WINTER 2020 • VOL. 4 • No. 1

MFP

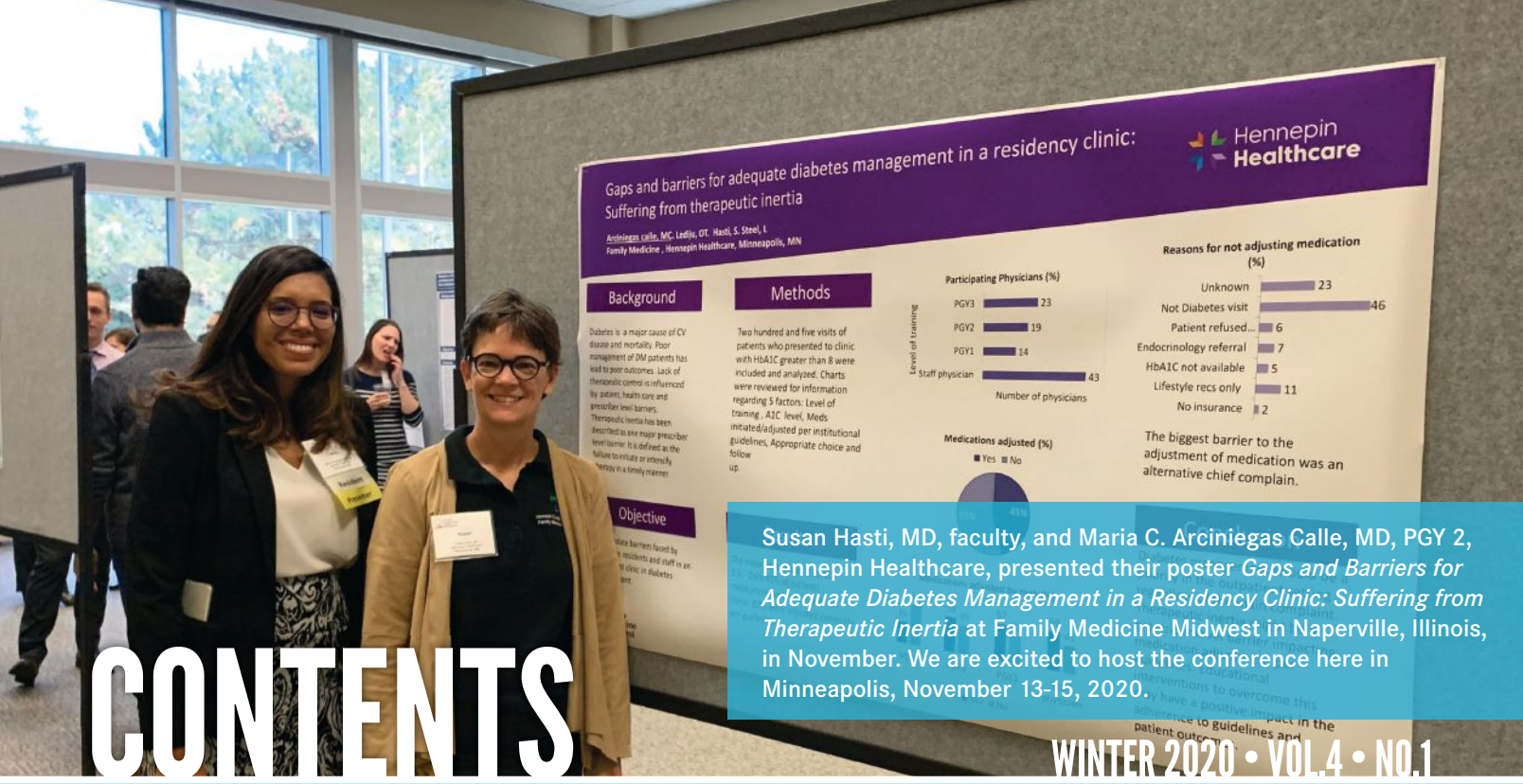
MINNESOTA FAMILY PHYSICIAN

COPIC
Better Medicine • Better Lives
CALLCOPIC.COM | 800.421.1834

Why COPIC?

COPIC connects you with expert guidance when you need it; with legal and HR helplines and a 24/7 risk management hotline.

Trusted knowledge from an engaged partner.
That's why.



Susan Hasti, MD, faculty, and Maria C. Arciniegas Calle, MD, PGY 2, Hennepin Healthcare, presented their poster *Gaps and Barriers for Adequate Diabetes Management in a Residency Clinic: Suffering from Therapeutic Inertia* at Family Medicine Midwest in Naperville, Illinois, in November. We are excited to host the conference here in Minneapolis, November 13-15, 2020.

CONTENTS

WINTER 2020 • VOL.4 • NO.1

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

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

YOUR CALLING, OUR PURPOSE

Every 365 days, we decide that a new year begins. And with each new year comes a time for reflection, evaluation and determination. We ask ourselves why and how we're doing the things that we are doing—reflect on our choices, reflect on our lives.

"Never separate the life you live from the words you speak."

Remember when you decided to be a family doc. Was it before med school? Was it in med school? Third-year rotations? Remember the first time you had to defend your choice. Was it the other students, that faculty, that family member or to yourself?

A lot of us had similar reasons for choosing the specialty. We liked all of the things. It was hard to narrow it down. We wanted to be in people's lives for their whole lives. We wanted long-term relationships with our patients that mattered. We wanted to make a difference in people's lives and be there when they needed us, whenever they needed us. We wanted to take care of the whole family, the grandkids to the grandparents, and all ages in between. It meant something to us—and it still does—to engage in building healing relationships with people who need us.

It means something to be a family doc, something different; and right now, there are too many people trying to get in the way of us being the kind of physicians we dreamed of being. Yeah, there are days when it's just amazing. You see that patient make that significant change. You deliver that baby and hand it over to the parents; a new family is born. You listen to patients as they feel grief, fear, rage, sorrow, uncertainty, happiness and sometimes even joy—the days that our patients need us and we are there as our full selves: confident, capable and caring. But then there are the forms, the charts, the electronic medical record, billing, insurance prior authorizations, etc. I don't know about you, but I didn't go to medical school to spend more time with my laptop than I do with my patients and fill out forms as much as prescriptions. Something has to change.

"Successful organizing is not built on self-interest but rather on dignity and a sense of purpose."

When you look at it now, what is the purpose of the MAFP? The Minnesota Academy of Family Physicians is here to help make Minnesota the best state in the country to practice as a family medicine physician. The MAFP is a membership-driven and membership-led organization here for all of us. We are here to stand together, to challenge what challenges our members, and to grow what helps our members. The MAFP's purpose is to help create and maintain a health policy environment that allows us, as physicians, to provide excellence in the care of our patients and the successful practice of our specialty of family medicine.

"We all do better when we all do better."

This is your MAFP. We hear and project your voice, your stories and your patients' stories. In this New Year, we are asking you to continue to engage, share and participate with the Academy. In 2020, many challenges await. We will stand together—membership driven, membership led and family medicine strong.

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.

pcipublishing.com
Created by Publishing Concepts, Inc.
David Brown, President • 1-800-561-4686 ext. 103
dbrown@pcipublishing.com
For advertising info contact
Malia Ford • 1-800-561-4686 ext. 106
mford@pcipublishing.com

Edition 13

Jay Sheree-Allen, MD, CentraCare Long Prairie, was re-elected to the AAFP Foundation Board of Trustees

The AAFP Foundation Board of Trustees pinned their new president **Julie Anderson, MD, FAAFP**, Simplicity Health, St. Cloud.

Doctors **Karlyn and Adam Armbruster**, Sleepy Eye Medical Center, were featured in the *AAFP News* article, "Family Physician Couple Returns to Rural Roots in Minnesota," October 18, 2019.

Renée Crichlow, MD, FAAFP, MAFP President, was appointed to the American Academy of Family Physicians Commission on Governmental Advocacy.

