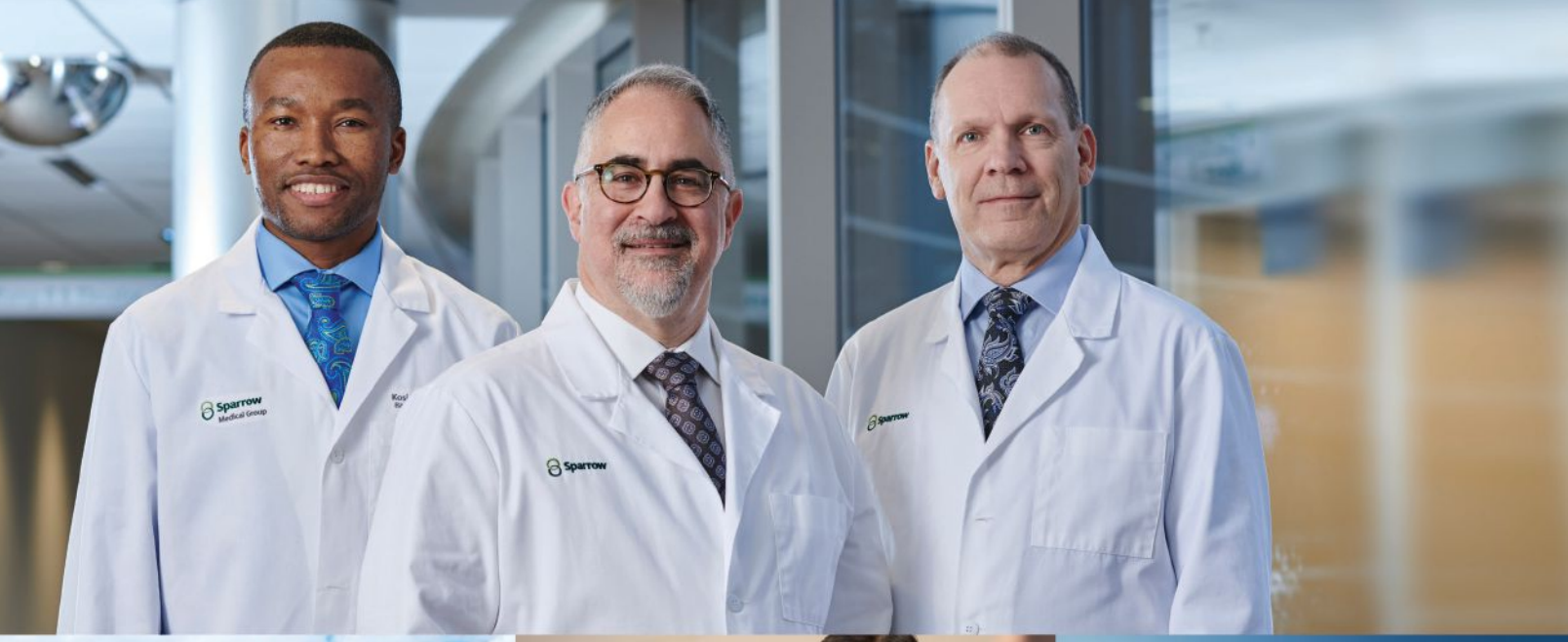
FALL 2019 • VOL. 3 • No. 4

MFP

MINNESOTA FAMILY PHYSICIAN

WHAT'S RACE GOT TO DO WITH IT?

WHY WE CARE ABOUT HOW RACE IS USED IN MEDICAL RESEARCH, PRACTICE AND CLINICAL DECISION-MAKING, AND WHY YOU SHOULD, TOO. **16**



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Dr. Ebiere Okah testifying at the AAFP Congress of Delegates on the resolution Denouce Race-based Medicine.

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ON COVER: Family medicine physicians who wrote the MAFP resolution challenging the use of race in medicine. Back Row (l-r): Zia Okocha, MD; Lauren Williams, MD; Nicole Chaisson, MD, MPH. Seated: Andrea Westby, MD, FAAFP, and Ebiere Okah, MD.

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

By **Renée Crichlow, MD, FAAFP**
MAFP President

CELEBRATING FIFTY YEARS OF EXCELLENCE AND LEADERSHIP

50 years ago, a lot of great things happened in this world, in this country, and in the state. The Apollo 11 landed humans on the Moon for the first time in 1969, as the entire Earth watched. ARPAnet sent the first messages across what would become eventually known as the internet. The training of family physicians at the University of Minnesota refined the great legacy of general practice within the state into a codified specialty of lifelong care.

Our Academy has been deeply integrated into the development and support of family physicians training throughout our state since its inception and even before. In 1965, Dr. Herb Huffington, President of the MAFP (then known as the MAGP, Minnesota Academy of General Practice), advocated the dean of the University of Minnesota Medical School regarding the need to train more physicians in a full spectrum of practice for patients of Minnesota. One year later, the UMN Medical School released a report discussing the need for further family practice training in Minnesota. Dr. Huffington was appointed to the Board of Regents in 1967 and, in 1969, the Department of Family Medicine and Community Health at the University of Minnesota was formed as one of the first family medicine residency programs in the country.

The UMN Department of Family Medicine and Community Health is celebrating its 50th anniversary this month, and the MAFP, which has been with them since the beginning, is celebrating along with them. Minnesota has 11 family medicine residencies in our state, all among the best in the country. Eight of these eleven are under UMN. Of the more than 3,200 family physicians in our state, more than 1,300 were trained at UMN. In fact, the University of Minnesota has trained more family medicine physicians than any other medical school in the country. In the COUNTRY.

In fifty years, the Department has grown and thrived. In addition to its excellence in training family physicians, the Department is highly regarded in many areas, including being among the leading family medicine departments in research, sports medicine, sexual health, and interprofessional training. I may sound a little biased because I chose to move to Minnesota to work with this fine organization, but the facts speak for themselves. The legacy of the MAGP has bound the MAFP and UMN together in our destiny. Minnesota proud is family medicine proud.

Happy anniversary, University of Minnesota Department of Family Medicine and Community Health! Strong work. You have achieved Fifty Years of Excellence and Leadership and we look forward to working together over the next fifty.

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.

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AAFP Foundation Board President-elect **Julie Anderson, MD, FAAFP,** was appointed to the search committee to replace **Doug Henley, MD, FAAFP,** who will be stepping down as CEO and executive vice president of the American Academy of Family Physicians.

Kyle Lau, a fourth-year student at the University of Minnesota and MAFP Student Director, was named as a 2019 Pisacano Scholar. Lau is one of only six medical students in the country awarded with the scholarship, which goes to students who demonstrate a strong commitment to the specialty of family medicine.

Rose Marie Leslie, MD, PGY2, University of Minnesota North Memorial, has been getting a lot of attention for her efforts on educating young people on the dangers of vaping through the social media platform TikTok. We've seen her in *Rolling Stone* and on MPR, KARE 11 and ABC News. Her profile on TikTok is @DrLeslie.

Mark Nelson, MD, University of Minnesota Physicians Mill City Clinic, was featured in the *Star Tribune* article *From Actor to Doctor: Lee Mark Nelson* on September 7.

