FALL 2020 • VOL. 4 • No. 4

MFP

TRANSFORMING PRIMARY CARE: LEVERAGING TEAMS & TECHNOLOGY

KRISTA SKORUPA, MD, CPE

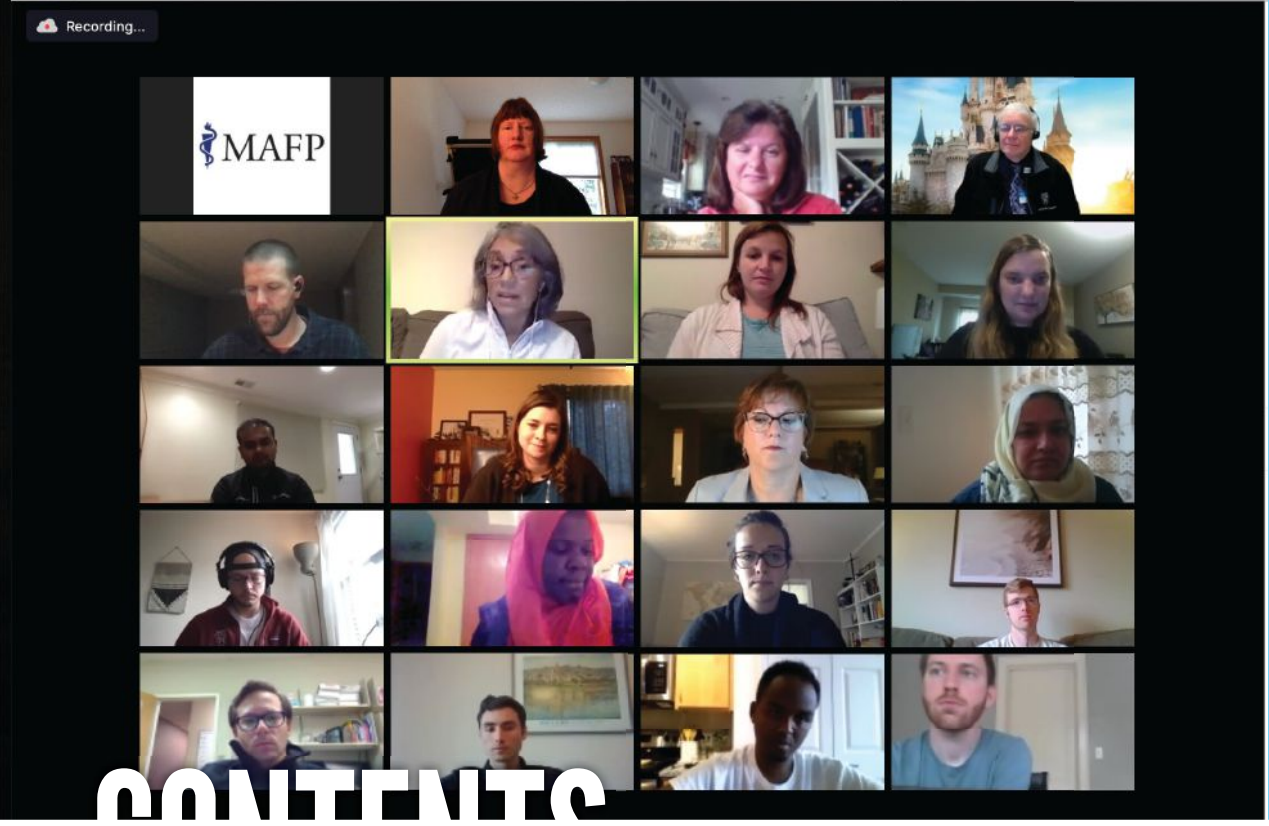
10

COVID-19 AND KIDS: TRENDS AND CLINICAL IMPLICATIONS

14

Heartfelt help for eating disorders.

The Emily Program



First-year residents took part in the Intern Social & Scholarship Event hosted by the MAFP Foundation on Saturday, September 12. This was a chance to get to know Academy leaders and learn about opportunities to get involved with our chapter. 11 residents were randomly selected to win scholarships provided by the **Arden Anderson, MD,** Fund.

CONTENTS

FALL 2020 • VOL. 4 • NO. 4

14 Emerging Medicine
COVID-19 and Kids: Trends and Clinical Implications

27 Events
AAFP Virtual National Conference

4 President's Message
SODOTO

6 Member News

8 New to Practice

10 Leadership
Transforming Primary Care: Leveraging Teams & Technology

12 Member Spotlight
A Conversation with **Jeffrey Scrivner, MD,** on Rural Primary Care Workforce Recruitment and Retention

18 Learning Together
Interprofessional Education: An RPAP – Augsburg University PA Program Learning Collaborative on Postpartum Care

22 Foundation Impact
Annual Review

26 Repurposing & Adapting: Fighting For The Community Served By St. Joseph's Hospital

28 Advocacy
A Doctor in the House

29 Coming Up Next

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

SODOTO

by **Andrew Slattengren, DO, FAAFP**
MAFP President

Even as family physicians demonstrate their adaptability to the changes in our health care delivery, our resilience is being tested with a barrage of seemingly endless hits from 2020 that include the ongoing COVID-19 pandemic, fears of a "twindemic," decreased patient volume and the associated furloughs, pay reductions and uncertainty of what our practices will look like moving forward. Additional societal stressors include a highly divisive election season, ongoing protests and counter-protests around issues of racism, historic wildfires, record-high food insecurity and the death of an iconic supreme court justice. These insults are compounded by changes in our work support networks that are so important in maintaining wellbeing. Many of us are hurting in ways unseen behind our masks and visors.

How can we respond in a way to support ourselves and our colleagues when we have not experienced anything like this before?

