WINTER 2021 • VOL. 5 • NO. 1

MFP

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Members met in December for a virtual dialogue about the 2021 legislative session and MAFP advocacy efforts.

Financial support was provided by the Twin Cities Pain Clinic and the AAFP Foundation Family Medicine Philanthropic Consortium.

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MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

A CALL TO ACTION IN UNCERTAIN TIMES

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

The SARS-CoV-2 pandemic has undermined health insurance coverage in the United States, caused deep financial losses for providers and highlighted substantial racial and ethnic disparities in the health care system.

I have heard from many of you that you want to effect change, yet it is challenging to consider the future of our health care system as you are adjusting to changes in how you provide care for your patients and balancing that with caring for your coworkers, families and selves. Professionally and personally, you are living through uncertain times.

So what's a family physician to do? How can you respond to the immediate adversity effectively and prepare to return to a post-COVID world?

RECONNECT WITH YOUR PURPOSE AND WHY YOU CHOSE A CAREER IN MEDICINE.

I invite each of you to take a moment and ponder how being a family physician relates to what gives your life meaning. Dive deeper than the classic "to help others."

CONSIDER THE FOUR POSITIVE VALUES THAT ARE COMMONLY REFLECTED IN THOSE WHO GO INTO MEDICINE: CURATIVE, EXCELLENCE, SERVICE AND COMPASSION.

Most of us can identify a combination of these values in ourselves. I challenge you to reflect on what is the one driving value that led you to make family medicine your life's work. Once identified, the real work begins.

TAKE ACTION BASED ON THAT VALUE AND CULTIVATE IT FOR THE BETTERMENT OF YOUR PATIENTS, YOUR COMMUNITY AND YOURSELF.

There are a number of avenues here at the MAFP to support you (as well as numerous opportunities outside of the Academy).

For those who identified curative and excellence, consider getting involved with the **MAFP Research & Quality Improvement Committee** and their work on the **Innovation & Research Forum**. If you identified service, the **MAFP Legislative Committee, Workforce Task Force** and **Academic Affairs Committee** are ideal places to make your voice heard. The **Health Equity Task Force** is primed to enhance your growth if you identified compassion.

Each of these groups works to support family physicians who devote their careers to advocating for their patients' needs and taking responsibility for their long-term care through long-lasting relationships.

FOCUS ON WHAT YOU CAN CONTROL—EVEN SMALL ACTIONS CAN HELP MAINTAIN HOPE AS YOU RECONNECT WITH YOUR PURPOSE.

Through our collective efforts, we will continue our commitment to caring for the people of Minnesota and evolve to meet their needs while strengthening the role of family physicians in the health care system of tomorrow.

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.

The ***Minnesota Family Physician*** (MFP) is the official publication of the MAFP.
Contact the MAFP at 952-224-3875 or Lisa Regehr, lisa@mafp.org.

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Jay-Sheree Allen Akambase, MD, CentraCare Long Prairie, was interviewed for the *NPR News* piece "Female Doctors Spend More Time With Patients, But Earn Less Money Than Men," by Mara Gordon, MD, posted October 28, 2020.

Carolyn Borow, MD, Allina Health West St. Paul Clinic, was featured in the *Star Tribune* article "After 41 Years of Practice, Mendota Heights Doctor Finds Renewed Purpose in Virtual Medicine" by Jon Bream, published on November 27, 2020.

Nicole Chaisson, MD, MPH, Assistant Professor, University of Minnesota Department of Family Medicine and Community Health, was recently appointed to the American Academy of Family Physicians Commission on Health of the Public and Science for a four-year term.

Courtney Cotsonas, first-year medical student, University of Minnesota Medical School, Duluth campus, is the recipient of the Buechner Native and African American Women Scholarship. Sisters Esther Timm Buechner, a University of Minnesota, Twin Cities graduate, and Dorothy Timm, a University of Minnesota, Duluth graduate, established this scholarship and the School of Medicine Buechner Female Scholarship to support women in medicine and research.

Roli Dwivedi, MD, Assistant Professor in the University of Minnesota Department of Family Medicine and Community Health and Chief Clinical Officer at the Community-University Health Care Center, was named chair of the University's Disparities in COVID Response Task Force. The task force is charged with looking at testing and immunization in diverse, underserved communities and identifying barriers, recommending culturally appropriate tools and practices for community engagement and education, identifying appropriate locations and collaborations and developing those collaborations to improve testing and immunization efforts.

Alex Harsha Bangura, MD, Lakewood Health System, has been selected to participate in the American Academy of Family Physicians 2021 Health Equity Fellowship. This year-long program was developed to recognize family physicians who are making promising contributions in health equity and provide them an opportunity to grow as leaders.

Diane Kennedy, MD, Sanford Luverne Medical Center, was quoted in the *Star Tribune* article "After Dodging the Worst of COVID-19, Rural Areas of Minnesota Are 'Lit Up With Cases'" by John Reinan and Christopher Snowbeck, published on October 25, 2020.

Greg McNamara, MD, CHI St. Gabriel's Health, was quoted in the *MPR News* piece "A Medical Haven for Latino Immigrants in Rural Minnesota" by Riham Feshir, published on November 23, 2020. McNamara is the volunteer physician at the Centro Hispano Clinic, which serves members of the Latino community who lack access to health care and is housed in a home owned by St. Joseph's Catholic Church in Waite Park.

Ramsey County's COVID-19 Racial Equity and Community Engagement Response Team is hosting a series of virtual community conversations with **Lynne Ogawa, MD,** Medical Director, Saint Paul – Ramsey County Public Health. She was also invited to address the Hmong 18 Council Inc. Virtual Townhall on December 17, 2020.

