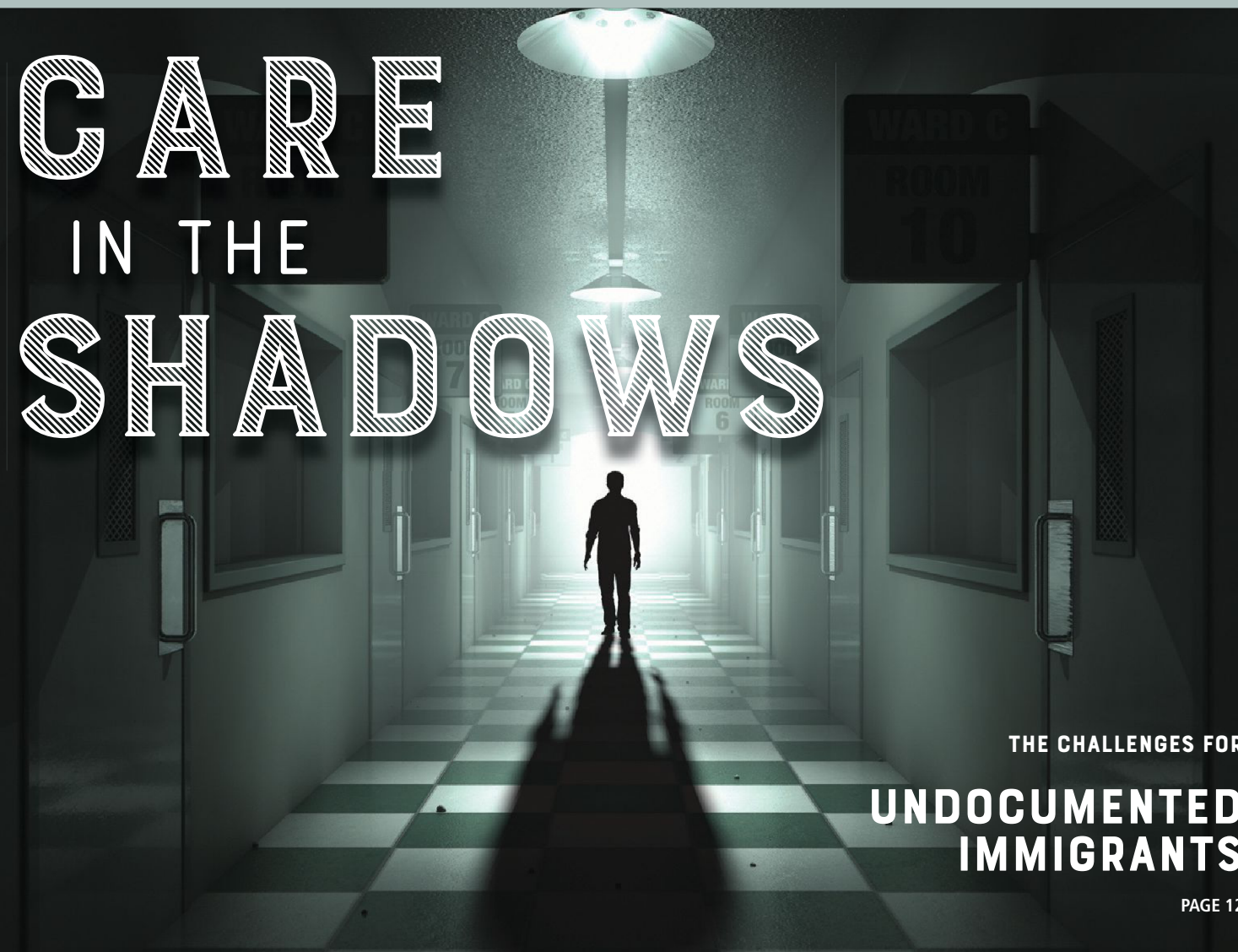


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CARE IN THE SHADOWS



THE CHALLENGES FOR
**UNDOCUMENTED
IMMIGRANTS**

PAGE 12

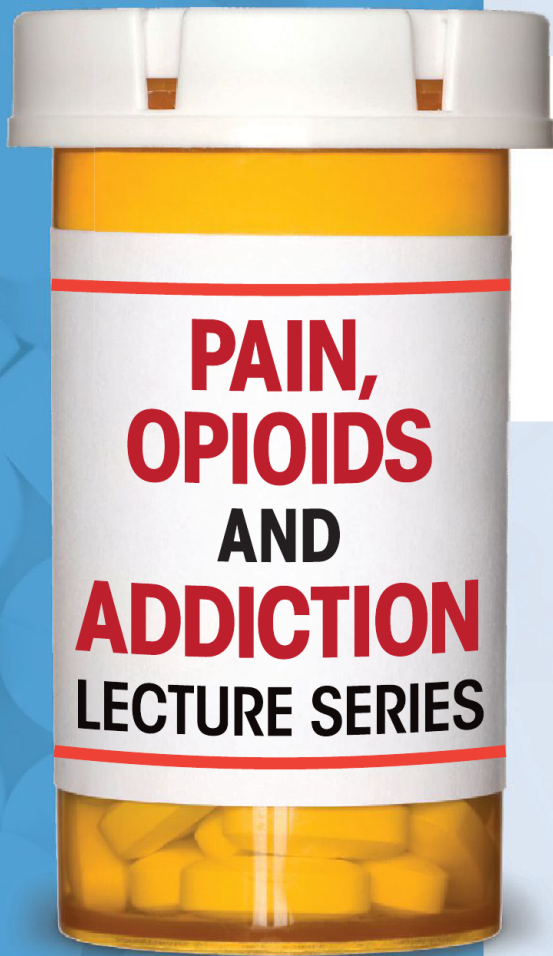
Medical needs in **SYRIA** PAGE 8

A glimpse at **HEALTH CARE IN CUBA** PAGE 16

MACRA: What to expect in 2017 PAGE 32






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CONTENTS

Jan/Feb 2017 | VOLUME 100 | ISSUE 1

FEATURES

ON THE COVER

12 Care in the shadows

The challenges for undocumented immigrants

BY CARMEN PEOTA

PERSPECTIVE

16 Informed dissent?

A glimpse at health care in Cuba

BY CARRIE ANN TERRELL, MD, FACOG

20 Living in the moment

A young father learns to let go of fear and embrace life.

BY SEAN SCHULZ, DO

BOOK REVIEW

22 Tales of people displaced

Two books shed light on the plight of Somali and Syrian refugees.

REVIEW BY CHARLES MEYER, MD

Clinical AND Health Affairs

32 A Look at MACRA: What to Expect in 2017

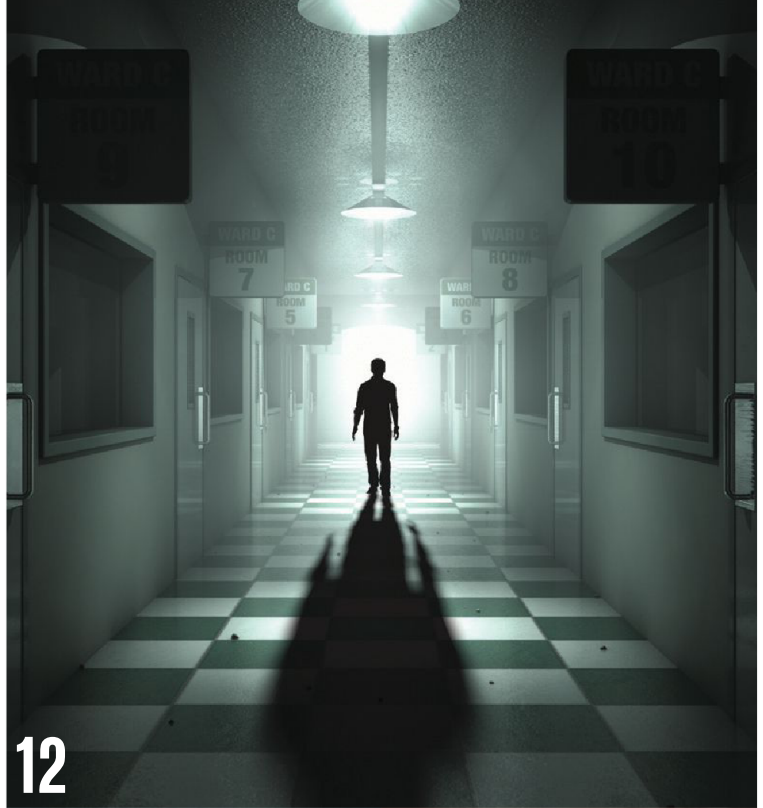
BY JANET SILVERSMITH

35 Raising the Minimum Legal Sale Age for Tobacco to 21: The Estimated Effect for Minnesota

BY RAYMOND G. BOYLE, PHD, JOHN H. KINGSBURY, PHD, AND MICHAEL J. PARKS, PHD

38 The Burden on Dementia Caregivers: How Can Communities and Health Care Organizations Help?

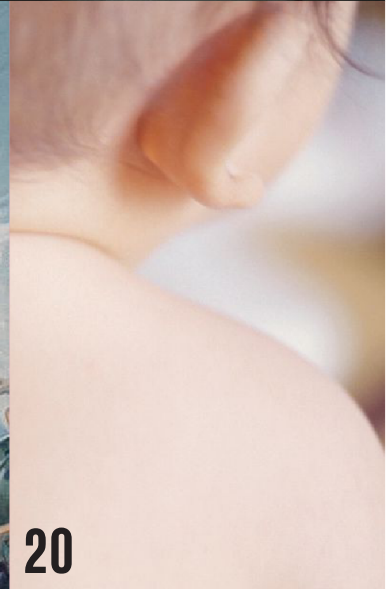
BY RACHEL D. HAVYER, MD, LAUREN R. BANGERTER, PHD, ANGELA M. LUNDE, MA, MICHELLE VAN RYN, PHD, AND JOAN M. GRIFFIN, PHD



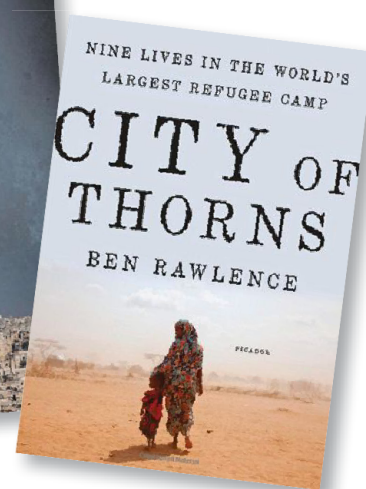
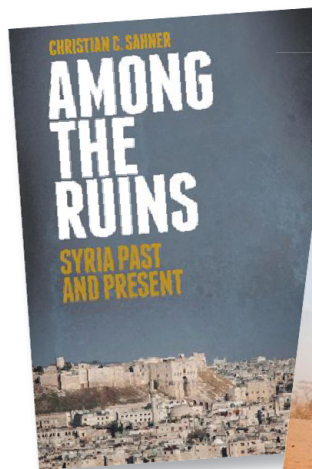
12



16



20



22

DEPARTMENTS

4 EDITOR'S NOTE

When the world comes to us

5 LETTERS

6 SHORT TAKES

Downtime: Magical thinker Michael Pitt, MD
Conversations: Aref Al-Kali, MD, on the needs in Syria
Update: New path to practice for immigrant physicians

27 THE PHYSICIAN ADVOCATE

The MMA's 2017 legislative priorities, board and committee news, MMA staff and leaders in action

40 EMPLOYMENT OPPORTUNITIES

COMMENTARY

24 Structural Racism and Supporting Black Lives: The Role of Health Professionals

Clinicians and researchers need to recognize the systems-level factors that contribute to health disparities.

BY RACHEL R. HARDEMAN, PHD, MPH, EDUARDO M. MEDINA, MD, MPH, AND KATY B. KOZHIMANNIL, PHD, MPA

END NOTE

44 Gene pool

BY E. KENNETH WEIR, MD



MINNESOTA MEDICINE

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Charles R. Meyer, MD, Editor in Chief

To do this job well,
we may need
to reanalyze our
attitudes toward the
potpourri of humanity
we encounter in the
exam room.

When the world comes to us

The world just won't stay out of our exam rooms. Clinics can seem like hermetically sealed systems geared for the rush of patients coming through the door—take the history, examine, diagnose, treat, next—with a regularity approaching monotony. Yet as our mentors taught us, each patient is unique and comes with a present, past and, sometimes, hidden history that we are charged to uncover.

Increasingly, we are finding that some of that hidden history includes parts of lives lived far from the Minnesota tundra, with sagas fraught with danger, uncertainty and trauma. Formerly monochrome Minnesota has become a colorful polyglot of ethnicities with rich, though troubled, pasts that present challenges to the delivery of medicine.

In the past 15 years, Minnesota cities of all sizes have seen a seismic demographic change as people trying to escape poverty, war and oppression in countries such as Somalia, Ethiopia and Mexico landed in a state ripe with cultural and meteorological polar opposites to their country of origin. For these arrivals, adapting can be rocky and traumatic. For physicians, caring for them can be challenging. Histories frequently come via the filter of an interpreter, leaving us to wonder if we got “the whole story.” Patient attitudes toward health and disease can seem tangled and even mystifying, confounding our attempts to establish rapport and prescribe treatment. The art of medicine gets complicated when dealing with the wider world.

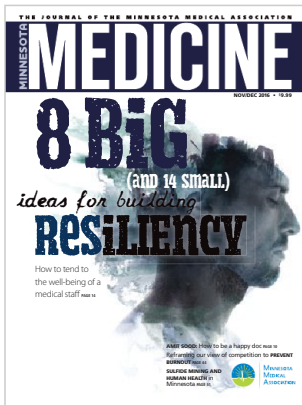
There's an added twist with undocumented immigrants, currently estimated at 90,000 in Minnesota. Fearful of jeopardizing their status, these patients may withhold information when the doctor starts asking questions. Hints in the history can

be subtle. Body language may not translate, so clues can be missed. Physicians have always had to read between the lines, but undocumented immigrants may use more invisible ink than most patients. And they frequently have no health insurance, which forces doctors to put on their social worker hats and do the daunting work of advocating for their patients as they navigate a health system unfriendly to them.

As physicians, some of this additional work might seem like an unnecessary burden, arduous duty requiring skills not acquired while in training in order to help people who have technically broken the law. But our charge and our mission is to be healers who don't choose whom we heal, to help those in need regardless of race, ethnic origin or financial capability. To do this job well, we may need to reanalyze our attitudes toward the potpourri of humanity we encounter in the exam room and question whether we carry biases that compromise our roles as doctors.

This job is easier when we understand the patient's history. When we hear where and how far they have walked, we can imagine what we would do if we had to travel that same odyssey. And then we can stretch wide our arms and welcome the world into our exam room.

