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In the United States, the gap between how long people live and how long they stay healthy is widening. That has important implications for patients as well as for society as our population ages.

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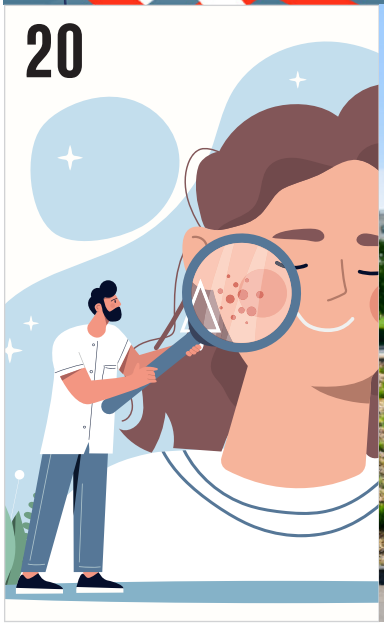

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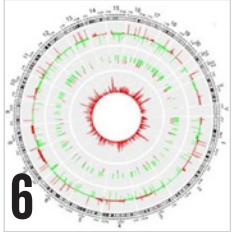

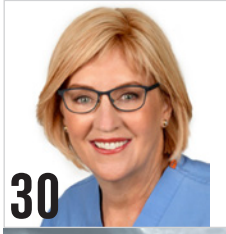

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Christopher Wenner, MD

The (under) funding of primary care

Last week, in one visit, I saw an elderly man in an assisted living facility, with: an acutely ruptured biceps tendon, marked volume overload due to heart failure, peripheral vascular disease with a pending angiogram, and labile, elevated blood glucose levels. The nursing staff wanted the patient sent to the ER due to the profound ecchymosis and edema of his arm concomitant with his biceps tendon rupture while anticoagulated. The patient wanted a cardiology consultation to address his dyspnea. The angiogram, already ordered by another consultant, threatened tenuous kidneys and offered little in quality-of-life enhancement.

What to do? As most of my colleagues in primary care would have done, I addressed all the problems. I did not send the patient to the ER regarding his biceps tendon rupture—I educated the patient and the nursing staff about the natural history of the diagnosis. I did not punt the volume overload to cardiology—I adjusted his diuretic regimen and ordered a follow up metabolic panel. I did not rubber-stamp the angiogram order and instead informed the patient about the risks and minimal benefits. I did not send the patient to endocrine for management of labile glucoses—I reviewed the continuous glucose monitor, adjusted the insulin regimen and pre-authorized the patient's GLP-1 agonist.

If all goes according to plan, I will be reimbursed $174 for my efforts. A remarkable value for Medicare. If I had elected to send the patient to the ER, obtained the cardiology and endocrine consultations and allowed the angiogram, the costs would have easily been 20 times that. Outcomes would likely have been worse with piecemeal care.

Primary care in our country is vastly understaffed, and this understaffing is a major driver of health inequity, poor outcomes, and outsized expenditures. One of the major reasons cited by new physician graduates for choosing specialty care as opposed to primary care is the fact they can earn two to five times as much in specialty practices. The problem perpetuates itself.

Accountable Care Organizations (ACOs) were constructed, in part, to help primary care doctors share in some of the Medicare savings for their consistently low-cost, high-value services (see above). However, ACOs require an inordinate amount of staff time and do a magnificent job of siphoning off a hefty portion of the savings. ACOs are not the answer to our primary care shortage. Shifting away from fee-for-service and applying nominal payments for care coordination services is a step in the right direction, but it barely moves the needle in the pay gap between primary care and specialty (procedural) care. Even the experiment of providing free medical school has not funneled more new graduates into primary care.

What to do? Pay primary care more. Full stop. Abolish the anachronistic hegemony of the RVU Update Committee. Provide significant global payments for *all* (not just Medicare) attributed patients. Do not tie additional reporting requirements to global payments. Eliminate the marked wage gap between physicians that perform procedures and those that do not. Primary care provides great value to our healthcare system. It is time that primary care is valued. The MMA and the AMA need to lead the charge in payment reform. The health of our state and our country depends on it. **MM**

Primary care in our country is vastly understaffed, and this understaffing is a major driver of health inequity, poor outcomes, and outsized expenditures.... Primary care provides great value to our healthcare system. It is time that primary care is valued.

Christopher J. Wenner, MD, is the founder of Christopher J. Wenner, MD, PA, an independent family medicine practice in Cold Spring. He is one of three medical editors for *Minnesota Medicine*.

Kids can live with safe gun storage

Just a few questions from physicians can save lives.

BY THOMAS E. KOTTKE, MD, MSPH, AND MARC GORELICK, MD, MSCE

Consider these recent headlines:

"Woman sues Scheels over teen son's gun death in Eden Prairie store," MPR, September 10, 2024.

"Toddler killed in Minneapolis: 911 caller said child shot himself," Fox 9, October 23, 2024.

"Teen killed in apparent accidental shooting, Minneapolis police say," CBS News, November 5, 2024.

These three youth, and others who died in similar circumstances, might still be alive if the guns that killed them had been stored safely and securely. The logic is simple: A gun that is secured cannot be fired. A gun that cannot be fired cannot kill.

Physicians have at least three opportunities—one with their patients, one with their families, and one with their communities—to promote safe storage and perhaps save a kid's life:

- Advising safe storage as part of their office visit safety check. Trials show that this advice does change behavior, and physicians we've interviewed say advising as part of the pediatric safety check is quick and easy, puts the advice in context, and never generates pushback.
- When setting up playdates or birthday parties for your own kids and grandkids, asking whether firearms are stored safely. A single question added to your playdate safety check—"Are all firearms in your home stored securely?"— could save the life of a child.
- Asking friends to ask the same question—"Are all firearms in your home stored securely?" Also ask them to ask others to ask. Make it a norm. If the question is asked frequently and consistently, safe storage of guns will become like kids' car seats—ubiquitous.

Unlocked firearms are a problem. Pediatric mortality rates from guns have been rising for more than a decade, and being shot is the leading cause of death for American youth. More than 40% of Minnesotans own a firearm, and political leanings are a poor indicator of whether there is a firearm in the house; this past September, *The Wall Street Journal* reported that, "A burgeoning number of liberals are buying firearms."

More than half of firearms in Minnesota are stored unlocked, and 20% are stored loaded. A rifle or shotgun that is stored loaded can quickly become the vector in the death of a distraught teen, and pistols stored loaded in a bedside table not infrequently end up at school in a child's backpack.

We've heard that unlocked and loaded is just part of Minnesota culture. "We've always kept a loaded rifle by the back door to shoot predators." Or, "I need a pistol at my bedside to protect against a home invasion." This culture is a problem because it kills, but cultures can evolve.

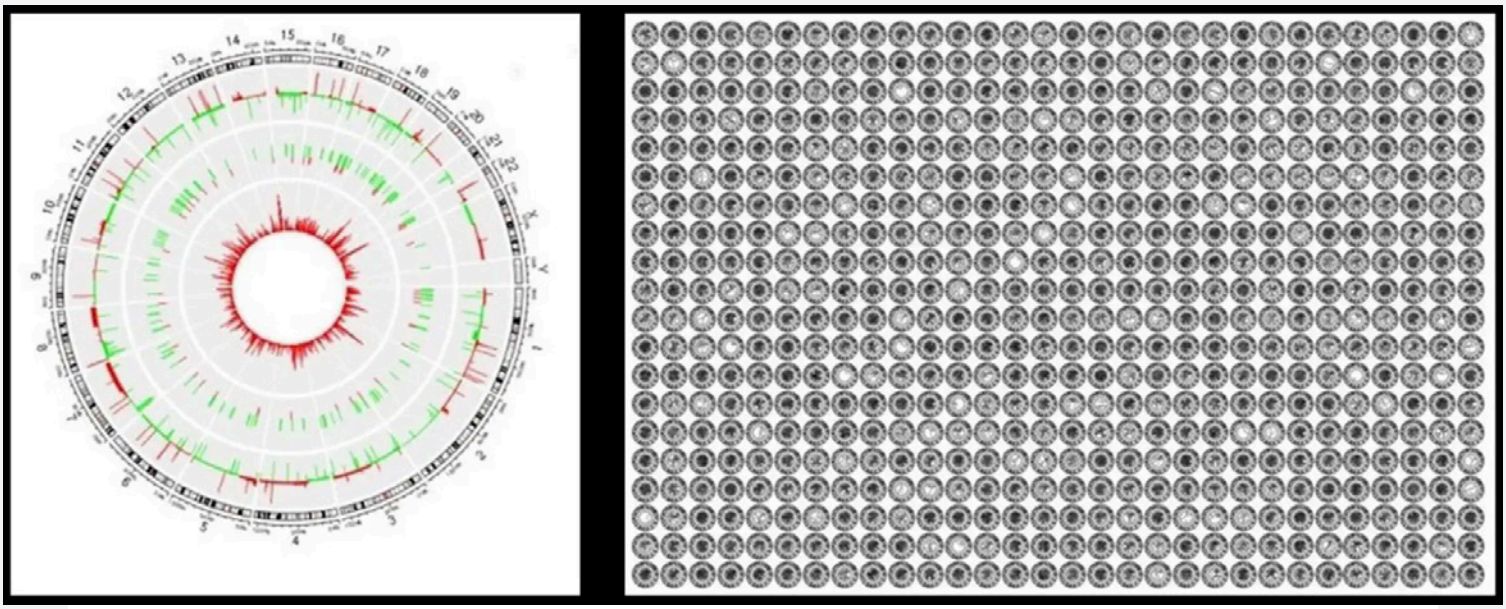
For the kids, Minnesota needs to evolve to a state where all firearms are stored locked and unloaded with the ammo elsewhere. A new norm is needed—just as a new norm was created when it came to car seats for kids. A safe storage norm won't mean that a firearm isn't available when needed. A rifle stored safely can still be unlocked and loaded quickly to shoot at a farmyard predator. A hundred-dollar biometric lockbox safely stores a pistol.

Supportive resources are available for physicians and their patients. The American Academy of Pediatrics, AMA, and the American Academy of Family Physicians all have position statements that legitimize safe storage advice. Training materials for physicians are available at the BulletPoints Project (bulletpointsproject.org). Be Smart (BeSmartforKids.org) provides resources for parents and other caregivers.

Promoting safe storage won't end gun violence, but it will prevent deaths of youth like those in the headlines. Contribute to a new norm. Ask your patients and ask your friends, "Are your guns stored safely?" And ask your family and friends to ask the same question. Kids can live with that. **MM**

Thomas E. Kottke, MD, MSPH, is the medical director for well-being at HealthPartners, a member of the Protect Minnesota board of directors, and a member of the Minnesota Medical Association. The views expressed here are entirely his own and do not necessarily represent those of his employer.

Marc Gorelick, MD, MSCE, is president and CEO of Children's Minnesota. He is also author of the book, *Saving Our Kids: An ER Doc's Common-Sense Solution to the Gun Crisis,* available from online bookstores. All proceeds from the sale of the book go to violence prevention programs at Children's Minnesota.



A circular OmicsFootPrint visualization (left) shows genetic and molecular changes, with chromosomes in the outer ring and gene activity changes inside—red for increased activity, green for reduced. A grid of OmicsFootPrints (right) summarizes multiomics data for nearly 700 cancer patients, with each circle representing a unique molecular profile.

Mayo Clinic's AI tool offers a new way to visualize disease

Mayo Clinic researchers have pioneered an AI tool called OmicsFootPrint that helps convert vast amounts of complex biological data into two-dimensional circular images. The details of the tool are published in a new study in *Nucleic Acids Research*.

"Data becomes most powerful when you can see the story it's telling," says Krishna Rani Kalari, PhD, lead author of the study and associate professor of biomedical informatics at Mayo Clinic's Center for Individualized Medicine. "The OmicsFootPrint could open doors to discoveries we haven't been able to achieve before."

Omics is the study of genes, proteins and other molecular data to help uncover how the body functions and how diseases develop. By mapping this data, the OmicsFootPrint may provide clinicians and researchers with a new way to visualize patterns in diseases, such as cancer and neurological disorders, that can help guide personalized therapies. It may also provide an intuitive way to explore disease mechanisms and interactions.

In their study, the researchers used the OmicsFootPrint to analyze drug response and cancer multiomics data. The tool distinguished between two types of breast cancer—lobular and ductal carcinomas—with an average accuracy of 87%. When applied to lung cancer, it demonstrated over 95% accuracy in identifying two types: adenocarcinoma and squamous cell carcinoma.

The study showed that combining several types of molecular data produces more accurate results than using just one type of data.

The OmicsFootPrint also shows potential in providing meaningful results even with limited datasets. It uses advanced AI methods that learn from existing data and apply that knowledge to new scenarios—a process known as transfer learning. In one example, it helped researchers achieve over 95% accuracy in identifying lung cancer subtypes using less than 20% of the typical data volume.

"This approach could be beneficial for research even with small sample size or clinical studies," Kalari says.

Beyond research, the OmicsFootPrint is designed for clinical use. It compresses large biological datasets into compact images that require just 2% of the original storage space. This could make the images easy to integrate into electronic medical records to guide patient care in the future.

The research team plans to expand the OmicsFootPrint to study other diseases, including neurological diseases and other complex disorders. They are also working on updates to make the tool even more accurate and flexible, including the ability to find new disease markers and drug targets.

–Susan Murphy, Mayo Clinic

New law limits charges on patient records

A new law that sets the maximum charges for patient records became effective January 1. In situations where the law, updated during the 2024 legislative session, applies and there are no other laws, rules, or contracts that provide for lower maximum charges, the new maximum charges will apply.

Exceptions include when a patient requests a copy of their record for the purpose of reviewing current medical care, no fee can be charged.

When providing copies of records upon a patient's request, not for the purpose of reviewing current medical care, the following charges will apply:

- Paper copies: $1 per page, plus $10 for time spent retrieving and copying the records; $10 limit if no records are available; $30 limit for copies of records up to 25 pages; $50 limit for copies of records of up to 100 pages; $50 plus an additional 20 cents per page limit for pages 101 and above; and an overall limit of $500 for any request.
- X-rays: total of $30 for retrieving and reproducing X-rays.
- Electronic copies: total of $20 for retrieving the records.

A $10 retrieval fee can be charged when records are requested to appeal a denial of Social Security disability income or benefits only.

State attorney general goes after delinquent tobacco manufacturers

Minnesota Attorney General Keith Ellison announced in December that two major tobacco manufacturers owe the state of Minnesota more than $58 million plus interest, according to the historic 1998 tobacco industry settlement.

Ellison's office filed a motion to enforce the settlement against the manufacturers Philip Morris and R.J. Reynolds in July 2024, asserting that they were wrongly using a 2018 change in the federal corporate tax rate to reduce their settlement payments to Minnesota.