Kate Schreck, MD, second-year resident, University of Minnesota North Memorial Family Medicine Residency, was appointed to the American Academy of Family Physicians Commission on Membership and Member Services. The goals of this commission are to guide the Academy's membership efforts and to assist the chapters in their membership efforts.

Janet Schmitt, MD, a semi-retired physician who volunteers her time at the South Minneapolis encampments, was quoted in the WCCO news piece "Tent Encampments Brace for Early Snow, Sub-Freezing Temps: How You Can Help," posted October 24, 2020. To help get needed supplies for the encampments, visit bit.ly/395EKm9.

Keith Stelter, MD, MMM, FAAFP, Mayo Clinic Health System Mankato, was the focus of the article "Doctor Reflects on Eventful Tenure as Minnesota Association President," by Brian Arola, published in the *Mankato Free Press* on October 22, 2020.

Todd Stivland, MD, Chief Executive Officer and Founder, Bluestone Physician Services, has been named as a new board member for Stratis Health. Board members are selected for their rich experience in driving health care transformation, equity, quality and access.

Andrea Westby, MD, FAAFP, was chosen as the inaugural chair holder of the University of Minnesota's Josie Robinson Johnson Endowed Chair in Justice, Equity, Diversity and Inclusion. Westby is the University of Minnesota Department of Family Medicine and Community Health Director for Equity, Diversity and Inclusion.

CODING FOR EVALUATION & MANAGEMENT SERVICES

Evaluation and management (E/M) codes are at the core of most family physician practices. Family physicians and other qualified health professionals (QHPs), such as nurse practitioners or physician assistants, can maximize payment and reduce the stress associated with audits by understanding how to properly document and code for E/M services.

E/M services represent a category of Current Procedural Terminology (CPT) codes used for billing purposes. Most patient visits require an E/M code. There are different levels of E/M codes, which are determined by the complexity of a patient visit and documentation requirements.

The Primary Care Add-on Code G2211 will not be implemented on January 1, 2021, as expected due to Congressional action. All other anticipated payment, coding and documentation changes for 2021 are expected to go into effect as planned.

CHANGES EFFECTIVE IN 2021**

In response to advocacy from the AAFP and other medical specialty societies, the CPT Editorial Panel revised the E/M documentation and coding guidelines for office visits effective January 1, 2021. These fundamental changes are intended to reduce administrative burden and increase the amount of time physicians spend caring for patients. The Centers for Medicare & Medicaid Services (CMS) accepted the CPT changes and increased the relative values for office visit E/M codes and created a primary care add-on code as part of the Medicare physician fee schedule.

Here are highlights of key changes:

History and physical exam elements eliminated (when not appropriate): The patient history and physical exam elements are no longer components of E/M level code selection. Physicians should still document the history and physical exam as medically appropriate. These elements may still be necessary for clinical practice, professional liability (i.e., malpractice) reasons, and quality measurement.

99201 is no longer a valid code: CPT code 99201 has been deleted and is no longer available as a CPT code selection.

1995/1997 E/M documentation guidelines have been replaced by medical decision-making (MDM) or total time for office visit E/M codes: The 1995 and 1997 E/M documentation guidelines no longer apply to office visit E/M codes. Physicians may select the level of office visit using either total time or MDM. The definition of total time in CPT office visit code selection is expanded to include all physician or QHP time (both face-to-face and non-face-to-face) spent in care of the patient on the day of the encounter. The elements of MDM have been updated. See below for more details on selecting E/M codes by total time or MDM.

**Please note, these changes apply only to office visit and outpatient E/M services (CPT codes 99202-99205 and 99211-99215).

Additional resources on the E/M coding changes are available at bit.ly/3s6p8qX:

- Complete list of fundamental changes
- Family medicine practice hack video on E/M coding
- E/M coding reference cards

Reprinted with permission from the American Academy of Family Physicians (AAFP).

Sanford Worthington invests $3M into local cancer care

Cancer patients can now get the most precise radiation treatment close to home thanks to the installation of a new, $3.4 million TrueBeam linear accelerator.

"At Sanford Health, we are committed to delivering the highest quality cancer care and health care to patients in Worthington and our surrounding communities," said Jennifer Weg, executive director of Sanford Worthington Medical Center. "With a new linear accelerator right here in Worthington, we are bringing new radiation treatment options close to home."

Linear accelerator in cancer treatment

So what is a linear accelerator? Well, it is a state-of-the-art device programmed to deliver high-energy X-rays that conform to the specific size, shape and location of a tumor. It will give providers the ability to target and destroy cancerous cells in a precise area of the body, with minimal exposure to surrounding healthy tissue.

"What this means for patients is accuracy, speed and comfort," said Sanford Health's Amber Frisch, supervisor of radiation therapy in Worthington. "What it means for the radiation oncology professionals is the ability to treat many different types of complex cancer cases."

The TrueBeam radiotherapy system can treat tumors in places that can be hard to reach or that are near critical organs, such as the heart and lungs. In addition, the accuracy of treatment permits higher radiation doses while reducing the risk of exposure to healthy tissue.

By having the capacity to deliver higher dosages of radiation, patients can heal in fewer sessions. A tumor that might need 20 to 40 sessions of conventional radiation therapy can be reduced to less than five, for instance. These shorter sessions also lower the risk of side effects in patients due to less sessions and less long-term exposure to radiation.