An interprofessional team at the University of Minnesota led by the Medical School's Head of the Department of Family Medicine and Community Health, **James Pacala, MD, MS**, has received a 5-year, $3.74 million Health Resources and Services Administration Geriatrics Workforce Enhancement Program award to improve the healthcare and health of older adults across the state through education and community partnerships.

Congratulations to **Keith Stelter, MD, FAAFP**, faculty at the University of Minnesota Mankato FMRP, who became the new president of the Minnesota Medical Association on September 22.

We caught up on our reading and learned that **Cody Wendlandt, MD**, Medical Director of Sartell Family Medicine, was named one of 5 under 40 of young business leaders making an impact in both career and community by the *St. Cloud Times* and *LOCALiQ*.

The Physicians Foundation is launching the Vital Signs campaign as part of the Foundation's ongoing commitment to protect physician wellbeing, including addressing burnout, which can have devastating effects on the access, quality and cost of our country's health care. It's estimated that one million Americans lose their physician to suicide each year. As part of this campaign, the Foundation is supporting physician wellbeing efforts throughout the nation, including **Hennepin Healthcare Research Institute's:** *Mentoring to Promote Professional Fulfillment and Reduce Burnout in a Department of Medicine* and **Mayo Clinic's:** *RCT: Effect of Coaching on Mid-Career Physician Wellbeing, Job Satisfaction, & Fulfillme*nt.

CORRECTION

In the summer issue of *MFP*, **Emily Benzie, MD**, was listed as a co-author of a letter-to-the-editor of *The Community Reporter* on gun violence along with **Jonathan Dickman, MD, PhD**. Dr. Dickman was the sole author of the letter. Dr. Benzie has written letters-to-the-editor on the theme of gun violence published in *MinnPost* on April 16, 2019; the *Villager* (Highland Park), April 24 – May 7, 2019; and the *Monitor* (Midway Como) April 2019 edition.

INVESTING IN FAMILY MEDICINE & GLOBAL HEALTH

SPOTLIGHT ON BRUCE DAHLMAN, MD, MSHPE, FAAFP

Grateful. Humbling. Hopeful. Three words Minnesota family physician **Bruce Dahlman, MD, MSHPE, FAAFP**, used to describe his journey in global health.

For more than 25 years, Dahlman has worked with a variety of medical missions and NGOs in Africa, providing essential medical care while also teaching and mentoring physicians. Among his accomplishments, he helped launch Kenya's first family medicine training program and was the founding head of the Department of Family Medicine at Kabarak University in East Africa.

While Dahlman has worked in Africa to expand family medicine training and develop physicians and faculty, he has continued to have a presence in Minnesota, teaching and educating family medicine residents, medical students and colleagues about the relationship between global health and family medicine.

We talked with Dahlman about his work at home and abroad, the power of relationships and opportunities to invest in the future.

WHY DOES FAMILY MEDICINE FIT SO WELL WITH GLOBAL HEALTH?

In any health system, to meet the quality health care needs of patients in a cost-effective manner, the primary care delivery team must be strong, integrated and valued.

However, in most Majority World countries, physician-level primary care is done by internship-trained "medical officers" who aspire to move on to specialty residency training. Because they constantly come and go from rural county hospital assignments, there is little continuity to build the primary care delivery team.

Once a group of residency-trained family physicians are given leadership roles at county level hospitals and district health systems, they are able to build trust and a continuous quality improvement ethic.

WHAT WAS IT LIKE TO DEVELOP FAMILY MEDICINE TRAINING IN KENYA?

Being part of the team that developed family medicine training in Kenya was challenging—so much so that I pursued a Master of Science in Health Professions Education at Maastricht University in the Netherlands to learn more about educational best practice.

Implementing the Digital African Health Library Service in Juba, South Sudan.

The Moi University program was THE FIRST post-graduate residency outside the flagship University of Nairobi and its 1,800-bed Kenyatta National Hospital; THE FIRST family medicine program in Kenya; THE FIRST time distributed, rural hospitals had been used for post-graduate training and THE FIRST partnership between a university medical program and several well-regarded, church-based hospitals.

The Moi University School of Medicine Dean **Barasa Khwa-Otsyula, MBChB**, grasped the need for primary care leadership through family medicine and paved the way at the Ministry of Health and Kenya's medical licensing body to recognize family medicine as an equal specialty with the others.

As a result, the Ministry of Health has valued family physicians with the same salary and benefits as other specialists. When a Kenyan chooses family medicine for a career, they have the same opportunities for advancement in clinical and academic pathways.

HOW HAS FAMILY MEDICINE TRAINING IMPACTED HEALTH CARE NEEDS IN KENYA?

There are now five University-based family medicine residency programs in Kenya and about 40 graduates since 2008, a modest but significant beginning.

Once one to four graduate family physicians are placed in each 80-to-200-bed county hospital, they move that facility forward to stabilize staff, expand services, improve working conditions and implement a continuous quality improvement model.

Before family doctors were available, physician staffing was predominantly one-year internship-trained medical officers who rarely stayed longer than 18 months and were more focused on finding further training.

The fact that there are only residency positions for 20% or so of medical school graduates compounds the issues and creates a brain drain, mainly to the West.

But the need for more residency training positions is also the door of opportunity for growing family medicine to more of the larger county level facilities.

WHY DO YOU FEEL RURAL TRAINING AND EDUCATION IS SO IMPORTANT?

Despite the growing capital megacities, the populations of African countries are still 70-80% rural, most living on subsistence farms. Yet only 20% or so of physicians are serving this population in district/county/church hospitals.

When you see figures for the health care workforce disparities of African countries, multiply that disparity by three to understand what the majority, rural population experience. My physician colleagues serving in the South Sudanese state of Jonglei number about 10 for more than a million people! Compare that to the US average of 1 physician to 390 people.

Clearly, the disparities shout for the need to come alongside and multiply the health workforce that will stay to build the health system and serve the people.

YOU HAVE HELPED DEVELOP AND DISTRIBUTE SOFTWARE FOR PRIMARY CARE WORKERS IN REMOTE AFRICAN LOCATIONS. HOW IS THAT CHANGING DELIVERY OF PRIMARY CARE?

We have embraced a learner-centered educational model for the family medicine residencies that emphasize mastering the skills for life-long learning. Yet, in rural health facilities, there may be no library, and Internet access can have marginal speed and/or be expensive.

The Digital African Health Library Service is a mobile-phone-based, integrated search engine with more than 50 evidence-based handbooks, guidelines, formularies and journals, including DynaMed. It has special emphasis on Africa-relevant resources

Listening to a boy's heart in Lolongesho in Maasai country.

that support clinical decision-making at the point of care.

Early studies with the initial few hundred users have shown that it affects the plan for care about 23% of the time and potentially changes patient outcome in 4% of cases. The digital library service has been used in about a dozen countries in East and Central Africa, with hopes for further expansion.

HOW CAN OTHERS GET CONNECTED INTO GLOBAL HEALTH EDUCATION AND TRAINING?

There is a significant need for long-term, several-year commitments or repeated short-term visits by culturally sensitive family physicians to come alongside their African colleagues to provide one-on-one mentoring.