A court recently confirmed that Ellison's office's reading of the settlement was correct, and the tobacco manufacturers were underpaying Minnesota. The court ordered them to make full payments in the future and held that the parties must meet and confer on the appropriate amount of damages, interest, civil penalties, and attorney fees owed to Minnesota based on the manufacturers' underpayment.

After a months-long trial in 1998, Minnesota reached a $6.5 billion settlement with the largest tobacco manufacturers that restricted the manufacturers' marketing of tobacco products and required annual payments to Minnesota. The payments to Minnesota are based, in part, on the size of the manufacturers' after-tax profits in a given year.

Ellison's motion alleges that after the federal corporate tax rate changed in 2018, Philip Morris misrepresented the content of the Minnesota settlement to the third-party payment administrator, PricewaterhouseCoopers, in a way that incorrectly reduced the manufacturers' payments to Minnesota by nearly $10 million per year.

The dispute over payment amounts arose from a settlement provision that increases the size of the manufacturers' annual payments if their current after-tax profits are greater than they were in 1997. The manufacturers recalculated their 1997 profits by applying modern corporate tax rates for this comparison, even though the Minnesota settlement explicitly calls for the use of 1997 tax rates when calculating 1997 after-tax profits. Because President Trump and Congress lowered corporate tax rates from 35% to 21% in 2018, using the new, lower tax rate to calculate 1997 profits resulted in the manufacturers' underpaying Minnesota by close to $10 million per year.

The state settlements with the tobacco industry are widely recognized as landmark public health achievements. Since 1998, overall cigarette use has declined by more than 50%, and cigarette use among high school students dropped from over 35% in 1997 to 1.7% in 2024.

Office of Cannabis Management stands pat for program additions in 2025

The Office of Cannabis Management (OCM) will not add any new medical delivery methods to the medical cannabis program in 2025.

OCM is required by law to conduct an annual petition process on delivery methods for Minnesota's medical cannabis program. Under state law, decisions on petitions are due by December 1. Any new delivery methods become available in August the year following approval.

Three petitions considered for the program this year were to allow for dry powder inhalation, infused flower, and concentrates. OCM evaluated the petitions based on a review of scientific evidence, and potential health and safety impacts for patients.

Dry powder inhalers are a method of consuming dry powder containing THC, CBD, and/or additional cannabinoids. These inhalers are similar to those used for asthma or chronic obstructive pulmonary disease medication.

While dry powder inhalers are being used to treat some chronic diseases, federal limitations on cannabis research means there are limited peer-reviewed studies to show this method would benefit or be safe for medical cannabis patients. As future research becomes available, this delivery method could be reconsidered.

Infused flower products and cannabis concentrates are products that have high levels of THC. Higher levels of THC, while beneficial to some patients, have also been shown to increase the risk of adverse health events and cannabis use disorder.

OCM is in the process of enacting new rules that will guide the medical cannabis program in the future. Approving new delivery methods that are impacted by rulemaking now would be premature while that process is underway.

Minnesota among states to test new model on maternal healthcare

Minnesota is among a group of states and the District of Columbia selected to participate in the Centers for Medicare and Medicaid Services' (CMS) Transforming Maternal Health (TMaH) Model, which is designed to improve maternal healthcare for people enrolled in Medicaid and the Children's Health Insurance Program.

The model, which launched on January 1 and will run for 10 years, will support participating state Medicaid agencies in the development of a whole-person approach to pregnancy, childbirth, and postpartum care that addresses the physical, mental health, and social needs experienced during pregnancy. The goal of the model is to reduce disparities in access and treatment. The model aims to improve outcomes and experiences for mothers and their newborns, while also reducing overall program expenditures.

Despite spending more per capita on maternal healthcare than any other nation, the U.S. has disproportionately high rates of adverse pregnancy outcomes as compared to other high-income nations. The TMaH Model provides state Medicaid agencies with targeted support in the form of funding and technical assistance. The goal of this support is to improve maternal healthcare and birth outcomes, while reducing associated health disparities. This support also enables states to develop a value-based alternative payment model for maternity care services that will improve quality and health outcomes and promote long-term sustainability of services.

Other participants in the program include: Alabama, Arkansas, California, the District of Columbia, Illinois, Kansas, Louisiana, Maine, Mississippi, New Jersey, Oklahoma, South Carolina, West Virginia, and Wisconsin.

U of M Medical School study highlights financial burden of medical equipment on cancer survivors

A University of Minnesota Medical School research study, published in *JAMA Network Open*, examined the financial burden of different medical services—including outpatient care, inpatient care, prescription drugs and physical therapy—on cancer survivors. Of all these medical services, the research team found medical equipment results in the highest percentage of out-of-pocket costs, including wheelchairs, canes, hearing aids and oxygen equipment, among other items.

The economic challenges faced by patients with cancer due to health care costs are well-documented, but most prior work focused on high drug costs. This study, however, examines the patterns of use and costs of medical equipment among cancer survivors in the U.S., underscoring the prevalence of equipment use and the significant out-of-pocket expenses associated with it.

"As the number of cancer survivors continues to rise, so do their unmet needs for medical equipment. This research highlights critical gaps in access and affordability, which must be addressed to improve cancer survivorship care," said Arjun Gupta, MD, assistant professor at the U of M Medical School, gastrointestinal oncologist with M Health Fairview, and member of the Masonic Cancer Center. MM

–University of Minnesota Medical School

CLOSING THE lifespan–health span GAP

In the United States, the gap between how long people live and how long they stay healthy is widening. That has important implications for patients as well as for society as our population ages.

BY SUZY FRISCH

Americans continue to live longer than ever, but the last dozen years of their lives are increasingly unhealthy. This phenomenon, called a lifespan-health span gap, is deepening in the United States compared to other countries around the world. The trends are so unfavorable that Mayo Clinic researcher Andre Terzic, MD, PhD, likens it to the Harrison Ford movie *Clear and Present Danger*.

"In simple words, the health and lifespan gap is a pressing and immediate danger. As we celebrate living longer, we also need to increase the awareness of the gap that is being created between living longer and living burdened by disease," says Terzic, the Marriott Family Director of Comprehensive Cardiac Regenerative Medicine for the Center for Regenerative Biotherapeutics.

Terzic and Armin Garmany, a MD-PhD student at the Mayo Clinic Alix School of Medicine, coauthored a *JAMA Network Open* study published in December 2024 that compares lifespan–health span gaps among the 183 countries that belong to the World Health Organization. Their findings: In the United States, the gap between lifespan and health span is on the rise, increasing to 12.4 years in 2019 from 10.9 years in 2000. This is the highest average lifespan–health span divide in the world. Comparatively, the average global lifespan–health span gap was 9.6 years in 2019.

Lifespan is the length of time someone lives, while health span encompasses the number of years the person lives an active, healthy, disease-free life. "The focus and goal of medicine has to remain living a long life, but increasingly we have to be very vigilant that we don't create years with the extra burden of disease," Terzic says.

Overall, life expectancy in the United States has started trending upward after falling during the COVID-19 pandemic and opioid crisis. The average current life expectancy is 75.8 years for men and 81.1 years for women, according to the U.S. Centers for Disease Control and Prevention. But all of those years aren't necessarily good ones.

"We do recognize that in the last century or so, there have been major strides in

"Increasingly, we are recognizing that chronic disease is the next big pandemic. It made us think: If we put lifespan on one end of the spectrum and the chronic disease burden on the other end, how does the chronic disease burden affect the years lived?"

ANDRE TERZIC, MD, PHD
RESEARCHER, MAYO CLINIC

Clinicians have made progress in the United States with extending patients' lifespans at a faster rate than health spans thanks to chronic disease management. "But it raises the question: What approaches can clinicians offer to not just help patients live longer but help them live longer in a healthy state?"

ARMIN GARMANY
MD-PHD STUDENT, THE MAYO CLINIC ALIX SCHOOL OF MEDICINE

extending lifespan around the globe. And that's a major triumph of humanity," Terzic says. With the new study, "we wanted to put some specifics around that success. Increasingly, we are recognizing that chronic disease is the next big pandemic. It made us think: If we put lifespan on one end of the spectrum and the chronic disease burden on the other end, how does the chronic disease burden affect the years lived?"

For many Americans, a host of conditions limit their health span. Mental health and substance use disorders, musculoskeletal diseases, and a high burden of chronic disease play significant roles in the lifespan-health span gap, Terzic says. The news is worse for women, who experience a 2.4-year larger gap than men—a 25 percent disparity. The study found that neurological, musculoskeletal, and genitourinary disorders were major contributors.

Clinicians have made progress in the United States with extending patients' lifespans at a faster rate than health spans thanks to chronic disease management, says Garmany, a cardiovascular researcher in Terzic's lab. "But it raises the question: What approaches can clinicians offer to not just help patients live longer but help them live longer in a healthy state?"

This looming problem is only going to become more serious as the U.S. population ages, says Nathan LeBrasseur, PhD, MS, director of the Mayo Clinic's Robert and Arlene Kogod Center on Aging. That makes it essential to extend the years people are healthy because looming demographic changes will lead to a multiplier effect for the lifespan–health span gap. In the United States and many developed countries, the silver tsunami has started coming ashore already.

"For the first time in history, the number of individuals over 65 will outnumber individuals under 5. We now have 11,000 people in the U.S. hitting 65 every day," LeBrasseur says. "That's a remarkable challenge. It has a major economic impact on our healthcare system and impacts many, many domains outside of healthcare."

A new lens on medicine

One key to closing the lifespan–health span gap involves shifting the healthcare system from a disease-centric stance to one that is focused on prevention, Terzic says. Efforts must start early and address people of all ages. For example, healthcare, public health, and educators should communicate frequently and with unified messages to youth about the importance of being healthy to having a long and active life, he says.

Peter Attia, MD, an author, podcaster, and clinician who focuses on longevity, advocates for approaching medicine with a new lens to address gaps between healthy life and life dominated by disease. In his *Peter Attia Drive* podcast episode called Longevity 101, he calls current practices Medicine 2.0 and asserts that healthcare should move toward Medicine 3.0. Instead of addressing conditions like cancer, dementia, cardiovascular conditions, and metabolic diseases as they occur, clinicians should act aggressively to prevent or significantly delay their onset.

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NATHAN LEBRASSEUR, PHD, MS,
DIRECTOR, THE MAYO CLINIC'S ROBERT AND ARLENE KOGOD CENTER ON AGING

Some of the hallmarks of Medicine 3.0 include "treating chronic diseases by acting early, acting aggressively, and tailoring therapies to the individual," Attia says in the podcast. "The second pillar of Medicine 3.0 is that health span is to be given at least as much effort and attention as lifespan. Most healthcare dollars are spent on addressing and trying to elongate lifespan."

To put these theories into practice, physicians should focus on the three contributors to a long and vibrant health span: physical, cognitive, and emotional health. Attia recommends putting the most attention on nutrition, exercise, sleep, and mental health, paired with pharmaceuticals and supplements.

Investing more in public health strategies that target the social determinants of health also might help medicine close the lifespan–health span gap, Garmany says. In addition, innovation will instigate more progress in the areas of individualized medicine, antisenescence therapies that target aging cells, regenerative medicine, and artificial intelligence. These modalities all can be used to help people with multiple conditions, which is more common later in life, he adds.

Focusing on health longevity by slowing the onset of chronic disease is important because they often have a compounding effect, LeBrasseur says. Many people live into their 60s before developing their first chronic condition, but often the second follows in three years, and the third and fourth just months after.

Researchers around the world are working to extend health span by deepening the understanding of the human biology of aging. Ultimately, LeBrasseur says, that could lead to transformative and broad-based approaches that delay age-related diseases "instead of playing whack-a-mole and targeting one disease at a time."

For example, scientists are working to discover the biomarkers of aging. Those biomarkers could provide insight into how someone is being affected by aging and at what rate. Biomarkers might eventually show that someone is at a higher risk for cognitive decline or musculoskeletal disorders; a personalized therapy could then be developed to prevent, delay, or reverse the condition. "Biomarkers would help clinicians be more proactive in decision-making," LeBrasseur adds.

> Healthcare should move toward Medicine 3.0, which would include "treating chronic diseases by acting early, acting aggressively, and tailoring therapies to the individual. The second pillar of Medicine 3.0 is that health span is to be given at least as much effort and attention as lifespan. Most healthcare dollars are spent on addressing and trying to elongate lifespan."
>
> PETER ATTIA, MD
> AUTHOR, PODCASTER, AND CLINICIAN

LeBrasseur also sees promise in practices with strong momentum in Europe and China. There, clinicians screen people for function in areas like cognitive, physical, and sensory function. Results in hand, clinicians then tailor interventions to the individual instead of waiting for a disease or diagnosis. That might include making recommendations to focus on muscle strength and mobility or finding ways to bolster cognitive health, he says.

Physicians' role in health span

Expanding health span is both an individual and a societal challenge, with opportunities for improvement unfolding in both arenas. Physicians can play a vital role in guiding patients to take steps that could enhance their longevity. Daniel Townsend, DO, a palliative care physician at HealthPartners, encourages clinicians to adopt a palliative care approach with patients even when people are well. To him, it embodies the central question he asks patients: How can I help you live the best life you can?

Though Townsend often counsels patients with serious medical conditions, he notes that the same tenets apply to everyone throughout their lives. "We want all clinicians to help patients think about what matters most, and then tailor care toward that," he says. "It's helping people adapt to their changing realities while clinging to the quality of life that makes life worth it. It's helping them live the lives they want to live."

Another core pillar of palliative care includes approaching health from a mind-body-spirit perspective. Interacting with patients shouldn't be just about health data but about their overall well-being, Townsend says. It also means building relationships with patients so that physicians can have hard conversations about people's

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>
> DANIEL TOWNSEND, DO
> PALLIATIVE CARE PHYSICIAN, HEALTHPARTNERS

"A good rule of thumb is that 70 percent of people over 70 have clinical hearing loss," Rosenstein says. "Part of the problem is that hearing aid coverage is pretty poor. It's common for older adults to remove themselves from more social activities because it becomes harder to hear and follow along in conversations."

BEN ROSENSTEIN, MD, MA
FAMILY MEDICINE PHYSICIAN AND GERIATRICIAN, M HEALTH FAIRVIEW

overall health trajectory—especially when things aren't going well.

Townsend acknowledges it's often difficult in the short window allotted for appointments, but forging these relationships goes a long way toward building trust. "Literature supports that patients want to have these conversations with their doctors," he says. "It doesn't mean we beat them over the head with bad news, but we're compassionately honest with them."

To help patients extend their health span, Ben Rosenstein, MD, MA, a family medicine physician and geriatrician at M Health Fairview, talks to people of all ages about the importance of exercise and a good diet. He tells them, "Those that keep walking, keep walking" and he advises them to put fewer square items in their grocery carts. Rosenstein explains further that "diet and exercise both have a good relationship to outcomes such as being protective against cognitive impairments and dementia, preventing heart attacks that can lead to heart failure, and reducing the risk of strokes, which can lead to cognitive impairment and disability."