"It integrates advanced imaging and motion management technologies that makes it possible to deliver treatments more quickly, while monitoring and compensating for tumor motion," Frisch said. "Before and at any point during a treatment, the linear accelerator can generate the 3D images used to fine-tune tumor targeting – something that wasn't possible with earlier technologies."

Better tumor targeting technology

The TrueBeam system will improve on cancer treatment in many ways including:

- **Improved precision:** The accuracy of the TrueBeam system is measured in increments of less than a millimeter.
- **Shorter radiation sessions:** Some treatments that once took 10 to 30 minutes can now be completed in half the amount of time. Faster treatment delivery is not only more comfortable for patients, but reduces the chance of tumor motion during treatment, which helps protect nearby healthy tissue and critical organs.
- **Advanced imaging:** The new imaging technology quickly produces 3D images in real time for more precise tumor targeting.
- **Motion tracking:** For lung and other tumors subject to respiratory motion, the TrueBeam system offers gating, which makes it possible to monitor the patient's breathing and compensate for movement of the tumor while radiation is being delivered.

SANFORD
CANCER CENTER

AN ADVOCACY Q&A WITH MAFP RESIDENT LEADERS

We asked resident director **Ramla Kasozi, MD, MPH,** third-year resident at University of Minnesota St. John's Hospital Family Medicine Residency, and alternate resident director **Rose Marie Leslie, MD,** third-year resident at University of Minnesota North Memorial Family Medicine Residency, to share about their work with the Academy and advocacy journeys.

TELL US ABOUT YOUR ROLE WITH THE MAFP

Kasozi: The resident director serves for one year, participating in board meetings, voting and connecting with other family medicine residents across the state. I was able to co-author the resolution "Addressing Health Disparities in Communities of Color During the COVID-19 Pandemic," which passed at the 2020 House of Delegates. My role as resident director began not only during the height of the COVID-19 pandemic but also following the murder of George Floyd. I knew entering this position that I had to play a significant role in advocating for racial justice, promote health care initiatives aimed at reducing health disparities and engage in conversations reimagining graduate medical education training.

Leslie: As alternate resident director, I hoped to gain an in-depth understanding of how family physicians can advocate for policy change within their local communities and at the state and national levels. Through this opportunity, I have been able to help write a resolution, participate in the Academy's voting process and witness meaningful change based on the resolution that was passed.

WHY IS ADVOCACY IMPORTANT TO YOU?

Kasozi: As a Black Muslim female family medicine resident navigating through residency, I have certain lived experiences which do not give me the privilege to ignore the racial health injustices happening around me and to my patients. Hence, I've intentionally been involved in activities that bring awareness to race-based medicine and social justice issues.

Leslie: My patients' health is determined by factors both inside and outside of the clinic. Advocacy gives me an opportunity to help on a broader scale, through promotion of education, social services, anti-racism work, housing and more.

WHAT ADVOCACY WORK ARE YOU INVOLVED IN?

Kasozi: In addition to my role as resident director, I'm also a member of the MAFP Health Equity Task Force, a member of the University of Minnesota Department of Family Medicine and Community Health Resident Advocacy Cohort Curriculum Committee and Advocacy and Policy Workgroup and heavily involved with the Institute for Healing and Justice in Medicine. I've also facilitated medical student education sessions on addressing microaggressions and legislative advocacy, conducted research, joined other residents in calls to action for medical community leaders to address racism and more.

Ramla Kasozi, MD, MPH, was recently featured by *Haute Hijab*, discussing the legitimate reasons for COVID-19 vaccination hesitancy in Black and Brown communities and has presented in several forums on the topic.

Rose Marie Leslie, MD, made "The Year on TikTok: Top 100" list for 2020, ranking number one in the "Voices of Change: Most Impactful Creators" category.

Leslie: Prior to getting involved with the MAFP, my advocacy work had been through health education and social media. I worked as a health educator before starting medical school. I currently create educational content on social media about a broad variety of important topics that we address as family physicians, including COVID-19 vaccinations, health equity, contraception, vaping, mental health and more.

ANY ADVOCACY TIPS?

Kasozi: I strongly encourage residents, especially who identify as white cisgendered, to sincerely engage with individuals who are not like them. Ask yourself: how can I use my privilege to dismantle the status quo that has allowed marginalized communities to have poor health outcomes?

Leslie: Advocating through social media can seem daunting. However, it is one of the simplest ways to get started. A few tips:

- Be yourself.
- Post about topics that you are passionate about and within your expertise.
- Do your research and use evidence-based medicine.
- Ask yourself: would it be okay if this post made it to the cover of the *New York Times*?
- Don't engage the trolls!

CLOSING THOUGHTS?

Kasozi: Be comfortable being uncomfortable—that is the only way to learn! A famous James Baldwin quote comes to mind: "Not everything that is faced can be changed, but nothing can be changed until it is faced."

WE CURE HEPATITIS C IN THE PRIMARY CARE CLINIC (AND SO CAN YOU!)




by **Paul Stadem, MD, Kaleigh Timmins, MD, Robert Levy, MD, FAAFP,** and **Andrea Westby, MD, FAAFP,** (pictured l-r)
University of Minnesota North Memorial Family Medicine Residency Program

INTRODUCTION

Hepatitis C Virus (HCV) infection is a major cause of chronic liver disease and cirrhosis in the United States and worldwide.[1] It is estimated that there are approximately 2.7 million people in the United States that have active HCV infection, with greater than 50% of all infected persons unaware of their HCV status.[2] Moreover, only a small percentage of those aware of their positive HCV status have been linked to treatment.

