, MD, have concluded their terms on the MAFP Foundation's Board of Directors. We thank them for all of their work with the Board.

Macaran Baird, MD, MS, professor emeritus and retired Head of the University of Minnesota Department of Family Medicine and Community Health, has been named the 2018 Shotwell Award recipient by Twin Cities Medical Society. The Shotwell Award is given annually to a community member for their noteworthy effort in the field of healthcare, including dedicated service to mankind, significant contribution to the field of medicine, significant breakthrough in some form of research, or innovations and/or improvements in healthcare delivery.

Macaran Baird, MD, MS, *receiving the Shotwell Award from Twin Cities Medical Society Foundation Chair, Chris Johnson, MD.*

Photo provided by Twin Cities Medical Society

Paul Sanders, MD, FAAFP, *receives The American Medical Association's Medical Executive Lifetime Achievement Award.*

Paul Sanders, MD, FAAFP, received The American Medical Association's Medical Executive Lifetime Achievement Award given to medical association executives who made substantial contributions to the goals and ideals of the medical profession. With more than 45 years in medicine, Dr. Sanders has always focused on improving the health of patients and the medical profession. He served for 13 years as CEO of the Minnesota Medical Association, and has served as president of the Minnesota Academy of Family Physicians.

An article published in the *Annals of Family Medicine*, "Unfinished Business: The Role of Research in Family Medicine," by Robin Gotler, MA, acknowledged our immediate past EVP, **Virginia Barzan**, along with the MAFP, for access to journal articles and cited past president **J.A. Cosgriff, MD**, and friend-of-the-Academy **CJ Peek, PhD**, University of Minnesota Department of Family Medicine and Community Health.

Jon Hallberg, MD, FAAFP, family physician at Mill City Clinic and associate professor with the University of Minnesota Department of Family Medicine and Community Health, will be presenting a Hippocrates Café performance at MDH's Health Care Homes Learning Collaborative Learning Days in April.

Alice Mann, MD, MPH, Northfield Hospital's Lakeville Family Health Clinic, was elected to the Minnesota House of Representatives.

Daniel Okubo, MD, PGY 1, United Family Medicine Residency, was appointed to the AAFP Tobacco Prevention and Control Committee.

Sandy Stover, MD, FAAFP, Department of Family Medicine and Biobehavioral Health at the Duluth campus of the University of Minnesota Medical School, was interviewed by reporter John Lundy for the *Duluth News Tribune*, January 15, 2019, in the article "How to Doctor Shop: Why Personalities Matter, and Why It's OK to Switch."

"WHEN I HAVE AN ASTHMA ATTACK I FEEL LIKE A FISH WITH NO WATER."

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2018 AAFP CONGRESS OF DELEGATES REPORT

By Julie Anderson, MD, FAAFP, Senior Delegate from Minnesota

This past fall, your Minnesota elected delegates traveled to New Orleans for the 2018 AAFP Congress of Delegates. The Congress is the rule-making body that helps to set the focus for the AAFP over the next year. Each state elects two delegates and two alternate delegates to represent their constituents, much like the senate of the federal government. We each take our roles very seriously and try our best to bring the issues forward that are important and timely to our fellow Minnesota physicians.

As it is currently a country divided, so it is at the AAFP Congress on certain hot button issues. Some resolutions have significant support and others have prompted angry responses from some members. As the Senior Delegate, I completely understand frustration when the AAFP does not always follow my line of thinking about a given issue. However, what keeps me involved and committed to the AAFP is the unyielding message that family physicians are the key to health care.

SOME OF THE RESOLUTIONS

We heard a proposal to work with the American College of Obstetricians and Gynecologists and other groups to stop closure of rural obstetrical services that increase the travel burden of patients and results in poorer outcomes. This resolution would work with the Centers for Medicare & Medicaid Services (CMS) to provide adequate Medicaid reimbursement and support family physicians in maintaining and continuing competency of obstetrical services.

