

MINNESOTA MEDICINE

OCTOBER 2015



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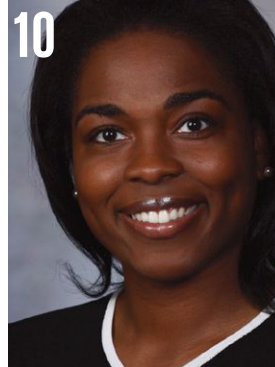
Our thinking about health, policy-making and the capacity of local communities must change if we are to address the wide health disparities in our state.

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MINNESOTA MEDICINE

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PHOTO BY SCOTT WALKER

Charles R. Meyer, MD, Editor in Chief

Equity in the exam room means treating each patient as if they were your most important patient, regardless of gender, sexual orientation, race, ethnicity or personal appearance.

Beneath the surface

An essay in family physician Therese Zink's 2012 collection of stories, *Confessions of a Sin Eater*, capsulizes health equity. In "Caring for Lucy," Zink tells the tale of a 9-year-old girl who presented to the rural urgent care clinic where Zink was working complaining that "sometimes I can't see." Zink sees a pre-adolescent with greasy hair and poor dentition accompanied by a concerned-but-reserved mother. Following her standard doctor script, Zink does a thorough physical examination and orders some tests, all of which were normal. The medical encounter could have ended there—flaky pre-teen with uninterpretable symptoms; pat her on the hand and reassure her and her mom that all is well. But Zink delves past the scruffy appearance of the child and the reticence of the mom and uncovers a frightening home environment: an ominous boyfriend, a history of past domestic abuse by a previous husband, trips to domestic shelters—all salted with debilitating poverty making every avenue of escape difficult, if not impossible.

The true etiology of her patient's symptoms would have remained obscure had Zink not treated the girl as she would any patient, ignoring her offensive appearance and working overtime to root out the source of her problem. Equity in the exam room means treating each patient as if they were your most important patient, regardless of gender, sexual orientation, race, ethnicity or personal appearance, working diligently to understand them and their problems and to solve those problems. We physicians think we always do that but our articles this month highlight statistics that suggest otherwise, whether in the exam room or in the research arena. Somehow, we fail certain groups of patients and our

failure is dramatized by increased death rates from coronary artery disease, breast cancer and hypertension in African-American women, higher infant mortality among Native Americans and African Americans, or longer waits in emergency rooms for non-Caucasian patients. We need to improve.

But the other aspects of health equity are even tougher to address. Dubbed "upstream" problems—lack of adequate nutrition, shelter or exercise; living in a dangerous environment; cultural misunderstandings—weave a strangling web that denies good health to the Lucys of our country. These are riddles that perplex lawmakers and social scientists and seem far beyond the reach of practicing physicians.

After her encounter with Lucy, Zink grieves over what she could not do for the girl and her mother: "I cannot remove this boyfriend from their lives. I cannot weave the safety net: find them low-income housing, create a good job for Lucy's mother, identify competent child care, locate a good teacher for Lucy and more." So much is beyond the therapeutic power of physicians.

The practice of medicine harbors lots of opportunities to feel impotent—the untreatable cancer, the irretrievably damaged heart, the recalcitrant alcoholic. We frequently sigh and move on to more approachable, workable problems. Our exam room health equity problem is approachable and solvable. To fix the bigger upstream conundrums, however, we can do what we can and also support those working on the upstream territory.

Charles Meyer can be reached at charles.073@gmail.com.



Pain, Opioids and Addiction LECTURE SERIES

The Minnesota Medical Association (MMA), the Steve Rummeler Hope Foundation (SRHF), and the University of Minnesota Medical School began a collaboration to bring medical education on the topic of opioids to medical students, residents, and practicing doctors. The lectures are recorded live at the University of Minnesota Medical School and made available for CME on the MMA website, with underwriting by the SRHF. The hope of the series is to create a medical curriculum on pain, opioids, and addiction, as it should be in a medical school setting: balanced, practical, evidence-based information free of commercial bias.

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VIDEO 3: "How to Choose an Opioid: Practical Pharmacology" Charles Reznikoff, MD, Division of Addiction Medicine, Hennepin County Medical Center, Assistant Professor of Medicine, University of Minnesota Medical School

VIDEO 4: "A Differential Diagnosis for 'Pain'" Charles Reznikoff, MD, Division of Addiction Medicine, Hennepin County Medical Center, Assistant Professor of Medicine, University of Minnesota Medical School

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VIDEO 3: "Pain Psychology, Mental Status Exam, and Non-Opioid Options for High Risk Patients" Charles Reznikoff, MD, Division of Addiction Medicine, Hennepin County Medical Center, Assistant Professor of Medicine, University of Minnesota Medical School. Adeya Richmond, PhD, LP, Senior Clinical Psychologist, Psychology Department, Hennepin County Medical Center. Sebastian Ksionski, MD, Pain Program/CMC Director, Hennepin County Medical Center

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Tested triathlete

After starting her first job as a pediatric emergency medicine physician in Columbus, Ohio, Paula Kocken experienced the luxury of free time for the first time

in years. Always fond of staying fit and active, when she saw a flyer for the city's triathlon in 1987, she decided to give it a try.

Triathlons were still an emerging sport at the time, and the Columbus race offered only the Olympic distance—a nearly 1-mile swim, 25-mile bike ride and 10K run. (Today, many triathlons have a sprint of roughly half those distances.) Training for that first event was no small feat, but after finishing, Kocken was hooked.

Ever since, she has completed a handful of triathlons each year, finishing between 50 and 70 races total. (She hasn't really kept track.) And although Kocken emphasizes that she's not an elite athlete, her commitment to the sport while balancing a high-pressure job is impressive.

"It's been a fun thing to have on the back burner," says Kocken, who competed in triathlons in Minneapolis and Door County, Wisconsin, this summer and has done the Chicago and Cleveland races in previous years. "There are some ER doctors who are fantastic at triathlons. I'm not super-fantastic. I just really like doing them, and I think it gives a lot to you."

Kocken splits her time 60/40 between clinical and administrative work. She practices pediatric emergency medicine at Children's Hospitals and Clinics of Min-

nesota, primarily in Minneapolis, and at the WestHealth ER in Plymouth. She also is the physician lead for disaster prepared-

ness at Children's and medical director of Minnesota's Emergency Medical Services

For triathlete Paula Kocken, MD, biking is her favorite part of an event.



PHOTO BY MIKE KRUIT

When you need it.

for Children, a federal program that promotes improved pediatric emergency services.

Kocken says biking is by far her favorite leg of a race, followed by swimming and then running. “I probably wouldn’t run if I wasn’t doing a triathlon,” says Kocken, who is married with two college-aged children. No one else in her family has adopted her tri habit.

Each season, she picks one discipline to improve. Already a strong swimmer, having competed in high school and college, Kocken took swimming lessons at the YWCA this year for the first time. The triathlon swim trainer told her to focus on swimming strongly with her arms, which saves her legs for biking and running. She says she now swims with much less exertion.

Kocken generally starts her training in the spring, with a goal of doing her first tri in July. She works out about five days a week, doing separate bike, run or swim workouts to build endurance, while working with a trainer once a week to build strength and flexibility. Then she adds brick workouts, which usually combine two of the disciplines in succession. Brick workouts are a key component of triathlon training, as they help an athlete switch from swimming to biking or from biking to running. In the off-season, she cross-country skis and runs.

Kocken enjoys the variety the sport offers and says the training offers stress relief and helps build endurance for long shifts in the emergency room.

“I think it helps me diffuse or get rid of a lot of the tension that comes from working in the ER,” she says. “With emergency room work, we never have organized breaks or downtime. You have to be constantly going for eight to 12 hours. Triathlon training helps you with that because you’re constantly pushing the whole time.” – SUZY FRISCH



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“I don’t feel respected ... My doctor doesn’t seem to take me seriously ... No, I’m not stressed out. No, I’m not depressed ... It’s not all in my head ... Something’s not right with my body, but no one seems to be listening to me.”

Tamiko Morgan, MD, reads those words slowly and deliberately in an audio recording from her book, *VIP: Very Important Patient: The African-American Woman’s Guide to Health Care, Healing & Wellness* (Outskirts Press). Morgan, a Minneapolis pediatrician and medical director for Metropolitan Health Plan (MHP), wrote it in 2012 to increase awareness of and help rectify health disparities between African-American women and other populations.

“African-American women have some of the highest rates of illness and death across population groups,” she said in an interview. For example:

- African-American women ages 35 to 44 years have a breast cancer death rate twice that of white women in the same age group.
- African-American women with coronary artery disease (CAD) have a death rate from CAD that is 69 percent higher than the rate for white women, and
- African-American women with hypertension die from the disease at a rate that is 352 percent higher than it is for white women with the condition.

She goes on to explain that many factors contribute to the poor outcomes. Most concerning, is the perception that physicians and other health care providers don’t take African-American women’s health concerns seriously; that their conditions are more likely to be misdiagnosed or underdiagnosed than those of other women; and that they may not be offered the same treatment options as others. As an example, she cites one study that showed African-American women were significantly less likely to be referred for cardiac catheterization than white men.

“The purpose of the book isn’t to place blame,” she says. Rather, it’s to build awareness and encourage all women to advocate for themselves when it comes to their health.

Morgan’s inspiration came from her own experience as a patient. She recalls how the tone of clinic visits changed once her doctor and the staff found out she was a physician. “I felt my concerns were taken more seriously once I revealed I was a physician.” She later heard similar stories from other African-American women who either were physicians themselves or had relatives or friends in medicine.

Morgan says her desire to make health care more equitable extends to her work with MHP, which serves Hennepin County residents enrolled in state-sponsored health programs (Medical Assistance, MinnesotaCare).

“In general, I try to be mindful of health equity,” she says, explaining that MHP has a very diverse community of members. “About 40 percent have mental health issues or chemical dependency issues. It’s important to be mindful of those factors affecting health as we make decisions about care.”



Tamiko Morgan, MD

One way MHP is doing that, she says, is through an offering called Hennepin Health.

Hennepin Health, which has drawn national attention, provides care coordination and help with housing, transportation and employment, in addition to medical, dental and behavioral health care to Hennepin County residents who are eligible for Medical Assistance. “What we’ve found, for example, is that when someone is able to get housing, their ER use decreases,” she says. “It really underscores the fact that you need to care for a person’s basic needs before you can address their total health.”

But taking care of a patient’s basic needs helps only a targeted few. To take her message about improving health and eliminating disparities to a broader audience, Morgan speaks to community and other groups about the importance of eating healthfully, exercising, getting regular preventive screenings, engaging in stress reduction and speaking up if you feel you aren’t being taken seriously—topics she discusses in her book. “If we want to reduce health disparities, we need to do a better job of taking care of ourselves,” she says. “We can’t wait for somebody else to do it.” – KIM KISER

Toward better health for all

ThaoMee Xiong, JD, MPA, has seen health inequity at close range. Her mother, who is a native of Laos and a limited-English speaker, was diagnosed with diabetes 10 years ago and still struggles to communicate with her health care providers. “To this day, she doesn’t understand how to control her diabetes,” Xiong says.

In observing her mother’s challenges, Xiong noticed that the health care system allows clinicians little time to connect with patients, regardless of their communication skills, or to address needs beyond the clinic that can affect a person’s health. “This can magnify the challenge of managing a disease like diabetes,” she points out.

As the new director of Minnesota’s Center for Health Equity, Xiong’s job will be to look for ways to prevent such situations from happening and, ultimately, reduce health disparities between white Minnesotans and those of color.

Such disparities are a concern in the state, which is otherwise known for the good health of its citizens. A recent report to the Legislature by the Minnesota Department of Health found that despite its high ranking on certain health measures, Minnesota was home to some of the widest health disparities in the United States—disparities that result from inequities built into systems and policies, rather than genetics and personal choices.

Those findings led Minnesota Commissioner of Health Ed Ehlinger, MD, MSPH, to establish the center within the Department of Health in December 2013.

Xiong, who took over as the center’s director in June, brings to her new job experience with public policy as it relates to poverty and other factors that contribute to metrics such as an infant mortality rate for African Americans that is double that for whites in the state. She notes that health care typically determines only 10 percent to 20 percent of a person’s health.

Xiong says rectifying health inequities requires a comprehensive solution that includes public investment in housing,

education and other social determinants. Her overall goal is to make the center a resource for communities experiencing the greatest health disparities and to expand people’s understanding of what creates good health. This includes encouraging community-based and community-led



ThaoMee Xiong, JD, MPA

solutions and encouraging health department leaders to view all of their activities through a lens of health equity.

“There needs to be a new way of thinking about how we provide health care services because our old model is not working for the people experiencing the highest rates of health disparities,” she says. — JANET CASS

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Caring for hearts and souls



LaPrincess Brewer, MD, MPH

Although heart disease is the leading cause of death in the United States, African Americans are at much higher risk for cardiac events than the overall population.

LaPrincess Brewer, MD, MPH, an advanced cardiovascular disease fellow at Mayo Clinic, wants to help African Americans lower their risk. Brewer has been working with African-American churches in Rochester to provide members with information about key heart disease risk factors (high blood pressure, obesity and high cholesterol) with the goal of preventing heart disease.


“Traditionally, the churches are the pillar of the African-American community, where members receive relevant information on social, political and community issues,” she says.


Brewer created a 16-week outreach program called Fostering African-American Improvement in Total Health! (FAITH!) that includes biweekly sessions with discussions, video presentations, fitness classes, health and nutrition classes, and lectures by Mayo Clinic faculty from internal medicine, anesthesiology, cardiology and other disciplines.

Brewer made sure each session began with a “testimonial period,” during which participants shared what they were doing to change their health behaviors and to educate others in their community. “It’s uplifting to everyone in the room, including us researchers,” she says.

In a December 2014 post-session evaluation, Brewer found that participants, most of whom were women, had significant increases in their knowledge of heart disease, heart disease risk factors and heart disease disparities between the African-American community and the community at large. (The findings have not yet been formally published.) She hopes to expand her work to other churches in Rochester and throughout the Twin Cities.

– JEANNE METTNER



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Sharonne Hayes, MD (right) says research on heart disease often excluded women and especially African-American and other women of color.

