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MFP

MINNESOTA FAMILY PHYSICIAN

MEET MAFP PRESIDENT DEB DITTBERNER, MD, MBA

4

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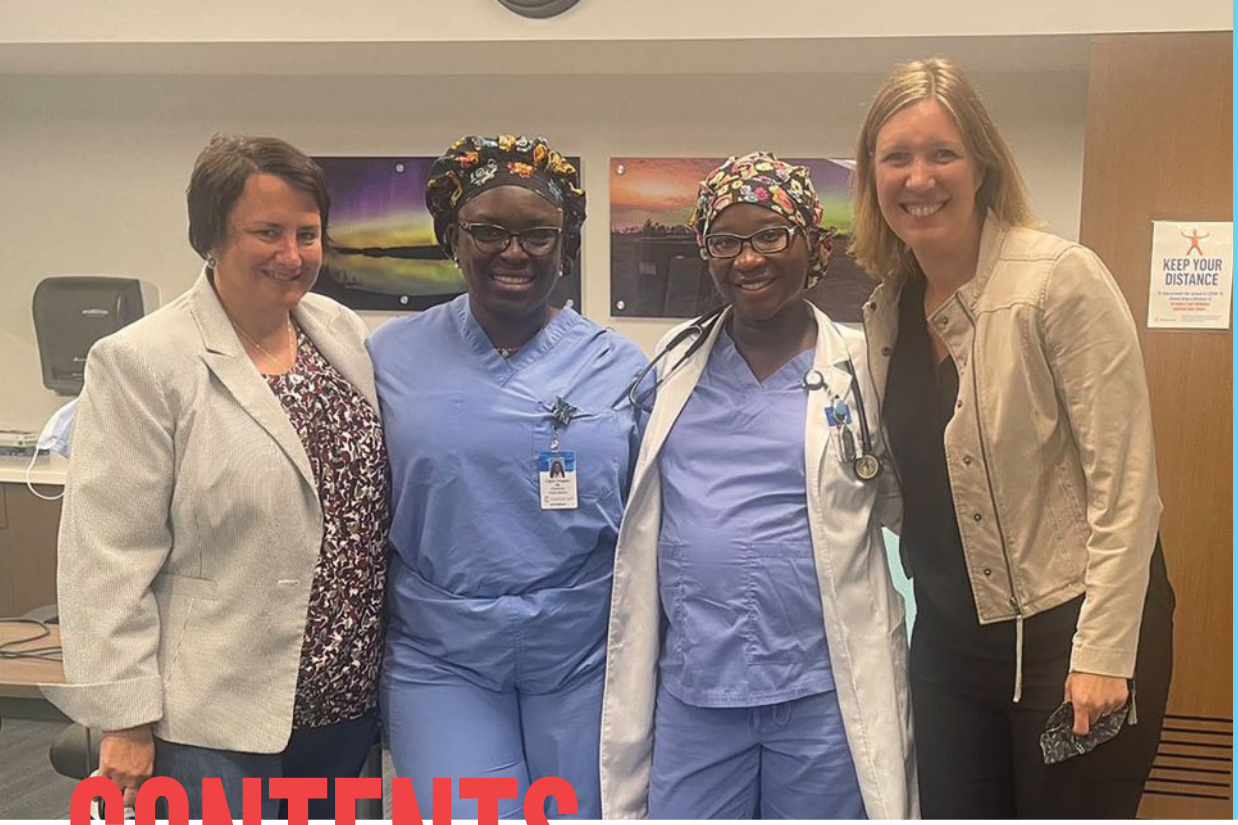

Pictured, L-R: MAFP CEO **Maria Huntley, CAE, MAM; Cybill Oragwu, MD**, and **Jay-Sheree Allen Akambase, MD,** of CentraCare - Long Prairie; and MAFP COO **Jami Burbidge, MAM**. Huntley and Burbidge road tripped across the state in July to connect with members and discuss issues of importance to family medicine.

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In "We Need a Better Solution for the Terrible Disease of Burnout," by **Michelle Wenner Chestovich, MD** (*Minnesota Family Physician:* 2021; 5(2):20-22), the URL for the "Re-Mind Yourself" podcast was incorrect. The correct address is https://redcircle.com/shows/re-mind-yourself.

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

by **Deb Dittberner, MD, MBA**
MAFP President

MEET MAFP'S NEW PRESIDENT, DEB DITTBERNER, MD, MBA

On July 1, 2020, **Deb Dittberner, MD, MBA,** became president of the Minnesota Academy of Family Physicians (MAFP) for the 2021-2022-term.

Dittberner is a rural family doctor and chief medical officer of Alomere Health, a 127-bed, general medical and surgical hospital with a Level III trauma center, located in Alexandria, Minnesota. She is also a medical student preceptor for the University of Minnesota's Rural Physician Associate Program and Rural Medical Scholars Program.

She has served in a variety of leadership roles, both in her health system and the MAFP, and appeared on Minnesota Public Radio and other news outlets sharing the perspective of rural primary care.

Dittberner has practiced family medicine for nearly 30 years and is an alumnus of the University of Minnesota Medical School and family medicine residency. She is passionate about population health and new models of health care.

We asked President Dittberner to share about the challenges facing our specialty and where the MAFP has room to grow.

WHY DID YOU GET INVOLVED IN THE MAFP?

I have been active in the MAFP since I was a medical student. My advisor/mentor at the time, **Pat Fontaine, MD, MS,** encouraged me to get involved. I quickly realized that if you are passionate about something you need to "be the change."

HOW DO YOU THINK THE MAFP IS OF VALUE TO FAMILY DOCS?

The MAFP creates a network of family physicians, residents and students across the state (and nation through the American Academy of Family Physicians). Via this network, we discover the work that needs to be done. If it's shaping Minnesota legislation on telehealth, offering opioid prescribing education or creating future virtual or in-person meetings for networking, the MAFP is here for you.

Your voice is important, and your participation in the Academy is valued and encouraged.

WHAT ARE THE CHALLENGES FACING FAMILY MEDICINE?

Health care is rapidly changing. *We all feel it.*

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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 133,500 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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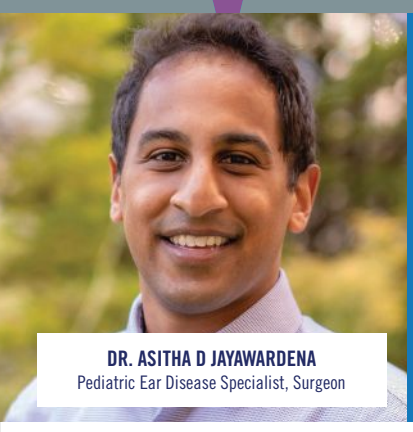

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MAFP Immediate Past President **Andrew Slattengren DO, FAAFP,** and MAFP President **Deb Dittberner, MD, MBA**

Third party payers (including government payers) are leading health care into more and more value-based contracts and away from fee-for-service reimbursement.

Primary care is now under the spotlight as these changes occur. Family physicians are experts in primary care, and family physicians must be leaders and strong advocates during this health care transformation.

Your physician membership with the MAFP is vital as we help shape the direction of future care and reimbursement of our medical practices.

WHERE DO YOU SEE THE MAFP HAS ROOM TO GROW?

We can't just be leaders within our specialty of family medicine or clinical practice; we must be in leadership roles throughout all of medicine and health care.

The future of how health care is delivered and reimbursed is being decided now.
If we believe in the model of family medicine and that strong primary care is foundational, then we must lead.

We need to be in all places where health care decisions are being made and shaping the future of medicine.