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



Issue missed the core diagnosis

Thank you for another good Editor's Note and the excellent bunch of articles in the November/December issue. As Dr. Meyer pointed out, our loss of connection with patients is a key factor driving burnout. Watching it happen to some of my Mankato Clinic colleagues from 1973 to 2003 made me realize that we are

partly responsible for the burnout problem. During those years, physicians tended to make decisions that were more financially based than "comfort of practice" based. I mean that when administrators suggested ways for us to make more money, we complied.

I began to understand that medical training is a form of indoctrination that leaves physicians not really capable of challenging authority. We are trained like Navy Seals and Green Berets. We go through a "training hell," in which we are taught to not challenge authority (our professors in medical school and faculty during residency). If we do, we often get shamed. Shame is a powerful motivator to not speak up. We learned to go along with, to do whatever needed to be done, even if it meant working all night or weekend because patient needs came before our needs. As is often the case, our greatest strength became our greatest weakness. We

learned to not set clear boundaries for ourselves, and that behavior was financially rewarded (but at the cost of overwork and burnout).

Clinic and hospital administrators began to understand three important things about us: 1) Most of us wanted to make more money, 2) we had a powerful sense of devotion to our patients and 3) we rarely would question or challenge authority. So they told us that if we saw 20 patients instead of 15 each day, we would cut waiting times for patients and get extra money in our paychecks each month. The number gradually grew to 25 and then 30 per day. Administrators were doing what they were trained to do (make the clinic financially successful), and doctors were doing what they were trained to do (take care of lots of patients and not question authority).

The articles in *Minnesota Medicine* had pieces of the puzzle, but the core diagnosis was missing. It was a systems problem that eventually led to two-thirds of us having symptoms of burnout. Our training taught us to comply with authority. Mergers led to larger and larger clinics that were usually led not by healers but by business people. Business people have a very different set of values than do healers. The downward spiral began. Hopefully, we have nearly reached bottom.

Change is possible. But we have to go a bit deeper with our diagnosis.

Bill Manahan, MD
Minneapolis

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The *magical* thinker



JAN TERRY/LURIE CHILDREN'S

Pediatrician and magician Michael Pitt, MD, does a flash-card trick with a patient at Lurie Children's Hospital in Chicago.

Speaking with the cadence of an entertainer who's spent hours in front of an audience, the assistant professor of pediatrics at the University of Minnesota describes the relationship between magic and medicine as he makes a crayon disappear from his hand and reappear behind his ear, catches a bubble and turns it into a marble, makes an otoscope tip vanish, and causes his knee to squeak every time he bends it. "This became my kid credentials," he says of the tricks. "I could build instant rapport with patients."

But teaching first- and second-year medical students to perform magic tricks isn't the point of his lunch-hour talk. Rather, it's to show these members of the pediatrics interest group how using magicians' centuries-old tricks of the trade can help them at the bedside.

He explains how to use misdirection (for example, pressing on a child's aching belly with a stethoscope rather than your hand to give the impression that you're listening rather than feeling) and patter (suggesting a disappeared otoscope tip may be in the patient's ear to gain permission to look further). He shows how to give someone the perception they have free will while getting a desired outcome

(asking *which* ear you can look in rather than *if* you can look in their ears). For this group of future pediatricians, the goal is to get them thinking like magicians so they can get their young patients to cooperate during exams and procedures.

Pitt has been cultivating these skills since he was 8 years old and performed his first magic trick during a talent show on a family cruise. "I bought a deck of cards in the gift shop and asked my dad to teach me a trick I had seen him do. I did it that night and loved being on the stage," he recalls. When he got home, he read every book on magic at the library and put together an act. He began performing at parties, at the hospital where his mother worked as a nurse and eventually at a restaurant in his hometown,

As nearly 50 medical students file into the lecture hall,

Michael Pitt, MD, unpacks the tools of his trade: crayons, otoscope tips, small bottles of soapy water, large clear marbles, quarter-sized rubber squeakers. Their purpose soon becomes clear: Pitt is also a professional magician.



Sanibel Island, Florida. “I remember telling people I wanted to be a Christian Magician Physician Pediatrician when I grew up. I went four for four on that,” he says.

During medical school at Johns Hopkins and residency at Northwestern University, Pitt began seeing parallels between medicine and magic. “From a child’s perspective, medicine is like magic,” he says, giving the example of how the reduction maneuver can “magically” fix a young child’s dislocated “nursemaid’s” elbow. He says one patient forever called him a wizard after his arm was healed.

He also found research on magic and medicine. In one study, investigators noticed the part of the brain that lights up on fMRI when a patient watches a magic trick is the same part that lights up under general anesthesia. In another, when dentists used magic tricks, procedures and X-rays took less time, and children were less likely to need sedation and had less anxiety. “If I had a pill that did this, it would be malpractice not to use it,” he says.

In addition to speaking to medical students, Pitt has led workshops for pediatric providers at grand rounds and national meetings. “There wasn’t an empty seat in the room,” he recalls of a Pediatric Academic Societies meeting. “A year later, I heard stories from all these people about how they’ve continued to use this with patients.”

Pitt says he only rarely performs magic tricks when he’s with patients but that he thinks like a magician all the time. He does,

JAN TERRY/LURE CHILDREN'S



Michael Pitt (left) doing a card trick at the National Kidney Foundation’s annual dinner in Chicago.

however, work his magic at home on his own kids, ages 4, 2 and 4 months. “My oldest daughter, Parker, is very intrigued that her daddy is a doctor and a magician,” he says. “She always wants me to make things disappear—like the vegetables on her dinner plate when her mom isn’t looking.” – KIM KISER



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Syrian American Medical Society's Mobile Clinic in Aleppo, where volunteers were providing care to displaced civilians, December 2015

AREF AL-KALI, MD: ON THE NEEDS IN **Syria**

Since the beginning of the Syrian conflict in 2011, it has been awful for Aref Al-Kali, MD, to see his native country at war and know that millions of people, including friends and family, are suffering. But the Mayo Clinic hematologist knew he couldn't sit idly by and watch when civilians and medical providers started being targeted. He already was involved in the Syrian American Medical Society's (SAMS) educational programs. As the war escalated, Al-Kali got involved with the SAMS Foundation's efforts to provide medical help, supplies and support to people in Syria and refugees around the world.

Today, Al-Kali serves as national vice chair of the foundation, and he's actively involved with its volunteer medical relief work. He recently made time to talk about the situation in Syria with *Minnesota Medicine* writer Suzy Frisch.

What is the current state of Syria, especially related to medical care?

There are 13.5 million people in need of humanitarian assistance. Six million people are displaced within Syria, and almost 5 million are refugees in neighboring countries. The worst thing about the crisis is that about 90 percent of the people killed are civilians, and half are women and children. They are targeting health facilities and besieging several towns and cities, like eastern Aleppo. There are 400,000 to 500,000 people there without access to anything. Even if we try to help, there are areas where help can't get in.

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What effect is this having?

All U.N. agencies have failed to get medical supplies to the people who need it—can you imagine—for more than four years. There's no fuel—how can you run a hospital with no electricity? How do you run a ventilator? They are doing ventilation by hand because a machine isn't available. Or there is no light in the OR and they have to operate with a flashlight. In eastern Aleppo, there is one CT scanner for 300,000 people, and they can't get another one.

How is SAMS helping?

We try to help as much as we can with everything we can: money, expertise and by trying to be an advocate for the Syrian crisis, especially regarding the medical aspect. SAMS tries to supply hospitals with money and support doctors with a salary so they can live. We get them supplies, and we also help with medical knowledge through telemedicine. We have physicians in the United States who are on call every night to help people in Syria take care of sick, traumatized patients. Many times, they are helping nurses because there are no physicians in the area or they don't have the specialties. SAMS treated 2.6 million people last year, and we have more than 100 medical facilities working in Syria, Turkey, Lebanon, Jordan and Greece.

Where are the greatest needs?

Different areas have different needs. In Turkey, refugees do have access to the medical system, but they don't have access to interpreters, so the problem is to find someone who can translate their problems. In Jordan, they don't have the same access to medical care and it's helping them with their complaints.

What is the status of Syrian refugees settling in Minnesota?

There were 10,000 refugees who came to the United States last year, and about 2,000 the year before. Minnesota had about eight to 10 families, with four of the families coming to Rochester. Most of them had been refugees in Jordan for several years.

SAMS Medical Mission to Jordan,
Neda Al Khair Clinic, November 2016



In the SAMS
Clinic at
the Zaatari
Refugee Camp
in Jordan,
November 2016



They are all families, and most of the kids are now in school, so they are coping and merging with society. They want to move on and build a life here. It's not easy.

What mental health problems do refugees face?

It is so difficult and terrible. There, you are in life-saving mode, so you don't have time to get stressed out. Once you get out and get your kids out, you settle into your life

and become stable, and then you become traumatized. They lost their house, their car. They had no food. And now their future is difficult. The psychosocial issues are devastating.

What would you most want people to know about the situation in Syria?

It goes back to what I said about targeting civilians and getting medical supplies into the area and allowing medical evacua-

tions. There is no official way of getting injured and traumatized patients out of the besieged areas, and doctors are being targeted for providing care. They need to stop targeting hospitals, and we need to get supplies and medical evacuations going. We're all asking, "When will this stop?" It's terrible. This is what we've been seeing for five years, and it's not getting easier. It keeps getting worse, and it's on a huge scale. — SUZY FRISCH

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A NEW WAY UP

Program funds residency slots for international medical graduates.

For the better part of a decade, Minnesota has searched for ways to use the knowledge and skills of physicians who have immigrated to the United States. Although they may have years of experience, they often can't practice in this country. In order to be licensed, they must pass the U.S. Medical Licensing Examination and complete a residency, among other requirements. Many find they are unable to compete with recent graduates for a limited number of residency slots.

"We have a need for doctors and a population that needs hands-on experience to learn the health care system in this state," says Michael Pitt, MD, an associate pro-

gram director of the University of Minnesota's pediatrics residency and director of global health education for the department of pediatrics. The Minnesota Department of Health estimates between 250 and 400 unlicensed immigrant and refugee physicians reside in the state.

A number of efforts have focused on helping these physicians prepare for residency. A recent one, the University of Minnesota department of family medicine and community health's Preparation for Residency Program, closed in 2012 even though five of the six physicians who completed the seven-month program were accepted to residency programs.

Fresh approach

In 2015, the Legislature established the International Medical Graduate Assistance Program, which not only prepares physicians for residency but also provides funds for new residency slots. Residency positions are generally supported through the federal Medicare program. "This is another bucket of money to fund a resident," says Pitt, who last year got support for an additional pediatric residency position. "And these are residency slots that didn't exist without the state's funding."

The positions are available to immigrant or refugee physicians who have resided in Minnesota for at least two years and are certified by the Educational Commission on Foreign Medical Graduates. Those who are accepted and complete a residency are required to work in an underserved part of the state for five years and pay back approximately 10 percent of their salary each year during that period. That money will be used to sustain the grant program.

Two physicians who practiced in Sudan before coming to the United States are in their first year of a pediatrics residency with the University of Minnesota as a result of the new program.

Pitt, who has applied for funding of an additional slot, believes helping immigrants into practice will also help the state address health disparities. According to the Minnesota Department of Health, persons from minority and immigrant communities make up 19 percent of the state's population. Only 13 percent of the primary care workforce is from these communities. "It is well-studied that one of the best ways to address health disparities is to have patients see doctors who have had similar life experiences," he says.

"We have such a strong east African population, and I have already seen the beneficial connections and relationships with patients that these two residents—both Muslim women from east Africa—are able to forge with these patients." – KIM KISER

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CARE IN THE SHADOWS

THE CHALLENGES FOR UNDOCUMENTED IMMIGRANTS

BY CARMEN PEOTA

THE MAN, MIDDLE-AGED AND AN IMMIGRANT FROM MEXICO, HAD CHEST PAIN.

It wasn't the first time, and this episode was more severe than the last. Christopher Reif, MD, a family physician at Community University Health Care Center (CUHCC), was worried. "When somebody has a big change in something like chest pain, you have to think seriously, do they have an impending heart attack coming?" he says.

Reif ran the tests he could at CUHCC, then recommended that the man go to the ER for a full cardiac workup. It was what any good doctor would do. But the patient said he'd just go home, take his medicine and take it easy. Although he had a job, he didn't have health insurance and couldn't afford the charges he might incur.

The decision seemed risky to Reif, who thought his patient needed stress testing and perhaps even cardiac catheterization. "It's very frustrating to me to know exactly what someone needs—and to be able to offer them the best standards of care—and it turns out they can't afford the medicine or testing," he says.

Reif didn't ask the patient about his immigration status—he never does; but when he learned the man didn't have health

insurance, he was pretty sure the reason was his immigration status. Reif wondered if he might qualify for Emergency Medical Assistance (EMA). But would his condition be considered an emergency?

Undocumented and with needs that were greater than a primary care doctor could meet, the patient had fallen into one of the remaining holes in the health care system.

DON'T ASK DON'T TELL

Theoretically, a patient's immigration status ought not to matter to those who are treating them. And generally, front desk staff and doctors and nurses don't directly ask about it. Adolescent medicine specialist Veronica Svetaz, MD, does, however. An immigrant herself, she feels more comfortable discussing it than some of her colleagues. She also believes that knowing a patient's status provides important information relevant to their health. "It gives you an idea about what things they can get and what they cannot," she says. "You can say, 'Hey, I'm going to ask about your immigration status and I'm not going to put it in the charts, and it's not for reporting. It's just that I need to know, What are the things I can do for you?'"

Family physician Christopher Reif, MD, says he often learns about a patient's immigration status during the health history. He might hear about family members far away or the patient having taken a harrowing journey. "People are not telling me their immigration or migration stories, they're telling me about how last summer they got really sick. It was so hot they got dehydrated," he says. "I'm hearing it as part of their health story."

Others such as internist Jennifer Rho, MD, say they only discover it when a patient needs care they can't provide and they must ask if he or she qualifies for health insurance. "Then it becomes a matter of me trying to work within the safety net of our community," Rho says.

CRISIS MANAGEMENT

Health insurance is out of reach for most of the 95,000 or so undocumented immigrants living in Minnesota. Most earn too little to afford the cost of premiums in the private market, and most government programs and supports are off-limits.

Without insurance, they seek out low-cost or free care at Federally Qualified Health Clinics (FQHCs) like CUHCC, rural health clinics and charity care providers. They might take generic medications that are on the \$4 lists at local pharmacies or drugs obtained through a pharmaceutical company's assistance program. They might share medications with family members who have insurance. Or they might forego care altogether.

If they break a bone or have chest pain, they *might* be eligible for EMA, which covers care for acute symptoms (including pain) and conditions so severe that without immediate (typically within 48 hours) medical treatment, the patient's health might be in serious jeopardy or bodily functions and organs or parts might be damaged. Examples of such conditions listed on the Department of Human Services website include stroke, heart attack, abscessed teeth, broken bones, ear infections and kidney failure. Among the longer list of things EMA does not cover are preventive care, prescription medications, home care and immunizations.

