Utah Academy of Family Physicians Journal

2020 Utah Legislative Session

Page 22

Utah Finally Expands Medicaid

Page 26

UTAH ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR UTAH


Together for:

UNIVERSITY NEUROPSYCHIATRIC INSTITUTE

CONSULTATION ACCESS LINK LINE TO **UTAH PSYCHIATRY**

CALL-UP

YOU'RE NOW EMPOWERED TO PROVIDE **BETTER MENTAL HEALTH** TREATMENT.

Utah now has a statewide psychiatric phone consult service. **CALL-UP** is a legislative funded program designed to address the limited number of psychiatric services in Utah and improve access to them. The program serves patients ages 24 and younger at no cost to providers or patients throughout the State of Utah.

HOW WE CAN HELP:

- Optimize primary care providers' ability and confidence to diagnose and treat mild to moderate mental health issues
- Improve quality of care and health outcomes for patients by affording early interventions
- Promote and improve behavioral health and physical health integration
- Ensure appropriate referrals for individuals with serious health concerns

CONSULT HOURS:

12:00 pm–4:30 pm, Monday through Friday (closed on holidays)

utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

HEALTH
UNIVERSITY OF UTAH

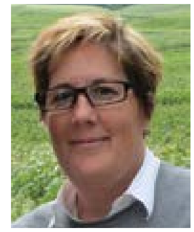
801.587.3636

UOFUHEALTH.ORG/CALL-UP

CONTENTS 2020

UTAH ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR UTAH

Maryann Martindale



As I write this issue's letter, we are in the midst of dealing with the COVID-19 pandemic. As a telecommuting office, we have already been working from home for over a year, but with spouses and children home, things are definitely different. The cloud of uneasiness and anxiety that hangs over everything is palpable.

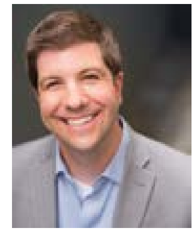
But as I deal with this new, current, reality, I find myself looking to the incredible inspiration I find in our dedicated physicians and other first-line health care professionals across the state. The commitment to providing the best care under less-than-ideal circumstances has certainly been tested, but your resilience is nothing short of inspiring.

Before the stay-at-home orders, I had the opportunity to visit with a group of students at the Rocky Vista University College of Osteopathic Medicine. One of the best parts of this job is the interaction I'm able to have with students and residents who are pursuing careers as family physicians. As we all age and move into different phases of our professional lives, we undoubtedly look at who will be coming up behind us, and who will the next leaders be. If I had to look no further than our upcoming family docs, I would have more than sufficient reason to be optimistic about our future.

I believe we can come out of this crisis stronger than ever. We've shown the state, and the whole world, that our health care professionals are here for us, no matter what, but also that you deserve better. We need to be better prepared. We need the equipment necessary to do the job at hand in as safe a manner as possible. We need support from governments and elected officials to support legislation that helps our practices and alleviates undue administrative burdens. We also need to nurture and aid the next generation of doctors, and we need to honor the profession for the life-saving and life-sustaining work that it truly is.

At UAFP, we want you to know we are committed to fighting for you every step of the way. Through legislative work, both state and federal, through our advocacy for students and residents, and through providing meaningful resources and comradery within the profession — we are here for you.

Kyle Bradford Jones, M.D., FAAFP



While the health care system has struggled with the COVID-19 pandemic due to multiple factors, one thing has become even clearer to me — supporting and emphasizing family medicine in our system is crucial to fighting all sorts of pathological and societal maladies.

Earlier in my term, I asked you all to share your stories as family physicians with patients, lawmakers, regulators, and the press, to anyone who would listen. I know that many of you are doing that. We have to keep spreading the gospel of an adequately supported family medicine as the key to a high-functioning health care system. Thanks to our efforts, certain media outlets seek out the UAFP and some of our physicians for any stories on healthcare-related issues. Our current president-elect, Dr. Isaac Noyes, myself, and others have had opportunities to support stories by local and national outlets, and the UAFP is increasingly viewed as a health care leader in our state. We have also been active in writing op-eds for our local papers on critical health issues.

Our influence at the legislature also continues to grow thanks to the efforts of our Executive Director, Maryann Martindale, and our Program Director, Barbara Munoz. Many family physicians are invited to testify in front of various legislative committees and are sought out for our expertise on patient health. Our presence is felt on Capitol Hill.

But these are not the most important ways in which our voices are heard. It is every day, with every patient, where family medicine truly shines. When people have been nervous or apprehensive about COVID-19, they turn to their trusted family doc. When help is needed, and many specialists have even less access during the pandemic, we step up and address our patient's needs. We are the ones who lead with virtual medicine, addressing questions over the phone, and providing expertise to local health departments. Family medicine has more than proven its worth through this crisis.

The legitimate worry now is what will happen after the pandemic is over. What will medicine look like? Will payment mechanisms change to better support the unmatched value and benefit of primary care? Will payers and regulators now realize how much beneficial non-face-to-face patient care we provide? Or will it just return to business as usual? One thing is clear — it's not going to change unless we change it.

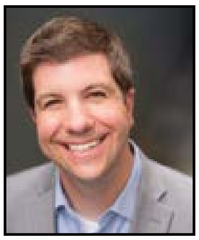
That's why we all need to continue building and furthering our relationships, and keep sharing our story, with everyone we can. The AAFP has done a tremendous job of connecting with decision-makers in Washington. As they continue to work on the national front, we have to make sure that health care in Utah is what our patients deserve — high quality, accessible, and coordinated with primary care at the helm. Time and again, studies have shown that primary care provides the best value in health care. Those with a primary care physician live longer, have better outcomes, go to the hospital less, and cost the system less, despite this including the sickest among us. Our response to the COVID-19 crisis proves this even more.

We need to raise our voices to those in power that family medicine carried the system during this pandemic, and we will continue to carry the system in the future if we receive the support needed to care for our patients.

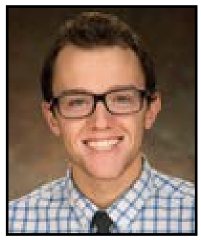
2020/2021 Utah Academy of Family Physicians Board of Directors

Thank you for your service on the UAFP Board!

Executive Committee



Kyle Jones, M.D., FAAFP
President



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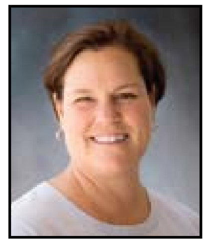
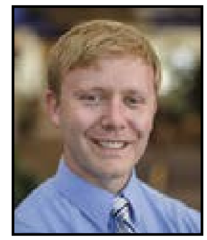


Nicole Clark, M.D., FAAFP
Immediate Past President



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Thea Sakata, M.D.
Sarah Scott, M.D.
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Jesse Spencer, M.D.
Karyn Springer, M.D.
Kirsten Stoesser, M.D., FAAFP
Mark Wardle, D.O.
Sarah Woolsey, M.D., MPH, FAAFP

Mission

The mission of the Utah Academy of Family Physicians: To improve the health of all Utahns by advocating for and serving the professional needs of family physicians.

Vision

The vision of the American Academy of Family Physicians and the Utah Chapter: To transform health care to achieve optimal health for everyone.

Interested in Becoming a Member of the UAFP Board in the Future?
Contact us at boardchair@utahafp.org for more information.

AAFP Delegates and Alternates

Jesse Spencer, M.D.
Kirsten Stoesser, M.D., FAAFP

AAFP Alternate-Delegate

Sarah Woolsey, M.D., MPH, FAAFP
Chad Spain, M.D.

McKay-Dee Family Medicine Resident Representative
Vacant

St. Mark's Family Medicine Resident Representative
Lyman Woolins, M.D.

Utah Valley Family Medicine Resident Representative
Tyson Schwab, M.D.

University of Utah Family Medicine Resident Representative
Sherilyn DeStefano, M.D.

Family Medicine Interest Group (FMIG) Student Representative
Ali Etman
Jessica Fullmer
Son Nguyen

Class of 2020

Congratulations to our Family Medicine Resident Graduates!

University of Utah Family Medicine Residency

Robin Brown, M.D.
Geriatric Medicine Fellowship
University of Utah

China Cox, M.D.
Hospital Medicine Faculty
University of Utah

Zach Fredman, M.D.
Future Plans Pending

Anna Holman, M.D.
Sports Medicine Fellowship
University of Utah

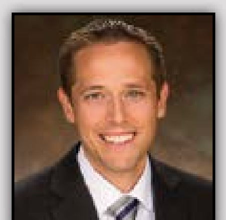
Cole Hurley, M.D.
Clinical Attending
Maine Medical Center

Jess Petrovich, M.D.
Family Medicine OB Fellowship
University of Utah

Cat Vanier, M.D.
Intermountain Healthcare
West Jordan, Utah

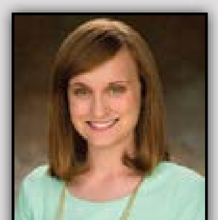
Lindsey Yanke, M.D.
Community Health Centers
Salt Lake City, Utah

St. Mark's Family Medicine Residency



Brian Johnson, M.D.
Cedar Ridge Family Medicine
Cedar City, Utah

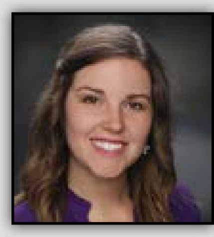
Taylor Williams, M.D.
Northwest Community Health Center
Libby, Montana



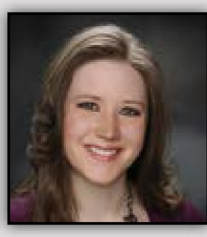
Danielle Williamson, M.D.
North Atlanta Primary Care
Alpharetta, Georgia

Cammey Young, M.D.
Hospitalist
Utah Regional Hospitals, Utah

McKay Dee Family Medicine Residency

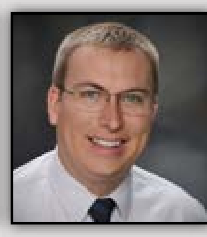


Madison Beatty, M.D.
Emmett, Idaho

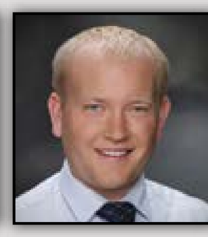


Haleigh Emerson, M.D.
Roy, Utah
Tanner Clinic

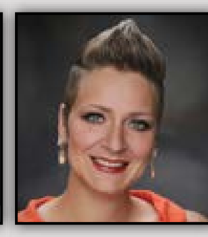
Laura Giove, D.O.
Riverton, Utah
Intermountain Healthcare — Rose Canyon Clinic