NEW FROM CDC

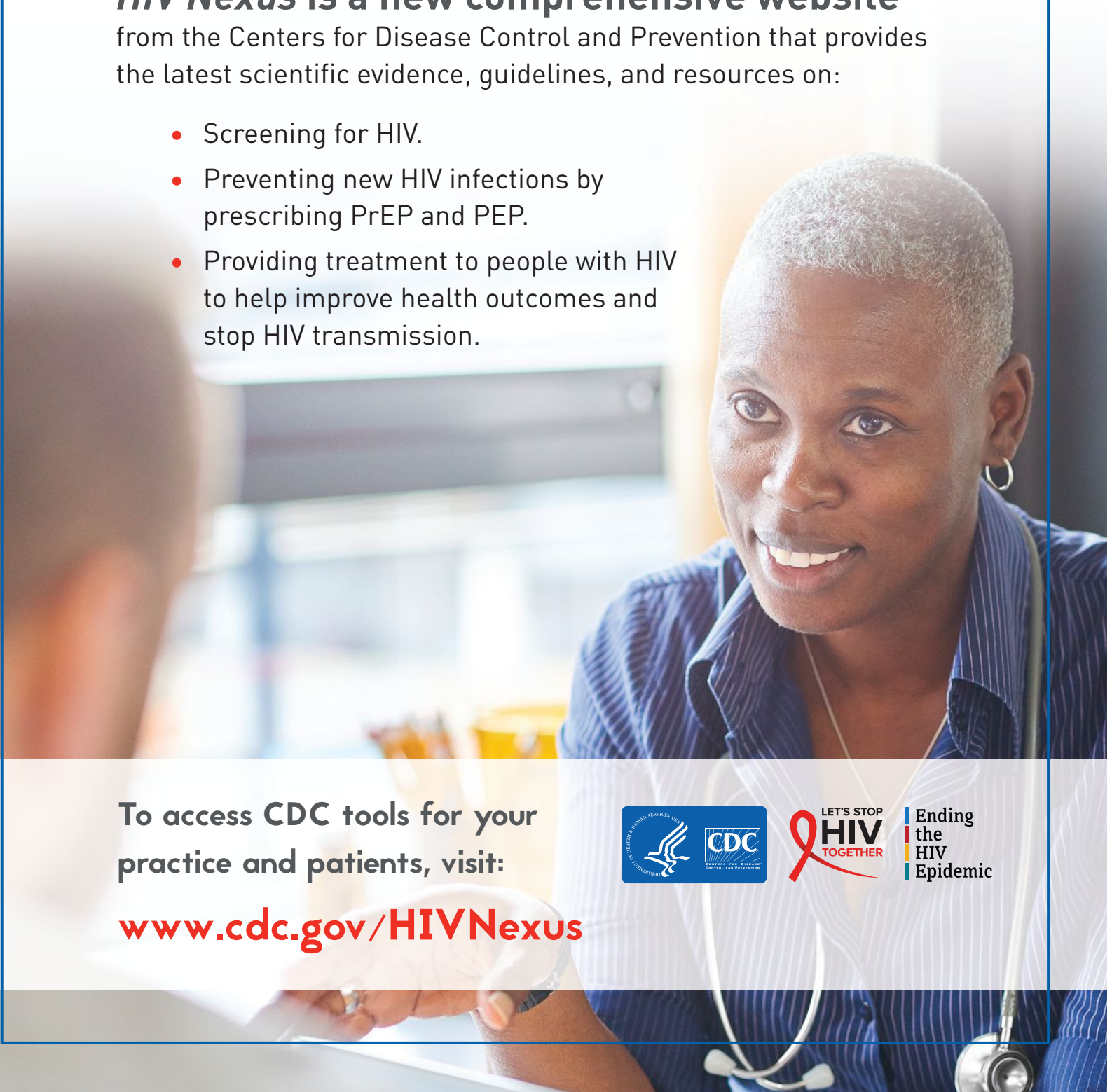
HIV NEXUS

CDC RESOURCES FOR CLINICIANS

HIV Nexus is a new comprehensive website

from the Centers for Disease Control and Prevention that provides the latest scientific evidence, guidelines, and resources on:

- Screening for HIV.
- Preventing new HIV infections by prescribing PrEP and PEP.
- Providing treatment to people with HIV to help improve health outcomes and stop HIV transmission.



To access CDC tools for your practice and patients, visit:

www.cdc.gov/HIVNexus

LET'S STOP HIV TOGETHER

Ending the HIV Epidemic

At the 2021 Virtual Minnesota Rural Health Conference on June 22 - 23, Minnesota Commissioner of Health Jan Malcolm honored Minnesota's 2020 Rural Health Lifetime Achievement Award winner **Deborah Erickson, MD, MBA, FAAFP** (left) and **Kim Kruger, MD** (right) recipient of the 2020 Minnesota Rural Health Hero Award. Both are MAFP members and alumni of the University of Minnesota Medical School, Duluth campus.

The 2020 Rural Health Team Award also went to the **rural family medicine physician preceptors of the Rural Medical Scholars Program at the University of Minnesota Medical School, Duluth campus**.

Congratulations to all! We are grateful for your contributions to rural health and rural family medicine across Minnesota.

University of Minnesota Mankato family medicine resident **Sara Robinson, MD,** and University of Minnesota Medical School student **Marvin So** were selected for the American Academy of Family Physicians Foundation Family Medicine Leads Emerging Leader Institute Scholar Program.

Both received a scholarship to attend the 2021 (virtual) AAFP National Conference of Family Medicine Residents and Medical Students and will participate in the seventh class of the Family Medicine Leads Emerging Leader Institute,which includes workshops, mentorship and a leadership project.

Congrats to Robinson and So!

MAFP Health Equity Committee Co-chair and University of Minnesota Department of Family Medicine and Community Health Vice Chair for Equity, Diversity and Inclusion **Andrea Westby, MD, FAAFP,** was highlighted by the American Academy of Family Physicians for their Family Doc Focus feature for her work to address health disparities and move toward racial and health equity.

Rose Marie Leslie, MD, recent graduate of the University of Minnesota North Memorial Family Medicine Residency, was selected as a plenary speaker for the Virtual 2021 Family Medicine Midwest conference held September 9 – 11. Don't miss her presentation "Going Viral: Social Media as a Tool for Patient Care and Advocacy," on September 9. Register to attend at www.fmmidwest.org.

Send us your news through our online form: mafp.org/mfp.

THE MAFP IS PROUD TO ANNOUNCE RECIPIENTS OF ITS 2021 ACADEMY AWARDS:

FAMILY PHYSICIAN OF THE YEAR

Heather Bell, MD, FAAFP, and **Kurt DeVine, MD**
Project ECHO and The Addiction Connection

EDUCATOR OF THE YEAR

Raymond Christensen, MD, FAAFP
University of Minnesota Medical School, Duluth campus

RESIDENT OF THE YEAR

Ramla Namisango Kasozi, MD, MPH
University of Minnesota St. John's Hospital Family Medicine Residency Program

INNOVATION & RESEARCH AWARD

Kathy MacLaughlin, MD
Mayo Clinic

MEDICAL STUDENT LEADERSHIP AWARD

Tegan Carr
University of Minnesota Medical School, Duluth campus

MAFP ACADEMY AWARDS

Read more about each awardee at mafp.org/awards, and watch for an upcoming feature in *Minnesota Family Physician* magazine!

WHAT MAKES CARE COORDINATION WORK BEST?




by (pictured l - r) **Leif I. Solberg, MD,** and **Steven P. Dehmer, PhD,** Senior Research Investigators, HealthPartners Institute; **Bonnie LaPlante, MHA RN,** Director, Minnesota Department of Health Health Care Homes Program; and **Elizabeth Cinqueonce, MBA,** Chief Operating Officer, MN Community Measurement

Like many important questions, the answer to what makes care coordination work best is that we don't really know. An analysis of 75 systematic reviews of care coordination concluded that health benefits have been demonstrated for patients with heart failure, diabetes, severe mental illness, recent stroke or depression.[1] However, it also found insufficient evidence to assess the impact of individual components of care coordination on effectiveness. Another thorough systematic review found evidence that "most changes for better coordination improve quality and save resources," but that "it depends on which approach is used, how well it is implemented and on features of the environment in which a provider is operating."[2] More recent systematic reviews and meta-analyses have not filled these knowledge gaps.[3-5] This lack of information about the models and factors contributing to successful care coordination makes it difficult for care systems, clinicians and payers to know how to structure their approach.

Fortunately, help is on the way for Minnesota's leaders and health care professionals in primary care and their complex patients with multiple morbidities that could benefit from care coordination. The Patient-Centered Outcomes Research Institute (PCORI) has funded a $4 million contract to a consortium of organizations in Minnesota to answer three important questions about care coordination.

