SUMMER 2019 • VOL. 3 • No. 3

MFP

MINNESOTA FAMILY PHYSICIAN

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20

St. Jude patient Keeton
blood cancer
pictured with his mom, Ginna

Keeton's family didn't give up. We won't either.

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MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

By Renée Crichlow, MD, FAAFP
MAFP President

THERE'S NO HAPPINESS IN HEALTH CARE REFORM. IF YOU WANT TO BE HAPPY, MEDITATE

I just got back from a big, fancy East Coast medical school discussion on the future of health care reform. The title of this article is a quote from one of the lead professors. Other quotes I heard that day are: "Yeah, we're just making it all up and seeing what happens" and "Just doing our best." And if I had to tell one person, I had to tell 10 people: "We are not family practice; we are family physicians. We practice family medicine and we are the backbone of decent, cost-effective health care in this country." I was clear that, if reform is going to be done correctly, family medicine must be in the conversation. I was subsequently informed that, in the composition of our current hyper-partisan, polarized governing atmosphere, the likelihood of any effective, sweeping health reform is as close to zero as you can imagine.

Fine. We are family medicine doctors and this is Minnesota, not Washington, DC. We are practical and innovative people. If this "atmosphere" is the reality of the situation we're living in, then we will work with what we have and do what we know we can. And we actually have a lot to work with, including more than three thousand members who care about their patients, their communities and the health of their state.

At the MAFP, we have an organizational structure that can facilitate listening to members and advising policymakers regarding reasonable and possible local health reform choices in Minnesota—local choices that can help make Minnesota's patients healthier and happier and maintain fair and sustainable investment in Minnesota's family physicians who are caring for Minnesota's people.

Local changes are possible when we work together. The pharmacy benefit manager (PBM) legislation, as mentioned in this issue of Minnesota Family Physician, is just the beginning. We are so grateful to all the many members who took part in this effort, including sending the email Speakouts, sharing their patients stories and directly explaining the harmful effects of PBMs and prior authorization on the patients we care for. Medical students, resident physicians and practicing family physicians all around Minnesota, taking a small amount of time, can actually make a big difference.

There may be no "happiness" and health reform on the federal level. Happiness is not what we're looking for. We're looking to make a difference in the lives of our patients and members and help the state that we love continue to be among the healthiest in the country and a great place to practice family medicine. Working together, the membership of the MAFP is actually quite powerful, and local reform will happen as we coalesce around this fact. It won't be easy, it won't be simple, but it is possible and it is worth it. Our patients are worth it and you, our members, are worth it. And you know what? That makes me happy.

Sorry, professor; you are wrong.

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 134,600 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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MAFP HEALTH EQUITY EFFORTS

The Minnesota Academy of Family Physicians Health Equity Task Force, created based on a 2018 House of Delegates resolution, is the vision of many family physician leaders working within their clinics and communities to address the overwhelming disparities affecting healthcare in Minnesota. Three of the founding members, Roli Dwivedi, MD, Andrea Westby, MD, and Christopher Reif, MD, MPH, shared their perspectives below on why family physicians should be thinking about the many areas affecting health equity in Minnesota and their role in addressing these disparities.

"Primary care physicians have a critical role in building healthier communities. It is common knowledge now that health inequities exist, but when it comes to addressing the inequities, there is lack of time and comfort among providers on when and how to address them. There are several experts and organizations within Minnesota who have done tons of work in the field of race/racism/social determinants of health and health equity which can be incorporated in a day-to-day practice, but not all members are benefiting from this great work. In order to improve knowledge of the current and future workforce and health outcomes of diverse communities in both urban and rural areas, a bigger outreach needed to happen to all the members. I have been engaged with the MAFP for the last 13 years and strongly think that the MAFP is the perfect platform to engage and educate members, collaborate at state, national and international levels with other organizations that are doing similar work and advocate for the policies that improve health equities," **Roli Dwivedi, MD**, shared.

Andrea Westby, MD, added, "Minnesota has some of the most significant health disparities in the country. Family physicians care for patients from birth to death and everything in between, and often have important insights into and relationships with families and communities, and the majority of Minnesotans receive care from family physicians at some point each year. With this lens and a wide breadth of patient experience, I believe that family physicians are ideal champions for health equity, and I felt strongly that the MAFP needs to be a leader in assisting family physicians in promoting health equity in Minnesota."

The task force led a track focused on health equity at the 2019 MAFP Spring Refresher and encouraged the invitation of keynote speaker Bruce Thao, the director of the Minnesota Department of Health's Center of Health Equity, to provide an overview on the state of health equity in Minnesota. Throughout the track, attendees learned about the impact of implicit bias and structural racism on many Minnesotans' ability to access the health care that they need.

The AAFP has also made health equity a priority issue nationally. Through the AAFP EveryOne project, members can find resources to help uncover potential unconscious biases within your practice and learn how to build a culture

of health equity. Members can access tools to help with the implementation of screening for social determinants of health within the clinic's workflow, connect with community resources and learn how to advocate for health equity in partnership with local communities.

The MAFP is committed to helping members understand what steps they can take to help address health equity. Through partnerships, the MAFP has offered programming on LGTBQ health, Native American health, structural racism and housing insecurity. The task force will continue to develop programming and resources to assist family physicians in addressing disparities.

"We want all our patients to achieve their highest level of health. We know that some of our patients face barriers to good health—inadequate insurance (or none), expensive medicines, beginning English, difficulty finding good housing or good food and discrimination because of their race or immigration status. It's important for family physicians to be aware of and sensitive to these barriers for our patients. And it's also important for us to advocate within the health systems and public health systems to reduce those obstacles," added **Chris Reif, MD, MPH**.

FIRST STEPS/NEXT STEPS IN ADDRESSING HEALTH INEQUITIES

"Think about how to make your clinic a welcoming place. It helps if we have staff who are also diverse in race, language, culture and sexual orientation. And to have artwork, magazines and health education materials that speak to different cultures. Also, realize that different people have different ideas of what good health means for diet, body size and exercise. Be sensitive to discrimination your patients may experience in their world of work, school and health care that could interfere with good care or cause stress. Offer help in finding resources in the community that can help get them affordable medicines and services. And then find opportunities to advocate at your clinic, and in your community and city, to provide the resources that will help level the playing field for all our patients to get good health. And advocate against policies or practices that discriminate against people based on race, religion, sexual orientation."

Chris Reif, MD, MPH
Director of Clinical Services
Community-University Health Care Center

"I think it is incredibly important for family physicians to educate themselves about the root causes of inequities and systemic oppression and the impact medicine and science has had on oppressed communities. There is a large volume of evidence (mostly in the sociology and public health, but more recently in the primary medical literature) about the effects of systematic oppression on populations and resulting health and opportunities for health, and for us, as medical providers, to make any amount of meaningful change, we need to listen and learn from the experts, including patients themselves about their lived experiences. Listen to podcasts, read books and articles, watch documentaries and have conversations with those whose experiences are different than yours."