Over the past few years, there have been significant advances in the pharmacologic treatment of HCV. The historically poorly tolerated, complex and ineffective interferon and ribavirin-based treatments have been replaced with direct-acting antiviral (DAA) therapy. Compared with previous interferon and ribavirin-based therapy, DAA therapy is simple, well tolerated and, in most cases, greater than 95% effective at obtaining sustained viral remission (SVR) in patients with HCV.[3]

Following these advances and with recommendations from the American Association for the Study of Liver Diseases (AASLD) and the Infectious Disease Society of America (IDSA), Minnesota Medicaid removed prescriber restrictions on DAAs for the treatment of HCV in certain patients without cirrhosis. Now, with proper workup and assessment, HCV can successfully be treated and cured in the primary care setting.

HEPATITIS C SCREENING

The United States Preventative Services Task Force recently updated the recommendation for screening for HCV to all asymptomatic adults aged 18-79 (grade B recommendation), replacing the previous aged based screening recommendations for persons born in 1945 through 1965.[4] Screening should be completed by obtaining anti-HCV antibody followed by reflex testing for HCV RNA if anti-HCV antibody is positive.

There are several risk factors for HCV, with the most common risk factors being current or former injection drug use, history of incarceration, tattoo from an unregulated establishment, men who have sex with men and persons who received a blood transfusion prior to July 1992.[1]

HCV RNA POSITIVE DETECTION

Once HCV is detected, additional history and risk exposures should be explored. Although the AASLD/IDSA guidelines recommend treatment of persons with both acute and chronic infection of HCV, if suspected exposure was less than six months ago, it is reasonable (and required by some insurances) to repeat HCV RNA in six months to confirm chronic infection. Up to 20% of patients will clear HCV on their own in the acute phase of infection.[1]

All patients who have chronic HCV should be offered treatment, and ongoing illicit drug use is not a contraindication to HCV treatment. Additional labs as shown in Table 1 should be collected prior to initiation of treatment.

Table 1. Laboratory workup required prior to initiation of HCV treatment

Any time prior to starting therapy:	HCV genotype, Hepatitis A antibody
Within 1 year of starting therapy:	HIV, HBV surface antigen (HBsAg), HBV core antibody (anti-HBc) and HBV surface antibody (anti-HBs), HCV RNA
Within 6 months of starting therapy:	Complete blood count, basic metabolic panel, liver function panel, INR
At initiation of therapy:	Urine pregnancy test (if applicable)

FIBROSIS/CIRRHOSIS ASSESSMENT

All patients should be assessed for cirrhosis prior to starting therapy, and known or suspected cirrhosis is a relative contraindication to treating HCV in primary care. Liver fibrosis is often difficult to fully characterize, and several tools are available to help the clinician assess fibrosis severity. One of the most utilized tools in the fibrosis assessment is the Fibrosis-4 Index (Fib-4). The Fib-4 has been shown to be both sensitive and cost effective at ruling out significant fibrosis. The formula to calculate the Fib-4 is shown below:

$$Fibrosis\ 4\ index = \frac{Age\ x\ AST}{Platelets\ x\sqrt{ALT}}$$

Many calculators are available online to assist with calculation.[5] Once the Fib-4 score is obtained, use Table 2 to guide next steps.

Table 2. Interpretation of liver fibrosis based on Fibrosis-4 index

FIB-4 Score	Interpretation	Action
<1.45	Significant fibrosis excluded	If albumin > 3.5 g/dL and platelets >150 x 10^9/L, no additional imaging is needed
1.45-3.25	Indeterminate	Additional imaging with FibroScan® is indicated
>3.25	Significant fibrosis/cirrhosis likely	Referral to hepatology or infectious disease is indicated

A Fib-4 score of less than 1.45 has a negative predictive value of 90% for excluding significant fibrosis.[6] A Fib-4 score of greater than 3.25 has a positive predictive value of 65-82% and specificity of 97% for significant fibrosis, and these patients should be referred to hepatology or infectious disease for treatment.[6] A Fib-4 score between 1.45-3.25 is considered indeterminate, and patients should undergo additional imaging such as MRI or FibroScan®, a specialized ultrasound, to assess for fibrosis severity. A FibroScan® is offered at a few facilities around the state, including M Health Fairview, Hennepin County Medical Center, Essentia Health and Sanford Health. Direct access to FibroScan® can be difficult for many family physicians, and collaboration with local specialty clinics can facilitate completion. Some experts have advocated for pursuing treatment without additional liver imaging if the history and physical exam does not show evidence of current or prior decompensated cirrhosis and platelets are greater than 150 x 10^9/L, though this approach has not yet been widely adopted.[7]

continued on page 16

continued from page 15

Additionally, there are several other proprietary lab tests that are marketed to assess for liver fibrosis. These include FIBROSpect®, FibroTest-ActiTest® and FibroSure®. These tests are expensive and have not been shown to be more accurate at predicting fibrosis than the Fib-4 index and are less accurate than FibroScan®.

TREATMENT

Since 2012, there have been several DAAs that have been approved for the treatment of chronic HCV depending on HCV genotype. In the past few years, pan-genotypic HCV DAA regimens have been approved, making the treatment process even easier. Patients are eligible for treatment in primary care if they have acute or chronic HCV (any genotype), do not have evidence of cirrhosis and have not previously received HCV treatment. Patients are not eligible for simplified treatment in primary care and should be referred to specialty care if any of the following are present:

1. Prior history of HCV treatment
2. Known or suspected cirrhosis
3. HIV
4. Hepatitis B surface antigen positive
5. Currently pregnant
6. Known or suspected hepatocellular carcinoma
7. Prior liver transplantation
8. eGFR < 30 mL/min/1.73m^2

For patients who meet the criteria for simplified treatment, the recommended regimens for HCV treatment are shown in Table 3.