SODOTO is a place to start.

William Stewart Halsted became the first Chief of Surgery at Johns Hopkins Hospital in 1890. Halsted's model of "see one, do one, teach one" (SODOTO) was used in his residency program to increase clinical competence that culminated in near independence. Halsted was interested in not only developing a system to train surgeons, but also in creating teachers and role models.

A century later, education theorist David Kolb put forward his experiential learning theory, which defines learning as "the process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience." Simplified, Kolb's continual cycle of learning by doing involves observation (see one), thinking, action (do one) and experience (teach one).

One way we can all take action, instead of quietly contemplating the issues we are facing, is to reach out to current colleagues to check on their wellbeing. If that makes you too vulnerable at first blush, reach out to someone you feel more comfortable with—a mentor, previous residency colleague or medical school friend.

I recently received the following text from a colleague: *"Just checking in. How are you holding up? I don't know if you have anyone checking in with you regularly, since you're often the strong one, and you deserve to be checked on too."*

This "see one" really hit home and primed me to reflect on how I was really doing and what other supports I needed in my life right now. After that thinking phase, I reached out to multiple colleagues (do one) with similar messages and that has led to some fruitful conversations that have built up my hope in the face of all we are experiencing.

As a "teach one," I share today's message in the hopes that you, too, can start to fill your cup of hope back up.

"Optimism is the faith that leads to achievement. Nothing can be done without hope and confidence." – Helen Keller

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 136,700 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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Julie Amaon, MD, was interviewed by Jennifer Gerson from *Bustle* for the article "Why I Started Providing Medication Abortions During the Pandemic" published September 29, 2020.

John Benson, MD, Mankato Clinic, was quoted in the article "Doctors Stress Vaccine Importance Ahead of Flu Season, COVID Overlap" by Brian Arola published in the *Mankato Free Press* on September 15, 2020.

Sylvia Blomstrand, MS4, University of Minnesota, had her poster *Late-Onset Psychosis in an 82-Year-Old: A Rare Case of Sporadic Creutzfeldt-Jakob Disease in Rural Minnesota* accepted for the 2020 Virtual AAFP Family Medicine Experience. It was selected as one of the top three posters in the medical student case study category.

The University of Minnesota Medical School is proud to announce the appointment of **Renée Crichlow, MD, FAAFP,** assistant professor and director of Advocacy and Policy in the Department of Family Medicine and Community Health, as the inaugural Mac Baird Endowed Chair in Family Medicine Advocacy and Policy.

Annie Ideker, MD, HealthPartners - Arden Hills, was interviewed by Angela Davis and Karen Zamora for the *MPR News* piece "Will Telemedicine Be the New Norm in Minnesota?" posted August 5, 2020.

Graham King, MD, Mayo Clinic Health System Mankato, was interviewed by Brian Arola from *Mankato Free Press* for the article "Children Still Need Routine Vaccinations During Pandemic" published July 1, 2020.

Elizabeth Maloney, MD, MPH, President of the Partnership for Tick-Borne Diseases, was quoted in the Insider article "Chronic Lyme Disease Is an Uncommon, but Serious Condition – Here's How to Know if You Have It" by Molly Glick, published on August 21, 2020.

Kurt Schwieters, MD, CentraCare Health - Melrose, was interviewed by Minnesota Public Radio's Kirsti Marohn for the piece "Doctor's COVID-19 Videos Offer Calm in the Pandemic Storm" on September 16, 2020.

James Smith, MD, MPH, PGY3, North Memorial Family Medicine Residency, appeared on WCCO-TV|CBS Minnesota on October 8 to talk about the flu and COVID-19.

Erin Westfall, DO, faculty, University of Minnesota Mankato Family Medicine Residency, and **Marjan Jahani Kondori, MD, MPH,** first-year resident, were interviewed for the TPT-Twin Cities documentary "Minnesota's Dental Crisis." The documentary will premiere in January 2021.

Rob Westin, MD, was interviewed by Frank Lee from the *Brainerd Dispatch* for the article "Cuyuna Regional Medical Center Physician Talks (factually) about COVID-19" published June 25, 2020.

PRACTICING MEDICINE "ON MY OWN"

by **Cora Walsh, MD**

We are reaching out to our members who are new-to-practice (defined by the AAFP as in their first seven years of practice) to learn about their hopes for our specialty and what advice they have for future family docs. Over the next four issues, we'll be shining a light on their voices and experiences.

We asked Cora Walsh, MD, for her advice to a doctor on their first day of practice. Dr. Walsh is a 2015 graduate of the University of Minnesota North Memorial Family Medicine Residency and practices at Allina Health West St. Paul Clinic.

On my first day in practice, I was so nervous about practicing medicine "on my own" without my residency faculty to help guide my decision-making process. What helped me was turning to my new colleagues and mentors with my questions, big and small. I quickly learned that we are never practicing medicine "on our own," per se; we are always surrounded by a community of mentors we can reach out to and learn from.

Further, using the interdisciplinary team environment to its fullest can greatly help with complex patients. I routinely consult or curbside my pharmacy, psychology, social work and specialist colleagues. Developing these relationships is a great aid to practice. If you're new to a system, ask your family medicine colleagues about which specialists they like to reach out to for consults. Take the time to introduce yourself and get to know the teams around you. Building your practice community and network is one of the most helpful resources as a practicing physician, and also the most enjoyable!

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U.S.ARMY

TRANSFORMING PRIMARY CARE: LEVERAGING TEAMS & TECHNOLOGY

Krista Skorupa, MD, CPE, is Vice President of Medical Practice at M Health Fairview. As a member of the primary care service line leadership team, Dr. Skorupa supports strategy and operations for East Region primary care clinics. She continues to practice medicine on the front lines, giving her valuable insight into how administrative decisions impact the direct patient care experience.