Andrea Westby, MD
Faculty, University of Minnesota North Memorial Family Medicine Residency

"Acknowledge that inequities and racism exist, being explicit about it and naming it. Reflect every day from patient to patient on why someone's health is better than others and what, as a physician, can be done. Center in the marginalized populations. Accept your own biases without feeling guilty about it. Advocate at different levels like community measures, payers, education system, health care systems, etc. And empower patients to speak up."

Roli Dwivedi, MD
Chief Clinical Officer
Community-University Health Care Center

HEALTHFINDERS COLLABORATIVE: CONNECTING CLINICAL CARE TEAMS WITH COMMUNITY-ENGAGED RESOURCES

HealthFinders Collaborative is a nonprofit community health center, providing medical, dental and wellness services and programming to the underserved in Rice County, Minnesota.

Charlie Mandile, MPH, its executive director, describes HealthFinders Collaborative as an organization built around the idea that health happens in communities. HealthFinders connects clinical care teams with community-engaged resources to provide effective, quality health and wellness care.

Since opening a clinic in 2005, HealthFinders Collaborative has served more than 8,000 patients across 40,000 appointments. Each year, more than 100 professionals and interns provide upwards of 3,500 hours of volunteer service.

We talked with the HealthFinders Collaborative executive director and two MAFP members, **Marshall Hansen, MD**, and **Michael Wilcox, MD**, who volunteer with HealthFinders, to learn more.

Photo provided by HealthFinders

WHY WAS HEALTHFINDERS COLLABORATIVE CREATED?

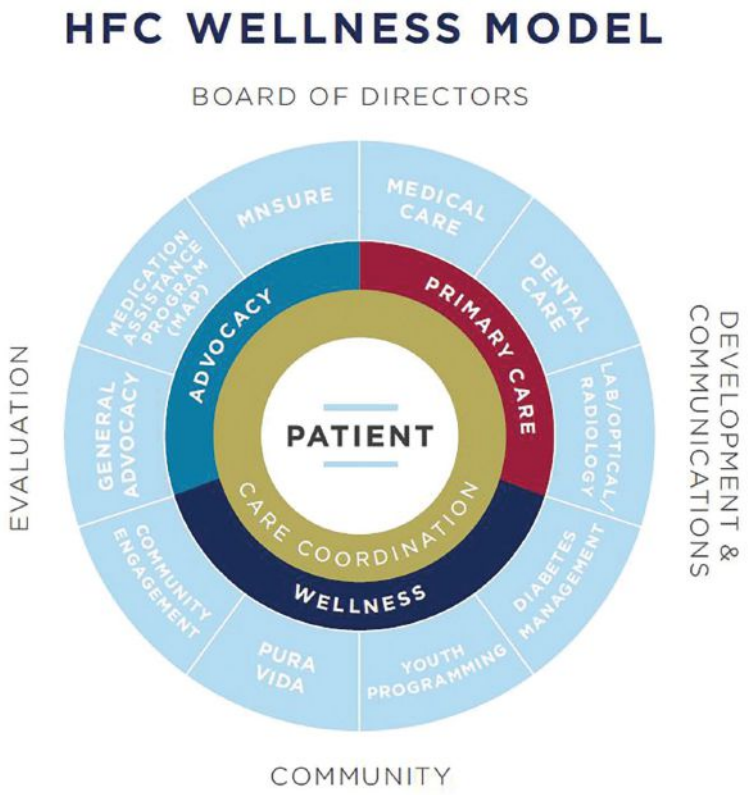
Mandile: HealthFinders began as a collaborative of community members dedicated to providing healthcare options for the underserved. We used our free clinic roots to innovate, putting everything on the table for health. We support folks to be healthy in their context, meeting them where they are with home visits, an array of wellness and chronic disease programs and robust patient advocacy and supportive services. As much as we are a safety net, we are also an access point. Not only do we serve patients at our clinics, we work to extend the reach of local health system partners through care coordination and clinic-community partnerships.

WHAT HAS BEEN THE IMPACT OF HEALTHFINDERS COLLABORATIVE ON THE COMMUNITY?

Hansen: We have a mission: to work as a team to improve the health of our [underserved community] without concern for ability to pay, citizenship or what we get out of it. Uninsured and underinsured patients still number in the thousands in nearly every county in Minnesota, with bad health, social and economic outcomes that affect everyone. Recent studies looking at how safety-net clinics, like HealthFinders, prevent lost work days, emergency room visits, hospitalizations, delayed diagnoses and worsened outcomes, as well as increase quality-of-life and life expectancy for patients, suggest at least a tenfold return on investment for both communities and patients. And this doesn't account for the benefits of keeping kids in school, families together and businesses running.

WHY DO YOU THINK THE HEALTHFINDERS COLLABORATIVE MODEL WORKS WELL?

Wilcox: This model works because of 1) the focus on community (specifically with providers going into the community to provide care), 2) the focus on training and education, 3) innovation in new(er) areas of patient care (like mental health, chemical dependency and chronic disease management, especially in the elderly) and 4) the combination of dental care with medical and wellness care. It's a great model to continue to build on. Going forward,



I think we'll see more of a focus on community paramedics and health workers in helping folks gain access to care who don't have it.

HEALTHFINDERS COLLABORATIVE WILL BE MOVING TO A NEW LOCATION. CAN YOU TELL US ABOUT IT?

Mandile: This fall, we will be moving into an 8,000-square-foot facility in Faribault from our current location, a storefront in historic downtown Faribault. The facility will include six dental operatories, four medical rooms, space for mental/chemical health services, a lab, a food pantry, wellness and advocacy space and more.

HOW CAN PEOPLE DONATE TO SUPPORT THE WORK YOU'RE DOING AND/OR GET INVOLVED THROUGH VOLUNTEERING?

Mandile: Visit our website at **healthfindersmn.org**. Click on "Donate" or "Get Involved" at the top of the page.

By Michael Butner, MD
Family Physician, HealthPartners
Central Minnesota Clinic

PTSD/PTRIP

Post-traumatic stress disorder (PTSD) is a watchword of our age. This useful acronym describes a set of symptoms just like "CHF" describes those of congestive heart failure. PTSD brings to mind the hyper vigilance, flashbacks, recurrent panic attacks and deep perceptions of dread triggered by stimuli that are connected to some previous traumatic loss.[1] Neither PTSD nor CHF, acronyms as they are, fully encompasses either condition and neither term definitely leads to a specific treatment protocol. Both terms are just shorthand descriptors of a set of symptoms related to a medical state that needs resolution. In the case of violent loss, this restorative process has been called the Post-Traumatic Re-Integration Process (PTRIP). As will be shown, it is a process very analogous to grief.