- What care coordination model produces the best outcomes for patients: a traditional medical-nursing model or one that incorporates a social worker on the team?
- What other components of either model are important for best outcomes?
- What other aspects of the community, care system or patients help to explain differences in outcomes?

Minnesota received funding to study care coordination because of our unique environment enabling the important observational study needed to answer these questions.

ORGANIZATIONS IN MINNESOTA ENABLING THE STUDY OF CARE COORDINATION

- A Minnesota Department of Health (MDH) program for certifying primary care clinics as health care homes that includes care coordination as a standard requirement and involves 60% of the primary care clinics across Minnesota
- A nonprofit organization—MN Community Measurement (MNCM)—that collects and reports, publicly, on key quality measures for all patients in the state
- Health care payors willing to provide utilization data for the study (Blue Cross and Blue Shield of Minnesota, UCare, HealthPartners and Minnesota Department of Human Services)

- A research organization with the resources and skills to put together a successful application and implementation of a study (HealthPartners Institute)
- A majority of clinics and care systems that want to support a study that will help them to improve their care
- Patient representatives

BACKGROUND ON THE MINNESOTA CARE COORDINATION EFFECTIVENESS STUDY

Although MNCARES (the Minnesota Care Coordination Effectiveness Study) was officially funded in May 2020 for three years, its initial plans were stymied (like much else) by the COVID-19 pandemic that overwhelmed care systems and greatly disrupted previous care processes and patient access. Instead, much of that first year was spent developing and obtaining approval for a modified plan and recruiting participating clinics. The new plan, just approved in May 2021, still aims to answer the original questions, but delays the sample of care coordination patients to 2021 and adds a second cohort of patients that began to receive care coordination prior to the pandemic. These changes will also allow us to learn just how problematic the pandemic has been for complex, high-cost patients—many of whom may also be more likely to be impacted by social determinants of health. PCORI has provided additional funding for a fourth year.

Fortunately, despite the conflicting pressures from the pandemic and (recently) from huge vaccination programs, recruitment of clinics and care systems has gone very well. Out of the 397 potentially eligible adult primary care clinics and 70 care systems in Minnesota and border areas that are certified as health care homes, 83% (329 clinics from 48 care systems) have agreed to participate. Representing considerable diversity in location and organizational type and size, these forward-looking clinics will help us all to identify the best ways to serve the patients who are in most need of complicated medical care and social services.

So, what are these care coordination patients like, and what are their needs? From the limited data we have available, it appears that, typically, only 1% of patients are receiving care coordination services, but those who are mostly have multiple chronic conditions. One early benefit of the study is that it will provide us with the ability to describe the patients chosen to receive these services and their needs, both medical and social. Since no other region has so many clinics providing care coordination, these data will provide a unique understanding of their problems for planning purposes.

If care coordination works, what outcomes are affected? With the cooperating organizations, we hope to be able to assess the impact of care coordination on care quality (as measured by MN Community Measurement), utilization (as measured by health care payor claims data) and patient reported outcomes (as reported on patient surveys). Through surveys of care coordination patients, we will be assessing the patient's perspective on the care coordination experience as well as its effect on their care and social factors that influence their health. We hope to also be able to identify which types of patients appear to benefit most from care coordination services. Additionally, the survey of care coordination patients who lived through the pandemic will allow us to describe the impact of the economic, medical care and social disruptions on the lives of patients with multiple morbidities or complex medical needs. That information may be important for better meeting their needs if/when another major disruption occurs in the future.

CONNECT WITH RESEARCHERS FOR THE MINNESOTA CARE COORDINATION EFFECTIVENESS STUDY

If your clinic/care system is participating in MNCARES (or if you are personally interested), here are some ways you can stay abreast of what's happening and let us know about your ideas:

- Visit and bookmark the MNCARES web page: www.health.state.mn.us/facilities/hchomes/mncares.html
- View the recorded May 11 "Welcome to MNCARES" webinar for clinics under the MNCARES Update tab at the page above or at mncm.org/past-events-webinars
- Watch for updates in newsletters from MDH (www.health.state.mn.us/facilities/hchomes/newsletter). and MNCM (mncm.org/news).
- Send your ideas about what factors are most important for effective care coordination to **mncares@healthpartners.com**, or reach out to any of the authors.

This study provides an opportunity to enhance the collaborative approach to health care that has made Minnesota stand out nationally. We also hope to provide information that clinics and care systems can implement to improve patient care quality, reduce utilization burden and

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improve patient-centered outcomes, while also illuminating the effect of social needs on overall health and identifying whether care coordination is effective in addressing social needs and reducing disparities. We will do our best to ensure that the lessons learned are widely disseminated and implemented.

REFERENCES

1. McDonald KM, Sundaram V, Bravata DM, et al. *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination)*. Agency for Healthcare Research and Quality; 2007.
2. Ovretveit J. *Does Clinical Coordination Improve Quality and Save Money? A Summary Review of the Evidence.* London: The Health Foundation. 2011.
3. Delaney RK, Sisco-Taylor B, Fagerlin A, Weir P, Ozanne EM. A systematic review of intensive outpatient care programs for high-need, high-cost patients. *Transl Behav Med.* 2020;10(5):1187-99.
4. Desmedt M, Ulenaers D, Grosemans J, Hellings J, Bergs J. Clinical handover and handoff in healthcare: a systematic review of systematic reviews. *Int J Qual Health Care.* 2021;33(1).
5. Conway A, O'Donnell C, Yates P. The effectiveness of the nurse care coordinator role on patient-reported and health service outcomes: a systematic review. *Eval Health Prof.* 2017:163278717734610.

PRIMARY CARE ACCESS FOR LGBTQ PATIENTS IN RURAL MINNESOTA

by **Mitchell Moe**, fourth-year medical student, University of Minnesota, Duluth campus and **Sandra Stover, MD, FAAFP,** Assistant Professor, University of Minnesota Medical School, Duluth campus, Department of Family Medicine and BioBehavioral Health

Mitchell Moe

Sandra Stover, MD, FAAFP

BACKGROUND

A patient's clinical encounter begins before they even enter the clinic—every interaction, every connection, every contact point with the clinic before, during and after a visit are part of a patient's experience. Patient perception of inclusivity impacts both comfort and satisfaction, directly affecting adherence to treatment. While messages expressed via the clinic environment are an important first impression, clinic employees also have a critical role in providing a welcoming, inclusive environment for the patients their clinic serves.[1]

LGBTQ patients face a variety of health disparities, including higher rates of homelessness, HIV/STIs, obesity, substance use, mental health issues and suicide. LGBTQ patients are also less likely to get preventative health services or to carry health insurance.[2] Multiple organizations have established recommendations in recent years for how health care facilities can be more aware and inclusive of their LGBTQ patients; but, in order to work towards further improving care for these patients, it is important to understand where the gaps still lie.[3]

Approximately 4.1% of Minnesota adults self-identify as LGBTQ, with 39% of them living in smaller towns—over 90,000 individuals.[4] This number is realistically much higher when accounting for those who feel uncomfortable disclosing their identity. In fact, only 52% of LGBTQ Minnesotans report being "out" to clinicians, and 27% report the need to educate physicians about LGBTQ people to receive appropriate care.[4]

There is limited literature available regarding the status of health care relevant to the LGBTQ demographic in rural areas, and that which does exist tends to focus on the awareness and inclusivity of primary care providers. We were curious to know more about rural clinics in Minnesota and how patients might perceive their care relative to a first encounter with a clinic's environment.

OBJECTIVES AND METHODS

To explore the markers for inclusivity regarding LGBTQ patients at rural Minnesota primary care clinics, we chose to look at features of the patient intake. This included intake forms, support within the electronic health record (EHR) and the physical clinical environment. We also explored employee experience and training regarding health services and understanding for potential referrals for specific LGBTQ health issues. We collected data from those at the "front lines" of clinics—the registration staff—via an anonymous, one-time survey. Clinic managers of rural clinics throughout Minnesota were contacted with requests to have their registration staff participate in this study. Upon approval from clinic managers, we gained access to the email addresses of employees, and they were sent a customized link to the survey. Data was collected June-August 2019.