Spencer Ruben, D.O.
Phoenix, Arizona



Jake Saunders, M.D.
Ogden, Utah
Midtown Community Health Center

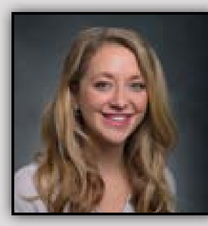


Jeanne Wigant, M.D.
Spokane, Washington
OB One-Year Fellowship, then to Monticello, Utah

Utah Valley Family Medicine Residency

Eric Franklin Bennett, M.D.
Southeast Idaho Family Practice
Idaho Falls, Idaho

Chase Benchley Brown, D.O.
Shenandoah Medical Center
Shenandoah, Iowa



Bethany Rose Jackson, D.O.
TBA

Eric Jacob Jemison, D.O.
Providence Family Medicine
Spokane Valley, Washington

Leslie Jean McNaughtan, M.D.
The Chautauqua Center
Dunkirk, New York

Blake Stephen Taylor, D.O.
Intermountain Bear River Clinic
Tremonton, Utah

Gregory Lee Winger, M.D.
Revere Health Care Clinic
St. George, Utah

2020 Match Results for Family Medicine

Congratulations to the following University of Utah medical students who matched into family medicine!

- Jessica Fullmer — Utah Valley FM Residency, Provo, Utah
- Ali Etman — University of Arizona College of Medicine, Phoenix, Arizona
- Son (Skyler) Nguyen — St. Marks FM Residency, SLC, Utah
- Fangda Jiang — Forbes FM Residency, Pittsburgh, Pennsylvania
- Michael Prestgard — Duke Family Health Centers of San Diego, California
- Stephen Gren — Transitional Year, Intermountain Medical Center, SLC, Utah. He will do family medicine training in the UK.
- Tessa Nell — Utah Valley FM Residency, Provo, Utah
- Joshua Hansen — McKay Dee FM Residency, Ogden, Utah
- Matias Calquin — Utah Valley FM Residency, Provo, Utah
- Houston Reynolds — Family Medicine Residency of Idaho Nampa Program, Idaho

We look forward to announcing the names of the first class graduating from Rocky Vista University — Southern Utah in 2021!

F. Marian Bishop Award of Excellence

UAFP congratulates Jessica Fullmer (pictured here with her husband, Cody Fullmer) who was awarded the F. Marian Bishop Award of Excellence this year. The award, named after the first woman ever named to lead a department at the University of Utah School of Medicine, is awarded each year to a graduating senior who has matched into family medicine. The winner is voted on by their fellow fourth years, who are also matching into family medicine. Fullmer will be starting her residency at Utah Valley Family Medicine Residency in June. Congratulations to Fullmer and all the graduates — based on the caliber of young doctors in this class, the future remains bright for family medicine!

AAFP Membership Cancellation Date and CME Reporting Changes

As you focus on serving your patients, and AAFP has cancelled all live, in-person CME events through May 31, we want to make sure you have one less thing to worry about. Thus, we are making the following changes related to CME requirements and dues, effective immediately:

- AAFP members whose CME reelection cycle ends on Dec. 31, 2020, who have not met the requirement, will have an additional year to fulfill their CME requirement.
- Members whose CME reelection cycle ended on Dec. 31, 2019, will now have until Dec. 31, 2020, to report their CME, which they earned prior to Dec. 31, 2019, to remain eligible for membership (the original deadline was May 5, 2020).
- Any members who have not yet paid their 2020 dues will now have until July 14, 2020, to do so.
- Additional details about the extension for members up for CME reelection in 2019 or 2020 will be available online soon.

We hope these changes provide you with the flexibility you need to remain an AAFP member.

For any questions, please contact the Member Resource Center at (800) 274-2237 or aafp@aafp.org.

Updates From the American Board of Family Medicine (ABFM)

Dear fellow UAFP member:
As I reported in the most recent UAFP Magazine, the American Board of Family Medicine (ABFM) has entered a dynamic phase of transformation in support of excellence for our discipline. Right now, though, as family physicians across Utah are making enormous changes in practice to continue serving our patients during and after the COVID-19 pandemic, I would like to emphasize just two points:

1. **ABFM is committed to ensuring that this crisis does not jeopardize your Board certification,** and
2. **You can be recognized with Practice Improvement credit** for changes you are making in your practice in response to the pandemic.

Please see below the message from the Board for details, and contact me directly if you have any questions or suggestions. ABFM also has a COVID Update section on its website at www.theabfm.org/covid-19, where you can find all information about current and ongoing changes to certification deadlines and activities.

Michael K. Magill, M.D.
Professor and Chairman Emeritus
Chair-Elect, American Board of Family Medicine

The American Board of Family Medicine thanks all family physicians for their exceptional commitment to caring for their patients and their communities during the COVID-19 pandemic. We recognize that these are truly unprecedented times and want to do everything we can to allow you to focus on what is most important: your patients and your families. Our commitment is **that no family physician will lose their ABFM certification because of the extraordinary patient care pressures associated with this pandemic.**

Family physicians across the country are learning rapidly about COVID-19, applying what they learn to their practice setting, and adapting their approach to provide better care for patients at an unprecedented rate. ABFM will recognize you for these contributions in its continuing certification program. Additionally, if you are unable to participate in certification activities or Family Medicine Certification Longitudinal Assessment (FMCLA) in 2020 because of the demands of this pandemic, **it will not jeopardize your certificate or your ability to continue your certification.**

At this time, ABFM has made the following accommodations to the deadlines for your continuous certification participation:

1. All diplomates with a three-year stage ending in 2020 will have a one-year extension on completing all stage requirements.
2. For diplomates participating in FMCLA, the Quarter 1 deadline has already been extended through June 15, 2020; we anticipate extending completion guidelines further for subsequent quarters. For first-year participants, we will adjust the meaningful participation guidelines.
3. Any diplomate in Year 10 of their certification cycle who opted for the one-day examination will have an additional year to meet their examination requirement.
4. Any board-eligible family physician with an eligibility end date in 2020, or anyone participating in the reentry process with an end date in 2020, will have an additional year to obtain their certification.
5. Any diplomate who also holds a Certificate of Added Qualification with an examination deadline in 2020 will have the option for an additional year to complete the examination requirement.
6. For those facing financial hardship as the result of the pandemic, we will establish a method for delaying 2020 payments. This change will take a short time to be implemented online, but once available, diplomates will find information about this in their Physician Portfolio, which can be found at https://portfolio.theabfm.org/

These extensions do not prevent anyone with a 2020 deadline from staying on the current timeline. Certification activities will be accessible for anyone who wants to use them. We are continuing our efforts to improve our current Knowledge Self-Assessments (KSA) and will begin to support learning on COVID-19 as evidence becomes more available. Specifically related to the Performance Improvement (PI) requirement, we will be providing a mechanism to meet the PI requirement by asking you to tell us about the unprecedented and rapid changes that you had to make in the ways that you deliver care, regardless of practice type or scope.

Further details will be communicated to those directly involved in the items listed above over the coming weeks. We are working out many operational details. It will take up to a month to reflect these changes in your Physician Portfolio, which you can find at https://portfolio.theabfm.org/. You can access updated information on our website at https://www.theabfm.org/covid-19. We are also committed to an ongoing review of what is happening as the pandemic evolves, and will adjust as necessary going forward.

We support you in the weeks and months ahead as you do the critical and challenging work required of this profession. It is nothing less than heroic.

Sincerely,
The American Board of Family Medicine

UAFP's Fifth Annual CME & Ski

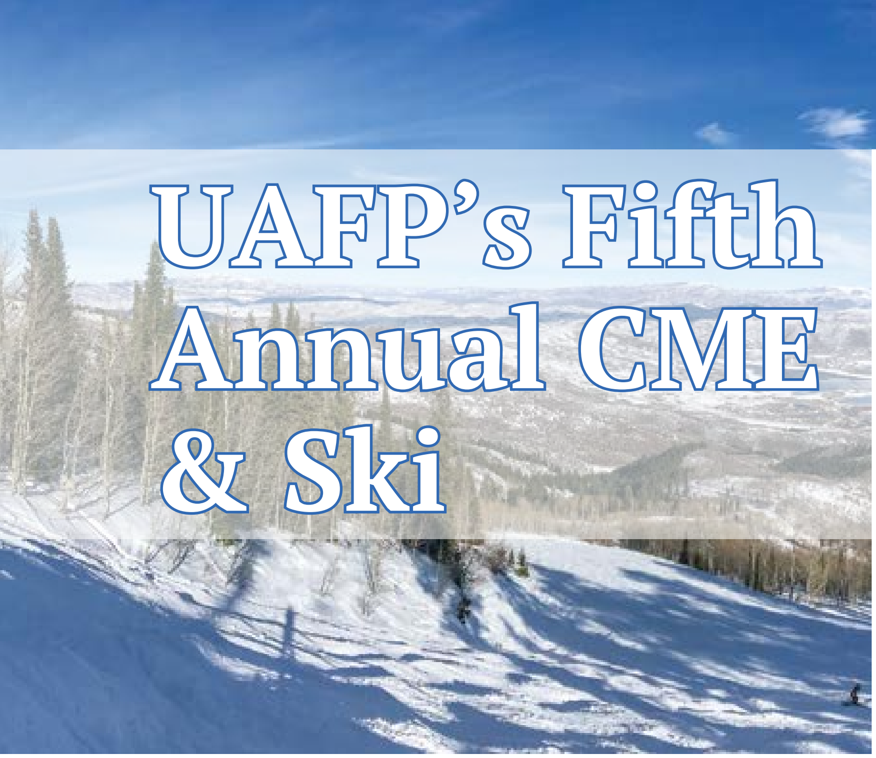
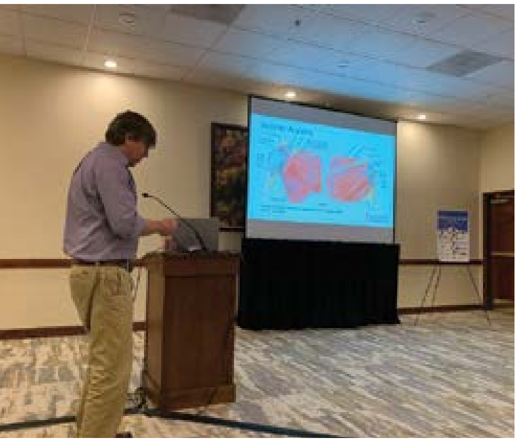


Photo credit to April Gordon



The 2020 UAFP CME & Ski Conference held at the Westgate Resort in Park City, Utah, was the most successful yet! We had over 100 people attend from 25 different states, including family doctors, nurse practitioners, residents and medical students. Attendees spent early mornings and late afternoons in the classroom but enjoyed a four-hour break in the middle of the day to enjoy skiing, snowboarding, and the many other winter activities Park City has to offer.