Table 3. Recommended regimens for the simplified treatment of HCV

Medication	Abbreviation, Trade Name	Instructions
glecaprevir (300 mg) / pibrentasvir (120 mg)	G/P, Mavyret™	Taken daily with food for a duration of 8 weeks
or		
sofosbuvir (400 mg) / velpatasvir (100 mg)	Sof/Vel, Epclusa™	Taken daily with or without food for a duration of 12 weeks

Laboratory monitoring is not required for patients on treatment who meet criteria for simplified treatment of HCV. There are several clinically significant medication interactions with DAAs, including warfarin, anti-arrhythmics, anti-epileptics and statins. Patients with diabetes should be monitored for hypoglycemia. Online and smartphone applications are available for assessment of medication interactions.[8] The most common side effects of DAAs are mild headache and fatigue, which are usually well tolerated. Utilization of an interdisciplinary team, including a clinical pharmacist, nursing and a prior authorization specialist, can increase adherence and treatment success.

Most experts will obtain HCV RNA at the end of treatment to ensure undetected HCV RNA. HCV RNA is measured 12 weeks following treatment completion, with undetected HCV RNA indicating sustained viral remission (SVR12). Patients without cirrhosis need no ongoing liver screening following cure. Patients with ongoing risk factors for HCV re-infection (such as IV drug use) may be screened yearly for reinfection with HCV RNA.

Of note, protease inhibitors (DAAs ending in "-previr") are contraindicated in patients with moderate or severe hepatic impairment (Child-Pugh Class B or C) or with any history of liver decompensation. Regimens that include protease inhibitors should be avoided in these patients as they have risk of causing acute liver failure.

PRIOR AUTHORIZATIONS

All DAAs are expensive and require a prior authorization for insurance approval. Per the Minnesota Department of Human Services, G/P (Mavyret™) is the preferred regimen for all HCV genotypes for patients without cirrhosis, though commercial insurance may dictate other preferred regimens. Providers must document a patient's substance use history and treatment plan in patients with prior or active substance use, hepatitis B screening that has been performed, cirrhosis status and HCV RNA viral load. All DAAs need to be prescribed to a specialty pharmacy and providers should work with staff members who are well-versed in prior authorization to ensure coverage is obtained.

CONCLUSION

Recent advances have dramatically simplified the pharmacologic treatment and cure of HCV, and Minnesota family physicians are well poised to identify and treat HCV in the primary care setting. By increasing access and decreasing stigma surrounding treatment, it is possible to greatly reduce the public health impact of HCV and strive for HCV eradication.

ACKNOWLEDGEMENTS

Thank you to **Ryan Kelly, MD, MS,** at the Community-University Health Care Center at the University of Minnesota for his advocacy for primary-care-based treatment of Hepatitis C in Minnesota and sharing of clinic protocols.

This work has been made possible by an innovation grant from the MAFP Foundation.

ADDITIONAL RESOURCES

Join the conversation tailored to primary care providers looking to start HCV treatment with knowledgeable hepatology and infectious disease specialists: Hennepin Healthcare Hepatitis C ECHO (hennepinhealthcare.org/project-echo).

AASLD/IDSA Hepatitis C Treatment Guidelines: hcvguidelines.org

For treatment protocols, Epic Smart Sets, other resources or questions/comments, email **Paul Stadem, MD,** at stad0107@umn.edu.

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EMILY ONELLO, MD, PROFILES PROMINENT RURAL MEDICAL EDUCATORS IN NEW BOOK

by **Emie Buege,** Freelance Writer

The new *Profiles of Rural Medical Educators* book shares the perspectives of 16 medical school faculty from across the U.S. who are thought leaders in supporting and developing our rural medical workforce. Many of the faculty profiled are nearing the end of their careers and have made it their life's work to address rural doctor shortages. They have much wisdom to share, and this book is meant to serve both as a guide for the next generation of rural medical educators and a resource for rural communities and government policy makers when it comes to addressing rural physician recruitment and retention.

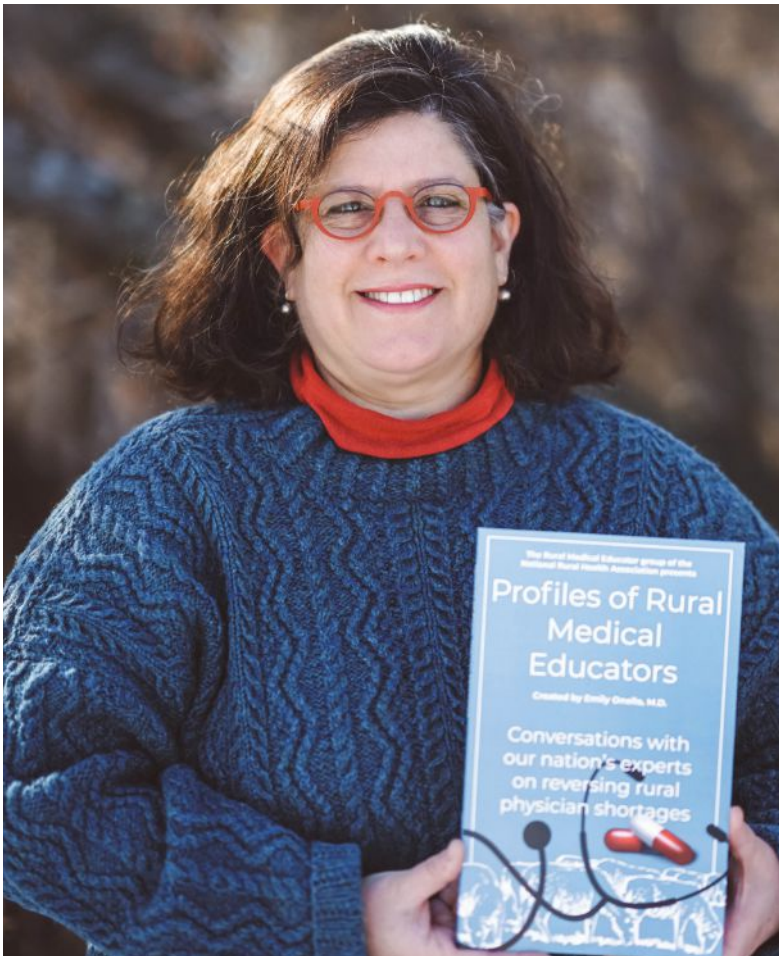
The e-book is available online (at no cost) via the National Rural Health Association Rural Medical Educator Group at www.ruralhealthweb.org/programs/rural-medical-education. *Paper copies are also available upon request* (**email econello@d.umn.edu**).