"It's very different than if they had Medicaid or Medicare or if they had private insurance," Reif says. "For people who don't have insurance, whether citizens or not, it's really a burden to their health and a burden to us as health care deliverers."

The real difficulties come when, like Reif's patient, someone needs more than primary care but less than emergency care. Veronica Svetaz, MD, MPH, an adolescent medicine specialist at Whittier Clinic in Minneapolis, sees how this plays out all the time. One of her patients has a chronic digestive condition, and Svetaz has tried, but thus far been unable, to get her specialty care. In the meantime, the young woman's condition is out of control, and she ends up in the hospital when it flares. "[EMA] will cover the admission, but in between nothing," Svetaz says. "So we go from one crisis to another." Another patient with depression has been hospitalized three times for suicide attempts. EMA covers her hospitalizations, but once she's discharged, she's on her own, with no opportunity for intensive, ongoing outpatient treatment, which Svetaz says she desperately needs. "It's like we're making sure the patient with a severe condition is always in the hospital," she says.

UPSIDE-DOWN APPROACH

Getting undocumented immigrants into specialty care has become more difficult in recent years for a number of reasons. One is the Affordable Care Act. Since its passage, programs that were in place to help the uninsured, such as pharmaceutical company assistance programs, have dried up because there's an assumption that people have insurance.

Another is that federal funding of EMA was scaled back in 2011. Before, it would cover some services provided in an ambulatory setting—services that might keep someone out of the hospital. Now it covers only care provided in the ER or hospital.

“In my opinion, it’s upside down,” says Jonathan Watson, director of public policy for the Minnesota Association of Community Health Centers. “We should be trying to prevent emergency conditions in these populations regardless of their immigration status. And from a cost perspective, a health center can provide one patient encounter for roughly \$250. I’m sure that’s a lot cheaper than for the ER doors to open even one time.”

In 2015, a Health Care Financing Task Force convened by Gov. Mark Dayton recommended extending MinnesotaCare benefits to uninsured, low-income individuals ineligible for Medical Assistance and other state programs because of their immigration status. That idea hasn’t moved forward. Detractors cite its cost, estimated at \$70.3 million. Watson says that amount doesn’t reflect the savings that could be had by providing care that could prevent hospitalizations.

THE COMPLICATED ORDINARY

For physicians, finding specialty care for undocumented immigrants has become sort of a specialty in itself. That’s the case for Jennifer Rho, MD, MPH, an internal medicine physician who sees patients at a Community Health Service Inc. clinic in Rochester. Formerly Migrant Health Services, the organization serves many people working in agricultural industries. To get her patients what they need, Rho says she taps into the network of safety-net providers and specialists she knows in the Rochester area, sometimes trading services. For example, her clinic allows a local charity clinic to send over patients for lab work. In return, she’ll ask them to call her when a cardiologist is volunteering at their clinic so she can send her patient over there. “It’s a lot of piecemealing things together,” she says.

Working that way can get complicated. Rho recently saw a 47-year-old man with diabetes who has eye damage. She referred him to a free clinic, where he was seen by an ophthalmologist. The free clinic got him into a hospital, where he underwent a procedure. But when he tried to get follow-up care, he was turned down. “Now we’re trying to get him EMA so he can get back to the same hospital for more treatment for his eyes,” Rho says, hoping to save his vision. If he does get EMA coverage, it will be for three to six months, during which time Rho will also try to get care for the nerve damage in his feet and a urological problem. “He might get EMA approved, but it actually might expire before he gets all the tests and referrals done,” she says.

In addition to piecing together care for patients, Rho is always thinking about the cost of care. For example, she mostly prescribes medications she knows patients can buy for \$4 at a pharmacy. If a patient needs screening for colon cancer, she’ll recommend a fecal occult blood test, which costs only a few dollars, instead of a colonoscopy, which can cost thousands.

WHO ARE THE UNDOCUMENTED IN MINNESOTA?

The population is estimated at between 80,000 and 95,000 individuals. The majority are from Mexico and other countries in Central America. Half have lived in the state 10 or more years.

Almost by definition, they are the working poor. Two-thirds work in industries such as agriculture, hospitality, entertainment and manufacturing. For a third of families, incomes are below 100 percent of federal poverty levels. Incomes are between 100 and 200 percent of poverty for another third.

Many immigrants have mixed-status families. Some members may be citizens and eligible to purchase insurance through MNSure or to be covered under Medicaid or CHIP, while others may be undocumented and thus ineligible for these programs.

Source: Migration Policy Institute, Pew Institute Foundation, U.S. Centers for Medicare and Medicaid Services

Svetaz says a big part of her job is maximizing what can be done through existing systems. For example, knowing that she can get two months of coverage through Medicaid for a teen for family planning, she’ll recommend an IUD, which will give the woman three to five years of protection. “It’s being aware and knowledgeable and having strategies,” she says.

Those who care for undocumented immigrants know that some may wonder why physicians should provide any care at all to people who have arrived in this country without visas or work permits. Many, like their patients, tend to shy away from the limelight and the political discussions about immigration. Rho’s response to those who wonder why she does what she does is simple: “As physicians, it’s not our job to make judgments about why people are here or if they should be here. It’s our job to take care of patients.” **MM**

Carmen Peota is a freelance writer in Minneapolis.

PHOTOS BY CARRIE ANN TERRELL



This painting shows that motherhood is revered in Cuba.

approved program. The women we met held doctorate-level degrees in areas such as mathematics, physics, cyber security, art studies and agricultural engineering even if their current job was bus driver, artist, teacher or housekeeper. As we interacted with them and toured hospitals and clinics, I learned a great deal about their health care system and Cubans' attitudes toward health and medicine. The following are some of my observations.

The health care system

Health care in Cuba is universal and free and considered a fundamental right. It is not tied to employment. It is highly regulated and "housed" under civil defense. Many Cubans view routine health care and screening as good for them and good for their country.

Family doctors live and work in the neighborhoods they serve. Most are responsible for the care of just more than 1,000 patients and follow those patients from birth to death. Their offices are generally located within their homes and they are available 24/7/365. In addition, a family nurse often lives in the same building as the doctor's office and helps the doctor manage the local population and maintain records. If the doctor cannot manage a situation or case, he or she may refer the patient to the polyclinic (a multispecialty clinic) or the hospital. The system is a stepwise pyramid. Clinics serve their immediate areas and are located within walking distance. Polyclinics serve larger areas and often require a bus or taxi ride. We saw only one ambulance and heard no sirens during our 10-day visit.

Informed Dissent?

A glimpse at health care in Cuba

BY CARRIE ANN TERRELL, MD, FACOG

In early March of 2016, I was part of a delegation from Witness for Peace to Havana, Cuba. This trip took place immediately prior to President Obama's lifting of travel restrictions to the island country. The goal of our trip was to gain an understanding of the Cuban health care system and how it affects the women of the country. I had few, if any, expectations and no preconceived notions about practicing

or experiencing medical care in a communist country. Our assigned pre-trip readings from Witness for Peace reviewed the country's pride in its socialized medical and education systems. I was not expecting the poverty, dated facilities and lack of resources I discovered.

Our delegation met with health care officials, medical school directors, community members and leaders, and physicians as part of a structured, government-



The imposing Art Deco facade of the Obrera Maternity Hospital in Havana



Members of the Witness for Peace delegation

PHOTOS BY CARRIE ANN TERRELL

It was explained to us throughout the trip that the medical system in Cuba operates on love and humanity. Medical training is free. We were told repeatedly that physicians practice for their love of patients not for compensation or prestige. This is easy to believe, given the average family doctor earns the same salary as any government employee: \$20 to \$35 per month. Because of the low pay, doctors are leaving Cuba by the thousands.

Cuban physicians receive clinical updates from the monthly government-produced MedInfo document. This information is available online, but most family doctors do not have Internet access and view it at a hospital. The physicians we interviewed do not subscribe to any journals published outside Cuba. At the medical school, we were informed by the school's two international affairs experts that students do not attend medical conferences outside Cuba but that some professors do.

Family doctors must see healthy patients (level I) once a year and maintain a paper medical record. For patients with mild chronic disease (level II), two visits per year are required. Those patients who are levels III and IV and have more severe illnesses are usually managed by a team

including the family doctor and consultants at the polyclinic and/or the hospital.

Cubans do not challenge health care recommendations. If a woman is due for a Pap smear, for example, she may be approached by her local family doctor not only in the clinic but also on the street or at a local gathering and counseled on the need for the examination. In our discussions with Cuban people and providers, our questions about autonomy were met with confusion. In general they could not comprehend a patient not wanting to comply with government-ordered or doctor-recommended tests. When pushed on the question, one doctor eventually said in essence that should she choose not to comply with a recommendation she would have to report to the courthouse to sign a waiver documenting that she understood the recommendations and risks. Hence, in the rare instance of noncompliance, a patient would need to sign off, in effect providing "informed dissent."

Maternity care

As an OB/GYN physician, I was especially interested in Cubans' approach to maternity care. I learned that pregnant women have regularly scheduled medical visits.

Because pregnancy is revered, women are expected to adhere to their doctor's recommendations. Prenatal screening includes hemoglobin, Rh status and AFP at 15 to 18 weeks. According to one polyclinic lab director, the tests are performed "if reagents are available." Neither quad screens nor any fetal DNA fragment testing were available in any of the institutions we visited. We also learned that ultrasounds are not widely used in routine pregnancies but are available at the polyclinic and hospital if problems are detected.

Women with complications such as gestational diabetes or hypertension are admitted at 37 weeks to a maternity home. They stay there under the supervision of a maternity nurse until they are admitted directly to the maternity hospital, which may happen during active labor or at 39 or 40 weeks. Given that most women have two or fewer children, cesarean sections and repeat cesarean sections are rarely complicated by pelvic adhesive disease or placenta accreta, increta or percreta. Overall, per the WHO, the Cuban cesarean rate is 35 percent, which is comparable to the U.S. rate of 32 percent.

(continued on next page)



A poster hanging on a wall at the Obrero Maternity Hospital features this shot of the building, as well as charts showing the hospital's cesarean, maternal and infant mortality rates.

Interestingly, abortion is widely available in Cuba, and it carries no stigma. It is covered by their health care system. Therefore, Cuban women have much more freedom than women in the United States when it comes to their decisions about and access to abortion.

On our tour of the Obrero Maternity Hospital in Havana, it was common to see four mothers/infants to a room with minimal bedding. All wore street clothes. Patient bathrooms had crumbling concrete walls, and toilets without seats and doors. Those issues aside, the building, completed in 1942, is a miraculous piece of art deco architecture, and an aerial view would reveal the shape of uterus, fallopian tubes and ovaries.

Signs documenting the hospital's maternal and infant mortality rates are posted. Rates at this institution are on par with national reported rates (unicef.org) and are equal to or better than those in the United States. The NICU appeared adequate but likely incapable of handling infants other than those who were born preterm but healthy. Given the antenatal screening provided and the overwhelming acceptance of abortion, we wondered if many pregnancies with severe fetal anomalies were continued.

Postpartum, women stay in the hospital for two to four weeks and are expected to breastfeed for one year. During this time, they receive a slightly reduced government salary. If, at one year, the child is walking, he or she can attend day care and the mother can return to work. If the child is not walking, the family may take four more months of paid leave. This can be taken by either parent. When asked about

postpartum depression, we were told there was a "program" for that. Our guides also insisted that women who had familial and community support were unlikely to experience any such thing.

The embargo and its impact

The embargo has resulted in extreme resource restriction. It is nearly impossible for Cuba to buy or trade supplies and medicines. When we asked about the incidence or management of gestational diabetes and hypertension, we were told "we have a program for that." We could not ascertain whether insulin, sulfonylureas or antihypertensives are available or utilized.

My most important discovery about the embargo was not only that there were restrictions on trade with the United States but also with any countries that trade with us. That said, the Cuban government has long supported medical research and drug development to the best of its ability. Cuba has developed a lung cancer vaccine that has shown strong results. It is currently being evaluated in the United States by the FDA.

The complete and utter lack of products became maddeningly clear during a trip to a fancier free-market grocery store. Aisles of shelves, empty save for a single brand of biscuit, dominated the lofty air-conditioned building. There was a long dark row of refrigerated units, all empty except for one containing eight canisters of yogurt and 20 half-gallons of milk. Cubans pick up rationed food and shop for state-produced soap, canned meat, boxed juice, and a meager selection of fruits and vegetables at bodegas. Pregnant and postpartum women are prescribed more meat, more than the rationed five eggs per month and supplemental milk.

Pharmacies have only a handful of items on a few shelves. Tourists are warned to bring abundant supplies of over-the-counter medications, toilet paper and snacks.

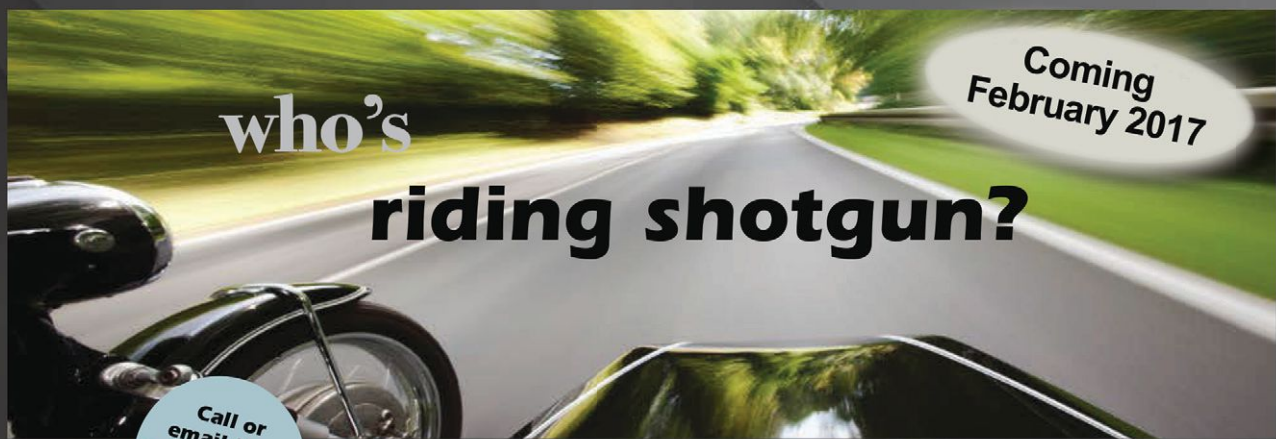
In all of our interviews, we asked women if they thought their lives, family circumstances, work and communities would improve if the embargo was lifted. Every one emphatically answered "yes," that things would be better.