We are incredibly fortunate in Utah to have an abundance of talented and knowledgeable physicians willing to present evidence-based and topical CMEs to our attendees. Those in attendance this year engaged in CME topics such as Screening and Treating Alcohol Use Disorders in Primary Care, Implicit Bias: Building a Culture of Inclusion, Fibromyalgia Treatment Updates, Asthma and COPD Pharmacotherapy, LGBT Health Topics, and Recent Advances in the Management of Hyperkalemia.

We want to extend our thanks to all of our incredible speakers this year. They include Steven Call, M.D.; Matthew Clayton, D.O., Paula Cook, M.D., DFASAM; Emily Hagn, M.D.; Jordan Knox, M.D., CAQSM; Michael Magill, M.D.; Bruce McGee, M.D.; Nick Monson, D.O.; Teshamae Monteith, M.D., FAHS; Hanna Raber, PharmdD, BCPS, BCACP; Ted Paisley, M.D.; Biff Palmer, M.D.; Tricia Petzold, M.D.; Joel Porter, M.D., FAAFP; Rohn Rigby, M.D.; Erika Sullivan, M.D., M.S., M.S.; Gabriela Vargas, M.D., M.S., FACS, and our KSA presenters Nikki Clark, M.D., FAAFP; Sarah Daly, D.O., FAAFP, and Michael Rhodes, M.D.

The conference would not be possible without our sponsors! Tremendous thanks to our PLATINUM sponsors, University of Utah Health and Utah Department of Human Services Substance Abuse and Mental Health; GOLD sponsor, LiveCare; and SILVER sponsor, Molina Healthcare; and to all our exhibitors who attended this year's conference!

UAFP is moving forward with planning for the CME & Ski conference, but we also recognize that there is still considerable uncertainty around the COVID-19 pandemic. Our staff and planning committee will continue to explore options to provide valuable CME to our members and other medical professionals around the country. Whether we can see everyone in person in February 2021, or we offer top-quality education virtually, UAFP will strive to provide the services and support our members need most during this uncertain time.

Member Spotlight

Theadora Sakata, M.D.

Dr. Theadora "Thea" Sakata possesses many great qualities: brains, wit, athletic prowess, compassion, and humility. This last one becomes evident when talking about her college and postgraduate education. She attended Harvard for her undergrad, Cambridge for her master's degree, and Northwestern for medical school. But when asked what she thinks set her apart to gain admittance into some of the most prestigious universities in the world, "Honestly, I think it's dumb luck," is her reply. However, just a few minutes of conversation with her demonstrates that "dumb luck" has nothing to do with it.

Sakata grew up in the San Francisco Bay Area, where her father practiced pathology and nuclear medicine. Her life started just north of the Golden Gate Bridge in Marin County, where she describes her childhood as somewhat charmed and bucolic. "There was a redwood grove behind my house, where my brother and I would spend hours playing. We called it the 'Ewok Forest' and were left to our own devices to explore and get into just the right amount of trouble." At the age of 10, Sakata's family moved closer to Stanford University when her father's job changed. Fearing that she would get lost in her new district's larger class sizes, her parents decided to put her in a private school and sent her to Castilleja School, the only nonsectarian girls' school in the Bay Area. Sakata says, "I really credit Castilleja for laying the foundation for how I think and how to form healthy woman-to-woman relationships. The school stressed critical thinking, a STEM education, and trying to make your world a better place."

Sakata went on from Castilleja to attend college at Harvard. When asked about the admission process, Sakata is less than impressed with herself and her credentials. "I was a good student and was involved in tons of extracurriculars, but there were a lot of applicants who were good students and involved in tons of extracurriculars. I feel like I won a lottery; honestly, after a point, I think it's all dumb luck." Despite having attended Harvard, she still feels that her college experience was pretty typical. She sang with the Radcliffe Choral Society, played a year of JV softball, and was a map editor for the student-run travel guide, Let's Go. In 2002, Sakata graduated with her bachelor's in environmental science and public policy.

After college, Sakata went on to pursue her master's degree in land economy at Cambridge University in England. When asked to describe that particular field of study, she says, "If you ask five different land economists, you'll get five different answers." She describes it as a cross between environmental policy, land-use planning and economics. After finishing her degree, she still was not sure what she wanted to do for a career and realized how much she liked working with people. She thought back to a course on human health and the environment that she completed as a Harvard undergrad, and this piqued her interest in medicine.

After completing her masters, Sakata returned to Boston and became a teaching assistant for the environmental health class she loved so much as an undergraduate. During that time, she also began looking into post-baccalaureate programs and decided to complete her pre-med courses at Barnard College in New York. Following her time there, she returned west to work at the University of California San Francisco (UCSF) Breast Care Center for Dr. Laura Esserman. Those years of training under Dr. Esserman were

Member Spotlight | Continued on page 14

> After graduating from medical school, Thea matched at the University of Utah for her family medicine residency. When asked why Utah was at the top of her rank list, she says she had a formula when looking at different programs. First was a set of key criteria: a strong program with both academic and community settings, the opportunity for a rural medicine experience, available outdoor recreation, and a location with a strong food scene.

Member Spotlight | Continued from page 13

fundamental in developing how she approached person-to-person care. In her position at UCSF, Sakata wore two hats: working both as a research coordinator for breast cancer trials and also with a group called the Decision Support Corps, which coached patients through a shared medical decision-making tool developed by the department. "Working at the Breast Care Center made clear to me the importance of setting up patients for success; and that success should be defined by the patient's values, not the practitioner's."

After two years at UCSF, Sakata started medical school at Northwestern University in Chicago. At first, she did not know what specialty she wanted to pursue. She shared that Northwestern is known for producing specialists, not family medicine doctors. Only 12 from Sakata's class of over 170 went into family medicine, an increase from three people the year before. She says that during the first summer of medical school, many students will do research; but she decided to look instead for an exploratory experience that would help her choose a specialty. The Illinois Academy of Family Physicians had a summer externship that placed students with a family doctor somewhere in Illinois. She applied, looking to have a rural placement. Her grandparents were lettuce farmers back in California, and spending time with them piqued her early interest in rural medicine. Sakata was placed in Quincy, Illinois, and that summer, she says she got to see family medicine in all its glory. She was able to participate in a farm safety day, helped with delivering babies, and spent some time with a sports doc there who got her started thinking about completing a sports medicine fellowship in the future.

After graduating from medical school, Thea matched at the University of Utah for her family medicine residency. When asked why Utah was at the top of her rank list, she says she had a formula when looking at different programs. First was a set of key criteria: a strong program with both academic and community settings, the opportunity for a rural medicine experience, available outdoor recreation, and a location with a strong food scene. "Bonus points" were given to a residency located in or near a state capitol so she could learn about advocacy. The Salt Lake area also got additional points for being home to an Olympic speedskating oval, as she had started speedskating in her fourth year of medical school. Finally, while she did not have many social or familial ties to Utah at the time, she had one significant historical link: her great-grandfather was a Presbyterian minister who led a congregation in Ogden for several years after getting out of the internment camps in the 1940s.

After finishing her residency, Sakata completed a sports medicine fellowship at the Cleveland Clinic. There, she was able to indulge her love of sports, particularly baseball. "Cleveland had the best opportunities for seeing how to manage the care of a professional baseball team." In addition to accompanying her attendings to Indians games and spring training, she and the other sports fellows took care of the Mahoning Valley Scrappers, a Class A minor league team in Niles, Ohio. "For the record," she states that she has been and always will be a San Francisco Giants fan. "I got a baseball card signed by Will Clark in 1988, and that was that."

Yearning once again for the mountains, Sakata returned to Utah after finishing her fellowship. She wanted to work for a health care system that prioritized innovation around health care delivery, which made working for Intermountain Healthcare an excellent fit. Sakata now works full time as an urgent care physician through Intermountain Healthcare's Instacare clinics. She was encouraged to look into work in urgent care by a fellow UAFP board member, and she says that so far, her experience has been fascinating. "A lot of people think it's all just coughs and colds, but it's a lot more interesting when part of a broader system. At urgent care, you see the times when people don't know where to start or how to otherwise access health care." Working in urgent care, Sakata describes seeing "another front of the front line" when patients arrive with a problem and don't have a primary care physician. In this position, she can start the conversation about why it is important to have a relationship with a doctor for continuity of care. "People aren't taught those things unless they are already involved in health care or have a family member who has had health issues," Sakata states. When patients arrive for an ankle injury or URI, she sees an opportunity to get them educated about having a family doc to help them stay otherwise healthy. "I tell patients that it's like having a car — if no one ever told you that you needed an oil change, how would you know you needed one prior to something going wrong?"

When discussing the need for more family physicians in states such as Utah, Sakata says there needs to be more training opportunities and further innovations around true team-based care. "I think there are two answers here: what is ideal and what is possible. When people see family medicine done well, that is an inspiring and beautiful thing. Family medicine done well is individualized human care; it's meeting the patient where they are and assisting them with getting where they need to go. Without meaning to sound like a broken record, it's setting up the patient for success. Having more residency spots and having institutional support from the heads of health care systems is critical; we need as many family docs as we can get, but I don't think we will get there through training alone. I am a very strong believer in team-based care, but it needs to be done appropriately, or you lose the individual. As soon as people feel like they are a number instead of a person, you lose the magic and the heart of health care. Team-based care consists of the M.D. and the APP sharing patients, both of them getting to know the patient well and determining who needs to see the patient and when. It takes incredible institutional support."