FINDINGS

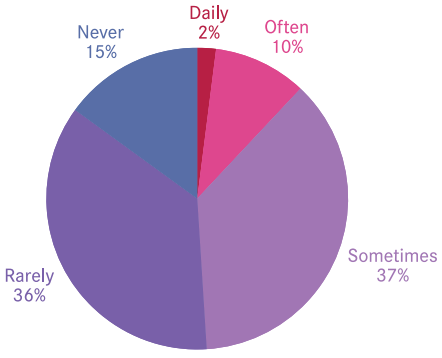
Sixty-eight employees from 30 rural Minnesota clinics completed our survey: 25% of respondents work at independent clinics; 75% work at clinics in communities with a population size of less than 5,000 people (nearly 40% were in communities of less than 2,500).

Almost half of respondents indicated they fill out the intake forms themselves for patients registering at clinics. Most said their forms specified gender identity, but less than 25% have specifications about pronouns and 15% about sexual orientation. Of those forms with gender identity specifications, the majority lack options outside male/female. Of those with pronoun specifications, a small majority include options outside he/him and she/her. Over 80% of respondents indicated patients' demographics are

updated at each visit, but usually only name and gender specifications—not pronoun or sexuality. Only half of respondents' EHRs included the option to specify a patient's sexuality or their current gender identity if it differs from the sex assigned at birth.

Most respondents indicated infrequent interactions with patients who self-identify as LGBTQ [Figure 1]. Over 90% did not receive training about LGBTQ patients during orientation for their current positions, and 94% indicated they had not seen their workplaces dedicate time to addressing LGBTQ-focused health care.

Figure 1. Frequency of Interaction with Patients Who Self-Identify as LGBTQ



While most clinics offer HIV testing/counseling and other STI testing/counseling, few offer other LGBTQ-relevant services [Figure 2]. While the majority of respondents knew of nearby resources to refer for HIV/STI testing/counseling and substance abuse treatment, few knew where to refer patients for other LGBTQ-relevant services [Figure 3].

The majority of respondents have single-stall bathrooms in their clinics, but only half with gender-neutral signage. Few indicated their clinics possess features of awareness/inclusivity outside of a visibly posted nondiscrimination statement—of which only half said includes sexual orientation [Figure 4]. Over 80% said their clinics' websites did not have any information pertaining to LGBTQ services/resources/health concerns.

Of respondents, 97% indicated they had never seen their clinics participate in or commemorate an LGBTQ holiday (e.g., Pride Month, National Coming Out Day, National LGBTQ Health Awareness Week).

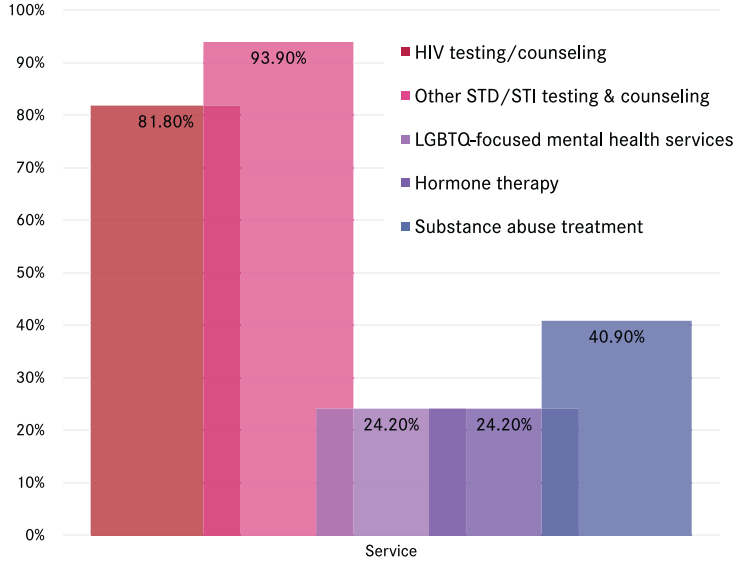
At the end of the survey, respondents were asked whether they thought an LGBTQ patient moving into the community would consider their clinic welcoming—88% said yes.

DISCUSSION AND RECOMMENDATIONS

Our study had several limitations. Because multiple staff from each clinic location were surveyed, responses were nested within clinics and not fully independent of each other. Survey questions did not have an "I don't know" option; so, if the staff did not know the answer to a question, they may have guessed. Without specific instructions or providing definitions, some respondents may not know the answers to some questions (e.g., without knowing the definition of gender identity). The "first contact" features at the clinic relied on the self-report and awareness of the staff. It is possible that the responses on the survey for an individual are highly influenced by their personal experiences, training and perceptions of the LGBTQ environment at their clinic. Additionally, some surveys were only partially completed. While these limitations restrict adequate quantitative analysis, qualitative impressions can be made.

This study highlighted several opportunities for rural primary clinics to address awareness of LGBTQ issues and ways to improve the patient experience. The initial patient intake is a process that should be improved. Clinics could expand questions and options pertaining to gender/sexual identity on intake forms and consider allowing patients to fill these forms out privately. Ideally, modification of clinic workflow could allow youth to answer questions

Figure 2. Services Offered at Respondents' Clinics



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about gender/sexuality without parents nearby. As identities and preferences can change over time, more opportunities to review this data would be helpful.

Comprehensive, consistent employee training around creating and fostering an LGBTQ inclusive, welcoming environment is essential. Employees may not know of EHR features that accommodate LGBTQ patients, such as specification of pronouns and gender/sexual identity. Our data showed that employees working under the same health care system with the same EHR had different responses to questions regarding EHR features. Some employees were unaware of the presence of LGBTQ members in their clinic population. Required diversity training during new employee orientation at clinics could address this. Clinics could also include LGBTQ patients in diversity competency/sensitivity training for all employees during annual training. It is essential for all clinic employees to understand and use patient-centered language and terminology as well as to understand health topics related to LGBTQ patients.

Rural primary care clinics may be limited as to the services they can offer LGBTQ patients, and employees may not be educated on outside resources for LGBTQ patients if unavailable within the surrounding community. Clinics could consider expanding the services they offer or better identify referral flows for the best out-of-facility resources.

Even though most clinic employees feel their clinics would be considered welcoming by LGBTQ patients, few of their workplaces possess standard features of awareness/inclusivity. Clinics could implement more of these features, including LGBTQ-related health education materials, gender-neutral bathroom signage, art, stickers and posters. Many patients, of all demographics, turn to the internet and social media when in search of quality health care. Clinics should consider adding LGBTQ-relevant health information to clinic websites and social media accounts. They should also publicly recognize LGBTQ holidays.

CONCLUSION

Best practices in health care include provision of a safe, inclusive environment for all patients. Patient perception of the positive inclusion of cultural sensitivity improves outcomes, as adherence to recommended care is more likely. Making appropriate workflows, utilizing available options in an EHR and supporting employee awareness training are a few steps that clinics can take to improve patient care, experience and outcomes. Future studies could address the limitations of this study and offer further insight into improving health care for LGBTQ patients across Minnesota.