Other important brain-protective steps include staying active and engaged in work, hobbies, volunteering, travel, learning new skills — anything that builds social connections and prevents isolation. Rosenstein also underscores the importance of hearing, noting that untreated hearing loss is another factor that leads to social isolation and cognitive decline.

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On a macro level, addressing social determinants of health would go a long way to helping people stay healthy longer, Rosenstein says. He sees a range of patients, some who are vibrant and lively well into their 70s and beyond, and others who are younger but seem older—geriatric by syndromes. Often, key reasons people age faster are the layers of hardships they experience in life, such as unstable housing or limited access to healthy food.

"Reports show that when thinking about dementia from a public health standpoint, which can be extrapolated into aging in general, about 40 percent of cases of dementia can be prevented or reduced by public health measures," Rosenstein says. "Some of that is individual diet and exercise and not smoking, and some of it is public health measures like decreasing pollution, expanding walkable spaces, and early childhood education."

People often ask whether it's too late to start now with trying to prolong their healthy years, and Attia argues that "while you still have breath in your lungs, it's not too late to do something. But I also think that if we're all in a car driving to the edge of a cliff, it's a lot easier to slow the car down and make sure you either avoid the cliff altogether or slow your route to the cliff's edge dramatically."

Still, with all the medical advice in the world, it can still be overwhelming to know where to start. Attia suggests picking one area to focus on, especially one where individuals believe they could succeed. If sleep is a major trouble spot, then start there without making any other changes. "If you get that better, it will make it easier to address the other things and it will give you the confidence that you have control over these things."

To help people with healthy aging, taking a multidisciplinary approach can be effective, LeBrasseur says. Clinicians shouldn't be shy about referring patients to a nutritionist to provide guidance about diet or a physical therapist to build strength or work on balance. "It's really about being aware of resources that can provide support to individuals who may have deficits and emphasizing that with healthy lifestyle factors, it's never too late," he says.

It's also important to remind patients that there is a lot they can control when it comes to aging. In fact, just 20 to 25 percent of aging is driven by genetics, while diabetes, cardiovascular diseases, and cancer are all strongly influenced by lifestyle, LeBrasseur says.

"We really need to recognize that aging is a life-course event. Yes, pick your parents wisely, but also recognize that early life behavior can really impact your life course," LeBrasseur says. "The beauty is that you can take active steps to adopt and then sustain healthy behaviors. That's absolutely foundational to countering the different forms of cellular damage that can occur and optimize your health span." MM

Suzy Frisch is a Twin Cities freelance writer.

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Are pharmacy benefit managers the boogeymen?

PBMs play a key behind-the-scenes role in drug pricing. Critics say they jack up prices, squeeze out independent pharmacies, and even played a role in the opioid crisis.

BY GREG BREINING

A relatively obscure link in the chain between drug manufacturers and consumers is getting more attention politically. That link is the pharmacy benefit manager, or PBM.

PBMs contract with insurers and employers to negotiate prices with pharmaceutical companies. PBMs not only help determine prices but also the lists of drugs that insurance plans will cover.

PBMs entered the scene in the 1960s, processing claims and providing administrative service for insurers. Over time their role expanded as they coordinated with drug manufacturers, pharmacies, health insurers, employers, unions, and state and federal governments.

Stephen Parente, PhD, MPH

In PBMs' early days, "there weren't a lot of drugs that people wanted to take that were very common. Valium was the number one drug people would take in the '80s, basically. You didn't have Prozac yet, you didn't have Lipitor, you didn't have any of the painkillers the same way," says Stephen Parente, PhD, MPH, professor and Minnesota Insurance Industry Chair of Health Finance in the University of Minnesota Carlson School of Management.

"Starting in the early '90s, there was a whole new range of drugs that hit the market starting with Prozac, then Vioxx, Celebrex for arthritis pain, Lipitor, later. Actually the biggest drug in the '90s, which eventually went over the counter, was Claritin, originally prescribed for allergy," Parente says. "The insurance companies basically were like, well, we don't know how to do this. We only manage doctors and hospitals. And so they started to try to start managing drugs. They realized pretty quickly that it was complicated. They needed different rules and structures. And so the insurance companies started creating their own pharmacy benefit side businesses with a goal of selling them to other insurance companies who couldn't figure that out."

As the industry grew, PBMs consolidated, taking advantage of economies of scale. They also integrated with other functions in healthcare companies. "The insurance companies started to buy these systems back and not have them as a stand-alone system," says Parente. "For the longest time, UnitedHealth Group didn't have Optum Rx. They contracted almost exclusively with Express Scripts. And then they decided, no, we want to keep this money internally. So then they created OptumRx."

Now, according to the Federal Trade Commission, "the top three PBMs—CVS Caremark, Express Scripts, and OptumRx (together, the "Big 3")—manage 79 percent of prescription drug claims for approximately 270 million people. With the next three largest PBMs—Humana Pharmacy Solutions, MedImpact, and Prime—the six largest PBMs… now manage 94 percent of prescription drug claims in the United States."

A Federal Trade Commission report issued in July said the major PBMs "wield enormous power and influence over patients' access to drugs and the prices they pay.… These powerful middlemen may be profiting by inflating drug costs and squeezing Main Street pharmacies."

According to the report, "PBM business practices and their effects remain extraordinarily opaque." Independent pharmacies "struggle to navigate contractual terms imposed by PBMs that they find confusing, unfair, arbitrary, and harmful to their businesses."

According to the FTC, "PBMs and brand drug manufacturers sometimes negotiate prescription drug rebates that are expressly conditioned on limiting access to potentially lower cost generic alternatives."

PBMs took exception. According to *The New York Times*, "The benefit managers defended their business practices, saying they save money for employers, governments and patients. They say that their scale gives them crucial leverage to take on the pharmaceutical companies."

But in a different story, the *Times* reported that the substantial rebates drug manufacturers pay to PBMs may have exacerbated and prolonged the nation's deadly opioid epidemic.

"For years, the benefit managers, or PBMs, took payments from opioid manufacturers, including Purdue Pharma, in return for not restricting the flow of pills. As tens of thousands of Americans overdosed and died from prescription painkillers, the middlemen collected billions of dollars in payments," the *Times* wrote in December. "From 2003 to 2012, for example, the amount Purdue was paying PBMs in rebates roughly doubled to about $400 million a year, almost all of it for OxyContin."

This report, too, did not go unchallenged by the PBMs. On its website, Evernorth Health Services, which includes

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the PBM Express Scripts, said the report "cherry-picks unrelated facts and unproven statements from over a more than two-decade period, taking them out of context to create an entirely false and misleading narrative."

So are PBMs the boogeymen of the U.S. healthcare system? Or a necessary link in the for-profit system the country has created to deliver healthcare? Parente's view is less critical than some others.

"I don't think they're the boogeyman in the system," says Parente. "I think they are the extension of a specialized part of the U.S. financing system that's a carve-out of the insurance market and dealing with a very specialized area that is highly dynamic, generally much more dynamic than the medical care market."

***Minnesota Medicine:* These entities are huge. Optum Health reported $95 billion in revenue. It's the largest employer of physicians in the country, with 90,000 employed or affiliated physicians, 10% of all U.S. physicians. Do those big entities give monopsony power over physicians and and make it harder for physicians to make a living, get employed, earn what they should?**

Parente: In some respects, it gives physicians a steady income. The physician market has changed a lot in the last 20, 30, 40 years. I date myself by saying this, but the Marcus Welby era is gone—the whole idea of the individual physician putting out a shingle, operating independently. The thing about those Optum clinics—more often than not, they're at the primary care level—they are paying people a wage for their services that's predictable.

The challenge for physicians these days is that they graduate on average with a tremendous amount of debt—$200,000 is what I remember. You can't set up your own independent practice and pay that back and establish a set of patients. But if you go work for Optum—or honestly, a hospital, it doesn't have to be Optum—you'll have a steady salary and you can make inroads.

When I've seen some of these Optum clinics popping up, they're popping up in pretty much Middle America, in places where you just don't see the same level of primary care services available anymore. To a certain extent they're filling the need. And to the extent that they're getting any economies of scale by setting up an office practice and streamlining practice management systems and things like that, that's not a bad thing.

And then the last thing is that the thing about monopoly power in general, people don't get concerned about monopoly power until your market share gets above 30, 40, 50, 60%. Not 10%. When I went to school in Rochester, New York, the Excellus BlueCross BlueShield health plan up there still does, I think, dominate 85% of all the health insurance market in Rochester, if not western New York. I mean, talk about monopoly power.

The Federal Trade Commission report was highly critical of PBMs. According to the report, "increased concentration and vertical integration may have enabled PBMs to lessen competition, disadvantage rivals and inflate drug costs." Those are pretty serious concerns, aren't they?

They are. The operative word there is *may*, right? When people very quickly start doing international comparisons to the U.S., drug costs are higher in the U.S. That's where they're going to run to the boogeyman argument. But to a certain extent, the PBMs are enabling us to get cheaper prices on generics, not just super expensive things on brand. In the U.S., just because we're wealthier than most other countries around the world, we get quicker access to new technologies than other people do, and the PBMs help distribute that, or pay for that product when that happens.

In the report, I was reading of some instances in which the

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PBMs, because of the vertical integration, steer the choice of drugs to their own pharmacies, and they may, in their formularies, limit access to generics in favor of more profitable brand name drugs. This would seem to work against consumers. Is that indeed something that's happening?

The only way to really verify if that's actually happening is to have essentially all payer claims data—to see that actually happening at a fairly specific detail. I do that sort of research. There's no database I can tap into that gives me access to prove what they're saying. I understand where the challenges are, and I understand where the weaknesses are for people concerned about PBMs. I certainly understand the issues of vertical integration, where, you know, CVS-slash-Aetna is both an insurance company and a retail pharmacy chain. Or UnitedHealth Group with Optum. It's like they got the whole thing covered and the insurance company, too. I get all that. But in terms of actually saying definitively, is this a major problem? We need better data for that to know exactly how the redirection is occurring.

What efforts are ongoing to change or regulate PBMs? What seems possible?

So I think the biggest thing that's happening right now is that there's a push from initially the Trump administration and then the Biden administration for price transparency. And that has happened in the medical care pricing system. I worked on that policy when I worked in the Trump White House, and it's one of the few things that the Biden folks didn't countermand when they countermanded all the executive orders when they came in. But the one thing that was also included in that was to get transparency in terms of pricing for pharmaceuticals and the pharmaceutical market.

One of my big concerns with that was just understanding better how the data flows for a lot of these things. How would that happen? I could understand pretty easily how the medical price transparency would happen with insurance companies. But the PBMs are challenging. On the one hand, we want to see pricing of pharmaceuticals. Well, does that mean you go to the drug company? To the insurance company? To the PBM? Which of the three are you talking about? Do you go to the retail pharmacy, the Walgreens of the world, and demand that they put all their prices out?

The most likely place you could probably try to get that data is the PBMs, because they're in the middle of it all. They see ultimately what the final price is going to be, both for the drug and for the consumer. So that's where I think there's regulation in the offing.

One of the reasons why I personally am not and was never a big fan of doing this was that, as I said before, it's a highly dynamic market. The drug pricing information does change very often. So having a monthly summary of it, it's not clear how that's going to help the consumer. MM

Greg Breining is the editor of *Minnesota Medicine*.

Dermatology update for primary care

New diagnostic techniques, treatment strategies, and therapies help family physicians and general practitioners treat commonly seen skin conditions.

BY KAMRUZ DARABI, MD

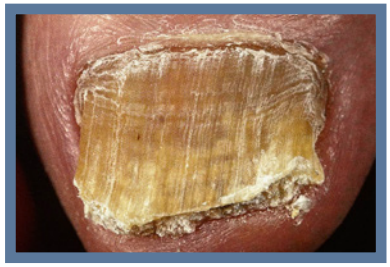
Skin diseases are common, and patients frequently consult with their primary care provider first to diagnose and treat them. Over the last 20 years genetic and molecular breakthroughs have revolutionized medicine. Our diagnostic and therapeutic tools have evolved to detect genetic polymorphisms and target key proteins in disease pathways, enabling us to diagnose more accurately, treat more effectively while also reducing side effects of treatments significantly. The field of dermatology is no exception.

In this first article of a two-part series, I will provide helpful tips for skin conditions commonly seen by primary care providers, highlight diagnostic clues, provide current treatment strategies, and discuss new therapies that have become available to manage these often chronic and burdensome skin diseases.

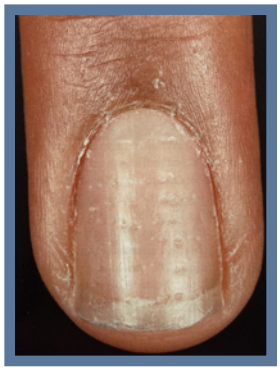
Kamruz Darabi, MD

Onychomycosis is a very common problem, especially for the elderly. First, remember that not all nail dystrophy is caused by fungus, even though the majority is. Psoriasis is common (an estimated 5% of the population is thought to have psoriasis) and can cause distal dystrophy, identical to onychomycosis. If the patient is young, or the dystrophy seems odd—for example only random nails are affected—think of psoriatic nail disease. Ask the patient if they get rashes in their scalp or ears, on their elbows and knees, or if they have a family history of psoriasis. Another clue that you're dealing with psoriatic nail disease are nail pits and oil drop pigmentation, both rarely seen in classic onychomycosis.

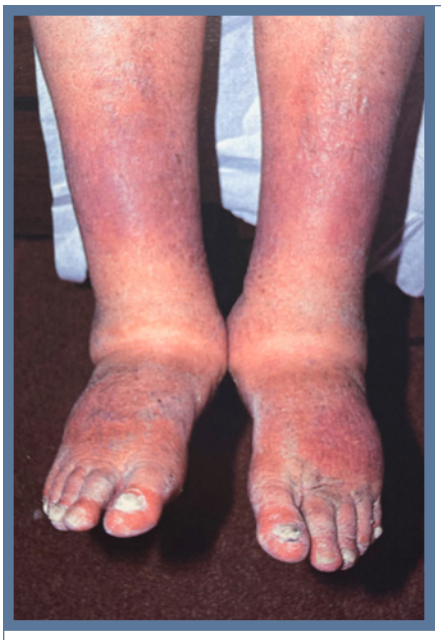
It is obvious why this distinction is so important: Onychomycosis is treated with antifungals. Psoriatic nail disease is treated with intralesional triamcinolone injections into the proximal nail fold where the nail matrix resides or with systemic agents such as methotrexate or biologics. For the treatment of onychomycosis topical antifungals alone are usually ineffective and patient compliance to use them for six to nine months daily is understandably very low. Topical keratolytics such as over-the-counter 20–40% urea ointment or Vicks VapoRub ointment with antimicrobial menthol can be cost effective and moderately effective adjuncts to oral antifungals, which have cure rates of only 50%. Pulse-dose oral antifungals are effective and better tolerated than daily dosing schedules. Terbinafine seems to be more effective than azoles. A two-pulse regimen of terbinafine 250 mg daily for four weeks, then four weeks off, then again four weeks on, seems to yield similar cure rates as continuous daily dosing. Baseline lab monitoring (AST, ALT, CBC with diff) is still suggested but the utility of repeat laboratory monitoring absent risk factors has been questioned for pulse-dosing. Another benefit of terbinafine compared to azoles is the lower likelihood of significant drug interactions, such as with statins, commonly used in the afflicted age group.