Having grown up in Silicon Valley, and having won her high school's first Technology Award as a senior, Sakata also has strong feelings about incorporating more tech into health care. "But it is paramount that health care should always be people-driven and technology-assisted, never the other way around."

As Sakata is now living and working near the state's capital, she is involved in legislative advocacy when time allows. She believes advocacy is important because "there is so much that happens outside of a clinic's doors that affects what goes on inside of them. Whenever I feel frustrated in clinic, nine times out of 10 I can trace that frustration to something that is out of my immediate control: a social determinant of health, a state or national policy, or some other circumstance of 'the system' that blocks a patient from what they need. When I was in college, I had a professor who advised us to always ask two questions of a situation (thank you, Richard T.T. Forman): Why aren't things a little bit different? And why aren't things very different? Applying these questions to health care helps me find a way forward, and getting involved with advocacy is just a part of answering these questions."

Thea lives in Cottonwood Heights with her partner Edwin and their dog, Barkley Maxwell von Muttface, Esq. On her days off, you can find her puttering in her garden, fly casting with a hope that it becomes fishing, or trying to ski away from anyone who might nominate her for Jerry of the Day. She also really likes maps.

Resident Spotlight

Robin Brown, M.D.

I was born and raised in Portland, Oregon. As shown in the show Portlandia, "the dream of the 90s" was absolutely alive during my childhood. It was an eclectic community with a strong sense of local culture, and I spent much of my childhood outdoors learning how to care for the environment and other people.

My mother is a foot care nurse, my father is an architect, and my sister is an airline pilot. They are all still living in Oregon. My sister and I spent our formative years enthralled in horse 4-H, riding English style, and studying horse behavior and anatomy, all of which was an early introduction to communication and leadership skills. In adolescence, my mother and I moved in with my then-95-year-old grandfather. He was one of the founders of modern psychiatry and community mental health. Despite his aging body, he continued to fuel his curiosity and fervor for life through his final years. He would read The New York Times from cover to cover and ride his stationary bicycle for 5 miles each day. He often assigned me to look up the meaning of obscure words or exotic subject matters, and then we would huddle over the dinner table, reviewing my findings. Although aged and in need of assisted care, the caregiving role between us was fluid and reciprocal. Fast forward to now, I find myself reflecting on that time in my life when I am working with families of my older patients, recalling the strengths and challenges of my own intergenerational relationship. There is no doubt that this experience informed my interest in geriatrics.

My list of hobbies is endless, and like many people who have transplanted into Utah, most of them are outdoor. I enjoy trail running, bike commuting, rock climbing, skiing and now backcountry skiing. Since starting residency, I do most of these activities at a "maintenance level," not making huge strides in my capabilities, but getting outside just enough to keep up my skills and love for the sport. My indoor hobbies have really blossomed since the coronavirus pandemic. These range from listening to vinyl from my parent's generation, napping with my black cat Ella, finding new podcasts, and in the last month, my boyfriend and I have been cooking our way through a Spanish tapas cookbook, Toro Bravo.

I received my undergraduate degree in biology from the University of Oregon. I stayed an extra year to complete an honors thesis in evolutionary biology where my project looked at genes involved in craniofacial development in a long-snouted fish, the pipefish. After graduation, I joined a research group at Oregon Health & Science University (OHSU) that was studying the role of exogenous melatonin to treat circadian rhythm disruptions in blind adults and children. Both this and my undergraduate research experience sparked my love for science, but they also fueled my desire to step out from behind the lab bench and into a role that would allow for more human interaction. This desire led me to a position at Old Town Clinic, a medical clinic that serves homeless adults in downtown Portland. It didn't take long at this job to realize just how passionate I was about patient care, particularly for underserved communities, and I applied to medical school shortly after that. During college summers, I had always worked food service jobs, and after college, I picked up hours at a local Italian restaurant. I bring this up because there were so many nonmedical experiences that informed the physician I am today. Last month I was on my rotation in the emergency room, and I found myself comparing the skills of customer service and multitasking in the ER to the fast-paced milieu of the restaurant industry.

My path to medicine was winding, but I am thankful for the time and experiences that happened in between undergraduate and medical school. It allowed me to truly choose medicine and to see that decision as a privilege. I always encourage those considering medical school to take time off after undergraduate; they will know themselves better and relate to their patients more genuinely.

Choosing Family Medicine

Like many who go into family medicine, I liked most of my rotations in medical school. But, slowly, I narrowed my interests to nonsurgical, outpatient specialties. A mentor in medical school told me that picking a specialty comes down to three things: the people, the work and the reading. He said that

I would discover my specialty by finding co-workers whom I wholeheartedly respect, liking what I do 90% of the time, and identifying which set of practice guidelines I would readily curl up at night with to read. I happily checked all three when I picked primary care via family medicine.

Residency and Living in Utah

I never imagined that Utah would now be my home, but I could not be happier to be here. I wanted an academic program and to stay in the Western states, so I found myself interviewing at the University of Utah. I fell in love with Utah on my interview day. It was a bluebird day after the first snow of the season. The mountains were shimmering, and the air was fresh. The faculty members I met on my interview day were infectious; they were clearly passionate about resident education and delivering effective primary care. I really connected with the fact that the leadership team was mostly women. It wasn't until that interview that I realized how much I wanted a program with gender diversity in its leadership. Now I look back and have no doubt that the women mentors in my program have been a huge part of my success in residency. They've inspired me and shown me what is possible as a young female physician.

Although I came here for the program, I think the location is really important, too. When medical students ask my advice about picking a residency, I always say the following: you will work six days a week for much of your training, so pick a place where on that one day off, you can do what rejuvenates you. For me, that is being in proximity to nature.

There have been so many memories from residency, but when I think about what has brought me the most joy, it is from experiencing what it feels like to have a continuity panel of patients. Finally, by the end of the intern year, there were a handful of patients that I knew really well. And now, I don't have a clinic session that isn't full of returning patients. The patient-provider relationship creates a new level of accountability and motivation for quality patient care. This kind of relationship was the reason I went into primary care, and it's so nice to finally experience it.

One of the more challenging aspects of family medicine residency is the constant setting changes, from inpatient to outpatient, from pediatrics to labor and delivery to intensive care. This change can be wearing, but it lends to one of the most treasured strengths of family medicine residents, which is adaptability and comfort with uncertainty. Everything in life is about attitude, and residency is no different. Last year we tragically lost one of our co-residents, and when I find myself struggling with the pace or expectations of residency, I think of how lucky I am to be here, and I try to honor her by living my best life and doing my best job.

It was refreshing to see how robust the LGBTQ community is in Salt Lake City. Working with this community in the clinic, particularly through transgender care and HIV pre-exposure prophylaxis (PrEP), has been one of the most rewarding parts of residency. There wasn't much training in medical school about transgender health or sexual health outside of what has traditionally been termed "women's health." The University of Utah clinics here have been a leader in delivering gender-affirming primary care, and I could not be more proud to be a part of this. As I move into geriatrics, I am really interested in staying connected with and caring for the aging LGBTQ community.

Geriatric Fellowship

During my residency, I realized how passionate I became when working with older patients. It was almost as simple as which patient visits I looked forward to the most. There was no particular moment in which I identified my passion for caring for older adults. Instead, I gradually gravitated toward this population. With my older patients, I found myself poring over their illness histories, looking for the disease culprits, and wondering how their comorbidities may have contributed to their aging organs or vice versa. The medical complexity was motivating. The awareness of and proximity to death for older people lends itself to shared decision making and discussions of goals of care. This awareness has allowed me to be more present for my older patients and provide the type of human-paced "slow medicine" I wish to practice.

I think there is often an illusion that simply because we (family or internal medicine residents) care for older patients that we are being thoughtful about, or are getting the teaching for how we might care differently for these patients. Older adults face unique medical, psychiatric and social challenges. One of the fundamental roadblocks for delivering better care to older adults is the paucity of research in this age group. This lack has led to the unfortunate reality of simply extrapolating data about medication safety and disease states from studies conducted in younger people. Other unique conditions of older people include the onset of cognitive disorders, polypharmacy from amassing medications, concerns of independence versus patient safety, and opportunities for palliative and hospice care interventions. Yet, given all of this, I would be amiss not to recognize one of the biggest misperceptions of geriatrics: that geriatrics is a homogenous population. There is incredible heterogeneity with age; one 80-year-old patient may be frail and a wheelchair user, while the next one is healthy and independent. Recognizing this is one of the attributes of geriatric-trained providers.

Once I realized I wanted to practice geriatric medicine, I knew immediately that I wanted to do a fellowship. That was an easy decision for me as I want to be a clinician-educator and stay in an academic environment after training. However, I do not think one needs to do a fellowship to be skilled in the care of older adults. Of course, medical schools and residency programs could do a better job and bolster their time and expertise in geriatric curriculums, but with motivation and the right tools, there is a lot of learning one can do on one's own.

For example, this is the perfect time to improve the care of your older patients. As the novel coronavirus (COVID-19) is challenging our health care system, primary care providers are in a unique position to be doing proactive planning with our oldest and most vulnerable patients before acute illness

Resident Spotlight | Continued on page 18

Resident Spotlight | Continued from page 17

occurs. Last week I gave a talk to our residency on this. These discussions are via advance care planning (ACP), a broad term that includes discussions about what matters most in life but also documentation with advance directives and POLST forms. We are having honest and difficult conversations about what we've learned about COVID-19, first globally and now within the country. Mortality rates for older people and those with comorbidities are soberingly high. The conversation you have is not "if your heart stops do you want us to restart it," but more along the lines of "if you were to become sick with COVID-19 and required heroic efforts, such as CPR at the time of your death, your chance at survival is exceedingly low." Long story short, these discussions are of the highest importance, not only for goal-concordant care, but also to reduce exposure of our medical personnel to high viral loads during code scenarios, and also to preserve PPE and ICU resources. Again, you do not need a geriatrics fellowship to deliver quality care to older adults.

Something we are concerned about at UAFP is the shortage of family physicians in Utah and in many other areas in the U.S. We know that one of the problems is lack of residency programs and not enough spots in those that exist. Do you have any thoughts on what Utah and the U.S. should be doing to encourage more students to go into family medicine?