Working with a medical researcher from Emory University who also is a member of The Links, the Mayo team asked members of the organization to complete an anonymous survey while attending their 2012 National Assembly in Orlando. The survey evaluated their thoughts about medical research by having them indicate their level of agreement with several statements (for example, “Participation in research will mean better care” and “Scientists cannot be trusted”).

The participants also were asked how willing they are to participate in clinical trials, interview studies, biobanks, genetic research, medical records reviews and studies that require providing biological samples. Findings from the study were reported in the *Journal of Women’s Health* in August 2014.

Says LaPrincess Brewer, MD, MPH, an advanced cardiovascular disease fellow at Mayo and a co-author of the article: “A lot of what we understand about African-American participation in research comes from more underserved communities, people who are in a lower socioeconomic status. No one had taken a look at the

“
The biggest barrier to participation is that the women simply were not being asked.”

– Sharonne Hayes, MD

Toward more equitable research

A Mayo Clinic team is digging deep to improve African-American women’s participation in clinical studies.

BY JEANNE METTNER

Minorities, especially African-American women, remain vastly underrepresented in clinical research studies, even though the National Institutes of Health (NIH) Revitalization Act of 1993 stipulates that scientists receiving NIH funding must explain in their proposals how they plan to enroll more minorities and women in their studies.

Disparities in care that result from too few women being included in such studies has been a source of frustration since the early 1990s for Sharonne Hayes, MD, a Mayo Clinic cardiovascular disease specialist who founded the Women’s Heart Clinic and is now medical director of diversity and inclusion at Mayo.

“When I had a man in my office who was recovering from a heart attack, I had

far more definitive answers based on scientific evidence than I did for the women who were sitting in my office because prior research had often excluded women,” she says. “Those disparities doubly disadvantage African-American and Hispanic women because even if they have access to a health care provider, that provider does not have the evidence available to them to give them the best care.”

When Hayes and her colleagues decided to find out why fewer African-American women participate in medical research studies, they got help from one of their patients, who is a member of The Links, Incorporated, a national service organization for African-American professional women.

highly educated, upper echelon of the African-American community.”

Willing—but wary

The findings supported the investigators’ hypothesis: That the desire to participate in medical research was much higher

among The Links members than among previously studied African-American women of lower socioeconomic status. “Many of The Links members had not participated in medical research, but the vast majority were willing to participate and believed that participation would

be good for the African-American community,” Hayes says. “The biggest barrier to participation is that the women simply were not being asked.”

What surprised the team is the fact that these educated, informed women still had concerns about the ethics surrounding research participation. “They were actually more willing to give blood and tissue samples to a biobank than to allow a researcher to review their medical chart,” Brewer says. “It shows us that we as researchers need to be more up-front and transparent about letting them know what we are doing with the data, and that the data not only are protected but also are beneficial to the public.”

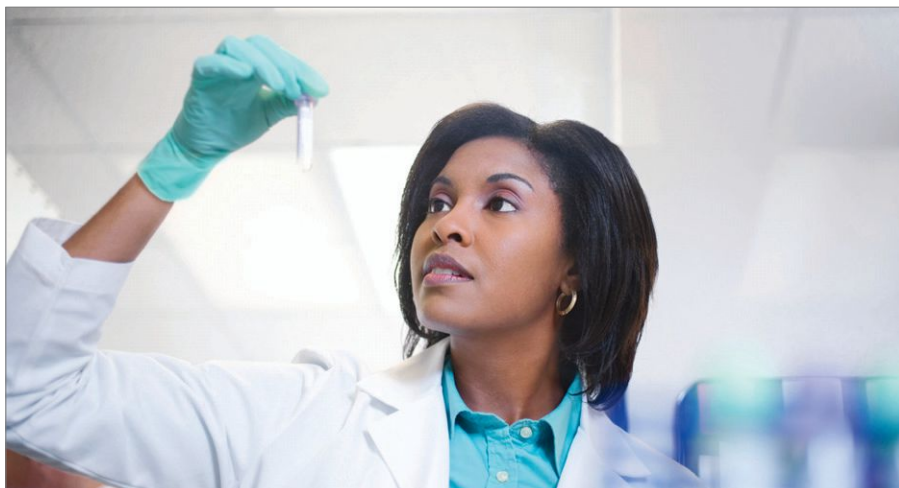
Many of the women surveyed said participating in research felt scary or made them feel vulnerable. But they also realized that the benefits outweighed these concerns. “The sense we got from participants,” Hayes says, “was, ‘Yes, I have reservations, and I have more reservations than the average 50-year-old white man. But I also understand that if I don’t participate, there won’t be anyone who knows about people like me.’”

Publishing the study’s findings was just the beginning. To get at some of the reasons for the women’s answers, the team received an NIH grant in the spring of 2015 to conduct focus groups with members of Upper Midwest chapters of The Links.

Led by Carmen Radecki Bretkopf, PhD, from Mayo, the research team will use information from the focus groups to work with members of The Links to develop an educational program about research participation for African-American women.

Hayes believes there are key takeaways from the survey that clinical researchers can act on immediately. “Ask African-American women to participate in your research,” she says. “We need to stop assuming that they’re not willing to participate. We still may have a lot of people who will say ‘no,’ but if they are never even asked, they certainly won’t participate.” **MM**

Jeanne Mettner is a Minneapolis writer and frequent contributor to *Minnesota Medicine*.



Cultivating diverse researchers

Studies have shown that when controlling for all variables, biomedical researchers from underrepresented racial and ethnic backgrounds are not funded by the National Institutes of Health (NIH) at the same rate as their white counterparts.

The University of Minnesota is trying to close that gap with the help of a \$22.4 million NIH grant it is sharing with four other institutions: the University of Wisconsin-Madison, the University of North Texas Health Sciences Center, Morehouse School of Medicine and Boston College.

“The hope is to change the face of science through mentorship, networking and professional development,” says Kristin Eide, MPH, assistant director of professional development for the University of Minnesota’s Program in Health Disparities.

The university is using its share of the grant dollars to coach less-experienced researchers in biomedical and federal grant writing. Participants interested in the program will prepare a grant application for a research project that will ultimately be submitted for review. Eide says they will collect data on whether the trainees’ projects get funded.

“The model is unique,” she says. “Rather than just listening to presentations, trainees go through a process that helps them understand the way an NIH reviewer thinks and what problems might stand out that might ultimately lead to their not getting funded.” — J.M.



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Equity Rx



Physicians confront the state's serious disparities in order to promote the best health for all.

BY GAYLE GOLDEN

As a pediatric hematologist specializing in sickle cell anemia, Stephen Nelson, MD, never considered racial bias a problem for him. After all, nearly all of his patients at his Minneapolis Children's Hospital clinic were African American and genetically prone to the blood disorder.

Yet in 2008, when Nelson attended a conference session on white privilege and racism, he was mortified. "I was embarrassed that I had never thought about the issues of privilege and whiteness and racism in this country," he recalls. And he began to wonder if the overwhelming whiteness of his staff—94 percent at the time—was affecting the care his patients received.

Nelson surveyed patients, families and staff, and found a majority of patients and families said race negatively affected their care and their relationships with caregivers; most of the nearly all-

white staff also perceived unequal treatment in the inpatient setting.

The problem was not the result of any deliberate action. Rather, it was caused by unconscious biases built into our assumptions and systems—black patients waiting longer than white patients to be called to exam rooms, or feeling that physicians don't spend as much time with them as

Healthcare Quality and Disparities report. Yet, when it comes to health equality for blacks, Hispanics and Asians, the state is in the bottom quartile.

When Nelson's survey findings were published as the cover article in *Pediatric Blood Cancer* in 2013, an accompanying editorial lit a fire under him. "It basically

Grim reality

Nelson's personal transformation reflects a growing awareness that Minnesota's reputation as one of the nation's healthiest states is marred by serious inequities.

The data are striking. The state's African-American and American In-

"It's hard to convince people that there's a problem because we are No. 1, or in the Top 5, on many national health outcomes—if you're a white Minnesotan."

—STEPHEN NELSON, MD



they do with white patients. Sometimes, the perception is rooted in what the clinic doesn't do. Offering free parking is nice for patients who have cars, for example, but many of the clinic's African-American families need to take the bus at times. "We don't pay for that," Nelson says. "The intention may not be to cause harm, but the perception—and that's the reality—is that patients know they're being treated differently."

Such inequities were already in the national spotlight. Five years earlier, an Institute of Medicine report made it clear that minority patients in the United States consistently received a lower level of care, even after controlling for factors such as access, and that the result was overall poorer health outcomes.

By then Minnesota's demographics were changing, and health inequities around race and ethnicity were developing. The state's inequities are now some of the most marked in the nation. Last year, Minnesota was in the top 25 percent of states for good health outcomes in its overall population, according to the most recent National

said, OK, we know this exists," he says. "So what are we going to do about it?"

For Nelson, it marked the start of a new path in his medical career. Today, while he still maintains a practice, he also teaches physicians and other health care providers about structural racism (the way public policies, institutional practices, cultural representations and other norms perpetuate inequities) and how it can affect care. Nelson has led three-session workshops at Children's and elsewhere where he focuses on issues such as: What is race and its social construction? What are the structural systems of race? What is whiteness?

Although he hopes to expand the sessions to more clinics across the state and country, he acknowledges there is "a lot of resistance" from administrators and doctors to spending time and resources on such training, most of which is aimed simply at raising awareness. "The first elephant in the room is that it [structural racism] exists, that it's a problem," he says. "The second elephant is that we as health care providers are part of the problem."

dian babies die at twice the rate of white babies. The highest rates of obesity afflict American Indian, Hispanic/Latino and African-American children. Breast cancer is more often diagnosed in later, less treatable stages among African-American and Hispanic/Latino women than among whites.

The problem doesn't just take the shape of a line graph; it manifests in real ways. One study of emergency room patients at Children's Hospitals and Clinics of Minnesota in Minneapolis showed African-American children waited an average 20 minutes longer for pain medication to treat a large broken bone than white children. Last year, the Minnesota Department of Health aimed a bright light on the issue of health inequities in a legislative report. Noting the marked correlation between race and economic status, the report blamed health inequities on nothing less than structural racism woven into the fabric of our policies around housing, transportation and education.

"It's hard to convince people that there's a problem because we are No. 1, or in the Top 5, on many national health outcomes—if you're a white Minnesotan," Nelson says. "When you show the data,

it's very upsetting. People say: 'How can this be? I'm a good person.' But it isn't that you're a bad person or that you're a racist. This is the system."

Within the past three years, momentum to address the systemic problem in Minnesota has grown. The nonprofit MN Community Measurement began issuing annual reports on health equity, identifying gaps in care for diabetes, vascular disease, asthma and colorectal cancer screening. The Minnesota Department of Health established the Center for Health Equity to coordinate policy changes.

Meanwhile, many physicians in the state are working hard to make a difference—holding down the front lines of health care in the poorest of communities, partnering with new immigrants to tackle health issues in culturally effective ways, and building solutions that strike at “upstream” issues of poverty that often lead to medical problems downstream. This year, the Minnesota Medical Association started a work group to provide doctors with resources to help them gain cultural competence when dealing with diverse patients, among other things.

The poverty problem

Physicians may need to make changes in their thinking and practice, yet they can only do so much in the exam room to reduce health disparities. That's because clinical care accounts for just 10 percent of what keeps people healthy. Genetics and behaviors play a bigger role. But by far the biggest factor in health—accounting for 40 percent—is socioeconomic.

Expanded access to medical insurance helps, but it doesn't solve the problem. Within the past two years, for example, the Affordable Care Act has reduced by half the number of uninsured patients at the People's Center, a Federally Qualified Health Center that offers medical, dental, behavioral and other services in the Cedar-Riverside neighborhood and other locations in Minneapolis. “But there is a limit to how much difference health insurance alone can make in the face of poverty,” says Steven Vincent, MD, chief medical officer.

Tips for Clinicians

Creating a more welcoming practice is really just good patient care. But sometimes it takes some extra thought to generate trust among people of color or those facing economic challenges. Pediatrician Fatima Jiwa, MBChB, who is chairing the MMA work group that's addressing racial and ethnic health disparities, says doctors can start by simply acknowledging patients' struggles with outside challenges. In her practice in Rogers, this means listening more acutely to parents who can't always put food on the table or who sometimes miss appointments because they lack gas money.

“I stop and listen more to patients of color or patients in poverty or even patients I cannot completely relate to,” she says. “Just acknowledging their challenges makes a big difference in how they relate to me.”

Christopher Reif, MD, MPH, director of clinical services at Community-University Health Care Center in Minneapolis, offers other suggestions for physicians.

- Accept all forms of insurance, including Medicaid and MinnesotaCare.
- Accommodate languages other than English either through staff or interpreter services.
- Have a multicultural staff, especially at the front desk answering phones.
- Display art that reflects people of color.
- Make your waiting room child-friendly.
- Allow patients to share their cultural identity on forms.
- Never make assumptions about a person's language, education, employment or finances.
- Be respectful in addressing people, using Mr., Ms. or Dr.
- Offer health education materials in different languages and at reading levels for all education levels.
- Spend extra time establishing trust; it may be lacking from the patient's previous experience with the health care system.
- Acknowledge gender differences, sexual orientation, religious concerns, immigrant status, family dynamics and home/alternative therapies.
- Be sure the patient has the resources and understanding to carry out a care plan, including insurance, money, transportation and home supplies.
- Ask patients if their needs were met by the exam or if there is something more you can do.
- Schedule follow-up visits sensitive to child care, work or transportation needs.
- Have clinic hours that match patient needs, which may include weekend or evening hours. – G.G.

Socioeconomic factors create a cascade of stresses that affect the well-being of the poor: not being able to eat well or get adequate rest or exercise because they lack access to or can't afford healthful food or adequate shelter in a safe neighborhood. “If you can't walk in your neighborhood

because it's not safe, that works against preventing diabetes and hypertension,” Vincent says. Poverty also leads to depression and other mental illnesses, making it even harder for patients to take care of their medical needs.