In the 1970s, Elisabeth Kübler-Ross published her landmark work, On Death and Dying[2]. In this work, she laid out a model that described five stages of reaction that followed one's recognition of end-of-life events. These stages were 1) shock, 2) denial, 3) bargaining, 4) sadness and 5) acceptance. In these same 1970s, military counselors adopted this five-stage model for the treatment of combatants. In this model, "death" was replaced by "violent loss", and the five stages were modified to 1) shock, 2) denial, 3) bargaining, 4) sadness or depression and 5) self-forgiveness. In the years that followed, it became obvious that this model for post-traumatic adjustment was applicable to anyone, not just soldiers, who had suffered any kind of violent loss, be that physical, emotional or spiritual. PTSD is not something new. In WW I, it was known as "shell shock." In WW II, the term changed to "combat fatigue." "PTSD" is just today's title for the same thing.[3]

During the twentieth century, valuable treatments were developed to assuage the distressing symptoms that follow

the violent loss of anything held precious by the patient (sense of security, honor, identity or continued existence). These treatments centered most notably in cognitive behavior modalities and supportive counseling. These modalities are still appropriate. However, during the post-Vietnam War period, additional insights were gained, whereby the tools of multiphasic personality inventory testing were integrated into the therapeutic process.[4] It is from the amalgamation of these treatment modalities, coupled with Kübler-Ross's model and personality definition, that "PTRIP" arose.

The history of personality inventory assessment in the military begins with its use as a method whereby new recruits were evaluated for different job assignments or specialties in the military.[5] A complicated numeric system was even developed that served as a guide for best job placement based on the recruit's attributes, everything from being a cook to a combat infantryman.

In this classification process, four basic personality types were commonly recognized. These types were 1) mission-driven people,
2) purpose-driven people,
3) self-centered people and
4) other-centered people. At times, other terms were used to describe these four types (adrenalin addicts, normal people, egomaniacs and selfless warriors). In the civilian world, these four classes have been titled 1) professionals, 2) normal working people, 3) narcissists and 4) dedicated care givers.[6]

TABLE 1

STAGES OF GRIEF/POST-TRAUMATIC RE-INTEGRATION

1) SHOCK
2) DENIAL
3) BARGAINING
4) SADNESS/DEPRESSION/ANGER
5) ACCEPTANCE/ SELF-FORGIVENESS

TABLE 2

PERSONALITY TYPES

1) MISSION DRIVEN – PROFESSIONALS
2) PURPOSE DRIVEN – NORMAL WORKING PEOPLE
3) SELF-CENTERED – NARCISSISTS
4) OTHER-CENTERED – DEDICATED CARE GIVERS

Mission-driven people are those who receive primary

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gratification from doing whatever it is they are doing. In the military, these are the highly valued individuals who follow orders and who are satisfied with the short-term gratification that comes from "completing the mission." In civilian life, this same personality type is fulfilled by doing what they love. Musicians, athletes, teachers or care-givers may or may not become rich or famous, but they are still gratified by the sounds, sights and results that their actions produce. In short, it is the action itself that has value.

Purpose-driven people do things for secondary gain. Men and women enlist in the military to gain job skills, funding for future education, satisfaction of family traditions or supplemental income or retirement. In civilian life, these are the people who work for a paycheck. It is the result, not the action itself, that gives self-definition.

Self-centered people are those who feel themselves to be above everyone else. These people are frequently very charismatic and good leaders. They frequently become officers and commanders in the military. In civilian life, these same people are frequently recognized as being powerful business leaders, aggressive lawyers, arrogant/always-certain doctors or professors or power-seeking politicians. The primary characteristic here is that this kind of person doesn't feel guilt like others do.[7] These are the self-made gods who have elevated themselves above normal law or social convention. They frequently dominate the media.

Finally, there is the **other-focused person**. In the military, these people are those who have proven by their actions that they will sacrifice themselves, either for others or for some ideal. These are the "heroes." In civilian life, these people are usually seen as being selfless caregivers (everything from being a dedicated parent to being a recognized social savior). The bottom line is that this kind of person values others more than self.

It is obvious that all people are composites of these four personality types. All have their heroic or selfish or driven moments. The takeaway is that everyone tends to spend more time in one of the four categories than the others. It is this preferred stance that indicates how one will pass through the first four stages of re-integration that follow trauma. What follows are the pearls.

Mission-driven people frequently get stuck in the second stage: denial. This denial may take the form of substance abuse, dysfunctional behavior or emotional disengagement. Alcohol abuse, workaholism or professional disassociation are all examples. The important point here it that this kind of person has addictive tendencies that the therapist must be careful not to facilitate.[8]

Purpose-driven people are those who tend to get mired down in the fourth stage of re-integration: depression. Certainly, loss is analogous to grief. It has been recognized that there are no curative chemicals for grief.[9] Likewise, there are no magic potions for the sadness related to violent loss. But this does not mean that well-proven modalities for depression management (be they supportive counseling or judicious use of medications) should be avoided. Depression is still "anger turned inward,"[10] and therapists must not be afraid to use what has been learned since Freud to treat this kind of victim.

Narcissists seldom seek counseling. The understanding here is that this kind of personality just doesn't have the internal psychic framework that allows for consistent introspection. When these folks decompensate, they are more likely to become the "homeless vet" or the emotional derelict.[11] These are the sad cases, as it is known that the narcissistic personality type is very resistant to change.

And then there is the selfless person. Here, there are three important points. First, this person can get stuck in any of the first four stages of re-integration. Second (probably because this kind of person doesn't value self very much), this personality type is the most likely to turn to violence when decompensation is present. (Most often, this violence will be self-directed, but sometimes not. Sometimes the "hero" becomes the "monster.") And third, there usually has been some change in social support system (divorce, death of loved one, loss of social stature, etc.) that has caused further social isolation, effectively acting like a trigger. The therapist must be willing to intervene with whatever resources are available to prevent tragedy.[12]

In summary, PTRIP and grief are nearly identical siblings. Loss is a universal condition. Understanding its pathways and pitfalls is a management

tool needed by all.

Michael Butner is a long-term family physician whose work history has included both the acute and chronic counselling of victims of trauma. He has cared for military and agency personnel, fellow professionals and victims of terrorism at multiple locations. He currently is employed by HealthPartners.