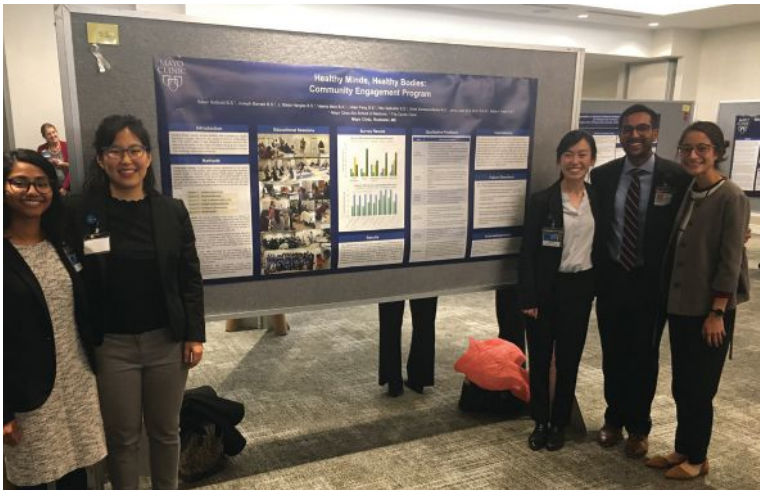
Kate Diaz Vickery, MD, MSc, Hennepin Healthcare, received the North American Primary Care Research Group's 2019 New Investigator Award.

Kate Diaz Vickery, MD, MSc, and **Susan Gust**, community engagement consultant, both from Hennepin Healthcare, were interviewed by the Center for Health Care Strategies, Inc. for the article "Leveraging Community Knowledge through Community-Based Participatory Research," published October 17, 2019. Read the article: *https://t.co/m0SJAXjM3e?amp=1*.

Kevin Gilliam II, MD, NorthPoint Health & Wellness Center, was among those honored for excellence in serving UCare's Medicaid, MinnesotaCare and Special Needs Plan members.

Katy B. Kozhimannil, PhD, MPA, University of Minnesota School of Public Health, and **Andrea Westby, MD**, University of Minnesota Medical School, co-authored "What Family Physicians Can Do to Reduce Maternal Mortality" in the October 15 issue of the *American Family Physician*.

Each year, 2nd-year students at Mayo Clinic Alix School of Medicine organize the "Healthy Minds, Health Bodies" program aimed at providing health education programing for the Latin-American community in Dodge Center, Minnesota. Events cover topics such as yoga, healthy relationships and LGTBQ/gender identity. This year, students presented their poster at the 20th Annual Mayo Clinic Family Medicine Forum, winning the audience favorite prize.



Mayo Clinic Alix MS2s (l–r) Hiba Saifuddin, Sarah Batbold, Lillian Peng, Vivek Somasundaram and Valeria Melo.

Shailey Prasad, MD, MPH, FAAFP

Shailey Prasad, MD, MPH, FAAFP, Executive Director of the University of Minnesota Center for Global Health and Social Responsibility and Vice Chair for Education at the Department of Family Medicine and Community Health, has been inducted into the Academy for Excellence in the Scholarship of Teaching and Learning.

Christopher Reif, MD, MPH, Assistant Professor, University of Minnesota Department of Family Medicine and Community Health, was recognized as the Luminary Physician in the latest issue of the Twin Cities Medical Society journal *MetroDoctors*.

William Roberts, MD, FAAFP, Professor, University of Minnesota Department of Family Medicine and Community Health, was quoted in *Runner's World* on October 28, in the article "Everything You Need to Know About Patellofemoral Pain Syndrome" by Laura Peill.

Sam Hanson Willis, MD, Allina Health Greenway Clinic, was a guest on MPR News with Angela Davis on October 11, along with a therapist and director from the DNR, on how the coming of winter with cold and dark can be hard on our mental and physical health and strategies to get through it and even enjoy it.

Congratulations to our 2019 fellows!

To learn more about the Degree of Fellow, visit *https://www.aafp.org/membership/involve/fellow.html*.

- **Ruth Archibald, MD, FAAFP**, Rochester
- **Jan Baldwin, MD, FAAFP**, Hibbing
- **Mark Bonneville, MD, FAAFP**, Plymouth
- **Mitchell Cardwell, DO, FAAFP**, Pengilly
- **Stephen Craane, MD, FAAFP**, Edina
- **Charles Dunham, MD, FAAFP**, White Bear Lake
- **Brian Ebeling, MD, FAAFP**, Bloomington
- **Gregory Garrison, MD, MS, FAAFP**, Byron
- **Robert Levy, MD, FAAFP**, Minneapolis
- **Stephen Merry, MD, MPH, FAAFP**, Rochester
- **Matthew Meunier, MD, FAAFP**, Rochester
- **Laura Wellington Miller, MD, FAAFP**, Minneapolis
- **Marcia Lynn O'Brien, MD, FAAFP**, Rochester
- **Steven Pitschka, MD, FAAFP**, Duluth
- **Justin Quo, MD, FAAFP**, Baudette
- **Timothy Ramer, MD, FAAFP**, Minneapolis
- **Paul Robelia, MD, FAAFP**, Rochester
- **David Sahlstrom, MD, FAAFP**, Wayzata
- **Thomas Satre, MD, FAAFP**, Sauk Rapids
- **Kevin Sirmons, MD, FAAFP**, Monticello
- **Andrew Slattengren, DO, FAAFP**, Minneapolis
- **Thomas Thacher, MD, FAAFP**, Rochester
- **Mari Thomas, MD, FAAFP**, Sauk Centre
- **Kimberly Tjaden, MD, MPH, FAAFP**, Saint Cloud
- **Fred Webber, DO, FAAFP**, Osseo
- **Amanda Weinmann, MD, MS, FAAFP**, Saint Paul
- **Andrea Westby, MD, FAAFP**, Minneapolis
- **Michael Wootten, MD**, FAAFP, Hopkins

ST. PETER FREE CLINIC FILLING GAP IN CARE

The **American Academy of Family Physicians Foundation Family Medicine Cares USA signature program** is awarding the **St. Peter Community Free Clinic** a $19,055 grant to purchase durable medical equipment and instruments.

The St. Peter Community Free Clinic is a **Volunteers in Medicine America Clinic**. It opened in St. Peter, Minnesota, in May 2019, and is championed by **Keith Stelter, MD, MMM**, a president of both the Minnesota Academy of Family Physicians (MAFP) and MAFP Foundation.

We talked with Dr. Stelter to learn more about the free clinic and how it's serving the community of St. Peter.

WHY START A FREE CLINIC IN ST. PETER?

Many people struggle to pay for basic medical care. So, in the fall of 2018, we partnered with the local food shelf and set up health screenings for diabetes and hypertension. We found that some people had not seen a doctor in many years. Others had seen a doctor; but, the cost of going back was so high that, unfortunately, they let their medications run out, and their blood pressure and diabetes fell out of control. With the free clinic, we're hoping to close that gap and provide care for those who previously have not seen a physician because of lack of insurance.

WHO STAFFS THE CLINIC?

We are all volunteers. The clinic has a pharmacist, two nurses and two physicians. Several times a month, we also have a psychologist to provide counseling and mental health services, and we have partnered with a local public health nurse to give vaccinations. We are looking into getting a dental hygienist and social worker to increase our services.

WHAT SERVICES ARE OFFERED?

We offer basic primary health care, which is essentially treatment of common infectious illnesses, hypertension, diabetes, depression, anxiety and musculoskeletal issues. We provide preventive care visits, pharmacist consultations and mental health counseling services (when we have a psychologist available). We are able to offer free comprehensive lab services from our local hospital *(a great service)* when we cannot do labs onsite. We offer vaccinations when a public health nurse is present. And, generous community members have given us funding to cover half the cost of medications that we provide to our patients.

(l-r) Kent Cova Suarez, Carrie Stelter, MD, Keith Stelter, MD, MMM, Beth Brinkman, MD, Ryan Brower, MD, and Joshua Ostrue, DO, in front ot the St. Peter Community Free Clinic.

DOES THE CLINIC HAVE LOCAL PARTNERSHIPS?

Yes, we partner and share space with the **St. Peter Area Food Shelf**. Our patients can access food and then come directly to the clinic for medical care, all in the same visit. We also have partnerships with public health and the local hospital, **River's Edge**, for lab services. **Mayo Clinic Health System** is supporting us by providing malpractice insurance for nurses and other Mayo physicians who volunteer in our clinic. If a patient needs more intense services or care, we coordinate with **Open Door Health Center in Mankato**, a Federally Qualified Health Center.