Lydia Caros, DO, helped start the Native American Clinic in Minneapolis 12 years ago with the goal of addressing health issues among American Indians, including the rising diabetes rates that have resulted from generations of poor access to healthful food. She says she has watched how decades of generational poverty and systemic obstacles have eroded her patients' capacities. "I can't tell you how many people come in and say their insurance is turned off because they didn't get some paper back in time," she says. "It sounds like a little thing, but it's huge. So people aren't getting their medicine, they're confused, they're frustrated. To them, it's one more thing the system is doing to them."

When Caros sees pediatric patients, she spends a lot of time talking with their parents about basic nutrition or trying to convince them to seek help for depression or anxiety. Yet their lives are often chaotic, she says, so they have trouble following through with recommendations. "The health care system is what needs the work and the money," she says. "Eliminating barriers to insurance, transportation, getting medicine, safe housing—all of those things we take for granted, they can't get past. So they don't get better."

Maria Veronica Svetaz, MD, MPH, agrees. She moved to the Twin Cities from Argentina in 1998, just as waves of Latino immigrants began moving into northern states such as Minnesota. Many of them were isolated, poor and struggling with high rates of teenage pregnancy and adolescent depression. "The community made me realize that when you are made vulnerable by the social situation, you actually have special needs," she says. "I remember saying there's no difference between a medical condition we treat in the clinic and a chronic condition like poverty."

Culture and care

Svetaz was one of the first area physicians to receive a state health disparities grant to address the special needs of Latino youth. She started *Aquí Para Ti* ("Here for You") in 2002. The program takes a holistic approach to care, offering both medical and

mental health services and connecting patients to resources in their communities. Teens are welcomed by Spanish-speaking staff at Hennepin County Medical Center's Whittier Clinic, where the program is located. "We have cultural competence. We speak the same language. There's no judgment," Svetaz says. "The patients don't need to explain much because we understand them."

Indeed, within the past two decades, awareness of how important language and culture are to clinical care has grown among clinicians who serve certain populations throughout the Twin Cities. When Vincent joined the People's Center staff full time in 1992, it had for years served mostly white students and social activists in the area. But soon waves of East African immigrants arrived, and the clinic initially struggled to meet their needs.

"I don't think it was a mindset. The staff has always been big-hearted here, generous, welcoming to all," Vincent says. "It was language. You just couldn't get things scheduled. You couldn't correctly explain things."

Now, in the light, airy waiting room decorated with African artwork, patients schedule appointments and receive instructions in Somali and other languages. Likewise, across Interstate 94, at the University of Minnesota's Community-University Health Care Center (CUHCC), more than half the staff speak one or more of the seven languages most spoken by their patients, including Somali, Spanish and Hmong.

Christopher Reif, MD, MPH, CUHCC's director of clinical services, says language is just the starting point with immigrants. Doctors must be sensitive to the patient's broader circumstances. "This means asking, When did you come to the U.S.? How did you get here? Are there any obstacles to your health care?" he says. "And being sensitive to cultural issues, including religion."

Such sensitivity can make or break a patient's ability to follow doctors' orders. Daily prescription medication doses can, for instance, conflict with fasting practices for many East African patients. Campaigns for colorectal cancer screening among



American Indians are more successful if framed as a benefit to the community rather than the individual. At HealthEast's Rice Street Clinic in St. Paul, cultural factors play a role in the diagnosis of late-stage cervical cancer among Hmong patients, says Laurel M. Ries, MD, who practices family medicine with obstetrics at the clinic.

"It's not a part of their culture to have a Pap smear, so it feels very foreign to them," says Ries, who grew up in the Wisconsin farming town of Viola (population 365), a community whose residents remind her of the hard-working, independent-minded yet often poorly educated immigrants she treats. "I have to really start on a basic level and explain how Pap smears keep them healthy even though they don't feel sick."

Equally important, says CUHCC's Reif, are connections clinics make with communities. CUHCC does this in a number of ways. On the outside of the facility, a mural depicts the multicultural staff and patients with words describing the meaning of community in eight languages including Hmong, Swahili and Anishinaabe. Inside, the clinic employs nine care coordinators who reflect the demographics of the population it serves. The coordinators help patients navigate challenges such as finding a pharmacy with staff who speak their language, remind patients about appointments, advise on transportation to specialty clinics or even help those with diabetes find culturally acceptable ways to exercise in their neighborhoods.

“There’s no difference between a medical condition we treat in the clinic and a chronic condition like poverty.”

—MARIA VERONICA SVETAZ, MD, MPH

Training the workforce

Also important to reducing inequities is having a culturally diverse, culturally sensitive medical staff, Reif says. Each year, CUHCC trains more than 200 medical students, residents and others from the University of Minnesota, which statistically has one of the whitest student bodies of all medical schools in the country. Yet Reif says today’s students, regardless of race, make him optimistic. “They are all asking, ‘Can you teach me how to be a doctor in a diverse world?’” he says. “We try to model that here. We have interpreters and a diverse staff show them how to do a good history, how to pay attention to the cultural issues of each patient.”

At Broadway Family Clinic in North Minneapolis, where 80 percent of patients are American-born blacks who have some of the state’s worst health outcomes, Renee Crichlow, MD, thinks a lot about how to expand the skills and reach of the 30 residents from North Memorial Medical Center who train there. Her approach: Don’t just treat the symptoms of illnesses such as hypertension or diabetes. Look upstream for the causes, which include poor food access, a failing educational system and lack of transportation that makes it difficult for many to hold jobs.

In order to learn to be upstream doctors, the residents attend seminars on poverty and regularly participate in Community Health and Advocacy Talks (CHAT) with neighborhood residents. They join The Ladder, a mentorship program in which college undergraduates, medical students and physicians meet monthly

with north Minneapolis middle and high school students interested in health care careers. They also help organize a weekly farmer’s market, where families in the neighborhood can buy fresh fruits and vegetables with tokens provided in food-education workshops offered at the nearby Northpoint Clinic.

Such programs focus on long-term goals and build on small progressions: a mentored middle-schooler who makes it through a year with no suspensions can become a high-schooler with college aspirations and eventually a medical student who will one day move back to the neighborhood as a physician.

“We play small ball and long game,” Crichlow says. “Every detail counts, but you’ve got to be aiming for a long-term intervention because these are complex, systemic problems. And you have to build complex, systemic responses in order to address them.”

Community solutions

The key, Crichlow and others argue, is empowering communities to solve their own health problems. Shana Sniffen, MD, who did her residency at North Memorial, has helped the state’s newest immigrants, Karen refugees do just that.

Three years ago, Sniffen was struggling to help Karen patients suffering from substance abuse—an all-too-frequent response to post-traumatic stress disorder caused by their refugee experiences near the Thai-Myanmar border. Treatment centers often refused to take them because of the language barrier. Even when they were admitted with an interpreter, Karen pa-

tients often would become confused while going through treatment.

“They’re coming from a place that has no public health system. Even the concept of addiction as something to get treated was foreign to many of them,” she says. “They’d think, while in a treatment group, ‘Why are we all sitting in this room?’ There was no awareness of how the treatment process works.”

With a grant from the Bush Foundation, Sniffen began helping Karen leaders craft their own treatment model at HeathEast’s Roselawn Clinic in St. Paul. The model, which the clinic plans to begin using by the end of the year, involves family, community, faith leaders, interpreters and public education.

Moral obligation

Creating culturally sensitive approaches to care will become even more necessary in the future. By 2035, 25 percent of Minnesotans are expected to be people of color, which is double from 2005. Today, 35 percent of children in the state are nonwhite. Nelson, the hematologist who teaches about structural racism, says those numbers require all doctors to take stock of their personal biases if they want to offer good patient care.

Minnesota Commissioner of Health Ed Ehlinger, MD, MSPH, argues that if they don’t, the state will see its health ranking continue to fall. He points out that in 1992, the United Health Foundation listed Minnesota as No. 1 in its state health ranking. Last year, the state fell to No. 6. “We’re going in the wrong direction, and we’ve been steadily going in the wrong direction,” Ehlinger told a gathering of public health professionals in August. Evoking the philosopher John Dewey, he argues doctors have a moral obligation to address the problem. “If we’re going to be a healthy state, we have to identify the things that are really intolerable. I think the disparities we have in this state are intolerable.” **MM**

Gayle Golden is a Twin Cities writer who is also a senior lecturer in the University of Minnesota School of Journalism and Mass Communication.

Tools OF THE *trade*

When listening is the best medicine

BY PRERANA M. BHATIA

She was the last patient of the afternoon. I made a mental note of the pertinent information about her case before leaving the workroom: Return OB visit. Flu symptoms. Recent ED visit. First trimester care completed.

With my favorite blue pen in my pocket and a blank piece of paper folded into quarters, I walked around the clinic until I found the correct room. I ran my hand over the pocket that held my stethoscope. I was ready. After I greeted her and introduced myself, I asked her, “How have you been doing since your last visit?”

The patient appeared well and was in no acute distress. She was seated on the exam table with her legs hanging off the end. Her puffy winter jacket was half-zipped and a Kleenex was poking out of the left pocket. She was looking down at her phone but quickly slipped it into her pocket. The front desk must have given her a mask to wear; it was now ill-positioned at her neck. She made no effort to cover her mouth. Instead, she greeted me with a warm smile.

“Hi, I’m doing OK,” she responded. She seemed shy. She covered her mouth with

her hands for a very wet-sounding cough—as if her nasal and hoarse voice wasn’t convincing enough.

“Oh,” I said sympathetically. “That doesn’t sound fun.” I rolled the stool from the computer desk and took a seat in front of the patient. She towered over me from the exam table, but the height difference seemed appropriate to me. We started with my agenda. I asked about her pregnancy. She was almost out of breath and coughed frequently as we talked. I tried to keep the conversation short. Finally, I asked her about her “cold,” which she seemed more eager to talk about. It had persisted for a week, and she had had difficulty breathing and fevers at times. She had visited a couple of different emergency departments during the last few days and had been prescribed an inhaler for her shortness of breath along with instructions to rest. However, with a new job and two young children at home, there was simply no time to rest. The “cold” just wasn’t getting better.

I asked some questions to clarify. Did she have a history of asthma? Had she been using the inhaler she was prescribed? Did it help? Her answers were brief, but she indeed had a history of asthma. I

probed some more and discovered she could barely afford food, let alone an inhaler. She apparently had planned to see a financial counselor in the hospital after leaving this appointment. I made a mental note of the time. The financial counselor’s office closed in less than half an hour. I quickly finished up the rest of my questions. As I made notes on my paper and stood to leave, I asked if there was anything else she wanted me to address today.

“Well, there is this other pain,” she said hesitantly. With my pen and paper tucked away I stood in front of her and gave her my full attention.

“I feel deep pain on my bones here sometimes.” She was pointing to her groin bilaterally. “Maybe you know what I mean . . .” I tilted my head to one side and waited for her to say more. She finished with, “It’s the same pain I felt when I was raped.”

Raped? I continued to look at her. There was absolutely no change in her expression when she said the word. Questions and concerns flooded my mind. What was really going on? Did I completely miss the fact that this woman wanted to discuss something besides her pregnancy today?

*“Did I completely miss
the fact that this woman
wanted to discuss
something besides her
pregnancy today?”*

Of all the people she had seen today, why did she think I would understand this pain? Was I, a medical student, qualified to talk about her rape? If we talked more, would she miss the appointment with the financial counselor? Would she come back another day to figure out how to afford her inhaler? But then, would she bring up being raped at another appointment, on another day, with another provider?

I took a deep breath and placed a reassuring hand on her shoulder. Suddenly,

I realized that an invisible wall between us had come down. There was no longer a forced smile on her face. The soft, slow speech that I had mistaken for shyness was also gone. Words and emotions flowed out of her. I stood there, saying nothing, writing nothing, offering only a reassuring hand and careful listening, as this wonderful, strong woman unloaded her burdens. MM



Prerana Bhatia

is a fourth-year medical student at the University of Minnesota. She says: *“Moving patient encounters leave a lasting impression,*

yet there is rarely a chance to discuss their impact. This piece was written in an effort to reflect and discuss the significance of connecting with a patient on the basis of trust and respect.”



The scariest mo

After witnessing a code blue, a medical student wonders, “What if?”

BY MIKE ROSE

Go hit the code blue button. We need more hands.”

Trying not get in the way of the nurses, I made my way to the head of the patient’s bed, to the wall where the ominous button that I had often looked at but never touched was located. I pressed it, and an automated announcement spread throughout the hospital corridors:

“Code blue, labor and delivery; code blue, labor and delivery; code blue, labor and delivery”

It was the first time I was involved in a vaginal delivery. All had been going well and then, unexpectedly, the fetal heart monitor showed decelerations, signaling the baby was in distress. At the same time, the laboring mother began bleeding more than normal. Because she was near full term and everything was going according to plan, the attending physician, two nurses, the father and I were the only people in the room. When the problems first began, the doctor asked the nurse to call for another pair of hands, but no one answered. The problems worsened, and we

were faced with no other choice but to call a code blue.

Most doctors and nurses will tell you that a code coming from the labor and delivery unit is the scariest. When it is called, the whole hospital holds its breath.

Nothing is more terrifying than the thought of losing a newborn and/or a mother on what is supposed to be one of the happiest days of a woman’s life. There is something so special about bringing life

ment

If a code blue in labor and delivery is this scary in a well-staffed hospital in the United States, what would it be like in rural Haiti? Malawi? Sierra Leone?

Within moments, the baby turned from a worrisome blue to a crying pink ball of energy, and mom's tears of concern turned to tears of joy. As quickly as the code started, it was cleared. Laughter and smiles filled the room.

After completing the necessary charting and comforting our patient, my attending physician and I headed downstairs to grab some lunch. As we ate, I finally had time to reflect on what I had just witnessed. Disturbing questions kept running through my mind: What would it be like to not have that button to hit? To not have a team come running when there was an emergency? Or what it would be like to not have a trained birth attendant there in the first place? If a code blue was this scary in a well-staffed hospital in the United States, what would it be like in rural Haiti? Malawi? Sierra Leone?

It hurts to even imagine.