Onychomycosis



Nail pitting of psoriasis



Acute stasis dermatitis versus cellulitis

Both conditions present with acute onset redness and swelling of the pretibial skin above the medial malleolus. Patients often have similar risk factors: peripheral venous and/or lymphatic disease, fluid overload such as chronic congestive heart failure, COPD/emphysema, chronic kidney and/or liver disease. What distinguishes them is cellulitis is unilateral and acute stasis dermatitis is bilateral. Stasis dermatitis patients usually report recent long-distance travel, attending an outdoor event on a hot day, exacerbation of their underlying medical condition, or therapy with an antihypertensive such as a calcium channel blocker with peripheral edema as a side effect. Compression socks, elevation and medical management of the underlying medical issue resolves the acute episode, and topical steroids help with the itchy dermatitis.

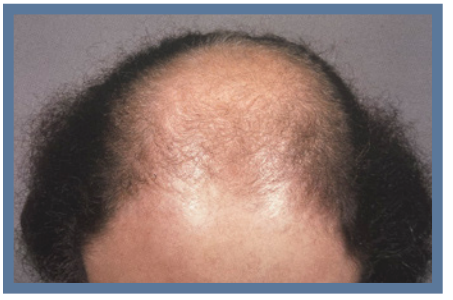
Hair loss

Entire chapters of dermatology textbooks are written about the many types of hair loss. The three most common ones are *alopecia areata* (patchy hair loss, autoimmune in nature); *androgenic alopecia* (male-pattern hair loss and its female equivalent, female-pattern hair loss, both driven by excessive genetic sensitivity of hair follicles to androgens such as testosterone); and *telogen effluvium* (physiologic hair shedding after intense physical or emotional stress). Let's go through them one by one.

ALOPECIA AREATA. As the name implies, patients develop area or patches of complete baldness in a random distribution in the scalp, beard, eyelashes, or brows. The bald scalp is smooth and hairless, with typical "exclamation point hairs" at the active border, which are hair shafts that taper towards the scalp. This disease is autoimmune in nature, with the hair follicle root becoming the target of the autoimmune reaction.

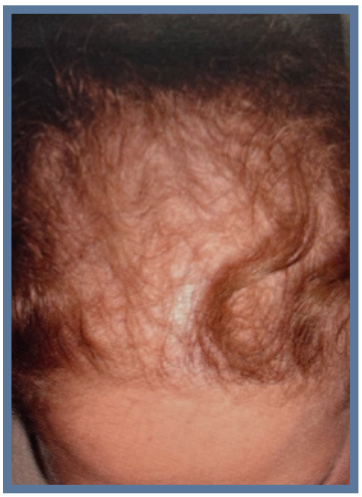
Limited disease has a very good prognosis and spontaneous resolution is common. I check a serum TSH with reflex to free T4 as some patients may also have autoimmune thyroiditis (Graves or Hashimoto's). First-line treatment for limited disease is intralesional triamcinolone acetonide injections, 5–10 mg/ml with a total of 20–30 mg injected every month until regrowth is established. A topical steroid solution or lotion may be used one to two times daily as well. I use clobetasol, fluocinonide, or triamcinolone based on patient age, location, severity, and affected skin surface area. If two to three months of treatment does not result in significant hair regrowth, topical 5% minoxidil foam or solution, twice daily, can be added for another two months.

In recent years, oral Janus kinase (JAK) inhibitors have been approved by the FDA for the treatment of severe disease. Oral baricitinib is approved for adults and resulted in significant hair regrowth in roughly 40% of patients after 36 weeks. Oral ritlecitinib is approved for patients age 12 and older and resulted in significant hair regrowth in 20% of patients after 24 weeks. These medications require annual TB testing, theoretically increase the risk of opportunistic infections, may increase the risk of major adverse cardiovascular events (heart attack, stroke, thromboembolic events) in patients older than 50 with other risk factors, may cause diverticulitis in patients on NSAIDs, steroids or methotrexate (as seen in trials of older rheumatoid arthritis patients), and they may elevate lipids. Before starting treatment with a JAK-inhibitor, I check QuantiFERON Gold TB test, fasting lipids, CBC with diff and AST/ALT at baseline and again after 12 weeks, and repeat the TB test only annually. Rapidly progressive severe alopecia areata (alopecia universalis or totalis) can be temporarily treated with oral prednisone at a dose of 1 mg/KG (up to 60 mg daily), tapered over four to six weeks to allow slow-acting JAK inhibitors to work while achieving short-term psychosocial relief.



ANDROGENIC ALOPECIA IN MEN (male-pattern hair loss)is very common and straightforward. Often familial, it starts with thinning of the occiput and bilateral temporal recession of the hairline. The cause of this condition is thought to be a genetic sensitivity of hair follicles of the crown of the scalp to androgens like testosterone and dihydrotestosterone, resulting in miniaturization of follicles.

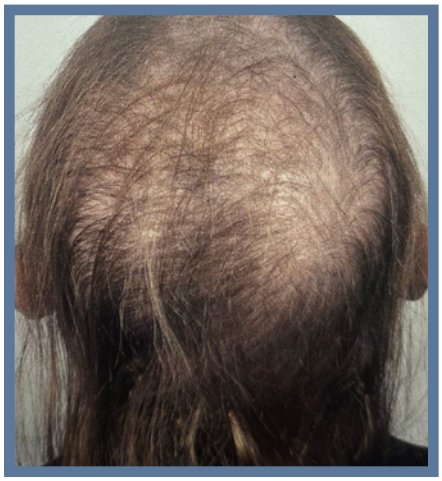
Topical 5% minoxidil in over-the-counter foam or solution form, twice daily for a three- to six-month trial, is a reasonable first option. If unsuccessful, I prescribe a topical compounded solution that contains 5–7% minoxidil and dutasteride or finasteride, twice daily, for a minimum trial of three to six months, or we start oral finasteride, 1 mg daily, based on patient preference. Combination therapy of topicals with oral finasteride could provide greater benefit than either alone. Reported side effects of oral finasteride are sexual dysfunction (erectile dysfunction, decreased libido, and ejaculatory dysfunction), reduced sperm count, gynecomastia, teratogenicity if pregnant women get exposed but not through male sperm. Side effects are mostly reversible with discontinuation but in some cases side effects persisting after discontinuation have been reported. Oral finasteride may lower levels of serum PSA and therefore interfere with test interpretation. Dutasteride is a more potent inhibitor of the production of dihydrotestosterone, the biologically most active form of testosterone. It can be used as a second-line agent in patients who have failed a six-month trial of oral finasteride; however, the risk of side effects is also higher. I use a dose of 0.5 mg daily for male-pattern hair loss. Low-dose oral minoxidil can be combined with finasteride or dutasteride, if needed. It is important to assess blood pressure and cardiovascular risk factors before initiating, as minoxidil is an antihypertensive at doses of 5 mg daily and higher. It could also result in hypertrichosis in undesired location such as the face and cause pretibial edema. In men, I start at a dose of 2.5 mg daily and go up in dose every 3 months up to 5 mg daily, if tolerated. Platelet-rich plasma scalp injections and low-level red light therapy helmets usually are ineffective in male-pattern hair loss.



ANDROGENIC ALOPECIA IN FEMALES (female-pattern hair loss) is also very common, especially in peri- and postmenopausal women, when follicle-protecting estrogen levels wane, and after menarche in women with a strong family history of hair loss. As in men, the cause of this condition is thought to be a genetic sensitivity of hair follicles of the crown of the scalp to testosterone, resulting in miniaturization of follicles in the crown area. Classically, unlike in men, female-pattern hair loss presents with diffuse thinning of hair of the entire crown area of the scalp. I usually don't check androgen levels, such as free and total testosterone and DHEAS, unless the patient has clinical signs of hyperandrogenism, such as irregular menses, hirsutism, acne, acanthosis nigricans, and galactorrhea. The utility of checking thyroid function tests in the absence of clinical signs of hyper- or hypothyroidism has also been questioned. If you suspect hyper- or hypothyroidism to be the cause of new-onset hair loss it is reasonable to check serum TSH with reflex to free T4 to distinguish primary from secondary thyroid disorders. Some practitioners check serum iron, ferritin and 25-hydroxy D3 to rule out anemia and vitamin D deficiency but there is very little evidence to support that.

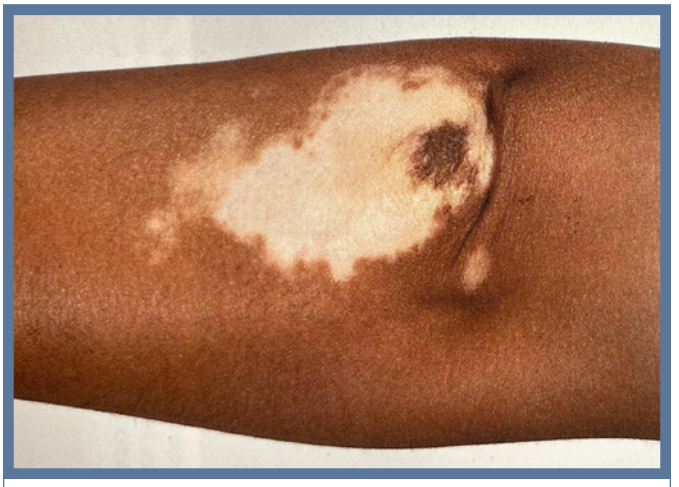
Treatment has similarities and differences with male-pattern hair loss. Similarities are 5% topical minoxidil foam or solution for three to six months as initial treatment. Women often struggle with application due to hair grooming practices and I encourage at least three times weekly bedtime use and to shampoo out residues in the morning. Compounded topicals with 5–7% minoxidil and finasteride or dutasteride can be used here as well, with the same application frequency for three to six months. Caution with women of childbearing age: Oral finasteride and dutasteride are teratogenic and women should be treated topically only if they use a reliable and effective form or contraception (birth control pill, IUD, subcutaneous implanted device, vasectomy of male partner, or have had a tubal ligation or hysterectomy).

Oral spironolactone is often favored as a treatment option as it is less messy than topical scalp treatments. Spironolactone's antiandrogenic effects are harnessed to counter the deleterious effects of androgens on hair follicles. Rarely, spironolactone's mild diuretic and antihypertensive effects pose a challenge at doses of 75–150 mg daily used for female-pattern hair loss. However, some patients may experience orthostatic hypotension and reflex tachycardia. I start patients with a low BMI at a dose of 75 mg at bedtime and patients with a higher BMI at 100 mg at bedtime and go up to 150 mg daily. The utility of measuring baseline and repeat serum potassium levels in healthy patients without cardiovascular risk factors and not on medications that otherwise affect blood pressure or electrolytes has been questioned. Therefore, I usually don't check serum potassium in young healthy patients that don't take other relevant medications or without cardiovascular risk factors. On higher doses, vaginal spotting and irregular menses could be a side effect due to effects on hormones. As in men, low-dose oral minoxidil is another option. The same precautions with regards to blood pressure, cardiovascular risk, facial hypertrichosis and pretibial edema apply to females. In women I use a lower dose than in men, starting at 0.5 mg daily at bedtime and add as needed 0.25 mg every three months up to a dose of 2.5 mg daily, if tolerated. Unlike male pattern alopecia, platelet-rich plasma scalp injections and low-level red light therapy helmets can be effective adjunct treatments for female-pattern hair loss but are often insufficient alone if the patient has a rapid or severe case. The roles of biotin supplementation and shampoos with claims to benefit hair loss have not been sufficiently studied to make a recommendation for or against them.



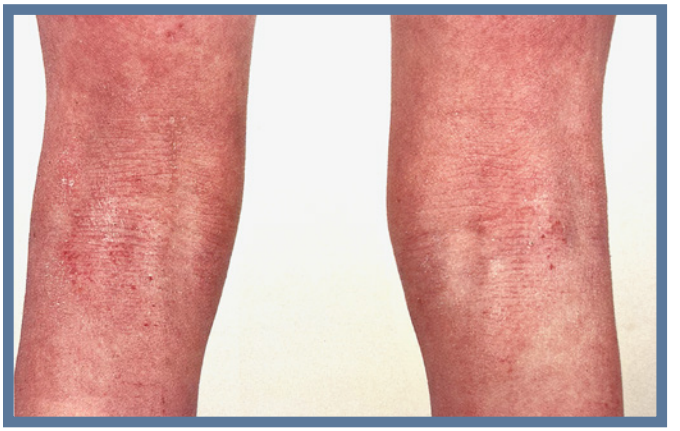
TELOGEN EFFLUVIUM is a physiological response to extreme physical or emotional stress in predisposed individuals. A severe infection, high fever, extensive surgery, pregnancy and child delivery, severe illness, a new medication, or periods of high emotional stress may result in sudden shedding of hair. Clinically, the entire scalp, including the temples and posterior occiput that is normally spared by androgenic alopecia is also affected. In almost all cases telogen effluvium is reversible after the stressor has been resolved, and within six to 12 months patients experience regrowth of hair. This can be aided by less aggressive treatments such as topical minoxidil 5% foam or solution, twice daily, for three to six months. It is reasonable to rule out a thyroid disease by checking serum TSH with reflex to free T4. Reassurance and clinical follow-up after three months is usually sufficient.

As you can imagine, not every case of hair loss presents with classic features. In these cases, a scalp biopsy, interpreted by a dermatopathologist who specializes in hair disorders, can help tremendously to get the correct diagnosis.