WHICH GROUPS HELPED GET THIS CLINIC OFF THE GROUND?

We initially worked with Volunteers in Medicine America, a national organization that supports free clinics, and the **University of Minnesota Mankato Family Medicine Residency**. Several family medicine resident physicians and residency faculty were key players in the initial planning and creation of the clinic. We were also lucky to have secured free "office space" from the organization that owns the building where the food shelf is located. The building

was previously used as a pharmacy, and we currently use the common meeting space and some office space for exam rooms and consultation areas. Our Board of Trustees, a diverse group of people from the community who are committed to eliminating health disparities, continues to drive the strategy for the clinic.

TELL US MORE ABOUT THE COMMUNITY YOU'RE SERVING.

We are seeing a large number of patients who are working more than 40 hours per week *(more than 70% are employed, according to our statistics)*, but their monthly income is very low for their family size. Many times, they are below the defined federal poverty level. They really have no ability to buy insurance through their employer and no ability to get medical assistance, due to a number of other demographic factors. We find that our patients are very concerned about their health, and they are good about coming back for rechecks when that is needed/advised.

HOW WILL THE CLINIC USE THESE GRANT DOLLARS?

The AAFP grant will be a huge "shot in the arm" for our clinic. We have been using old medical equipment from our medical school days to examine patients—some of it is more than 30 years old! We will now be able to purchase exam tables (instead of examining patients on a sofa). We will also get more lab medical equipment for point-of-care testing, e.g., A1C, lipid and hemoglobin. We are hoping to buy a point-of-care ultrasound machine, so that we can do lung and other imaging onsite instead of having to send patients to the hospital. We will be transitioning to an electronic medical record and will need some computers and printers. We also plan to create more consultation rooms, using movable commercial room dividers, since we only have three private office spaces now for exams and counseling.

PARTING THOUGHTS?

Working on the free clinic has been one of the most gratifying endeavors of my career. I encourage other physicians who have the desire to do something like this to start the process!

See clinic hours, volunteer to serve, donate to patient care and more at **www.stpeterfreeclinic.org.**

By **Julie Anderson, MD, FAAFP**
Senior Delegate to the AAFP House of Delegates

2019 CONGRESS OF DELEGATES REPORT

This past fall, your Minnesota elected delegates travelled to Philadelphia for the 2019 AAFP Congress of Delegates. The Congress is the rule-making body that helps to set the focus for the AAFP over the next year. Each state elects two delegates and two alternate delegates to represent their constituents—much like the senate of the federal government. We each take our roles very seriously and try our best to bring the issues forward that are important and timely to our fellow Minnesota physicians.

THIS YEAR, WE HAD A NUMBER OF MINNESOTA RESOLUTIONS BROUGHT TO CONGRESS:

Health in all policy: ADOPTED. After discussion, it was felt that, while this resolution was in line with current AAFP policy, it went further in its statement asking for the use of health impact assessments as related to environmental impact.

Impact of social media: SUBSTITUTE RESOLUTION ADOPTED. Minor changes to the language were made in order to focus on the relationship between youth utilization of social media and mood disorders and allow for the sharing of existing resources rather than creating new resources.

Oppose criminalization of providing abortion care: REAFFIRMED AS CURRENT POLICY. It was felt that the AAFP has current policy that protects family physicians providing legal care within the bounds of their training and expertise.

End the practice of using race as a proxy for biology or genetics in their educational events and literature, and require race be explicitly characterized as a social construct when describing risk factors for disease: REFERRED TO THE BOARD. Because the topic of race-based medical care is nuanced, it was felt that more research and information be available to determine a plan on how to address the intent of the resolution.

The Congress selected Dr. Ada Stewart as the AAFP's president-elect, who will follow in the footsteps of our current president, Dr. Gary LeRoy. I can personally vouch for the character of both of these physicians and know that we are well represented at a national level. This is an historic moment at the AAFP; we have elected our first African American female president, who also happens to be an active colonel in the US Army Reserves. I know that you all will be as proud of her as I am as she serves us next year.

I would like to thank Drs. Daron Gersch, Dania Kamp and Renée Crichlow, who serve as fellow delegates and alternate delegates to the Congress. They are hard-working family physicians who have their pulse on the needs of Minnesotan family physicians. Please remember that we serve you, and we are always willing to discuss resolutions or take recommendations to bring to a national level. Consider becoming active in our state chapter or on a committee, or attend the **MAFP House of Delegates (Saturday, June 13, 2020, in Brooklyn Center, MN)**, where we debate local issues and consider future resolutions that we bring to the national meeting. If you aren't part of the conversation, we can't advocate on your behalf.

MAFP Chief Executive Officer, **Maria Huntley, CAE, MAM**; Senior Delegate **Julie Anderson, MD, FAAFP**; MAFP President and AAFP Junior Alternate Delegate **Renée Crichlow, MD, FAAFP**; AAFP Senior Alternate Delegate **Dania Kamp, MD, FAAFP**; Junior Delegate **Daron Gersch, MD, FAAFP**; and MAFP President Elect **Andrew Slattengren, DO, FAAFP**.

SNAP WORK REQUIREMENTS WON'T WORK

Here I am in a pickup loading food with other volunteers. The Mountaineer Food Bank and the United Way of West Virginia provide food to an average of more than 1,000 people—roughly 10% of the county—at food distribution events in Clay County, W.Va.

My 12-year-old son recently asked me, "Why would anyone refuse food to the people without jobs? Isn't that backward?" He was listening to the news on the way home from school when discussion turned to the administrative rule change that would enforce an employment requirement for people to receive Supplemental Nutrition Assistance Program benefits.[1] Unfortunately, food and employment are two extremely complicated issues.

In 2016, West Virginia conducted a small pilot in nine counties that was similar to the new federal rule change, which will require 20 hours of employment per week to receive SNAP benefits.[2] Not only did the pilot fail to spark an increase in employment, food pantries had difficulty compensating for increased demand, there were negative economic outcomes and, obviously, people's access to food was diminished.

The impact of SNAP dollars goes far beyond food itself. It is estimated that there is an economic multiplier effect[3] that yields $1.79 for every $1 of SNAP benefits.

I sat in a West Virginia Senate Health Committee meeting in 2017 when outcomes from the nine pilot counties were discussed. The pilot had been specifically designed to test counties with the lowest unemployment rates across the state. However, people not only struggled to find employment, they struggled to find even volunteer opportunities that were allowed in lieu of paid employment when there were no jobs to be had.

Although the work requirement pilot failed miserably, Gov. Jim Justice signed legislation that pushed the program statewide in 2018.[4] It doesn't surprise me that our state's only billionaire and luxury resort owner wouldn't understand hunger. (And I guess it shouldn't surprise me that he doesn't understand the economic impact this legislation will have because he seems to have a hard time paying his own bills.[5])

There is a provision for waivers for counties with peak unemployment rates and limited opportunities, but even those waivers will be phased out by 2022. Forty-six of West Virginia's 55 counties qualify for exemption due to a lack of jobs.

I see patients making choices that have negative impacts on their health, which will only worsen when their SNAP benefits are gone. And I'm not the only one. The AAFP urged the USDA[6] to use caution when the agency issued the proposed rule that would limit SNAP benefits, noting that food insecurity is a predictor for higher health care utilization and negative psychological and health outcomes.

My state is not alone in having food access challenges, and it's not alone in having outrageous poverty rates.[7] But it is a great

place for studying social service programs and the impact that things like the work requirement for SNAP can have because we have a population that already is on the edge of survival without more hurdles being added. High poverty, including among employed people, means increased reliance on support services for food. Often our counties with the highest poverty rates are the same counties with poor infrastructure that lack public transportation and clean drinking water. The county I work in doesn't even have a grocery store. Recent data shows West Virginia has the lowest median household income in the country.[8]

My primary identity in the community is as a physician, but I have spent quite a bit of time working on the food access issues here. When our county's only grocery store closed in 2015[9], I was shocked. It eventually reopened[10], but when it failed again this year, I was ready. I rallied a group of organizations and individuals who I thought could save the store. We met via conference call a couple months before the actual closure, but we weren't able to keep the store open. And we haven't been able to open another store. So now we are thinking outside the box.