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NEW LEGISLATION ESTABLISHES PHARMACY BENEFIT MANAGER LICENSURE

With the only divided legislature in the country, Minnesota's legislators worked to find common ground to pass legislation on behalf of Minnesotans. In the healthcare arena, one concern arose early and found bi-partisan support: a desire to understand more about the role of pharmacy benefit managers (PBMs) and how they affect drug pricing and availability. Two family physician legislators, Representative Alice Mann (D-Burnsville) and Senator Scott Jensen (R-Chaska), were instrumental in creating and shepherding legislation that addresses the role of PBMs through both chambers. This legislation will require licensure for pharmacy benefit managers and mandates that licensed PBMs provide the health plans sponsoring the prescription drug benefit and the Commissioner of Commerce with information on the costs, rebates, fees and de-identified claims level data on the utilization and cost associated with prescriptions. The legislation also removes the "gag clause" many PBMs have used in their pharmacy contracts, allowing pharmacists to share with patients information on potentially less expensive therapeutically equivalent drugs. The MAFP's Director of Advocacy and Engagement, Jami Burbidge, reached out to Representative Mann and Senator Jensen to learn more about their goals for the legislation, how being physician legislators impacts their approach to their work and the process of driving the legislation from first draft to the governor's desk.

Representative Alice Mann, a legislator in her first term, authored and championed this legislation in the House. "My goal for the PBM legislation was to bring some transparency to a very obscure player in our healthcare system. PBMs are allowed to make some very consequential medical decisions, such as what goes on a formulary, without any oversight. Those decisions have real medical outcomes, such as new visits to the emergency room and increased costs to patients."

Senator Scott Jensen spoke to the timing of this legislation. "There is an emerging awareness that pharmaceutical costs are currently the leading driver for inflation in the health care arena. It has culminated in widespread legislative efforts to address this challenge. Pharmacy benefit managers serve in the role of middlemen and operate largely through protected contracts and gag clauses. By blowing open the doors of transparency, this legislation should bend the health care cost curve downward in a real and measurable fashion. In 12 months' time, data will likely demonstrate that significant savings have been produced, particularly for patients and local independent pharmacies."

Minnesota is fortunate to have these two family physicians serving in the legislature. Their unique experiences and voices were pivotal in the success of this legislation. When asked about how her experiences as a family physician prepared her for her legislative service, Representative Mann stated, "In a clinic or emergency room, we diagnose the patient, try to find the best solution and immediately work on that solution. That experience helped me identify my goals immediately. By keeping the patient as my focus, because I knew the struggles they face, I was better able to craft legislation that would have a direct impact on people's lives and make their lives a little better. The entire process of how a bill moves from a piece of paper on a desk to a state law is very intricate. Many different players are at the table. In crafting legislation, I truly learned how many different elements go into just one bill."

Senator Jensen added, "As a physician working in the trenches of medical care for 35 years, my familiarity with the supply chain of pharmaceutical products allowed me to aggressively confront pharmacy benefit management companies and lobbyists in order to arrive at acceptable statute language that would produce genuine reform in regards to pricing, rebates, discounts, spread pricing and claw back mechanisms. My working knowledge of medicine made it difficult for lobbyists to convince me that their clients were conducting business in the only way possible. I protested and was able to get my legislative colleagues on board with me such that the PBM bill in Minnesota passed with widespread bipartisan support in both the House and Senate and was promptly signed by the Governor."

When asked to reflect on the process of getting this legislation passed, Representative Mann shared, "I'm really proud of the final product, and the feeling of knowing that a bill that I personally researched, revised and rewrote became a law is intensively satisfying. I ran for office to make these kinds of changes. Learning the process of how to do that, and getting this bill across the finish line, knowing that it will help people, was the high point. However, working through that process was a battle. Learning about the power that lobbyists have over certain legislators, and how those outside groups can influence whether a legislator ultimately supports a bill, was a low point."

Governor Walz signed SF 278 into law on May 17. The licensure of pharmacy benefit managers will begin in January 2020, and required reports to the Commissioner of Commerce and the sponsoring health plans begin in subsequent months.

By Alex Vosooney, MD

You don't have to be a legislator to have an impact on the legislative process! MAFP member **Alex Vosooney, MD**, testified before multiple committees and spoke to the press on the role of pharmacy benefit managers in healthcare. She shares her thoughts below on using her voice to influence the legislative process on behalf of her patients and profession.

Family physicians' strength is being able to translate the legislation in front of the committee to real world scenarios—to humanize the legislation. I focused on sharing how PBMs affect my ability to choose medications for my patients, how gag clauses at the pharmacy prevent the pharmacists from helping my patient find the most affordable medication, formulary changes that mean we have to switch off of a medication that's working well and how those rules affect my patients in terms of money and need for office visits.

The MAFP staff and lobbyist Dave Renner were so helpful in guiding me through the process of writing testimony and prepping me on how to speak to the committee. It was a little intimidating to sit in front of the committee—a little less intimidating then presenting at grand rounds—but that faded quickly as I realized the committee really wanted to hear a physician perspective on how patients are affected by PBMs.

Speaking to the press was also a little intimidating, mostly because I didn't know which direction the journalist would take the questioning, but the journalist was quick to explain what the focus of his story was, his experience on the topic and the specific questions he had for me. Like the legislature, the journalist really wanted a physician perspective on how patients are affected.

The MAFP is a fantastic resource to help you develop advocacy skills. Reach out to the MAFP advocacy staff if there is an issue you're passionate about and want to get involved. Having perspective from physicians all over the state helps us create a better future for our patients and our profession.

WE MADE IT THROUGH RESIDENCY. HERE'S HOW YOU CAN, TOO

By **Dr. Astrud Villareal, M.D., D.I.M.P.H**

Editor's note: *As a new class of family medicine interns begins orientation and prepares for the start of a new academic year, third-year University of Texas Southwestern Family and Community Medicine resident Astrud Villareal, M.D., D.I.M.P.H. -- with help from her faculty mentors -- compiled the following tips for future family physicians.*

Your Why, Your Resources and Your Mentors

Recall the hours you spent critiquing your residency personal statement. Perhaps you sent a draft to an English major friend who reminded you to change your verbs to a more active form. You spent time and energy perfecting it because what you were saying -- why you chose family medicine -- mattered. Hold on to that why. Hold on to that personal statement. Our personal whys give meaning and purpose to what we do.

Residency is a rough road. There will be moments when you will need to refresh your memory about the reasons you stepped onto it. When those moments appear, remind yourself of your why.

While you are on this road, remember that residency is demanding, time consuming and sometimes frustrating for everyone. Rules change from rotation to rotation. Just when you feel comfortable in one area, you switch.

One way to help ease the struggle is to know your resources. Do not limit resources to items like The Washington Manual of Medical Therapeutics or VisualDx (though both are great). Remember that people -- fellow residents, residents from other programs, faculty, behavioral health teams, social workers, pharmacists and more -- are also valuable resources. Spend time with a senior resident and learn how they maximized learning opportunities without sacrificing their hobbies and well-being.