Another resolution asks the AAFP to study all-payer claims databases in order to demonstrate the value of our services in family medicine and quantify the current spending on primary care at a state and federal level.

The Congress also heard testimony to ease the credentialing process, ensure adequate payment for mental health services and prior authorizations, advocate for a national immunization registry and ensure that CMS only pays family physicians and internists for Medicare Annual Wellness visits, since there are many reports of external companies including insurance companies who are attempting to syphon these off from family medicine clinics.

One of the possibly more contentious resolutions that passed easily in the Congress referenced medical aid in dying and differs from the AMA Code of Medical Ethics Opinion. It states that the AAFP takes a position of "engaged neutrality" toward medical aid in dying in the context of the relationship between a physician and their patient.

The Congress selected Dr. Gary LeRoy as the AAFP's President-Elect, who will follow in the footsteps of our current President, Dr. John Cullen. I can personally vouch for the character of both of these physicians and know that we are well represented at a national level.

I would like to thank Drs. Daron Gersch, Dania Kamp and Renée Crichlow, who serve as fellow delegates and alternate delegates to the Congress. They are hard-working family physicians who have their pulse on the needs of Minnesotan family physicians. Please remember that we serve you, and we are always willing to discuss resolutions or take recommendations to bring to a national level. Consider becoming active in our state chapter or on a committee, or attend the MAFP House of Delegates, where we debate local issues and consider future resolutions that we bring to the national meeting. If you aren't part of the conversation, we can't advocate on your behalf.

COMING UP NEXT

Spring Refresher
March 28 & 29, 2019
The Depot, Minneapolis

House of Delegates
March 30, 2019
The Depot, Minneapolis

Welcome to Minnesota (You Are Here) — A Free Event for Family Medicine Residents
April 18, 2019 6 – 8 pm
Amherst H. Wilder Center, St. Paul

Application Deadline Research & Innovation Grant and David Mersy, MD Student Externship
May 1, 2019
Visit **mafp.org/apply** to learn more.

AAFP National Conference of Family Medicine Residents and Medical Students
July 25 – 27, 2019
Kansas City Convention Center
Kansas City, MO

HOUSE OF DELEGATES MOVING TO SATURDAY!
March 30
The Depot, Minneapolis

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MARCH 30, 2019
HOUSE OF DELEGATES

Photo credit: Akil Photography

THE DIRECT PRIMARY CARE DIFFERENCE

Mark Holder, MD, founder of Mperial Health, about the benefits and challenges of direct primary care

A little over a year ago, MAFP member **Mark Holder, MD**, founded Mperial Health, a direct primary care (DPC) practice in Edina, Minnesota.

Holder is a board-certified family physician and graduate of the Morehouse School of Medicine and University of Miami/Jackson Memorial Hospital Family Medicine Residency Program. He is also a second-generation medical doctor, preceded by his mother Wilhelmina Tolbert Holder, MD CM, DTPH.

His motivation for launching Mperial Health was to provide high quality primary care at affordable prices, using a more holistic and personable approach to patient care. He believes that primary care doctors can better serve their patients by excluding third-party payers.

We chatted with Holder about his new practice and the DPC model.

HOW IS WORKING IN A DPC SETTING DIFFERENT THAN WORKING IN A MORE TRADITIONAL HOSPITAL/HEALTH SYSTEM?

In the DPC model, billing and payment arrangements are made directly between patients and their physicians, without sending claims to insurance providers.

DPC is a paradigm shift in healthcare delivery—from a disease/treatment model to a model focused on advancing wellness. Other differences in direct primary care include:

- Clinic visits are scheduled hourly.
- Patients have e-mail, phone and/or text access to their physician.
- Telemedicine, home visits and same/next day appointments are offered.
- There is less documentation.

WHAT DO YOU SEE AS THE CHALLENGES OR LIMITATIONS OF DPC FOR BOTH PROVIDERS AND PATIENTS?