This one-of-a-kind resource is authored by MAFP member and University of Minnesota Medical School, Duluth campus, faculty **Emily Onello, MD**.

Onello directs and teaches several medical student courses, serves as a medical student faculty advisor, helps to develop and evaluate medical student curriculum and serves as adjunct faculty at the University of Minnesota Duluth Family Medicine Residency.

She is the current course director of the Duluth campus' Rural Medical Scholars Program, a longitudinal rural family medicine experience for first- and second-year medical students. The program's 80-plus family physician preceptors were recently recognized with the **Minnesota Rural Health Team Award** (by the Minnesota Rural Health Conference in November 2020).

Onello has also published a variety of peer-reviewed articles, and her research interests include rural physician workforce challenges, vaccination attitudes and environmental health.



Pictured, **Emily Onello, MD,** with her book *Profiles of Rural Medical Educators.*

We asked her to share more about Profiles of Rural Medical Educators and its message.

CAN YOU PROVIDE A HIGH-LEVEL OVERVIEW OF YOUR BOOK?

The book reveals the opinions of individual medical school educators on rural workforce shortages, sharing from their own lives—what has worked, what hasn't, where misconceptions can delay progress, what they think are long-term solutions and more.

It's my hope that readers new to this topic will realize that there are experts out there. Often, people who don't know a lot about rural training programs can view the rural doctor shortages with defeatist hand wringing and pessimism. Yet, over the past

half-century, we have learned a lot about what works and what doesn't in terms of recruiting and retaining rural doctors.

The most important message, I hope, is a positive one. We know what works—we, as a nation, need to act decisively to expand personnel and resources in addressing rural physician shortages.

WHY DID YOU WRITE THE BOOK?

The motivation for this book was my realization that many of the thought leaders on the subject of rural physician workforce development were nearing the end of their careers, and I wanted to archive and share their knowledge.

I hope that the book provides a resource—a "playbook," of sorts—for educators who are preparing physicians for rural and frontier medical practice.

But I hope that it is also used by people and organizations with a vested interest in the health of people in rural places. The book highlights the need for more resources to be dedicated to workforce shortages. Many of the educators recognize that success is only possible with strong and lasting partnerships with rural communities and rural health care organizations. I hope that the book will result in action on the local, state and federal levels to robustly support rural physician training and retention programs.

WHO DO YOU THINK SHOULD READ THIS BOOK?

The book invites a broad readership, including rural communities who are looking to address local physician shortages. Rural communities have long recognized the need to be innovative with finite resources, collaborate with others toward a common goal and look for solutions locally. This book reinforces many of these rural values to think long-term, build partnerships and invest in the future.

Also, this book can be a quick primer for medical educators at large, tertiary academic medical centers and policy makers at the state and federal levels. The vast majority of medical students across the U.S. are not trained in rural communities. Most medical schools are located in urban centers far from the practices of rural, full scope family physicians. I hope that leadership at medical schools and in government may use this book to understand that resources must be allocated differently to address the urgent need for rural physicians.

WHY IS IT IMPORTANT TO RECOGNIZE EXPERTS IN RURAL MEDICAL EDUCATION?

Without an awareness and recognition of the expertise of rural medical educators, it becomes easier for society to dismiss the rural physician shortages as inevitable and irreversible. Yet such a dismissal has dire consequences for rural communities who experience limited access to many important mental, physical and dental health services. Rural residents demonstrate poorer health in a multitude of categories.

The educators in the book represent over *500 years* of collective experience! They have studied which approaches and programs yield the best results. They have the experience and wisdom to guide us toward success. As I say in the book's preface, "…an adequate rural physician workforce is not

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Voices from Profiles of Rural Medical Educators

"Only about 5% of U.S. medical students are from rural or frontier backgrounds. Find them and admit them. Consistently, this has been the best predictor."
- **James Boulger, PhD** (Minnesota)

"Teach those who will follow."
- **Ray Christensen, MD** (Minnesota)

"Create narratives of equity for residents in rural areas by providing high quality health care."
- **Matt Hunsaker, MD** (Wisconsin)

"Start very early in the lives of rural children, K-12."
- **Michael Kennedy, MD** (Kansas)

"I always had the interests and the needs of the students as my top priority."
- **James Leeper, PhD** (Alabama)

"Remember and revisit your roots in rural communities—the beginning and end and the why of all that we do."
- **Randy Longenecker, MD** (Ohio)

"Organize from the grassroots up and from the grasstops down to develop the expectation and demand for rural medical education that can be tailored to specific rural populations."
- **John Wheat, MD** (Alabama)

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an impossible fantasy. Instead, it is a potential reality that will demand new commitments, resources, partnerships and passion to realize."