Figure 3. Awareness of Outside Resources Within 30-Mile Radius to Which Referrals Can Be Made

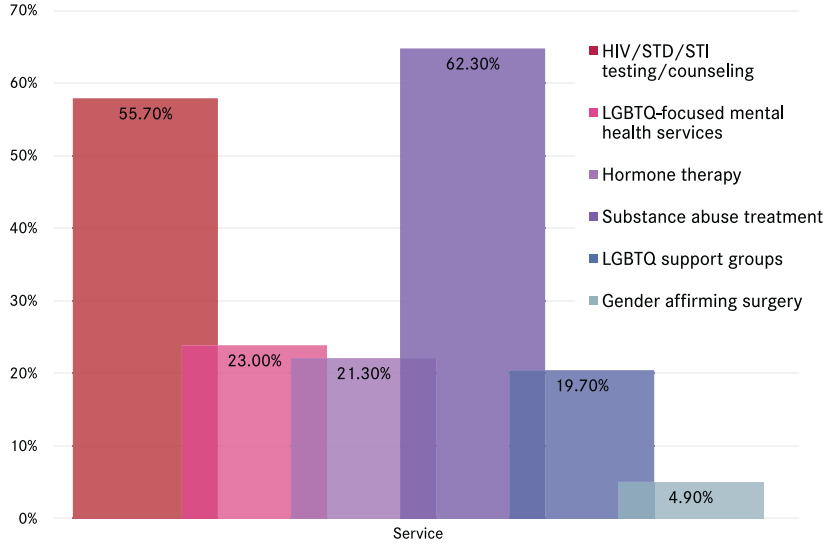
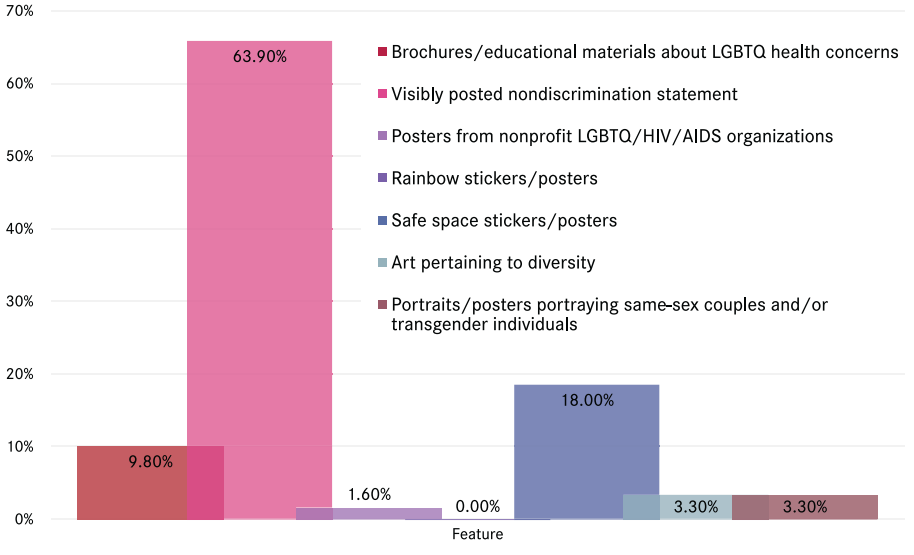


Figure 4. Features Found in Respondents' Clinics

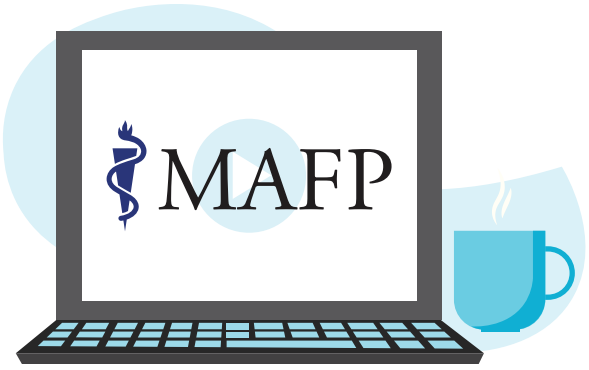


REFERENCES

1. Roncoroni J, Tucker C, Wall W. Patient perceived cultural sensitivity of clinic environment and its association with patient satisfaction with care and treatment adherence. *American Journal of Lifestyle Medicine.* 2014; 8(6).
2. Lesbian, Gay, Bisexual, and Transgender Health. Lesbian, Gay, Bisexual, and Transgender Health | Healthy People 2020. https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health#18. Accessed June 11, 2021.
3. Providing Inclusive Services and Care for LGBT People: A Guide for Health Care Staff. LGBTQIA+ Health Education Center. http://www.lgbthealtheducation.org/publication/learning-guide/. Published May 26, 2020. Accessed June 11, 2021.
4. LGBTQ. Culture Care Connection. https://culturecareconnection.org/cultural-responsiveness/lgbtq/. Published May 20, 2021. Accessed June 11, 2021.

REFLECTION

These recommendations may feel tedious, and continuously pursuing both personal and institutional growth in cultural/social competency can be daunting, especially when all other aspects of medicine are concurrently evolving. However, I can say from personal experience that improvement is necessary for the health and wellbeing of our patients everywhere, including rural Minnesota. I grew up as a closeted gay child in a small Minnesota community, and there were many occasions in which I wanted to ask someone at my clinic visits throughout middle and high school what was wrong with me. I had been told throughout those years that being queer was a mental illness and punishable by God if acted upon, which provoked anxiety and self-hatred. I longed for the opportunity to confide in a health provider about what I was experiencing so they could "fix" me, but never reached a point where I felt comfortable in doing so because my clinic did not feel welcoming. All patients need and deserve a safe space in health care, and it takes everyone at a clinic to create this. So before being quick to conclude that your clinic is welcoming enough, consider: What work has there been to show this to your patients? Is there more to be done? – *Mitchell Moe, fourth-year medical student, University of Minnesota , Duluth campus.*



VIRTUAL PROGRAM

COVID-19—A Mini-Course: Updates on Clinical Care, Long-term Complications & Health Disparities

On the morning of May 8, 2021, MAFP members from across the state gathered online for a COVID-19 CME course, covering clinical updates, long-term complications and health disparities.

The course was hosted by ECHO training facilitators **Heather Bell, MD, FAAFP,** and **Kurt DeVine, MD,** and included a panel discussion on disparities, a case presentation on post vaccination infection, a case presentation highlighting a local physician's story of survival and updates on cardiac implications in kids as well as ICU survivorship and provider burnout.

DISPARITIES IN HEALTH CARE (PANEL)

Facilitator: Roli Dwivedi, MD
- Family Physician and Chief Clinical Officer, Community-University Health Care Center
- Assistant Professor, University of Minnesota Department of Family Medicine and Community Health
- Chair, University of Minnesota Disparities in COVID Response Task Force
- Co-chair, MAFP Health Equity Committee

Panelist: Saida Abdi, PhD
- Clinical Social Worker
- Assistant Professor, University of Minnesota School of Social Work
- Member, University of Minnesota Disparities in COVID Response Task Force

Panelist: Jonathan Kirsch, MD
- Internist
- Assistant Professor, University of Minnesota Division of General Internal Medicine

Panelist: Eduardo Medina, MD
- Family Physician, Park Nicollet Clinic Minneapolis
- Adjunct Assistant Professor, University of Minnesota Department of Family Medicine and Community Health

Panelist: Mary Owen, MD
- Family Physician
- Director, University of Minnesota Center of American Indian and Minority Health
- Assistant Professor, University of Minnesota Department of Family Medicine and BioBehavioral Health

COVID-19 CASE PRESENTATIONS

Post-vaccination SARS-CoV-2 Infection and Diagnostics

Amanda Noska, MD, MPH, infectious disease specialist, Essentia Health

Surviving COVID-19: The Physician as a Patient—106 Days at HCMC

Nyan Pyae, MD, nephrology fellow, Hennepin Healthcare

CARDIAC IMPLICATIONS OF COVID-19 INFECTION IN KIDS

Christopher Carter, MD, pediatric cardiologist, Children's Heart Clinic and Children's Minnesota

POST COVID: ICU SURVIVORSHIP AND PROVIDER BURNOUT

Sakina Naqvi, MD, internist, pulmonary service line director and director of pulmonary and critical care at M Health Fairview

Thank you to our presenters, attenders and sponsors!
We enjoyed learning and growing, together.

Financial Support Provided By:

Event Sponsor

WAPITI MEDICAL STAFFING

Grantor

AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION

FAMILY MEDICINE PHILANTHROPIC CONSORTIUM

COMING UP NEXT

Dest[IN]ation CME
Ongoing – ends September 30
Virtual (on demand)
Register by September 16

Family Medicine Midwest
September 9-11
Virtual
www.fmmidwest.org

Member Picnic & Awards Celebration
September 11
11:00 am – 2:00 pm
Elm Creek Park Reserve , Maple Grove

Family Medicine Experience (FMX)
September 28 – October 2
Virtual

Foundation Grant Application Deadline
October 1
mafp.org/apply

Virtual KSA: Health Counseling & Preventive Care
October 17
4:30 pm – 8:30 pm
Virtual

New Resident Welcome Event
November 13
11:00 am – 12:30 pm
Location TBD

KSA: Diabetes
November 20
8:00 am – 12:00 pm
CentraCare – Family Health Clinic
St. Cloud, MN

Visit mafp.org to register for events listed here (unless otherwise noted).