A healthy medical system has a foundation in excellent primary care. We need to create a culture in U.S. medicine where that is, in fact, the paradigm. To encourage more students to go into family medicine, we need to model for them what successful family medicine looks like. That modeling means we need to be supported and celebrated within medicine. One of the ways we could be better supported is through an exploration of alternative payment models, allowing us to take more time with our sicker patients. We could also use more support with documentation, either by increasing our training and tools for efficient electronic medical record use or, in some cases, considering hiring scribes. Being a generalist is one of the hardest specialties. You need to have comprehensive knowledge, insight into your limitations, and tailored communication skills. This breadth of knowledge can be intimidating for students. For more exposure, I think medical students need to spend the majority of their MS3 rotations in generalist fields, such as family medicine, rural medicine, pediatrics, internal medicine, emergency medicine and general surgery. You should not be an accredited medical school if you are not able to offer these generalist rotations.

"A healthy medical system has a foundation in excellent primary care. We need to create a culture in U.S. medicine where that is, in fact, the paradigm."

Where do you hope to practice once you have completed your fellowship?

I could not be happier to be in Utah for my residency and fellowship, but afterward, I'm looking to head back to Oregon to be closer to family. In addition to the sunshine, I'm hoping to bring back skills as a clinician-educator, teaching medical students and residents about primary care and geriatrics.

Student Spotlight

Kathryn Forneris

To start, tell us a little bit about yourself and your background — where you grew up, went to school, your family, interests, hobbies, etc.

I grew up in Sioux City, Iowa, with my older brother, my parents and several dogs. As a family, we spent a lot of time outside playing various sports. Weekends were split between my brother's baseball games and my soccer games. As I've grown older, skiing, hiking, and camping have taken the place of organized sports for the most part, although I play on intramural teams when possible. I spend most of my free time pursuing outdoor activities and catching up with friends and family.

When did you become interested in science and medicine?

I always enjoyed learning, and I found the sciences, particularly those related to the human body, to be deeply interesting. A career in medicine was always on the radar. However, I took time off after graduation from the University of Iowa to further explore my interests. At that time, I worked as a nursing assistant and traveled abroad when possible. I'm grateful for that period, because my time as a nursing assistant taught me a lot about the patient experience and the health care system, while my time traveling taught me a lot about myself and what I needed to be content. Through both of those experiences, I realized that the ideal position for me would challenge me, allow for plenty of social interaction, and position me to use my skills to benefit others.

Tell us about your journey that took you to medical school:

I graduated from the University of Iowa with a B.A. in psychology and a B.S. in human physiology. I then went on to pursue my MPH from Des Moines University. Between my formal education and my work as a nursing assistant, I was provided multiple perspectives of health care. I grew to better understand the factors affecting health and wellness, from societal to psychological factors. I thoroughly enjoyed my coursework, which strengthened my desire to continue pursuing a degree in medicine. More importantly, I realized how much I enjoyed working as a member of the clinical team and working closely with patients.

What was it that drew you to Rocky Vista? How has your experience been with the program overall?

I actually stumbled upon Rocky Vista-Southern Utah very serendipitously. During my travels, I happened to drive through Utah and instantly fell in love with the red rocks and wide-open space. I convinced some friends to come back out and explore all of the national parks with me in the two summers preceding my application to medical school, and so my feelings toward the state only grew stronger. I had high hopes coming into the interview, and RVU-SU did not disappoint. I noticed the students seemed very close to one another and very happy. Between the atmosphere, the COMLEX scores, the format of the curriculum, and the beautiful surroundings, I was sold.

Since then, RVU has not disappointed. The sense of community is extremely strong, the faculty and staff are kind and knowledgeable, and my free weekends are spent traveling around the Mountain West to hike. It has been everything I could have asked for in my medical education, plus more.

Student Spotlight | Continued on page 20

> The work is difficult, but it has been extremely rewarding to push through the challenges and to do so in the company of good friends. You become extremely close to your classmates, all of whom are in the same boat. Additionally, I have very much enjoyed the chance to interact with the faculty and practice my clinical skills. Several members of the faculty have become role models for me, so the opportunity to learn from them is extremely exciting.

Student Spotlight | Continued from page 19

What are the best aspects of medical school? The most challenging?

As you may be able to tell already, I have really enjoyed my medical school experience thus far. The work is difficult, but it has been extremely rewarding to push through the challenges and to do so in the company of good friends. You become extremely close to your classmates, all of whom are in the same boat. Additionally, I have very much enjoyed the chance to interact with the faculty and practice my clinical skills. Several members of the faculty have become role models for me, so the opportunity to learn from them is extremely exciting.

However, the dedication required throughout medical school can be draining. There have been several occasions where I have really struggled to adjust to the constant grind. As someone who studies best alone, it can begin to feel isolating. The stress and isolation together can become a heavy burden to bear. That is when those relationships mentioned above with other members of the RVU community have become especially valuable. I have had several peers and professors who took the time to help me through those rough moments, and I am immensely grateful for them.

How has it been adjusting to doing classes online due to social distancing?

A large portion of our curriculum has always been available online, so the classwork itself has not changed much. However, I miss interacting with my peers, my professors, and the rest of the staff at RVU-SU. As an osteopathic student, specifically, going without labs has been difficult. But on the bright side, all of this time at home has allowed me to pick up new skills. I am currently working on learning to juggle. I may need a few more months of social isolation to achieve this goal, but I'm closer than I was two months ago.

You've taken on a leadership role in family medicine in your program at RVU. Tell us a little bit about that experience. What are the aspects about family medicine that interest you the most?

I became involved with the Student Association of the American College of Osteopathic Family Physicians (ACOFP) early in my medical career, acting as OMS-I Representative my first year and Chapter President my second year. I chose to do this for a couple of reasons. I knew I was interested in future leadership within the field, and so I felt it necessary to gain experience early. In that regard, my skills have grown immensely. I've learned how to delegate, organize a group behind a cause, and effectively and efficiently run meetings and events. Membership in our chapter of the ACOFP led to additional leadership opportunities at the national level, as well as scholarships/awards for myself and our chapter.

I chose the ACOFP, specifically, because family medicine/primary care excites me! I had the same family physician for roughly 18 years. He cared for not only me but also my brother and my parents. I loved the idea of getting to know a patient, as well as their family and their overall background. Over the years, I grew to trust him, confide in him, and take direction from him (even throughout my teenage years). Health is an extremely personal matter, and I think a trusting relationship between a provider and a patient forms the foundation of effective primary care and strengthens the ability of a provider to impact a patient's well-being. As I grew older and talked to other people, I realized that not everyone had that relationship with their physician, and so I hoped to shed light on the potential for other medical students. I think primary care offers a perfect opportunity to provide preventive care and impact the well-being of the community one patient at a time. I'm acutely aware of the importance of that role, as well as the shortage of primary care physicians, so I thought the ACOFP was a perfect fit for me.

Where do you hope to complete your residency? Where and what kind of practice do you hope to go into? Why?

I ponder these questions all of the time, and truth be told, I don't have it all figured out yet. I am confident that I would like to pursue a career in primary care, but there are a multitude of settings within which I could practice. I am confident that throughout rotations this year, I will receive the training necessary to delineate my residency interests further.

If you could give one or two REALLY valuable pieces of advice for first-year medical students, what would you tell them?

As my second year comes to a close, and I prepare to move into the next phase of my education, I've come to realize

> **"Enjoy your time with your classmates, because it's over a lot quicker than you would think."**

a lot of things I will miss about my first two years. Classes are tough, but you're struggling alongside all of your peers, and that shared "misery," of sorts, brings people together. Enjoy your time with your classmates, because it's over a lot quicker than you would think. On the same note, know that when you're struggling, you aren't alone. It's tough for everyone, and everyone reacts to the pressure in different ways. Impostor syndrome is real, and it can make it very difficult to confide in others, but every time I've taken that chance, my relationships have grown stronger, and I've felt much better as a whole. Make time for others and enjoy that time. Lean on them in times of need, and be there to return the favor. Every phase of life has associated challenges and triumphs. While the first two years of medical school present immense challenges, they also provide the opportunity for incredible growth, professionally and personally. Enjoy it!

2020 Utah Legislative Session

Our Legislative and Advocacy Committee was hard at work again during this year's legislative session. We reviewed hundreds of bills, analyzed their impact on family physicians, testified during committees, lobbied legislators, all to promote favorable legislation for the practice of family medicine.

We prioritize bills based on three categories — Practice Management, Healthy Outcomes for Patients, and Promotion of Family Medicine. Some of our priority bills for the 2020 session included:

- HB313 Telehealth Parity Amendments: We really had to pull out all the stops to get this bill passed before the session ended. It got stalled at the end, as bills will do, and we used all our political muscle to get it through its final vote. This is a great bill that expands rules to allow all physicians to provide telehealth services, including for patients with Medicaid. It requires certain health benefit plans to provide coverage parity and commercially reasonable reimbursement for telehealth services and telemedicine services. We plan to continue working to refine this law and expand reimbursement parity with in-office visits.
- HB207 Insulin Access Amendments: As you've no doubt experienced, drug prices have spiraled out of control. One of the most egregious examples of this is the high cost of insulin, a drug that costs between $2 and $6 to make often costs several hundred dollars per vial. We were successful in helping pass this bill that caps the monthly out-of-pocket cost at $30. It has some creative provisions to ensure support by the insurance industry, and it includes a study that will provide important information that could prove useful in future legislation related to drug pricing.
- HB285 Utah Professional Health Program: We recognize the high level of stress and the unfortunate potential for substance abuse among health professionals. This bill enacts a program for health care professionals to provide an alternative to public disciplinary action for licensees who have substance use disorders. UAFP was a strong supporter of this bill, and we see it as a positive way to provide help to those physicians who may be struggling with addiction without risking their livelihood when they seek treatment.

UAFP Executive Director, Maryann Martindale, testifying in support of HB 207 Insulin Access Amendments.

Dr. Kirsten Stoesser testifying in support of legislation sponsored by Representative Jennifer Dailey-Provost that would provide a tax credit for preceptors. While it did not pass this year, UAFP will continue to work with Representative Dailey-Provost to pass this important legislation.

Dr. Sarah Woolsey (left) testifying in support of HB313 Telehealth Parity Amendments sponsored by Representative Melissa Ballard (center).