The future

We left Cuba on March 9. And since then, I've thought about my country's relationship with Cuba. I fear little will change. To end the embargo literally requires an act of Congress. Given Cuba's small size, insignificant trade products and continued communist government, ending the embargo is unlikely to be a major American concern. President-elect Trump has been quoted as saying both that he'd return to a hardline against Cuba and normalize relations with the country.

I've also thought about how ineffective universal health care is when a system lacks reagents and medications, is unable to buy or lease equipment, and has deteriorating facilities. I have been and continue to be an advocate for universal, single-payer health care. However, my trip clarified for me some of the challenges in administering such a system and the required buy-in by the populous. **MM**

Carrie Ann Terrell is an assistant professor and division director general OB-GYN and medical director, Women's Health Specialists, at the University of Minnesota.



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Living IN THE moment

A young father learns to let go of fear and embrace life.

BY SEAN SCHULZ, DO



My wife was in labor. It was hour 20 or perhaps 30. I lost track of time when she shifted from words to moans. My son's heart rate traced along on the monitor as an oscillating line with accompanying beeps. I remembered all the times I had checked such tracing for a patient, interpreting it, trusting it, relying on its omniscient ability to predict good and bad outcomes. And yet now I was doing my best to ignore it as I sat, slumped in a chair across the room, staring at the opposite wall.

This was the beginning of my journey, as a father and a physician—and the beginning of my inability to let go of my fear. The fear of the unlikely, the unpredictable, the improbable, the it's-never-going-to-happen-to-you-it-will-only-happen-to-someone-else.

Just a few months prior, I'd been involved in what seemed like a routine delivery. The air was filled with the metallic smell of amniotic fluid and blood, and the sounds of crying and pushing. The father, stuck somewhere between tears and laughter—unsure if he should crack a joke or grab a tissue—ushered the mother through the final stages of birth. I was nervous. I was not such a hardened veteran that I assumed it would all go smoothly. With a push, the baby's head emerged and I held it loosely. But with the next push, the head stayed still. I felt the cord wrapped tightly around the neck. I tried to reduce it but couldn't. There was no time for mistakes. We cut the cord to allow the body to deliver, and that was when it happened—a shoulder dystocia.

I shouted orders. The woman's legs went up and I pulled down on the head, knowing too much force could cause permanent nerve damage and too little could leave the child brain dead from hypoxia. It was an impossibly long few seconds, but the

baby delivered. I held the baby for a brief moment—grey and floppy and silent. I handed the limp newborn over to the NICU team. The mother asked questions I was not yet ready to answer. We collectively held our breath as the NICU team did their work. Within minutes, the baby was crying. I exhaled. My attending patted me on the back. No harm, no foul. This patient was going to be fine.

My own son's birth proved much less exciting. He came out happy and fierce, ready to light up our lives and change them forever. That first night in the hospital, I felt a calmness that escaped me in the months after. I trusted in the universe, despite its entropy.

Perhaps nothing could prepare one for having a child during residency. How do you prepare for the collision of two things with such an insatiable need for time? But I had failed to anticipate how caring for the sick, injured and dying would affect my ability to handle the chaos of parenting. I had pictured myself feeling annoyed by a crying baby, perhaps frustrated, or maybe numb in the throes of an 80-hour work week—a sleep-deprived dad who shushed and swung his crying child while trying to microwave his dinner. But none of those things happened. Instead, I found that I translated the cries of my baby as sounds of pain, disease, fever, cancer or some other destructive, malevolent process.

The ability to recognize disease and read into subtle findings led to an exhausting vigilance as I found myself watching my son's every breath at night, for perhaps a second of apnea signaling the onset of SIDS, or watching his every movement for some evidence of a budding-but-reversible neurologic disease.

The worry and work wore me down, and as much as my son continued to be healthy and normal, I couldn't shake the fear that my perfect life would come to an end. How could I ignore what I saw daily in the clinic and hospital? I understood the randomness and inevitability of mortality, and yet I still came home hoping my child would be shielded from the chaos.

At work, though, my pediatric practice flourished as I was able to connect on a much more personal level with parents of young patients. Things I might once have attributed to overly worried parents I now took seriously—a mother's concerns over a simple virus, a father's worry about sleep, a mother's devastation by inadequate milk production. Weakness, however, presented itself in unexpected ways.

During my pediatric ER rotation, I found myself blindsided during a trauma case. When the ambulance brought in a toddler who'd pulled an aquarium down on himself and had suffered multiple large and painful lacerations, I felt overwhelmed. I'd made the crippling mistake of over empathizing with the parents and the patient and was subsequently overcome with emotion as the child, scared and confused, cried and searched for his mother in the crowd of unfamiliar faces. Luckily, the ER fellow took charge and I was able to fall back into my cocoon of unexpected and powerful emotions. I was able to do my job, but I avoided pediatric trauma cases if I could, still wary of my ability to separate work and home when faced with a horribly injured child.

As the months passed and my son went from walking to talking, I felt my love for him grow into something I never could have imagined. The father-physician complex moved into the background, and I began to trust in life's innate ability to perpetuate and flourish despite its native fragility.

So when tragedy did strike, I felt guilty in my unpreparedness. A colleague—the most careful, thoughtful, loving and present father possible, truly the embodiment of the father-physician guardian—lost his child in a horrible, senseless accident. I was barely able to absorb the news. Yet it shattered my uneasy sense of control. He'd been there when tragedy struck—ready, prepared—but just as life seemed stubborn, unstoppable, death was equally so, and while life was fleeting, death was permanent.

I left the clinic early that day and went home to hold my son. As I held him, I thought, This could be it. This could be all

we have, this moment. The thought held a truth about the struggles I had found myself going through as a physician who faced death and decline every day and a father who watched life itself sprouting before him every night. I only had each moment.

Life is fragile and impermanent, but also strong and exuberant—a synchronous paradox holding that much more contrast for those of us who care for the ill. But there is beauty in this transient state. I thought of all the times I was with my son, so worried about the future and missing the present. I refused to let it consume me any longer.

In unexpected ways, confronting life's inherent tragedy was liberating. We only have each moment, and life only exists within each. **MM**



2016 WRITING CONTEST

HONORABLE MENTION



Sean Schulz completed a family medicine residency at Smiley's Family Medicine Clinic in 2016.

He now practices at Legacy Medical Group in Sandy, Oregon.

ABOUT THIS PIECE:

"I was inspired to write the piece because of the stark contrast between watching my son grow up healthy and dealing with sick and dying patients day to day."

Tales of people displaced

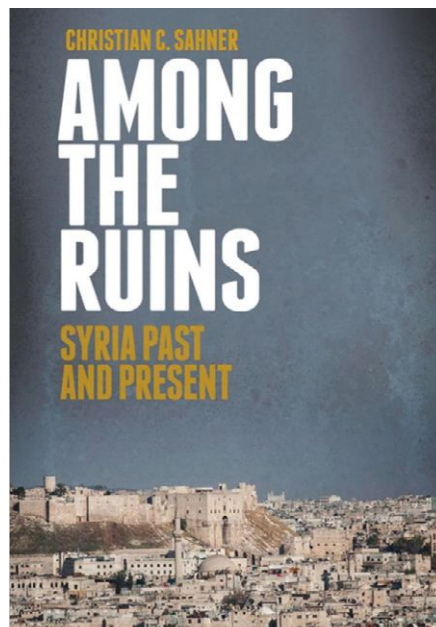
Two books shed light on the plight of Somali and Syrian refugees.

REVIEW BY CHARLES MEYER, MD

In the recent presidential election, immigration vaulted from a sleepy, backburner issue to a hot topic as emotional reactions flared in response to Donald Trump's Mexican wall proposal and his threats of massive deportations. Some invoked America's history as a "nation of immigrants," while others began looking askance at anyone with darker skin, a strange accent or a veiled face. "Fear of the other" stoked frightening memories of 9/11 terrorists crying *Allahu akbar* enroute to the Twin Towers. Regardless of the response to it, the campaign highlighted the issue of immigration.

Lost in the discussion, however, was much coverage about the plight of immigrants and the reasons for their willingness to undertake such perilous journeys. From the sketchy hygiene of tented refugee camps to the hardscrabble existence in a new land, refugees and immigrants face hardships few of us can fathom. Two recent books provide pictures. One profiles one of the countries fueling the worldwide immigration crisis and the other one of the refugee camps that serves as home for the displaced.

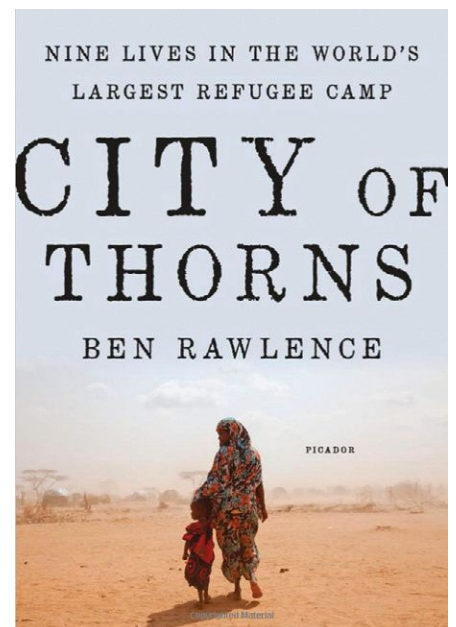
Most immigrant stories start with chaos as civil order and economic stability crumble in the immigrant's home country. Current poster child for countries in the throes of self-destruction is Syria, whose civil war has spawned 4.8 million refugees spread across Europe and the rest of the



Among the Ruins: Syria Past and Present, Christian Sahner, Oxford, 2014

world and 6.6 million internally displaced, producing a refugee deluge not seen since World War II. In *Among the Ruins: Syria Past and Present*, Middle East historian Christian Sahner presents an engaging history-cum-travelogue of Syria from medieval times to the beginning of the current civil war.

Sahner travels back historically to Damascus during the Umayyad rule in 701 AD, when Caliph al-Walid I razed a building where Muslims worshipped in the eastern end and Christians in the western and built a magnificent mosque and purged the Christians, establishing Islam as the "main show." When he visits the mosque in the modern-day city, Sahner finds a shrine in the middle that reputedly holds



City of Thorns: Nine Lives in the World's Largest Refugee Camp, Ben Rawlence, Picador, 2016

the head of John the Baptist. A Christian saint honored in the midst of a Muslim mosque is a talisman for the complexity of religiosity that has existed in Syria for centuries. The mosque contains another head, that of Hussein, a direct descendant of the Prophet Muhammed and forefather of today's Shi'a, who was savagely defeated by the Umayyads at Karbala in 680 AD. Most Syrians are Sunni Muslim, yet they retain a shrine to a Shi'a hero in their primary mosque and Syria continues to have close ties with Shi'a-dominated Iran. Nothing is ever simple in explaining ancient or mod-

ern Syria, but Sahner makes the subject understandable and approachable.

The current civil war is also a complex political tangle, with the clash of government forces of Bashar al-Asad, a multiplicity of rebel forces including ISIS, and the military might of Russia and the United States supporting opposing sides. The current annihilation of Aleppo, which evokes the quote from the Vietnam era “To save the city we had to destroy it,” has added to the flood of refugees fleeing the conflict. They go to a different part of Syria, they go to Turkey, they cross over to Europe and a few make it to the United States. Their medical problems are a product of atrocious living conditions and a decimated medical system in what used to be a developed country.

Far from Syria in northeastern Kenya is Dadaab, the world’s largest refugee camp, housing 500,000 people. Ben Rawlence’s book *City of Thorns: Nine Lives in the*

World’s Largest Refugee Camp supplies a flavor of the hazards of life there. Violence around every corner, corrupt security forces and scant food supplies, despite the United Nation’s efforts, beleaguer the nine Somali people Rawlence follows through the book. For one, Isha, “hunger had become a normal thing ... familiar with the bleeding gums, the inflamed limbs, the cramped pain of drinking, the torture when the empty stomach eats itself.” Medical care, supplied by the United Nations and Medecins Sans Frontieres, is a constant battle with sanitation and scarcity. Refugee camps are no place to get well.

City of Thorns is not an easy book to read. Partly, it’s its structure. With scattered chapters about the lives of its protagonists, it is hard to weave together a coherent narrative. And partly it’s the subject matter, with one shocking inhumanity after another. Yet Rawlence does articulately summarize the refugees’ predicament and the world’s response: “At a time when there are more refugees than

ever, the rich world has turned its back on them. Our myths and religions are steeped in the lore of exile, and yet we fail to treat the living examples of that condition as fully human. Instead, those fleeing the twenty-first century’s wars in Syria, Iraq, Afghanistan, Somalia and elsewhere are seen as a potential fifth column, a threat.”

The chaos of Syria, Somalia and other refugee-spawning countries is far from the comforts of the United States, but their political, economic, medical and humanitarian tremors continue to shake us all. American physicians will see more patients carrying the physical and psychological scars of the refugee experience, challenging our medical prowess and our humanity. **MM**

Charles Meyer is editor in chief of *Minnesota Medicine*.

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Structural Racism and Supporting Black Lives

The Role of Health Professionals

BY RACHEL R. HARDEMAN, PHD, MPH, EDUARDO M. MEDINA, MD, MPH, AND KATY B. KOZHIMANNIL, PHD, MPA

On July 7, 2016, in our Minneapolis community, Philando Castile was shot and killed by a police officer in the presence of his girlfriend and her 4-year-old daughter. Acknowledging the role of racism in Castile's death, Minnesota Governor Mark Dayton asked rhetorically, "Would this have happened if those passengers [and] the driver were white? I don't think it would have." Such incidents are tragic—and disturbingly common. Indeed, in recent weeks, our country has witnessed the well-publicized deaths of at least three more black men at the hands of police: Terence Crutcher, Keith Scott and Alfred Olango.

Disproportionate use of lethal force by law-enforcement officers against communities of color is not new, but now we increasingly have video evidence of the traumatizing and violent experiences of black Americans. Structural racism—a confluence of institutions, culture, history, ideology, and codified practices that generate and perpetuate inequity among racial and ethnic groups¹—is the common denominator of the violence that is cutting lives short in the United States.

The term "racism" is rarely used in the medical literature. Most physicians are not explicitly racist and are committed to treating all patients equally. However, they operate in an inherently racist system. Structural racism is insidious, and a large and growing body of literature documents disparate outcomes for different races despite the best efforts of individual health care professionals.² If we aim to curtail systematic violence and premature death, clinicians and researchers will have to take an active role in addressing the root cause.

Structural racism, the systems-level factors related to, yet distinct from, interpersonal racism, leads to increased rates of premature death and reduced levels of overall health and well-being. Like other epidemics, structural racism is causing widespread suffering, not only for black people and other communities of color but for our society as a whole.³ It is a threat to the physical, emotional and social well-being of every person in a society that allocates privilege on the basis of race.³ We believe that as clinicians and researchers, we wield power, privilege, and responsibility for dismantling structural racism—and we have a few recommendations for clinicians and researchers who wish to do so.