Skorupa shared her experience in health care transformation and physician leadership.

YOU'VE BEEN INSTRUMENTAL IN A MAJOR TRANSFORMATION IN PRIMARY CARE AT M HEALTH FAIRVIEW. WHAT DOES THE TRANSFORMATION AIM TO DO?

We're making major improvements to the delivery of primary care in our system. It's no secret that the traditional one-size-fits-all model across our country's health care system has fallen behind patient and provider needs. Patients are rightly coming to us expecting care to fit their lives, and—what's just as important—providers are seeking ways to streamline care delivery so they can get back to the joy of practicing medicine and see their patients reach better outcomes.

HOW DOES IT WORK IN PRACTICE?

We're bringing together multidisciplinary teams to create a tailored approach based on patient needs and thinking holistically about the populations we serve to truly improve patient and community wellbeing.

The transformation leverages technology to better manage patient information and segments patients into "service bundles" so a provider can quickly view a patient's level of medical complexity. That helps us, as a care team, make sure we're allocating resources appropriately to address each patient's needs. A new role called the Personal Advocate and Liaison (PAL) provides personalized support to the patient and care team when needed.

HOW DOES THIS TRANSFORMATION IMPACT THE PATIENT EXPERIENCE?

Patients will experience a care plan that is easier to navigate and delivers better support. For example, a patient might experience an unexpected job loss on top of uncontrolled medical issues, and food insecurity suddenly impacts their diabetes control. In the old model, the provider might only see that the person is an uncontrolled diabetic. Under our new model, the care team can be more proactive by seeing the fuller picture that that person might need additional resources. The model truly recognizes the impact that social determinants of health have on patient outcomes.

WHAT HAVE YOU HEARD FROM PROVIDERS ABOUT THE NEW MODEL?

Our providers tell us they're leveraging the multidisciplinary care team around them and finding the joy again of practicing medicine. In many cases, they're able to get through documentation more efficiently, they leave the office with their work complete and can see their own personal health and wellbeing improve.

HOW DID THE COVID-19 PANDEMIC IMPACT THE TRANSFORMATION?

We've been able to expand this work from two to five clinics during the pandemic. Despite the challenges faced by all health systems, the pandemic helped expedite some key components to this work. In addition to rapid expansion of virtual care as part of our response to COVID-19, we realized the power of coming together across our organization and the power in those relationships to transform care. This will be instrumental in our success as an organization moving forward.

WHAT HAVE YOU TAKEN AWAY FROM WORKING THROUGH THIS TRANSFORMATION?

Providing direct patient care throughout this transformation—and knowing, in many cases, how much of a barrier to care the traditional model can be because of its complexity—gives me passion every day for this work. It's exciting because the future is here, and we aren't going back. It gives me energy to know that going forward is the only direction.

WHAT INSIGHT WOULD YOU SHARE WITH OTHER HEALTH SYSTEMS?

You need senior leaders who are present and eager to support and encourage you through what can be a complex transition. Take the time to develop front line leaders. Their role will be critical to a successful transformation effort like this. Tap into that desire on the front line, where they're asking for a change. Be crisp on that vision, honor the past, but stay steadfast in your effort to go forward.

RURAL PRIMARY CARE WORKFORCE RECRUITMENT AND RETENTION

A conversation with **Jeffrey Scrivner, MD**

Jeffrey Scrivner, MD, is chief medical officer and a practicing family physician at Scenic Rivers Health System's Bigfork Medical Clinic and medical director of Bigfork Valley's long-term care facility. He's had a critical role in primary care workforce growth in Bigfork.

We asked Scrivner to share his perspective on what rural health systems are facing when it comes to primary care workforce issues and how his system has successfully recruited and retained physicians.

HOW HAVE YOU INFLUENCED THE GROWTH AND DEVELOPMENT OF THE MEDICAL COMMUNITY IN BIGFORK?

I have tried to cultivate a work environment that would encourage the growth and development of our medical community. Elements like being quality driven with an emphasis on quality improvement activities, valuing physician and provider input on organizational decisions, achieving parity by sharing clinical and on-call responsibilities equally and improving transparency and communication result in a more desirable place to work. This type of practice distinguishes us from a "corporate medicine" culture and makes us able to recruit practitioners looking for this alternative work environment.

HOW HAS YOUR HEALTH SYSTEM RECRUITED AND RETAINED PHYSICIANS?

In addition to the traditional forms of recruitment, we have employed experiences in medical education to recruit for our workforce. We have served as a teaching site for the University of Minnesota Medical School Rural Physician Associate Program (RPAP), a longitudinal clerkship, for approximately 12 years, which has directly and indirectly resulted in the recruitment of four highly qualified family physicians. We have also hosted first- and second-year medical students for clinical rotations, supervised clinical rotations for physician assistants and nurse practitioners and precepted for residents attending the University of Minnesota Duluth Family Medicine Residency. These types of opportunities allow learners to experience our organization firsthand and may spark their interest in returning after completion of their medical education.

Other recruitment/retention efforts include not having incentive-based contracts, resulting in more time with the patient and less stress for the physician/provider; offering a full spectrum family medicine practice experience without OB; and assisting recruits in applying for loan repayment programs.

WHAT DO YOU SEE AS THE BIGGEST CHALLENGES IN GROWING A RURAL PRIMARY CARE WORKFORCE?

There are simply not enough physicians being trained that are interested in rural practice. Take RPAP, for instance. The University of Minnesota Medical School designates cities lying just outside of the Twin Cities metro area as "rural," which undermines the intent of the program—to give students a truly rural health care experience that may lead to an interest in rural practice.