We have increased food distribution events because the small food pantries in the area don't have the necessary infrastructure or storage for things like produce and protein. We have huge distribution events where the Mountaineer Food Bank and the United Way of West Virginia come together, and we are averaging more than 1,000 people—roughly 10% of the county—receiving food at these events during a two- to three-hour window. Cars, and lots of trucks, line up blocking roads in town waiting to pull through the line, and volunteers load food into vehicles based on the number of people who live in each house. It is not uncommon for someone in a truck to pick up food for multiple families. It is just as common for a car driver to pick up for a neighbor or family member and get nothing for themselves. Obviously, this is not a sustainable way to feed people, but it is a way to fill the gap while we work on solutions.

We have had meetings and discussions about options, resources, economic viability and need, but to be honest, there isn't much agreement or momentum toward a brick-and-mortar store. So those of us who are tired of waiting on a plan everyone can get behind are moving forward with a less traditional plan of a mobile grocery store. The United Way is leading the charge with an encouraging amount of support. No, it won't be like going to Walmart or Kroger, but it will be adaptable to the needs and requests of an area. It can get closer to people who may be able to get to the end of the holler but can't get all the way to town. Sure, there are hurdles to overcome, and no, it isn't ideal, but I'm tired of trying to do things the traditional way and failing.

Most of my patients face a 40- to 50-mile drive one way to reach a grocery store. If it costs $10 in gas to get to a store and back, that is $10 they can't spend on food, which is a significant amount of money for those who might only have $50 to start with. When the trip itself is a financial burden, you don't go to the store often. People buy processed, shelf-stable foods, the exact things we advise them to avoid. And sometimes they choose a trip to the store rather than a visit to my office, a subspecialist or the pharmacy.

I can't help but be reminded of a quote that's attributed to Winston Churchill: "Americans will always do the right thing—after they have tried everything else." So, I'm glad my son realized that the new administrative rule isn't the right thing. I wish our wealthy elected leadership could see it, too. You can't demand work for food in a community where there is not enough work, and you have to be open to new ideas regarding work and food.

Kimberly Becher, MD, practices at a rural federally qualified health center in Clay County, W.Va. You can follow her on Twitter **@BecherKimberly**.

This post originally appeared in the AAFP Fresh Perspectives Blog on Monday, December 16, 2019. Reprinted with permission from the American Academy of Family Physicians.

REFERENCES

[1] https://www.theatlantic.com/family/archive/2019/12/trump-snap-food-stamps-cuts/603367/
[2] https://time.com/5744647/trump-food-stamps-rule/
[3] https://ageconsearch.umn.edu/record/262247/
[4] https://www.wvgazettemail.com/news/politics/wv-gov-justice-quietly-signs-snap-work-requirement-bill article_677504e4-655a-5cce-9245-5bfe6bcb3ef0.html
[5] https://www.forbes.com/sites/christopherhelman/2019/04/09/the-deadbeat-billionaire-the-inside-story-of-how-west-virginia-gov-jim-justice-ducks-taxes-and-slow-pays-his-bills/#73ec3b002acc
[6] https://www.aafp.org/content/dam/AAFP/documents/advocacy/prevention/strategy/LT-USDA-SNAPWorkRule-04102019.pdf
[7] https://data.ers.usda.gov/reports.aspx?I=17826&AspxAutoDetectCookieSupport=1
[8] https://wvpolicy.org/breaking-down-more-poverty-data/
[9] https://www.aafp.org/news/blogs/freshperspectives/entry/fooddesertacommunitycoping.html
[10] https://www.aafp.org/news/blogs/freshperspectives/entry/afooddesertrevealsmuch.html

LONGITUDINAL ADVOCACY COHORT TEACHES UNIVERSITY OF MINNESOTA FAMILY MEDICINE RESIDENTS HOW TO INFLUENCE PUBLIC POLICY

The University of Minnesota Department of Family Medicine has developed an advocacy cohort to teach residents how to speak on behalf of their patients, communities and profession. Throughout the year, this group has been meeting monthly to learn about the many aspects of advocacy. During the legislative session, they will be advocating on behalf of their patients for the passage of legislation, sponsored by Representative Hunter Cantrell, that would limit the possibility of switching drug formularies mid-year. Below are some of their perspectives on the importance of physician advocacy.

Stephanie Aldrin, MD
PGY2, UM St. Joseph's
@stephaniealdrin

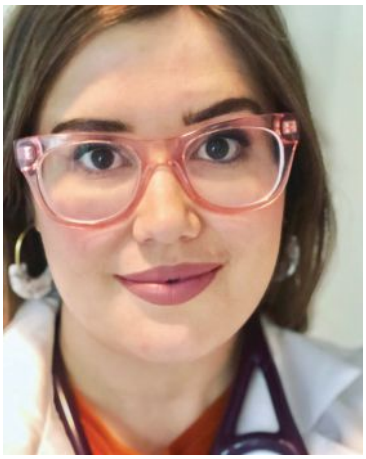
For me, part of being a doctor means working beyond the walls of the clinic to improve the health of the community I serve. From the beginning of medical school, we are taught that the work we do in clinic only accounts for a small percentage of the factors impacting a person's health. Advocacy is an opportunity to improve health in our community by addressing those other factors, whether environmental, structural, economic, etc. Working toward improving health equity through advocacy drove me to learn more and participate in this program.

Julie Amaon, MD, PGY3
UM Medical Center
@AmaonJulie

I am very passionate about sexual and reproductive health. That work has some controversial topics that tend to be heavily legislated. In order to continue to provide safe and compassionate care for my patients, I felt that I needed to be more involved. Find something that you are passionate about or whatever affects your patients and your ability to provide good care for them and get involved. Your voice matters and carries a lot of weight.

Anne Doering, MD, PGY3, UM North Memorial @annedoering

It is so frustrating to see my patients and the care I can offer negatively impacted by systemic problems with our healthcare system. I find it meaningful and empowering to speak up on behalf of my patients and our communities and to advocate for change. For me, this helps prevent burnout and keeps me engaged in the "big picture" of what my work as a family physician is all about. Remember that this work takes many forms and that many different perspectives and skills are needed to move things forward. Reach out to those you know who are active in advocacy work, or to the awesome MAFP staff, for ideas about how to get involved. Sometimes just showing up and saying "yes" is all it takes!



Rose Marie Leslie, MD, PGY2
UM North Memorial
@DrLeslie_MD

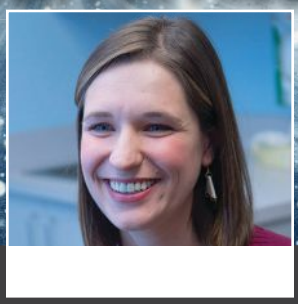
As family medicine physicians, we are in the unique position of understanding the impact that health regulations, policies and systems have on the lives of individual patients. I want to help shape these health policies and systems to impact my patients in a more beneficial and equitable way. Engaging in advocacy can come in many forms, from social media to meeting with a legislator. Find an avenue that feels comfortable to you and just go for it!

Joseph Renier, MD, PGY2, UM St. John's @JoeRenierMD

As family medicine physicians, I feel that we are responsible for recognizing that patients live life outside of our (very short) clinic visits. Similarly, the role of a family medicine physician extends outside the bounds of the office. It's important to just jump into it. I saw advocacy as something too daunting to tackle without the help of someone else. I've quickly learned that if you express interest, help will come to you. Talk to someone who is involved in advocacy. Get on Twitter and start to follow family medicine physicians. From there, you can create your own connection of physicians focused on the same things.