As you begin residency, equip yourself with the right tools from the start and hold onto ones you find along the way. It can be exhausting, but it is rewarding.

Finding mentors is an important part of equipping yourself. If you had to think about it, I'm sure it would not take long to identify a mentor who already helped you during your journey to family medicine. As you transition from student to resident, it's important to find another mentor who can help you navigate your new role.

Mentors have built wisdom from a culmination of personal experiences, challenges and learning opportunities. Yes, they are able to point out areas that need improvement, but they are also your biggest cheerleaders, and as a resident (who might already be critical of yourself to begin with) you should have cheerleaders.

As I near residency graduation, I reflect on the importance of having mentors who challenged me in various ways, especially to establish boundaries -- reminders that while residency is an important part of my life, it is not the only part.

-- Astrud Villareal, M.D., D.I.M.P.H., PGY-3, chief resident, University of Texas Southwestern Family and Community Medicine Residency

Hobbies, Reflection and Help

Remember what you wrote on the "hobbies and interests" section of your application to residency? As a faculty member reading residency applications, I often ask interviewees about these and truly enjoy speaking to applicants whose eyes brighten when I ask about an unusual hobby. Seeing an applicant's passion for something nonmedical reassures me they will be able to handle the rigors of residency.

As a resident, when a harsh attending's words or a frustrating patient experience made me question my abilities as a physician (or worse yet, my worth as a person), turning to outside hobbies reminded me of all the talents and skills I have, and prevented a single rotation experience from influencing how I view myself. Furthermore, I realized that attempting to fill every waking moment with studying or focusing on medicine actually tipped me in the direction of burnout. But when I gave my brain, heart and spirit a break from resident duties, I came back to work

refreshed, came back to studying with more focus and came back to resident life with renewed zeal for family medicine. Though it may seem counter-intuitive, maintaining interests outside of medicine protects against burnout, augments physician performance and makes it easy to create human connections with patients.

It also helps to reflect on what it means to be a physician. As an applicant, I enjoyed the residency interview trail because many of the questions required me to think deeply and articulate how my experiences in medical school had fostered my growth as a physician and a person. Then residency began -- and with the often-overwhelming pace and volume of work, it was easy to get lost in daily routines without stepping back to reflect on the gravity of what we do daily as physicians. These moments can affect each of us profoundly, sometimes leaving lasting impressions -- or wounds -- that we may not readily notice.

Formal venues like support groups or Balint groups in residency are opportunities to safely discuss such experiences with peers and mentors, but I have found other strategies equally helpful. Opening up to a close friend or family member, regardless of whether they are in the medical field, has often helped me get frustrations off my chest or allowed me to share a proud moment. Sharing stories with those outside medicine has reminded me of the sanctity, privilege and burden inherent in being a physician that can be forgotten when one is immersed in work all the time.

Regarding those burdens, it's helpful to consider a tradition from my residency where each resident shared a three-minute "about me" presentation. This included answering the question, "When I am stressed, you can help me by …" It forced me to really think about how I react to stressful situations and how I interact with others during times of stress. Because of the variety in our responses to stress, those around us may not understand how to help us in these moments.

The value of telling others how to help is that it allows us to be proactive and intentional about recognizing our own stress management methods and communicating these to our colleagues. The end results are a better understanding of ourselves and a tailored approach to how we can best support each other.

-- Turya Nair, M.D., associate program director and assistant professor, UT Southwestern Family and Community Medicine Residency

Relationships, Acceptance and Boundaries

My first tip is a two-for-the-price-of-one. First, the training process affects not only residents, but also their friends, family and significant others. Stressful work environments can create imbalance, distance and conflict at home.

It's important to stay cognizant of how the stresses of residency can spill over to close relationships, and how you usually share them. Telling friends and family about the daily and structural elements of residency -- including choices, stresses, constraints and cultural rules -- can help them feel informed and better able to support you during this learning process. It can be hard to remember that although you're embedded in the training process so intensely, people outside of it really have no idea how it works. Being transparent with loved ones can help decrease negative spillover effects and promote closeness.

Second, residents should not be responsible for ameliorating everything that threatens physician wellness, and self-care alone will not be enough to thrive. Close relationships can be key to promoting resilience, so maintain connections with others -- even if how you connect is a little different because of residency work schedules. Let people know if you're struggling, invite them to support you and let them in when they offer.

With all these challenges, try to remember what is in your power to change and what isn't. I regularly use a secular version of the Serenity Prayer to help calibrate my actions and reactions in medicine: "I aim for the serenity to accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference." I even teach it to patients.

If you're facing a frustration, can you do something about it? Do you have the necessary agency, power, resources and support to help make a change? And if not, can you mindfully accept what is, rather than hitting your head against a wall or repeatedly throwing yourself under the bus in attempts to save the system? Keep these boundaries in mind -- and others. Boundaries define who you are, what you're responsible for, and how you want to exist within your training program and workplace. Setting boundaries includes giving yourself permission to say "no" to new tasks.

If "no" is too challenging, start with, "I'll take some time to think about that." Then reflect in private and return with either, "yes" or "I've decided I don't currently have enough time to devote to this task in order to do it well." You might also be able to suggest others who could take on the task in question.

Know what your limits are and respect them. Residency and health care systems will always ask for more of you, and that

continued on page 18

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doesn't change when you graduate. Use the many opportunities during residency to practice defining your boundaries, what you can take on and your professional identity. This will make it easier to do so in the future.

-- Sarah Woods, Ph.D., L.M.F.T., director of behavioral health and assistant professor, UT Southwestern Family and Community Medicine Residency

Astrud Villareal, M.D., D.I.M.P.H., is a board-certified family medicine physician finishing her last year of residency at UT Southwestern Family and Community Medicine. She will be joining the residency faculty and will focus on curriculum development, global health and population health. You can follow her on Twitter @rechargeability.

Originally posted at 10:30 am June 12, 2019 by Astrud Villareal, M.D., D.I.M.P.H., on the AAFP Fresh Perspectives Blog.

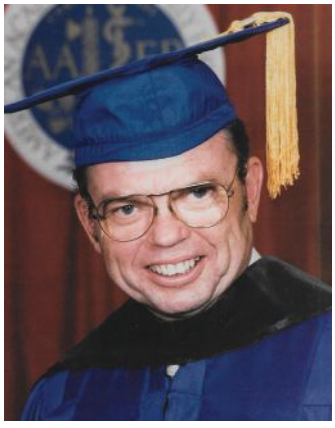
Welcome to MINNESOTA

A FREE EVENT FOR INCOMING FIRST-YEAR RESIDENTS

Fifty-one incoming Family Medicine residents gathered for the Welcome to Minnesota Event at the Science Museum of Minnesota on Sunday, June 23. This event is an opportunity for our interns to connect with Academy leaders, network with colleagues and meet with physician recruiters and representatives of community resources. As part of the event, 10 - $1,000 scholarships are awarded through a gift to the MAFP Foundation from the late **Arden Anderson, MD**. His daughter, Gayle Ober, shared stories with the residents about her father's commitment to family medicine and his experiences caring for patients in the Brainerd community. Resident Director, **Emma Erickson, MD**, talked about her experience as a leader with the MAFP and how residents can get involved and stay informed.

