THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

MINNESOTA MEDICINE

JAN/FEB 2024 • $9.99

Healthcare in a strange land

Minnesota's immigrant communities are a kaleidoscope of nationalities, but the core principles of providing good care remain constant. PAGE 8

ALSO

Nasreen Quadri, MD

Internal medicine–pediatrics hospitalist

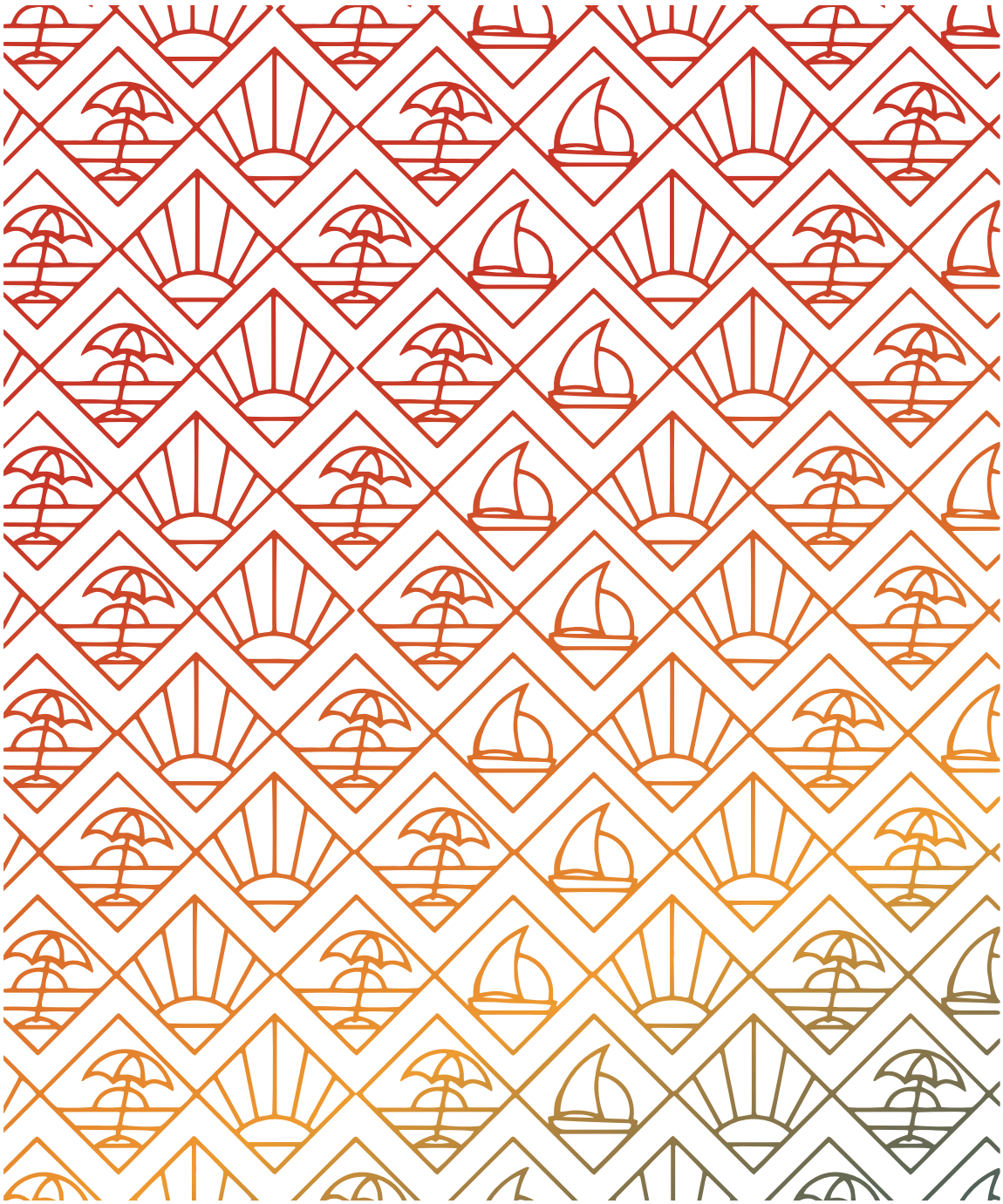
Abbott Northwestern and Children's Minnesota hospitals