There are also many qualified pre-med students originating from rural areas who would be more likely to establish practices in rural communities if given the opportunity. This would require the admission committees of medical

schools to make this quality a priority. Expanding the class size at the University of Minnesota Medical School, Duluth campus, would contribute to achieving this goal.

Another concern is the tendency for new family physicians to enter practices that are hospital-based, ER-based or strictly clinic-based. There is not the emphasis on practicing full-spectrum family medicine that is usually required in rural areas. This tendency dilutes the pool of potentially recruitable physicians.

HOW CAN FAMILY MEDICINE HELP TACKLE RURAL PRIMARY CARE WORKFORCE ISSUES?

A disproportionate percent of the rural workforce is older and nearing retirement consideration. There is an urgent need for academic medicine to deliver clinicians interested in practicing rural medicine. It should be a priority for family medicine to advocate for a solution to this problem.

COVID-19 AND KIDS: TRENDS AND CLINICAL IMPLICATIONS

by **Aimee Sznewajs, MD,** Medical Director of the Pediatric Hospital Medicine Department at Children's Minnesota

While there is still much more to learn about COVID-19, clinicians have a growing body of literature to support their understanding of the virus among the pediatric population. Children make up the smallest percentage of COVID-19 cases, hospitalization and mortality, both worldwide and in the US.[1] This is a reassuring finding for children and for pediatric providers. We also have more information about the small subset of children who are more vulnerable to the virus and require hospitalization and ICU care.

In response to the COVID-19 pandemic, Children's Minnesota has adjusted our patient age limit for inpatient care, extending it to 25 years of age, in an effort to support our adult-system partners with their increased volume in medical units and ICUs. As cases rise again in our region, we remain prepared to accept patients for hospitalization up to 25 years with conditions that we routinely manage in our clinical practice.

While Minnesota has fared relatively well compared to neighboring states, with steady rates of COVID-19, the Midwest is a current hotspot.[2] This means clinicians may expect more pediatric COVID-19 cases as the overall positivity rates climb in the region. This article aims to review some of the current COVID-19 epidemiology, provide clinical updates on pediatric COVID-19 patients and describe what is known about COVID-19 transmission in children.

PEDIATRIC COVID-19 EPIDEMIOLOGY

Children make up less than 10% of all COVID-19 cases in the U.S. Of all U.S. children infected with SARS-CoV-2, less than 8% of cases result in hospitalization and less than 0.2% in death. Notably, children experience a milder disease from SARS-CoV-2 infection than adults.

Reviewing other research provides a more nuanced understanding of these findings. According to the Minnesota Department of Health, we see a spike of COVID-19 positive cases among early and older adolescents, in the age groups 15-19 and 20-24, making up 9% and nearly 14% of total positive cases respectively. During March 1 through July 25, 2020, 576 pediatric COVID-19 cases were reported to the COVID-19 Associated Hospitalization Surveillance Network (COVID-NET), a population-based surveillance system that collects data on laboratory-confirmed COVID-19-associated hospitalizations in 14 states. Based on the data, the cumulative COVID-19-associated hospitalization rate among children less than 18 years old was 8 per 100,000, with the highest

rate among children less than 2 years old at a rate of 25 per 100,000. Furthermore, infants less than 3 months old accounted for 18.8% percent of all children hospitalized due to COVID-19. This shows that there is particular vulnerability among the very young.[3]

In both pediatric and adult data, we also see an alarming trend suggesting a disproportionate impact of COVID-19 on communities of color. Among more than 90 percent of children in the COVID-NET study for whom race and ethnicity information were reported, 45.8% of those hospitalized as a result of COVID-19 were Hispanic and 29.7% were Black. This is in alignment with what clinicians have seen among the general population. The rates among Hispanic and Black children were nearly eight times and five times higher, respectively, compared to the rates in white children.

Exact details of pediatric COVID-19 transmission are not yet known; however, important trends are emerging. Low case numbers in the pediatric population suggest a more limited role than we initially speculated at the beginning of the pandemic. Contact tracing data in household contacts from several countries demonstrate that young children—especially those less than 10 years of age—are approximately half as likely as adults to acquire COVID-19 given equivalent exposures.[4]

CLINICAL FEATURES

It's important for providers to be aware of the variable symptom manifestations of COVID-19 in children. We know that children experience a milder disease than adults, and many of them are asymptomatic—best estimates currently are that roughly around 50% of children with COVID-19 will be asymptomatic.[5] Clinical features in symptomatic children are slightly different than adults. Children tend to have milder illness. The most common presenting features are fever and cough but upper respiratory tract symptoms such as rhinorrhea and sore throat can be seen in up to 30-40% of children.[6] Additionally, around 10% of children may have abdominal pain, nausea, vomiting and diarrhea.

Laboratory studies are also different from adults. Lymphocytopenia is relatively uncommon in children; rather, the majority have elevated lymphocyte counts. In addition, inflammatory markers such as CRP and procalcitonin are typically only mildly elevated in the acute phase. Lastly, radiographic features differ, as well, from adults. Chest x-rays are often normal, as are CT chest scans. When abnormalities are seen on CT chest, they are commonly mild, bilateral ground glass opacities but with less peripheral predominance than reported in adults.[7]

Like many viruses, there are little hallmark features in the way of clinical signs in children to differentiate COVID-19 from other childhood respiratory viral infections, or other mild childhood illnesses. Therefore, clinicians should retain a certain degree of suspicion for COVID-19, regardless of the patient's presenting symptoms or lack thereof.