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

Resident Director Emma Erickson, MD, shared her experiences as a leader in the Academy.



Scholarships were made possible by the late Arden Anderson, MD (1926-2004), a family physician from Brainerd, MN, who served as MAFP president from 1972-1973 and 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.

Thank you to our Amazing Sponsors!

Avera Medical Group • CARE Counseling
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Scenic Rivers Health Services

In 50 years, family medicine will continue to approach patient care in a meaningful way that impacts not only the lives of our patients but of their families. My hope is that, in the future, we continue to expand on our practice techniques and outreach platforms so that, regardless of who our patient is, they feel supported by their family medicine physician.

Avosuashi Akande, MD
Hennepin Healthcare

Over the next 50 years, my hope is that family medicine will continue to grow and become the largest specialty of physicians, not just in the Midwest, but also in the United States as a whole. Through increased and ever-growing preventative health services, healthcare advocacy, and a strong presence in underserved areas, we will have reduced healthcare disparities for our patients, colleagues, friends and families!

Kate Roselius, MD
UM Methodist

Family medicine doctors will be part of a team of providers in a medical home that focuses on preventative strategies and integrated care for chronic illness, behavioral health and substance abuse disorders, as well as addresses health care disparities and the social determinants of health using community resources and rigorous patient advocacy. In a technologically advanced world, family medicine providers will continue to provide high quality, evidence-based, comprehensive, compassionate and affordable primary care.

Jonathan Colin Rizo, MD
United

AS WE CELEBRATE 50 YEARS OF THE FAMILY MEDICINE SPECIALTY

We asked 6 of our family medicine interns what they think family medicine will look like in 50 years

I believe that, in 50 years, we will continue to have compassionate family medicine practitioners providing the highest quality of full spectrum care with focus on continuity of care as well as meeting the needs of the community. I also think it is likely there will be an increased focus on team approaches to patient care. Family medicine has an exciting future!

Katie Ehman, MD
Mayo Clinic

In 50 years, family medicine will continue to play a key role in eliminating health disparity and physician shortage. According to a study published by AAMC last year, the United States could see a shortage of up to 120,000 physicians in both primary and specialty care by 2030. This is one of the health care issues that family medicine aims to solve by training more physicians, especially in the field of primary care. In addition, this specialty will continue to provide a better model for expanding access to medical care as it opens the door of opportunity for physicians to practice full scope medicine in areas where health inequality is rampant.

Gam Ferrer, MD
UM St. Cloud

Who knows what medical technology will look like in 50 years? Maybe patients will have a fingerstick for instantaneous labs and walk through an MRI all on their way into the exam room! But whatever happens, patients will always need someone they can trust in the medical world. I think the fundamental role of family physicians will be the same: to be there with our patients from cradle to grave, in their best times and in their worst times.

Maddie Grosland Sather, MD
UM St. Joseph's

Elephant in the Room

Courageous leaders need to stand up to incivility in the health care workplace.

By Laurie C. Drill-Mellum, MD, MPH

Incivility—rude behavior, reluctance to assist, negative comments, lack of respect—we know it when we see it, when we hear it and by marking how we feel when we witness or experience it. The challenge is less about identifying it than about ensuring a culture and leadership committed to addressing it.

From my research, I can definitively state that there are real costs to incivility, from diminished employee and patient experiences to clinician and team turnover to adverse clinical outcomes to, ultimately, reduced financial returns. I believe the time has come to address this problem. It will take strong leadership, courage, commitment and tools—as well as accountability—to succeed.

Parker Palmer, author, educator and founder of the Center for Courage and Renewal, challenges leaders to stand in what he calls "the tragic gap" between reality and possibility. He elaborates: "On one side of that gap are the harsh and discouraging realities around us. On the other side is the better world we know to be possible—not merely because we wish it were so, but because we have seen it with our own eyes."

It's time we stand up and address the "elephant" in our house of medicine, the better to focus on the better world we know is possible.

View the webinar, The Costs of Incivility in Health Care: What We Do and Say Matters, featuring Dr. Drill-Mellum, Chief Medical Officer at Constellation.

MMIC is a member of Constellation, a growing portfolio of medical professional liability insurance and "beyond insurance" companies formed in response to the ever-changing realities of health care and dedicated to reducing risk and supporting physicians and care teams, thereby improving business results.

A version of this article appears in the Spring 2019 issue of Common Factors, published by Constellation.

NEW TO THE LAND OF 3,100 FAMILY DOCS

- Joseph Aziz, MBChB, St. Paul, has transferred from Iowa.
- Khanh Nguyen, DO, Lino Lakes, has transferred from Kentucky.
- Susan Bauer, DO, Park Rapids, has transferred from New Mexico.
- Gerardo Lantoria, MD, Worthington, has transferred from North Dakota.
- Austin Spronk, MD, Luverne, has transferred from South Dakota.
- Laura Padhye, MD, Eau Claire, WI, and Mohammad Taha, MD, Fridley, have transferred from Wisconsin.