First, learn about, understand and accept the United States' racist roots. Structural racism is born of a doctrine of white supremacy that was developed to justify mass oppression involving economic and political exploitation.³ In the United States, such oppression was carried out through centuries of slavery premised on the social construct of race.

Our historical notions about race have shaped our scientific research and clinical practice. For example, experimentation on black communities and the segregation of care on the basis of race are deeply embedded in the U.S. health care system.⁴ Disparate health outcomes and systematic inequalities between black Americans and white Americans in terms of wealth, well-being and quality of life must be seen as extensions of a historical context in which black lives have been devalued. We would argue that health care professionals have an individual and a collective responsibility to understand the historical roots of contemporary health disparities.

Second, understand how racism has shaped our narrative about disparities. Researchers and clinicians have long used rhetoric implying that differences between races are intrinsic, inherited or biologic. Pre-Civil War physicians attributed poor health among slaves to their biologic inferiority rather than to their conditions of servitude.⁴ Such beliefs persist today: A study published earlier this year revealed that 50 percent of white medical students and residents hold false beliefs about biologic differences between black and white people (eg, black people's skin is thicker; black people's blood coagulates more quickly)⁵ Implicit bias and false beliefs are common—indeed, we all hold them—and it's incumbent on us to challenge them, especially when we see them contributing to health inequities.

Third, define and name racism. In health care and health services research, we need consistent definitions and accurate vocabulary for measuring, studying, and discussing race and racism and their relationships to health. Armed with historical knowledge, we can recognize that race is the "social classification of people based on phenotype"—"the societal box into which others put you based on your physical features," as Camara Jones of the National Center for Chronic Disease Prevention and Health Promotion puts it. Racism, Jones continues, "is a system of structuring opportunity and assigning value based on phenotype (race) that: unfairly disadvantages some individuals and communities; unfairly advantages other individuals and communities; [and] undermines realization of the full potential of the whole society through the waste of human resources."¹ If we acknowledge

and name racism in our work, writing, research, and interactions with patients and colleagues, we can advance understanding of the distinction between racial categorization and racism and clear the way for efforts to combat the latter.

To pursue those efforts, we will have to recognize racism, not just race. We frequently measure and assess differences according to race. Patients check race boxes on forms; clinicians and health systems may assess racial differences in care; and researchers include race as a variable in regression models. When a person's race is ascertained and used in measurement, is it merely an indicator for race, or does it mask or mark racism? For example, race is often used as an input in diagnostic algorithms (eg, for hypertension or diabetes), which may deflect attention from underlying causes—beyond biology—that may be contributing to the medical condition. Black Americans, on average, have more poorly controlled diabetes and higher rates of diabetes complications than white Americans. Successful treatment of such chronic conditions requires attention to structural factors and social determinants of health, but antiracism strategies are rarely recommended for improving diabetes control. Perhaps if we shift our clinical and research focus from race to racism, we can spur collective action rather than emphasizing only individual responsibility.

Finally, to provide clinical care and conduct research that contributes to equity, we believe it's crucial to “center at the margins”—that is, to shift our viewpoint from a majority group's perspective to that of the marginalized group or groups. Historical and contemporary views of economics, politics and culture, informed by centuries of explicit and implicit racial bias, normalize the white experience. In describing Castile's death, for example, Governor Dayton noted that the tragedy was “not the norm” in our state—revealing a deep gap between his perception of “normal” and the experiences of black Minnesotans.

Centering at the margins in health care and research will require re-anchoring our academic and health care delivery systems—specifically, diversifying the

A Minnesota physician on why he's speaking out

INTERVIEW BY CARMEN PEOTA

After St. Paul resident Philando Castile was shot by a police officer during a traffic stop in Falcon Heights last summer, three Minnesotans felt compelled to put into words what they were feeling and thinking. The resulting article, “*Structural Racism and Supporting Black Lives: The Role of Health Professionals*,” was published online in October and in the December 1 issue of the *New England Journal of Medicine*. We asked one of the authors, Eduardo Medina, MD, MPH, who practices at Park Nicollet's Minneapolis clinic to tell us more about why he chose to speak out on this controversial topic.

PHOTO BY KATHRYN FORSS

What prompted you and the other authors to write this article?

Throughout the summer of 2016, almost weekly there was a news story about someone getting shot or killed. It was very psychologically taxing. Then, when the incident happened so close to home, we really felt compelled to do something. We saw both the extrajudicial killings and the things that we deal with on a day-to-day basis in the health care system as intertwined. It was an opportunity to shine a light on something that was important.

Can you explain how you connect these issues?

You have to stand back and ask, Is it coincidence that a population that has historically been marginalized and exploited also happens to have the least economic opportunity, some of the largest challenges getting quality education and housing that is substandard? And then you look at the health care system and read the 2002 IOM report, “*Unequal Treatment*,” and you can clearly see that race is an independent variable in care. You could be of a mind that all these things are just happening to a population by chance. Or you can understand these things as a historical process, which is what we certainly ascribe to. Structural racism is somewhat invisible. Doctors aren't actively racist. Police officers aren't actively racist. But we inhabit a system that is. What allows structural racism to prevail is that it exists as a default. Our focus on structural racism does not excuse or ignore interpersonal racism, but it attempts to explore the underlying cause of persistent structural inequity.

How does structural racism affect the health care that people get?

There are many studies demonstrating this. One published this year in *Emergency Medicine* found that in Minnesota, African American, Hispanic and American

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Eduardo Medina, MD, MPH

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Indian pediatric patients were triaged differently than their white counterparts. Another showed that patients who were born in Somalia and/or who prefer to speak Somali get less preventive care than other patients. Only 22 percent are appropriately screened for colorectal cancer, for example. That compares with 70 percent of Minnesota patients overall.

How does structural racism affect people's health?

The research showing this is extensive. A recent study published in *Social Science and Medicine* found that black Americans living in states with high levels of structural racism were more likely to report myocardial infarction than blacks living in states with low structural racism indicators. The Minnesota Department of Health has reported on health disparities. For example, we know African American and American Indian babies die in the first year of life at a rate twice that of white babies. That has been the case for more than 20 years.

Why should the medical community take on this issue?

If I told you there was a condition out there that increased your risk for disease, that increased the likelihood that you would not get the right treatment, that more or less can predict a pathology, you'd want to know what it is and how we could treat it.

As health care professionals, we go where problems are. If we see the problem is lack of vaccinations, then we need to study the issue. If the problem is a disproportionate number of African American men being killed by police, we need to address that. We conceive of this as any other public health problem. We want to identify risk factors and what interventions are helpful, just like we would any epidemic, any major chronic disease.

What can physicians do?

As a profession, if we're really going to start taking care of the health of our populations, and we're identifying racism as an underlying cause of health problems, then it's incumbent on us to speak to legislators or professional organizations and say it is unacceptable.

We'd encourage physicians to address this issue like any other they would face in their clinical practice: to gather information including from high-quality research and expert opinion—in this case, that may mean going beyond medical journals and into the realm of public health, sociology and anthropology—and to form their own conclusions on how to address the problem. We'd recommend starting with the National Academy of Sciences 2002 report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" and the Minnesota Department of Health's 2014 report "Advancing Health Equity in Minnesota: Report to the Legislature."

What are you and your co-authors doing to further the discussion?

Our first author, Dr. Rachel Hardeman, is working with her colleague, Dr. Brooke Cunningham, in the medical school on additions to the curriculum to help increase future physicians' capacity to understand these things. The U of M produces the majority of physicians in Minnesota. We feel that anyone graduating from the U of M medical school should understand how structural racism relates to health and health care.

Is there a reason to be hopeful?

If there's any state that can fix health disparities, it's Minnesota. The tradition in Minnesota is to prioritize health and opportunity. If we thought this wouldn't make a difference, we wouldn't have written the article.

workforce, developing community-driven programs and research, and helping to ensure that oppressed and underresourced people and communities gain positions of power. Centering at the margins in clinical care and research necessitates re-defining "normal." We can do so by using critical self-consciousness—the ability to understand how society and history have influenced and determined the opportunities that define our lives. For clinicians, that means reflecting on how they arrived at their understanding of a diagnosis or clinical encounter and being willing to understand how patients arrived at theirs. Centering at the margins not only provides an important opportunity to practice more patient-centered care but can also generate new findings and clinical insights about the experiences of people who are often overlooked or harmed by our institutions.

We believe that in Minnesota and throughout the country, health care professionals have an obligation and opportunity to contribute to health equity in concrete ways. Addressing violence against black communities can start with antiracist practices in clinical care and research. Do we have the courage and conviction to fight to ensure that black lives do indeed matter? **MM**

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THE 2017 LEGISLATURE

MMA prepares for session

Given the unexpected November election, there are many unknowns as the 2017 legislative session begins.

“With the Republicans now controlling both the House and Senate, it would appear that they wield a lot of power,” says Dave Renner, the MMA’s director of state and legislative affairs. “However, in order to govern effectively, they will still have to work with Gov. Dayton to pass legislation, including a biennial budget that he will be willing to sign into law.”

Whether having a majority in the House and Senate leads to the passage of pro-medicine legislation remains to be seen. What is known is the direction on priorities provided by the Board of Trustees in November. The MMA enters the session, which began January 3, focused on the following key issues:



Pass Prior Authorization Reform

A priority in the last two legislative sessions, medication prior authorization

(PA) reform remains a top priority for Minnesota’s physician community and, even more so, for patients who depend on critical medications. A coalition of more than 40 patient advocacy groups has formed to support passage of the patient protections included in a bill championed by the MMA the last two years. The legislation has received strong bipartisan support in the past but has been blocked by special interests opposed to re-

form. The MMA hopes legislators will work to put patients first in 2017.



Maintain the Provider Tax Repeal

Thanks to a bipartisan 2011 budget agreement between legislative

Republicans and Gov. Mark Dayton, the 2 percent provider tax has been set for repeal on December 31, 2019. The MMA will work to make certain the tax repeal remains on pace for 2019 while continuing to ensure that low-income Minnesotans have access to quality health care.



Addressing the Opioid Epidemic in Minnesota

While great progress has been made in addressing

inappropriate prescribing of opioids and doctor-shopping by patients, there remains a crisis in Minnesota related to opioid abuse and drug overdoses. The MMA will support efforts to facilitate the use of the Prescription Monitoring Program (PMP) by advocating for funding to integrate the PMP with electronic health records. The MMA will also support efforts to allow greater access to treatment, such as removing PA requirements for buprenorphine, naltrexone and naloxone.



Alignment of Quality Measures

The 2015 passage of MACRA by Congress has created strong

new incentives for physician clinic quality measurement reporting. The national mea-

asures, however, do not align with most of the measures required by Minnesota's State-wide Quality Reporting and Measurement System. The MMA will support efforts to better align state and federal measures and, where alignment does not exist, lobby for greater flexibility for clinics. While the MMA remains supportive of efforts to measure the quality of health care provided to patients, the existing system is needlessly burdensome and often duplicative.

Republicans appoint chairs to influential health care committees

Sen. Jim Abeler (Anoka) will chair the Senate Human Services Reform Finance and Policy Committee. A chiropractor by training, Abeler chaired the HHS finance committee from 2011 to 2012 when he served in the House of Representatives.

The Senate Health and Human Services Finance and Policy Committee will be chaired by **Sen. Michelle Benson** (Ham Lake).

Sen. Julie Rosen (Vernon Center) has been named chair of the Senate Finance Committee, considered one of the more powerful positions in state government. Rosen has long been active on issues related to health care and public health.

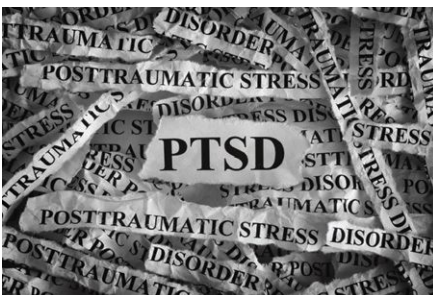
Sen. Karin Housley (Saint Mary's Point) will chair the Senate Aging and Long-Term Care Policy Committee.

Rep. Matt Dean (Dellwood) will continue to chair the House Health and Human Services Finance Committee.

Rep. Joe Schomacker (Luverne) will take over the House Health and Human Services Reform Committee.

Rep. Debra Kiel (Crookston) will hold the gavel in the House Subcommittee on Aging and Long-term Care, a position formerly held by Schomacker.

News Briefs



PTSD added to qualifying conditions for medical cannabis program

In early December, Health Commissioner Edward Ehlinger, MD, added post-traumatic stress disorder (PTSD) to the growing list of qualifying conditions allowed in the state's medical cannabis program.

"This decision was made after careful deliberation of available evidence, consultation with experts in the field and public input," Ehlinger said. "While the process of reviewing these potential additions was difficult due to the relative lack of published scientific evidence, PTSD presented the strongest case for potential benefits. PTSD also has few effective treatment alternatives available for some patients with the condition."

"The MMA urges restraint in the use of medical cannabis as a treatment for PTSD but is cautiously optimistic that the unique research component of the state's medical cannabis program may generate data that ultimately could lead to a better understanding of cannabis' effectiveness," said MMA President David Agerter, MD, in a statement to the media.

In addition to adding PTSD as a qualifying condition, Ehlinger approved the use of patches, lotions, creams, gels and ointments as application methods. Currently, patients can purchase cannabis in pill, liquid or oil form at any distribution center in the state.

MMA reacts to attorney general's opioid prescribing recommendations

Minnesota Attorney General Lori Swanson released a comprehensive report in

November containing 23 recommendations for addressing the opioid abuse crisis plaguing Minnesota. Some of the recommendations, including a call for mandatory use of the state's Prescription Monitoring Program (PMP) and required CME for prescribers, are oft-cited ideas that have not been shown to be effective in other states.

The MMA is a strong supporter of the PMP and supported legislation in 2016 requiring all physicians to register for a PMP user account. But mandatory use for every prescription would be a cumbersome administrative requirement, particularly given the PMP's current limitations, most notably its lack of interoperability with most electronic health record systems.

In September, the Institute for Clinical Systems Improvement (ICSI) unveiled its guidance on opioid prescribing, which addresses the entire continuum for acute, sub-acute and chronic non-cancer pain in adults. The ICSI guideline recommends querying the PMP only in certain circumstances.

The MMA has also opposed mandatory CME for prescribers as an overly blunt requirement that fails to recognize the variable educational needs among physician specialties. The state attempted CME mandates in the past and subsequently repealed the requirements.

The MMA strongly encourages physicians who treat pain and prescribe opioids to address their knowledge gaps with specific and relevant information. To support physician education, the MMA has partnered with the University of Minnesota Medical School and the Steve Rummeler Hope Foundation to offer a variety of free webinars, which are available on the MMA website at www.mnmed.org/painseries.