WHAT ARE THE "TAKE HOME" MESSAGES FROM THOSE PROFILED?

Though the educators differ in their responses to many of the questions, common themes emerged.

Many respondents recognized the necessity for long-term organizational commitment to training rural doctors. As **James Boulger, PhD** (Minnesota), noted, **"Dabblers need not apply".**

Partnerships with rural communities are paramount, with **Joseph Florence, MD** (Tennessee), encouraging us to **"promote presence—BE in rural; live and work in rural communities; place students to live and train in rural communities."** **Ray Christensen, MD** (Minnesota), echoes this theme, saying, **"All med students need a rural experience."**

Lisa Dodson, MD (Wisconsin), adds that programs should **"develop and reward rural faculty and provide meaningful financial and educational support for those hard-working rural docs in the trenches."**

ANYTHING ELSE YOU WANT TO SHARE?

As many of the featured educators are "passing the baton" to the next generation of educators, I look forward to a *Profiles* "2.0" where I can feature the future successes of *new* rural medical educators across the U.S.

ALIGNING PRIORITIES TO BETTER SUPPORT FAMILY MEDICINE

by **Maria Huntley, CAE, MAM,**
Chief Executive Officer

The MAFP Foundation, the Academy's nonprofit arm, has a strong history of providing grant funding to medical students, family medicine residents and practicing family physicians in support of family medicine research, innovation and community outreach. These grants have been funded through a variety of sources, including allocating a portion of dues from each active member, donations from the MAFP general fund and generous donations from members like you.

Over the past two years, the MAFP and the MAFP Foundation have engaged current and past leadership to evaluate how the two organizations could enhance their collaboration to best support family medicine in Minnesota. This was done through member interviews, organizational benchmarking, a member task force and environmental scans. The result of the work is the identification of three strategic pillars that will help guide the work of BOTH the MAFP and Foundation in the coming years.

STRATEGIC PILLARS/PRIORITY AREAS

Grow the Next Generation of Family Doctors. Ensure Minnesota has the family physicians it needs to take care of all Minnesotans no matter where they live, which will lead to improved health outcomes, reduction of statewide health disparities, increased number of family medicine residency slots, full family physician coverage in rural and underserved areas and a workforce that reflects the diverse population of Minnesota.

Eliminate Health Disparities in Minnesota. Focus our efforts on ensuring all Minnesotans, not just certain demographics or locations, have equal access to comprehensive health care.

Bring the Family Doctor Voice to Advocate for Health System Changes. Strengthen our voice in the state of Minnesota to change how health care is done. Encourage Minnesota state health systems to evolve from being focused on outputs and productions to being focused on heath and prevention—these efforts can also help decrease physician burnout and increase career satisfaction.

In the coming months, the leadership of the MAFP and MAFP Foundation will continue the work of aligning the focus and programming of the two organizations around these three identified pillars. Some of the changes will include transition of the student and resident programs and support from the Academy to the Foundation.

While these shifts are more operational in nature, they will create new opportunities to access additional funding to support future family physicians in Minnesota. Our goal is to increase the resources needed to further move the needle on these three pillars.

MAFP leaders are committed to continue to support the important work that is being done at the Academy AND the Foundation, and we are excited to see what more we can be doing to support our members and their patients across the state.

Want to learn more about how you can support this transformational work? Contact **Maria Huntley, CAE, MAM,** Chief Executive Officer, at mhuntley@mafp.org.

GUIDING VISION IMPACT STATEMENT:

Minnesota will lead the nation in health outcomes for all Minnesotans fueled by three things:

1. A robust family physician workforce
2. A focus on addressing and eliminating health disparities
3. A stronger health care system centered on prevention and wellness

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Call: 412-953-7624
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NEW TO THE LAND OF 3,100 + FAMILY DOCS

- **Ryan Ban, MD,** Woodbury
- **Mousumi Kundu, MD,** Chaska
- **Pascual Sevilla, MD,** Bemidji
- **Lisa Staber, MD,** Grand Rapids
- **Arie DeGrio, MD,** Grand Rapids, has transferred from Arizona.
- **Ryan Russell, DO,** Minneapolis, has transferred from Connecticut.
- **Andrew Jaeger, MD, St. Paul,** and **Zaynab Rasheed, MD,** St. Paul, have transferred from Illinois.
- **Mary Ann Cladis, MD,** Minneapolis, has transferred from Indiana.
- **Heather Leong Hulstein, DO, PhD,** Edina, has transferred from Iowa.
- **Ramon Nola, MD,** St. Paul, and **Brian Ruggle, MD,** Duluth, have transferred from Kansas.
- **Sarah Fischer, MD,** Dumont, has transferred from North Dakota.
- **Orlando Zarate, MD,** Faribault, has transferred from Pennsylvania.
- **Jennifer Brooks, MD,** Plymouth, has transferred from the Uniformed Services.
- **Matt Cabrera Svendsen, MD, MPH,** Austin, and **Claire Philippe, DO, MPH,** Minneapolis, have transferred from Wisconsin.