Persons interested in exploring options for global service can learn more from the **World Organization of Family Doctors (WONCA)** at www.globalfamilydoctor.org. Medical school and residency programs may also have partnerships to global educational efforts. For those with a faith background, the **Christian Association of African Physicians** (www.caaphome.org) can facilitate connections, as well.

MUCH OF YOUR WORK IN GLOBAL HEALTH HAS BEEN IN KENYA. WHY?

One of the wonderful lessons of global service is how much you learn. The priority of relationships is one of those lessons. Relationships are prioritized over goals, efficiencies and deadlines.

Once I was connected with these wonderful colleagues in Kenya and their goals for developing family medicine, it became a shared goal toward which we are working together.

Relationships that developed over time with University health education leaders, the Ministry of Health and other health service players then become important to shared

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continued from page 9

goals. That continuity is important for any person considering global service.

ANYTHING ELSE YOU'D LIKE TO SHARE?

The opportunity to invest in the future of primary care in Africa and elsewhere has never been greater.

African leaders are striving to bring universal health care to their peoples and are recognizing that it is built on a strong primary care system. Family physicians need to multiply quickly to be available at all these district-level facilities to lead and be consultants for primary care teams to maximize their effectiveness.

Coming alongside these efforts, whether as a long-term career or as a regular short-term connection, is a commitment to learning from the strengths of another culture and worldview as you share from what you know. It is hard work, but a very fulfilling investment that has significance.

BREAKING DOWN BARRIERS FOR LEADERSHIP

Maria Huntley, CAE, MAM
Chief Executive Officer

In 2015, the MAFP Board of Directors approved a strategic plan that included a goal to evaluate and streamline our governance structure. While exploring best practices in governance, we noticed a trend to make leadership roles more accessible to different perspectives. This triggered our leadership to think about how we can create opportunities for all members to engage in leadership roles. One barrier we identified is the requirement for members to "put in their time" to move into certain leadership positions. While it is important to have experienced perspectives at the table, it is just as important to have the voice of the future of family medicine.

The Leadership Development Committee recommends a slate of board and officer candidates to the House of Delegates for approval each year. In 2019, the House of Delegates approved a slate that included **Dr. Lauren Williams** to serve as an officer on the board, filling the Vice Speaker of the House position. It is believed that this is the first time in the history of the MAFP that a new to practice physician has been elected as an officer.

Dr. Williams started her term as Vice Speaker of the House on July 1, 2019, and is well positioned to move her way up the leadership ladder—if that is something she chooses to do. Dr. Williams is in her second year of practice at North Clinic in Maple Grove, an independently owned clinic.

Dr. Williams is a natural leader who is going to help shape the future of healthcare. She has an impressive list of accomplishments on her CV, and she shows up time after time when the family physician voice is needed. In the past two years, she has testified at the state legislature about the impact of mid-year formulary switching for patients and the importance of retaining funding for family medicine residency slots at the University of Minnesota. She has also attended the AAFP National Conference for Constituency Leaders multiple times, often serving in mentorship roles for new attendees. This year, she attended the AAFP Congress of Delegates meeting in Philadelphia to bring her voice to issues that matter to her. The future of family medicine is bright with inspiring leaders like Dr. Williams paving the way.

SAMPLE OF ACCOMPLISHMENTS (INCOMPLETE LIST):

AAFP

- Resident Member – Commission of Governmental Advocacy
- Resident Member – Commission on Quality and Practice
- Member and Chair – National Conference Reference Committee

MAFP

- Reference Committee member, House of Delegates
- Resident Director, Board of Directors
- Co-chair, Legislative Committee
- Co-founder, Advocacy 101 program

MMA

- Resident Representative – Policy Council

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James Pacala, MD, MS, Professor and Head,
University of Minnesota Department of Family Medicine
and Community Health

MAKING STRIDES TOWARD AGE-FRIENDLY HEALTH CARE

OUR CURRENT STATE

Today, we face a massive implementation gap between what is known to produce better healthcare outcomes for older adults and what healthcare providers and systems actually do. For the past 30 years, the field of geriatrics has developed and tested interventions that have been shown to produce better Triple Aim outcomes in older adult patients.

Despite these proven advances in geriatric care, healthcare systems aren't implementing them. Why is this? One could surmise that it is due to the entrenched system of healthcare we find ourselves mired in. Another factor at play is an overall lack of awareness around the interventions and expertise in the realm of geriatric care. Further, we lack adequate geriatrics leadership in the guidance of healthcare systems.

What's particularly disheartening about this state of affairs is that we know that particular interventions can make older adults healthier, yet we simply don't practice them—at least, not consistently. The practice of family medicine is no exception. If you take outpatient primary care, for example, we still approach our geriatric patients largely the same way we treat a middle-aged patient. We often do not tailor the primary care of patients according to age, health or functional status.

ONE STEP CLOSER: THE 4Ms

All of the above considerations may leave a person wondering if any positive strides have been made over the years. The short answer is: Yes. Since 2017, the Institute for Healthcare Improvement (IHI) has teamed with stakeholders (such as the John A. Hartford Foundation) to create a movement designed to close the implementation gap—an effort that is known as Age-Friendly Health Systems. The IHI reviewed all available literature to determine which care models tended to improve the health of older adults, identifying 11 different interventions that worked well. The next step involved distilling the effective interventions into what is known as the 4Ms:

1. **What Matters:** understanding each patient's health goals and care preferences so that we can align care appropriately
2. **Mentation:** preventing, identifying, treating and managing dementia, depression and delirium across care settings

3. **Medications:** using Age-Friendly medications and being aware that older adults use more medications and are therefore more likely to suffer harm from their medications
4. **Mobility:** ensuring that older adults move safely while considering the increased likelihood of falls, the importance of exercise and maintaining physical function to enable social engagement and personal safety

Now there is a central strategy for delivering Age-Friendly Health Care that promotes efforts to systematically address the 4Ms. Hundreds of healthcare systems are signing on to the Age-Friendly Movement.

OUR MISSION TO IMPROVE HEALTH CARE FOR OLDER ADULTS

At the University of Minnesota Department of Family Medicine and Community Health (DFMCH) and the Medical School, our efforts to meet these high-care standards have recently received a great boost: the Minnesota Northstar Geriatrics Workforce Enhancement Program (GWEP)—a five-year, $3.74 million project funded by the Health Resources and Services Administration (HRSA). While the MN Northstar GWEP is housed within the DFMCH, it is a collaborative project that involves the Medical School, the DFMCH, the School of Nursing, the School of Public Health, the College of Pharmacy and eight community partners.

The MN Northstar GWEP will train the healthcare workforce to: address gaps in the care of older adults and promote Age-Friendly primary health care; support Minnesota's older adults with complex illness, their caregivers and their families; and promote better care for persons dealing with Alzheimer's disease and other dementias (i.e. Dementia-Friendly care).

Further bolstering our efforts, the University of Minnesota Medical School received a $1 million grant from the Otto Bremer Trust to improve geriatric training and care. We will leverage these funds to enhance and supplement our program.