WHEN THE "WEATHER OUTSIDE IS FRIGHTFUL" ...WATCH FOR FROSTBITE

Kate Diaz Vickery, MD, MSc
Clinician-Investigator, Hennepin Healthcare, Hennepin County Health Care for the Homeless



Martha Trevey, DNP, APRN
Family Nurse Practitioner and Clinical Services Manager, Hennepin County Health Care for the Homeless

Danielle Robertshaw, MD
Medical Director, Hennepin County Health Care for the Homeless; Senior Medical Director, Hennepin Healthcare Community Care Ring

It's winter in Minnesota, and you're working at an urgent care clinic. A young woman comes in complaining of finger pain. She walked outside last night after a party where she had two drinks. The weather was cold, but not sub-zero—5^{0}F but substantial wind (50-55mph). She had a winter coat, hat and gloves but she fell in the snow and her gloves got wet. This morning, she had increasing pain and numbness in her fingers. After further discussion, you realize she is homeless and has been hearing voices she doesn't think others hear. You examine her hands, finding pale, discolored fingers which are numb and beginning to develop blisters with clear fluid. The surrounding skin is red and swollen.

In cold climates such as Minnesota, frostbite is a common seasonal condition. Frostbite, defined as "acute freezing of tissues when exposed to temperatures below the freezing point of intact skin,"[1] preferentially impacts people exposed to prolonged cold weather, including those experiencing homelessness. Risk of frostbite relates most strongly to duration of exposure rather than to specific temperature and is estimated by the wind chill index (a standardized calculation that combines wind speed and air temperature and estimates length of exposure time needed until skin can freeze).[2] This means people sleeping outside during winter months are at some of the highest risk for this condition. [3,4] Most commonly, the hands and feet are affected, followed by ears, nose, cheeks and penis.[3]

Homelessness in Minnesota increased 10% from 2015 to 2018, according to a recent report by Wilder Research.[5] During this time, there was a 62% increase in unsheltered homelessness (from 18% to 27% of adults who stayed outside more than a week out of the past month). Despite interest in affordable housing at various levels of government, 32% of people interviewed had been turned away from shelter in the previous three months due to lack of space.

Population-wide epidemiologic data about frostbite are lacking. Most studies focus on specific geographical regions and occupations, e.g. researchers in Antarctica. Hospitalization rates are low overall, with an estimated 0.001% of cold-related injuries across Canada resulting in hospitalization.[6] But US prevalence estimates of the most severe cases of frostbite, derived from trauma and burn registries, indicate 80-120 patients nationally are admitted annually to these specialty services and experience prolonged hospitalization and critical injury.[7] During last winter's cold snap, Hennepin County Medical Center had to open an additional unit to accommodate admissions from weather-related injuries. More than half of admissions involved people experiencing homelessness.

In addition to homelessness, other risk factors for frostbite include alcohol and drug use and psychiatric illness.[8] Further, those who have experienced trauma or had challenges with health systems in the past might be hesitant to engage in care when they develop early symptoms, leading to more severe sequelae later. Chronic physical conditions such as diabetes, spinal cord injuries and atherosclerosis/peripheral vascular disease also lead to decreased blood flow and sensation and also increase susceptibility to frostbite.[9] The Minnesota Wilder Study estimates that more than three-fourths of adults

experiencing homelessness are impacted by serious mental illness, substance use disorder or physical health conditions.[5] Frostbite is treated best with preventive measures, especially when the wind chill index falls to -25^{0}F or below (which correlates to, for example, 5^{0}F with 55 mph wind or -5^{0}F with 15 mph wind) and frostbite can occur in 10 minutes or less. Prevention measures should include:

- Cover all exposed skin in wind-resistant and insulated clothing.
- Layer clothing, with a water-repellent top layer (preferably).
- Stay dry and avoid tight-fitting clothing or boots.
- If you get wet, get inside and remove wet clothing as quickly as possible.
- Maintain adequate hydration and nutrition.
- Avoid alcohol, drugs smoking and medications that cause sedation or vasoconstriction.
- Encourage people experiencing homelessness to use warming centers and sleep indoors. See resource list below.

Management of frostbite must begin with assessment and management of hypothermia and other cold-related injuries.

Frostbite management can be divided into three phases: field care, which occurs while still in cold environments before re-warming; care in the clinic or hospital; and post-thaw care.[10]

- **Field care** should include replacing wet with dry clothing when possible and protecting extremities by placing them in a companion's armpit or groin for 10 minutes. It's important to avoid rubbing the affected body part or rewarming (especially using fire, electric heaters or heating pads).
- **Clinic/hospital care** (see Table) increasingly includes the use of tissue plasminogen activator (tPA), vasodilation medications such as pentoxifylline, and hyperbaric oxygen as adjunctive therapies in the treatment of severe frostbite.
- **Post-thaw care** involves consultation with specialists to determine if amputation is needed. New use of bone scan imaging is helping and can speed up the typical 6-12 week delay in decision-making about the extent of injury and need for surgery.[11]

See Table and Rathjen NA et al.[13] for more details.

continued to page 18

Frostbite can happen in minutes

Prevent frostbite:

Cover skin
(fingers, toes, ears, nose)

Seek shelter
See back for downtown warming locations

Keep feet and hands dry, remove wet socks and gloves

Do not drink alcohol to get warm

continued from page 17

TABLE: FROSTBITE DIAGNOSIS AND MANAGEMENT

Sources: Frostbite Management tip sheet, HCMC Burn Center, Jan. 10 2018.[3,9,13]

Severity (determined only after re-warming)	Symptoms	Signs	Treatment in clinic or hospital setting
Frostnip: Pre-frostbite injury	Transient numbness and tingling	No blistering or wounds	1. Management at home is acceptable. 2. Apply lotion or aloe vera to keep skin moist. 3. Use ibuprofen as needed for pain control.
Mild: First degree or clear-cut second degree	Cold progressing to numbness. Clumsiness of involved body part. After rewarming, severe throbbing pain, electric shock sensation. Long term: Sensory loss, increased cold sensitivity, hyperhidrosis. Some patients develop chronic pain and arthritis.	Numbness Central white plaque Surrounding erythema	1. Rewarm in 40°C/104-108°F water bath for 15-30 minutes until skin becomes red/purple. 2. Debride serous blisters >1cm diameter. 3. *Consider referral to burn clinic* with any significant blistering. 4. First 72 hours: Apply aloe vera, cover with oil emulsion dressing, and wrap in stretch gauze BID; scheduled ibuprofen (if not contraindicated, 600mg QID), consider tetanus shot if not up to date, consider antibiotics if open wound. 5. Later: Apply bacitracin, cover with oil emulsion dressing, and wrap with stretch gauze daily; ibuprofen as needed. 6. PT/OT as needed.
Moderate: Second degree or small area of third degree		Dark skin color Blisters filled with clear/milky fluid develop in first 24 hours Surrounding edema and erythema	1. Rewarm in 40°C/104-108°F water bath. 2. Debride serous blisters >1cm diameter; leave hemorrhagic blisters intact. 3. First 72 hours, *in addition to above:* Consider gabapentin (300mg TID or more) or hydroxyzine if itching. 4. Later: Apply bacitracin with oil emulsion dressing to wounds daily; ibuprofen/gabapentin as needed. 5. PT/OT as needed.
Severe: Third and fourth degree		Initially, hemorrhagic blisters Two weeks later, eschars (hard, black sores) with complete necrosis and tissue loss	1. Rewarm in 40°C/104-108°F water bath. 2. Hospital admission, STAT bone scan if non-perfusion, consideration of hyperbaric oxygen and/or tPA per input of specialists. 3. Keep non-weight bearing, immobilized for 72 hours; consider IV penicillin if significant skin edema. 4. Close follow-up with specialists is needed. Risk for infection. Occasional need for escharotomy or fasciotomy. Tissue viability can be considered between 22-45 days post-injury. It's at this point that decision about amputation is often made.

Care for people experiencing homelessness is best done in coordination with a multi-disciplinary team. Critical to the successful management of frostbite is supporting improvement in behavioral health conditions.[12] Outreach of teams into encampments and other areas not meant for human habitation can build trust and lead to increased confidence of people to seek out medical care and other support. Additionally, advocating for local affordable housing should also be seen as an important medical intervention.

You diagnose your patient with mild frostbite. Thankfully, she has avoided hypothermia and other cold-related injuries. She has already re-warmed her hands but is grateful for your help debriding several small blisters. You dress the wounds with aloe vera and oil emulsion dressing and give her supplies and instructions to change her dressings daily. You give her ibuprofen and instruct her to take it four times daily for one to two days. Your clinic social worker is able to connect with the Hennepin County Adult Shelter Connect and find her a bed for the night. You speak by phone with the Health Care for the Homeless team who can have a psychiatric nurse practitioner meet with the patient in the morning.