A NOTE ABOUT THE DIFFERENCE BETWEEN INFLUENZA AND COVID-19

While clinically one may not be able to distinguish features of COVID-19 from influenza, a recent study comparing influenza and COVID-19 in pediatric patients provided further insight into hospitalization patterns for the two viruses. It appears that pediatric COVID-19 follows a more U-shaped curve with a more severe course and hospitalization required in the youngest (those < 1 years old) and the oldest (those > 15 years). In contrast, we are all familiar with influenza having the most severe course predominantly in the youngest children.[8] Clinicians should encourage flu vaccination this year and have a high index of suspicion for both infections. The best way to distinguish between the two viruses is to rely on testing, rather than clinical symptoms.

UNDERLYING CONDITIONS

A growing body of literature reflects a small increased risk of children with comorbidities and COVID-19 needing hospitalization or intensive care. European and U.S. data show that around 40% of hospitalized children with COVID-19 have one or more underlying conditions.[9,3] The most common comorbidities include prematurity, respiratory conditions, cardiac conditions and obesity. It also seems that children with chronic lung disease, neurological disease or malignancy had an increased relative risk of needing admission to an intensive care unit. All in all, the rate of hospitalization and rate of complications from SARS-CoV-2 infection in children with underlying conditions does not appear disproportionate to those from other respiratory viruses.

MULTISYSTEM INFLAMMATORY SYNDROME IN CHILDREN

Multisystem inflammatory syndrome (MIS-C) is a new hyperinflammatory syndrome similar to Kawasaki shock syndrome. MIS-C is a delayed, hyperimmune response to COVID-19 that occurs 2-4 weeks after SARS-CoV-2 infection. Children tend to present with abdominal pain, vomiting and diarrhea, as well as persistent high-grade fever, and then often

continued on page 16

continued from page 15

progress to shock with cardiac involvement. High inflammatory markers, myocarditis, maculopapular rashes and conjunctivitis are common.[10] Respiratory involvement is mostly absent. Investigations are underway to better understand the mechanism of the disease. Most cases recover quickly, but there have been deaths reported. Consistent with adult literature, children from Black, Asian and minority ethnic backgrounds seem to be at higher risk of severe disease from acute COVID-19 infection and are significantly overrepresented in case reports of MIS-C. As the pandemic continues, clinicians should have a high index of suspicion in children with persistent fever, especially after recent known or suspected SARS-CoV-2 infection.

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MENTAL HEALTH CONSIDERATIONS: COPING WITH COVID-19 BY DEVELOPMENTAL STAGE

by **Sarah Jerstad, PhD, LP**, pediatric psychologist at Children's Minnesota

At Children's Minnesota, we aim to be every family's essential partner in raising healthier kids and understand that there are unique new challenges as COVID-19 continues to upend daily life, adding new stressors on families. When adults and caregivers are experiencing high levels of stress, this has a significant impact on the mental health of the children in their lives. Beyond the stress of parents and caregivers, many kids have been dealing with their own set of new challenges, particularly as it relates to distance learning and a loss of social support networks. Students in distance learning may not have easy access to the essential support schools provide, including therapists, counselors, special education aids and supportive teachers. The most basic needs have been affected, including access to meals provided by schools. Food insecurity is on the rise, with one in eight Minnesotans now facing hunger, up from one in eleven before the pandemic, according to Second Harvest Heartland. The upheaval of daily life and the new challenges of the pandemic have taken a toll on the mental health of families as a whole. The current situation is fraught with triggers that lead to worry and anxiety. Outlined here are approaches for clinicians to provide to families on supporting kids through the pandemic based on a child's developmental stage, from infancy to adolescence.

From as early as infancy and toddlerhood, children can experience stress. While they may not have the ability to understand COVID-19, they can sense disruptions in routines and parental anxiety. To minimize stress in that age group, caregivers should aim to keep life as routine as possible. For toddlers, play with dolls and telling stories can help explain the restrictions of COVID-19 and give them a better sense of the world around them. Caregivers should stay in tune with a child's emotions and note any behavior changes, as these could be signs of distress. Primary attachment relationships are essential at this stage, and children will look to those parents and caregivers to provide comfort, soothing and reassurance.

Preschool aged kids are focused on their individuation from caregivers, with increased skill development and social awareness. As they navigate the outside world more, parents can use simple language and basic play interactions to support them in understanding new social norms. Parents can use playful practice to teach kids about masks and social distancing, making it fun. Because of their desire for independence, it is important to give kids choices, like which mask to wear. Regressions, such as a return to bed-wetting or thumb-sucking, and temper tantrums are often a common response to stress. Clinicians should continue to ask families about the changes in their household and talk about coping mechanisms to minimize the effect on children.

Kids in middle childhood are developmentally focused on rules, self-control and structure, and therefore are often preoccupied with fairness. Caregivers should emphasize rules and the reasons behind them, highlighting repercussions without an emphasis on blame. At this stage, it's important to help kids filter information coming from friends. Caregivers should also help guide children in finding new and creative ways to continue developing skills and strengths. Explaining the virtue in following the rules and how it helps the larger community can help children feel a positive sense of involvement.

Adolescence is a developmental stage focused on autonomy, independence and developing self-identity. Before caregivers can give advice to a teenager, it's important to first listen and understand what they already know. This gives a sense of autonomy and allows them to be a part of the discussion. Guiding teens to appropriate sources for information is also important. Because of their developmental preoccupation with forming friendships and relationships with their peers, teens can form pods or groups to continue socialization. Teens can also be encouraged to find creative outlets to channel their energy.

The current global pandemic is a significant source of stress for kids and their families. Understanding how it affects kids based on development can guide clinicians in how to best help families navigate new challenges. As part of our mission to champion the health needs of children and families, Children's Minnesota will continue to be a resource to the community by supporting our patients and other clinicians during these unprecedented times.