MAFP: BY THE NUMBERS

In spite of the unpredictable, tumultuous year, our member numbers remained strong: *3,100+ Minnesota family physicians, family medicine residents and medical students continued to see value in membership in the MAFP and AAFP.*

MEMBER-LED, MEMBER-FOCUSED

We remain a member-led, member-focused organization, with members from across Minnesota leading and participating in MAFP's advocacy and offerings.

- **110+ members** served the Academy via our Board of Directors, task forces and committees.
- **87 members** participated in our policy-setting body, the House of Delegates.
- **350+ members** participated in our events and programmatic offerings.

LEGISLATIVE ADVOCACY

MAFP members, leaders and staff were also active in advocacy on a variety of legislative issues, including telehealth, maternal health and primary care investment, and met virtually with state and federal representatives and senators to elevate issues of importance to family physicians and patients.

VIRTUAL EVENTS/PROGRAMS

We pivoted from in-person events to offering timely, virtual content (both live and on-demand) covering clinical topics, practice management, public policy and advocacy. The MAFP hosted or helped facilitate 19 virtual events/programs in the last year. Members from across the state regularly engaged in our offerings. The COVID-19 ECHOs [that we helped facilitate] saw a total attendance of 1,300+ participants.

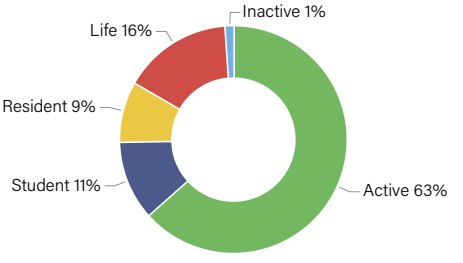
MEMBER-SUPPORTED

Member dues provide the majority of MAFP funding, but we leverage sponsorships and partnerships when it will benefit our members. We are excited to be working closely with our MAFP Foundation on new philanthropic opportunities in upcoming months.

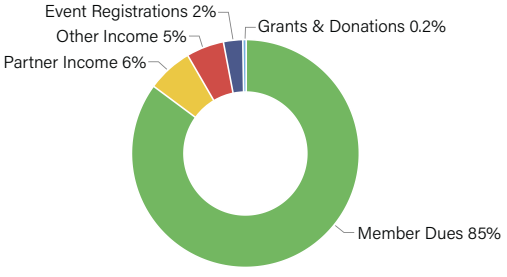
EVENT ENGAGEMENT

JUL 2020	AAFP National Conference *(Minnesota medical students)* – Jul 29
AUG 2020	Resident Advocacy Connect – Aug 10
	Addressing Minnesota's Rural, Underserved Primary Care Workforce Gap – Aug 18
SEP 2020	Race in Medicine: A Mini-Course *(on-demand CME)* – Sep 1 - Dec 31, 2020
	Intern Social & Scholarship Event – Sep 12
	Dementia: What Not to Forget – Sep 23
OCT 2020	Destination CME *(year-long, on-demand conference)* – Oct 1, 2020 - Sep 30, 2021
	KSA session: Hypertension – Oct 4
	Essential Role of Primary Care in the Diagnosis, Assessment and Co-management of SLE – Oct 20
	Telemedicine: How Workforce, Medical Education and Health Care Delivery Will Change for Family Medicine in Minnesota – Oct 29
DEC 2020	Advocacy Summit – Dec 5
JAN 2021	Media Training – Jan 26
FEB 2021	KSA session: Palliative Care – Feb 2, 9 & 16
MAR 2021	Innovation & Research Forum – Mar 20
APR 2021	COVID-19 ECHO sessions *(year-long, co-hosted series)* – Apr 2, 2020 - Apr 6, 2021
	Implicit Bias Training – Apr 13, 20 & 27
MAY 2021	COVID-19—A Mini-Course – May 8
	Virtual Refresher *(year-long, on-demand conference)* – Jun 1, 2020 - May 31, 2021
JUN 2021	House of Delegates – Jun 12

MEMBERSHIP TODAY



INCOME SOURCES



MAFP FOUNDATION GRANTS AWARDED IN SPRING/SUMMER 2021

The Minnesota Academy of Family Physicians Foundation selected four grant recipients for its spring 2021 grant cycle—two are summer externships and two are innovation grants.

DAVID MERSY, MD, SUMMER EXTERNSHIPS

Medical students with a passion for under-resourced communities (urban or rural) explore the specialty of family medicine through a summer externship. David Mersy, MD, Summer Externships are awarded annually.

Progesterone, Impulsivity and Perceived Stress in Marijuana and Tobacco Users

Dina Belhasan, a second-year medical student at the University of Minnesota, received a $2,000 grant to assess the relationship between the administration of exogenous progesterone in tobacco and marijuana co-users and measures of impulsivity and perceived stress. She is conducting her research under a parent study that examines the relationship between progesterone administration and cessation rates in marijuana and tobacco co-users.

Her mentor is **Sharon Allen, MD, PhD,** a professor in the University of Minnesota Department of Family Medicine and Community Heath and researcher at the University's Tobacco Research Program. Allen's past work has demonstrated associations between progesterone and tobacco use, showing decreased smoking-related symptoms, including impulsivity. This project seeks to build on that research by looking at the effects of progesterone administration on co-users of tobacco and marijuana.

Impact of ACEs on Impulsivity in Tobacco and Marijuana Users

Sally Jeon, a second-year medical student at the University of Minnesota, received a $2,000 grant to explore the impact of Adverse Childhood Experiences (ACEs) and impulsivity scores within tobacco-only users and tobacco and marijuana co-users. She will be looking at data from two larger double blind clinical trial parent studies. She is also mentored by **Sharon Allen, MD, PhD**.

INNOVATION GRANTS

Innovation and Research Grants are open to any MAFP member. Projects should focus on improving patient care and outcomes and be important to family physicians. Grants are awarded two times per year.

Effectiveness of Healthy Minds Healthy Bodies Education Program

Laura Maciejko and **Liset Falcon Rodriguez,** third-year medical students at Mayo Clinic Alix School of Medicine, received a $1,000 grant to assess the efficacy of an existing adult health education program at The Center Clinic in Dodge Center, Minnesota—*Mente Sana Cuerpo Sano / Healthy Minds Healthy Bodies*. They will specifically look at patient identified health behavior change from pre- and post-program surveys and knowledge checks from each session. Their mentor is **Christopher Boswell, MD,** of Mayo Clinic in Kasson, Minnesota.

Outreach-based Telehealth for Native American Patients Experiencing Homelessness

Marvin So, MPH, a fourth-year medical student at the University of Minnesota, received $1,000 to pilot an outreach-based telehealth project aimed at improving access to health care for Native Americans who are experiencing homelessness. He is partnering with the Native American Community Clinic (NACC) in Minneapolis. NACC's outreach team will visit parks or encampments and arrange real-time telehealth visits for patients that indicate a health need. His project mentors are **Kari Rabie, MD,** Chief Medical Officer, and **Shannon Fahey**, Chief Information Officer, of NACC.

Learn more about the MAFP Foundation Innovation and Research Grants and David Mersy, MD, Summer Externship and how you can apply on our website at mafp.org/apply.

Human Trafficking Warning Signs

Warning Signs

- Signs of physical abuse (burn marks, bruises, cuts)
- Pelvic or abdominal pain; appears malnourished
- Tattoos or branding
- Possession of large amounts of cash, multiple cell phones and/or hotel keys ; offers to pay in cash
- Caught lying about age/possession of false ID; lacks official identification documents
- Avoids social interaction and authority figures/law enforcement
- Seems to adhere to scripted or rehearsed responses in social interaction; someone always speaks for them
- Unable or unwilling to give an address or information pertaining to parents/guardian
- Maintains sexually explicit profiles on social networking sites; over-familiar with sexual terms and practices
- Suicide attempt
- Bizarre relational dynamics/unsettling behavior
- Disorientated about date, time, and place
- Appears fearful, anxious, depressed, submissive, hyper-vigilant, paranoid, or excessively hostile
- Seemingly excessive number of sexual "partners"
- Multiple or frequent pregnancies and/or abortions
- Fearful attachment to a cell phone (often used for monitoring or tracking)

How Hospitals Can Help

What is Human Trafficking?