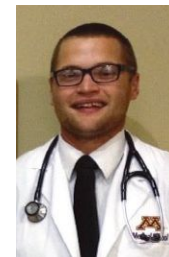
That is reality, however, for more than a billion people around the world. In places such as Lesotho, where lifetime maternal mortality is one in 62 (compared with one in 2,100 in the United States), or Haiti, where infant mortality is more than nine times higher than it is here. The good news is that these inequities can be overcome.

Although people often say we live in a world of limited resources, Partners in Health co-founder Dr. Paul Farmer notes that we have more resources today than ever before. In addition, we know that investing in health for all is affordable and wise. Dr. Farmer and many others have often pointed out that the reason we haven't achieved health equity is that we

haven't treated health as a human right. And I believe there is no greater argument for treating health as a right than being a part of a code blue on a labor and delivery ward. In that room no one asked if it was cost-effective to invest in the lives of that mother and child. The doctors and nurses simply acted on what they knew to be the right thing to do.

So why does our global community still fail to meet the basic needs of so many mothers and children? I believe it's because we lack empathy, not resources, and history tells us feeling empathy for our fellow humans who are far away is extremely difficult. To overcome this lack of empathy, we need to be telling the stories of individuals rather than only looking at data. We need to see the people who make up the numbers.

I can't tell you about the mother from Malawi who died without access to a birth attendant. That is another story. But I can tell you about a mother from Minnesota who went home with a beautiful, healthy baby girl following a scary delivery. And I can ask you to imagine a time when the story about a mother in Malawi will have a happy ending as well. MM

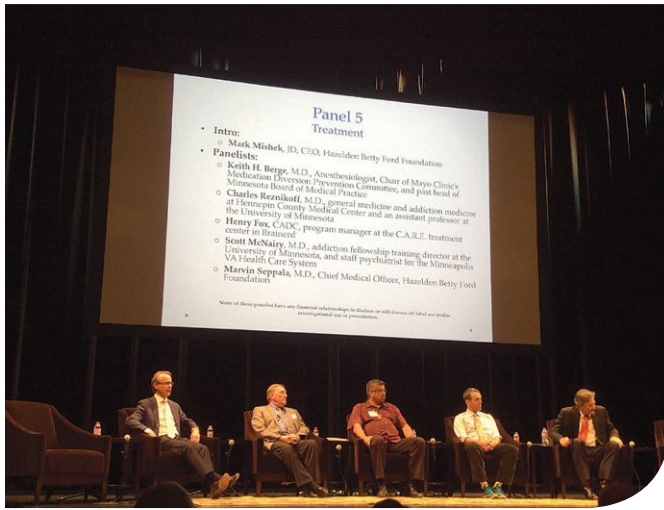


Mike Rose is a second-year medical student at the University of Minnesota, Duluth. This story was inspired by a delivery he took part in while working with a preceptor in a rural community.

into the world—and something so terrifying about things going awry.

This is why, only seconds after hitting the code blue call light, a flock of out-of-breath doctors, nurses and other staff arrived. The code team suctioned, poked, prodded, warmed and worked as a well-oiled machine as I stood out of their way (as we first-year medical students are trained to do). I felt partially frozen with fear and in awe of their deftness, speed and composure.

News Briefs



A large crowd gathered at the University of Minnesota to hear panelists discuss the nation's prescription opioid problem.

Prescription opioids summit draws huge crowd

More than 1,200 people learned that prescription opioid abuse, addiction and diversion have reached a crisis level in the United States at a day-long seminar in late August at the University of Minnesota. The event was co-sponsored by the MMA and included several MMA members as panelists.

MMA members taking part included:

- **Charlie Reznikoff, MD**, who promoted the MMA's "Pain, Opioid, and Addiction Lecture Series" as part of his presentation. Reznikoff and a multidisciplinary team that includes pain specialists, psychologists, addiction counselors, pharmacists and physical therapists provide care for opioid-dependent patients through an addiction medicine program at Hennepin County Medical Center.
- **Chris Johnson, MD**, an emergency medicine specialist, provided an overview of the prescription opioid abuse problem in Minnesota and suggested that a societal response is needed. He also noted that medical schools don't teach physicians about pain and addiction.
- **W. Michael Hooten, MD**, from Mayo Clinic, noted that not all patients who are exposed to prescription opioids become addicted or overdose. There are certain risk factors for adverse outcomes that need to be factored in such as age, gender, history of addiction or substance abuse, and psychiatric comorbidities.
- **Marvin Seppala, MD**, chief medical officer with the Hazelden Betty Ford Foundation, pointed out that although effective treatment exists, many people don't access it.



Independent physician education event planned for November

Physicians can learn new strategies to improve efficiency and expand patient access at a special event co-sponsored by the MMA and the AMA. "Transforming Your Practice to Regain the Joy of Medicine" will be held November 11 from 6 to 8 p.m. at the Continuing Education and Conference Center on the University of Minnesota, St. Paul campus. The program will be webcast to reach physicians throughout Minnesota. For details, go to www.mnmed.org/IPEvent.

MMA health disparities work group begins work

A 16-member MMA Health Disparities Work Group, formed to address health disparities between racial and ethnic groups in Minnesota, began meeting in late August. Chaired by Fatima Jiwa, MBChB, the work group will meet for approximately 12 months. Its purpose is to:

- Understand the various drivers behind racial and ethnic disparities in health care,
- Guide the identification and development of information, tools and resources to support physicians and
- Examine other roles the MMA could play in assisting physicians as they combat racial and ethnic health disparities in their practices

Along with Jiwa, work group members include: LaPrincess C. Brewer, MD, MPH; Demeka Y. Campbell, MD; Brooke Cunningham, MD, PhD; Brooke Dugdale (medical student); Deenah Farrell (medical student); Dionne Hart, MD, FAPA; Alice Lehman (medical student); Tamiko Morgan, MD; Stephen C. Nelson, MD; Michael Pitt, MD, FAAP; Chris Reif, MD, MPH; Laurel Ries, MD; Daniel Riley, MD; Maria Veronica Svetaz, MD, MPH, FSAHM, FAAFP; and Steve Vincent, MD.



Stearns Benton holds another successful drug take-back event

In mid-August, the Stearns Benton Medical Society (SBMS) held another successful drug take-back event as part of a senior expo in St. Cloud. Physician volunteers worked with local law enforcement officers to dispose of unwanted medications. “Our goal is to get unwanted drugs out of citizens’ cabinets,” says SBMS President Patrick Zook, MD. “We don’t want these medicines falling into the wrong hands.” This is the second year SBMS has participated in the expo, which attracts thousands of attendees from the St. Cloud area.

Survey: Patients pleased with care

For the most part, Minnesotans are pleased with the health care they are receiving, according to a survey released in late August by MN Community Measurement and the Minnesota Department of Health. The 2015 Patient Experience of Care Survey includes results for more than 200,000 patients at 765 clinics in Minnesota and neighboring communities in Iowa, North Dakota and Wisconsin. Nearly 80 percent of Minnesota’s patients give their health care providers a rating of 9 or 10 on a 10-point scale (10 being the highest rating), but only about 60 percent of patients said they experienced such satisfaction with their access to care.

The survey, which included patients who had appointments between September 1 and November 30, 2014, measured opinions on whether they felt they were:

- Getting care when needed
- Being listened to and receiving information and instructions that are easy to understand
- Being treated in a courteous and helpful manner by office staff
- Satisfied with their provider.

Minnesotans named to “Influential People in Healthcare” list

Four Minnesotans are included in *Modern Healthcare*’s 100 Most Influential People in Healthcare for 2015. They are Stephen Hemsley, president and CEO of UnitedHealth Group (ranked No. 5), John Noseworthy, MD, president and CEO of Mayo Clinic (No. 8), Omar Ishrak, chairman and CEO of Medtronic (No. 46), and Mary Brainerd, president and CEO of HealthPartners (No. 94).



Physicians encouraged to attend intractable pain, medical cannabis meetings

State law mandates that by January 1, 2016, Health Commissioner Ed Ehlinger, MD, MSPH, must provide the Legislature with a recommendation on whether to include intractable pain as one of the qualifying conditions for patients to be eligible for medical cannabis. In an effort to hear from constituents across the state, the Office of Medical Cannabis is convening a series of community meetings through October 27. The MMA encourages physicians to attend and provide their opinions on the issue. For more information visit www.health.state.mn.us/news/pressrel/2015/cannabis082115.html.



CHANNEL YOUR PASSION

Join a committee

The MMA is seeking volunteers to serve on its policy committees.

As a committee member you

- influence the MMA's direction,
- acquire new leadership skills, and
- network with physicians who care about the same issues you do.

It is easy and only includes four evening meetings annually. If you can't make a meeting in person, you can also call in.

For specific committee assignments, go online to: www.mnmed.org/committee.

If you are interested in volunteering, send an email to mma@mnmed.org and indicate the specific committee. An MMA staff person will follow up with you.



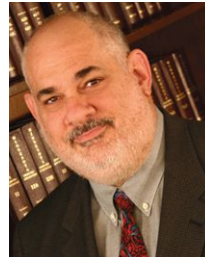
MINNESOTA
MEDICAL
ASSOCIATION



Cindy Firkins Smith, MD

MMA in Action

Past President **Cindy Firkins Smith, MD**, moderated the MMA's Resident Retreat in mid-September at the University of Minnesota, St. Paul campus.



Robert Meiches, MD

Robert Meiches, MD, MMA CEO, met with PrairieCare CEO Joel Oberstar, MD, in September at PrairieCare's new facility in Brooklyn Park.



Dave Renner

In late August, **Dave Renner**, director of state and federal legislation; **Janet Silversmith**, director of health policy; **Eric Dick**, manager of state legislative affairs; and **Dan Hauser**, director of communications, education and events, met with members of the Fix PA Now Coalition to discuss passage of a prior authorization reform bill. The coalition includes more than 40 members representing physician, pharmacist and patient groups.



Janet Silversmith

Renner and Hauser also attended a meeting of the Minnesota Health Care Access Network in St. Paul. Renner discussed the importance of passing the PA reform bill.



Eric Dick

Brian Strub, manager of physician outreach, joined leaders from the MMA's Medical Student Section in welcoming the new first-year class at Mayo Medical School on August 31 and the University of Minnesota Medical School, Duluth campus, on September 2.

Teresa Knoedler, MMA policy counsel, discussed the new medical cannabis law at the Cambridge Medical Center in Cambridge.



Dan Hauser

Kathleen Baumbach, manager of physician outreach, spoke with Twin Cities-area GME coordinators at the University of Minnesota about the transition-to-practice programs the MMA has been conducting for residents and fellows.

HOW TO BE HEARD

Got an idea that should become MMA policy? Follow these steps to get it considered.



STEP 1

Introduce your idea through one of these nine channels.

- LETTER
- EMAIL
- CALL
- WEBSITE
- SPECIALTY SOCIETIES
- COMPONENT MEDICAL SOCIETIES
- CLINIC VISITS
- LISTENING SESSIONS
- OPEN-ISSUE FORUMS

IF YOUR IDEA GENERATES INTEREST, PROCEED TO STEP 2



STEP 2

Your idea has moved forward for consideration by one of these three forums:

- POLICY COUNCIL
- STANDING COMMITTEES
- TASK FORCES

IF ONE OF THESE THREE GROUPS PASSES YOUR IDEA ON, PROCEED TO STEP 3



STEP 3

Last step! Your idea will be discussed and decided upon by the Board of Trustees.

- BOARD OF TRUSTEES

DID THE BOARD OF TRUSTEES ACCEPT IT? CONGRATULATIONS!

SUCCESS!

Your idea made it all the way through, and has become **NEW MMA POLICY**.

We need a Triple Aim for Health Equity

Our thinking about health, policy-making and the capacity of local communities must change if we are to address the wide health disparities in our state.

BY EDWARD P. EHLINGER, MD, MSPH

Although Minnesota continues to be one of the healthiest states in the nation, its ranking has slowly been falling.¹ A major factor behind its decline from No. 1 to its current rank of No. 6 is the growing disparity between the health outcomes of whites and populations of color and American Indians, populations with high and low incomes, and residents of suburban and some inner city and rural communities. These disparities are not the result of poor medical care (in fact, Minnesota's health care system was rated No. 1 by the Commonwealth Fund in its 2014 scorecard on state health performance).² Rather, they're driven by the socioeconomic circumstances in which people live.

The Institute for Health Care Improvement's (IHI) Triple Aim (the goals of which are to improve the patient experience, reduce per capita costs and improve the health of populations)³ has prompted medicine to focus more intentionally on preventive care and the role health care can play in improving the health of a population. However, with the growing understanding of the influence of the community on individual health (which is not addressed by the IHI Triple Aim), there is an evolving consensus that we need to broaden our focus and embed health care in a community-based framework. We need a Triple Aim that's equity-focused.

Policy, programming and health

We now recognize that many of the policies and systems in our state place populations of color and American Indians at a disadvantage. Whether it's housing, transportation, education, employment/wealth, broadband connectivity, the criminal jus-

tice system or environmental quality, low-income and minority populations have fewer opportunities than others. Rarely is this because of intentional discrimination; rather, it reflects a lack of awareness of how policy and programming decisions affect the most disadvantaged Minnesotans. For example, targeting educational efforts at homeowners (an efficient strategy) doesn't recognize the fact that 75.5 percent of whites but only 21.3 percent of African Americans in the state own homes.⁴ Regardless of intent, our policies and systems can contribute to differences in health outcomes.

Highlighting the effect a lack of opportunity can have on health, a report from the Robert Wood Johnson Foundation showed a 13-year difference in life expectancy between communities that are located less than three miles apart along the Twin Cities' I-94 corridor yet are very different from one another in terms of socioeconomic conditions.⁵ The Minnesota Department of Health's 2014 "White Paper on Income and Health" further documents the impact of economic conditions on the health of Minnesotans, particularly populations of color and American Indians.⁶ The authors note that being on the bottom rung of Minnesota's economic ladder leads to an average decrease in life expectancy of 8.4 years and a nearly 10-fold increase in poor/fair health days. Increases in income lead to improvements in health. This explains why the increase in Minnesota's minimum wage in 2014 was such an important public health achievement.