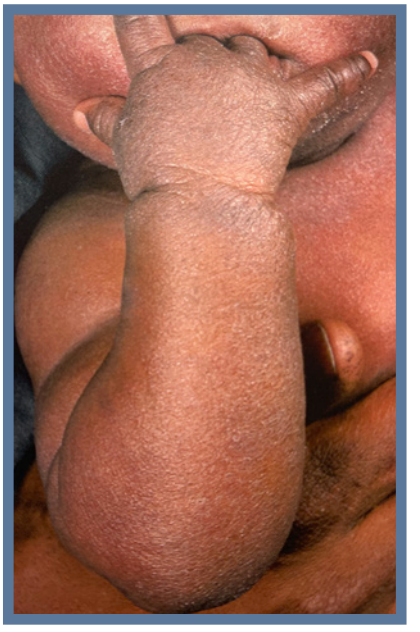


Vitiligo. This is another autoimmune disease where pigment-producing melanocytes in the skin are the target. Commonly affected areas are the face, hands, and genitals. Very rarely, patients suffer from vitiligo of the iris (uveitis), retina (retinitis), and meninges (acoustic nerve) where melanocytes are also found and patients rarely may present with ocular, oto, and neurologic symptoms as well. Patients with darker skin tones often seek treatment, and to be frank, treatment is challenging, particularly in long-standing vitiligo. Initially, I try a topical steroid (usually triamcinolone 0.1% cream) in the morning and calcipotriene ointment in the evening for four weeks. If unsuccessful, I offer the patient to add narrow-band UV-B, either in the office or the patient may purchase a medical grade home UV-B device and use it every other day for another eight to 12 weeks, in addition to the aforementioned topicals. After four weeks, for the face and genitals, I switch to a steroid-free topical calcineurin inhibitor like tacrolimus 0.1% ointment or pimecrolimus cream. If topicals and narrow-band UV-B is unsuccessful and the patient wants to pursue further treatment, the FDA has recently approved a topical JAK inhibitor, Opzelura cream, which resulted in significant repigmentation in 30% of patients after 24 weeks. No more than 10% of body surface area should be treated due to concerns of systemic absorption and increased risk of side effects as discussed under alopecia areata treated with oral JAK inhibitors. If everything fails and the patient is motivated, chemical depigmentation of normal skin or pinch grafts of normal skin into skin affected by vitiligo can be tried at specialized centers.

Atopic dermatitis is a common skin disease and affects different areas of the skin at different ages. Infants with atopic dermatitis develop eczematous dermatitis in areas irritated by rubbing up against sheets, such as the scalp, cheeks, the lateral forearms and calves. Saliva and food can cause facial eczema. During toddler age and later childhood, the predilection sites migrate to the classic lower eyelids, neck, flexor surfaces of elbows, and popliteal fossae. Many patients present with the classic atopic triad of atopic dermatitis/eczema, asthma, and hay fever. Diligent skin care alone can help a great deal and reduce flares and minimize the use of topical steroids. I recommend daily baths with gentle soaps to reduce bacteria on skin, as staph has been shown to activate the native immune system



in the skin and contribute to flares. Moisturizing creams (as opposed to watery lotions) with ceramides or Aquaphor/Vaniply ointment are helpful when used daily or twice daily. Weekly bedsheet changes and dilute bleach baths further reduce bacterial colonization of skin. For atopic dermatitis flares I use topical corticosteroid ointments of mild potency, such as desonide or hydrocortisone 2.5% for areas with thin skin, such as the face, neck, genitals, axillae or groins. For the torso and extremities with thicker skin, I use moderately strong steroids such as triamcinolone 0.1%. For the scalp, I use solution vehicles such as fluocinolone solution.



Steroid-sparing topical calcineurin inhibitors (TCIs) can be used for more frequent intermittent use in areas of thin skin: Tacrolimus (Protopic) 0.03% ointment can

be used for children ages 2–15, and 0.1% can be used for patients 16 and older. Pimecrolimus (Elidel) cream may be used after age 2 as well. The FDA placed a black box warning on TCIs for lymphoma, based on animal studies where animals received TCIs with serum concentrations much higher than ever measured in humans. To date, a convincing relationship between use of TCIs and lymphoma has not been established in humans.

Newer approved topical steroid-sparing options are PDE4 inhibitor crisaborole (Eucrisa) ointment for age 3 months and older, and JAK inhibitor ruxolitinib (Opzelura) cream for age 12 and older. Ruxolitinib (Opzelura) cream should not be applied to more than 20% of body surface area (the patient's palm is roughly 1% of body surface area), as systemic absorption may approach levels at which we start to worry about the same side effects as with oral JAK inhibitors, specifically thromboembolic events, major cardiovascular events, malignancies such as nonmelanoma skin cancers and lymphoma, and serious infections due to immunosuppression.

Systemic biologics and targeted therapies approved for atopic dermatitis have been a game changer for pediatric and adult atopic dermatitis patients with moderate to severe disease not adequately controlled with topicals or when topicals are not advisable.

Dupilumab (Dupixent), a subcutaneously injected IL-4/IL-13 inhibitor, has been approved for age 6 months and older. It's also approved for moderate to severe steroid-dependent asthma, which is a common comorbidity. Lebrikizumab-lbkz (Ebglyss) is a IL-13 inhibitor and indicated in patients 12 years and older, who weigh at least 40 kg.

For patients age 12 years and older with moderate to severe atopic dermatitis whose disease is not adequately controlled with other systemic therapies, including biologics, or when those therapies are inadvisable, approved oral targeted therapy JAK inhibitors are abrocitinib (Cibinqo) and upadaciainib (Rinvoq). These agents require close monitoring by a physician who is familiar with managing these drugs. Safety and monitoring concerns include pregnancy test, hepatitis and TB testing, lipid panel, CBC, renal and liver monitoring, and skin exams.

Older oral immunosuppressives sometimes used in moderate to severe treatment-resistant atopic dermatitis are oral methotrexate, cyclosporine, and mycophenolate mofetil.

Some patients do well with narrowband UV-B light therapy in the office or via a home unit. **MM**

Kamruz Darabi, MD, is triple board-certified by the American Board of Dermatology in Dermatology, Mohs skin cancer surgery, and Dermatopathology. He practices at Darabi Dermatology, Chaska. Email: kdarabi@darabiderm.com. Www.darabidermatology.com.

Changing political tides


Dave Renner

After 37 years of pushing the MMA's priorities at the Legislature, Director of Advocacy Dave Renner reflects on how politics, issues, and the MMA have changed.

The son of a small-town attorney and Republican legislator, Dave Renner grew up splitting time between living at home in Walker and then in St. Paul, when his family traveled to the capital for the legislative session. He grew up fascinated by politics and leveraged that interest to a position with the Minnesota Senate Republican Caucus not long after graduating from St. John's University. And in 1988 he went to work as the director of state and federal legislation for the MMA.

Thirty-seven years ago.

This June, Renner, now titled the MMA director of advocacy, will retire. No more sessions spent at the Legislature, engaging with the important players in policy, advocating for the issues affecting physicians in Minnesota.

Before he escapes the web of the legislative intrigue and the MMA, *Minnesota Medicine* cornered Renner to ask how the Legislature, politics, and policy, especially at the state level, have changed in the ways relevant to physicians. The interview has been edited for clarity and brevity.

You come from a political background.

I got a bachelor's degree from St. John's in political science. And I always had an interest in public policy, for the Legislature. Part of it goes back to my dad, Rep. Robert Renner, who served in the Legislature 1957–69. My oldest brother worked for then-Gov. Al Quie and he became a lobbyist. I always said, I'd love to work at the Legislature.

Back when my dad served, the Legislature was nonpartisan. My dad caucused with the conservatives. That was back when the Legislature met every other year. But he and my mom—I don't know how they did it—they packed up the family to St. Paul and rented a house and put all the kids in school for six months. My oldest brother, who was nine years older than I was, went to half of second, fourth, sixth, and eighth grade in St. Paul, each year moving around.

Out of college I did work, session only, at the Capitol in 1983. I did one stint working on a political campaign for U.S. Sen. Rudy Boschwitz. I came back and I started working for the Minnesota Senate Republican Caucus in research.

I had no special training in health and human services. That was the area that was open, and that's what I got hired for. I covered the Health and Human Services Committee. Back then—this was in the mid-1980s—much more the focus of the Health and Human Services was on welfare reform and less on healthcare. That may have been just kind of a Republican bent of, you know, we got to cut back on welfare cheats, I don't know.

How did you make the connection with the MMA?

Working in the Health and Human Services Committee, you get to know all the players. You get to know the lobbyists. Interestingly, a very good friend of mine, who was a longtime lobbyist, used to lobby for the Minnesota Medical Association. He took me out to lunch one time. And he somewhat kiddingly, but somewhat seriously, said, "Hey, if you ever get an offer from the MMA, turn it down. Don't take it."

During my four years at the Capitol, the MMA had gone through about eight lobbyists. It was a hard organization to work for, because they were a lot of independent physicians—"Don't tell me what to do," and "I know more than you do." Plus, it was also the time when there was a real growth in managed care. So some of those lobbyists left the MMA to go work for managed care companies. Anyway, there was a lot of turmoil.

You didn't take the advice.

Roger Johnson, who was a former MMA employee was hiring. They were trying to start new and he offered me the job, which was really somewhat surprising.

Why surprising?

Well, just because I was young. I'd never lobbied before. But I knew politics, I knew healthcare a little bit. Just the fact that he took a chance, right?

You had mentioned all the lobbyists that MMA had burned through right before you joined. Had the MMA been involved for quite a long time in lobbying at a state and federal level?

When I first started, clearly there were lobbyists everywhere. There were a lot fewer lobbyists than there are today, but there were a handful of groups that were known—you needed to get their input. The MMA clearly was one of those. The MMA has been around for a long time—well-respected organization. Advocacy has been at their core since they first started.

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When it came to the practice of medicine, or the delivery of medicine to the public, what were the big issues the Legislature seemed to be preoccupied with?

The first big issue that I worked on in my first session in 1989 was the creation of the first living will law that recognized advance directives. And this was really a touchy issue, the whole end-of-life issue. [Just a few years earlier, an auto wreck left 25-year-old Nancy Cruzan in a persistent vegetative state. Her parents fought to remove her feeding tube. They wouldn't win that right until 1990, and Cruzan died 12 days later.]

This was a huge fight from those who believed that everything must be done to preserve life and those who argued that these patients were brain dead and the care only delayed certain death. The science was changing as technology advanced. Yes, we can keep the heart pumping, but they have no brain activity.

You make it sound as though that there was a division among physicians in their attitudes toward that?

Yes, partly because it was relatively new science, right? Like the general population, physicians are represented across the political spectrum. Issues related to when does life start and when does life end are strongly felt. There's clearly a religious component to that. On the living will, the advanced directives, there was less opposition among physicians, but there was a lot of ambivalence for physicians who didn't work in this area. But with legislators, as an example, one of the big fights was if somebody who has an advanced directive can direct that someone doesn't want forced food and water, hydration, nutrition, is that allowing a person to die naturally, or is that starving them to death? So those kinds of debates.

We had a malpractice crisis back in the early '80s. There were some counties up in the St. Cloud area and others where they could not hire OB-GYNs because malpractice premiums were so high. So that was a big issue.

How was that resolved?

The MMA started what was then called Minnesota Medical Insurance Exchange [now called Midwest Medical Insurance Company, MMIC], as a physician-owned company. A year or two before I started, the Legislature did adopt some tort reforms to help get rid of, you know, fraudulent cases, nuisance cases, to make sure we have a short statute of limitations.

What were other big issues? Scope of practice has always been a big issue—what kind of practitioner can do what? Some of these included fights between optometrists and ophthalmologists about—is an optometrist trained to be able to prescribe or do certain surgeries? The role of chiropractic care was much less accepted back then. Those issues have always been around. They continue today.

Health insurance was clearly not as expensive when I first started. Most people in Minnesota were covered by their employer. We were a large union state, and healthcare costs had not bubbled up among employers as a major issue yet. So that has changed.

You know, the biggest change I have seen on the physician side is the structure of clinics and physician employment sta-

tus. When I started, I would go to meetings with state medical societies in other states, and when they used the term *clinic*, it was a derogatory term—welfare clinic. In Minnesota it was *Mayo Clinic*. The concept of a large, integrated multi-specialty group was not well accepted across the country as it was in Minnesota.

But even in Minnesota, when I first started, most physicians were independent owner-operators. Some may have been a multispecialty group, but most were in single-specialty clinics. At the time a five-, 10-, 15-person physician group was a large group. That clearly has been the biggest change that I have seen as most physicians now are in groups of 100 or greater. And most physicians now are employed and no longer clinic owners. And that has changed the types of issues we care about. Our focus has shifted from the business side of things to a greater focus on the patient side of things. Business issues remain important, like this year we're trying to make a major push to increase reimbursements in the Medical Assistance program. In the past that was an annual fight we had because these were small business owners that were struggling to keep the doors open, and if they didn't get reimbursed enough, that was a problem. Malpractice insurance the same way, right? You were buying your own malpractice insurance individually, so it was a much bigger issue to the individual physician.

Now, as physician employment status has shifted, the business side doesn't hit them as directly as it used to. So our issues have shifted much more to the public health issues, to the social drivers of health issues, how do we expand coverage. These are issues that are more patient focused.

Another big issue back when I first started was tobacco. [In 1975, the Minnesota Clean Indoor Air Act requiring separate smoking areas in public places went into effect. In 1984 U.S. Surgeon General C. Everette Koop challenged Americans to "create a smoke-free society in the United States by the year 2000."] Several organizations began promoting the smoke-free generation. The MMA created the Smoke Free 2000 Coalition. This divided our members a bit. Not because physicians didn't care about the health impact of smoking, but because some members were like, "How does this help me keep my practice running? That's a white hat issue. That doesn't help me as a practicing physician." Versus others who were saying, "Tobacco use is killing Minnesotans and we've got to be fully behind this."

That effort continues today. Blue Cross has kind of taken the lead on it. But there still is a smoke-free coalition that we are a member of, and we still participate in. We passed the first Clean Indoor Air Act in the country. Then we prohibited the sales of cigarettes in vending machines. We've raised the cigarette tax many times. Then we passed the Freedom to Breathe Act, which prohibits all indoor smoking. So we made significant strides.

Speaking of controversial issues, abortion certainly has been. But for the entirety of your time with MMA, a compromise had prevailed, if you will, through Roe v. Wade. Now, all of a sudden, the regulation of abortion is being thrown back to the states, and it's become an issue in a way it hasn't been for 50 years.

That's true. And it's been interesting to watch the evolution of physicians and the MMA on issues of reproductive health. When I first started, Rowe was in place. So there were abortions clearly going on. But as a medical association, we had a position that was pretty meek. We did not have a position on the moral question of the abortion debate. Our position was that, if it is legal, then it's a medical decision between a physician and a patient. So we got involved on legislation that created barriers to legal medical care, but we did not advocate that it should be legal.

The Legislature rarely introduced a bill to outlaw abortion because, of course, the U.S. Supreme Court said you couldn't do that. So they tried to regulate it through efforts like saying parents had to be involved with a minor needing an abortion, regulating the types of facilities in which an abortion takes place. There were many bills over the years to interfere with what at the time was a legal procedure. We would sometimes weigh in on those bills if we felt they interfered with good patient care. But we tiptoed. We made it clear we don't have a position on whether abortion should or shouldn't be legal, because we had members on both sides of the moral question, and our leadership believed that the MMA should stay out of that.

We have become much more active on that, and much more of a force of saying, no, abortion is medical care and it should be legal and it needs to be allowed. That has been a shift, probably in the last 15 years or so.

Have you lost members because of that?

I'm sure we have. But I don't think as many as we feared. I think some physicians now may say that I personally would not encourage somebody to have an abortion, but I understand that it is critical healthcare for certain cases.