NEW RESIDENT MEMBERS

- Avosuashi Akande, MD, Minneapolis
- Michael Babcock, MD, Rochester
- Prakhya Bhatnagar, MD, St. Cloud
- Joseph Blessman, MD, Rochester
- Brian Boben, MD, Minneapolis
- Eleazar Briones, MD, Minneapolis
- Jene Carter, MD, St. Paul
- Jonathan Colin Rizo, MD, St. Paul
- Dustin Collins, MD, Rochester
- Janelle Damon, MD, Minneapolis
- Matthew Decker, MD, Rochester
- Kelsey Deeter, DO, Mankato
- Lance Deeter, DO, Mankato
- Aditya Dodla, MD, Minneapolis
- Katherine Ehman, MD, Rochester
- John Evenocheck, MD, Grand Forks, ND
- Oluwatobi Falade, MD, St. Cloud
- Gamaliel Ferrer, MD, St. Cloud
- Ashley Forstrom, MD, St. Paul
- Ryan Fox, MD, Cannon Falls
- Adam Gonzalez, MD, Rochester
- Brandi Gorden Klukas, MD, Minneapolis
- Madeleine Grosland Sather, MD, St. Paul
- Anthony Hacker, MD, St. Cloud
- Sarah Halloran, MD, St. Paul
- Trenton Harder, DO, Mankato
- Natalie Hemmerich, MD, St. Paul
- Maja Johnson, MD, Hermantown
- Evan Jungbauer, MD, St. Paul
- Kushal Khera, MBChB, Rochester
- Emily Kvasnicka Friedrichsen, MD, St. Paul
- Christopher Mullet, DO, St. Cloud
- Thuy-Linh Nguyen, MD, St. Paul
- Kim Oelhafen, MD, MPH, Minneapolis
- Luis Ortega, MD, Minneapolis
- Laura Padhye, MD, Eau Claire, WI
- David Park, MD, Minneapolis
- Mikhail Reyes, MD, Minneapolis
- Conor Richardson, MD, St. Paul
- Angelina Rohlfs, MD, Mankato
- Lindsay Ryan, MD, St. Paul
- Anatol Silotch, MD, Minneapolis
- Jon Stoffer, DO, Minneapolis
- Jennifer Strong, MD, St. Paul
- Lily Thompson, MD, St. Paul
- Donna Ugboaja, DO, St. Paul
- Katherine Wikholm, MD, Rochester
- Erica Zell, DO, Rochester

NEW STUDENT MEMBERS

American University of the Caribbean School of Medicine

- Shelby Nordmann, Paynesville

Mayo Clinic Alix School of Medicine

- Archis Bhandarkar, Rochester
- Yvonne Bui, Rochester
- Dyda Dao, Rochester
- Mike Fort, Rochester
- Kristyn McLeod, Rochester
- Somaira Nowsheen, Rochester
- Aunika Swenson, Rochester

University of Minnesota Medical School – Duluth Campus

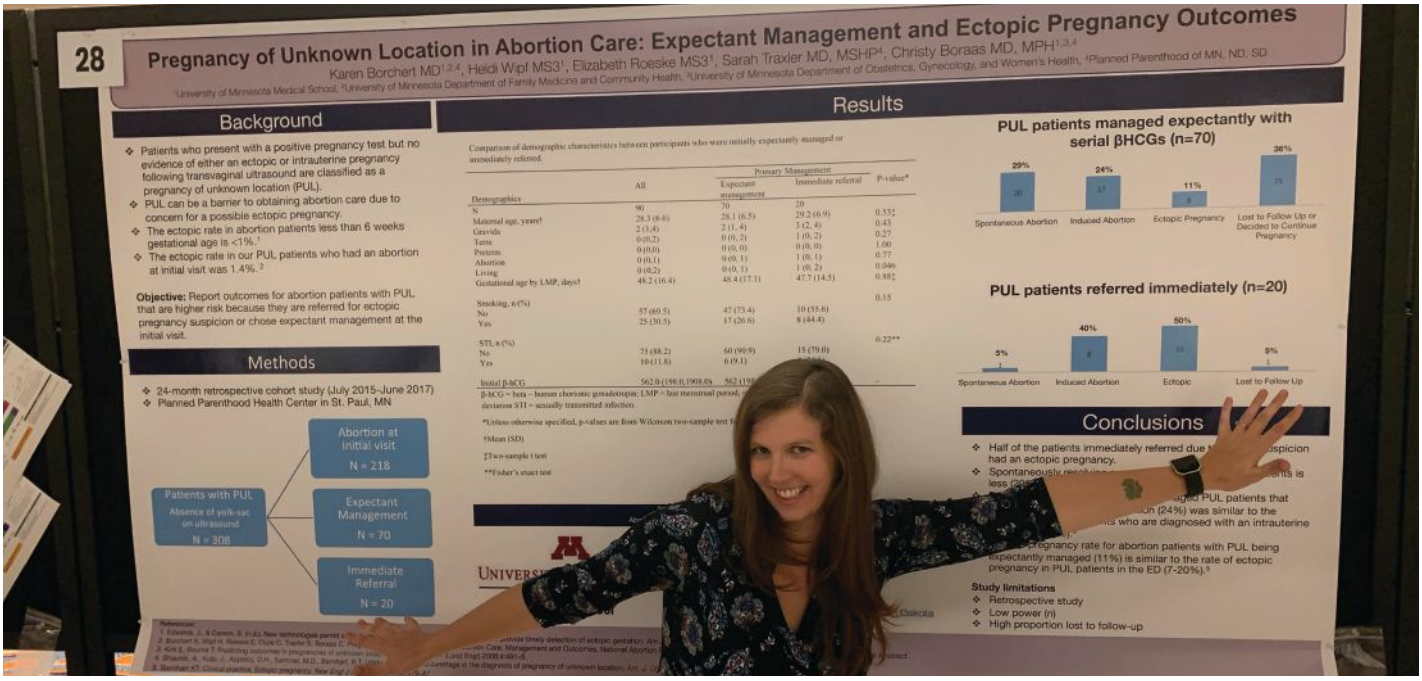
- Abdullahi Abdow, Minneapolis
- Claire Arnold, Duluth
- Maren Bettermann, Duluth
- Mitchell Moe, Montevideo

University of Minnesota Medical School – Twin Cities Campus

- Sowda Ahmed, Minneapolis
- Ruth Baker, Minneapolis
- Kristin Chu, Woodbury
- Alex Conway, Wauwatosa, WI
- Tony Cui, Vadnais Heights
- Kayla Dharampaul, Lakeville
- Cecilia Di Caprio, MPH, St. Paul
- Tobias Donlon, Minneapolis
- Mariah Eggebraaten, Maple Grove
- Brooke Hendricks, Minneapolis
- David Brendan Johnson, Eden Prairie
- Stuart Lien, Minneapolis
- Megan Lucas, Minneapolis
- Nirmal Lumpkin, St. Paul
- Alexa Lyon, Minneapolis
- Elisabeth McAlister, Minneapolis
- Jillian Millares, Minneapolis
- Christian Ndekwe, Minneapolis
- Kelsey Simmons, Minneapolis
- Kyra Valentine, Minneapolis
- Madeline Youngberg, Rochester

IN MEMORIAM

- Daniel Casey Conlon, Sr., MD, Richfield, MN



Karen Borchert, MD, Associate Program Director, University of Minnesota Medical Center Family Medicine Residency

The University of Minnesota Department of Family Medicine & Community Health named **Pita Adam, MD, MSPH**, UM Medical Center, as 2019 Faculty Teacher of the Year.

Robert Bonacci, MD, FAAFP, Program Director, Mayo Clinic FMRP

Robert Bonacci, MD, FAAFP, Family Medicine, Mayo Family Clinic Kasson, received the 2019 Mayo Clinic School of Graduate Medical Education Program Director Award. The award acknowledges extraordinary contributions to the success of the school, trainees and clinical and learning environments. Dr. Bonacci was also recognized by the Association of Family Medicine Residency Directors with the Silver Level Program Director Award, which recognizes the achievements of program directors in light of their unique roles, responsibilities and challenges.