DPC is a relatively new practice model, and we are still becoming aware of challenges or possible limitations.

A few challenges that I've encountered:

- There is a lack of awareness about DPC in the community.
- Some patients may not have credit cards or bank accounts for arranging automatic payments.
- Forming relationships with specialists for referrals for cash paying patients can be challenging.
- Time can also be a challenge, as most DPC practices begin with one provider.

WHAT DO YOU SEE AS THE BENEFITS OF DPC FOR BOTH PROVIDERS AND PATIENTS?

In the DPC model, patients tend to spend more time with their doctor and have direct access via email and/or phone. This fosters a uniquely positive physician-patient relationship. It also allows for more thorough medical evaluations, which can lead to more thoughtful diagnoses and comprehensive care plans.

Physicians tend to have smaller patient panels, less daily visits and less documentation. The DPC model offers physicians the opportunity to get off the insurance/hospital system treadmill and do what they love best—take care of people.

CAN A DPC PRACTICE TREAT PATIENTS WHO HAVE INSURANCE?

Yes! Mperial Health and other DPC practices certainly treat patients who have insurance, but we do not use insurance to process payments.

About 90% of our patients at Mperial Health have insurance (high deductible, low premium).

WHAT IS THE PATIENT DEMOGRAPHIC OF YOUR CLINIC?

At Mperial Health, our patients range in age from 1 to 73. We see slightly more women than men and most of our members are employed.

HOW HAVE YOUR PATIENTS RESPONDED TO YOUR PRACTICE MODEL?

My patients appreciate the practice model and have invited their friends and family members to join.

The most favorable aspect to patients of the DPC model appears to be the incomparable access to and time with their doctor.

DO YOU HAVE ANY CONCERNS ABOUT THE LEVEL OF ACCESS PATIENTS HAVE TO PHYSICIANS IN THE DPC MODEL?

The level of access patients have to their physician is the greatest benefit to the DPC model.

In traditional practices, patients may not seek medical attention because of costs and lack of access. This typically leads to patients presenting to the health system sicker (waiting longer to be seen) or not at all. However, in the DPC model, patients have the ability to call, text and/or email a physician—many issues are resolved without clinic visits.

HOW DO YOU THINK THIS MODEL SAVES MONEY FOR PATIENTS?

At Mperial Health, we offer three membership plans, with monthly and annual payment options. Our plans are significantly less expensive than health insurance premiums. When one factors in the amount of care paid prior to deductibles, we are able to save tens of thousands of dollars for individuals and families.

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- Tremors
- Dizziness
- Dementia
- Stroke
- Numbness
- Head Injury/Concussion
- And other Neurological Disorder

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THANK YOU, DONORS!

Your generous donations this past year have helped suport the next generation of family physicians in Minnesota—a.k.a #NexGenFM

The following members and organziations donated to the MAFP Foundation between July 1, 2017 and December 31, 2018. Every effort has been made for accuracy, but if we inadvertently overlooked your gift, please let us know.

- Kerrie Allen, MD
- Michele Allen, MD
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- Debbie Allert, MD
- American Academy of Family Physicians Foundation
- Emily Anderson, MD
- Julie Anderson, MD, FAAFP
- Gregory Angstman, MD, FAAFP
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The MAFP Foundation is celebrating its 30th anniversary...

...and, with your help, we'll raise $30,000 for our student and resident programs.

Donate today and support Minnesota's next generation of family physicians.