This is probably an overgeneralization about the politics of physicians, but when I started, I always used to tell people that we clearly were viewed more as a Republican organization. Our political action committee supported more Republican legislators. Our members were small business owners, so they kind of leaned towards business-related issues. I don't know exactly what the political makeup of our members were, but I'm guessing it was 60-40 or 70-30 Republican.

But my sense is that in the last five years, 10 years, the politics—if not of our members then for sure our issues—have shifted significantly to the left. The issues we support align much more closely with issues supported by Democrats. We want to spend money. We want more coverage. We want to make sure that insurance companies are not interfering with medical decision-making. We support public health initiatives. We support immunizations. We support the social drivers of health—all those issues that clearly align more closely with Democratic policies than Republican policies, especially in today's world.

When I first started working for the legislature, the Republican leaders in the Senate were people like Glen Taylor, who owns

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the *Star Tribune*. George Pillsbury from the old Pillsbury family. Jim Ramstad was in our Senate—pro-choice Republican. There were a lot of pro-choice Republicans back then, and they were basically from the classic definition of a Republican—less government, not anti-government, but less government, more private industry, more innovation. Clearly, the Republican Party has now shifted.

I assume MMA would claim to be nonpartisan officially, yet of 12 endorsements for the Minnesota House of Representatives last year, only two were for Republicans.

I just want to clarify, we cannot get involved in partisan politics. But that is why we created MEDPAC, which is our political action committee. MEDPAC is a separae organization that serves as the political arm of the MMA. When I first started, MEDPAC endorsed approximately 70% Republicans, and 30% Democrats. Until right before COVID, we were probably closer to 50-50.

As with most political action committees, endorsing decisions partly depend on which party is in control, because you tend to support whoever's in control, whoever's got the chair. But since COVID, I have seen a shift among many Republicans that has made it more difficult for our MEDPAC board to endorse a lot of Republicans. Legislators who have supported us on many issues in the past became very vocal opposing proven public health efforts to address COVID. Our MEDPAC board said we can't support them. So it has been much more difficult to find support for some Republicans because of the direction some of them have gone.

But you're right about the MMA's approach on public policy. We really do try to take the partisan politics out of it. We really stress and rely on our mission, which is, will this help us make Minnesotans the healthiest, and will this help make Minnesota the best place to practice?

How do you think MMA is perceived at the Capitol, on both sides of the aisle?

I think the MMA is well respected and a valued voice in healthcare policy. We contracted with Todd Rapp of Rapp Strategies a few years ago to assess what outside groups thought about the MMA. That survey contacted other stakeholder groups, legislators, and healthcare leaders. His findings were that the MMA continues to be well respected. We continue to be viewed as a voice, a respected voice that provides assistance in the healthcare debate. Are we viewed as overly partisan by some? Maybe, but I think of the legislators that we work with closely, both Republicans and Democrats, I think most of them still respect the work we do. I think they still have a great deal of respect for physicians. We try to present ourselves as, while clearly having a point of view, we are here to help. We are here to provide information. We are here to help you make good decisions that meet that goal of our mission.

I suspect that the whole issue of physician burnout is not something that was much discussed when you first landed in the Legislature in 1988, was it?

No, not at all. But has the problem gotten worse, or do we just not know how much of it is just being vocalized more? Were there always unhappy doctors? I'm sure there were. Back then, a lot of it was related to running a business and all kinds of headaches related to that. My impression is a lot of today's burnout results from physicians feeling like they're not valued. They're a cog. Their decisions are being questioned by their employer, by the insurer, by the patient, and they are asking is it worth it to me anymore? Physicians have always had pressure and challenges. I think even back when they were an owner-operator, there were always the issues of working too long. You would hear some doctors say, I would never recommend my kids go into medicine. Or you would hear some kids say, I chose not to go into medicine because I saw the hours my dad worked.

What are your plans and on what schedule?

Other than deciding that my last day will be June 27, I don't have a detailed plan.

While I am excited to start a new phase of my life, I'm sure I'm going to miss the camaraderie. I know I will miss the intellectual pursuits of problem-solving, and I will miss the social side of being around the capital. Most of my good friends have come from my years there. But beyond that, I'm not certain where we go next.

Somebody told me, you need to have the mindset that you don't retire from something, but you retire to something. My wife is also planning on a similar date. So, we are both starting the adventure together. How much traveling can you do? How much golf can you play? We have our family, our kids all live in town with four grandkids, so we'll spend a lot of time there.

The ultimate question of where do I find meaning and what do I do? I haven't figured that one out yet. MM

Interview by Greg Breining, editor of *Minnesota Medicine*.

News Briefs

MMA board authorizes creation of AI task force

At its December meeting, the MMA Board of Trustees authorized the creation of an MMA task force focused on artificial intelligence in healthcare. Recruiting efforts for task force members began in January.

The task force is charged with considering the complex landscape of AI in healthcare, and identifying and recommending policies and principles that will allow for innovation while also ensuring that patients and physicians are protected.

The task force will focus its work on transparency in the use of AI, potential bias in the use of AI, liability considerations, and clinical decision-making.

The task force, which will have up to 15 members, will hold its first meeting in early 2025.

For questions, contact Stephanie Lindgren, policy counsel (slindgren@mnmed.org).

MMA sponsors Medical Discovery Day for BIPOC Youth

Volunteers at the event include: Nardos Dawit, MD, resident (PGY-3) (left); Steffan Okorafor, UMN medical student (MS1); Amina Qureshi, UMN medical student (MS1); Sarah Murad, UMN medical student (MS3); Elise Toussaint, UMN medical student (MS2); Kacey Justesen, MD; and Verna Thornton, MD.

In November, Gillette Children's hosted a day filled with learning, mentorship, and networking—all with the goal of building a stronger and more equitable future for the healthcare field.

The event, Medical Discovery Day for BIPOC Youth, brought together students, parents, educators, clinicians, and community leaders to inspire youth to consider careers in healthcare. Throughout the day, the youth in attendance engaged in hands-on activities and had the opportunity to learn from and network with healthcare professionals from diverse backgrounds.

The MMA sponsored the event, and hosted two sessions, titled, "Growing Your White Coat," for the parents and guardians in attendance. Staff from the University of Minnesota Medical School Office of Admissions provided content development and event day support.

In addition, Kacey Justesen, MD, and Verna Thornton, MD, (co-chairs of the MMA Barriers to Workforce Diversification in Physician Education, Training and Licensure Task Force and

Other volunteers included: Olivia Swaim, UMN medical student (MS1) (left); Jordan Key, UMN medical student (MS1); Verna Thornton, MD; Maria Landherr, UMN medical student (MS2); Andrea Lopez, UMN medical student (MS2); and Kacey Justesen, MD.

members of the MMA Foundation's Board of Directors) provided session leadership support.

The MMA sessions helped parents and guardians gain a better understanding of how they can support their kids and teens in exploring a career in healthcare. They heard advice on what this journey looks like from the perspective of medical students, residents, and practicing physicians.

MMA member appointed to AMA's AMPAC board

Mary Lawrence, MD

MMA member Mary Lawrence, MD, was recently appointed to AMPAC, the AMA's political action committee board.

Lawrence, an ophthalmologist in Minneapolis, has been heavily involved in advocacy on many fronts, including membership on the board of trustees for MMA's political action committee, MEDPAC. Lawrence's involvement in advocacy also includes a bid for the DFL endorsement for Minnesota's 3rd Congressional District in 2016.

In her experience in state and federal advocacy, Lawrence has been an active champion for patient safety, most recently regarding optometric scope of practice proposals. This includes work on a 2024 bill that would lift existing statutory caps on optometric prescribing of oral antiviral drugs, steroids, and oral carbonic anhydrase inhibitors, among others. The proposal also authorizes optometrists to perform some surgical procedures, including needling in and around the eye. The MMA along with multiple other medical societies, have opposed this legislative proposal. The bill is expected to be reintroduced this legislative session.

The AMPAC Board of Directors is made up of 12 physicians from across the country. AMPAC accepts voluntary contributions from members of its parent organization to support candidates for political office.

Select medical practices now must post charges online

As of January 1, select medical practices and all freestanding outpatient surgery centers in Minnesota are required to post stan-

dard charges on their websites. This requirement was passed by the Minnesota Legislature in 2023.

Select medical practices, identified at the federal tax identification number level, include those that have revenue greater than $50 million per year *and* acquire a majority of that revenue by providing any combination of the following services:

- Diagnostic radiology services.
- Diagnostic laboratory testing.
- Orthopedic surgical procedures, including joint arthroplasty procedures within the CPT code range of 26990 to 27899.
- Ophthalmologic surgical procedures, including cataract surgery coded using CPT 71.4 code 66982 or 66984, or refractive correction surgery to improve visual acuity.
- Dental services.
- Oncology services, including radiation oncology treatments within the CPT code 71.9 range of 77261 to 77799 and drug infusions.
- Anesthesia services commonly provided as a support to services given at a hospital, outpatient surgical center, or medical practice that provides orthopedic surgical procedures or ophthalmologic surgical procedures.

According to the law, "standard charges," include:

- The charge for an individual item or service that is reflected on a medical or dental practice's charge master, absent any discounts.
- The charge that a medical or dental practice has negotiated with a third-party payer for an item or service.
- The lowest charge that a medical or dental practice has negotiated with all third-party payers for an item or service.
- The highest charge that a medical or dental practice has negotiated with all third-party payers for an item or service.
- The charge that applies to an individual who pays cash, or cash equivalent, for an item or service.

The MMA is committed to ensuring that all price reporting requirements imposed on medical practices are meaningful to patients. The MMA will urge MDH to regularly evaluate the utility and adverse effects of these reporting requirements.

For questions, contact Adrian Uphoff, policy analyst (auphoff@mnmed.org).

Medical Assistance reform bill goes to Minnesota Senate

A bill that would increase Medical Assistance (MA) and MinnesotaCare reimbursement rates for outpatient physician services—a top legislative priority for the MMA—was introduced in the Senate February 13. This bill will raise outpatient payments to at least the Medicare level.

A 2024 Department of Human Services study concluded that outpatient MA payments in Minnesota are too low and must be increased to ensure access to services. The study recommended increasing rates to 100% of Medicare. MA currently reimburses 60–70% of Medicare, and only about 30% of what commercial insurers pay.

Proponents of the bill argue that payment rates have not received an across-the-board increase for 10 years and these payments have failed to keep up with the cost of delivering care, causing clinics to make difficult business decisions about services to cut or limit.

MMA priority bill on physician well-being introduced

Legislation to support physician well-being and mental health was introduced in the Minnesota Senate early in the session. Sen. Liz Boldon (DFL-Rochester) introduced the bill to appropriate money for the MMA's Treat Yourself First campaign.

Treat Yourself First is an awareness and education campaign focused on addressing burnout and improving healthcare worker well-being. Treat Yourself First is designed to reduce stigma associated with receiving mental health treatment and encourage healthcare workers who are experiencing workplace-related fatigue to receive the care they need. Its advisory committee includes well-being experts from the MMA, the Minnesota Nurses Association, the Minnesota Dental Association, the Minnesota Pharmacists Association, the Minnesota Advance Practice Registered Nurse Coalition, and several physician specialty societies.

MMA submits comments on rules for cannabis industry

On February 12, the MMA re-emphasized its concerns with Minnesota's new cannabis industry and its potential effects on the health, safety, and welfare of Minnesotans.

The MMA first voiced these concerns in August during the Office of Cannabis Management's proposed rules comment period. After these concerns went unheeded, the MMA submitted its comments again to an administrative law judge.

The MMA requested that:

- Appropriate health warning labels must be included on all cannabis products.
- Cannabis products must be stored in child-resistant packaging or containers, and must be stored out of children's reach or in locked locations.
- The medical cannabis consultant, who will advise consumers on cannabis products, must be a medical professional. If the medical cannabis consultant is not a medical professional, they must only be able to provide advice on dosage, advice on the best type of cannabis product for a particular condition, and so on, in consultation with a pharmacist.

"Minnesota's cannabis industry needs to ensure that the rules designed to regulate the adult-use cannabis, medical cannabis, hemp-derived consumer products, and lower-potency, hemp-derived edibles markets in Minnesota have public health and safety at their core," said MMA President Edwin Bogonko, MD, MBA. MM

FROM THE CEO

Finding the right balance

Balance matters. The dictionary offers numerous examples of how balance applies to our lives—physical equilibrium, stability, even distribution, harmony, mental and emotional steadiness. Yet balance is not always easy—consider the risks of poor balance facing the frail elderly or the challenges of finding balance between our professional and personal lives.

Balance is important to the MMA. The mission of the MMA is to be the leading voice of medicine to make Minnesota the healthiest state and the best place to practice. It is a mission statement with two key aims—the health of the public, and optimal conditions in the broader environment in which physicians practice medicine. This dual focus was an intentional decision by the Board of Trustees to recognize that physicians' work is in service to their patients and their health, and that to be successful in that work physicians need a supportive and empowering ecosystem that enables them to deliver excellent care.

Most of the time, the two key aims of the MMA mission are well-aligned. For example, MMA's interest in limiting exemptions from Minnesota's vaccine law to medical contraindications will improve the health of the public and make it easier for physicians to deliver evidence-based care. Similarly, the MMA's work to increase Medical Assistance (MA) physician payment rates will help preserve access to care for the one in four Minnesotans enrolled in MA and MinnesotaCare, and support medical practice financial viability because current rates have failed to keep up with the cost of delivering care.

There are many forces—internal and external—that threaten to disrupt balance, including that of the MMA. Organizationally, the MMA is subject to financial forces, including inflation, investment returns, and changes in membership. The MMA's advocacy work is subject to political forces, notably changes in priorities, philosophy, and leadership—at both the state and national level. Although nonpartisan, the MMA must be engaged in political advocacy to advance its mission. As German physician Rudolf Virchow aptly said, "Medicine is a social science and politics is nothing else but medicine on a large scale."

As MMA leadership articulated in a December 2024 *Insights* column (available online at mnmed.org/insights), some of the proposed priorities of the new federal administration have the potential to significantly shift the healthcare landscape and how MMA balances its work. Although our primary focus is state regulatory and legislative action, we will continue to coordinate with the AMA to understand, communicate, and respond to, as appropriate, federal actions.

Fortunately, the MMA has robust policies and procedures in place to guide its work and ensure balance in our advocacy. For example, the Board of Trustees has adopted a health equity "timeout" prior to acting on policy proposals to help identify potential conflicts—imbalance—between the two aims of the mission. For example, does a policy proposal improve practice conditions at the expense of patient health or that of historically marginalized communities? Would a proposal help the public but undermine the ability of physicians to recruit staff or ensure high-quality care? The MMA also has numerous mechanisms in place to listen to the voice of members. Nearly all policies adopted by the MMA originate with committees or task forces comprised of members. In addition, prior to the Board taking action on proposed policies, the proposals are routed to members via The Pulse to understand member sentiment and to gather comments.