ADDITIONAL RESOURCES:

- To find housing for people experiencing homelessness, consult your county government. In Hennepin County, call Adult Shelter Connect at 612-24-2350 or visit https://www.hennepin.us/coordinated-entry.
- To find the closest warming station, consult your city/county government websites. In Hennepin County, see http://www.hennepin.us/staywarm, and in Ramsey County, see https://www.ramseycounty.us/content/safety-information-extreme-cold-and-winter-weather.
- For consultation or medical referrals to Hennepin County Medical Center:
  - For direct admission, please contact Hennepin Connect at 612-873-4262.
  - For Burn Clinic, please contact 612-873-2912.
- For consultation or medical referral to Hennepin County Health Care for the Homeless, please call 612-348-5553.
- For other tips and a printable graphic, *visit* http://emergency.cdc.gov/disasters/winter/staysafe/index.asp.

REFERENCES

1 Murphy JV, Banwell PE, Roberts AHN, McGrouther DA. Frostbite: Pathogenesis and Treatment. Journal of Trauma and Acute Care Surgery. 2000;48(1):171.

2 National Oceanic and Atmospheric Administration, National Weather Service. Wind Chill Chart. 2001. *https://www.weather.gov/media/safety/windchillchart3.pdf*

3 Reamy BV. Frostbite: Review and Current Concepts. J Am Board Fam Pract. 1998;11(1):34-40. doi:10.3122/15572625-11-1-34

4 National Health Care for the Homeless Council. Healing Hands, HCH Clinicians Network Newsletter. 2007; 11(6). *https://nhchc.org/wp-content/uploads/2019/08Dec2007HealingHands.pdf*

5 Wilder Foundation. Single Night Count of People Experiencing Homelessness. 2018 Minnesota Homeless Study. 2018:4. *https://www.wilder.org/sites/default/files/imports/2018_HomelessCounts_FactSheet3-19.pdf*

6 Hassi J, Makinen TM. Frostbite: Occurrence, risk factors, and consequences. Intl Jo Circumpolar Health. May 2000; 59: 92-98.

7 Nygaard RM, Endorf FW. Frostbite in the United States: An Examination of the National Burn Repository and National Trauma Data Bank. J Burn Care Res. 2018;39(5):780-785. doi:10.1093/jbcr/irx048

8 Valnicek SM, Chasmar LR, Clapson JB. Frostbite in the prairies: a 12-year review. Plast Reconstr Surg. 1993;92(4):633-641. doi:10.1097/00006534-199309001-00012

9 Biem J, Koehncke N, Classen D, Dosman J. Out of the cold: management of hypothermia and frostbite. CMAJ. 2003;168(3):305-311.

10 Imray C, Grieve A, Dhillon S, Group CXER. Cold damage to the extremities: frostbite and non-freezing cold injuries. Postgraduate medical journal. 2009;85(1007):481–488.

11 Cauchy E, Chetaille E, Marchand V, Marsigny B. Retrospective study of 70 cases of severe frostbite lesions: a proposed new classification scheme. *Wilderness & environmental medicine*. 2001;12(4):248–255.

12 Maness DL, Khan M. Care of the Homeless: An Overview. AFP. 2014;89(8):634-640.

13 Rathjen NA, Shahbodaghi SD, Brown JA. Hypothermia and Cold Weather Injuries. 2019;100(11):7.

FAMILY PHYSICIANS

WHAT YOU NEED TO KNOW

New-to-practice physicians, **Jay-Sheree Allen, MD,** CentraCare Long Prairie and **Eduardo Medina, MD, MPH**, Park Nicollet Clinic Minneapolis, hosted this event, at which expert panelists discussed what is asked of practicing family physicians when it comes to CME, quality measures, licensing and board certification. The event was held, Monday, November 4 at Pinstripes in Edina.

Panelists included **Warren Newton, MD, MPH**, President and CEO, American Board of Family Medicine; **Julie Sonier**, President, Minnesota Community Measurement; **Ruth Martinez**, Deputy Director, Minnesota Board of Medical Practice; **Lisa Regehr**, Director of CME Accreditation, Minnesota Academy of Family Physicians.
Slides and handouts from the event can be found at *https://mafp.org/need-to-know-2019*.

Thank you to the **American Academy of Family Physicians Foundation Family Medicine Philanthropic Consortium** for their support of this event and to our event partners **Mankato Clinic, Physicians' Diagnostics & Rehabilitation Clinics, Pfizer and Voyage Healthcare.**

Brynna Lu Goraczkowski, MS1
University of Minnesota Duluth Medical School
Cadaver Reflection
January 12, 2020

An Unwarranted Gift

Giving oneself
For strangers to see
Wounds and scars no one else has
A body to us
But a loved one to others
Who carried
Joys and sorrows
Whose eyes witnessed
Decades unbeknownst to us
Whose palms
Created and caressed
Whose soles
Imprinted and trekked endless terrains
Whose brain, a vessel
Of memories from a lifetime
More than we harbor now
Whose arms and legs
Embraced and danced
And in the end gifted
A profound knowledge we did not merit
A celebrated generativity
A life's value carried to the future
Gratitude

In this season's Independent Voices, we hear from **Cody W. Wendlandt**, **MD**, founder and medical director of Sartell Family Medicine, a Direct Primary Care practice in Sartell, MN. He is the former founder and medical director of Elite Medical Scribes. Dr. Wendlandt can be reached at ***cody.wendlandt@vandaliahealth.com***.

THE ABCs OF DPCs

Direct Primary Care (DPC) practices are a growing trend in the United States. Despite Minnesota's notoriety for both family medicine and innovation in medicine, DPC practices have only recently gained a foothold in the Land of 10,000 Lakes. Nonetheless, if you speak to any physician who has started a DPC practice, they will tell you the same thing: "I wish I would have done it sooner!"

WHAT IS A DPC?

For those who are unfamiliar with the concept, DPC practices contract with patients directly, rather than using an insurance company to pay for services on the patient's behalf. Patients pay an affordable monthly membership fee that provides them access to several defined services, such as a certain number of office visits (or unlimited visits), certain lab tests, longer appointment times or increased access to a physician by phone. This differs from a concierge practice, which relies on a large, annual retainer and oftentimes continues to bill a patient's insurance. DPC practices work nicely for patients who have a high-deductible insurance plan or do not carry insurance.

WHAT ARE THE DIFFERENT TYPES OF DPCs?

DPC practices can be further divided into pure or hybrid practices. While pure DPC practices only deal in cash, hybrid practices will accept both cash and insurance as forms of reimbursement. The advantages of a hybrid practice include higher reimbursement rates and an easier transition for patients coming from an insurance-based practice. However, hybrid practices are still plagued by significant administrative burden (credentialing, documentation for reimbursement, billing and coding, Quality Metrics, Meaningful Use, HCAHPS Surveys, payment "adjustments," etc.). In addition, because hybrid practices continue to collect fee-for-service, providers are incentivized to see as many patients as possible each day. Pure DPCs have a lower administrative burden, but lower reimbursement rates and increased difficulty seeing patients on Medicare or Medicaid.

WHAT ARE SOME CHALLENGES OF A DPC?

Starting a Direct Primary Care practice can require a great deal of time, effort and money. One of the more difficult issues in starting a practice is public education. Most patients (and physicians) are unfamiliar with the advantages of a DPC practice and how it differs from a traditional practice. Patients who have insurance can be reluctant to pay cash for medical services. Explaining the cost savings to patients requires a conversation, rather than a brief advertisement on a billboard or in a newspaper. Because only a small fraction of an existing panel is needed to support a DPC model, it is oftentimes easier to transition an existing practice to DPC. Of course, physicians must always be mindful of non-compete agreements. Due to these challenges, it is common for physicians who are building a DPC practice to moonlight in urgent cares or emergency departments.

This can create additional strain on wellbeing, marriage and family.

WHAT ARE THE BENEFITS OF A DPC?