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- Roman Zownirowycz, MD
- Katie Zurek, MD

Per End-of-Month AAFP Reports for the Following Months:

- October 2018
- November 2018
- December 2018

NEW TO THE LAND OF 3,100 FAMILY DOCS

- **James Boulger, PhD**, Duluth, has been inducted as an honorary member.
- **Charity Reynolds, MD**, Duluth, has transferred from Colorado.
- **Joshua Butler, MD**, St. Louis Park, **Craig Mason**, Rochester, and **Jonathan Rief, MD**, South St. Paul, have transferred from Foreign AFP.
- **Scott Maanum, MD**, Glenwood, and **Brett Van Kley, MD**, Windom, have transferred from Iowa.
- **Lauren Graber, MD**, Minneapolis, has transferred from Massachusetts.
- **Aisha Chaudhry, MD**, Maple Grove, **Lynne Didrikson, MD, FAAFP**, Roseau, and **Douglas Forgit, MD**, Mendota Heights, have transferred from North Dakota.
- **Renee Schlabach, MD**, Duluth, has transferred from Ohio.
- **Michael Baule, DO**, Detroit Lakes, has transferred from South Dakota.
- **Clarice Konshok, MD, FAAFP**, St. Cloud, has transferred from Uniformed Services AFP.
- **Leo Bay, DO**, Duluth, has transferred from Washington.
- **Nicholas Cooley, MD**, Ely, has transferred from Wisconsin.

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- Sophie Feng, Rochester
- Tina Hendricks, Rochester
- Sydney Larkin, Rochester
- Camilo Mejia, Rochester

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- Savannah Nelles, Hermantown

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- Minna Ding, St. Paul
- Thomas Kaiser-Powers, Blaine
- Lisa Marshall, Minneapolis
- Morgan Thornton, St. Paul
- Nicole Westphal, BS, Afton
- Jennifer Zick, St. Paul

IN MEMORIAM

KARLA F. KAMMUELLER, MD

Karla F. Kammueller, MD, age 47 of Farmington, passed away peacefully at her home on February 7, 2018. Karla was born in Brooklyn, New York on September 25, 1970. Karla attended University of MN Duluth, majoring in biology, then pursued a medical degree at the University of Minnesota Twin Cities, specializing in family medicine. She interned at Methodist Hospital before joining the staff at the Allina Health Farmington Clinic. She worked there as a dedicated physician and leader. Her passion for providing care to the geriatric population led to an additional opportunity at Trinity Nursing Home in Farmington, MN. She is survived by her husband, Davey; daughters, Lindsey and Rachael; parents, Georg and Carol Fischer; siblings, Georg (Amy) Fischer, Erica (Scott) Olson, and Lynda (Jerry) Sirek; also by her loving nieces and nephews, other relatives, and many friends.

DONALD LEE WERNER, MD

Donald Lee Werner, MD, 87, of Virginia, and formerly of Aurora, died on Tuesday, Sept. 12, 2017, in Virginia. He was born May 21, 1930, in Randolph, Wis. Don was a battle group surgeon with the 9th Infantry Regiment in Fairbanks, Alaska, from 1956-1958, with the 130th Field Artillery Battalion of the Wisconsin National Guard from 1958-1960, the U.S. Army reserve from 1960-1962 and Employer Support for the Guard and Reserve with the Department of Defense from 1995 to present. Dr. Werner began his medical career at St. Joseph's Hospital in Marshfield, Wis. In 1960 he moved to Aurora, where he practiced at the East Range Clinics in Aurora, Virginia, and Eveleth from 1960 until 1992. He was an active member of the Peace United Methodist Church, Phi Chi Medical Fraternity, and General Chairman of the Mining Section National Safety Council 1975-1996. Don is survived by his wife, Elva; children, Sara L. (Thomas) Thompson of Hockessin, Del., Mark D. (Debbie) Werner of New Braunfels, Texas, and Ross R. (Nancy) Werner of Elk River, Minn.; sisters, Christa L. (Stephen) Slinger of Randolph, Wis., and Nancy A. Masche of Pewaukee, Wis.; grandchildren, Amanda (Andrew) Bird, Robert Thompson, Luke Werner, Katelyn (Spencer) Le, Nicholas Werner, and Alexandra Werner; extended family and friends.

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