- HCR7 Encouraging Congressional Action on Medicare Drug Prices: Along with bills that enact legal change, we also support resolutions that encourage action by our federal delegation. This resolution strongly encourages Congress to take action in negotiating and reducing the cost of Medicare drug prices.
- Insurance Coverage for Children (this was an appropriation request and did not have an associated bill file): Continuity of care is critical, especially when dealing with higher-risk populations. UAFP strongly supported this appropriation that will provide coverage for children under Medicaid, regardless of a change in family circumstances during a calendar year.

As is typical of a whirlwind session with hundreds of bills, we're not always successful in pushing every piece of legislation we have prioritized. We will continue to lobby for appropriations to provide loan repayment funding for those who elect to serve in rural or underserved areas. Also, we had proposed legislation this year that would give a preceptor tax credit. While it passed committee, it did not ultimately pass, and we'll be working with legislators to educate them on the importance of these critical medical education opportunities while providing a small amount of relief to offset the impact on the preceptor's practice.

If you have suggestions for legislation, we would love to hear from you, and if you would like to get more involved, please consider joining the Legislative and Advocacy Committee. We are your voice on the hill and are working hard to ensure positive legislative outcomes for family physicians and their patients.

For a complete list of all bills during the 2020 legislative session, visit le.utah.gov.

Lunch With a Legislator and Family Medicine Advocacy Day

Every year, UAFP hosts several advocacy events to coincide with the annual Utah Legislative Session. This year, we applied for a grant from AAFP, and thanks to their generosity, we were provided with additional funds to expand our advocacy work.

Our annual Lunch with a Legislator is a great opportunity for legislators to provide insights into the legislative process and to highlight important bills that will be of interest to family physicians. It also provides the chance for physicians to share concerns they may have, discuss the impacts legislation has on their practices, and make recommendations for pro-family medicine legislation. We added another legislator lunch in Utah County, held at the Adobe offices, and we are hoping to host one in Southern Utah this fall.

Family Medicine Advocacy Day is our annual day on Capitol Hill. Legislative process and advocacy ideas are explained, and physicians spend time visiting with legislators and advocating for UAFP targeted bills. This year we also had a presentation from AAFP on their advocacy efforts at the national level.

Advocacy is critical to represent the positions and needs of family medicine. We appreciate everyone's participation, the legislators' willingness to meet and listen, and encourage all to participate in these important efforts in the future.


OUR MISSION
To improve the health of all Utahns by advocating for, and serving the professional needs of family physicians
UTAH ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR UTAH

Utah Finally Expands Medicaid

By Jessie Mandle, Senior Health Policy Analyst at Voices for Utah Children

When I moved to Utah almost six years ago from the San Francisco Bay Area, many people were talking about "Medicaid Expansion." It's embarrassing to admit now, but I was not familiar with expansion. I was lucky enough to have insurance. California had long ago expanded its Medicaid program. What was everyone talking about?

I would soon become deeply immersed in Utah's fight to expand Medicaid when I joined the nonprofit children's advocacy group, Voices for Utah Children. My organization, along with many others, including the Utah Academy of Family Physicians, the Utah Health Policy Project, AARP of Utah, the Association for Utah Community Health, and others, worked together over the years to close the Medicaid coverage gap.

Utah's fight to expand Medicaid has been long and challenging: numerous legislative efforts; a 2018 statewide ballot initiative in which Utahns voted for full expansion; the Legislature's complicated multiphased modification to the voter-approved expansion, which left many Utahns frustrated and confused and still without coverage. Finally, on Jan. 1, 2020, Utah accepted full expansion and became the 37th state in the nation to expand Medicaid and close the coverage gap.

As we now face the dual crises of a pandemic and economic downturn, it is more important than ever to look at what Medicaid expansion means for Utahns and the actions we need to take going forward.

What was the Medicaid Coverage Gap? A Quick Refresher: Since its inception, Medicaid has been a health insurance program for low-income children, seniors and people with disabilities. Medicaid is financed through a shared state-federal financial arrangement. The feds take on most of the cost of the program, with states providing a "match." In Utah, the federal government pays about 70% of our Medicaid costs, while Utah puts up the other 30%. Over the years, new categories of people have become eligible for Medicaid, such as pregnant women and extremely low-income parents. But until recently, most parents and almost all low-income adults under 65 and without a disability had not qualified for Medicaid coverage.

A key piece of the Affordable Care Act was that it directed all states to expand their Medicaid program. Knowing this would be a financial challenge for states, the ACA said that states would pay no more than 10% of the cost to expand Medicaid, and the federal government would cover the remaining 90%.

> **What's more, Medicaid is particularly important to help low-income children stay healthy. In Utah, approximately 160,000 children are enrolled in Medicaid — two-thirds of all Medicaid enrollees. Decades of research show that children with Medicaid coverage had better health outcomes, higher graduation rates, and greater economic success as adults, compared to low-income children unable to obtain Medicaid.**

But as we know, the Supreme Court did not uphold this provision of the ACA — leaving many states who chose to simply not expand.

Unfortunately, the elaborate health care marketplace the ACA set up did not account for states rejecting Medicaid expansion. The ACA health care marketplace only allowed people to enroll if they made above the federal poverty level. As a result, in states that did not expand Medicaid, many low-income Americans were left in an "insurance coverage gap," making too much for Medicaid, but too little to enroll in the ACA marketplace. In Utah, it was estimated that anywhere from 100,000-150,000 people were in this coverage gap and unable to get health coverage.

A Look at Why Medicaid Matters for Children and Families

At Voices for Utah Children, many questioned why we were fighting for full Medicaid expansion. After all, the majority of low-income children in Utah are already guaranteed Medicaid and CHIP coverage. However, children's advocacy groups across the nation are fighting for expansion because parents need health insurance, too. When parents are healthier or not worried about medical bills, the whole family has better outcomes. Also, when parents are covered, children are more likely to be covered too. States that expanded Medicaid saw a significant decline in the number of uninsured children. Ensuring children is especially important here in Utah, where we have one of the highest rates of uninsured children in the nation. According to the most recent census data, Utah ranked #44 with over 72,000 uninsured children. Compared to other states in the nation, Utah also has one of the highest rates of children who are eligible for Medicaid or CHIP, but not enrolling in these programs. Medicaid expansion is one of the most effective changes states can make to not only help more adults but also ensure that more children are covered.

What's more, Medicaid is particularly important to help low-income children stay healthy. In Utah, approximately 160,000 children are enrolled in Medicaid — two-thirds of all Medicaid enrollees. Decades of research show that children with Medicaid coverage had better health outcomes, higher graduation rates, and greater economic success as adults, compared to low-income children unable to obtain Medicaid.

At its heart, Medicaid is, in many ways, a children's program. It guarantees all children a comprehensive set of benefits, known as the acronym EPSDT (early and periodic screenings, diagnostics and treatment). EPSDT is widely recognized as the definitive standard for children, allowing them to get preventive care and treatment before a condition escalates. Children on Medicaid can get the care they need, without restrictions or barriers.

What Lies Ahead? Additional Actions Needed

As we now face a pandemic and economic downturn, Medicaid should be an important resource for families and individuals in need. Unfortunately, many Utah families do not know about Medicaid. Across the state, we need to increase Medicaid outreach and enrollment assistance. Confusion around who is eligible for Medicaid and the stigma associated with enrolling in public assistance programs often leads many families to miss out on the health care they need. Public awareness and outreach can help change this.

In addition to helping families enroll in Medicaid, we also need to help them stay enrolled. Too often, eligible children or their parents lose Medicaid because of a minor change in income or a missed piece of paperwork. Progress was made this past Legislative Session when the Legislature funded a policy to ensure 12-month continuous eligibility for children on Medicaid. This policy helps keeps children covered and reduces gaps in their health coverage. While the Legislature only funded continuous eligibility for children through age 6, this is a critical step forward

Utah Expands Medicaid | Continued on page 28

Utah Expands Medicaid | Continued from page 27

and a win for children's health coverage. What's more, the federal government has said that during the COVID-19 pandemic, no one enrolled in Medicaid can lose coverage (unless requested). This decision ensures that, at least for a few months, low-income families will retain their coverage.

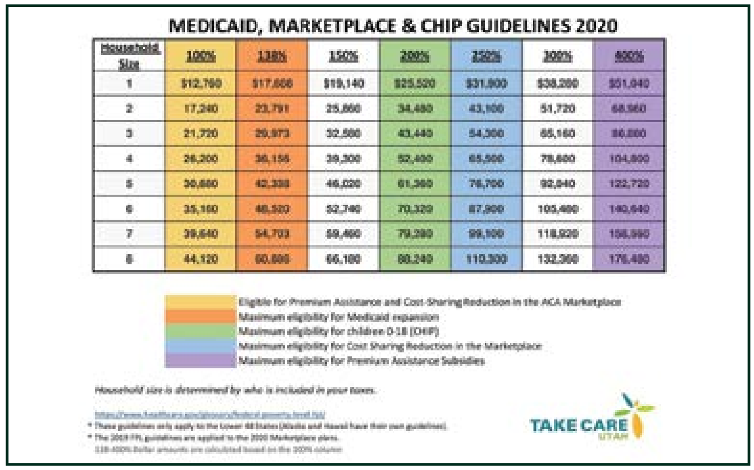
Utah's Governor Herbert has also made some important changes to our Medicaid program in response to the COVID-19 pandemic. Perhaps one of the most significant changes was suspending new, onerous Medicaid work reporting requirements. Utah was the only state with active Medicaid work requirements. Other states, which had initially instituted work requirements, found they created more bureaucratic red tape and program confusion, did not produce substantive increases in employment, and instead led to eligible enrollees losing their coverage. We hope the decision to suspend work requirements and other harmful barriers to care becomes permanent.

Finally, while Utah closed the Medicaid coverage gap, another gap remains. Thousands of low-income, working Utahns are still shut out of Medicaid because of their citizenship status. Thousands more are in mixed-status immigrant families and afraid to seek Medicaid. No Utahn should be afraid to get health care or denied coverage — especially now.

The COVID-19 crisis has exposed many gaps and disparities in our current health care system, but it has also highlighted the power that we can have when we work together and respond as a community, including statewide support for full expansion in the 2018 ballot initiative. As a result, thousands of additional Utahns will be covered and receive care during the pandemic and economic crisis. I believe we can build on this success work to ensure that all Utahns, no matter their background or immigration status, can receive comprehensive, affordable, accessible health care. Utah's Medicaid expansion tale is not the end of the story — there are many chapters ahead.