Karen Borchert, MD, Associate Program Director, University of Minnesota Medical Center, received the Scientific Poster Award at the National Abortion Federation Conference in May.

Doctors Jonathan Dickman and **Emily Benzie** penned a letter to the editor of the *The Community Reporter* on gun violence prevention and safe storage, which was printed June 2, 2019.

Roli Dwivedi, MD, Chief Clinical Officer, Community -University Health Care Center, was featured in the *Star Tribune* article *Minnesota Medical Providers Work with Patients to Balance Health with Fasting during Ramadan* on May 31, 2019.

This year's recipients of the Society of Teachers of Family Medicine (STFM) Resident Teacher Award include **Jesse Susa, MD**, UM Duluth; **Zachary Maass, DO**, UM Mankato; **Christopher Leonard, MD**, and **Isaac Zoller, MD**, UM Methodist; **Lonzale Ramsey, Jr., MD**, and **Jessica Wilson, MD**, UM North Memorial; **Sujitha Yadlapati**, **MBBS**, UM St. Cloud; **DJ Fahey-Ahrndt, MD**, UM St. John's; **Brandon Ng, MD**, UM St. Joseph's; **Dan Johnson, DO**, University of Minnesota Medical Center; and **Hailon Wong, MD**, Mayo. The award is presented for demonstrated interest, ability and commitment to family medicine.

Should I test for measles?

a guide for Minnesota healthcare providers

Consider the patient's clinical presentation:

Does the patient have fever, rash (beginning on the face and progressing downwards), and conjunctivitis, cough, or runny nose?

If ***NO***, not measles, no testing required.

If ***YES***, continue.

Consider the patient's history:

Was the patient born before 1957 or have documented history of receiving MMR?

Yes to either; patient was born before 1957 or has a history of receiving MMR

In the 21 days prior to symptom onset, was there any of the following?

- ? known exposure to infected person
- ? international travel
- ? contact w/ international travelers
- ? travel to outbreak state
- ? contact w/ travelers from an outbreak state

If ***NO***

not measles, no testing required.

If ***YES***

is there an alternate explanation for a rash? (antibiotics, strep, mono)

YES

not measles, no testing required.

NO

Has the patient been symptomatic for > 7 days?

YES

not measles, no testing required.

NO

Measles unlikely, but out of an abundance of caution, may choose to

Isolate Call Collect

No to both; patient was born after 1957 and does not have a history of receiving MMR

In the 21 days prior to symptom onset, was there any of the following?

- ? known exposure to infected person
- ? international travel
- ? contact w/ international travelers
- ? travel to outbreak state
- ? contact w/ travelers from an outbreak state

If ***YES*** to any

Isolate Call Collect

If ***NO*** to all

Has the patient been symptomatic for > 7 days?

YES

Measles unlikely,

Call

your local health department for consultation.

NO

Isolate Call Collect

ISOLATE

Isolate the patient according to airborne precautions.

CALL

Call your local health department.

COLLECT

Collect specimens for laboratory testing.

Throat swab on VTM.
Consult with public health for submission to lab.

MAFP FOUNDATION GRANTS

When you donate to the MAFP Foundation, your gift supports MAFP students and resident members working on projects that improve patient care. Last quarter, the Foundation approved six grant applications and will provide funding support to student and resident innovators and researchers. These grants allow students and residents to explore another aspect of improving patient care through the development and implementation of a project, evaluating the results and presenting the findings at the MAFP Innovation & Research Forum. Here are two of the projects made possible by our generous donors:

Assessing Knowledge of Reproductive Justice with Focus Groups of Family Medicine and OB/GYN Resident and Physicians

Student Innovators: Ruth Baker, Brooke Hendricks, Cecilia DiCaprio, Megan Lucas
Medical School: University of Minnesota, Twin Cities
Family Physician Mentor: Andrea Westby, MD
Summary of Project: Believed to be the first project to organize family physician focus groups as a way to assess physician knowledge about the reproductive justice framework and when and how family physicians use a reproductive framework with their patients and identify obstacles in conversations with patients.

Importance to Family Medicine: Findings from the eight focus groups will be used to create a toolkit for physicians to feel more comfortable interacting with patients of all genders through the lens of reproductive health. Patients will feel empowered to make well-informed choices regarding their own bodies while feeling supported in those choices by their physicians and providers.

Effect of Socioeconomic Status on Diabetic Outcomes within a Patient Centered Medical Home Practice

Resident Researchers: Katie Zurek, MD, Jade Grimm, MD, Jason Greenwood, MS, MD
Residency Program: Mayo Clinic Family Medicine Residency Program
Family Physician Mentor: Gregory Garrison, MD

Summary of Project: Test the hypothesis that adult diabetic patients with lower socioeconomic status (SES) as measured by the HOUSES index (a validated individual-level SES measure) have reduced odds of D5 compliance after controlling for confounders. Resident researchers will use a retrospective cohort study to analyze 8,107 diabetic patients at five primary care clinics, in a mix of rural, small town and urban settings, for a period of three years. This will be combined with individual housing features from the HOUSES index available to the public from the county assessor's office.

Importance to Family Medicine:
If lower HOUSES z-scores correlate with worse diabetic outcomes, then tailored services could be developed for at-risk patients in the patient centered medical home practice.

The MAFP Foundation has a goal to raise $6,000 at Destination CME August 17 & 18 at Arrowwood Resort in Alexandria.

Members can donate when registering for the conference
OR
visit https://mafp.org/foundation.

COMING UP NEXT

Destination CME
August 17-18, 2019
Arrowwood Resort
Alexandria, MN

Application Deadline: Research & Innovation Grants
September 1, 2019
Visit https://mafp.org/apply

Made for Medical Students: The Family Medicine Resident Experience
September 14, 2019
9:00 am - 2:00 pm
Pinstripes
Edina, MN

Mayo Advocacy Workshop
September 19, 2019
6:00 - 9:00 pm
Mitchell Student Center - Mayo Clinic
Rochester, MN

Virtual Group KSA: Mental Health in the Community
October 27, 2019
Online
5:00 pm Central (allow up to four hours for completion)

New-to-Practice Education/ Networking
November 4, 2019
6:30 – 8:30 pm
Pinstripes
Edina, MN

Family Medicine Midwest
November 8-10, 2019
Naperville, IL

Intro to Advocacy
January 25, 2020
8:00 am - Noon
Fueled Collective Uptown
Minneapolis, MN

Innovation & Research Forum
March 7, 2020
8:15 am - 2:00 pm
HealthPartners
Bloomington, MN

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