Along with mandatory use of the PMP and required CME for prescribers, Swanson recommended a statewide standing order for naloxone, removing prior authorization requirements on

buprenorphine by Medical Assistance, reducing from one year to 30 days the maximum length of time a narcotic prescription can be filled.



Board approves new policies on HPV vaccination, firearm safety and more

At its November meeting, the MMA Board of Trustees approved several new policy positions on topics ranging from HPV vaccination to firearm safety.

With the board's action, the MMA now:

- Supports legislation that would add HPV vaccination to the list of health services to which minors can consent.
- Will promote conversations between providers and patients on responsible firearm ownership and safe storage in the home (much like current conversations on the use of child-restraint systems in the car); supports the growing movement for common-sense changes to gun laws to promote responsible gun ownership and supports efforts in Minnesota to require criminal background checks on all purchases and transfers/exchanges of firearms, with reasonable exceptions for immediate family and law enforcement and military acting in an official capacity; urges elected leaders to ensure that law enforcement officials have adequate resources to enforce the laws that hold sellers accountable when they sell firearms to prohibited purchasers; and supports state investment in Minnesota's

firearm surveillance system to improve data collection, analysis and research on firearm injury prevention.

- Identifies substance use disorders as chronic conditions that are both preventable and treatable, and urges greater attention and increased resources for substance use disorder prevention, treatment and recovery services in Minnesota.
- Supports efforts to move oral contraceptives to over-the-counter (OTC) status, noting that the benefits in terms of reducing unintended pregnancy outweigh the risks of OTC access and broader use. (This position is consistent with the position of the American College of Obstetricians and Gynecologists.)

Board takes action to reduce script drug spending

The MMA Board of Trustees approved recommendations from the MMA's MARCH (Minnesota Action to Reduce Costs in Healthcare) steering committee about ways



the MMA can address the rising and unsustainable cost of prescription drugs.

The board approved three broad strategies to address this problem:

- Working to increase appropriate prescribing
- Supporting passage of state legislation to improve the prescription drug market, protect patients, increase accountability of pharmaceutical benefit managers and reduce administrative complexity
- Partnering with and informing stakeholders, including patients, about steps they can take to reduce prescription drug spending.

The MMA recognizes that actions taken at a state level will have a more

limited impact than changes made on a national level.

Task force on mental health submits recommendations

The Governor's Task Force on Mental Health submitted its final report to Gov. Mark Dayton in mid-November. The report contained the following nine recommendations:

- Creating a comprehensive mental health continuum of care
- Redesigning governance of Minnesota's mental health system
- Using a cultural lens to reduce mental health disparities
- Developing a mental health workforce
- Achieving parity
- Promoting mental health and preventing mental illness
- Achieving housing stability
- Implementing short-term improvements to acute care capacity
- Implementing short-term solutions to improve crisis response.

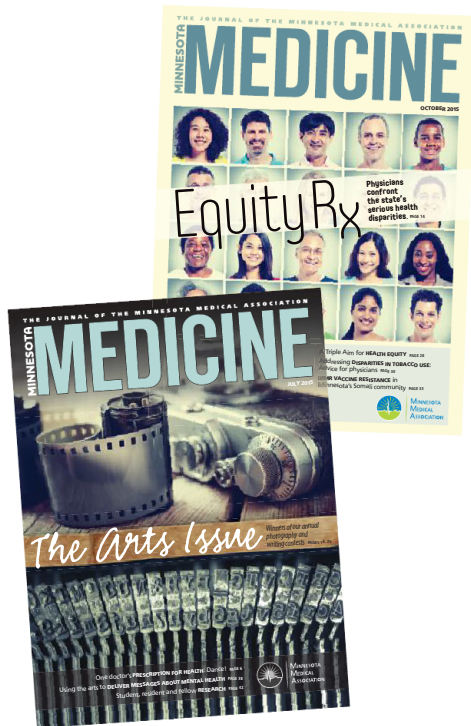
Dayton convened the task force to advise him and the Legislature on mental health system improvements within Minnesota. The 24-member task force included two MMA members, Paul Goering, MD, and Bruce Sutor, MD, as well as representatives of patients and families, service providers, counties, courts, law enforcement, corrections, public health, education, housing and legislators.

Be sure to sign up to attend
Day at the Capitol.

www.mnmed.org/DAC2017



Day at the Capitol
FEB. 15



Minnesota Medicine wins five magazine excellence awards

Minnesota Medicine won five awards at the annual Minnesota Magazine & Publishing Association (MMPA) Excellence Awards in November.

Here's the breakdown:

- **Gold** in the “Regular Column for Association Under 30,000” category for the magazine’s Perspective column
- **Silver** in the “Feature Article for Association Under 30,000” category for “Equity Rx,” which appeared in the October 2015 issue
- **Silver** in the “Editorial: Technical for Association Under 30,000” category for “The Opioid Epidemic and the Minnesota Board of Medical Practice” that appeared in the May/June 2016 issue
- **Bronze** in the “Overall Excellence for Association Under 30,000” category
- **Bronze** in the “Single Topic Issue for Association Under 30,000” category for the magazine’s arts issue (July 2015).

The MMPA is an organization of publishers, vendors, freelancers, educational institutions and sponsors.



Robert Meiches, M.D.



Dave Renner



Janet Silversmith



Eric Dick



Teresa Knoedler



Juliana Milhofer

MMA in Action

In early December, MMA CEO **Robert Meiches, MD**; **Dave Renner**, director of state and federal legislation; **Janet Silversmith**, director of health policy; MMA President **David Agerter, MD**; and MMA Board Chair **Douglas Wood, MD**, met with Erin Sexton, Mayo Clinic director of state government relations, to discuss MMA legislative priorities. Meiches, Renner and Silversmith also met with Sexton and Mayo’s Robert Nesse, MD, and Paula Santrach, MD, to discuss value-based payment reform.

Renner participated in a meeting of hospital and physician groups from southern Minnesota to discuss the problems caused by the MNsure changes and narrow networks. The late November meeting, convened by Sen. Julie Rosen (R-Vernon Center), included 11 provider groups from the Mankato, Fairmont, St. Peter, Madelia and Blue Earth areas. Rep. Bob Guthrie (R-Fairmont) and Sen.-Elect Nick Frenz (DFL- Mankato) attended as did Lauren Gilchrist from Gov. Mark Dayton’s office and Deputy Commissioner Dan Pollock and Assistant Commissioner Gil Asavados from the Minnesota Department of Health (MDH).

Eric Dick, manager of state legislative affairs, presented the MMA’s legislative agenda for the 2017 legislative session to the Rural Health Advisory Committee (RHAC) in mid-November. The RHAC is a statewide group at the Minnesota Department of Health that is tasked with serving as a forum for studying and investing in rural health care needs. The 15-member panel is composed of health care providers, consumers, legislators and others.

In mid-November, Meiches, Renner, Silversmith, Dick, **Teresa Knoedler**, policy counsel, and **Juliana Milhofer**, policy analyst, met with Minnesota Council of Health Plans staff to discuss upcoming legislative issues, individual market/MNsure challenges and the MMA’s MARCH effort.

In mid-December Meiches, Renner, Silversmith, Dick, Knoedler and Milhofer met with Minnesota Hospital Association staff to discuss legislative issues and priorities for 2017.

Also in mid-December, Meiches, Renner, Silversmith, Dick and Knoedler met with Health Commissioner Edward Ehlinger, MD, and senior MDH staff to discuss the upcoming legislative session.

VIEWPOINT

Medicine is best served when physicians participate in governing

This past November, a wave of Republican support washed over the country, including Minnesota where the GOP once again controls the House and Senate. The only thing standing in the way of a trifecta is DFL Gov. Mark Dayton, who wasn't up for re-election.

Does this bode well for physicians? It's difficult to say at this point. With Dayton's pen ready to veto any overstepping by the Republicans, legislators will have to play nicely at the Capitol. Compromise will be necessary for both parties.

Given its history of disdain for taxes, the GOP will likely support the sunset of the provider tax, which tacks on 2 percent to almost all physician and health care services. Thanks to a 2011 bipartisan agreement the MMA helped secure, the tax is scheduled for repeal at the end of 2019. The MMA has fought long and hard to keep this date on the calendar, and here's hoping that continues with the Republicans in power. We will also remain vigilant in our efforts to ensure that repealing the provider tax does not mean an end to the important programs that provide affordable care.

We may see more resistance when it comes to our efforts to reform medication prior authorization. Although our efforts have received bipartisan support during the past two sessions, the bill we supported has stalled because of arguments made by the special interests opposed to reform, including the health plans and pharmacy benefit managers. Their argument that reform will be expensive for both the state and employers, while dubious, may continue to hold sway with the Republican-controlled House and Senate and hold PA legislation back.

Given these challenges, I am calling on our members to get involved—at our annual Day at the Capitol on February 15; with our political action committee, MEDPAC; and when we call upon you to send Action Alerts to your state representative and senator. Legislators listen to physicians! We need more of our members to get active politically. I know that we are all busy with our careers, but think of the ever-increasing administrative burdens placed upon us. This bureaucracy keeps us from what we love to do most—take care of our patients. We need to influence those who seek to legislate how we practice.

Every voice counts.

Fortunately, the physician's voice will be amplified this year. Two doctors—Scott Jensen (R-Chaska) and Matt Kline (DFL-Mendota Heights)—were elected to the Minnesota Senate in November. It has been 14 years since we've had a physician serving at the Legislature, and now we have two. They sit on different sides of the aisle, but we know that Jensen, a family physician, and Kline, a hospitalist, will both be strong voices for the practice of medicine.

Physicians are leaders. Let's prove that more than ever this session. Get active. Take the time to get to know your legislator. They want to hear from you. Offer to be a resource to them so they can hear how their policy decisions will affect the patients you serve. Be the face of medicine to them. Let's make sure that the physician's voice is heard loud and clear in state and federal government because the decisions lawmakers make affect our patients and practices daily.



David Agerter, MD
MMA President

Physicians are leaders.
Let's prove that
more than ever this
upcoming session.

A Look at MACRA

What to Expect in 2017

BY JANET SILVERSMITH

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 fundamentally changes how physicians who care for Medicare patients will be paid. Although physicians won't see changes in their payments in 2017, they need to understand that their performance in 2017 will be the basis for the payments made to them starting in 2019. This article summarizes the two paths for determining future Medicare payments established by the law: the merit-based incentive payment system and advanced alternative payment models.

Big changes are coming for clinicians as the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) takes effect January 1, 2017. The law changes the way Medicare Part B payments to clinicians will be determined. MACRA does not affect hospital (Part A) or other facility payments; it also does not affect payment from Medicare Advantage (managed care) plans, which enroll approximately 55% of all Medicare beneficiaries in Minnesota. Although payments won't be changed under MACRA until 2019, physician performance in 2017 matters, as it will serve as the basis for those payments.

At its most basic, MACRA moves Medicare toward a value-based payment approach and establishes two paths for determining future Medicare payment for physician services: 1) the merit-based incentive payment system (MIPS) and 2) advanced alternative payment models (advanced APMs). Together, MIPS and advanced APMs are known as the Quality Payment Program. Starting in 2019, payments will be based on the MIPS or advanced APMs.

Most clinicians (an estimated 590,000 to 640,000 nationwide in 2017) will be subject to the MIPS. The law defines "MIPS-eligible clinicians" as physicians (MDs/DOs), dentists, chiropractors, podiatrists, optometrists, physician assis-

tants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and groups that include these clinicians who bill Medicare Part B. There are some specific exclusions, notably newly enrolled Medicare providers (for their first year); those with a low volume of Medicare business (defined in the final regulation to be those with \$30,000 or less in annual Part B allowed charges, or those who serve 100 or fewer Medicare Part B patients a year); or, those determined to be qualifying participants in advanced APMs.

As there are strict eligibility criteria for advanced APMs, far fewer physicians (70,000 to 120,000 in 2017) are expected to be eligible for the advanced APM path. The Centers for Medicare and Medicaid Services (CMS) will notify clinicians/groups if they qualify for the advanced APM path early in 2017.

This article summarizes the new payment approach under MACRA, focusing on the primary provisions of the law that take ef-

fect in 2017 in order to help position physicians for success under the new law.

Merit-Based Incentive Payment System

The design of the MIPS represents an intent to integrate and simplify existing Medicare incentive payment programs, specifically the physician quality reporting system, the meaningful use program and the value modifier. These programs will continue to affect payments through 2018 (note that payments are based on performance from two years prior, so payments in 2018 are based on 2016 dates of service). At the end of 2018, all three of these programs end.

Under the MIPS, physicians will be evaluated based on performance in four domains: quality, advancing care information using certified electronic health record (EHR) technology, clinical practice improvement activities, and resource use/cost. Each of these domains is weighted to calculate the final performance score (see Table 1). In a somewhat surprising

TABLE 1

2017 MIPS Performance Assessment Categories and Weights

ASSESSMENT CATEGORY	PERCENT OF OVERALL SCORE
Quality	60%
Advancing care information using electronic health records	25%
Clinical improvement activities	15%
Resource use/cost	0%

move, CMS applied a 0 percent weight to resource use/cost in the final regulation for 2017. Over time, however, that will change; the resource use/cost component will be 10 percent in 2018 (2020 payments) and 30 percent of the overall performance score by 2019.

Depending on their score, physicians/groups will see negative, neutral or positive payment adjustments in 2019. For the first year of the MIPS, physicians/medical groups must achieve a score of at least 3 (out of a maximum of 100 points) to avoid a negative payment adjustment; those with a score of 70 or higher will receive up to a 10 percent “exceptional performance” adjustment. The performance threshold will be redefined for 2018 (2020 payments) and annually thereafter.

The first year of the MIPS is a transition year, allowing practices to participate at their own pace and, as needed, to develop the necessary data-tracking and reporting capacity. Physicians can avoid payment cuts in 2019 by participating. Table 2 outlines the three participation options. Depending on the option selected and the demonstrated performance, practices may be eligible for a payment increase. Physicians should select the quality measures and clinical practice improvement activities that are most meaningful to and best reflect their practice. Failure to submit any data will automatically result in a 4 percent payment cut for 2019; the maximum payment increase in 2019 (excluding the exceptional performance adjustment) is 4 percent. The size of the payment increases/decreases will increase each year until 2022, when the maximum payment adjustments will be +/-9 percent.

Importantly, the MIPS payments will be budget neutral, meaning that the amount of the payment is subject to the available funds captured through payment cuts. The one exception to this is for “exceptional performance,” for which payment adjustments of up to 10 percent will be financed through new funding, for payment years 2019 to 2024 only. For 2017, physicians/groups must earn a MIPS score of 70 or higher to qualify for the exceptional performance payment.