Minnesota Medical Association

Build on 150+ years of **life-changing care.**

Discover a life-changing Internal Medicine career at Mayo Clinic – the #1 US hospital and #3 employer in Minnesota. Our patient-centric approach, led by physicians, has defined us for over 150 years – and now it can define you too. After all, as part of the Mayo team, you won't just be building a stable career in a supportive environment. You'll also be building on our legacy for award-winning patient care.

Learn more about the impact you can make at Mayo Clinic:
jobs.mayoclinic.org/internalmedicine



DISCOVER NEW ADVANCEMENTS IN CARDIOVASCULAR CARE

March 1-2, 2024

Register Now

NHICardioSummit.com

Arthrex One Conference Center
1250 Creekside Pkwy Naples, FL

NCH ROONEY HEART INSTITUTE

Allina Health
MINNEAPOLIS HEART INSTITUTE

CONTENTS

Jan/Feb 2024 | VOLUME 107 | ISSUE 1

IN THIS ISSUE

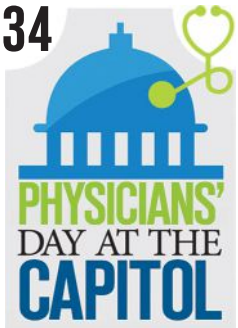
Minnesota immigrant communities are an ever-changing kaleidoscope of nationalities and ethnicities, but the core principles of providing good care remain constant.

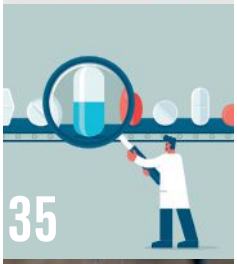
ON THE COVER

FEATURES

DEPARTMENTS

Minnesota Medicine is intended to serve as a credible forum for presenting information and ideas affecting Minnesota physicians and their practices. The content of articles and the opinions expressed in *Minnesota Medicine* do not represent the official policy of the Minnesota Medical Association unless this is specified. The publication of an advertisement does not imply MMA endorsement or sponsorship.





MINNESOTA MEDICINE

CONTACT US
Minnesota Medicine
3433 Broadway Street NE, Suite 187
Minneapolis, Minnesota 55413-2199
PHONE: 612-378-1875 or 800-DIAL-MMA
EMAIL: mm@mnmed.org
WEB AND DIGITAL EDITION: mnmed.org

OWNER AND PUBLISHER
Minnesota Medical Association

EDITOR
Greg Breining

DIRECTOR OF COMMUNICATIONS
Dan Hauser

ART DIRECTOR
Kathryn Forss

CIRCULATION/WEB CONTENT
Mary Canada

MEDICAL EDITORS
Rahel Nardos, MD
Christopher Wenner, MD
Colin West, MD, PhD

ADVISORY COMMITTEE
Veda Bellamkonda, MD
Grant Botker, MD
Devon Callahan, MD
Derrick Lewis
Charles Meyer, MD

SUBSCRIPTIONS
Annual subscription: $45 (U.S.) and $80 (all international)

MISSING ISSUES AND BACK ISSUES
Missing issues will be replaced for paid subscribers at no additional charge if notification is received within six months of the publication date. Replacement of any issues more than six months old will be charged the appropriate single back issue price. Single back issues of *Minnesota Medicine* can be purchased for $25 (U.S.) and $30 (Canada, Mexico, and other international). Send a copy of your mailing label and orders to Mary Canada, 3433 Broadway Street NE, Suite 187; Minneapolis, Minnesota 55413-2199 or fax it to 612-378-3875.