Additional resources: www.childrensmn.org/behavioral-support-hub/

INTERPROFESSIONAL EDUCATION: AN RPAP/ AUGSBURG AUGSBURG UNIVERSITY PA PROGRAM LEARNING COLLABORATIVE ON POSTPARTUM CARE

by **Hannah Fordahl, MS4,** University of Minnesota,
previous RPAP student in Little Falls, 2019-2020

COVID-19 caused many drastic changes throughout the world, affecting everyone in many different ways. For me (now a fourth-year medical student), COVID-19 changed the way medical education was delivered.

In March, medical students were removed from clinics; I, myself, was removed from my Rural Physician Associate Program (RPAP) site in Little Falls. Many students were left wondering what would happen with their education, and the "hard stop" of hands-on learning resulted in many curriculum adjustments.

I was extremely saddened to have my time in Little Falls shortened. Knowing my education was "unknown" for a while, I wanted to stay connected to my site—not only for my education, but also for Little Falls and my preceptor, **Heather Bell, MD, FAAFP,** and her projects. I offered to help with any projects, as we know she is VERY busy with many adventures. Shortly after, she reached out to ask if I wanted to help put together a PowerPoint lecture on the topic of postpartum complications and care of the newborn for the Augsburg physician assistant students she mentored. Joining this project gave me the opportunity to continue my education and research on a topic pertinent to my education and allowed me to think "outside the box" of typical medical student training in interprofessional collaboration.

Since all RPAP students were removed from their sites and left to independent and distance learning, I thought it would be fun to include them in the project. This not only provided another opportunity for learning, it facilitated conversation among students with different medical specialty tracks. It was an optimal opportunity that allowed both RPAP and PA students to be together and converse through one teaching platform. Augsburg was thrilled, gracious and welcoming to this learning and interprofessional interaction.

The lecture was delivered on May 28 with roughly one third of RPAP students joining the conversation with the PA students, along with the ever-so-comical **Kurt DeVine, MD** and **Heather Bell, MD, FAAFP**. It was a great learning experience, and the opportunity to hear our PA colleagues' ideas was both enlightening and educational. COVID-19 has truly taught me flexibility and adaptability to new situations, and this experience was an unexpected highlight that came from this ever-changing pandemic.

Tommie L. James III,
Augsburg University

Generally, I am not a fan of online lectures, but I enjoyed the interactive and engaging lecture style of Dr. Bell and Dr. DeVine. Not only were they thorough in covering the intricacies of postpartum care, they presented in a way that made the information more relatable to me, through the use of stories and examples. Being a PA student, sharing the lecture and discussions with the third-year medical students from U of M was validating to me. I felt that it reinforced the concept that no matter what our scope of practice is, we are all equally expected to be highly competent when providing care to our patients.

K.C. Riley, MS4, University of Minnesota - Duluth; RPAP Marshall

During RPAP, I had the opportunity to work with various health professionals, from nurses to APPs to doctors, but this opportunity was unique in the sense that we were all learning as pre-professional students. It was nice to hear/understand what these PA students learn in their curriculum, as well as how this lecture augmented and added to my own knowledge of obstetrics. I enjoyed working with a group who came from a different educational model and perspective on training than my own, and I feel that this opportunity fostered the collegiate, team nature of medicine. Lastly, it was nice to have a pre-conception through post-conception lecture in one day to highlight the complexity and constant changes that the obstetrical journey is for providers and patients.

Vanessa S. Bester, EdD, MPAS, PA-C, Associate Program Director, Assistant Professor, Augsburg Physician Assistant Program

Drs. Bell and DeVine's recent interprofessional lecture with our Augsburg physician assistant students and UMN RPAP students on postpartum complications exemplified their skill as educators and clinicians. Their use of humor, knowledge and experience as family physicians engages every learner in the room. They underscore the importance of asking the right questions to provide the best care possible and modeled interprofessional collaboration that enabled the students to see the value and role of each member of the health care team. Drs. Bell and DeVine are a phenomenal team in both patient care and medical/PA education!

Kelsey McFarling, Augsburg University

To teach medicine effectively and entertainingly so that students can learn and grow from a lecture is a difficult task. Dr. Kurt DeVine and Dr. Heather Bell have not only mastered this feat but are even able to do it through video lectures, which is an impressive accomplishment. I was thoroughly impressed by how much I learned and have still retained from the lecture they gave the Augsburg PA class on "Postpartum Complications, Care and the Newborn." Their high-spirited, playful lecture style allows students to easily remember the information by including personal experiences, quippy banter and amusing stories. It is clear that Dr. DeVine and Dr. Bell are not only extremely experienced in obstetrics and neonatal care but are also ridiculously passionate about providing a safe and nurturing environment for their patients. I am lucky enough to have the opportunity to see them work in the clinic where they make it apparent that they not only want their students to be proficient in medicine but also be compassionate and empathetic communicators. It has been an awesome and humbling experience to learn from them.

continued on page 20

LEARNING TOGETHER

continued from page 19

Nissa Brekke, MS4,
University of Minnesota;
RPAP Princeton

This OB session with Dr. Bell and Dr. DeVine was a welcomed added informational session. As a student interested in pursuing OB/Gyn in residency, I was excited to be offered any additional teaching on a subject that I am very interested in. Attending the session with the physician assistant (PA) students was also a great way to learn about the education they receive and the role they can serve in obstetrics in order to better understand how I can work interprofessionally with a PA in my future practice.

Taneasha Muonio,
Augsburg University

I really enjoyed the content and style of this lecture. I feel as though it provided a space for PAs and MDs to learn together, which mirrors our collaborative relationship in the field. I also valued the opportunity it presented to provide a counter narrative to the stigma of a PA's abilities and level of autonomy. Highly encourage more collaborative learning! Thanks for the opportunity, Drs. Bell & DeVine.