The health department's 2015 "White Paper on Paid Leave and Health" underscored the impact of one specific social policy on health by demonstrating that ac-

cess to paid family leave (maternity/paternity leave) leads to better health for both infants and mothers; lower rates of infant mortality and maternal depression; and higher rates of breastfeeding, immunizations and well-child checkups.⁷ In making the case for family leave, researcher Jody Heymann, MD, and colleagues wrote in a 2011 article in *Public Health Reports*, "An increase in 10 full-time-equivalent weeks of paid maternal leave has been shown to be associated with a 10 percent lower neonatal and infant mortality rate and a 9 percent lower mortality rate for children younger than 5 years of age."⁸

Similarly, paid sick leave reduces infant mortality and benefits adults and employers by increasing the use of preventive health services and decreasing occupational injuries and emergency room visits. Unfortunately, access to paid leave is disproportionately skewed toward populations that are white, have higher incomes and are educated, rather than those who need it most.⁷

Although having access to excellent medical care is critically important, only 10 to 20 percent of population health is determined by clinical care, whereas more than 40 percent is determined by social and economic factors.^{9,10} It is these social determinants (the conditions in which people are born, grow, work, live and age, and that shape daily life¹¹) that are the major contributors to Minnesota's health disparities.

A new Triple Aim

The Minnesota Department of Health is attempting to reverse the trend of growing health disparities. In collaboration with communities around the state, it has ana-

lyzed data from multiple sectors, worked on health impact assessments, partnered with agencies in the health and non-health sectors, and sought best practices from throughout the country to develop a framework for assuring health and health equity. We call this framework Healthy Minnesota 2020. As a result of this effort, we have developed a Triple Aim for Health Equity. Its focus is to:

- expand the understanding of what creates health
 - take a “health in all policies” approach, with health equity as the goal
 - strengthen the capacity of communities to create their own healthy future.
- Here’s how it should work:

Expand our understanding of what creates health. Our hope is to change the dominant narrative that health is determined mostly by medical care and personal choices. One manifestation of this belief is our nation’s current investment strategy, which allocates more than 50 percent of our total health and human services resources to health care (unique among industrialized countries)¹² and more than 95 percent of our health care resources to treatment as opposed to prevention.¹³ Without diminishing the importance of medical care and personal choice, a new narrative needs to embrace the role of community and acknowledge the impact of local, state and national policies on health. This will bring new voices into the discussion about how to create optimal health for all.

Take a “health in all policies” approach with health equity as the goal. By taking a broader view of what creates health, we can better understand how policies related to transportation, housing, education, public safety or environmental protection can affect health outcomes. However, without a focus on health equity this approach could lead to unintended consequences. For example, a public transportation initiative could trigger gentrification and exacerbate the gap between rich and poor. Similarly, paid leave only made available to full-time employees might

widen the gap between those with high and low incomes.

Strengthen communities’ capacity to create their own healthy future. We need to acknowledge that communities themselves need to be involved in creating policies and systems that improve conditions for their residents. This approach can be effective. For example, when residents of the St. Paul Midway area, which has an ethnically diverse population with a lower-than-average annual income, realized that no stops along the Green Line light-rail route were being planned for their neighborhood, they organized a community effort to demonstrate how this would affect them in terms of economics, housing, education and physical health. Because of their efforts, three stops were added to the line. The residents’ work also changed federal policy about how to evaluate public transportation projects. The initial metric used by the U.S. Department of Transportation to measure success was how long it took to get from one end of a line to the other. Now they must evaluate the impact any project has on the health and well-being of the communities along the line.

Another example is the Statewide Health Improvement Program (SHIP). With funding from SHIP, communities throughout Minnesota have developed strategies for increasing physical activity and promoting good nutrition. Those efforts have started to turn the obesity curve downward. This is in comparison with neighboring states and the entire United States, where obesity rates continue to climb.

Conclusion

The IHI Triple Aim provided an important framework for improving the health of people in the United States and prompted a new focus on preventive and population health. Yet, since its adoption, we have continued to see wide health disparities. That has been particularly true in Minnesota, where people with low incomes or members of certain groups have some of the worst health indicators in the nation while the rest of the popula-

tion enjoys some of the best. The Minnesota Department of Health is proposing that in addition to the IHI Triple Aim, the state should embrace a Triple Aim for Health Equity. Under this new framework, we would expand our understanding of what creates health, take a “health in all policies” approach with health equity as the goal and strengthen the capacity of communities to create their own healthy future. This framework will help reduce health disparities in Minnesota, advance health equity and assure optimal health for all members of our community. **MM**

Edward Ehlinger is Minnesota’s Commissioner of Health.

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The Clinician's Role in Addressing Disparities in Tobacco Use

BY ANN W. ST. CLAIRE, MPH, AND RAYMOND G. BOYLE, PHD, MPH

Although the overall smoking rate in Minnesota is now less than 15%, the rates among certain populations are much higher. For example, 60% of American Indian adults smoke. The rates are also higher for people with low incomes and little education, those who have a mental illness or are substance abusers, and those who are transgender or identify as lesbian, gay, bisexual, transgender or queer. With more people covered by health insurance and smoking-cessation treatment now included in insurance plans thanks to recent health care reforms, physicians and other members of the health care team have a new opportunity to address tobacco use. This article discusses ways they can tailor the discussion as they seek to help patients in populations with the highest smoking rates.

The prevalence of cigarette smoking in Minnesota has declined dramatically over the last two decades, falling from 22.1% in 1999 to 14.4% today. Although this reflects considerable progress, about 580,000 adult Minnesotans continue to smoke, and rates are markedly higher for certain populations.¹

Recent epidemiologic data show tobacco* use is much more common among individuals with relatively fewer years of education and lower household incomes, those with mental health and substance abuse diagnoses, American Indians, and lesbian, gay, bisexual, transgender and queer (LGBTQ) people.^{2,3} According to the 2014 Minnesota Adult Tobacco Survey, 28.6% of Minnesota adults with less than a high school education smoke, compared with 5.1% of those with a college education. In addition, 24.4% of adults earning \$35,000 a year or less smoke, compared with 8.7% of those who earn \$75,000 a year or more.¹ In another study, 57% of Minnesota adults identifying as LGBTQ were found to be smokers.⁴ Perhaps most

alarming, about 60% of American Indian adults in Minnesota currently smoke.⁵

Clearly, if we are to eliminate the harm resulting from smoking in Minnesota, we need to focus on these populations. Before doing so, however, it is important to note that these groups have a history of being underserved and discriminated against by the health care system. This presents an added layer of complexity when it comes to engaging with them. Also, clinicians should know that these groups often face the greatest challenges when trying to quit, as stressors such as poverty, underlying comorbidities, and racism, homophobia and marginalization can exacerbate the difficulties of smoking cessation.

We have new opportunities to help people in these groups. Thanks to recent changes resulting from health care reform efforts, the number of uninsured Minnesotans fell by more than 180,000—a 40.6% decline—between September 2013 and May 2014. Most of the newly insured enrolled in public insurance programs, indicating that more low-income individuals now have coverage and, thus, access to health care.⁶ Not only has the proportion of Minnesotans with health insurance

increased, but the Affordable Care Act (ACA) requires most insurance plans to provide preventive services including tobacco-cessation treatment. Federal guidance states that health plans should include coverage for at least two attempts to quit smoking each year, including use of an FDA-approved cessation medication for at least 90 days and at least four counseling visits of at least 10 minutes each.

Four Tips for Clinicians

When working with a patient who smokes, members of the health care team should look for opportunities to have conversations about tobacco use, then tailor their conversations to the individual smoker. Smoking is a complex pattern of behaviors that can be considered as a continuum. Patients can make small steps along the continuum to reach the ultimate goal of quitting. The clinician's job is to support their efforts in a culturally sensitive manner. Here we offer four ways clinicians can help their patients succeed.

Meet patients where they are

Although almost all smokers want to stop smoking and plan to do so at some time,

* In this article, tobacco use refers specifically to the use of commercial tobacco products such as cigarettes, and not to the sacred and traditional use of tobacco by American Indians and other groups.

many are reluctant to plan a quit attempt. Individuals with low incomes and those with mental illnesses are particularly reluctant to try quitting. In addition, about two-thirds (66.0%) of Minnesota smokers believe they can quit smoking without smoking-cessation medication.¹ So initially, clinicians need to work to draw out patients' interest in quitting, their beliefs about medications and strategies they have already tried in order to best encourage future attempts to quit.

It is essential that physicians and other health care providers be culturally appropriate during conversations about tobacco use. For example, we know that standard statements about quitting tobacco do not resonate with American Indians, who hold tobacco as a sacred gift to be used and honored as part of traditional practices. Within American Indian communities, "traditional tobacco use" is separate and distinct from "commercial tobacco use" such as cigarette smoking. Therefore, clinicians need to clarify that their focus is commercial tobacco use and show they still respect traditional tobacco use. (For more information on traditional tobacco use go to: <http://keptobaccosacred.org/policies> and www.epa.gov/oar/tribal/pdfs/CocoVillaluz.pdf.)

Because of possible side effects or drug interactions with medications they may already be taking, people with mental health concerns may be reluctant to try smoking-cessation medications. Therefore, a suggestion to use these medications to assist with an attempt to quit may be met with apprehension. The physician should first talk with these patients about their concerns and then work to motivate and guide them. For instance, a clinician can explain that research has shown that psychotropic medications often can be reduced when people quit smoking.^{7,8} Reducing use of these medications is highly valued by this population, and this can be a motivator.

Finally, the financial cost of smoking also can be leveraged for certain patients. Talking about the high cost of cigarettes

may resonate with smokers who have low incomes, who may be spending as much as 20% of their income on tobacco products.⁹ We know that price increases have motivated many smokers to move toward quitting.¹⁰

Tailor the treatment

Knowing that not all smokers are alike, clinicians need to assume that not all patients will follow the same treatment path. Historically, rates of using smoking-cessation medication have been lower for certain ethnic groups compared with the population overall because of a perception that these medications cause more harm than benefit. This may be changing for some groups. A recent study, for example, showed that these medications are becoming more acceptable to African Americans.¹¹ Although education about these clinically proven approaches may help overcome people's fears and dispel myths, clinicians should remain open to trying approaches other than medications.

Cutting back on smoking rather than quitting altogether may be more acceptable for individuals who have tried to quit many times without success. The idea of suggesting that tobacco users cut down was dismissed years ago because of fear that smokers would never quit. But there is new evidence to suggest this approach has merit. A recent Cochrane review, which looked at studies examining the differences in quit rates between smokers who quit abruptly and those who reduced their tobacco consumption prior to quitting, found that quit rates for the two groups were comparable.¹² The United Kingdom recently issued a new standard of care for smokers unable or unwilling to stop the use of nicotine altogether. Their approach is to offer nicotine replacement therapies and to encourage the smoker to cut down, recognizing that there are some benefits to be gained from reduced use.¹³ Providing additional support in the form of resources and medications while the patient is cutting down the number of cigarettes smoked could help them move toward their ultimate goal of abstinence from tobacco.¹⁴

Many smokers have questions about using e-cigarettes in their attempts to quit. Currently, there is limited evidence showing that e-cigarettes are helpful as a cessation aid. Mayo Clinic's Jon Ebbert, MD, provides talking points for appropriate counseling on the topic of e-cigarettes and quitting in a recent article in *Mayo Clinic Proceedings*. The article notes that e-cigarette products vary widely and are unregulated, and that more studies are needed before they can be added to the list of proven cessation aids.¹⁵

Encourage smokers to make their homes smoke-free

Studies have shown that making both public (workplaces) and private (homes and cars) places smoke-free supports smokers in their efforts to quit.¹⁶ Thus, clinicians should recommend that smokers make their homes, cars and other spaces smoke-free as they prepare to quit. In 2007, Minnesota passed the Freedom to Breathe Act prohibiting smoking in indoor public places. The vast majority of all Minnesotans (89.3%), including 61.4% of smokers, have implemented voluntary smoke-free rules in their homes.¹ However, we know that not all communities are adopting these rules. For example, only 57% of American Indians in Minnesota have smoke-free homes.⁵ In a brief discussion with patients, clinicians can share actionable ideas on ways to change behavior, including making their homes smoke-free. This will help build confidence and support patients in their future quit attempts.

Take advantage of tobacco-cessation resources available in Minnesota

Some smokers face greater barriers to quitting and have fewer resources to support their attempts to quit than others. Clinicians have several options when working with such patients. One is the use of "treatment extenders" (tobacco cessation counselors and community health workers). Last year, Minnesota added tobacco-cessation counselors to the list of providers who can deliver educational and counseling services to people enrolled in state-funded health insurance programs. ➔

As treatment extenders, tobacco-cessation counselors can seek reimbursement for services delivered to people in state programs such as Medical Assistance and MinnesotaCare. Similarly, certified community health workers can provide patient education services, including tobacco-cessation counseling. Because community health workers understand the communities in which they work, they can be particularly effective at extending the reach of health care providers in underserved communities. More information about reimbursement for cessation counseling by these treatment extenders is available in the Minnesota Health Care Programs Provider Manual.¹⁷

Other options available to Minnesota clinicians who wish to help patients quit include Minnesota's QUITPLAN Services and the Call it Quits program. QUITPLAN Services are free and available to all Minnesotans. The Call it Quits program has streamlined the referral process to smoking cessation programs.

Conclusion

Minnesota has made undeniable strides in reducing tobacco use in recent years. Dramatic declines in smoking have occurred in large part because of the state's comprehensive approach to tobacco control, which includes a strong smoke-free state law, counter-marketing media campaigns, access to cessation services and high tobacco prices.¹⁸ Despite these efforts, rates of tobacco use remain high for specific populations in the state. Physicians and their teams can play a key role in addressing these disparities if they reconsider how to talk with patients from these groups about tobacco use and then provide assistance as they attempt to quit. Tailoring treatment to the patient, recommending specific actions such as making their home smoke-free and reducing the number of cigarettes they smoke, and connecting them with resources such as QUITPLAN Services are just a few steps physicians can take to help smokers quit successfully. ■■

Ann St. Claire is senior research program manager and Raymond Boyle is director of research programs for ClearWay Minnesota.