To submit an article
Contact the editor at mm@mnmed.org.
The editors reserve the right to reject editorial, scientific or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors or any of its constituents.


Rahel Nardos, MD

Cultural humility verses cultural competence

This issue of *Minnesota Medicine* focuses on the healthcare barriers experienced by our state's large immigrant community. As an immigrant physician, a patient with a serious chronic condition, and someone who routinely navigates our health system on behalf of my own family, I see firsthand what a privilege it is to have access to quality healthcare and at the same time the tremendous inequities in our system that put some who are vulnerable at high risk for poor health outcomes because of their identity, their sociocultural background, or level of health literacy.

My own mother recently had a stroke while visiting from Ethiopia. My husband, a neuroscientist, was home and recognized her symptoms right way and got her into the hospital within a half hour. Although she had lost her ability to speak and half of her motor functions, because of the efficiency with which she got care, she made a fast recovery, even to the surprise of her stellar healthcare team. Because of my family's familiarity with the healthcare environment, we were able to advocate for her, and she was cared for by people we knew personally.

My mom and I were supposed to travel to Ethiopia where I was scheduled to give surgical education for doctors. My mom's outcome would have been much different in Ethiopia, and not for the better. We are fortunate to have access to such care in the U.S. But this is not true for a lot of other people.

Just last year, I operated on a Somali patient who endured a bladder injury during her cesarean section at a refugee camp in Sudan. Her injury caused her to leak urine through a hole in her bladder. She was misdiagnosed for many years after immigrating to the U.S. before she found a physician who listened to her story and made the right referral. A simple surgery restored her bladder function. During the years she was not listened to by healthcare professionals, she was robbed of her dignity and her ability to be a contributing member of society. Sadly, she is not an exception. I have seen many others with similar stories.

The challenge of healthcare inequity reminds me of the simple message shared by Phakchok Rinpoche, a spiritual Buddhist leader and author of *Awakening Dignity*. He acknowledges that giving compassionate care for our patients in an environment where healthcare systems seem to be failing and where our own well-being is compromised is incredibly challenging. But he emphasized that to relieve the suffering of others (our sacred calling in medicine) or to transform our system, we need first to transform ourselves. At the core of this transformation is a commitment to daily self-reflection and setting of intentions, based on the practice of humility.

In their paper *Cultural Humility verses Cultural Competence*, Melanie Tervalon, MD, and Jann Murray-García, MD, talk about the critical need for cultural humility, not competence, when serving others who are different from us. They define cultural humility as incorporating "a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and nonpaternalistic partnerships with communities on behalf of individuals and defined populations."

Cultural humility incorporates "a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and nonpaternalistic partnerships with communities on behalf of individuals and defined populations."

I hope we all take these wise words from those who have built a tradition of self-reflection and humility so we are best positioned to reduce our own suffering, relieve the suffering of others, and create a more equitable healthcare system. **MM**

Rahel Nardos, MD, MCR, is associate professor, Department of Obstetrics, Gynecology, and Women's Health, and director, Global Women's Health, at the University of Minnesota. She is one of three medical editors for *Minnesota Medicine*.


Rx
Patient name
Minnesota physicians
Address
Anywhere in
Minnesota
Prescription:
Renew your MMA
membership today at
mnmed.org/renew
Minnesota
Medical
Association
Signature
Laurel Ries, MD
MMA President

Expanding the scope of wastewater surveillance

Minnesota is streamlining its process for monitoring effluent for the SARS-CoV-2 virus. More important, it's trying to look for additional pathogens.

BY GREG BREINING

Minnesota is making changes to the wastewater surveillance system it set up to detect the SARS-CoV-2 virus in communities across the state.

This fall the Metropolitan Council dropped out of the laboratory testing program, which will be handled now by the University of Minnesota Medical School and the Minnesota Department of Health (MDH) Public Health Laboratory.