Despite the many challenges of starting a DPC practice, the advantages can be much greater. During the first few months of working my own DPC, it felt like a breath of fresh air. I felt like I had re-discovered my love for medicine. I found that I was able to focus on relationships and clinical science, rather than insurance claims, paperwork and documentation. I found myself truly invested in my patients' wellbeing and progress, rather than being overwhelmed with running from room to room. I have spoken with many other DPC-based physicians, who will echo these exact sentiments.

WHAT ARE OTHER WAYS A DPC CAN DIFFER FROM A TRADITIONAL PRACTICE?

Another benefit of a DPC is the ability to tailor the practice to a physician's personal interests, while also choosing additional services that create value for patients. In addition to offering primary care and urgent care, our practice has also chosen to administer intravenous medications, treat opiate addiction and offer mental health counseling with integrated behavioral health.

WHAT ABOUT LABS, RADIOLOGY AND MEDICATIONS?

DPC practices can offer CLIA-waived laboratory tests in addition to collecting blood/urine specimens, which are picked up daily by an external laboratory. Cash prices for these studies are usually very reasonable. DPC practices can purchase radiology studies (and reads) from local imaging centers for a negotiated cash price. In addition, some DPC practices dispense prescription medications out their office. Patients can oftentimes walk out of an office with a medication in hand for less than their co-pay at a pharmacy. Offering these low-cost services with price transparency is greatly appreciated by patients.

WHAT'S NEXT FOR DPC?

DPC has certainly filled a need for better patient care and physician access, while concurrently allowing for more physician autonomy and increasing their ability to focus on medicine. In speaking with other DPC physicians, I can see the future of DPC growing to include multi-location partnerships, increasing patient engagement through the utilization of technology and offering more inpatient-style services outside a traditional hospital setting.

As physicians, we are only limited by our imagination, ingenuity and willingness to take risks. If you're a physician who's looking to fall in love with medicine again, I invite you to consider starting a DPC practice!

NEW TO THE LAND OF 3,100 FAMILY DOCS

- **Danyelle Fenner, MD**, Ely, and **Natalie Krier, MD**, Cloquet, have transferred from Colorado.
- **Kelley Jewett, MD, FAAFP**, Minneapolis, has transferred from Foreign AFP.
- **Donn Tiu Tong, MD**, Rochester, has transferred from Indiana.
- **Sunnah Doesken, MD**, Barnesville, has transferred from Iowa.
- **Priya Alagappan, MD**, St. Paul, has transferred from Michigan.
- **Minakshee Mohanty, MD**, St. Paul, has transferred from New York.
- **April Coming Hay, MD**, Lakeville, and **Scharazard Gray, MD**, International Falls, have transferred from North Dakota.
- **Brent Furomoto, DO**, Eagan, has transferred from Ohio.
- **Kathryn Dobbs, MD**, Cloquet, has transferred from South Dakota.
- **Teresa Meyer, DO**, Waconia, and **Meetul Shah, MD**, Minneapolis, have transferred from Wisconsin.

NEW STUDENT MEMBERS

American University of St. Vincent School of Medic

- **Alex Kemei**, Minneapolis

Mayo Clinic Alix School of Medicine

- **Ilana Breen**, Irvine, CA
- **Noelle Driver**, Rochester
- **Oluwatomilona Ifelayo**, Rochester
- **Aditya Khurana**, Phoenix, AZ
- **Jason Lin**, Rochester
- **Christopher Livia**, Rochester
- **Andrea Lorenzo**, Scottsdale, AZ
- **James Markos**, Jackson, TN
- **Ryan Smith**, Scottsdale, AZ
- **Holly Thomson**, Scottsdale, AZ
- **Patrick Vaughn**, Rochester

St. James School of Medicine Bonaire

- **Badra Ali**, St. Paul
- **Kelly Thao**, St. Paul

University of Minnesota Medical School – Duluth Campus

- **Alexa Alfred**, New Ulm
- **Shelbie Shelder**, Minneapolis

University of Minnesota Medical School – Twin Cities Campus

- **Leah Alemu**, Woodbury
- **Beret Fitzgerald**, Glencoe
- **Aisha Mohamed**, Minneapolis
- **Austin Pickup**, Minneapolis
- **Maryssa Poderzay**, St. Paul
- **John Scheuer**, Minneapolis
- **Marvin So, MPH**, Minneapolis

IN MEMORIAM

- **Gary Davis, PhD, LP**, Duluth, MN
- **Maurice McNeil, MD, FAAFP**, Glencoe, MN

Family Medicine Physicians

Signing Bonus, Retention Bonus, and Opportunity for 4 Day Work Week

JOIN TEAM UPG. The University of Virginia Physicians Group is seeking full time, part time and PRN Family Medicine Physicians for its Culpeper, Staunton, and Charlottesville, VA locations.

ASPIRE TO WORK WITH THE BEST. These practices are associated with a well-respected, academic affiliated community hospital.

ASPIRE TO PERFORM AT THE HIGHEST LEVEL. Requirements include graduation from an accredited medical school with degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO) with completion of Accredited Residency in chosen specialty. Board certification in specialty (if newly graduated from residency, must be obtained within 2 years of graduation) must be kept current; unrestricted license to practice within the Commonwealth of Virginia; and current DEA certificate without restriction.

ASPIRE TO LIVE IN THE BEST. The Physicians Group works collaboratively with the University of Virginia School of Medicine, School of Nursing, and Medical Center to provide the highest quality patient care. We serve patients at sites throughout Central Virginia, including Charlottesville, Richmond, Louisa, Augusta, Orange, Zion Crossroads, Nelson, Culpeper, Winchester, and others—currently 24 primary and specialty care practices, all with direct access to hospital of the University of Virginia Medical Center, ranked #1 in Virginia by U.S. News & World Report.

ASPIRE TO ENJOY THE BEST. We offer a highly competitive salary and benefit package in addition to affiliation with UVA Medical Center.

ADVANCE YOUR CAREER ENRICH YOUR LIFE. Join our team of over 1,200 physicians, nurse practitioners, and allied health professionals delivering uncompromising patient care.

University of Virginia Health System | Physicians Group

To apply please contact:
Ellen Gilliland @ esg8w@virginia.edu; or call Ellen @ 434-970-2489 or 434-282-5854 (cell).

Affirmative Action / Equal Opportunity Employer / Drug Free Workplace

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.

OCTOBER

- 2 Attended *It's Time to Talk About Race* forum
- 6 Attended Associations North *Fall Leadership Conference*
- 11 Attended U of M Department of Family Medicine & Community Health *50th Anniversary Celebration*
- 11 Met with new Mayo Department of Family Medicine Chair David Rushlow, MD
- 14 Presented at U of M Medial Center Family Medicine Residency on *Health Equity*
- 15 Met with Minnesota Department of Health
- 16 Met with United Family Medicine resident to discuss ways to support advocacy at their program
- 22 Met with physician recruiter partners regarding Spring Refresher partnership opportunities
- 27 Presented at AAFP *New CEOs* session in Kansas City

NOVEMBER

- 4 Presented at MAFP *What Physicians Need to Know* member event
- 5 Met with Representative John Huot
- 7 Attended *TIME'S UP Healthcare*
- 8 Attended *Family Medicine Midwest* and served on Host Committee
- 9 Attended *MMA Legislative Day*
- 12 Attended *Advancing Equity: A Racial Equity Journey* webinar
- 12 Met with Representative Alice Mann
- 13 Met with Shriners Healthcare for Children - Twin Cities
- 14 East Metro Chapter met with Representative Rena Moran and representatives from Integrated Care for High Risk Pregnancies Initiative
- 19 Presented legislative priorities to Rural Health Advisory Committee
- 21 Attended AAFP *Primary Care Spend* online meeting
- 25 Met with Representative Jennifer Schultz
- 25 Met with OSH Healthcare partner
- 26 Met with Minnesota Association of Community Health Center
- 26 Met with Minnesota Rural Health Association

DECEMBER

- 3 Met regarding AAFP *25 X 2030 Student Choice Collaborative*
- 3 Met with Grand Itasca Health partner
- 4 Met with Minnesota Council of Health Plans
- 5 Co-hosted *Buprenorphine Boot Camp*
- 6 Met with EQB/MDH/Network for Public Health Law re: HIAs in the environmental review process
- 10 Attended *White Privilege 101* workshop
- 12 Met with MDH Health Care Homes team
- 18 Met with BOLD Ideas Rural Health Care Network
- 18 Met with Minnesota Health Action Group

Practice primary care in ideal surroundings.