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Smoking Cessation Resources

QUITPLAN Services

QUITPLAN Services are free and available to all Minnesotans. Services include text-messaging support, a two-week nicotine replacement therapy (NRT) starter kit, an email program and a guide to quitting tobacco use. Free telephone counseling also is provided by the QUITPLAN Helpline. With the exception of the texting program, all QUITPLAN Services are available in Spanish. QUITPLAN Services partners with the Asian Smokers' Quitline to provide phone coaching in Cantonese, Mandarin, Korean and Vietnamese. Phone coaching in more than 170 additional languages is available through interpreter services. Clinicians and patients can learn more about QUITPLAN Services at www.quitplan.com or by calling 888-354-PLAN (7526). For services in Spanish, call 855-DEJELO-YA (335-3569). For phone coaching in a language other than Spanish, call 888-354-PLAN (7526).

Call it Quits Referral Program

Clinicians can further assist their patients in quitting tobacco by participating in the Call It Quits program. Clinicians fax a standard referral form to one number for any patient interested in quitting, regardless of the patient's insurance. The appropriate health plan quitline makes the first call to the smoker. Call it Quits is a collaboration of Minnesota's major health plans and ClearWay Minnesota and is administered by the Minnesota Department of Health. For more information on the Call it Quits referral program and to register your clinic, visit www.health.state.mn.us/callitquits.

Addressing MMR Vaccine Resistance in Minnesota's Somali Community

BY LYNN BAHTA, RN, PHN, AND ASLI ASHKIR, RN, PHN, MPH

Over the past 10 years, Minnesota clinicians have noticed increased resistance to MMR vaccination among Somali Minnesotans. Misinformation about a discredited study asserting a link between the MMR vaccine and autism has permeated this community as parents have increasingly become concerned about the prevalence of autism spectrum disorder among their children. As a result, MMR vaccination rates among U.S.-born children of Somali descent are declining. This article reports findings from an investigation by the Minnesota Department of Health, which was undertaken to better understand vaccine hesitancy among Somali Minnesotans. Based on these and other findings, we propose a multi-pronged approach for increasing vaccination rates in this population.

Parents in Minnesota's Somali community have voiced concern that their children are disproportionately affected by autism spectrum disorder (ASD) compared with children of other ethnicities. Many in the community blame the MMR vaccine. In an August 2008 news story on WCCO-TV, one parent was quoted as saying, "It's the vaccines."

Shortly after the story aired, the Minnesota Department of Health reached out to members of the Somali community to gather more information. Health department staff attended meetings with Somali parents, many of whom were unfamiliar with ASD. Repeatedly, they stated that they don't even have a word for autism in their language. In telling her story, one mother reported that in their attempt to understand ASD, she and others discovered groups that supported the claim that vaccines, particularly MMR, cause autism.¹

Misinformation can spread rapidly in the Somali community, which has a rich oral tradition of passing information to one another. It is now widely accepted among Somali Minnesotans that MMR is to blame for autism.

During the 2011 measles outbreak in Hennepin County, in which 38% of the cases were among children of Somali descent, the Department of Health compared the vaccination rates of 24-month-old children of Somali descent with those of other 24-month-old children in Hennepin County and found that the rate for children of Somali descent was much lower (54.0%) compared with that for non-Somali children (88.3%).² A formal analysis showed there had been a significant decline in the MMR vaccination rate among children of Somali descent in the state since 2004, with a visible drop between the 2007 and 2008 birth cohort.² A

recent analysis of data from the Minnesota Immunization Information Connection (MIIC)—Minnesota's immunization registry—showed a continued decline. Children of Somali descent who were 24 months of age had an MMR vaccination rate of 46%; the rate among non-Somali children was 88% (Figure 1).³

In 2013, the Minnesota Department of Health set out to discover why immunization rates among Somali children continued to fall despite broad efforts to educate the community about the dangers of measles and the fact that MMR does not cause autism. Over the past two years, health department staff, including a nurse and outreach worker of Somali descent, gathered information about the attitudes and beliefs about vaccines and autism held by members of Minnesota's Somali community. Staff had conversations and meetings with Somali health professionals, commu-

nity leaders, parents of children diagnosed with ASD and parents within the broader Somali community. The purpose of this effort was to uncover information that could be useful to developing culturally relevant, effective approaches to addressing vaccine hesitancy in this population.

This article shares some of the findings and recommendations for dealing with vaccine hesitancy among Somali Minnesotans.

Findings

Minnesota Department of Health staff found that fear of autism was often the reason for parents' refusal to have their children vaccinated. Highly educated Somali Minnesotans are not exempt from this fear. As one Somali educator admitted, "My children did not get the MMR; my evidence is the Somali children I see who have autism."

Parents who cited fear of autism as the reason for their vaccine hesitancy told health department staff that they received their information mostly from other Somali Minnesotans. Being told that MMR does not cause autism was not satisfactory for many parents because no one could tell them what *does* cause autism. Yet, when asked whom they would trust for health information, nearly all said they trusted their health care provider. And a significant number who refused vaccinations said they would reconsider their decision if they were given more information.

Parents of children diagnosed with ASD were articulate about their belief in an association between MMR and autism and sometimes also implicated receipt of multiple vaccines as the cause of their child's autism. Some Somali parents have come to realize that autism and vaccines are unrelated, but they are in the minority.

Parents who are less familiar with ASD also had less knowledge about vaccines. Many would say, "I vaccinate, except for the triple-letter vaccine." When asked if they knew what the three letters actually were or what diseases were prevented by the "triple-letter vaccine," only some were able to answer. Recently, some parents said that they stopped taking their children to

their clinic after the first well-child visit because they weren't sure when the baby would get the "triple-letter vaccine."

In addition, health department staff sought to find out what parents do understand about ASD and its signs and symptoms. Many parents could not describe autism except to say that their child stopped talking. The importance of observing the development of a baby is an unfamiliar concept to most Somali Minnesotans, who think a healthy baby is one who is eating well and gaining weight. Parents are not prepared for the questions physicians and other health care providers ask about development and may answer positively when asked if they have observed a specific behavior even though they may not understand the question or have witnessed the behavior. Additionally, Somali health care providers said we should stop saying, "We don't know the cause of autism" and instead discuss what is known about its causes and the immense amount of research that is occurring in this area.

Somali Minnesotan parents are strongly influenced by their community, and there is both a lack of information and an abundance of misinformation about vaccines and ASD within the community. Regardless of whether parents have more or less familiarity with the issue, they perceive autism as a greater threat to their child than measles and are basing their decisions about vaccination on that perception. Yet, because Somali Minnesotans hold health care professionals in high esteem, they are open to learning from physicians and other clinicians.

Strategies for Working with Parents

Using information gleaned from conversations with members of Minnesota's Somali community, we developed strategies for addressing the problem of low MMR vaccination rates in children of Somali descent. They include holding informational sessions about child growth and development, as well as about autism and vaccine-preventable diseases for parents, interpreters and spiritual leaders; and keeping local health departments and health care

providers updated regarding what they are learning. Already, there has been outreach through charter schools and child care centers aimed at increasing awareness of Somali children's growing vulnerability to preventable diseases.

Finding ways to leverage the respect Somalis have for doctors and other health care professionals is challenging. In studies examining how clinicians can provide effective care to Somali patients, building trust has been identified as important.^{4,5} Two things that contribute to trust that are repeatedly cited in the literature are the availability of a competent interpreter and not feeling rushed by the clinician.⁴⁻⁷ Clinic policies such as ensuring that a professional interpreter is available, adding time to appointments when interpreters are needed, and consistently scheduling families with the same clinician can support efforts to build trusting relationships with Somali patients.

The Minnesota Department of Health's Somali staff members report that Somali parents appreciate when a health care provider calls a baby by his or her name and is familiar with some Somali words. They also want clear direction from their physicians. Providing parents with options may confuse them. A statement such as, "We can give your child the vaccine today, or if you want, we can wait," may be perceived by the parent as meaning that the clinician also has reservations about vaccines or thinks that either choice is acceptable. One Somali interpreter described an interaction this way: "When the mother told the doctor that she did not want her child to get the triple-letter vaccine, the doctor said, 'OK.'" The interpreter was worried that the parent thought the doctor agreed that the MMR vaccine wasn't needed or that he, too, was worried about its effects.

There are a number of evidence-based approaches to addressing vaccine hesitancy. Studies show parents prefer to get vaccination information before their visit with the doctor.⁸ A small study by Williams et al. suggests that a brief discussion about vaccines during the two-week well-child visit improved parents' attitudes about vaccines.⁹ In Burke's work, Somali

parents acknowledged the importance of vaccinating infants but wanted to understand why their babies were receiving so many vaccines.⁶

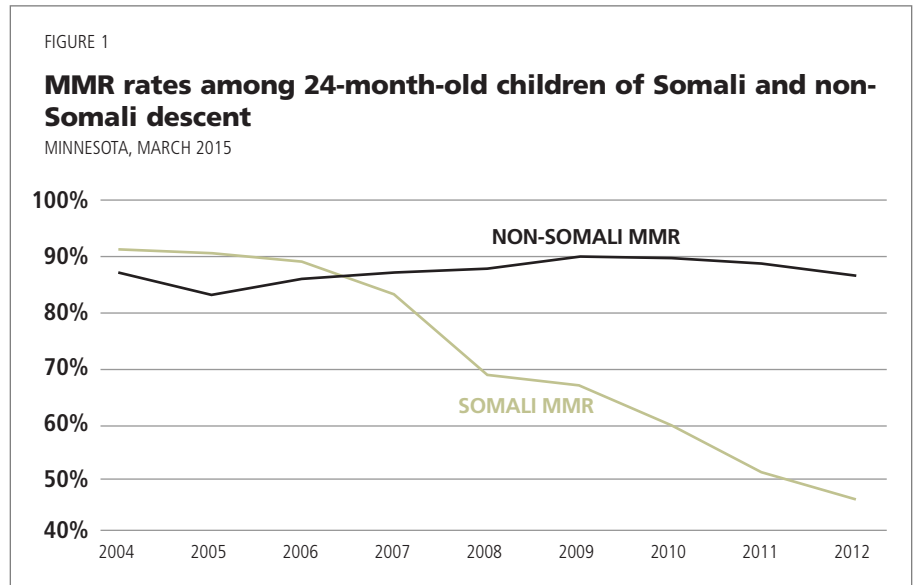
Considering this, we propose explaining vaccines using a pictorial tool that shows when certain vaccines are due (Figure 2). The idea is to start the MMR conversation at the 6- or 9-month visit. This may ease the parent into allowing their child to receive timely vaccinations. It also provides the opportunity to invite the other parent to the 12-month visit for further conversation and decision-making, if the one parent is hesitant about MMR vaccination.

Opel's work highlights the importance of pursuing the recommendation when a parent indicates hesitancy or resistance.¹⁰ When a parent is refusing the MMR vaccine, clinicians can follow up by asking:

- What triple-letter vaccine do you mean?
- Tell me your concern about this.
- What have you heard about this?
- What do you know about autism?

A professional interpreter can facilitate the relationship between clinician and patient/parent. Expectations about the ethical and professional behavior of interpreters working in the exam room are clearly defined, but their influence may extend beyond the exam room. Some interpreters may be put into the position of advising. In particular, they may be asked if they gave their child the MMR vaccine. It may be helpful to ask the interpreter about his or her understanding of autism and developmental milestones as well as his or her beliefs about vaccines and any concerns he or she may have about them, and to provide training where gaps are identified. Having interpreters share correct information outside the exam room can be a powerful extension of the health care provider's influence.

In our pilot informational sessions, parents who changed their mind about MMR vaccination asked if it was too late for their child to receive it. This is a reminder to assess for vaccinations at every visit and to continue to offer the MMR vaccine even when parents initially refuse it, letting them know that "it's not too late." Doing this illustrates the importance of the MMR



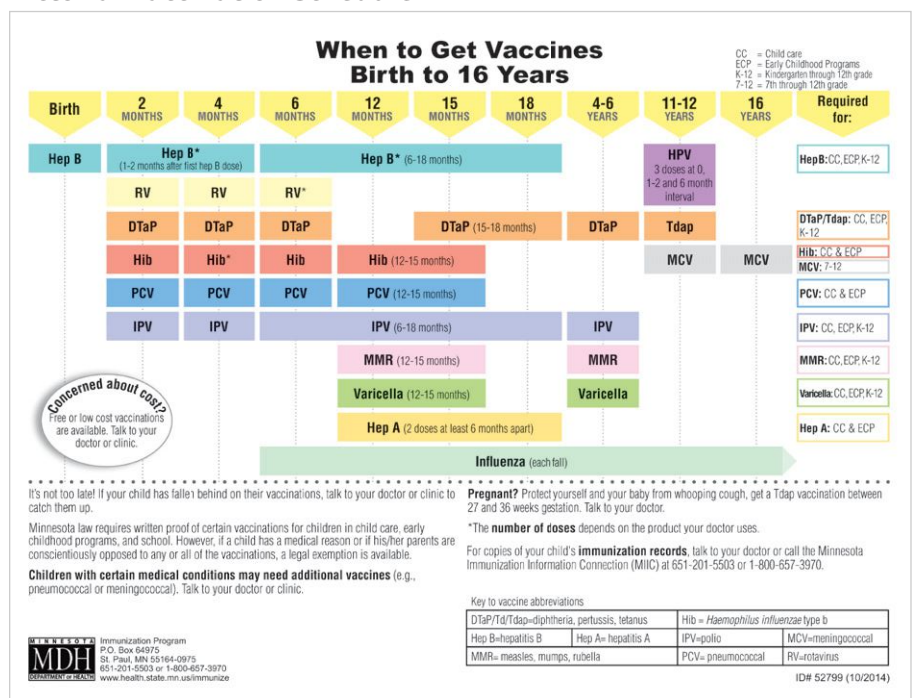
vaccination and the clinician's continued concern about the child's vulnerability to a dangerous disease.