Some helpful resources for patients and providers are as follows:

- Dial 2-1-1 from any phone in the state of Utah for in-person assistance on health care enrollment.
- Contact the Utah Department of Health information on how to apply for medical benefits: https://medicaid.utah.gov/apply-medicaid/.
- Use remote enrollment options from the Utah Health Policy Project: https://bit.ly/3bopwaU.
- Watch a video about Medicaid expansion that was created by the Utah Department of Health. You can find it at https://bit.ly/3dTtfz5.



MEDICAID, MARKETPLACE & CHIP GUIDELINES 2020

Household Size	100%	138%	150%	200%	250%	300%	400%
1	$12,760	$17,608	$19,140	$25,520	$31,900	$38,280	$51,040
2	17,240	23,791	25,860	34,480	43,100	51,720	68,960
3	21,720	29,973	32,580	43,440	54,300	65,160	86,880
4	26,200	36,156	39,300	52,400	65,500	78,600	104,800
5	30,680	42,338	46,020	61,360	76,700	92,040	122,720
6	35,160	48,520	52,740	70,320	87,900	105,480	140,640
7	39,640	54,703	59,460	79,280	99,100	118,920	158,560
8	44,120	60,886	66,180	88,240	110,300	132,360	176,480

Eligible for Premium Assistance and Cost-Sharing Reduction in the ACA Marketplace
Maximum eligibility for Medicaid expansion
Maximum eligibility for children 0-18 (CHIP)
Maximum eligibility for Cost Sharing Reduction in the Marketplace
Maximum eligibility for Premium Assistance Subsidies

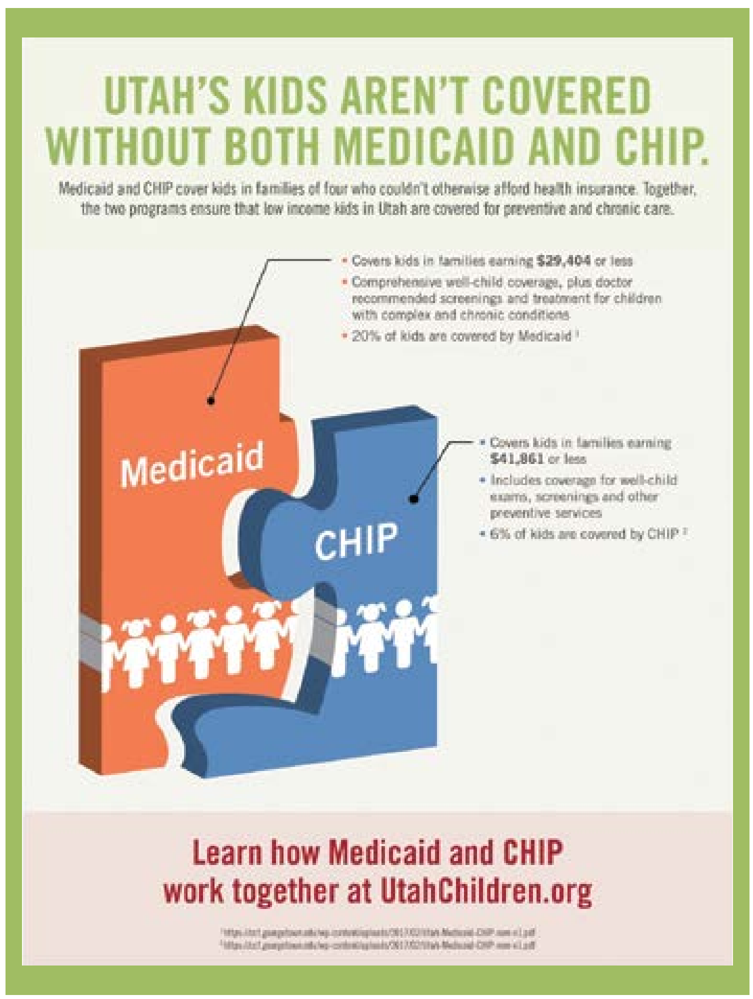
Household size is determined by who is included in your taxes.

* These guidelines only apply to the Lower 48 States (Alaska and Hawaii have their own guidelines).
* The 2019 FPL guidelines are applied to the 2020 Marketplace plans.
138-400% Dollar amounts are calculated based on the 100% column

TAKE CARE UTAH

CHIP (the Children's Health Insurance Program) vs. Medicaid
A common misconception is that low-income children are enrolled in CHIP. But CHIP covers a fraction of the children that Medicaid covers, because CHIP is for kids with slightly higher incomes. The two programs work together to provide a foundation of coverage for kids:

Program	Eligibility
CHIP	Children 138- 200% of the federal poverty level
Medicaid	Children 0-138% of the federal poverty level



UAFP Staff Tours Rocky Vista University — Southern Utah

Back Row: Joshua Clason, Kasey Call, Christian Wiscombe, Michael Stephens, Nicholas Longe, Dr. Ben Wilde
Front Row: Dr. Mark Wardle, Autumn Dach, Maryann Martindale, Barbara Muñoz, Kathryn Forneris, Jessica Harper.

UAFP Executive Director, Maryann Martindale and Program Director, Barbara Muñoz had the wonderful opportunity to take a quick trip to Ivins, Utah, in late January to meet with faculty and students at Rocky Vista University (RVU) — Southern Utah.

Dr. Mark Wardle, assistant professor of Primary Care in the Department of Primary Care Medicine, coordinated a full morning of activities. UAFP staff met over breakfast with faculty and students who have either committed to or are considering pursuing a career in primary care after graduation. A lively discussion was had with the group of bright, engaging, and passionate future physicians who bring a variety of backgrounds and perspectives to the classroom and their careers.

Dr. Wardle also took the staff on a tour of the impressive, cutting-edge facilities. These include two 200-seat lecture halls, three seminar rooms, 36 small-group study rooms, clinical skills and OPP lab, a full dissection gross anatomy lab, a multipurpose lab, a simulation center, standardized patient rooms and a 9,000 square foot library. The Southern Utah Veterans

Home is adjacent to the campus and provides the students with a continuity of care experience.

The first class to graduate as doctors of osteopathic medicine from RVU — Southern Utah will do so in the spring of 2021. We look forward to celebrating with them next year, and with many additional cohorts of young physicians in years to come!

What Is an AAFP Commission?
And Why Should I Be on One?

By Sarah Woolsey, M.D., MPH, FAAFP

The American Academy of Family Physicians (AAFP) is a member-driven organization and does amazing work on our behalf. AAFP Commissions are one of the organization's most effective structures used to ensure member input is considered on critical topics. Commissions are nationally representative bodies of members and Chapter Executives that give feedback to the AAFP on all sorts of areas. They assist with the development of programming, assist with policy adaptation, help ensure the Academy appropriately acts on Resolutions, and help decide if specific programs should be discontinued. Members apply and are chosen to participate for a four-year term. During their term, members travel to Kansas City, Missouri, for two in-person sessions each year and have web-based documents to review and edit, comment on, and vote to approve throughout the year. The in-person sessions provide added learning and current topics, opportunities to network with members from across the U.S., and "breaking" policy updates from AAFP Leadership.

AAFP Commissions include:

- Continuing Professional Development
- Membership and Member Services
- Education
- Health of the Public and Science
- Finance and Insurance
- Quality and Practice
- Governmental Advocacy

I was chosen to participate in the commission on Quality and Practice in December 2018 and just finished a year and a half of attendance and participation. The COVID-19 pandemic has caused the cancellation of the planned May in-person session, replaced by an online event instead. Additionally, the AAFP has required rapid and front-line feedback from us this month to produce advocacy position papers, and advocate for funding for testing, access to Personal Protective Equipment, and financial protection from the crisis. We have been "on-call" for quick reviews and to help craft the content that comes from the AAFP to Washington and to CMS and the CDC. More than ever, I value my role in shaping the AAFP's message to truly impact the course of current events.

In the usual course of a commission year, I will participate in the two weekend meetings (leaving Friday afternoon to start early Saturday meetings, then home by dinner Sunday). I participate in up to twice-monthly written requests for feedback and position revisions and then spend a small amount of time on calls and email mentoring a brand-new commission member. I am also a part of my commission's executive team, which includes a monthly 30-minute call to take care of interim business with the AAFP staff. I spend 2-3 hours reading the prework materials before the commission in-person meetings to be ready for the discussions and to be able to seek out opinions from other family physicians on the topics to be raised.

Why should you be on a commission?

Utah members have a variety of perspectives and types of practices, and the AAFP wants to hear from people like us. We have both employed practices and strong independent and solo practices. We have a high number of clinicians that maintain obstetric care privileges and still work in the hospital. Family Medicine is the largest specialty in the state, and we have good relationships with our specialty colleagues. We have adjusted to independent practice for nurse practitioners and have a strong physician assistant presence that shapes how we work. These perspectives are relevant and useful to the AAFP.

What is the benefit to you?

The commission is a chance to understand AAFP's inner workings. It gives you opportunities to meet with the leadership and share your opinion of AAFP's "final products." You will influence the direction of CME offerings, length of conferences, specific language in policies, and how investments into new products are prioritized. You will participate alongside AAFP Board members and have breakfast with them regularly. You will learn about cutting edge ideas for furthering the practice of our specialty before they are shared with the public. You will meet a broad representation of family physicians and hear how their practices are run and what challenges face their patients and their communities. You will have a chance to practice speaking and writing eloquently to represent your perspective. You will experience how leaders work together for a great cause. I also make time for a good meal with my commission friends and have found some great jazz spots in KC.

How do I apply?

Applications are now open, and it's easy to apply:

1. Email Maryann Martindale, UAFP Executive Director, at martindalemm@utahafp.org and let her know you want to apply.
2. Go to utahafp.org/aafpcommission/ to download a copy of the application.
3. Complete the online application and submit a photo.

The chapter will recommend you for the commission of your choice. Letters are sent in late November or early December for attendance at the January meetings. You should know that many who apply do not get picked on the first try. The AAFP chooses members based on state size, geography, and general mix of the commission. Do not hesitate to reapply and try again; needs are different each year. Also, you may not be selected for your first choice of commission, and that is OK, too; all the commissions are relevant and have their strengths. I say go for it!