- Modern day slavery
- Exploiting a person through force, fraud or coercion
- Sex trafficking, forced labor or domestic servitude
- Human trafficking is happening everywhere around the globe to people of any age, gender, race, socioeconomic status or nationality
- Any person under the age of 18 involved in a commerical sex act

Identifiers of a Trafficker

- Significantly older than their female companions
- Encourages illegal activities and/or inappropriate sexual behavior
- Vague about his/her profession
- Demanding or pushy about sex
- Someone that exerts an unusual amount of control over the patient

How to Help a Victim of Trafficking

- Separate any companions from the patient and provide a quiet, safe place for the patient
- Attend to any physical needs of the patient; don't rush the patient
- Adopt open, non-threatening body positioning (sit at eye level, avoid touching patient unless given permission, be aware of body language, avoid crossing arms)
- Engage the patient with active listening skills, respectful and empathetic language; avoid judgment
- Educate hospital staff on the red flags and the protocol of actions to be taken
- Document suspected and confirmed trafficking using the new ICD-10 codes
- Invest community benefit dollars towards anti-trafficking initiatives
- Become acquainted with community groups/resources that help victims

NEW TO THE LAND OF 3,100 FAMILY DOCS

- **Elena Canfield, MD,** Worthington
- **Caitlin Canton, DO,** Minneapolis
- **Aparna Jain, MD,** Burnsville
- **Lori Melby, MD,** Shakopee
- **David Ross, MD, MBA,** Litchfield
- **Brian Schroeder, MD,** Woodbury
- **Scott Tongen, MD,** St. Paul
- **Meghan Kinsel, DO,** St. Paul, has transferred from Indiana.
- **Ese Aghenta, MD,** Plymouth, has transferred from Oregon.
- **Anthony Le, DO,** Osseo, and **Ryan Morgan, DO,** Duluth, have transferred from Pennsylvania.
- **Kiran Sidhu, MD,** St. Paul, has transferred from Texas.
- **Lisa Hayes, MD,** Owatonna, has transferred fromWisconsin.

NEW RESIDENT MEMBERS

Hennepin Healthcare

- **Kouadio-Assi Anon, MD,** Minneapolis
- **Safiyya Carrim, MD,** Minneapolis
- **Goodness Chinweuba, MD,** Minneapolis
- **Robert Mosley, DO,** Minneapolis
- **Chika Okpobiri, MD,** Minneapolis
- **Temitayo Olabisi, MBBS,** Minneapolis
- **Amauchechukwu Ononenyi, MD,** Minneapolis
- **Christopher Sebas, MD,** Minneapolis
- **Likhita Shaik, MBBS,** Minneapolis
- **Nasser Suleiman, MBBS,** Minneapolis
- **Nathanael Yoon, MD,** Minneapolis

Mayo Clinic

- **Badro Ali, MD,** Rochester
- **Christina Barsoum, DO,** Rochester
- **Taylor Cammack, DO,** Rochester
- **Autumn Hargraves, DO,** Rochester
- **Trevor Henderson,** Rochester
- **Halden Nielsen, DO,** Rochester
- **Brittanee Samuelson, MD,** Rochester
- **Hannah Scott,** Rochester
- **Sara Shu, DO,** Rochester

University of Minnesota CentraCare St. Cloud Hospital

- **Palistha Amatya, MD,** St. Cloud
- **Megan Krotzer, MD,** St. Cloud
- **Olson Leif, MD,** St. Cloud
- **Alex Shaykevich, DO,** St. Cloud
- **Adam Sommers, DO,** St. Cloud

University of Minnesota Duluth

- **Bailey Wolding, DO,** Duluth

University of Minnesota Mankato

- **Abdifatah Ahmed, MD,** Mankato
- **Kaila Anderson, DO,** Mayer
- **Tristan Pennella, DO,** Minneapolis
- **Austen Roselius, MD,** Mankato
- **Anna Viere, DO,** Sauk Rapids

University of Minnesota Medical Center

- **Deepti Shanbhag, MD,** Minneapolis

University of Minnesota St. John's Hospital

- **Angeline David, MD,** Wauwatosa, WI

NEW STUDENT MEMBERS

Mayo Clinic Alix School of Medicine

- **Emily Buress, MPH,** Minneapolis
- **Liset Falcon Rodriguez,** Rochester
- **Anna Beatrice Grimaldo,** Rochester
- **John Hargiss,** Rochester
- **Jennifer Neufeld,** Rochester
- **Emily Stickney,** Rochester
- **Jeffrey Woods,** Rochester

University of Minnesota Medical School, Duluth Campus

- **Madeleine Hinojos,** Wadena
- **Clare Kelly,** Duluth
- **Holly Olson,** Duluth

University of Minnesota Medical School, Twin Cities Campus

- **Miller Balley,** St. Paul
- **Dina Belhasan,** Minneapolis
- **Courtney Bostrom,** Minneapolis
- **Joseph Buytendorp,** Minneapolis
- **Ian Durbin,** Andover
- **Matthew Foman,** Minneapolis
- **Denijal Gluhic, BSN,** Blaine
- **Megan He,** Minneapolis
- **Sally Jeon,** Minneapolis
- **Thomas Marcroft,** St. Paul
- **Austen Ott,** Bloomington, IN
- **Jamee Schoephoerster,** Mound
- **Sruthi Shankar,** Minneapolis
- **Amy Song,** Edina
- **Justice Spriggs,** Minneapolis
- **Molly Vail,** Elk River
- **Sruthi Valluri, PhD,** St. Paul
- **Jillian Wothe,** Hopkins
- **Anastasia Young, NP,** Minneapolis

Medical University of the Americas (Nevis)

- **Linda Her,** Minneapolis

Ross University School of Medicine

- **Ryan Franz,** Rochester

St. George's University School of Medicine

- **Blaze Beecher,** Minneapolis

IN MEMORIAM

- **Radhika Lal Snyder, MD,** Minneapolis
- **Ellen Stubbs, MD,** Lutsen

GOT KIDS? AN IMPORTANT QUESTION FOR PHYSICIANS TO ASK PATIENTS LIVING WITH OPIOID USE DISORDER




by **Michelle Sherman, PhD, LP, ABPP** (top left), professor and psychologist, UMN FMCH, North Memorial FMRP; **Adam Sattler, PhD, LP** (top right), postdoctoral fellow in primary care psychology, UMN North Memorial FMRP; **Stephanie Hooker, PhD, LP, MPH** (bottom left), research associate, HealthPartners Institute; and **Tanner Nissly, DO** (bottom right), assistant professor and physician, UMN FMCH, North Memorial FMRP

Primary care is an appropriate place to support many patients living with substance use disorder. Prior to the pandemic, opioid use disorder (OUD) was deemed a public health emergency; sadly, the opioid epidemic has only worsened during the time of COVID-19. Office-based medication for opioid use disorder (MOUD) can effectively help patients living with OUD in managing cravings, improving quality of life and increasing engagement with some life roles (e.g., employment). One important role—namely parenthood—has received very little research, and guidelines for how to support affected families are lacking. Research has found that comorbid conditions, such as depression and anxiety, may go unchanged with management of the substance use disorder alone, so families affected by OUD may benefit from support across the entire course of treatment and recovery.

A strength of primary care is a holistic, longitudinal, family-based approach in which all aspects of patients are considered in assessment and treatment. However, when treating OUD, physicians very rarely ask about the parenting role and how offspring are functioning. Patients may be reluctant to share parenting challenges due to stigma and the valid fear of losing custody. As a result, a "don't ask, don't tell" situation often arises, with no supports being provided to parents or children.