Conclusion

For the last two years, Minnesota Department of Health staff have been seeking ways to address the low MMR vaccination rate among children in Minnesota's Somali community. Staff members have had conversations with parents, interpreters,

educators and community leaders about the issue. Insights gleaned from these conversations have helped guide clinicians as they attempt to educate parents about the safety and efficacy of vaccinating their children. Perhaps the most important points to remember are to never stop inquiring about patients' vaccine status and to take time to address a parent's concerns. Although Somali Minnesotans are influ-

FIGURE 2
Pictorial vaccination schedule



This schedule is available at: www.health.state.mn.us/immunize

enced by their friends and family when it comes to information about the MMR vaccine, they respect advice from their physicians and other health care providers. Therefore, clinicians have an important role to play in helping ensure that Minnesota children aren't at risk for preventable diseases. MM

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The Unequal Burden of Suicide among Minnesotans

Three Strategies for Prevention

BY NATE WRIGHT, MPH, JON ROESLER, MS, AND MELISSA HEINEN, BSN, MPH

Minnesota's suicide rate has been increasing for more than 10 years. This article describes the demographic groups at highest risk for suicide and suicide attempts in the state. It also highlights prevention strategies outlined in the Minnesota State Suicide Prevention Plan 2015–2020.

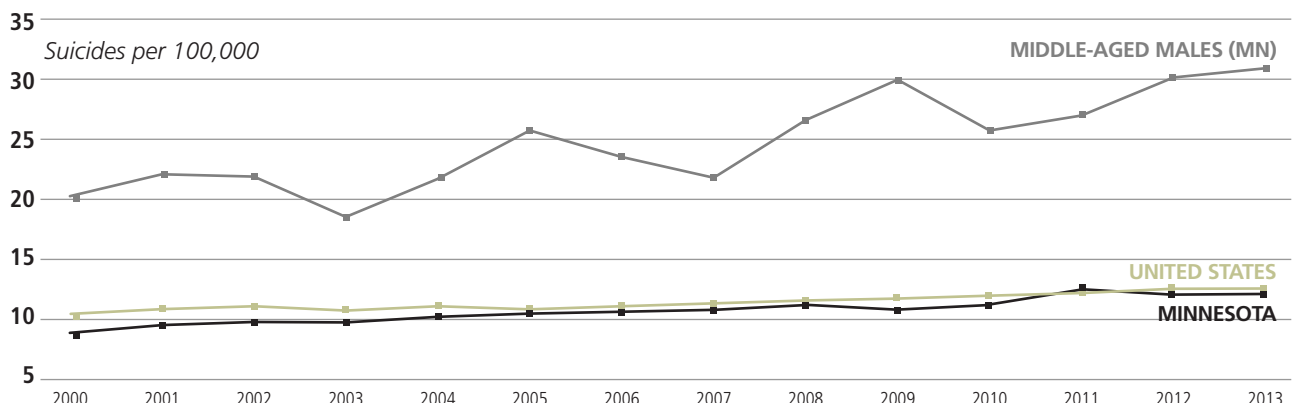
The suicide rate has been rising for more than a decade (Figure 1). In 2000, the rate was 8.9 per 100,000 population in Minnesota. By 2014, the last year for which data are available, the rate was 12.5 per 100,000 people.¹ It has long been noted that certain populations experience a disproportionate burden when it

comes to suicide. One of those is middle-aged men. In 2013, males 45 to 54 years of age had the highest rate of suicide in the state (31.1 per 100,000). During the past decade, the suicide rate among middle-aged males has increased faster than the overall suicide rate in Minnesota (Figure 1). Significant disparities in suicide rates are

also seen across races. Between 2009 and 2013, American Indians 10 to 24 years of age had a significantly higher rate of suicide than young people from other racial and ethnic groups (28.0 per 100,000 compared with 8.8 per 100,000 white youths, 7.6 per 100,000 Black/African-American

FIGURE 1

Suicide rates—United States, Minnesota, middle-aged males in Minnesota



youths, and 6.7 per 100,000 Asian/Pacific Islander youths) (Figure 2).

Disparities are seen not only in suicide rates, but also in hospital-treated self-inflicted injuries. In 2013, females of all ages were more likely than males to attempt suicide and seek hospital treatment for a non-fatal self-inflicted injury. The age-adjusted rate for females was 169.9 per 100,000, while the rate for males was 99.6 per 100,000. Females 15 to 19 years of age had the greatest burden of hospital-treated self-inflicted injuries, with a rate of 587.7 per 100,000 (Figure 3). These data show a worrisome trend, and a need for further resources and support directed toward the populations at greatest risk for suicidal thoughts and behaviors.

In order to address the larger public health concern of suicide in Minnesota, and to address the suicide and self-inflicted injury rates in those groups at highest risk, the Minnesota Department of Health and the Minnesota State Suicide Prevention Task Force have created a five-year suicide prevention plan for the state. The Minnesota State Suicide Prevention Plan 2015–2020 calls for a comprehensive public health approach to promoting health and wellness in our communities, and to reducing suicide in Minnesota by 10% in the next five years and 20% in the next 10 years, with the ultimate goal of zero deaths from suicide.² The plan, which is being implemented across the state, outlines a significant role for physicians. The following are highlighted prevention strategies that involve physicians.

1. Reduce Access to Lethal Means

One of the plan's objectives is to ensure physicians and other health care providers routinely assess for access to lethal means (eg, medicines/

poisons, keys, sharp objects, firearms, materials used in hangings or suffocation, etc.) when caring for individuals at risk for suicide. Reducing access to lethal means not only decreases the likelihood that a

safety counseling to patients and families, with safe storage of firearms an important component.³ Physicians should know that Minnesota is one of only 18 states with a law requiring safe storage of firearms. Fur-

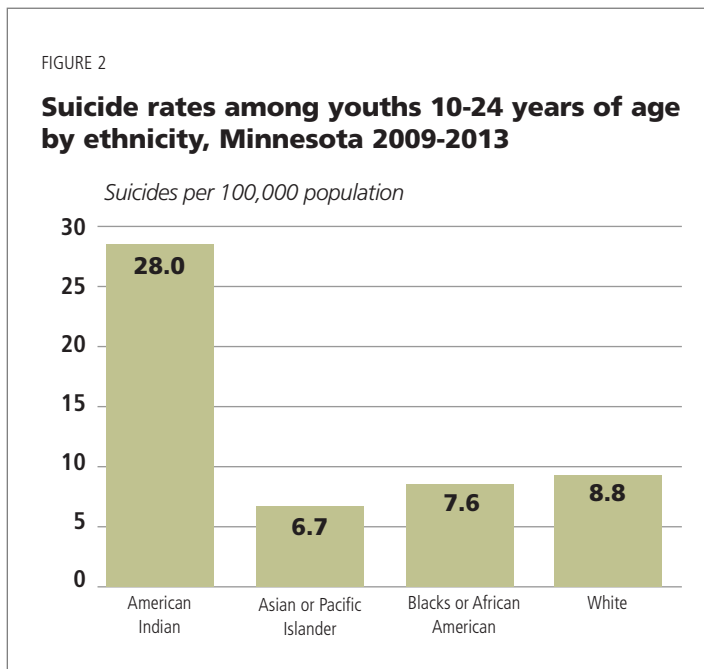
thermore, the AAP's revised preventive care guidelines advise parents of children who are diagnosed with depression and at risk for suicide to remove any firearms and ammunition from their home.³ The Suicide Prevention Resource Center offers Counseling on Access to Lethal Means (CALM) training, an online course for medical and mental health professionals that includes practical advice on when and how to ask suicidal clients about their access to lethal means.⁴

2. Increase Depression Screenings

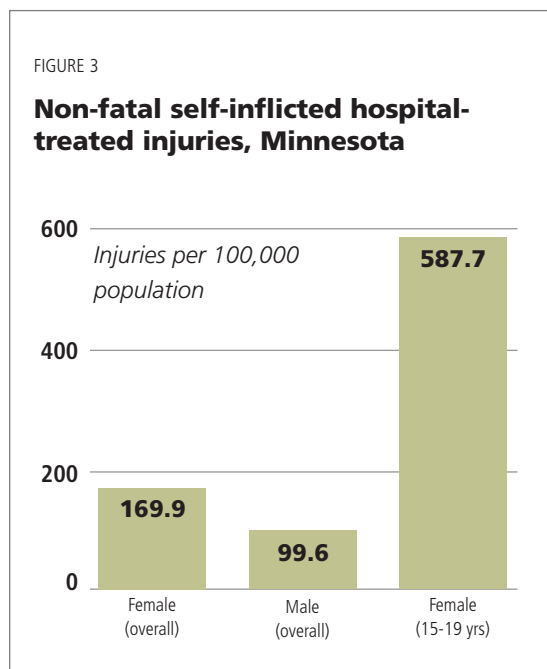
Another goal of the state's suicide prevention plan is to promote suicide prevention as part of routine health care. Physicians can do this by regularly screening patients for depression. The AAP recommends that all children 11 to 21 years of age be screened for depression as part of their annual physical using the Patient Health Questionnaire (PHQ-2) or other tools available in the Guidelines for Adolescent Depression in the Primary Care toolkit (GLAD-PC toolkit). Similarly, the U.S. Preventive Services Task Force (USPSTF) encourages primary care physicians to screen all adult patients for depression and offers recommendations about specific screening tools on its website.⁵ Screening for depression is the first step toward promoting timely access to high-quality culturally appropriate services for persons at heightened risk for suicide.

3. Promote Follow Up and Continuity of Care

Developing and implementing protocols to ensure rapid and continu-



person with suicidal ideation will engage in suicidal behavior but also decreases the possibility of injury and unintentional overdose. In 2012, the American Academy of Pediatrics (AAP), in an effort to prevent gun-related deaths and injuries, recommended that pediatricians provide firearm



ous follow up after a hospitalization for a non-fatal self-inflicted injury is another method through which physicians can improve outcomes for those at increased risk of suicide. When possible, first follow-up appointments should be scheduled before the patient is discharged. Ideally, the appointment should take place 24 to 72 hours after discharge. Patients should also receive contact information for the National Suicide Prevention Lifeline as well as for local mobile crisis teams.⁶

Leaders from the Minnesota Department of Health and Beltrami County who participated in a 2007 suicide-prevention task force have proposed a framework for follow-up care for suicidal behavior.⁷ It includes phone calls from physicians and other health care providers to families and youths to help them solve problems, identifying resources for recovery, and connecting youths and families to existing programs for support after discharge from the hospital.⁷ This framework is based on an existing program for patients hospitalized with traumatic brain injury and can be customized for specific cultures and communities.

Physicians also can promote continuity when transferring care of a patient at risk for suicide from one provider to another. Continuity of care ensures smooth and

uninterrupted care for the patient, as well as the sharing of essential clinical information. Encouraging continuity of care allows for better, more coordinated treatment and improved long-term outcomes.⁸

Conclusion

A combination of factors, including serious mental illness, physical illness, alcohol or other substance abuse, a painful loss, exposure to violence, social isolation and easy access to lethal means, increase a person's risk for suicidal thoughts and behaviors. Yet, much can be done to reduce the chance that an individual will act on those thoughts. Physicians, along with family members, peers and others, have a role to play in preventing suicide. By implementing the interventions outlined in Minnesota's suicide prevention plan and targeting those groups at highest risk (ie, middle-aged males, American Indian youths and young women), physicians can help to significantly reduce the suicide and suicide attempt rates in the state. **MM**

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Resources

American Academy of Pediatrics – Safe Storage of Firearms
www.aap.org/en-us/advocacy-and-policy/state-advocacy/Pages/State-Advocacy.aspx

Suicide Prevention Resource Center. Counseling on Access to Lethal Means (CALM) Training
<http://training.sprc.org/>

American Academy of Pediatrics. 2014 Recommendations for Pediatric Preventive Health Care, with Screening for Depression as Part of Annual Physical Checkup
<http://pediatrics.aappublications.org/content/133/3/568>

Metro Children's Crisis Response Services. Immediate help for youth experiencing a mental health crisis
www.childcrisisresponsemn.org

Continuity of Care for Suicide Prevention: The Role of Emergency Departments

www.sprc.org/sites/sprc.org/files/library/ContinuityCare_Suicide_Prevention_ED.pdf

National Suicide Prevention Lifeline

www.suicidepreventionlifeline.org
800-273-8255

Minnesota Department of Health – Injury and Violence Prevention Unit

www.health.state.mn.us/injury

Health Disparities between Rural and Urban Women in Minnesota

BY KIM TJADEN, MD

With much discussion about health disparities in Minnesota in recent years, there has been growing awareness about the inequities between rich and poor and between majority and minority groups. Attention also needs to be paid to the disparities between women who live in rural areas and those who live in urban parts of the state. Rural women are poorer, older and less likely to have adequate health insurance than their urban counterparts, which can compromise their health status. They also fare worse on a number of health indicators and face barriers to adequate health care that can exacerbate disparities. This article describes the root causes of health disparities between women living in rural and urban parts of the state and explores strategies to mitigate them that include increasing the rural physician workforce, improving access to primary and specialty care through telehealth services, and expanding health insurance options.

In the United States, women face poorer health outcomes and have a greater incidence of illness than men. Heart disease and stroke, for example, are responsible for a greater percentage of deaths in women than men. In addition, women are more likely than men to suffer the physical and emotional limitations of chronic disease.¹ Disparities also exist between women in rural* and urban areas. Contributing to those disparities are the facts that women living in rural areas have access to fewer health care providers and have higher levels of poverty than women in urban areas. Women in rural areas also have less education, more transportation challenges and lower levels of adequate health insurance coverage than women living in urban areas.¹ Poor health in women affects more than just individuals. It often translates into poor health for families, as women are frequently the ones who are responsible for making sure their family members

receive needed care.² This article examines some of the reasons why women living in rural parts of Minnesota have poorer health indicators than women in urban parts of the state and offers suggestions for eliminating health disparities between these two groups.