Anna Ayers Looby, MS4,
University of Minnesota;
RPAP Princeton

I so appreciated the opportunity to co-learn with the Augsburg program. Prior to that online OB course, my training provided essentially no overlap with the PA program. It was such an important interprofessional opportunity. Not only did I have the chance to see the faces of a critical peer group, I also got to build baseline knowledge alongside my future colleagues.

Kirby Clark, MD, Director of University of Minnesota Rural and Metropolitan Physician Associate Programs

Due to the COVID-19 pandemic, medical students were out of the "in-person" clinical learning environment for about three months. Medical students and medical educators worked hard to pivot to virtual learning experiences, while educators were also working to shape the rapidly changing patient care needs and delivery in their practices. Third-year medical students participating in the nine-month Rural and Metro Physician Associate Programs were eager to find virtual learning opportunities with practicing physicians. Dr. DeVine and Dr. Bell's invitation to combine a virtual learning activity for both PA students and medical students was incredibly gracious. Our interprofessional training goals include learning about the role and training experiences of fellow healthcare professionals, and this was a great way to have PA students and medical students truly interact. The learning session was engaging and interactive and, in addition to gaining a solid foundation in the care of post-partum complications and initial newborn assessment, students noted the effectiveness of sharing training experiences to develop mutual understanding and respect among health care professionals.

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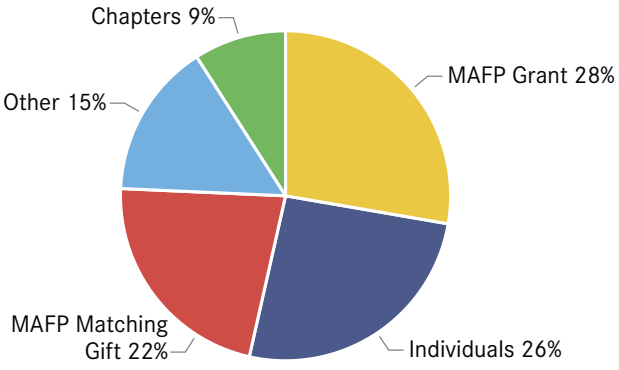

MEMBER DRIVEN

Program Highlights – July 1, 2019, to June 30, 2020

GRANTS

2 awarded through **David Mersy, MD, Student Externship Program**

11 awarded through **Family Medicine Innovation Projects**

1 awarded through **Family Medicine Research Projects**

SCHOLARSHIPS

10 awarded through **Arden Anderson, MD, Scholarship Program**

SPECIAL PROJECT

Vision Impact Alignment assessment by **Fox Consulting**

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REPURPOSING & ADAPTING: FIGHTING FOR THE COMMUNITY SERVED BY ST. JOSEPH'S HOSPITAL

by **Katie Freeman, MD,** Faculty, University of Minnesota St. Joseph's Hospital Family Medicine Residency

The October 5th announcement by M Health Fairview of the "repurposing" of Bethesda and St. Joseph's Hospitals in St. Paul, as well as the permanent closure of 16 primary care clinics, came as a shock but not a surprise to us at St. Joseph's Family Medicine Residency Program. With COVID-19 cases on the rise, and both hospitals serving as COVID-19 specialty centers, many felt that providing essential services outweighed the financial difficulties of maintaining the two old hospitals that had supported our program over the past 50 years.

Our inpatient hospital teaching service at St. Joseph's was busy, and patients in the clinic were transitioning back from low-paying virtual visits to face-to-face encounters. New refugee screening visits returned, and our MAT program was growing in patients and providers. A stellar class of new interns brought new energy and hope to the day-to-day work. We took steps forward locally to improve education, service and policies of inclusion, equity and anti-racism. Yet all were feeling the fatigue of a long and challenging year. Monday's announcement left us stunned and worried. How could we reconcile these large system changes with our longstanding commitment to our St. Paul community during an already challenging time?

Yet there is much to be grateful for as we consider the future of our residency program. Bethesda Family Medicine Clinic will remain our home at the corner of Rice and Como, and its doors will stay open to patients. We've been welcomed at Woodwinds Hospital, which has housed our labor and delivery services for the past three years. Woodwinds has a strong family medicine tradition, including many fantastic family medicine trained hospitalists. It's a beautiful and serene setting, a small and tightly knit hospital.

And, if plans are secured with Ramsey County, Bethesda Hospital will provide much-needed housing for 100 people who are experiencing homelessness and at high risk for COVID-19 complications through the upcoming winter months. Preliminary plans for St. Joseph's include much-needed mental health and addiction services, as well as housing and social services. Our residency program can have a role in shaping this work to match the needs of our patients and community.

We in family medicine have a broad skill set. We are more than just physicians. We consider public health, advocacy, leadership, policies and systems, research, innovation and, most importantly, community as being critical to the work we do. We understand that health care access, transportation and social services, culture and language support, diversity in the workforce and longstanding community-based relationships, built over years of conversation, all enhance the quality of care and health of our patients.

These losses to our program, our clinic and our community through the loss of St. Joseph's Hospital are painful. It will take time to both heal and rebuild. Looking forward, we must strongly advocate for our St. Paul neighbors, developing programs with a true vision of equity, improving the health and outcomes of our diverse patient population, especially those most impacted by COVID-19 and structural racism. We are family medicine; we will both fight and adapt. We will strive to build a more just, equitable and patient-centered system for future generations.

I've made it through the pandemic through the healing power of music. The song "Fix Me" by Coldplay emerged as my anthem for St. Joseph's. We WILL try to fix you.