Our family medicine clinic asked MOUD patients to complete self-report measures of psychiatric and psychosocial functioning at their first MOUD visit. Our sample included 144 participants—61 of whom had a child (under 18) in the home at least half the time. Mean participant age was 34+10 years; 55% were male; and, 71% were white and 10% Black. Parents reported considerable disruption in their families, with over 25% reporting that a child lived with friends/relatives over three months, and 11% noting a child had been removed from the home by child protective services. Parents endorsed considerable shame about their role as a parent, and shame was related to higher levels of depression, anxiety, anger, stress and loneliness. However, when examining the entire sample, parents endorsed less anxiety and loneliness, as well as greater social connection, life satisfaction and life meaning than nonparents. Although it's possible social desirability may have contributed to this difference (i.e., parents' fear of disclosing distress), it may be that parenthood could serve as a protective factor. Research in parental mental illness has documented that parents often derive a sense of meaning in parenthood, and their children can be a motivator to start and remain in treatment.

Thus, the first (but often neglected) step is to add a question to all MOUD intakes to assess parenthood. Simply asking the question, both at intake and then repeatedly over the course of treatment, shows the patient that you recognize the potential impacts of OUD on parenting and want to help the entire family. Inviting parents to share their feelings about parenthood, potentially including pride and joy as well as shame and sadness, can open the door for rich conversations. Further, clinicians may leverage parents' strengths and commitment to their children when bolstering motivation for the hard work of recovery. Further, MOUD treatment programs may partner with both in-house and community-based mental health providers and parenting programs to provide wraparound care for the entire family. As offspring of parents living with mental illness and substance use disorders are at elevated risk for developing psychological problems themselves, investing in a prevention model to support the entire family holds promise.

Future research is sorely needed in this area to better understand parents' experiences, needs and preferences for treatment. Assessing the perspectives and functioning of co-parents and children, observing parent-child interactions and conducting qualitative research would also be invaluable next steps. At a minimum, however, asking the simple question, "Got kids?" and then genuinely listening and offering supports can have positive ripple effects on the entire family.

TWELVE RESOLUTIONS HEARD AT THIS YEAR'S HOUSE OF DELEGATES

Twelve resolutions—*written motions that guide the work of the Minnesota Academy of Family Physicians (MAFP)*—were submitted by Academy members and heard at the House of Delegates on June 12, 2021. Sixty-seven members attended via Zoom to deliberate and vote on resolutions.

All but one resolution was adopted. Many of the resolutions were amended—meaning members edited the resolutions for clarity or to better reflect the consensus of the House.

An overview of each resolution follows; more detailed information is available at mafp.org/resolutions.

*Under the guidance of Speaker of the House **Alex Vosooney, MD,** Vice Speaker **Bob Jeske, MD,** and Reference Committee chair **Dave Bucher, MD, FAAFP,** your 2021 House of Delegates took the following actions:*

ADOPTED RESOLUTIONS

Equity in Education Funding

The MAFP will support equitable education through legislative action that assures the right to a properly funded education system for all Minnesota children.

Self-Directed Medical Care

The MAFP will support state and/or federal rebates (such as tax credits) for direct primary care and health savings accounts to help people establish self-directed medical care.

This resolution will go on to be heard at the AAFP Congress of Delegates in October 2021.

Separating Employment from Health Insurance

The MAFP will support and advocate for acceptable, affordable health care without binding employment to health insurance.

Weight-Neutral Health Care

The MAFP will provide two CME credits on weight-neutral health care from content experts and work to incorporate weight-neutral language in our educational materials and offerings.

Addressing Native Health Disparities

The MAFP will consult Minnesota Indigenous leaders, the Minnesota Coalition of Tribes, Native physicians and other reputable sources to craft a Native land acknowledgement statement to be included on the About page of the MAFP website, incorporating language that represents the experiences of Native people in Minnesota and serving to educate and inspire MAFP members to fight Native health disparities and collaborate on health reparations.

The MAFP will also encourage and financially support research co-created by Tribal communities and family physicians to support the health and wellness of Native patients and communities, and the MAFP Legislative Committee will evaluate and support state and local policies that enhance resources, decrease barriers and support the health of Native communities, including policy that enforces treaties.

Prevention of Workplace Violence Against Physicians

The MAFP will petition the AAFP to provide education and guidance about how to decrease its members' risk of

becoming victims of workplace violence and how to report workplace threats of violence; support enforcement of penalties for violent threats or actions against physicians and all health care workers; and continue to support legislation, including an Extreme Risk Protection Order and criminal background checks on all gun sales, that would help to keep guns out of the hands of people deemed a danger to self or others.

This resolution will go on to be heard at the AAFP Congress of Delegates in October 2021.

Gender-Affirming Care for Children and Adolescents

The MAFP will oppose any efforts in Minnesota to criminalize physicians for providing access to gender-affirming medical care for children, adolescents and adults and will speak out publicly to support access to best-practice, age-appropriate, gender-affirming care.

High Quality Interpreters in Clinical Settings

The MAFP will support the need for high quality health care interpretation services, including:

- Supporting research comparing patient satisfaction and outcomes based on different forms of interpretation services (in-person, video and telephone).
- Creating and disseminating an information campaign informing patients of their rights to access interpreters and of opportunities to become certified interpreters.
- Advocating for legislation and health care system efforts to increase access to interpreter training, including mitigating costs and increasing awareness of training programs.
- Advocating that health care interpreters, as essential members of the patient care team, should have full access to PPE and vaccinations.
- Supporting research regarding strategies to improve interpreter services for telehealth visits.

Universal Single-Payer Health Care

The MAFP will provide information about universal single-payer health care on the MAFP website, and the MAFP Legislative Committee will support universal single-payer policies within the Minnesota Legislature and provide updates to members on these policies. The MAFP will also ask the AAFP to promote universal single-payer health care, especially during the Family Medicine Advocacy Summit.

This resolution will go on to be heard at the AAFP Congress of Delegates in October 2021.

Paid Family Leave

The MAFP will advocate for and support state and national legislation in favor of gender inclusive paid family leave.
This resolution will go on to be heard at the AAFP Congress of Delegates in October 2021.

Religious Accommodations for Health Care Providers in the Workplace

The MAFP will publicly support sincere efforts made by employers and health care institutions to accommodate all individuals, including medical learners, requesting religious accommodations in the workplace as granted under the United States and Minnesota Constitutions and as required by Federal Civil Rights law in accordance with the United States Equal Employment Opportunity Commission. The MAFP will also send letters to all Minnesota medical school admission offices and Minnesota family medicine residency programs requesting that they review their institutional policies and hiring/application processes to make sure they are in compliance with the United States Equal Employment Opportunity Commission laws regarding requests for religious accommodations in the workplace to help prevent the systemic discrimination of individuals based on their religious beliefs.

REFERRED TO THE BOARD OF DIRECTORS

The following resolution was not adopted but referred to the Board of Directors for further consideration.

Addressing Patient-related Violence Against Physicians

This resolution asked the MAFP to provide education to members on workplace violence; encourage legislation that would impose legal penalties and classify threats and acts of violence against physicians and other health care workers by patients as a special class of violent offense; collaborate with other medical associations on ways to address violence against physicians; and study the viability of creating a workplace violence reporting system/repository for family physicians, providing a family physician advocate to handle cases of workplace violence and creating a recommendation about establishing requirements for workplace violence prevention and resolution.

The board will work with the author to clarify and determine what next steps might make sense for the MAFP.

ACCESS RESOLUTIONS ONLINE

Read the 2021 resolutions in their entirety on our website at mafp.org/resolutions (under 2021 Resolutions). *You can also access recent actions on resolutions, find out how a resolution becomes policy and search current and past resolutions via our public resolutions library.*

continued on page 30

continued from page 29

ABOUT THE HOUSE OF DELEGATES

The MAFP House of Delegates is the policy-setting body of the Academy, meeting annually to inform and direct the work of the MAFP leadership and staff and elect the MAFP Board of Directors.

This year's House of Delegates had new ways for members to engage and make their voices heard in our policies and advocacy work, including online meetings to collaborate on resolution writing and the opportunity to comment online on submitted resolutions before they advanced to the reference committee ahead of voting.

Learn more about the House of Delegates and how you can get involved at mafp.org/HOD.

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