Should winds shift or intensify, as they are prone to do, the MMA is prepared to lean in and provide the counterbalance needed to uphold our mission—to support the health of Minnesotans and the practice of medicine in our state. **MM**

Janet Silversmith
JSilversmith@mnmed.org

PHOTO BY KATHRYN FORSS

Edwin Bogonko, MD, MBA
MMA President

VIEWPOINT

172 years and counting

Since 1853, the MMA has been advocating on behalf of Minnesota physicians and physicians-in-training as well as the patients we treat. Advocacy is central to our work to make Minnesota the healthiest state in the nation and the best place to practice medicine.

Our advocacy efforts are grounded in our strategic plan, which aims to improve patient and population health, improve health equity, increase physician professional satisfaction and well-being, and empower physicians. The MMA deploys its influence broadly and in collaboration with the physician specialty organizations and other stakeholders—at the Legislature, in the courts, before state agencies, with health plans, and in communities. Often this work is not visible to our physician membership but is critical for ensuring that enactment of healthcare policies and laws do no harm to patients or undermine evidence-based practice that is core to the physician-patient relationship.

Advocacy is the main reason so many of you cite for being members—I know it is for me. Consequently, we all need to support the MMA's efforts to always have the voice of physicians represented whenever legislators, the courts, or state agencies make decisions that affect the practice of medicine in Minnesota. The MMA has a track record closing in on two centuries of hard work in this regard. Ultimately, it's advocacy that fuels the MMA's engine and the unwavering commitment of our organization's physician leaders.

In a survey sent to members and nonmembers a few years ago, 21% of respondents said they could use even more help with advocacy for patient and public health efforts. In fact, current laws such as Tobacco 21, food labeling to show ingredients and calorie counts, and the promotion of school feeding programs that offer healthy alternatives to the growing children of Minnesota have their roots in physician advocacy—a clear example of our commitment to the growth of healthy communities in our great state.

To amplify the MMA's work, there's something you can do to help—get involved. Join a committee, become a mentor to a medical student, or contribute an article to *Minnesota Medicine*. More than ever before, we need you!

When we send out an Action Alert, take a few minutes to send an MMA-supplied email to your elected officials to support our advocacy efforts. If there is something that is specific to your community that you deeply care about, contact us so that we can help craft the most impactful appeal, including stories to your legislators that you can download into your email; then hit send.

Donate to MEDPAC, our political action committee, which supports politicians on both sides of the aisle who support our cause.

Donate to the MMA Foundation and help fund its great work, including sponsoring medical students venturing into our communities to better understand drivers of health and exposing them to the necessary work that needs to be done regarding our public health.

Provide your opinion on policy issues by participating in The Pulse, our online opinion-gathering tool. This invaluable platform allows all of us and all views to be heard by MMA's physician leaders.

Whatever fits your style, please just get involved. We need physicians to be at the table whenever decisions are made on how medicine is practiced in Minnesota.

As is our practice, as the new legislative session embarks on setting priorities for the next biennium, we spent February 19 doing key advocacy work at the Physicians' Day at the Capitol, where physicians in their white coats, medical students, and allies met with legislative leaders and engaged in person on issues affecting medicine, our practices and more importantly, patients in our state. Beyond our state borders, as your leaders, we spent the week of February 10 camped in Washington, D.C., as we joined others from across the country, united in our asks to the 119th Congress regarding matters affecting patients, physician practices, and the health of the nation.

Every voice counts! Keep engaged and continue supporting your fellow physicians as we make Minnesota the healthiest state and the best place to practice. Let us also continue to take care of each other. Together, we will thrive! **MM**

WADE SWENSON, MD, MPH, MBA

Wade Swenson, MD, MPH, MBA, is a medical oncologist and hematologist dedicated to providing cancer care to patients in rural communities. He leads the oncology program at Lakewood Health System in Staples, where he works to ensure that patients receive the specialized care they need close to home. "Whether caring for my patients, spending time with family and friends, or advocating for causes I'm passionate about, my goal is always to make a meaningful and lasting impact in the lives of those I serve," he says.

Wade Swenson takes a selfie two summers ago during a one-week camp at the McNeil River State Game Sanctuary and Refuge in northeastern Alaska. The sanctuary spans about 200 square miles and is home to brown bears, salmon, red foxes, arctic ground squirrels, harbor seals, and bald eagles.

When did you become an MMA member?

I became a member of the Minnesota Medical Association in 2005, shortly after completing my fellowship and starting my career. I served on the Board of Trustees from 2008 to 2011. Joining the MMA was pivotal in fostering my interest in healthcare policy and advocating for solutions to the unique challenges physicians and patients face.

Where did you grow up, and where did you complete your education?

I grew up in Moorhead, Minnesota, where I attended high school and graduated from Minnesota State University Moorhead. I then completed my medical education at the University of North Dakota, followed by my residency, fellowship, and MPH in epidemiology at the University of Iowa. In 2022, I earned an MBA in healthcare from the University of St. Thomas.

Tell us about your family.

I have two adult children. My daughter, Abby, is in her second year of medical school at the Medical College of Wisconsin–Green Bay, and my son, Aidan, is a sophomore at the University of Minnesota Twin Cities. We share a love for travel and discovering coffee shops.

Hobbies or side gigs?

Beyond my professional work, I dedicate time to advocacy, serving on policy committees, and supporting initiatives that improve rural healthcare access and outcomes. I am the founder of the Rural Cancer Institute (ruralcancer.org) and am committed to advancing awareness and solutions for the unique challenges rural cancer patients and providers face.

Why did you decide to become a physician?

Medicine is a unique profession where science, compassion, and problem-solving converge. I became a physician because I felt called to make a tangible difference in people's lives by treating disease and advocating for changes to improve healthcare for individuals and communities.

What was the greatest lesson of your medical education?

The greatest lesson I've learned is the vital role of trust and communication in patient care. While medical knowledge is essential, truly understanding a patient's fears, values, and goals often defines the quality of care. Building trust is complementary to clinical interventions and foundational to their success.

What's the greatest surprise that your education left you unprepared for?

Medical education didn't fully prepare me for the administrative challenges of healthcare. Navigating insurance complexities and managing systemic barriers often demand skills that go well beyond the scope of traditional clinical training.

What's the greatest challenge facing medicine today?

The greatest challenge in healthcare today is ensuring equitable access to care while simultaneously addressing the need to control spending and improve care quality. Geographic, socioeconomic, and systemic disparities undermine health outcomes, particularly in rural areas. Overcoming these inequities demands innovative care models, robust workforce development, and meaningful policy reforms that prioritize efficiency and patients' diverse needs.

How do you keep life balanced?

Maintaining balance means prioritizing what matters—spending quality time with family and friends, engaging in outdoor activities, and staying connected. Traveling offers a chance to disconnect. Whether hiking, exploring a new city, or visiting a national park, these adventures help me recharge and gain perspective. Closer to home, I enjoy hobbies that keep me connected to my Minnesota roots, like ice fishing at Lake of the Woods or catching a Wild, Gophers hockey, or Vikings game.

If you weren't a physician—?

If I weren't a physician, I would likely pursue a career at the intersection of entrepreneurship, technology, and healthcare. MM

Annual Report

2024

EMPOWERING PHYSICIANS

Minnesota Medical Association

TRACKING PROGRESS IN 2024

On behalf of the MMA, I invite you to take a few minutes to review this combined 2024 MMA and MMA Foundation Annual Report. It is not easy to summarize a year's worth of work in a few pages, but it is a gratifying exercise to reflect on and document our many meaningful accomplishments.

Each year MMA leadership and staff craft a to-do list that advances our mission to make Minnesota the healthiest state and the best place to practice. As with any good list, I find great satisfaction in placing a checkmark by completed items. For me, the following checkmarks were particularly notable this year:

- ✓ Led advocacy efforts to pass nation-leading prior authorization reform legislation;
- ✓ Developed new physician leaders with completion of the inaugural cohort of the Minnesota Physician Leadership Institute;
- ✓ Delivered valuable services to reduce physician burnout and career fatigue;
- ✓ Defended medicine in the courts;
- ✓ Created critical tools to expose more Minnesota youth to careers in medicine;
- ✓ Championed health equity through the launch of a new LGBTQ+ Section;
- ✓ Delivered timely and relevant accredited education, including new training in serious illness communication;
- ✓ Invested, via the MMA Foundation, in community health projects and future physicians;
- ✓ Improved the MMA financial position;
- ✓ Increased MMA membership.

The MMA's progress would not be possible without you – our members and volunteers. You can read more about our collective progress in the following pages. Just imagine what we can do in 2025!

On behalf of MMA leadership and our incredible staff, thank you.

Janet L. Silversmith, CEO

MMA LEADERSHIP

(JANUARY THROUGH SEPTEMBER 2024)

2024 Officers

PRESIDENT
Laurel Ries, MD, St. Paul

PRESIDENT-ELECT
Edwin Bogonko, MD, MBA, Shakopee

IMMEDIATE PAST PRESIDENT
Will Nicholson, MD, Maplewood

SECRETARY/TREASURER
Amrit Singh, MBBS, Mankato

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Kimberly Tjaden, MD, MPH, St. Cloud

CHIEF EXECUTIVE OFFICER
Janet Silversmith

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Melissa Edgar, Minneapolis, Medical Student
Elizabeth Elfstrand, MD, Minneapolis
Dionne Hart, MD, Rochester
Dania Kamp, MD, Moose Lake
Gaurav Mehta, MBBS, Detroit Lakes
Lora Princ, MD, MBA, Minneapolis, Policy Council Appointee
Caleb Schultz, MD, Minneapolis
David L. Smith, MD, Sartell
Rebecca Thomas, MD, Plymouth

AMA Delegation

CHAIR: Cindy Firkins Smith, MD, MHCI, Willmar
John Abenstein, MD, MSEE, Rochester
Andrea Hillerud, MD, St. Paul
Dennis O'Hare, MD, St. Paul
David Thorson, MD, White Bear Lake

AMA ALTERNATE DELEGATES
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George Morris, MD, St. Cloud
Ashok Patel, MD, Rochester
Laurel Ries, MD, St. Paul

MMA Committees

FINANCE AND AUDIT
CHAIR: Amrit Singh, MBBS, Mankato

ETHICS AND MEDICAL-LEGAL AFFAIRS
CHAIR: Lindsey Yock, MD, JD, Minneapolis

EQUITY IN ACCESS & QUALITY
CHAIR: Kevin Donnelly, MD, St. Cloud

PUBLIC HEALTH
CHAIR: Maria Starchook-Moore, MD, MPH, Edina

PHYSICIAN WELL-BEING ADVISORY COMMITTEE
CO-CHAIR: Natalia Dorf Biderman, MD, SFHM, St. Louis Park
CO-CHAIR: Colin West, MD, PhD, Rochester

COMMITTEE ON ACCREDITATION AND CONTINUING MEDICAL EDUCATION
CHAIR: Robert Moravec, MD, Oakdale

MMA Policy Council

CHAIR: Benjamin Meyer, MD, Minneapolis

MMA Medical Student Section

CO-CHAIR: Saliha Chaudhry, University of Minnesota Medical School - Twin Cities Campus
CO-CHAIR: Spencer Breen, University of Minnesota Medical School - Duluth Campus

MMA Resident and Fellow Section

CHAIR: Michael Rigby, MD, PhD, Rochester
VICE CHAIR: Olga Lopez, MD, Rochester

LGBTQ+Section

CO-CHAIR: Victor G. Chedid, MD, MS
CO-CHAIR: Fí D. Fonseca, MB, BCh, BAO, MS

MMA Foundation

BOARD PRESIDENT: George Schoephoerster, MD, St. Cloud
CEO: Kristen Gloege

BOARD MEMBERS
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Janet Silversmith, MMA CEO, Secretary
Verna Thornton, MD

MEDPAC (MMA'S POLITICAL ACTION COMMITTEE)

CHAIR: Will Nicholson, MD, Maplewood


Laurel Ries, MD


Edwin Bogonko, MD, MBA


Will Nicholson, MD


Amrit Singh, MBBS


Kim Tjaden, MD, MPH

MAKING MINNESOTA THE HEALTHIEST STATE

Physicians are dedicated to improving the health of Minnesotans, one patient at a time. The MMA, too, is dedicated to improving the health of all Minnesotans as part of our mission to make Minnesota the healthiest state.

Here's where the MMA focused its efforts in 2024.

Maintaining a commitment to health equity

Through education, workshops, and other resources, the MMA continued to bring focus to the important work of reducing health inequities. For example, the MMA continued to offer the workshop *Understanding and Mitigating Implicit Bias in Healthcare*. In the two-hour interactive workshop, participants worked to examine implicit bias in healthcare settings, understand how it contributes to health disparities, and learn practical strategies for mitigating the effects. To date, the MMA has offered the workshop to the public five times and delivered private workshops to 10 different health systems reaching more than 500 learners.

In November, the MMA presented the workshop *Centering Diverse Voices: Stories of Racism and Resilience from Minnesota Physicians* at the inaugural Hennepin Health Equity Summit. This interactive workshop featured compelling video stories from physicians of color about their experiences studying and practicing medicine in Minnesota. Through hearing these stories, participants engaged in critical dialogue around racism and how to work toward an anti-racist culture of medicine.

Additional health equity programming in 2024 included:

- Online forums on gender-affirming care and race-based trauma and trauma-informed care
- Quarterly Community of Practice meetings addressing topics such as workforce diversification and statewide health equity initiatives
- Publication and release of an *Inclusive Communication Guide* for language that promotes equity
- Development and launch of new workshop: *Best Practices for Communicating about Equity*
- Development and launch of new workshop: *Reckoning with Racism in Medicine*
- Launch of the new LGBTQ+ Section

Advancing serious illness communication training

The Center for Advancing Serious Illness Communication (CASIC) is a joint program of the MMA and Minnesota Hospital Association, sponsored by Blue Cross and Blue Shield of Minnesota. Its primary goal is to establish serious illness communication as part of the standard of care for patients with serious illness as they approach end-of-life decisions. Based on Ariadne Lab's well-established, evidence-based serious illness conversation (SIC) guide and protocol, the training provides healthcare organizations and providers with the necessary tools, training, and support. CASIC's training launched in early 2024, comprising a three-module online, on-demand introduction to SIC, followed by a three-hour live, virtual classroom session focusing on becoming more familiar with the SIC guide and developing the skills clinicians need to have effective conversations with patients, their families, and caregivers. Faculty members have extensive professional experience working with seriously ill patient populations and are Ariadne Labs-trained.

Improving firearm safety

The MMA continued to lead the Minnesota Firearm Safety and Suicide Prevention Coalition, focused on raising awareness of suicide and the role that firearms play in them. Current efforts underway include a firearm safety physician interview study, which is analyzing the role of physicians in talking with patients about safe firearm storage during clinic visits. The coalition is also advancing a firearm safety storage map project, which is designed to develop regional maps of temporary firearm storage options near a few primary care clinics, maps that can be incorporated by physicians into their firearm safety counseling with patients.