Through the MN Northstar GWEP, we will form a partnership among the University of Minnesota Academic Health Center, the Fairview Health System and eight community organizations, all devoted to improving the health care and health of older adults across Minnesota.

THE MN NORTHSTAR GWEP PROJECT IN ACTION

We have our mission. We have our funding. What will follow is a carefully crafted plan for meeting our goals. The MN Northstar GWEP will create a geriatrics education and training repository of materials for healthcare providers, spanning the full range of health professional trainees and learner levels. Upon deployment of the training materials, we can then realize our subsequent goal of integrating the practice of and training for Age-Friendly geriatrics care throughout the primary care sites in our region.

In the course of our collective work, we will transform all eight of the DFMCH family medicine residency clinics and the Community-University Health Care Center in Minneapolis into Age-Friendly systems that address the 4Ms. We will likewise transform the Primary Care Service Line at M Health Fairview, comprising 62 primary care clinics in Minnesota and western Wisconsin.

Another key facet of our mission revolves around outreach and public education. For the tens of thousands of Minnesotans who serve as caregivers for an older adult, MN Northstar GWEP investigators, led by Joe Gaugler, PhD, in the School of Public Health, are implementing a Caring for a Person With Memory Loss program for caregivers of persons with Alzheimer's disease or other dementia, a Dementia Educational Experience Roadshow and skills training delivered in-person and via telehealth. To address the public awareness component, the MN Northstar GWEP also includes educational programs offered through Minnesota Public Radio and Hippocrates Cafe, a live show created by Dr. Jon Hallberg, associate professor in the DFMCH, that explores healthcare topics through stories, poetry, music and other creative activities designed to resonate with and engage the public.

LOOKING AHEAD TO A SUSTAINED POSITIVE IMPACT

By taking these measures, we hope to make major strides toward closing the gap when it comes to Age-Friendly care. Our ultimate goal is for all geriatric patients to receive treatment that faithfully adheres to the 4M framework: what matters in their lives, their medications, their mobility and their mentation.

The MN Northstar GWEP will positively touch many lives, including patients and their families. We have undertaken a critically important, much-needed mission—one that will call upon the passion and dedication of hundreds of providers and personnel as we take vital steps toward ensuring Age-Friendly health care across Minnesota.

This article, and other efforts to incorporate greater education on care for older adults, are the result of a resolution adopted by the 2019 House of Delegates. Ben Rosenstein, MD, resident at St. John's, authored the resolution:

BE IT RESOLVED that the MAFP will seek to support increased education opportunities for medical students, family medicine residents, and practicing physicians in multiple facets of care of older adults;
BE IT FURTHER RESOLVED that the MAFP will explore offering specific CME in older adult and dementia care for residents and practicing physicians.

Ben shared the following regarding his experience creating this resolution:

I have a passion for care of older adults (I'm currently applying to geriatrics fellowships), yet I have found it surprisingly difficult over the years, as both a medical student and a resident, to find opportunities to expand my education into this area. As is well known, our older (patient) population is growing. On top of this, increasing comorbidities and social health determiners will make the care of older adults more complex. I wrote the resolution with these factors in mind to encourage the MAFP to take a greater role in advancing training in care of older adults throughout the medical education continuum. I found writing the resolution to be pretty simple, essentially taking an area I am already passionate about and putting words to paper. It was satisfying as a way to allow me to continue advocating for this population. I hope that, with this resolution, students, residents and practicing physicians will find greater access to expand their knowledge in geriatric principles and the most up-to-date research of care in older adults. Hopefully, this in turn expands the available geriatrics workforce (given the lack of certified geriatricians) and creates amore age-friendly health system.

Dr. Rosenstein received a MAFP Foundation Innovation Grant for his study Implementation of a Standard Fall-risk Assessment within a Family Medicine Clinic.

Please join us at this year's House of Delegates on Saturday, June 13 at the Earle Brown Heritage Center.

HOW ONE COMMUNITY-DRIVEN RESPONSE TO THE OPIOID CRISIS BECAME A CATALYST FOR HOPE

Fed up with how the opioid crisis was ravaging their community, **Drs. Heather Bell** and **Kurt Devine**, family physicians at Little Falls' CHI St. Gabriel's Health, worked with members of their clinic team and other stakeholders to establish a community-driven response. Below, they share from their experiences and a bit about their efforts to encourage other rural primary care clinics and their communities to utilize medication assisted treatment (MAT) to take care of those suffering from substance use disorder.

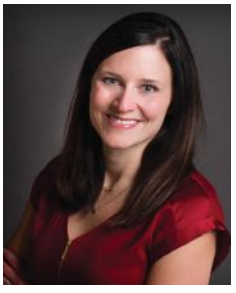
AS YOU DEVELOPED YOUR ABILITY TO CARE FOR YOUR PATIENTS SUFFERING FROM SUBSTANCE ABUSE DISORDER WITH MAT, YOU INVOLVED OTHER STAKEHOLDERS IN YOUR COMMUNITY. CAN YOU SHARE WITH US WHAT LED TO THAT DECISION AND THE RESPONSE AND PARTNERSHIPS THAT AROSE?

Our community has a decade-old task force that had previously come together to address methamphetamine abuse. The task force included law enforcement, schools, local pharmacy, county attorney and county social services, plus our hospital administrator, foundation, nurse manager, CNP and Dr. Bell. At St. Gabriel's, we developed a controlled substance care team (CSCT). This group came together initially in 2015 to review the charts of each patient prescribed controlled substances. In 2016, this group decided to begin offering MAT. We educated the task force around our decision to begin utilizing Suboxone. We wanted to make sure that meds were available, that support services were ready for patients and that our very supportive law enforcement understood that we wanted to treat, not punish or jail. Our primary goal was to save lives and get people on medication assisted treatment, with the rest falling into place once we "had them." There are so many components to the opioid epidemic—heroin, diverted pills, OD deaths. As physicians, it is our moral, ethical and Hippocratic duty to help people. Choosing to do MAT felt, to us, like the obvious next step to best help our patients.

PART OF YOUR IMPORTANT WORK HAS BEEN REPLICATING THESE EFFORTS IN OTHER RURAL COMMUNITIES. WHAT HAS THAT LOOKED LIKE AND HOW HAVE YOU HELPED SUPPORT EFFORTS IN OTHER RURAL COMMUNITIES?

We initially simply started talking about our work to try to encourage other communities to consider MAT to take care of those suffering in their communities. We received some pilot programming funding, which allowed us to help communities replicate our efforts—including setting up their CSCT, a dedicated CSCT nurse, physician champion, at least one Suboxone prescriber and a community task force. We have an every-other-week meeting with these nurses and other non-funded communities to troubleshoot and share information.

Our ECHO has been the most impactful (and super fun) part of our replication. Through our ECHO teleconferences, multi-disciplinary clinicians from across the state come



Doctors Heather Bell and Kurt Devine,
family physicians at Little Falls' CHI St. Gabriel's Health

together for a CME hour that includes didactic teaching around a related topic and a case presentation. This has allowed the group to create a network with the same basic workflow, mentality and care goals. It's our intent that patients receive the best care regardless of their location, and that we are able to transfer patients to each other based on what's most convenient for our patients. We make ourselves available to take phone calls, text and emails when another care team or provider has questions or concerns.