TABLE 2

2017 MIPS Pick-Your-Pace Participation Options

1. **TEST:** Submit 1 quality measure, 1 clinical practice improvement activity or the 4-5 required advancing care information using EHR technology measures.
This option may be particularly attractive to practices that have not had experience submitting data to CMS through programs such as the Physician Quality Reporting System (PQRS). If this option is selected, physicians can avoid a negative payment adjustment in 2019.
2. **PARTIAL PARTICIPATION:** Report for at least a 90-day period and submit more than 1 quality measure, more than 1 clinical practice improvement activity or more than the required 4-5 advancing care information using EHR technology measures.
Physicians can avoid a negative payment adjustment and, depending on performance, are eligible for a positive adjustment in 2019.
3. **FULL PARTICIPATION:** Report data reflecting the full 2017 calendar year and report 6 quality measures (or a defined specialty-specific measure set) and the 4-5 required advancing care information using EHR technology measures, and demonstrate use of up to 4 clinical practice improvement activities.
This option gives practices the best opportunity for the greatest number of performance points and the highest potential payment update. This option does not, however, guarantee the maximum 4% payment adjustment as the update is based on performance, not simply the amount of data submitted.

Quality

For full participation, quality is based on the submission of six quality measures, including at least one outcome. If an outcome measure is not available/applicable, then the physician/group must report one other “high-priority” measure (outcome, appropriate use, patient safety, efficiency, patient experience or care coordination). Physicians/groups can choose from a list of approximately 260 options, which are a mix of outcome, process, efficiency, structure and patient engagement/experience measures. From these measures, 26 specialty-specific measure sets have been created, and groups may either choose from the full list of measures or report a predefined specialty set. For groups with 16 or more clinicians and with a minimum case size of 200, CMS will calculate from claims data and attribute to the group an all-cause hospital readmission rate. An initial proposal to also calculate and attribute acute and chronic conditions composite measures has been dropped for 2017.

Advancing Care Information

Minimum participation in this category requires reporting of four or five “base” measures. The specific measures for 2017 will depend on which certified EHR edition (2014 or 2015) is used by the physician/group. Generally, the base measures reflect e-prescribing, patient access, security risk analysis and health information exchange capabilities. Additional measures can be reported for “performance” and for “bonus” points.

Clinical Practice-Improvement Activities

This category, which is new, is intended to recognize efforts employed by physician practices aimed at improving care coordination, beneficiary engagement, population management and health equity. For full participation, physicians can choose from a list of 94 different activities and attest to employing (for a minimum of 90 days) either two high-weighted (20 points each) or four medium-weighted (10 points each) activities. For small practices, rural practices or practices located in geographic health professional shortage

areas (HPSAs), and non-patient-facing clinicians (ie, those who bill for 100 or fewer patient-facing encounters [general office visits, outpatient visits and surgical procedures, including telehealth services] during performance period), full participation is set at one high-weighted or two medium-weighted activities. Practices that are certified as patient-centered medical homes can automatically achieve full credit in this category. In a change from the proposed rule, a medical home can be recognized if certified by a national program, a regional or state program, a private payer or another body that administers patient-centered medical home accreditation. With this change, Minnesota certified health care homes are eligible for full credit in this category.

Advanced Alternative Payment Models

The advanced APM path is designed for those physicians/groups that are participating in alternative (to fee-for-service) delivery and payment structures that create incentives for quality and value and expose physician practices to some financial risk. As a matter of policy, MACRA favors the advanced APM option and included strong financial incentives in hopes of expanding their use. From 2019 to 2024, qualifying participants in advanced APMs can receive an annual lump-sum bonus payment equal to 5 percent of their annual aggregate Medicare payments for the preceding year. In addition, beginning in 2026, the base Medicare fee schedule increase is higher for APM participants than for MIPS clinicians (.75 percent versus .25 percent per year).

Qualifying as an advanced APM, however, is challenging. For 2017, CMS will recognize only six models:

- Next Generation ACO
- Medicare Shared Savings Program – Track 2
- Medicare Shared Savings Program – Track 3
- Comprehensive End-Stage Renal Disease Care Model
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model

Participating in one of these, however, is not enough. A sizeable portion of a physician group’s business—meaning, for 2017, either 25 percent of Medicare Part B payments or 20 percent of Medicare patients—must flow through the advanced APM in order for a physician to be considered a “qualifying participant.” Beginning in 2021, revenue and patients from other payers’ APMs can also be counted; however, the revenue and patient thresholds also increase. It is expected that additional advanced APMs will be available in future years. CMS has identified at least four new models that will likely be added in 2018, including new bundled payment models and a new ACO Shared Savings model.

Looking Ahead

Health care, specifically the Affordable Care Act or Obamacare, is expected to be an early and major focus of the 115th Congress and President-elect Trump’s administration. Although there are some early hints that Medicare may also face a variety of changes if the new congressional majority has its way, there is no current evidence that the bi-partisan MACRA law will be affected, at least in the short term. Minnesota physicians are encouraged to understand MACRA and their participation options now in order to maximize their Medicare Part B payment. This is particularly important as the potential penalties under MACRA will rise to 9 percent and in light of the growing share of revenue Medicare represents for many physician practices. Exploring the variety of options available in 2017 will help position physicians for success in 2018 and beyond. **MM**

Janet Silversmith is director of health policy for the Minnesota Medical Association.

SOURCE MATERIAL

Information in this article was derived from Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, Pub. Law 114-10, and Final Rule with Comment Period, Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models. FR Doc. 2016-25240 Filed: 10/19/2016 4:15 pm; Publication Date: 11/4/2016.



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Raising the Minimum Legal Sale Age for Tobacco to 21

The Estimated Effect for Minnesota

BY RAYMOND G. BOYLE, PHD, JOHN H. KINGSBURY, PHD, AND MICHAEL J. PARKS, PHD

A campaign to raise the minimum legal sale age for tobacco products from 18 to 21 years known as Tobacco 21 is having a nationwide impact, with at least 200 localities in 14 states having already implemented a Tobacco 21 policy. A 2015 report from the Institute of Medicine (IOM) estimated the effects of such policy on cigarette use at the national level; however, little is known about the expected effects for individual states. The purpose of this study was to consider the effect on smoking initiation in Minnesota if the minimum sale age were 21 in 2015. Estimates from the Minnesota Adolescent Community Cohort and Minnesota Adult Tobacco Survey were used to calculate the uptake of smoking in a hypothetical cohort of Minnesota adolescents 15 to 20 years of age. Expected reductions in initiation in the IOM report were used to calculate the effects of Tobacco 21 policy on smoking uptake in this cohort. Results revealed that raising the sale age to 21 in 2015 would prevent 3,355 young Minnesotans from starting to smoke.

Minnesota addresses tobacco use through a comprehensive approach that includes coordinating smoke-free policies, promoting normative changes in the social acceptability of tobacco use, establishing and expanding the reach of cessation programs, keeping the price of tobacco high and preventing young people from initiating tobacco use. The overall effect of these actions has been a 35% reduction in cigarette smoking in Minnesota since 1999;¹ however, tobacco use remains popular among young adults in Minnesota and nationally.^{1,2}

The persistence of tobacco use among young adults, coupled with an evolving marketplace that includes new flavored products (eg, flavored cigars and cigarillos) and new delivery methods (eg, electronic cigarettes), has led to a desire for increased regulation of tobacco. In 2009

the U.S. Congress granted authority to the Food and Drug Administration (FDA) through the Family Smoking Prevention and Tobacco Control Act to regulate the manufacture, distribution and marketing of tobacco products.³

Although this law prohibited the FDA from increasing beyond age 18 the national minimum sale age for tobacco products, state and local governments are able to raise the minimum sale age for tobacco. In addition, the law required a study of the health implications of a higher minimum age of legal access. The Institute of Medicine (IOM), now the National Academy of Medicine, conducted the study using national data to consider the effects of different minimum purchase ages (19, 21 or 25 years) and examine multiple outcomes, including preventing young people from starting and encouraging current smokers to quit smoking, and the health benefits from reduced smoking because of an in-

creased purchase age. Nationally, increasing the purchase age to 21 would result in approximately 223,000 fewer premature deaths and 50,000 fewer deaths from lung cancer.⁴

Adolescents younger than age 18 frequently obtain tobacco from social sources who are older than 18 but younger than 21.⁵ If tobacco could not be sold to 18- to 20-year-olds, they would be far less likely to provide tobacco to younger teens. By age 21, young adults are likely to have friends older than high-school age and, therefore, less likely to provide tobacco to minors.

The IOM's 2015 report is particularly important because it provides scientific guidance for state and local governments as they seek to protect public health. Although the report provided novel information on the expected effects of Tobacco 21 policy on a national level, it provided little

information about the expected effects at a state level.

The purpose of this study was to consider the effects on smoking initiation in Minnesota if the legal minimum sale age for tobacco products were 21. The specific goal was to calculate how many young people ages 15 to 20 years would not start smoking if the assumptions from the IOM report were applied to Minnesota.

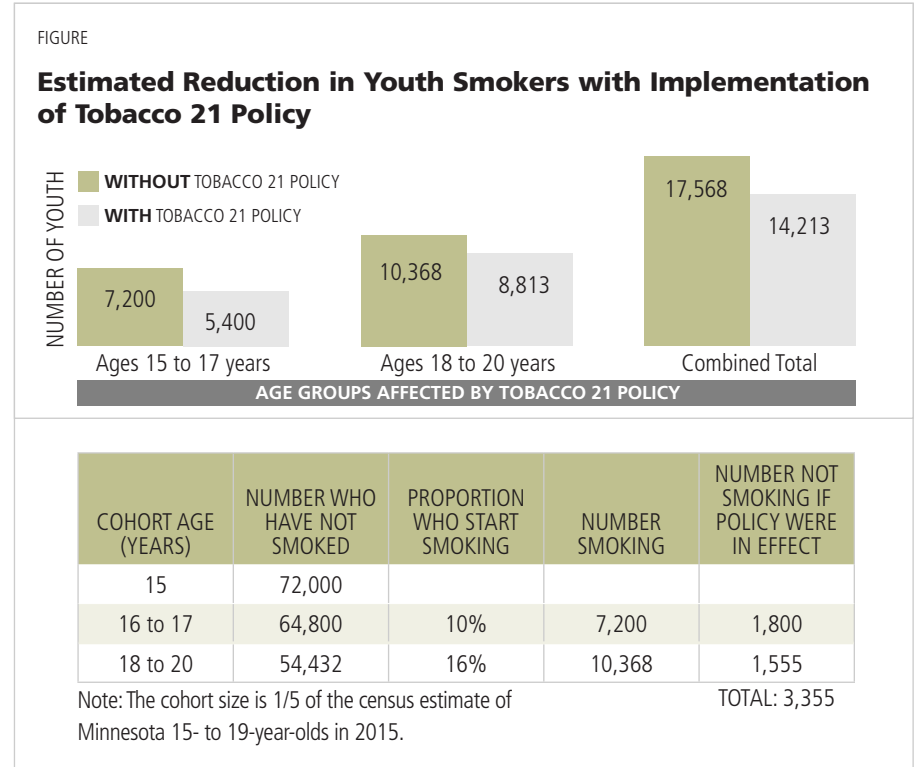
Methods and Assumptions

Age groups: The 2015 IOM report examined effects among specific age groups: under 15 years, 15- to 17-year-olds and 18- to 20-year-olds. In this analysis, we limited the consideration to ages 15 and older.

Initiation rate: Cohort studies that follow participants over time provide the best estimates of smoking initiation. The Minnesota Adolescent Community Cohort (MACC) study was a population-based study of Minnesota youth ages 12 to 16 in 2000 who were followed until 2008. In 2003, approximately 19% of the cohort reported smoking in the previous month.⁶ Smoking among Minnesota high school students has fallen to about 10% since 2003. Therefore, in this analysis we used 10% as the estimate of smoking initiation among youth 15 to 17 years of age.

In a later analysis of the MACC data, 16% of the cohort who did not start smoking in high school took up smoking (smoked in the past month) between the ages of 18 and 21.⁷ This estimate of smoking uptake is consistent with the prevalence of smoking among young adults in the Minnesota Adult Tobacco Survey. For this analysis we used 16% as the estimate of 18- to 20-year-olds who would initiate smoking.

Estimated effects of Tobacco 21 policy: An increase in the minimum sale age is expected to apply to all commercial tobacco products; however, for the purpose of estimating effects similar to those in the IOM report, the scope of this study was restricted to cigarette smoking. In addition,



tion, the expected reduction in smoking initiation is thought to vary by age. The effect is expected to be larger among youth 15 to 17 years of age, with an expected reduction in the uptake of smoking of 25%. Among those 18 to 20 years of age, the expected reduction is 15%.⁴

Variation by demographic variables: Smoking rates vary substantially by population groups in Minnesota. For example, in 2014 the overall adult smoking rate was about 14%,¹ but within the urban American Indian population the smoking rate was 59%.⁸ There is a lack of literature on how smoking initiation would be affected in population groups with higher smoking rates if the sale age were increased. Thus, the estimate here is not adjusted by gender or other demographic variables (eg, race/ethnicity, income).

Enforcement: States are required to enact and enforce laws prohibiting the sale or distribution of tobacco products to individuals younger than 18 years of age. A major assumption of Tobacco 21 policy is that the same level of current enforcement and retailer compliance would remain in effect. Although Minnesota has a high rate of retailer compliance with current law,⁹ retailer cooperation has been lower

in other places. For example, in New York City, compliance has fallen over time after Tobacco 21 policy was implemented.¹⁰

Calculation: In this analysis, we began with a cohort of Minnesota 15-year-olds in 2015—approximately 72,000. We estimated the smoking initiation rate in two periods: during high school (ages 15 to 17 years) and after high school (ages 18 to 20 years). Next, the reduction in smoking was calculated for each period if the sale age for tobacco were raised to 21 in 2015. We assumed that the smoking uptake in high school and after high school would not change in future years. The difference is reported as the number of young people 15 to 20 years of age who would not have started smoking.

Results

In 2015, the Minnesota population of those 15-year-olds was approximately 72,000. Of these, an estimated 7,200 will start smoking during their high school years. If the minimum legal sale age in 2015 were 21, an estimated 1,800 would not start smoking in high school.

Of those who finished high school without initiating smoking, 10,368 will begin smoking between ages 18 and 21. Under a Tobacco 21 policy, 1,555 fewer young people would start smoking after high school. Overall, 3,355 fewer young people would start smoking in this cohort of youth if a Tobacco 21 policy were in effect (see Figure). In other words, increasing the sale age to 21 would increase the proportion of nonsmokers in a cohort of 15-year-olds from 76% to 80%.

Discussion

Increasing the sale age to purchase tobacco products from 18 to 21 would have a positive effect on Minnesota, where tobacco use remains popular among young adults.¹ Given that almost 95% of smokers start smoking by age 21, raising the age of sale to 21 years would prevent the vast majority of young people from becoming addicted to the nicotine in tobacco.