Hardin Memorial Health is one of Kentucky's most dynamic hospital organizations in one of Kentucky's most progressive and family friendly communities. Elizabethtown is just 30 minutes south of Louisville on I-65. If you're looking to practice primary care in comfortable surroundings near large city attractions, we may just have the perfect fit for you.

Competitive Salary & Benefits | Startup Bonus & Relocation | Student Loan Repayment

We continue to expand to meet the region's healthcare needs.

- Serving a 10-county area with over 400,000+ people; one tenth of Kentucky's population
- One of the state's largest employed medical groups with 240+ providers
- Newly expanded Emergency Department is second busiest in Kentucky
- Region's only Level II NICU facility
- Over 40 medical specialties and 50+ offsite facilities
- Managed by Baptist Health / Kentucky & Southern Indiana

HMH **Hardin Memorial Health**

hmh.net | touretown.com

…And that's just skimming the surface. To learn more about HMH, Elizabethtown and the wonderful personal and career opportunities available, please contact:

Jonell Dailey
Hardin Memorial Health
Director, Professional Relations

jdailey@hmh.net
(270) 706-5728

MEMBER SUPPORTED, MEMBER DRIVEN

Here at the MAFP Foundation, we have the goal of supporting members in their pursuit of improving patient care. We meet that goal through philanthropy, which allows us to award innovation and research grants to physicians, residents and students pursuing family medicine research, clinical innovations, clinic-community partnerships and work in healthcare policy/family medicine advocacy. We have members examining important issues such as novel treatments for PTSD, convening a learning cohort of residents as patient advocates, the fight against the opioid epidemic and dental care access for people who are homeless. Donations from MAFP members make a real difference in the lives of patients and communities across Minnesota.

Thank you to these individuals and organizations for their financial support of the MAFP Foundation in 2019.

Gifts from MAFP Local Chapters

Central Chapter
East Metro Chapter
Heart of the Lakes Chapter
Lake Superior Chapter
Park Region Chapter
Southeast Chapter
West Metro Chapter

Grants and Matching Grants

AAFP Family Medicine Philanthropic Consortium
Minnesota Academy of Family Physicians

Gifts from Individuals (not amounts)

Anonymous
Olusola Adegoke, MD, MPH
Jay-Sheree Allen, MD
Sharon Allen, MD
Amazon Smile
Emily Anderson, MD
Macaran Baird, MD, MS
Nancy Baker, MD
Lynn Balfour, MBA
Virginia Barzan, CAE
Jolene Berg, MD
Kathryn Brown, MD

continued on page 30

COMING UP NEXT

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

Day at the Capitol
March 4
12:30 - 6:00 pm
Minnesota State Capitol
St. Paul, MN

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

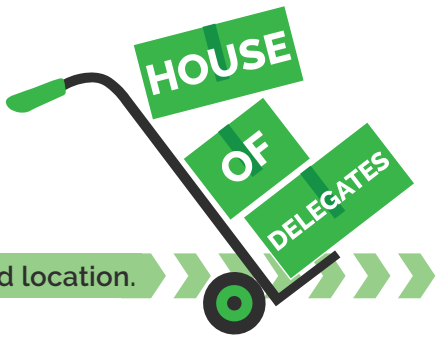
Spring Refresher
March 28 & 29
The Depot
Minneapolis, MN

Rural Health Livestream: Course Designed for Rural Health Physicians
May 14-16
Online
http://bit.ly/2Pu5dRQ

Family Medicine Advocacy Summit
May 18-19
Washington, DC
https://aafp.org/events/fmas.html

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

House of Delegates is moving!



...to a new date and location.

continued from page 28

Gifts from Individuals cont...

David Bucher, MD, FAAFP
Michael and Peg Bucher
Jami Burbidge, MAM
Nicole Chaisson, MD
Schwab Charitable
Lindsey Chmielewski, MD
James Conniff, MD, MPH
Renee Crichlow, MD, FAAFP
Kathleen Culhane-Pera, MD
John Dickhudt, MD
Deborah Dittberner, MD
Pamela Dumke, MD
Roli Dwivedi, MD
Angela Esquibel, MD
Carol Farchmin, MD
Pamela Fisher, MD
Patricia Fontaine, MD, FAAFP
Kathryn Freeman, MD
Richard Gebhart, MD, FAAFP
Daron Gersch, MD, FAAFP
Betsy Gilbertson, MD
David Goodman, MD
Dawn Graham, MD
David Gregornik, PharmD
Jon Hallberg, MD, FAAFP
Michele Hanson, MD, FAAFP
Rachel Hardeman, PhD, MPH
David Henke
Douglas Henley, MD, FAAFP
Walter Hinck, MD
Larry Hook
Suzanne Human, MD
Maria Huntley, CAE, MAM
Sue Inoue, MD
Gerald Jensen, MD
Sandra Johnson, MD
Kathryn Justesen, MD
Dania Kamp, MD, FAAFP
Carolyn Kampa, MD
Curtis Keller, MD
Thomas King, MD
Timothy Komoto, MD, FAAFP
Rahul Koranne, MD, MBA, FACP
Robert Koshnick, MD, FAAFP
Louis Kuritzky, MD
Patricia Lindholm, MD, FAAFP
Brian Livermore, MD, PhD
Steven Longbotham, MD
Russell Luepker, MD, MS
Kathleen Macken, MD
Rosa Marroquin, MD
Marc Matthews, MD
John McCabe, MD
Eduardo Medina, MD
David Mersy, MD, FAAFP
Peter Meyers, MD, MPH
Deborah Mielke, MD
Laura Miller, MD, FAAFP
Lauren Moak Williams, MD
Adrianne Moen, MD
Shannon Neale, MD
Stephen Nelson, MD
Glenn Nemec, MD
Tanner Nissly, DO
Jennifer Oberstar, MD, FAAFP
Lynne Ogawa, MD
Sheri Olsen, MD
Shelley Overholt-Thiesen, MD, FAAFP
Jennifer Pecina, MD, FAAFP
Kerui Peng
Donald Pine, MD, FAAFP
John Punderson, MD
Teresa Quinn, MD
Timothy Ramer, MD, FAAFP
Lisa Regehr
Britta Reierson, MD
Christopher Reif, MD, MPH
Jason Ricco, MD
Randy Rice, MD, FAAFP
Lori Ricke, MD
Jerry Rogers, MD, FAAFP
Edward Rosenbaum, MD
Erik Sather, MD
Brittney Schultz
Mike Sevilla, MD
Alexandra Sharp, MD
Andrew Slattengren, DO, FAAFP
Angela Smithson, MD, MPH
Roman Smulka, MD
Julie Spina, MD
Jeremy Springer, MD
Paul Stadem, MD
Keith Stelter, MD, FAAFP
Maria Svetaz, MD, FAAFP
Morgan Thornton
Alexandra Tsvilina, MD
Aaron Ulland, MD, MPH
Paul Van Gorp, MD, FAAFP
Gabrielle Vencel Olson, MD
Katherine Vickery, MD
Nicholas Vidor, MD
Shanna Vidor, MD
Alexis Vosooney, MD
Andrea Westby, MD, FAAFP
Anne Whitworth, MD
Lauren Moak Williams, MD
Tricia Wright
Barbara Yawn, MD, FAAFP

Every effort was made to ensure the accuracy of the list, but please alert us to corrections by contacting Lynn Balfour at lynn@mafp.org or 952-224-3872.

It Takes Some Courage, But Saving Money Is Worth The Leap.

Get Free Savings Tips

Put Away A Few Bucks.
Feel Like A Million Bucks.

Ad Council

AICPA

FeedThePig.org

MINNESOTA ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA
1400 Van Buren St NE, Ste 215
Minneapolis, MN 55413-4605

Presorted Standard
U.S. Postage Paid
Little Rock, AR
Permit No. 2437