"The transition is all about long-term sustainability and looking at how do we keep this program going successfully into the future," says Sara Vetter, assistant division director of the MDH Public Health Laboratory. The Met Council found itself involved in a very successful program that wasn't part of its mission, she says, "so we kind of as a group made the decision to phase out Met Council and just have the U of M take over for the COVID testing."

But the more significant change, with greater ramifications for healthcare, is that the medical school and MDH will be exploring protocols for detecting not only the SARS-CoV-2 virus, but also viruses for flu and RSV, genes associated with antibiotic resistance, and potentially other pathogens circulating in Minnesota communities.

Minnesota's wastewater surveillance program began in May 2020, during the early days of the COVID-19 pandemic, the brainchild of two faculty at the University medical school in Duluth. "This was a brand new idea, at least for this particular disease," says Tim Schacker, executive vice dean of the University of Minnesota Medical School and director of the program in HIV medicine. "They were initially collecting from five sites and showed that the technique worked, that they could reliably identify SARS-CoV-2 RNA. And so we rapidly expanded the network to include 44 sites from around the state, sampling twice a week. And we still do that today."

The Met Council was involved because it ran the metro-area sewage treatment plants that provided much of the effluent for testing. The surveillance program was funded by a grant from 3M, as well funds from the medical school, MDH, and the national Centers for Disease Control and Prevention, Schacker says.

The levels of virus detected in wastewater quickly proved their worth in warning of an increase in infections. "We showed that it has pretty good predictive power to inform us when a surge is coming," Schacker says. "As we saw the levels consistently rise in wastewater, we knew that in 10 days hospitalizations would go up."

The correlation between virus levels in wastewater and hospitalizations in the population has changed as most people have contracted COVID or have been vaccinated. But the system still works to warn health officials of an upsurge in infections, such as the small outbreak that peaked in September. Says Schacker, "We saw it coming in mid- to late August."

This fall the Metropolitan Council dropped out of the laboratory testing program, which will be handled now by the University of Minnesota Medical School and the Minnesota Department of Health Public Health Laboratory. "The transition is all about long-term sustainability and looking at how do we keep this program going successfully into the future."

SARA VETTER, ASSISTANT DIVISION DIRECTOR OF THE MDH PUBLIC HEALTH LABORATORY

The levels of virus detected in wastewater quickly proved their worth in warning of an increase in infections. "We showed that it has pretty good predictive power to inform us when a surge is coming," Schacker says. "As we saw the levels consistently rise in wastewater, we knew that in 10 days hospitalizations would go up."

TIM SCHACKER, EXECUTIVE VICE DEAN OF THE UNIVERSITY OF MINNESOTA MEDICAL SCHOOL AND DIRECTOR OF THE PROGRAM IN HIV MEDICINE

The value of wastewater surveillance, compared with data such as hospitalizations or positive tests, is that it samples nearly everyone. It does not depend on access to healthcare, the availability of COVID testing, or a decision to test someone who appears ill.

"Looking at wastewater is an unbiased sample, you're looking at everybody," says Schacker. "It's not perfect, but it's population-based. If I were to go to clinics and say, how many people are being tested, and how many people are positive? Well, the people are there for symptoms." And many people are asymptomatic but can still spread the disease to others. So reporting symptoms doesn't necessarily give an accurate picture of the level of COVID in the community.

Moreover, symptoms and hospitalizations take time to develop. Surging levels of a virus in wastewater is one of the earliest predictors available to health officials.

Still, wastewater analysis must be compared with clinical evidence in the community. "The data has to be interpreted in combination with the regular surveillance data that you're talking about," says Schacker. "It's never going to be the one method that's used. It's putting all of the data together to draw a picture."

Early surveillance

Researchers began culturing urban wastewater for disease pathogens such as the *Salmonella* species that cause paratyphus in the early 1900s. By 1939, scientists had detected the polio virus in wastewater during polio outbreaks in Charleston, South Carolina; Buffalo, New York; and Detroit. Coxsackievirus was also found to be traceable in sewage. By the 1960s wastewater surveillance programs had been set up to warn of the presence of polio virus in urban populations.