WHAT ADVICE DO YOU HAVE FOR OTHER RURAL PRIMARY CARE PROVIDERS INTERESTED IN INITIATING MAT IN THEIR CLINICS? WHERE SHOULD THEY START?

MAT and care for patients with opioid use disorder and other substance use disorders is truly a highlight in our practices. This is an area in medicine where a tangible difference can be made, and a societal impact can be seen in real time. There is so much support out there that no rural provider should be left alone trying to navigate this need. We recognize that treating substance use disorder is a topic many of us had little to no education on as students. The easiest place to start would be to reach out to us in Little Falls and/or join the ECHO. You are welcome to just observe for a free hour of lunchtime CME to begin to get a feel for this work. We truly love what we do, and helping others do this work is so rewarding.

WHAT'S RACE GOT TO DO WITH IT?

WHY WE CARE ABOUT HOW RACE IS USED IN MEDICAL RESEARCH, PRACTICE AND CLINICAL DECISION-MAKING, AND WHY YOU SHOULD, TOO.

By: Ebiere Okah, MD, Resident
University of Minnesota North Memorial Family Medicine Residency

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

The practice of medicine—the traditions, diagnoses, treatments and guidelines—is ever-changing. We now acknowledge human papillomavirus infection as the primary driver of cervical cancer. Hormone replacement therapy is no longer routinely recommended for postmenopausal women. Rate control is preferred over rhythm control in atrial fibrillation. However, as we look back at the past hundred years, our profession has been slow to release the grip that the concept of biological race has had on our science and our medical practice.

Most of us have heard and acknowledge the truth of race as a social construct. While we may accept the truth of this science in theory, this has not changed the way we practice medicine. In fact, we often have perpetuated the myth of race and ethnicity as markers of disease. We describe our patients in racial terms and our guidelines and laboratory criteria, like glomerular filtration rate, use race. We use race as a proxy for genetics, ancestry and biology when it is not.

We are not the first people to challenge the use of race in medicine. Many prolific researchers and activists have been arguing against treating race as biological for years[1-3]. We brought our resolution on eliminating race-based medicine to the Minnesota Academy of Family Physicians' (MAFP) House of Delegates this year because we see the negative results of medicine's error when it comes to race, and we wanted the MAFP and Minnesota's family physicians to be part of the change. When we started to bring this issue forward, we encountered some resistance, but mostly many questions. We wanted to share our answers with you, not because we are the experts, but because we see the importance of this issue and the need for reform.

WHAT IS RACE?

Race is a social construct that does not represent shared genetic ancestry. It is, instead, a way of categorizing people based on physical characteristics and geographic ancestry. The United States (US) Census identifies five racial categories: white; black; Asian; American Indian and Alaska Native; and Native Hawaiian and Pacific Islander. Under this system, Middle Easterners and North Africans are classified as white, and people who hail from countries as different as Afghanistan, India and China are all classified as Asian.

These racial categories, however, are not universal, as they vary between societies and have changed over time. For example, an individual could be both white in Brazil and black in the US. In addition, at various points in Virginia's history, people who had 1/4th, 1/8th, 1/16th or any African ancestry were legally defined as black and, therefore, subject to racially discriminatory laws[4]. In the US, blackness was constructed to be overly inclusive, such that a person with seven white great-grandparents and one black great-grandparent could still be considered black and, therefore, used for slave labor. Thus, it is curious that, given this broad definition of "black," black people are treated as a distinct racial category with genetically distinct health risk factors and different treatment protocols.

Given that politics, not science, guided the construction of race, it is not surprising that there are no genetic features shared by all people who belong to the same racial category. Most of our genetic variability occurs within racial groups, and belonging to the same racial group does not imply greater genetic similarity[5,6]. For example, an Asian person may have more genetic similarity to a white person than to another Asian person. This is because blacks, whites and Asians are not actually distinct groups of people, although we have been socialized to see them as such.

IF RACE ISN'T REAL, THEN WHY ARE THERE GENETIC DIFFERENCES THAT CLUSTER WITHIN DIFFERENT POPULATIONS?

Our genetic diversity is derived from random genetic mutations passed down over generations. Very few genetic mutations provide a survival benefit or are clinically relevant. Natural selection is the theory that genetic mutations that are advantageous to survival result in an increase in the prevalence of these mutations, as the people with said mutations have greater longevity and more time to reproduce. A common example of this can be seen in sickle cell disease. People with sickle cell disease have a shorter life expectancy than those without the disease. However, sickle cell carriers—those who are capable of passing on the sickle cell gene but do not carry the

disease—are less likely to die from malaria. Therefore, in malaria-endemic areas, having sickle cell trait is a genetic advantage, which is why people with sickle cell trait and disease are clustered in malaria-endemic regions.

Sickle cell disease is often perceived to be limited to black people, but the prevalence of sickle cell varies significantly between black-majority countries, and it is also present in countries with few black people. For instance, sickle cell disease is not common in South Africa, but it is a common disease in Saudi Arabia and India, which are white and Asian countries, respectively[7]. In fact, there are tribes in India where approximately 40% of the population are sickle cell carriers[8]. When one considers that there are more people living in India than in the continent of Africa, the notion that sickle cell disease is an African or black disease is false. So rather than thinking about sickle cell disease in racial terms, we must consider it a disease more prevalent in populations with genetic ancestry from malaria-endemic areas.

WHAT ABOUT EPIGENETICS?

Epigenetics is the study of changes in gene expression that are not due to changes in the genetic code itself. Evidence suggests that trauma and adverse events lead to epigenetic changes that are then inherited by offspring. Racial trauma, stress, discrimination and systemic racist practices, such as financial and environmental disinvestment in minority communities, have been proposed as an etiology of epigenetic changes[9]. Mouse models indicate that epigenetic changes can be reversed with removal of the initial stressors and exposure to an enriched environment[10]. Therefore, what we perceive to be health disparities caused by innate racial difference could, in actuality, be due to reversible epigenetic changes.

WHAT IS THE HARM OF USING RACE IN MEDICINE?

Race is a social construct and, when we treat it as a substitute for genetic ancestry, it prevents us from investigating and addressing racism, the cause of the racial health disparities. Treating race as a proxy for genetics also actively harms black, brown and Indigenous communities. By treating race as biological, we place the blame of racial disparities on communities already suffering from racism and enforce the racist belief that these communities are genetically inferior.

Additionally, the way we think and talk about race and racial health disparities affects how we perceive and treat patients. Recent research by Brian Donovan presented at the American Association for the Advancement of Science Conference[11,12] showed that merely mentioning the prevalence of certain diseases by race was associated with the belief that race influenced intelligence. A 2016 study evaluating medical students and residents showed that those who believed blacks and whites to be biologically different rated the pain experienced by black patients, in comparison to white patients, as lower and recommended inappropriate treatments[13].

WE USE RACE IN MANY OF OUR MEDICAL CALCULATIONS AND GUIDELINES. THESE MEASUREMENTS (EGFR, ASCVD, ETC.) ARE VERY USEFUL. HOW CAN WE CONTINUE TO USE THESE VARIABLES IF WE DO NOT USE RACE?