Feel free to email me at sarahwoolsey@gmail.com and let me know if I can answer any questions. I hope to see many of you on AAFP commissions soon!

Building Partnerships in Eswatini

In the fall of 2019, Dr. Erin McAdams and Dr. Zachary Fredman worked with other medical professionals to plan a two-day medical conference. They had assessed the educational needs of their audience, researched evidence-based information, and prepared informative and topical presentations. What made this medical conference very different from most, however, was that it took two days and over 10,000 miles to get there — because this conference was held in a small southern African country called Eswatini.

Adventures in Missions

In the early 2000s, Matt and Carike Gerber, a couple living in South Africa, became aware of some of the significant challenges facing the people in what was then Swaziland. The Gerbers wanted to find a way to assist the communities there that complimented the efforts already in place. What they learned was that groups of local women had set up informal resource points on plots of lands throughout the country to provide meals to children. The women were not paid for this service. They saw it as their duty to the community. Matt and Carike worked with the community members to formalize the plots of land that would come to be known as "Care Points." The Gerbers' objective was to provide support on the backend to ensure that food would be available for the women to prepare and provide to the children. While the Care Points initially served only a few hundred children, they now provide meals to over 7,500 children from around the country. As the Care Points interacted with more and more children as an organization, they looked to offer more asset-based development and empower children with skills applicable to life in their communities. The organization provides a discipleship training, pays for school fees so children can get their primary education, and one meal a day, five days out of the week.

The Gerbers formalized their efforts into two mission-based organizations; Children's Hope Chest, a stateside organization with a fundraising and administrative focus, and Adventures in Missions (AIM), which recruits and trains individuals who work on the ground in the communities they partner with. Many of the people employed by AIM in Eswatini are born and raised in the community where they serve.

Over the years of building relationships with local community members, the mission group saw a burgeoning need to try and address some of the medical concerns in the area. What they had discovered through their partnership was that you could not meet a community's basic needs and ignore their health.

The Capitol Church Connection

Shortly after Dr. McAdams began her residency with the University of Utah, she also started attending Capital Church in Salt Lake City. She learned that the church had developed a longstanding partnership in Eswatini with members of a community through a missionary organization. A church group had been making a trip once or twice annually for about nine years with the missionary group. Together, they provided support and resources to communities that were struggling with access to basic needs. Members of Capital Church had been approached because the congregation happens to have several members with medical training. Volunteers were asked if they were interested in providing basic medical training and screening exams for community members who did not otherwise have easy access to care and basic health education. McAdams was always interested in global health and had gone on other medical service-related trips. This particular venture interested her because the group already had a longstanding relationship with the community. Also, the request for assistance was coming from the local community members instead of an outside group making Western-based assumptions about the community's needs. The goal was to provide medical education to leaders who would then share the information with the larger community, making the education and access to information more sustainable in the community. She has since led annual medically-education focused trips for the last four years to Eswatini through this partnership.

Challenges and Opportunities for the Youth of Eswatini

One of the biggest challenges faced by the people of Eswatini is their high rate of community members who are HIV positive. Approximately 27% of those ages 15-49 in Eswatini are HIV positive. This percentage is the highest rate of infection of any country in the world. A large swath of the middle generation is missing because parents have died or abandoned their children. This situation results in a family structure where many grandparents are taking care of large groups of grandchildren. These family units might have one parent still present, but rarely both. Unfortunately, the public education system is lacking as well, which has left many children in the country without basic resources such as food and education. The support provided by the Care Points has become critical to the wellness of the children in Eswatini.

The children who grow up in the Care Point system can apply to work in a leadership position known as a "shepherd," when they have aged out of high school. The position is a paid partnership with AIM and includes one year of leadership training in South Africa. Those accepted into

Building Partnerships | Continued on page 34

From left to right: Alyssa Gale, Michelle Hicks, Erin McAdams, Georgia Yalanis, Zach Fredman.

Volunteers assembling first aid kits to be delivered to the Care Points.

Building Partnerships | Continued from page 33

leadership positions are required to work for a Care Point for two years following the year of training. Shepherds act as adult role models and teachers and help to hold children utilizing the Care Points accountable. This leadership role serves as a valuable transitional role for young adults in their late teens and early 20s.

Training the Trainers

Over the years, the shepherds have asked to learn information on several topics, including health-related subjects such as:

- Complications of HIV
- Learning more about tuberculosis and other types of pneumonia
- Treating skin infections
- Signs of asthma exacerbations
- What causes diarrhea and how to treat it
- Determining who is sick enough to need more intensive medical care

They also have questions about depression and mental health because these are not often spoken about in their community. There are also concerns about identifying and managing domestic violence. The mission group tries to provide these young adults didactic and hands-on training for themselves and their families so that they can better care for the children in the community. The training has been very well-received and is now mandated for shepherds to attend. During these trips, medically-trained volunteers also perform some basic screening for leaders to help direct their care. McAdams has been able to recruit many nurses and physical therapists to come on previous trips but would like to recruit more physicians for future trips as well. Last year she was excited to have a fellow physician, Zachary Fredman, join her.

Dr. Fredman grew up in Litchfield, Minnesota, and attended medical school at the University of Minnesota. As a student, he did a rural rotation in New Ulm, which has a population of about 13,500. Since he was the only medical student there, he had opportunities more akin to what a resident would experience. This experience served him well on his trip to Eswatini, which he says was very similar to his work in a rural community, "just with a lot fewer resources." Fredman started attending Capital Church after moving to Utah to begin his family medicine residency with the University of Utah, which is where he first heard about the mission trip from McAdams. They were looking for physicians to accompany the group because the community's educational needs had grown over the years.

For this trip, the main objective of the medical team was to hold a small medical conference where leaders from all the Care Points throughout the country would attend. The leaders had been asked in advance which subjects they wanted to learn about. Fredman presented information on how to properly care for snake bites, seizures and the stigma sometimes associated with them, and puberty development and sexual maturity. He provided sex education to both the shepherds and a separate group of 10- to 18-year-olds. He

started with very basic anatomy and then covered maturity, intercourse and consent. With the high rate of HIV in the country, community members needed more comprehensive sex education, including information about circumcision, condoms, other protection and abstinence.

While not the primary purpose of the trip, the medical volunteers also took some time with leaders to perform some basic medical screenings, addressing concerns ranging from dry eyes to much more complex questions dealing with anxiety and depression and socioeconomic conditions.

Personal Impact

For Fredman, the biggest takeaway from his experience is the reminder that when visiting an underdeveloped country, guests need to ask the people who live there what they would benefit from the most and then try and provide those resources and education. While potentially more difficult, it is more beneficial to provide education that they can pass on to others in the community.

One of the most rewarding aspects of this partnership, according to McAdams, is building relationships with the community over several years — developing a trust with the people you are working with. Over time, McAdams says seeing a measurable, objective improvement in the community allows her to feel like she is part of a partnership. She wants to continue to support the community in whatever way she can and is grateful they see knowledge about health as an important part of their growth as a community. McAdams says, "Your words have more weight, and people are more willing to adapt when you build a relationship because they realize it's in their long-term best interests."

Dr. Erin McAdams is an assistant professor, clinical, in the Department of Family and Preventive Medicine at the University of Utah. She's originally from Indiana and lives in Salt Lake City with her husband. She enjoys being active in the outdoors and playing sports, traveling and reading.

Dr. Zach Fredman is a third-year Family Medicine resident at the University of Utah, originally from Minnesota. He enjoys being outside, hiking, skiing and playing sports. He also spends his time reading and cooking.

Pilates:

An Exercise Option for You and Your Patients

As a physician, it can be challenging to know how to motivate patients to exercise. Motivation is particularly difficult for patients who are older, overweight, out of shape or suffering from chronic pain.

The human body loses a great deal of resilience with age. As a result, people get injured more easily as they get older, and this can present a real challenge when they decide to start going to the gym for regular workouts, especially because those injuries take longer to heal as the body ages. It is extremely easy for someone to overdo a program such as, say, lifting heavy weights, and then be unable to exercise for a period of weeks or even months as the body recovers. Problems may not be apparent immediately, but once they reach a certain level, they can prevent people from being able to continue their exercise programs. The long gaps in an exercise program that are caused by injuries make it unlikely that a patient will continue exercising after recovery.

A German athlete named Joseph Pilates invented Pilates. Physical activity triggered his asthma, and his study of Greek culture and ideology led him to look for a program that would balance body, mind, and spirit by concentrating specifically on the body's core (the center of the muscle system) and would then improve strength, control, and flexibility as the patient continued to use the program. Studies have shown that this approach benefits the entire body. Pilates is particularly useful for dancers and yoga enthusiasts because it helps with the following problems:

- Equilibrium issues
- Flexibility problems
- Injuries related to wear and tear
- Neck problems
- Poor posture
- Spinal abnormalities
- Sprains
- Strains
- Torn muscles

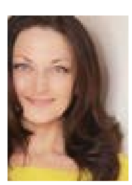
Pilates is also a useful tool for physical therapists, who often use Pilates exercises as part of the recovery plan for their patients.

Although Pilates can provide a rigorous and difficult workout, it can also be easily modified to help patients take that first step toward resolving pain issues and becoming healthier in every aspect of their lives. The program is sensible and is unlikely to harm participants if done correctly. As patients build strength, Pilates can be modified again repeatedly to make it more challenging.

Pilates is not a rigorous cardio program. Instead, Pilates involves focusing on breath while moving through controlled stretches. You can do Pilates with or without machines; the purpose of the machines is to make it easier for a student to perform the exercises with correct form. However, you can also do Pilates on a floor mat. For patients with specific physical problems, or for patients who are older and whose physical condition is poor, they must receive appropriate instructions about how to modify the program so that it is within their ability to do the exercises correctly.

The results can be astounding, especially for people who have learned to think exercise is about going to the gym and getting hurt. The movements invented by Joseph Pilates are sometimes subtle, but they work, and an instructor can show you how to make the movements as challenging as they need to be.

Pilates is a wonderful supplement to other forms of exercise; best of all, it provides a safe way for people to exercise no matter where they are on their journey to improved physical health.



Erica Lukes started her practice in 1997. Her expertise in Pilates based rehab has made her highly sought after by clients with hip and knee replacements spinal fusions, herniated discs and chronic pain.
Totalbodypilates.com (801) 244-3445.

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