"It's not going to work for every pathogen, because you've got to secrete it in your waste, and not every virus or bacteria will do that," says Schacker. "Polio, of course, will because it replicates in the gut. And SARS-CoV-2 does because it replicates in the gut or has been known to replicate in the gut. We think that we're having some success at monitoring flu and RSV. But there are some pathogens that you just probably won't pick up."

In early days, wastewater was filtered and cultured to detect the presence of target pathogens. Nowadays, in the search for SARS-CoV-2, effluent is physically filtered and the virus is amplified and identified through a polymerase chain reaction test. Says Vetter, "We've put little primers in there, little markers that are specific to the virus, and it's able to detect it and amplify it to a level where we can see that it's there."

The results are available on a University of Minnesota dashboard: z.umn.edu/ww_dashboard.

Looking farther down the road

The MDH and university medical school are collaborating to expand wastewater surveillance to include not just the coronavirus that causes COVID, but also the viruses that cause RSV, influenza A, and influenza B, says Vetter. They are also hoping to identify genes associated with antibiotic resistance.

But Schacker says the medical school has even more ambitious plans.

Current PCR testing for public health surveillance requires that the laboratory focus on specific pathogens in effluent. Says Schacker, "If you're using PCR, you've got to know what your target is, you've got to have a probe for that. And if something is there that you don't know about, you'll miss it."

The medical school has begun a project to genetically sequence everything in wastewater and is working with the National Institutes of Health "to put all the sequences together and put that data into a very large database that has sequences of all known pathogens," says Schacker. "And then you get a readout that says, you have so many reads of COVID, you have so many reads of HIV, you have so many reads of tuberculosis, etc. And so the advantage of that is you can find stuff you weren't expecting, or you didn't know you were looking for."

But as with the more straightforward PCR testing, it's important to correlate analysis of wastewater to other measures of public health, says Schacker. "It becomes critically important in evaluating this technique, or any of these techniques, to be able to relate it back to clinically what's going on in the community." MM

Greg Breining is editor of *Minnesota Medicine*.

Nasreen Quadri, MD

Internal medicine–pediatrics hospitalist

Abbott Northwestern and Children's Minnesota hospitals

Healthcare in a strange land

The countries where Minnesota's newest residents come from change, but the core principles of providing good care remain constant

BY SUZY FRISCH

Born in the United States to parents who were Indian immigrants, Nasreen Quadri, MD, and her family share many experiences with her patients from around the world. Difficulty communicating with clinicians due to language barriers. Navigating a new system for obtaining healthcare. Needing to integrate physicians' recommendations with their own religious and cultural traditions.

Quadri, an internal medicine–pediatrics hospitalist, finds that she relates to many of her patients at Abbott Northwestern and Children's Minnesota hospitals because she lived through similar challenges that stem from being a new or first-generation American. This lived experience informs her work as a clinician, global health researcher, and advocate for ways to improve access and quality care for newcomers to Minnesota.

A physician collaborator at the National Resource Center for Refugees, Immigrants, and Migrants (NRC-RIM), Quadri works to build health department and community-based partnerships that uncover the most effective models for delivering care to newer residents. Launched as part of the COVID-19 response, NRC-RIM is funded by the Centers for Disease Control and Prevention and housed at the University of Minnesota. It now focuses on newcomer communities that disproportionately confront barriers to obtaining healthcare, including transportation, cost, and language barriers.

NRC-RIM is doing research to find ways to actively address such obstacles. "Many clinical researchers keep describing the disparities," Quadri says. "Now we are getting to the point where we are asking better research questions into the why and putting money into doing something about it rather than just describing it."