Equations ultimately provide estimates and are only as good as the data used to validate and develop them. Medical calculations using race were developed without a clear and consistent definition of race. Also, there is no guidance on how these equations should be used with multiracial people. How should we treat patients with one black and one Asian or one white parent? Which GFR calculation or ASCVD risk score do we use? Which first line blood pressure medication do we start? Does self-perceived identity or external physical appearance matter more when determining race?

IF WE TREAT ALL INDIVIDUALS WITHOUT REGARD TO OBSERVED BIOLOGICAL RACE DIFFERENCES, AREN'T WE DOING PEOPLE OF COLOR A DISSERVICE?

While not biologically real, race has had actual negative biological effects through racism (see epigenetics above for one, but not the only, example). Thus, while it may be necessary to continue to be knowledgeable of the race-based health disparities when screening for disease, it is equally important to avoid attributing these differences to genetic ancestry or immutable biological differences. We, as clinicians and researchers, need to look further than race as the cause for these disparities and identify and address the actual causes of the disparate disease burden and treatment outcomes. Racially disparate treatment and lived experiences result in racially disparate health outcomes. We need to treat the socially-induced racial disparities by addressing racism.

Dr. Okah received a MAFP Foundation Resident Research Grant for her study The Association Between a Color-blind Racial Ideology and the Use of Race in Medical Decision-making.

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Families enjoying Family Fun Night at Destination CME sponsored by Sanford Health Physician Recruiting Office.

Medical students try their hands at suturing taught by UM St. Cloud FMRP.

Medical students caucus before the AAFP Student Congress.

DESTINATION CME

Destination CME was held at Arrowood Resort in Alexandria August 17 & 18. This conference was a chance to combine continuing medical education with time to spend with family and colleagues. Just a few of the sessions were *A Community Response to the Opioid Crisis, Updates in Alzheimer's Disease, Less is More: Deprescribing in the Nursing Home and Collaboration and Integration of Psychiatry.*

Thank You to Our Event Partners:
Explore Alexandria Tourism, Gillette Children's Specialty Healthcare, Physicians' Diagnostic & Rehabilitation Clinics (PDR), Sanford Health Physician Recruiting Office, University of Minnesota Department of Family Medicine and Community Health and Wapiti Medical Staffing.

MADE FOR MEDICAL STUDENTS: THE FAMILY MEDICINE RESIDENT EXPERIENCE

Medical students gathered at Pinstripes in Edina on September 14 to connect with Family Medicine Residency Programs and practice hands-on procedures. "It was really helpful to put faces to the programs I've been thinking about. This was much more informative than visiting the programs' webpages, and much more fun as well," said **Eric Rogers DeMaris, MS4**, Des Moines University. "Awesome, excellent venue, low-key environment, beneficial for MS1 – MS4s to attend," said **Kelsey Simmons, MS4**, University of Minnesota.

Thank You to Our Event Partners:
CentraCare, Mayo Clinic, Scenic Rivers Health Services, Tri-County Health Care and Voyage Healthcare.

AAFP NATIONAL CONFERENCE

Forty Minnesota medical students traveled to the AAFP National Conference July 25–27 in Kansas City, sponsored by MAFP local chapters, the University of Minnesota and Mayo Departments of Family Medicine and Riverwood Healthcare Center.

Three resolutions were brought forward by our residents and students. *Denounce Race-based Medicine* (adopted as amended on the floor) was assigned to the Commission on Health of the Public and Science. *Mental Health Disclosure on Health Care Credentialing and Licensing Applications* (adopted) was assigned to the Commissions on Education, Governmental Advocacy and Continuing Professional Development. *Oppose Criminalization of Physicians Providing Abortion Care* requesting that the American Academy of Family Physicians publicly oppose any law or proposed law which would criminalize physicians for providing abortion care. This resolution was reaffirmed.

The University of Minnesota – Duluth FMIG was named a 2019 Program of Excellence.

Thank You to Our Event Partners:
Allina Health, CentraCare Health, Cuyuna Regional Medical Center, Essentia Health, Fairview Health Services, Gundersen Health System, HealthPartners, Mankato Clinic, Mayo Clinic, Riverwood Healthcare Center, and Scenic Rivers Health Services.

James Benzie, MD
Entira Family Clincs - West St. Paul

MY DECLARATION OF INDEPENDENCE

The time to advocate for independent family physicians and clinics has never been more critical. We all know there has been a steady decline in independent family physicians in both rural and urban areas of Minnesota over the last 20-30 years. In May 2019, the AMA noted that, for the first time, the percentage of employed physicians in the U.S. (47.4%) was greater than that of independent physician (45.9%). We have seen large health systems continue the practice of buying up hospitals and primary care clinics, putting their focus on improved market share ahead of patient or community care. There has also been a rapid rise in the incidence of burnout among family physicians over that same period of time. When surveyed, two of the common reasons for burnout are loss of autonomy and not feeling valued. As family physicians, our independent voice needs to be heard. We need to continue to advocate for the health of our patients, families and communities. We need to stand up for the core values of our profession as family physicians.

My journey to independence started 3-4 years ago, when the large health system I worked in for more than twelve years started to make more business-centered decisions than patient-centered decisions. The large health system even changed their marketing to call our patients "customers." The role of physicians as leaders within the organization started to diminish, as well. It was during that time that I realized that my core values as a family physician did not align with the values of the business-minded large health system I worked for. What I needed was a practice that was focused more on the care of patients and families in the community. What I was looking for was a practice that valued physicians as professionals and allowed them the opportunity to have input in the direction and mission of the organization. What I needed was my independence.

I had some understanding about life as an independent family physician. I grew up in the town of Moose Lake, MN, with parents who were both family physicians. I was lucky enough to work side by side with them at the Gateway Family Health Clinic for a year after my residency training. During my second-year clinical clerkship at the UMD Medical School, I was able to go to the Scenic Rivers Health System Clinic in Bigfork. I also spent nine months in the Rural Physician Associate Program (RPAP) in Onamia at the Mille Lacs Health System Family Clinic. While in residency, I had clinical preceptors and hospital staff from Northwest Family Clinics and North Clinic (now Voyage Healthcare). All of the teaching and mentoring I got from those dedicated and passionate independent family physicians helped shape my understanding and belief about what being independent meant.

So how did I finally decide where to find my independence? My wife, Emily, is also a family physician who practices at Sheridan Clinic, a community clinic in Northeast Minneapolis. We regularly attend the MAFP Spring Refresher to catch up with colleagues and get CME. In 2018, the Spring Refresher had a booth of independent clinics promoting the benefits of independent practices. One of the clinics at the booth was Entira Family Clinics, a group of independent clinics in St. Paul and the surrounding east metro. Entira seemed like a very good fit as I learned about the mission and values of the organization. Still, I struggled to make the move. I struggled with the idea of leaving my previous practice because of the special bonds I had made with the patients and families I cared for. I had great partners at my clinic and hospital, as well as a dedicated, hard-working staff. There were lots of reasons to stay and try to accept the things that would not change. In the end, it came back to my core values and beliefs of who I am as a family physician. Now, after almost one year at Entira Family Clinics, with the feeling of value as a physician and having more control over how I care for my patients, I can definitely say that I am very glad I followed my core values and became an independent physician.