Women in Rural Minnesota

Demographics

According to Women's Health USA 2013, 16.7% of all women in the United States reside in rural areas.³ The mean age of women living in rural parts of the country is 50 years compared with 46 years for those living in urban areas.³ In Minnesota, 18% of women in rural areas are age 65 and older, compared with 12% of women in urban areas.⁴ In addition, women living in rural Minnesota are less ethnically diverse than women living in the state's urban communities.⁴

Women in rural areas also are less affluent than their urban counterparts. Women's Health 2013 found 18% of women in rural parts of the United States live below the poverty threshold compared with 15% of women in urban areas.³ In Minnesota,

the household poverty rate for women over age 18 is 9.7%, while the poverty rate for males over 18 is just 7.1%.⁵ Twelve percent of women in rural Minnesota live below the poverty line, while only 10% of women in the state's urban areas do so.⁴ In addition, 33% of rural women in the state live below 200% of the poverty line compared with 22% of urban Minnesota women.⁴

Men and women in rural Minnesota are also less likely to have at least some college education than those living in metro areas (just over 50% in rural regions compared with 67% statewide).⁶ Although rural women have similar high school graduation rates to those of their urban counterparts, they have lower college graduation rates. In 2006, the high school graduation rates for rural and urban Minnesota women were 94.3% and 94.9%, respectively, while their respective college graduation rates were 25% and 40%.⁴

Health indicators

Women living in rural areas fare worse than those in urban areas on a number of health indicators. The greatest differences

* For the purposes of this article, rural is defined as the population living outside of a metropolitan area of 50,000 people. It is further defined as large rural, small rural and isolated rural based on the distance to a major town or city.

can be seen in terms of cervical cancer, sexually transmitted infections and teen pregnancy.⁷ Cervical cancer is quite rare in Minnesota, but rural women have a 30% higher risk of being diagnosed with invasive disease than urban women. Sexually transmitted infections (STIs) are increasingly diagnosed among women in rural Minnesota.⁷ Although STI rates are higher in metro areas, the rate of increase has been higher in rural areas. For example, the rates of chlamydia and gonorrhea among women in rural parts of the state increased 10% and 14%, respectively, in 2008.⁷ Rural areas experience higher-than-average teen pregnancy rates. In 2010, the teen birth rate in rural counties in the United States was nearly one-third higher than in the rest of the country (43 versus 33 births per 1,000 females 15 to 19 years of age).⁸ In Minnesota, 43 counties have teen birth rates higher than the state average of 16.8 live births per 1,000 females 15 to 19 years of age, with the highest rates being in the most rural counties (Mahnomens, 64.7; Cass, 40.1; and Pennington, 39.8 per 1,000).⁹

In addition, women in rural areas have higher rates of obesity, cancer, heart disease and diabetes than women in urban areas.¹⁰ In Minnesota, 28% of rural women are obese compared with 21% of urban women. Furthermore, this percentage has increased since 2004, when 23% of rural and 20% of urban women in the state were obese.⁶ Mortality or death rates from heart disease and diabetes are significantly lower among individuals living in Minnesota's urban communities than in its rural areas.⁶

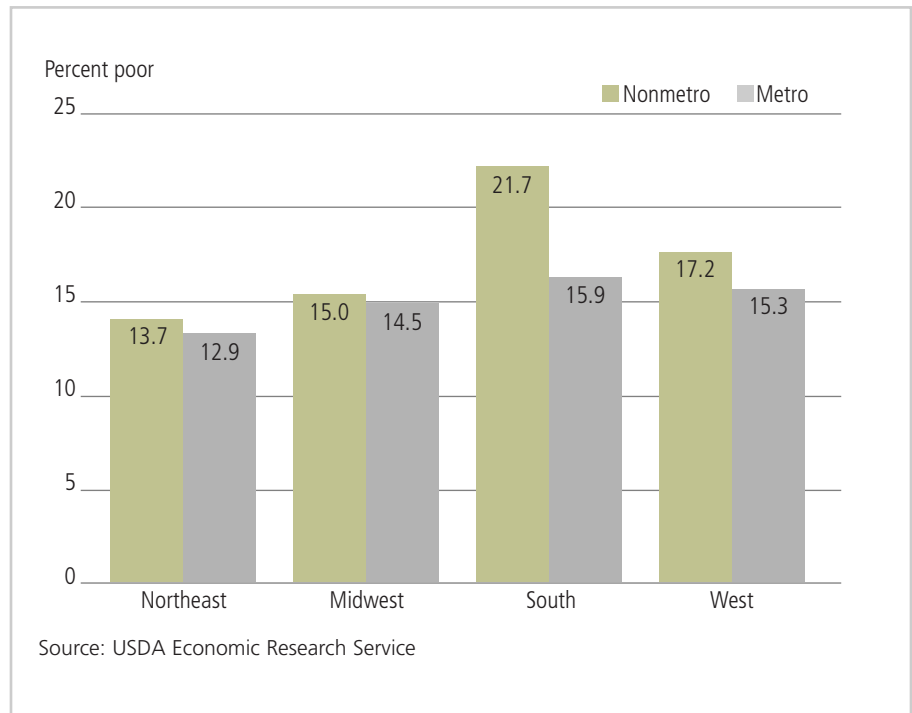
Root Causes of Health Disparities

Poverty

Nationwide, nonmetro areas have higher rates of poverty than metro areas (Figure). In Minnesota, 27% of people in rural areas live in poverty, which is defined as having an income lower than the federal guideline (\$24,250 for a family of four in 2015), as opposed to 12% in metropolitan areas.¹¹ Reasons for this include a lack of high-paying jobs in rural areas, a population with less education, and a prevalence of part-time or seasonal agricultural jobs. In

FIGURE

Poverty rates by region and metro/nonmetro status—United States, 2009-13



addition, people in rural areas tend to pay more for goods and services than people in urban areas.¹¹

In general, women are more likely than men to be poor, and households headed by single women are more likely to be poor than those headed by men.² Lack of financial stability negatively affects access to health services and decreases health status. People who live in poverty have a higher incidence of chronic diseases, including mental illnesses such as depression and anxiety.¹² Additionally, poor women in rural Minnesota have higher rates of tobacco and substance use than their urban counterparts, contributing to poorer overall health.⁶

Lack of access to health care

Rural areas have fewer physicians per population than urban areas, making access to care a challenge for individuals living in rural parts of the state. A Minnesota Department of Health summary found isolated rural parts of Minnesota have only one primary care physician for every 3,191 residents, whereas urban areas have one for every 1,098 residents.¹³ In

addition, data from a Minnesota Office of Rural Health and Primary Care workforce survey show a 48% decline in physicians providing obstetrical care in rural areas between 2003 and 2007.⁷

The future does not bode well, as it is difficult to attract young physicians to work in rural areas. This may be because there are fewer primary care residency positions in rural communities and because positions pay more in urban areas.¹⁴ Adding to these challenges is the fact that the primary care workforce in rural Minnesota is older than that in metropolitan areas. In isolated rural parts of the state, 51% of the physicians are older than 55 years of age; in urban areas only 34% are 55 or older.¹⁵

Other factors expected to make it more difficult to access care in the future are the aging of the population and the increase in the number of people covered by insurance, both of which increase demand for services. It is estimated that Minnesota will need 1,187 primary care physicians in addition to its current 4,215 by the year 2030.¹⁴

The shortage of physicians in rural areas affects women in a number of ways. For example, having fewer doctors providing obstetrical care in rural areas results in decreased access to prenatal care, which leads to poor maternal and infant outcomes.⁷ It also forces women to travel greater distances for pregnancy care.

Inadequate health insurance

Lack of or inadequate health insurance coverage are additional barriers to care faced by women in rural areas.¹⁶ Rural women who hold low-paying agricultural jobs or who only have part-time employment are less likely to have employer-sponsored health insurance.¹⁷ Those who purchase coverage on their own often have higher copayments, larger deductibles and higher premiums than those who receive coverage through their employer.¹⁸ These higher out-of-pocket expenses cause many women to forgo preventive health screenings¹⁶ as well as ongoing care for chronic conditions such as diabetes, hypertension, depression and anxiety.¹ It has been shown that individuals with insurance are more likely than those without it to establish and maintain a relationship with a primary care provider, which decreases costs and improves health outcomes.¹⁷

Recommendations

The following may help reduce, if not eliminate, the health disparities between women in rural and urban parts of the state.

Expand the rural health care workforce

In order to increase the number of rural primary care physicians, medical and premed students must be exposed to primary care practices in rural communities. Efforts must be made to provide more experiences such as that offered through the Rural Physician Associate Program (RPAP) at the University of Minnesota Medical School, through which third-year medical students spend nine months living and training in rural Minnesota settings.¹⁹ A similar program should be created to

expose undergraduate premedical students to the benefits of rural medical practice.

Because medical school debt is one reason graduates choose higher-paying nonprimary care specialties, we need more loan-repayment programs for those entering primary care in rural areas.²⁰ In 2015, the Minnesota Legislature voted to increase funding by \$5.2 million for loan forgiveness programs in 2016 and 2017 for physicians and other health care providers who serve in rural and underserved urban settings. Lawmakers also allocated \$1.5 million for additional residency slots and included funding to better utilize the skills of foreign-trained immigrant physicians in hope of increasing the primary care workforce.²¹ These are good first steps, but the burden of medical school debt is greater now than ever. We also need to promote real payment reform at the national and state level to bring primary care salaries in line with those for specialty care, which would encourage more medical students to pursue primary care careers.²²

In addition, we need to increase efforts to promote job satisfaction among doctors who currently practice rural medicine so that they will be less likely to retire early or leave their practices. One way to do that is to decrease paperwork and other administrative burdens that consume their time. Another is to allow physician extenders such as nurse practitioners and physician assistants to do as much as they are allowed to do within the scope of their licensure so physicians can concentrate on their more challenging cases.

Improve access to care through telehealth services

Electronic or virtual medical visits (e-visits) can be used in conjunction with office visits for monitoring chronic conditions such as diabetes and high blood pressure as well as addressing straightforward acute issues such as sinus infections. E-visits also would be extremely effective for contraceptive counseling and reproductive care for younger women who may not have access to such services in their com-

munities. Using telehealth technologies in this way would enable women with complicated pregnancies to remain at home longer and avoid having to travel to a city for late-term pregnancy care. Electronic consultations also could be used to provide specialty care in rural areas where specialists are not as available as they are in urban areas. A number of barriers limit the use of such consultations. For one thing, they are poorly reimbursed by insurance companies. In addition, many rural areas lack broadband Internet service, and hospitals and clinics do not have the technical infrastructure needed to engage in such activities.²³ Better payment models for telehealth services and expanded Internet capabilities in rural areas would greatly improve access to care, thereby decreasing disparities.

Expand health insurance options to women in rural Minnesota

One of the goals of the Affordable Care Act (ACA) is to reduce the number of uninsured people in the United States. Under the ACA, states could expand access to Medicaid to individuals with incomes less than 138% of the federal poverty level.²⁴ Minnesota was one of the states that expanded access to Medicaid. As a result, the number of people who were uninsured declined by 40.6% during the first year of implementation.²⁵ In addition, individuals and families with incomes between 100% and 400% of the federal poverty level who purchase private coverage through an insurance exchange now receive tax credits. About 75% of rural residents in the state who were once without insurance are now eligible to receive coverage through one of these options.²⁵ Although data on the numbers of rural women who are still uninsured and underinsured are not yet available, we know that not all have coverage. Anecdotally, we now know that many individuals who gained health insurance through the ACA have been unable to pay the high deductibles and copays associated with the lower-cost products, leading to delays in care.

Conclusion

Public health officials, rural physicians and rural community leaders must all work together if we are to improve the health status of women in rural Minnesota. Achieving health equity among rural and urban women is important to improving the health of the state's population in general and to controlling rising health care costs. Bringing awareness to the problem of health disparities between rural and urban women in the state is the first step toward solving the problem. With the continued hard work on the part of the public health and medical communities, health equity is attainable for women in rural parts of the state. **MM**

Kim Tjaden is a family physician practicing in St. Cloud. She is currently pursuing a master's in public health at the University of Minnesota.

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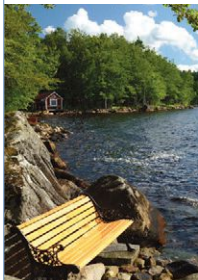
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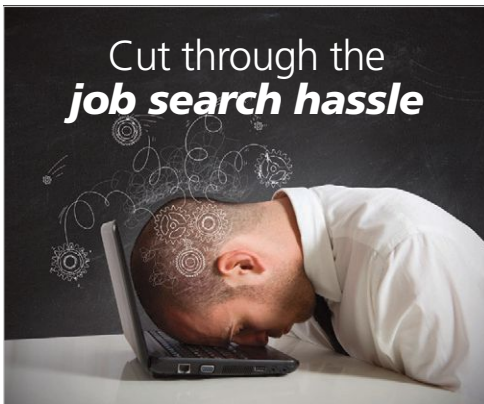


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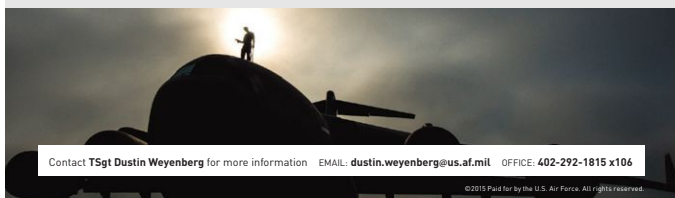
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Flight

BY ANDREA WESTBY, MD

I close my eyes
Try to slow my breath
My heart beating so hard,
I feel it move from my chest
into my neck
My hands trembling,
I try to steady them as I put my cold stethoscope
to his gray glistening chest

“It’s going to be OK, the flight will be here soon”
I hear my voice,
shaking

But I am not sure it will be OK
Praying that they will arrive in time,
that his fight will last

His eyes meet mine
and I can see and feel his fear
As I hope he cannot see and feel mine

Helpless, unable to provide the treatment he needs
My warm dry hand meets his cool damp one
and I squeeze gently

It’s going to be OK, the flight will be here soon
If only to fool myself



PHOTO BY THRUJIM PHOTOGRAPHY

Andrea Westby is a family physician with Perham Health in Perham, Minnesota. She wrote this after a patient encounter she had while working in the emergency room. “Our referral center is approximately a 30-minute flight or 50- to 60-minute ambulance ride away, and this man presented with chest pain, which I suspected was caused by a re-occluded coronary vessel after a recent bypass. Moments like this one, feeling helpless as I did, stay with me.”



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