On the advocacy front, the MMA supported legislative proposals that would: require that firearms be secured in a safe or lockbox and stored separately from ammunition; mandate that lost or stolen firearms be reported to law enforcement; and prohibit the "ghost purchase" of a firearm, where one person purchases a firearm and then transfers it to a person who is prohibited from owning it. The prohibition on ghost purchasing passed, but bills on safe storage requirements and mandatory reporting of lost or stolen firearms did not.

Suicide prevention training

In 2024, the MMA Foundation delivered free suicide prevention training to 135 healthcare professionals across the state. These sessions equipped participants with essential tools such as Question-Persuade-Refer (QPR) and Counseling on Access to Lethal Means (CALM) — building a life-saving network of support.

Reducing morbidity and mortality of substance use disorders

The MMA continued its work in 2024 to advocate for care for Minnesotans with substance use disorders. MMA members filled two seats on the Task Force on Holistic and Effective Responses to Illicit Drug Use established by the Legislature, and also provided leadership on the Minnesota Office of Addiction and Recovery's (OAR) Medication for Opioid Use Disorder (MOUD) in Jails Work Group, which was co-created by OAR, the MMA, and the Minnesota Sheriff's Association. The work group is tasked with identifying barriers and solutions to providing medications to Minnesotans who are incarcerated and have opioid use disorder.

Providing essential care for the unhoused

The MMA Foundation advanced the MMA's mission of addressing health inequities and fostering physician engagement through a $5,000 grant to Churches United in Ministry (CHUM) in Duluth. The grant supported the creation and distribution of 1,400 wound care kits.

Investing in the future of medicine

The MMA Foundation has a long-standing commitment to investing in the future of medicine, and in 2024 the Foundation awarded nearly $20,000 in project-based scholarships to medical students and residents. By awarding scholarships, the Foundation empowers promising medical students and residents to pursue innovative projects and research that address health disparities and improve community health outcomes. Here are just two examples of Foundation dollars at work:

1. **Expanding Rural Medicine Opportunities –** An MMA Foundation scholarship grant provided support for the Mayo Clinic Alix School of Medicine's Rural Medicine Curricular and Outreach Development Program. This scholarship gives medical students practical experience in rural settings, addressing the unique healthcare challenges these communities face.

2. **Increasing Access and Inclusivity in Healthcare –** Another scholarship allows medical students at the University of Minnesota Medical School to work alongside American Sign Language interpreters and Certified Deaf Interpreters in a simulated clinical environment. This program prepares future physicians to provide inclusive, patient-centered care to diverse populations, ensuring that no patient is left behind.

MAKING MINNESOTA THE BEST PLACE TO PRACTICE MEDICINE

The MMA advanced its mission to make Minnesota the best place to practice medicine by advocating at the Capitol and throughout the state in 2024.

Here are some of the highlights of the MMA's work.

Prior authorization successes at the Capitol

Following significant work and support from multiple partners, in 2024 the MMA succeeded in advancing one of the most comprehensive state prior authorization (PA) reform laws in the nation. Included in the new law, which will take effect January 1, 2026, are the following: PA laws will now apply to all state-regulated payers, including Medical Assistance and MinnesotaCare, which were previously exempted; a PA received for a chronic condition does not expire unless the standard of treatment changes; PA is prohibited for nonmedication treatments for cancer, outpatient mental health, and substance use disorders, and PAs for the m00edications for these treatments must be decided within 48 hours; PA is prohibited for preventive services, pediatric hospice care, and for pediatric neonatal abstinence programs; PA companies are required to annually report to the Minnesota Department of Health data on how often they use PA, how often they approve PA, and how often they deny PA; and PA companies are required to utilize an automated process that is consistent with the new federal requirements that identifies whether a PA is required and what documentation is needed.

Limiting Medicare payment cuts and preserving telehealth

After months of pressure directed at Congress by the MMA and AMA, Congress halved the 2024 Medicare physician fee schedule proposed cut of 3.37% to a final cut of 1.68%. The MMA will continue to fight for reform of the Medicare physician payment methodology that triggers cuts, including adoption of inflation-based payment adjustments.

The MMA and AMA were successful in securing an extension through March 2025 of Medicare coverage for telehealth services, which was first adopted during the COVID-19 pandemic. The MMA will continue to advocate for this coverage indefinitely.

Increasing physician leadership

In June, the first cohort of the MMA's Minnesota Physician Leadership Institute (MNPLI) completed its 10 months of coursework, giving the program excellent reviews. In September, the MMA launched the second cohort of MNPLI, consisting of 21 students. The MNPLI offers innovative, best-in-class leadership training to provide Minnesota physicians with the skills, insights, and competencies required to build leadership acumen. Two new courses were added for the second year—physician leadership in quality and safety, and physician well-being. The University of Minnesota Carlson School of Management is the MMA's faculty partner for the program.

Increasing and diversifying the physician workforce

The MMA launched a new website (www.healthcarecareersMN.org) in October to support the healthcare career aspirations of students from across the state. The website grew out of a recommendation from the MMA's Barriers to Workforce Diversification in Physician Education, Training and Licensure Task Force. The website includes information about pathway programs and other resources that provide mentorship, training, exposure, and inspiration to students interested in healthcare careers in Minnesota. The website is geared toward elementary, middle school, and high school students in the state, as well as their families/guardians, school guidance counselors, and STEM teachers. The website was developed and launched with partial funding from UCare.

Defending the practice of medicine

The MMA, along with AMA and American Society for Aesthetic Plastic Surgery participated in a lawsuit as an amicus, or "friend of the court," in a case involving MMIC, a Minnesota-based medical liability insurer that denied coverage for the defense costs of a discrimination lawsuit against a Minnesota physician. MMIC argued that the physician's policy did not cover claims alleging violations of state law, such as discrimination, and only covered claims arising out of medical incidents. The MMA participated in this case, arguing that MMIC should be required to cover the physician's claim because the underlying discrimination lawsuit was based on the physician referring the patient to a specialist for a procedure that was outside the scope of his training and expertise, a medical incident. By not covering the claim, the MMA argued that MMIC was encouraging physicians to conduct procedures and treatments that are not within their scope of expertise. The MMA further argued that a physician should not be penalized for making the medical determination that a referral is needed.

Helping future physicians find their path

In November, the MMA again partnered with Gillette Children's in its "Medical Discovery Day for BIPOC Youth," which brought together students, parents, educators, clinicians, and community leaders to inspire youth to consider careers in healthcare. The MMA hosted "Growing Your White Coat" sessions, which helped the parents/guardians in attendance gain a better understanding of how they can support their kids/teens in exploring a career in healthcare.

Supporting physician well-being

In partnership with the MMA Foundation, the MMA continued to support physician well-being by offering a suite of services through SafeHaven (www.mnmed.org/safehaven), a confidential and comprehensive resource for MMA members and their families. This initiative is funded by a grant to the MMA Foundation from The Physicians Foundation. The SafeHaven program offers tailored services, including peer coaching on topics such as work-life balance and leadership, counseling sessions with licensed behavioral health professionals, and a WorkLife Concierge to manage daily tasks. The SafeHaven services gained greater value following the MMA's legislative efforts. New legislation allows the MMA to operate confidential support programs, such as SafeHaven, for clinicians facing burnout, fatigue, or general wellness challenges. Enacted on August 1, 2024, the law includes critical confidentiality protections, ensuring participation in SafeHaven is shielded from discovery or subpoena during investigations or lawsuits, and is not disclosed to licensing boards unless mandated by state law.

Empowering physicians: A blueprint for well-being

The MMA's Physician Well-being Advisory Committee took decisive action to identify innovative, actionable strategies to combat burnout, promote resilience, and create workplace cultures where physicians can thrive. Adopted by the MMA Board of Trustees in May, the committee's report emphasizes three key focus areas: protecting physician health, reducing work burdens, and cultivating thriving organizational cultures.

Changing the Face of Medicine initiative

Through the Changing the Face of Medicine initiative, the MMA Foundation is helping to build a physician workforce that truly reflects the diverse communities of Minnesota. To date, the initiative has secured more than $51,000 in funding to develop programs like the MCAT® fee relief fund that elevates underrepresented voices in medicine. By amplifying the voices of future physicians, this initiative is laying the foundation for sustainable improvements in health equity, patient care, and community trust.

MMA'S 2024 AWARD WINNERS

Four physicians, two physicians-in-training, a state representative, and the Minnesota Rare Disease Advisory Council, were all honored with 2024 MMA awards. Each year, the MMA honors those in medicine for going above and beyond.

Distinguished Service Award

David L. Estrin, MD, of Golden Valley, received the MMA's highest honor, the Distinguished Service Award, for his years of dedicated service to the association and to medicine. Estrin served the MMA as committee member, trustee, and AMA delegate over the many years of his career.

President's Award

Natalia Dorf Biderman, MD, SFHM, and **Colin West, MD, PhD,** received the MMA's President's Award, which recognizes those who have given much of their free time to help improve the association. Dorf Biderman and West were recognized for their work leading the MMA's Physician Well-being Advisory Committee. The group delivered a report and recommendations to the MMA Board of Trustees for further action needed to improve well-being and professional satisfaction.

Medical Student Leadership Award

Rashika Shetty received the Medical Student Leadership Award, which recognizes physicians-in-training who demonstrate exemplary leadership in service to medical students, the profession of medicine, and the broader community. Shetty is a second-year medical student at the University of Minnesota Medical School. She was recognized for her commitment to serving underserved communities.

Resident and Fellow Leadership Award

Jack McHugh, MB BCh, BAO, received the Resident and Fellow Leadership award which recognizes physicians-in-training who demonstrate exemplary leadership in service to residents and fellows, the profession of medicine, and the broader community. McHugh, who is based in Rochester, was recognized for his work on the Zumbro Valley Medical Society's Street Medicine program.

Copic/MMA Foundation Humanitarian Award

Tori Bahr, MD, received the Copic/MMA Foundation Humanitarian Award, which recognizes MMA members who go above and beyond to address the healthcare needs of underserved populations in Minnesota. Bahr's award noted her dedication to advancing pediatric-to-adult healthcare transition for children and youth with special health needs.

David L. Estrin, MD

Natalia Dorf Biderman, MD, SFHM

Colin West, MD, PhD

Rashika Shetty

James H. Sova Memorial Award for Advocacy

State Rep. **Tina Liebling**, of Rochester, received the James H. Sova Memorial Award for Advocacy. Sova served as the MMA's chief lobbyist from 1968 until his death in 1981. This award is given to a person who has made a significant contribution to the advancement of public policy, medical sciences, medical education, medical care or the socioeconomics of medical practice. Liebling was selected for her long-term healthcare advocacy work at the Capitol.

Eric C. Dick Memorial Health Policy Partner Award

This award is given to an individual, group of individuals, a project or an organization that demonstrates a commitment to pursuing sound public policy, building coalitions, creating and/or strengthening partnerships with the goal of improving the health of Minnesotans or the practice of medicine in Minnesota. Dick served as the MMA's manager of state legislative affairs from 2010 until his untimely passing in 2021. This year's recipient was the Minnesota Rare Disease Advisory Council, which was selected for its efforts in helping the MMA pass important prior authorization legislation during the 2024 legislative session.

2024 Advocacy Champions

Each month, the MMA honors a member who has championed advocacy, whether by testifying at the Capitol, speaking out at a city hall meeting, or standing up to drive meaningful change.

January Zachary Shaheen, MD, PhD
February Mary Gilbert Lawrence, MD, MPH
March Laurel Ries, MD
April Michelle Chestovich, MD
May Dominik Dabrowski, MD, MPH
June Mark F. Liebow, MD, MPH
July Colin P. West, MD, PhD
August Melissa Edgar
September Michael J. Rigby, MD, PhD
October Dania Kamp, MD
November Patrick Crowley, DO
December Kevin Donnelly, MD

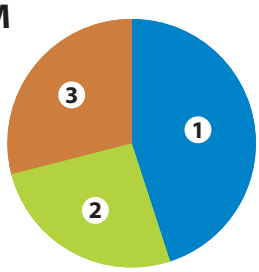

Jack McHugh, MB BCh, BAO


Tori Bahr, MD


Rep. Tina Liebling

2024 MMA Financial Highlights

Total MMA revenue: $3.7M



1 **DUES** 45%

2 **NON-DUES REVENUE** 26%
Advertising, sponsorships, event registration, grants, lobbying services, educational programming and accreditation services

3 **SPENDING POLICY** 29%
Portion of investment returns used to support operations

How your dues are used

1 **MEMBER ENGAGEMENT** 13%

2 **ADVOCACY** 24%

3 **COMMUNICATIONS AND EDUCATION** 20%

4 **GOVERNANCE** 18%

5 **INFRASTRUCTURE AND OVERHEAD** 25%

2024 membership information

Total: 10,356

Minnesota Medical Association

3433 Broadway Street NE, Suite 187; Mpls, MN 55413
PHONE: 612-378-1875 or 800-342-5662
FAX: 612-378-3875
EMAIL: mma@mnmed.org
WEB: mnmed.org
JOIN US ON FACEBOOK, X, INSTAGRAM AND LINKEDIN

2024 MMA Foundation Financials

Total Net Assets: $2.168M

MEDICAL STUDENT & RESIDENT SCHOLARSHIP FUNDS
- Friedman-Bowen $405k
- Reuter-Lien $68k
- Indihar $10k

COMMUNITY GRANT & INITIATIVE FUNDS
- Community Health & Physician Engagement $37k
- Stearns Benton Community Health & Physician Engagement $68k
- Changing the Face of Medicine $55k
- Physician Volunteerism $55k

UNRESTRICTED $1.475M

Total Revenue: $324K

CONTRIBUTIONS

MEDICAL STUDENT & RESIDENT SCHOLARSHIP FUNDS
- Friedman-Bowen $122k
- Reuter-Lien $2k
- Indihar $2k

COMMUNITY GRANT & INITIATIVE FUNDS
- Community Health & Physician Engagement $20k
- Changing the Face of Medicine $4k

Unrestricted $16k

GRANTS
- The Physicians Foundation $24k

Investment income $135k

Total Expenditures: Grants, Scholarships & Operations: $99K

MEDICAL STUDENT & RESIDENT SCHOLARSHIP FUNDS
- Friedman-Bowen $5k
- Indihar $1k

COMMUNITY GRANT & INITIATIVE FUNDS
- Community Health & Physician Engagement $5k

PROGRAM EXPENDITURES FROM GRANTS $24k

ADMINISTRATIVE COSTS $63k

Net Income: $225K

MMA Foundation Impact

Number of medical students and residents on scholarship-funded projects: 8

Community Health & Physician Engagement grant dollars awarded: $5,000

Copic & MMA Foundation Humanitarian Award: $10,000

Number of physicians and other healthcare workers trained in suicide prevention: 135

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This activity has been approved for AMA PRA Category 1 Credit™

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