What does independence look like at Entira Family Clinics? We have only practicing family physicians on our board of directors. The CEO and CMO are both practicing family physicians in the organization, as well. As owners of the organization, we have the ability to decide the direction of the organization and determine our mission. Our independence allows us to design systems of care and operations that affect the quality of care we provide, as well as how we care for our patients and families. We utilize care coordinators and RNs to help with our chronic disease management, transition of care and Health Care Home patients. We have incorporated a culture of responsibility and pride throughout the clinics, from the front desk to rooming staff to physicians, to attain high rates of screening, immunizations and health care maintenance. Our high level of low-cost, quality care gives us important leverage with negotiating reimbursement from payors, which helps keep our compensation and benefits competitive.

We are not immune from financial stressors. In the current health care environment, we need to prove our value as a low-cost, high-quality, health care deliverer on a regular basis. We do not have the benefit of scale for leverage with reimbursement like the large health care systems. What we do have is the commitment to the highest quality of care for our patients.

As owners of the organization, we have also created ways to reduce the ever-increasing frustration of our administrative burden. We have developed systems that reduce the paperwork we are doing on a daily basis for refills, prior authorizations

and medical supplies, which allows us more time to spend with our patients. While in the exam room with patients and families, I have found that the practice and art of medicine that I love has not changed. What has changed is the alignment of my values with those of my organization (with a shared primary focus on patient care) and the autonomy I now have as an independent physician.

The time to stand up for independent family physicians and clinics is now. We need to continue to find ways for medical students and residents to get exposure to independent family physicians and practice opportunities during their training. We need to continue to give independent medical practices exposure at conferences like the MAFP Spring refresher or in articles like this in the *Minnesota Family Physician*. We need to continue to be active in the MAFP and MMA, advocating for policies and resolutions that support independent physicians and clinics. We need to continue to have networks and collaboration among independent clinics to improve bargaining power, contracting and quality reporting. We need to continue to advocate on the legislative level for health care reform and improved reimbursement that support independent practices. Most importantly, as family physicians, our independent voice needs to be heard, loud and clear, advocating for our patients, families and the communities we care for.

NEW TO THE LAND OF 3,100 FAMILY DOCS

- **Peter Nalin, MD, MBA, FAAFP**, Duluth, has transferred from Indiana.
- **Daniel Hanson, MD**, Burnsville, **Erin Kastl, DO**, Austin, and **Kathleen Savio, DO**, Pipestone, have transferred from Iowa.
- **Jackie Anderson, DO**, Pipestone, and **Matthew Runde, DO**, Minneapolis, have transferred from Kansas.
- **Zhen Geng, MD**, Lakeville, and **Islam Zineldin, MD**, Minneapolis, have transferred from Michigan.
- **Syed Asad Shah, MD**, Worthington, has transferred from North Carolina.
- **William Haug, MD**, Duluth, and **Susan Hoyum, MD**, Cohasset, have transferred from North Dakota.
- **Diana Heilig, DO**, Minneapolis, has transferred from Ohio.
- **Alma Dzafic, MD**, Maple Grove, and **Seng Yue Joshua Foong, DO**, Albert Lea, have transferred from Pennsylvania.
- **Aislinn Rogalla, DO**, Pine City, has transferred from Tennessee.
- **David Polzin, MD, FAAFP**, Glenwood, has transferred from the Uniformed Services.
- **Briana Rueda, DO**, Chanhassen, has transferred from Utah.
- **Dustin Stewart, MD**, Pipestone, has transferred from Virginia.
- **Victoria Bodendorfer, MD**, Brownsville, **Nicholas Deeter, DO**, Belle Plaine, and **Ana Norell, MD**, Hastings, have transferred from Wisconsin.

NEW RESIDENT MEMBERS

- **Ryan Aberle, MD**, Minneapolis
- **Jaya Durvasula, MBBS**, St. Louis Park
- **William Fischer, MD**, St. Paul
- **John Goodnow, MD**, St. Paul
- **Clifford Hall, MD**, Duluth
- **Brooke Jensen, MD**, St. Paul
- **Andrea Knievel, MD**, St. Louis Park
- **Mattie Strub, MD**, St. Louis Park

NEW STUDENT MEMBERS

Mayo Clinic Alix School of Medicine

- **Walker Asprey**, Mantorville
- **Laura Barron**, Rochester
- **Weslyn Bunn**, Scottsdale, AZ
- **Katerina Castillo**, Rochester
- **Devika Das**, Phoenix, AZ
- **Alanna De Mello**, Scottsdal
- **Emma DiFilippo**, Rochester
- **Ryan Dunn**, Tempe, AZ
- **Annica Eells**, Scottsdale, AZ
- **Leyton Galapia**, BS, Phoenix, AZ
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- **Rachel Perez**, Phoenix, AZ
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- **Gabriela Severiano**, White Bear Township
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- **Brynna Goraczkowski**, Litchfield
- **Morgan Kresl**, Duluth
- **Julia Lasswell**, Hermantown
- **Brooke Leaf**, Duluth
- **Emily Ortiz**, Albert Lea
- **Hannah Schull**, Kimball

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- **Rachel Feliciano**, St. Paul
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- **Mary Soderlund**, St. Paul
- **Amanuel Zewdie**, Minneapolis

University of Queensland Medical School, Brisbane, Queensland

- **David Thompson**, Minneapolis

Windsor University School of Medicine

- **Faysal Awil**, St. Paul
- **Mohamed Hussein**, Rochester

IN MEMORIAM

- **Martin R. Weems, MD**, Maple Grove, MN
- **Merle Mark, MD, FAAFP**, St. Louis Park, MN

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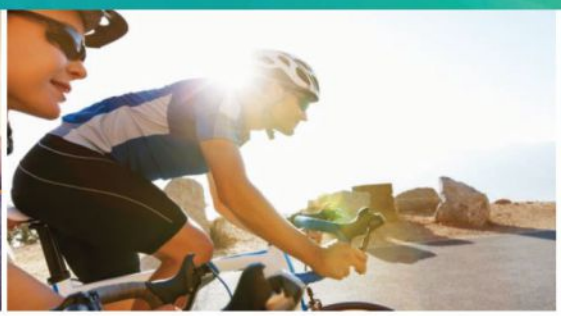
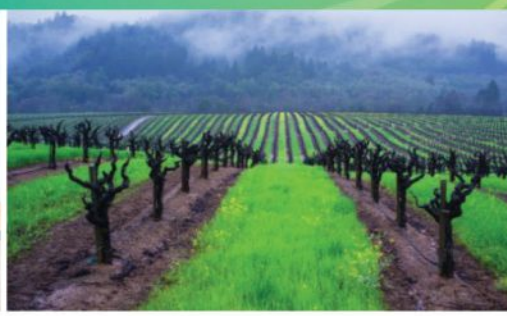

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CONNECTING, LEADING, LISTENING

Here are just a few of the things your Academy staff has been up to, furthering our mission and working for you.