NEW RESIDENT MEMBERS

University of Minnesota Duluth Family Medicine Residency

- **Ben Dummer, MD,** New Richmond

NEW STUDENT MEMBERS

Mayo Clinic Alix School of Medicine

- **Shane Ford,** Rochester
- **Nathaniel Gipe,** Rochester
- **Derrick Lewis, MS,** Rochester
- **Alexa Thomas,** Rochester

St. George's University School of Medicine

- **Crystal Marshall,** Cedar
- **Ishan Sahu,** Bloomington

University of Minnesota Medical School

- **Katherine Beck-Esmay, MS,** Minneapolis
- **Christopher Little,** International Falls
- **Brian Thielen,** Chanhassen

University of Minnesota Medical School, Duluth Campus

- **Megan Bristow,** Duluth
- **Abbygail Coyle,** Hermantown
- **Catherine Eisenreich,** Duluth
- **Alexandra Perron,** Hermantown
- **Sarah Reichhoff,** Duluth
- **Lauren Ross, MS,** Moose Lake
- **Drew Vechell, MS,** Side Lake
- **Benjamin Wils,** Duluth
- **Rebecca Windschitl,** Sartell

IN MEMORIAM

- **Christopher Jennen, MD,** Minneapolis
- **Gary Skrien, MD,** Marshall
- **Sonja Swenson, MD,** Duluth

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THE COMPASSION AND CRUELTY OF COVID-19

by **Eduardo Miguel Medina, MD, MPH**

The Academy is 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.

As a family physician caring for COVID patients in the clinic, at the hospital and via telehealth—and as a person of color witnessing our communities' disproportionate incidence and mortality from COVID-19—I have come to accept the cruelty and compassion associated with this pandemic.

THE COMPASSION

Since March 2020, our health care system has undergone a revolution, working to ensure that we can serve our patients. Every member of our health system has an important role—from environmental services to door screeners, laboratory professionals and nursing staff who have been on the frontlines the entire time. Our respiratory therapists, pharmacists, immunologists, bench scientists and, yes, administrators have all demonstrated what one system working with a common purpose can achieve.

This work has not come without a cost. The anxiety of putting one's body in harms way, the worry from and for our families, the distance—all have taken its toll. I, like many others, have needed to quarantine until I tested negative. The palpable fear I experienced, the dreams of being on a ventilator and of leaving my family alone were real. And yet I was fortunate in light of the health care workers who have paid the ultimate cost. We paused and thought of them and their families and continued our work.

THE CRUELTY

The COVID-19 pandemic has robbed us of so much, but what is truly cruel is the role our health care system and government played in abetting its destruction. The story starts before 2020. It begins with the American phenomenon that allows our access to health care and healthy opportunities to be determined by our employment status; our zip code; an insurance industry that dictates health policy at the expense of providers and patients; and a history of unequal opportunity for Native, Black, Brown, Immigrant, Queer, Female and Disabled communities.

Who did not expect that patients who were at a higher risk for chronic conditions, who did not have access to primary care, who worked or lived in long-term care facilities, who could not miss work, who could not quarantine, who did not have a doctor who spoke their language, who were uninsured or had no means by which to become insured would be the most vulnerable to COVID-19?

The losses have been many. As family physicians, we feel these losses deeply. Our grief and the grief of the families and communities we care for washes over us.

On the precipice of a new phase that may represent an end to this pandemic, I see hope and warnings. When challenged, we have responded in kind, often valiantly. We changed the way we practice medicine, shifted resources and did not take 'no' for an answer. *Yet for all we have done, have we changed enough to honor those who did not have to die?* Will we commit *to prevent* the preventable? Will we learn that we cannot *effectively* respond to *this or any pandemic in the absence of equity and justice?*

Medina practices at Park Nicollet Clinic, Minneapolis and is an Adjunct Assistant Professor with the University of Minnesota Department of Family Medicine and Community Health. He also serves on the MAFP Foundation Board of Directors.

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IMPROVING INSTITUTIONAL HEALTH EQUITY CHECKLIST

While the downstream causes of health inequities are myriad, we can begin to advance health equity and decrease health disparities by looking at our own practices, and those of the clinics, hospitals, and systems we work in. The only way we can close an equity gap is to first know that one exists, and then marshal the resources and the institutional will to eliminate it. While Minnesota is a leader in healthcare delivery and innovation, there are still significant health disparities that exist along racial and socioeconomic lines.

Questions to ask yourself, your colleagues, and your leaders about what your hospital, clinic, and system are doing to advance health equity:

Is there an equity infrastructure?

- Is there a person or committee responsible for coordinating health equity work?
- Does that person or committee report to a person or group able to enact recommendations, alter the budget, set policies, and make priorities?
- Are those recommendations followed?
- Does the health equity committee set attainable, measurable, and time bound goals to improve health equity?

Are data broken down by Race, Ethnicity and Language (REL)?

- Is the REL data widely distributed?
- Is it used to drive quality improvement projects?
- Is it delivered directly to front-line providers?

Is there education around racial equity?

- Implicit bias training?
- Cultural humility training?
- Training on the use of interpreters?

Does the organization actively engage with the community?

- Is the Community Health Needs Assessment (CHNA) created jointly with the communities the hospital serves?
- Is it widely distributed and are the recommendations enacted?
- Are there ongoing hospital-community partnerships?

What is the interpreter services program or strategy?

What is the strategy around hiring for diversity?

This resource was developed by Minnesota Doctors for Health Equity and reprinted with permission. More resources and information on their important work can be found at their website: https://mdheq.org/

COMING UP NEXT

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

Dest[IN]ation CME
Ongoing
Virtual (on demand)

Virtual Refresher
Ongoing
Virtual (on demand)

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

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