At least 200 localities in 14 states have raised the minimum legal sale age for tobacco products to 21 years.¹¹ Notably, Hawaii was the first state (2015) followed by California (2016), and New York City (2013) is the largest city to adopt a Tobacco 21 policy. This policy has broad support and is viewed positively by both smokers and nonsmokers. In New York City, 60% of smokers and 69% of nonsmokers have supported the age increase.¹² In a national sample of adults, 70.5% supported the increase.¹³ And in an online survey, 77.5% of never smokers and 70% of current smokers either strongly favored or somewhat favored raising the legal purchasing age to 21.¹⁴

We acknowledge that some young people will begin using tobacco at a later age. The amount is unknown; but even if 5% eventually take up smoking, this would not diminish the overall effect of Tobacco 21 policy. In addition, while we have highlighted how Tobacco 21 would inhibit more than 3,300 youth from initiating smoking, it is important to note the policy could have additional and more indirect benefits. Youth tend to respond more

strongly to smoking bans than to other types of tobacco control¹⁵ in part because a ban is an unambiguous anti-tobacco message that indirectly influences social norms, creating a social environment that discourages health-risk behavior.¹⁶ Put differently, the effects of Tobacco 21 policy would extend into the future as new cohorts of young people do not start using tobacco.

Our analysis considered only cigarette smoking; but a Tobacco 21 policy would apply to all tobacco products. Whether the effects of raising the purchasing age to 21 would be similar across all demographic and racial/ethnic groups is not known. Similar to the IOM, we did not adjust the Minnesota estimate for any variation by demographics other than age. This question should be examined when there is sufficient data on communities that have implemented the policy.

Conclusion

Raising the minimum sale age for tobacco to 21 would prevent the uptake of smoking among youth and young adults, subsequently reducing smoking prevalence over time. Applying national estimates from the 2015 IOM report to Minnesota, we found that implementing a Tobacco 21 policy could have a marked impact on smoking initiation among Minnesota's young people. Tobacco 21 should be considered an effective strategy for reducing smoking initiation. Preventing smoking among youth remains a primary focus for reducing morbidity and mortality as well as promoting health across the lifespan. **MM**

Raymond Boyle is director of research programs for ClearWay Minnesota. John Kingsbury and Michael Parks are research scientists for the Minnesota Department of Health.

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THE BURDEN ON DEMENTIA CAREGIVERS

How Can Communities and Health Care Organizations Help?

BY RACHEL D. HAVYER, MD, LAUREN R. BANGERTER, PHD, ANGELA M. LUNDE, MA, MICHELLE VAN RYN, PHD, AND JOAN M. GRIFFIN, PHD

Family members are integral to the care, safety and overall well-being of persons with Alzheimer's disease and related dementias. Being a caregiver is often associated with significant isolation as well as emotional, psychosocial and financial burden. In recognition of the toughness of this job and the increasing prevalence of dementia, there has been growing momentum among public policy makers and within communities and the health care system to address the challenges caregivers face. This article describes efforts in Minnesota communities to do so. The authors make recommendations for communities and health care systems.

More than 46 million people worldwide are living with dementia, and that number is projected to double every 20 years.¹ Dementia has an impact on not only the individuals who experience it but also the ones, often family members, who care for them.

In the United States, an estimated 15 million people provide full-time care, typically without pay, for a loved one with cognitive impairment.^{2,3} The care that these individuals provide has been shown to improve quality of life and delay time to nursing home placement for persons with dementia.⁴⁻⁶ Yet caregivers often struggle with the emotional ramifications of their responsibilities. This is commonly referred to as "caregiver burden." Given that a person with dementia may live for many years with their disease, those who care for them may experience significant caregiver burden for many years resulting in psychosocial and physical consequences.^{2,3,7-9}

Increasingly, it is being recognized that communities and health care systems need to and can do more to support both persons with dementia as well as their caregivers. Many communities and health care systems are taking steps to better assist people with dementia and those who care for them. This article describes ef-

forts already underway in Minnesota and explores opportunities for future improvement.

Engaged Communities

A dementia diagnosis often leads to isolation for caregivers as well as their patients. Businesses, religious organizations, community organizations and local services are not routinely equipped to acknowledge, accommodate and support persons with dementia and their caregivers. If a community does have a resource, often it is a dementia program such as an adult day program. Although such programs provide needed respite for caregivers, they are typically separated from the mainstream of the community, which can perpetuate the stigmatization and marginalization of those with dementia. And such marginalization exacerbates the isolation of caregivers.

Communities in Minnesota have been looking for new ways to care for those affected by dementia and change attitudes about it. ACT on Alzheimer's, a statewide, volunteer-driven collaboration, is seeking large-scale societal change and building community capacity to transform Minnesota's response to Alzheimer's disease.¹⁰ ACT on Alzheimer's provides a number of tools ([friendly-toolkit\) to help communities identify their priorities and specific actions to take to become "dementia-friendly."¹¹ Currently, more than 40 communities in Minnesota are engaged in this work.](http://www.actonalz.org/dementia-</p>
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Many of the communities have identified dementia education and awareness as their top priorities. Rochester, Minnesota, for example, has taken steps to improve awareness that have included the creation of an educational booklet, "Living in our Dementia Friendly Communities." The booklet targets a broad audience, including those with age-related memory loss, mild cognitive impairment or dementia, as well as families, friends, youth, neighbors and businesses in the city and surrounding areas. The booklet emphasizes that each person in the community has a role to play in making sure that people living with memory loss, as well as their caregivers, feel understood and respected, and are given opportunities to participate and thrive in the community.

ACT on Alzheimer's is also helping communities train individuals and people in businesses and community groups to become more dementia-friendly through two programs: Dementia Friends (www.actonalz.org/dementia-friends) and Dementia Friendly @ Work (www.actonalz.org/dementia-friendly-work).

org/dementia-friendly-work). To date, Rochester has trained more than 500 hundred people in the community through these programs.¹⁰ In Dementia Friendly @ Work seminars, businesspeople learn to better recognize and offer assistance to persons with dementia and their caregivers, and to modify their environments to make it easier for persons with dementia to navigate. The training covers issues such as how to respond to looks of distress, how to provide assistance with and allow extra time for decisions or transactions, and how to create clear signage.

Some Minnesota communities are offering caregiver-preparedness courses. In addition, they are creating opportunities for both caregivers and individuals with dementia to recreate together such as by singing in choirs (www.givingvoicechorus.org) and offering “memory cafes,” which are safe places where they can gather and share their experiences (www.memorycafedirectory.com/memory-cafes-in-minnesota/).

Beyond Minnesota are national initiatives, including Dementia Friendly America (www.dfamerica.org), with the same passion to help communities become better able to meet the needs of those with dementia and their caregivers. Currently, Dementia Friendly America is helping to expand work that started in Minnesota to Tempe, Arizona; Santa Clara County, California; Denver, Colorado; Prince George’s County, Maryland; Knoxville, Tennessee; and the state of West Virginia.^{11,12}

Opportunities for Health Care Organizations

Health care organizations are realizing they need to improve in a number of areas if they are to effectively meet the needs of patients with dementia and their caregivers. One area of need is around communication. Caregivers typically have to navigate the health care system on behalf of a loved one with Alzheimer’s disease or a related dementia, which adds to the overall burden of caregiving. Health care teams rely heavily on caregivers and other family members to communicate with the individual about the progression of their disease and to help enact a care plan.

Training for health care providers on how to integrate family caregivers into the shared decision-making conversation is needed.¹³ Also needed is training for staff members on how they should approach, communicate with and interact with persons with dementia.

There also is a need for more early diagnosis of dementia. One of the goals of National Alzheimer’s Project Act is early and appropriate diagnosis of dementia.¹⁴ Clinically, there may be some reluctance on the part of health care providers to give a patient a diagnosis of dementia because of the difficulty of diagnosing the disease in its early stages and the lack of effective treatment options.¹⁵ A delayed diagnosis, however, may lead to fewer opportunities for persons with dementia and their caregivers to engage in anticipatory planning regarding care preferences. It also may delay their connecting with support groups or community programs.^{16,17}

Another need is around identifying and supporting caregivers. The presence of a caregiver is rarely documented in electronic health records. Even when clinicians recognize a caregiver is strained, there may be no integrated mechanism to formally assess the caregiver’s needs. Health care organizations need to develop ways to routinely identify caregivers and assess their needs and preferences in order to support their well-being, as it has an impact on the well-being of the patient as well.

Finally, caregivers need training when their loved one is being discharged from the hospital. Legislation requiring caregiver training prior to hospital discharge has been passed in at least 32 states, including Minnesota.^{18,19} Health care organizations may in the near future find they are required to better train caregivers during this care transition time.

ACT on Alzheimer’s has a number of tools including video tutorials that health care organizations can use to help their clinicians become more comfortable doing cognitive screening, delivering a diagnosis of Alzheimer’s disease or a related dementia, and managing the patient with dementia (www.actonalz.org/provider-practice-tools).¹⁰

Conclusion

There is growing recognition of the significant impact of dementia on patients, their families and their caregivers, and there is increasing momentum for whole communities and health care organizations to support people with dementia. There also is growing recognition of the importance of caregivers and the need to provide support and training for them. Many academic and community organizations in Minnesota have been on the forefront of a movement to better respond to the needs of those with dementia and their care givers; however, others including health care institutions, have fallen short. All organizations need to work toward acknowledging, accommodating and supporting persons with dementia and their caregivers. Health care organizations need to create streamlined systems for identifying and working with caregivers of persons with dementia. They also need to educate staff about how to approach, communicate with and interact with these patients and their caregivers. Doing so will enable their staffs to feel more comfortable diagnosing and talking with patients about the disease, and allow patients and their caregivers to better plan for the future.

Communities and health care organizations can do much to support caregivers and individuals with dementia. And with better alignment of that work, there is the potential of better outcomes for everyone involved. **MM**

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EMPLOYMENT OPPORTUNITIES

St. Cloud VA Health Care System

OPPORTUNITY ANNOUNCEMENT

Opportunities for full-time and part-time staff are available in the following positions:

- Internal Medicine/Family Practice
- Physician (Compensation & Pension)
- Physician (Extended Care & Rehabilitation)
- Physician (Pain Clinic)/Outpatient Primary Care
- Psychiatrist
- Urgent Care

US Citizenship required or candidates must have proper authorization to work in the US. Physician applicants should be BC/BE. Education Dept Reduction Program funding may be authorized for the health professional education that was required for the position. Possible recruitment bonus. EEO Employer



Since 1924, the St. Cloud VA Health Care System has delivered excellence in health care and compassionate service to central Minnesota Veterans in an inviting and welcoming environment close to home. We serve over 38,000 Veterans per year at the medical center in St. Cloud, and at three Community Based Outpatient Clinics located in Alexandria, Brainerd, and Montevideo.

Competitive salary and benefits with recruitment/relocation incentive and performance pay possible.

For more information:

Visit www.USAJobs.gov or contact

Nola Mattson (STC.HR@VA.GOV)

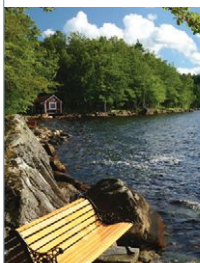
Human Resources

4801 Veterans Drive

St. Cloud, MN 56303

(320) 255-6301

EEO Employer



Located sixty-five miles northwest of the twin cities of Minneapolis and St. Paul, the City of St. Cloud and adjoining communities have a population of more than 100,000 people. The area is one of the fastest growing areas in Minnesota, and serves as the regional center for education and medicine.

Enjoy a superb quality of life here—nearly 100 area parks; sparkling lakes; the Mississippi River; friendly, safe cities and neighborhoods; hundreds of restaurants and shops; a vibrant and thriving medical community; a wide variety of recreational, cultural and educational opportunities; a refreshing four-season climate; a reasonable cost of living; and a robust regional economy!



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Minneapolis VA Health Care System (MVAHCS) is a teaching hospital providing a *full range* of patient care services with *state-of-the-art technology*, as well as *education and research*. Comprehensive health care is provided through *primary care, tertiary care and long-term care* in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics and extended care.

Minneapolis VA Health Care System

Opportunities are available in the following specialties:

- Anesthesiology
- Anesthesiology Chief
- Associate Chief of Ambulatory Care
- Director of Geriatrics Center of Excellence
- Emergency Medicine
- Hospice and Palliative Care Physician
- Hospitalist
- Internal Medicine/Family Practice (FT or PT)
- Outpatient Clinics: Maplewood, MN; Ramsey, MN; Rochester, MN; Chippewa Falls, WI; Hayward/Rice Lake, WI; Superior, WI
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EMPLOYMENT OPPORTUNITIES

Sioux Falls VA Health Care System

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- Pain Medicine
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- Pulmonary Medicine
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- OB/GYN
- Oncology
- Orthopedic Surgery
- Pediatrics
- Psychiatry
- Psychology
- Pulmonary/ Critical Care
- Rheumatology
- Sleep Medicine
- Urgent Care

FOR MORE INFORMATION:

Shana Zahrbock, Physician Recruitment
shana.z@acmc.com | (320) 231-6353

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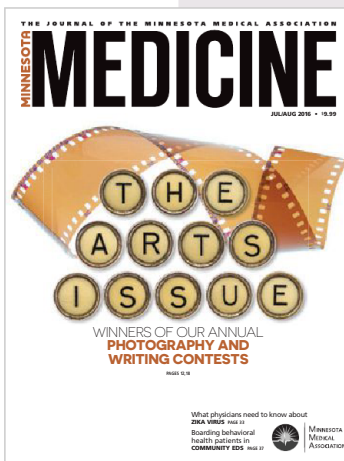
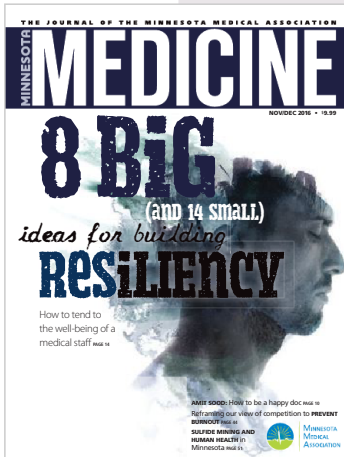


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Deadline for submissions

February 21, 2017

Submit your abstracts and vignettes at
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Questions? Contact editor at
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BY E. KENNETH WEIR, MD

Smart? She was smart,
never lost at Scrabble,
remembered relatives of
neighbors, dead for decades,
chemical formulae and forms
of etiquette, all stacked
in the library of her mind.

Later, it seemed, she
could no longer find
the right shelf. Rummaged
around to recall those
who had eaten at her table
the previous night.
Mother had - - - what's his name?
You know, that, that disease.



E. Kenneth Weir is a professor of medicine and of integrative biology and physiology at the University of Minnesota.

ABOUT THIS PIECE:

"This poem was inspired by memories of my mother struggling to remember, when I forget a name or place."

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