AAFP VIRTUAL NATIONAL CONFERENCE: NEW LOCATION – ANYWHERE YOU ARE

July 30 - August 1, 2020

This year's AAFP National Conference of Family Medicine Residents and Medical Students moved online, picking up the tagline "New Location – Anywhere You Are." Attendees listened in on mainstage sessions, took part in discussions on trending topics and visited with residency programs and connected with future employers in the virtual exhibit hall.

Even with no bus heading down to Kansas City, we had a record attendance of 66 Minnesota medical students, who received scholarships provided by our local chapters and the AAFP Foundation Family Medicine Philanthropic Consortium.

Congratulations to the University of Minnesota Medical School Duluth Family Medicine Interest Group, which received a Program of Excellence award.

Renée Crichlow, MD, FAAFP, MAFP Immediate Past President, was part of the Mainstage "Storyteller Session: First-hand Accounts of Family Medicine's Community Impact."

Mayo Clinic Family Medicine Residency led a session on maternal health: "Beyond the Fourth Trimester: Family Physicians Caring for the Entire Family from Pre-conception through Childhood." They also taught a hands-on procedure workshop using easy-to-create models.

A poster by **Mitchell Moe, MS3,** University of Minnesota Twin Cities, "Access to Primary Care for LGBTQ Patients in Rural Minnesota," was accepted for presentation at the 2020 AAFP National Conference.

University of Minnesota Duluth Campus FMIG Leaders **Kaitlin Geisenhof, Brynna Goraczkowski, Alexa Alfred, Ashley Frankhauser,** and **Ali Ostfeld** received a 2020 Program of Excellence Award.

Renée Crichlow, MD, FAAFP, (lower right) takes part in the *Storyteller* session.

A DOCTOR IN THE HOUSE

A conversation with **Representative Kelly Morrison, MD**

Representative **Kelly Morrison, MD,** is completing her first term in the Minnesota Legislature. She is an obstetrician/gynecologist from Deephaven, Minnesota and serves as Vice Chair of the House Health and Human Services Policy Committee.

She responded to the following questions from Minnesota Academy of Family Physicians lobbyist Dave Renner.

HAVING COMPLETED YOUR FIRST TERM IN THE MINNESOTA HOUSE OF REPRESENTATIVES, HOW DID YOUR EXPERIENCE AS A PHYSICIAN HELP YOU AS A LEGISLATOR?

One of the reasons I ran for office was because of the growing suspicion around science and expertise in our culture. I wanted to be a voice for science and evidence-based policy. Unfortunately, that same suspicion has creeped into our politics and is impacting the way policy is made. Now more than ever, we need policy makers with science backgrounds who understand the complexity and nuance of our challenges.

Physicians care for people from a diversity of backgrounds and perspectives and work with them to create treatment plans. We see firsthand how the social determinants of health impact people's lives and wellbeing and how devastating lack of access can be. We are also listeners by profession, and I think we can all agree that we need more listening and less talking in politics!

AS A RESULT OF COVID-19, THE STATE IS EXPECTED TO EXPERIENCE A BUDGET SHORTFALL OF OVER $4 BILLION. WHAT DO YOU SEE AS THE MAJOR HEALTH CARE ISSUES THAT THE LEGISLATURE WILL BE ABLE TO PASS, KNOWING THERE WILL BE NO NEW MONEY AVAILABLE?

In the face of a large budget deficit, we will be forced to make difficult decisions. Having said that, the importance of a robust public health system has never been more apparent and must be protected. There is a lot of policy that can be addressed without fiscal impact, such as reform of the prior authorization process that I championed this year in the House and Senator Julie Rosen championed in the Senate. Next year, we must continue telehealth and address maternal and infant morbidity and mortality disparities in Minnesota through the Dignity in Childbirth Act that I am co-authoring with chief author Rep. Ruth Richardson.

BOTH COVID-19 AND OUR CURRENT SOCIAL UNREST HAVE AGAIN HIGHLIGHTED MINNESOTA'S LARGE HEALTH DISPARITIES. HOW DO WE TRANSITION TO A HEALTH CARE PAYMENT SYSTEM THAT ADDRESSES PREVENTION AND SOCIAL DETERMINANTS OF HEALTH?

This is an important issue and a challenge for the way we approach health care. There is a growing recognition that a fee-for-service model does not encourage prevention or improve people's health. Moving to a system that pays providers to be accessible and more collaborative with their patients is part of that solution. Family physicians are well-positioned to play an important role in that transition, as they are better trained to care for family units and communities and to emphasize prevention and health. We know that only 10-20% of a person's "health" has to do with health care, per se. The social determinants of health are the main drivers, so investing in education, housing, environmental protection and employment opportunities/job training are essential for improving our health disparities and our overall societal health.

IS THERE ANYTHING FURTHER YOU WOULD LIKE TO SAY TO FAMILY PHYSICIANS INTERESTED IN ADVOCATING FOR THEIR PATIENTS?

I implore you to get involved! It is essential that legislators hear physicians' voices to be educated about health care issues. We are at an inflection point in society right now on many issues, including addressing racial injustice and our health care disparities. We all must be in this conversation if we want to improve our community and our patients' lives. Doctors are trusted voices in these debates, and I believe it is our obligation to step up and lean into this moment.

COMING UP NEXT

COVID-19 ECHO
Tuesdays 12:15 - 1:30 pm
Virtual (live)
(recordings are available following the live presentations but are not accredited)

48th NAPCRG Annual Meeting
November 20-24
Virtual (live & on demand)
www.napcrg.org

Foundation Grant Application Deadline
December 1

MAFP Academy Awards
Nominations Open
December 1

Advocacy Summit
December 5
10:15 - 11:45 am
Virtual (live)

Innovation & Research Forum
Saturday, March 20, 8:00 am - 1:05 pm
Virtual (live)

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