AUGUST

- 1 Lisa at AAFP National Research Network Advisory Group Meeting in Kansas City
- 8 Lisa and Lynn begin FMIG Leadership visits with Mayo Clinic Alix School of Medicine
- 12 Maria and Jami begin FMRP "State of the Academy" visits
- 12 Maria and Jami meet with Lake Superior Chapter members to discuss resolutions
- 13 Jami at MERC Meeting
- 14 Jami presents at advocacy training for Hennepin Healthcare Whitter Clinic
- 14 Lynn at the AAFP Foundation Family Medicine Philanthropic Consortium
- 16 Jami presents at United Family Medicine Retreat on Advocacy
- 19 Maria, Jami and Lake Superior members meet with Environmental Quality Board Commissioners
- 26 Maria at Chapter Executives Leadership Program in Chicago

SEPTEMBER

- Lynn presents to six supporting partners interested in sponsoring MAFP events and conferences
- 12 Maria at Lake Superior Chapter Meeting
- 12 Lisa and Jami at Minnesota Community Measurement Conference
- 16 Lisa at MDH Statewide Quality Reporting and Measurement System Update
- 20 Maria at MMA Annual Meeting Duluth
- 23 Maria and Jami at AAFP Congress of Delegates
- 24 Lynn at AAFP Foundation Family Medicine Philanthropic Consortium
- 26 Lynn meets with Minnesota Department of Health
- 26 Lynn at Give to the Max fundraising planning workshop
- 27 Jami presents at University of Minnesota Community Health Course

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NOMINATE A PEER, MENTOR OR COLLEAGUE FOR A 2020 MAFP ACADEMY AWARD!

*It only takes **5 minutes.***

Each year, the MAFP honors outstanding individuals in the Minnesota family medicine community with these awards:

Family Physician of the Year

Family Medicine Educator of the Year

Family Medicine Resident of the Year

Innovation & Research Award

Medical Student Leadership Award

Deadline for nominations is **Friday, December 6.**

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MEET THE MAFP FOUNDATION BOARD'S NEWEST MEMBERS

The MAFP Foundation is our nonprofit arm, carrying out the philanthropic work of our members and working to improve the health of ALL Minnesotans.

Through the financial support of our members and donors, the Foundation furthers educational and scientific initiatives that advance family medicine and improve health outcomes of patients and communities.

We regularly award innovation and research grants to practicing family physicians, family medicine residents and medical students.

We asked our newest Foundation board members to share why they're serving on the board, what excites them most about the Foundation's impact on family medicine in Minnesota and why YOU should join them in financially supporting the work of the Foundation.

To learn more or donate, visit **mafp.org/foundation.**

"I volunteered to serve on the MAFP Foundation Board to carry on the outstanding tradition of philanthropy in family medicine in our state. The mission statement of the Foundation is broad, encompassing clinical programs, research and education. I'm impressed by the Foundation's key contributions to ongoing scholarship programs, and I'm excited to develop new initiatives that align with the values of Minnesota family physicians."

Pat Fontaine, MD, MS
MAFP Legislative Committee Co-Chair & Foundation Board Member Retired Family Physician

"As a Foundation board member, I hope to contribute to the change and development of family medicine, both locally and nationally. The Foundation is attempting to give strength to local physicians, researchers, legislators and lobbyists to ensure our specialty is well represented and continues to grow. I believe that is an effort that anyone devoted to our practice can get behind."

Adrianne Westmoreland, MD
MAFP Foundation Board Member
Practice location: Community Memorial Hospital Family Clinic (Cloquet)

"I decided to volunteer for the Foundation Board in an effort to stay engaged with the MAFP and give a voice to rural and newer-to-practice physicians. I believe that the Foundation's grant funding for students and residents has a positive impact on their decision to practice family medicine and stay involved in primary care. Supporting the Foundation is an investment in our future! Family medicine is the greatest specialty, and we have to continue to get the word out in Minnesota and be an example nationally. Engaging students, residents and mentors in projects means we will have physicians who are willing to look at the big picture as the practice of medicine continues to evolve."

Lindsey Chmielewski, MD
MAFP Foundation Board Member
Practice location: CentraCare – Melrose Clinic

"I became interested in serving on the Foundation Board as a way to become more involved in the promotion of family medicine as a specialty, serve and support Minnesota's family physicians and medical students and engage in the exciting research of our members. I encourage ALL members to financially support the Foundation as a way to demonstrate their commitment to our specialty and show their support of colleagues and future family physicians."

Britta Reierson, MD
MAFP Foundation Board Member
Practice location: Park Nicollet Clinic – Target Health & Well-being Center (Minneapolis)

COMING UP NEXT

What You Need to Know CME, Quality Measures, Licensing & Board Certification
November 4, 2019
6:00 – 8:00 pm
Pinstripes
Edina, MN

Family Medicine Midwest
November 8-10, 2019
Naperville, IL
Visit https://www.iafp.com/family-medicine-midwest-conference

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

Buprenorphine Boot Camp – Getting Your Clinic Off the Ground
December 5-6, 2019
Sheraton Bloomington Hotel
Bloomington, MN
Visit https://mafp.org/BootCamp2019

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

Nomination Deadline: MAFP Academy Awards
December 6, 2019
Visit https://mafp.org/awards

Intro to Advocacy – Rochester
February 4, 2020
6:00 – 8:30 pm
Mayo Clinic Alix – Mitchell Student Ctr.
Rochester, MN

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

Spring Refresher
March 28 & 29, 2020
The Depot
Minneapolis, MN

House of Delegates
Saturday, June 13, 2020
7:30 am (breakfast)
8:30 am – 5:00 pm
Earle Brown Heritage Center
Brooklyn Center, MN

WE'RE MOVING

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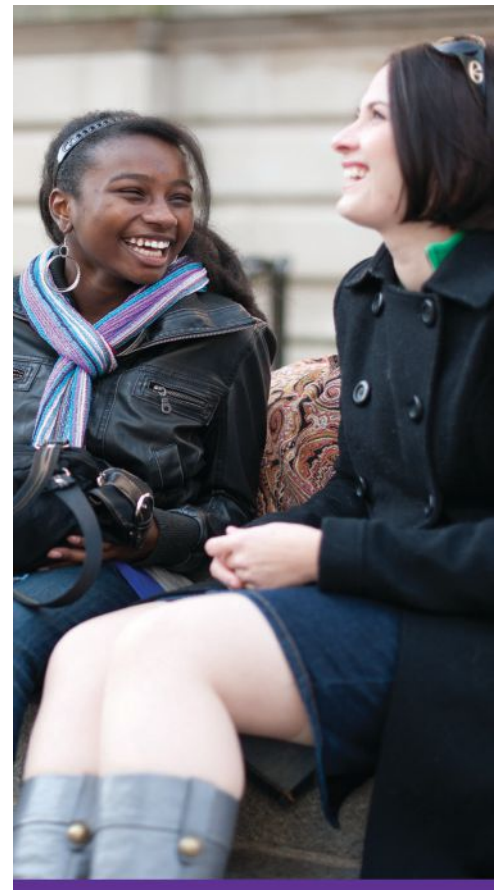
Brooklyn Center, MN



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