"Because of my lived experience, I personally think about this a lot broader than just newcomers immediately in need of consideration," Quadri adds. "There are people who are new to the United States and people who are living in multigenerational families, so how are we thinking about all of these groups of people and their well-being?"

Finding ways to ensure that refugees, immigrants, and migrants obtain the medical and mental care they need to thrive has been a long-term focus in Minnesota. Though the populations of people arriving continually shifts based on current events, global conflicts, and natural disasters, the overall healthcare needs remain relatively consistent, says Patricia Walker, MD, an internal medicine physician and medical director of the HealthPartners Center for International Health.

Rich history of resettlement

It's no surprise that Minnesota is considered a pioneer in developing best practices for taking care of our country's newest residents. The state has been a hotbed of refugee resettlement and immigration since the 1970s, when thousands of people affected by the Vietnam War started arriving, notably Hmong people, plus others from Cambodia, Laos, and Vietnam. Today, Minnesota has the largest populations in the United States of people who are Hmong, Somali, and Karen (from Myanmar), plus significant numbers of more recent arrivals from Ethiopia, Eritrea, the Democratic Republic of Congo, Afghanistan, Ukraine, and many Latin American countries.

The state government, health systems, and institutions in Minnesota have grown accustomed to shifting care based on the mix of people who are arriving, says Blain Mamo, refugee health coordinator at the Minnesota Department of Health. From 2017 to early 2021, refugee arrivals ground to a halt during the Trump administration. When nearly 1,400 refugees from Afghanistan started coming to Minnesota in fall 2021, there was a scramble because the state had little community or healthcare infrastructure focused on Afghan people.

"We didn't have enough interpreters to work with the Afghan community. We had to work very closely with the community to help them navigate the healthcare system, which is very different from their experience in Afghanistan," Mamo says. "We had to learn about their culture and what was acceptable to them in the clinical setting."

For example, it quickly became apparent that female patients were uncomfortable with male clinicians or interpreters and often stayed quiet in exam rooms. If the care team was female, though, the women opened up and shared more about their health or their needs. "When we have a new community, we need to be very open-minded and listen to them and see what's going to work best for them," Mamo says. "Then we work with the healthcare system to adapt to the communities we're seeing."

Nasreen Quadri, MD
Internal medicine–pediatrics hospitalist
Abbott Northwestern and Children's Minnesota hospitals

"Because of my lived experience, I personally think about this a lot broader than just newcomers immediately in need of consideration. There are people who are new to the United States and people who are living in multigenerational families, so how are we thinking about all of these groups of people and their well-being?"

Walker has been steeped in immigrant and refugee healthcare from her days as a Mayo Medical School student. In 1979, she took a leave to work for the American Refugee Committee, helping people during the refugee crisis on the Thailand-Cambodia border. It certainly helped that Walker grew up in Thailand and speaks Thai and Cambodian, though she knew little about refugee or immigrant and tropical medicine. From there, she devoted her career to caring for newcomers to the United States.

Healthcare for newcomers must start with the foundational premise—what Walker calls her true north—that refugees and immigrants should not get lesser care than anyone else in Minnesota. "Don't separate the immigrants and refugees from other patient populations," she says. "Keep your patients and their outcomes at the center. We should have the same goals for them, that we want them to have high-quality care and be satisfied with their care."

Walker developed four essential pillars to providing newcomers with excellent healthcare, based on her lifelong experience as a clinician, researcher, and writer on immigrant and refugee medicine, and a founder of the University of Minnesota Medical School Global Health program. They are universal and apply no matter what country people come from, she says.

- Hire staff with expertise in the field of immigrant and refugee medicine.
- Employ trained and accredited medical interpreters who can operate in-person, on the phone, or online.
- Provide multidisciplinary care under one roof.
- Cultivate staff at all levels that reflect the patient population, from receptionists and medical assistants to nurses and physicians.

Another key focus should be building trust with newcomers. For Walker, that means showing that she knows something about patients' culture, history, or why they came to the United States. "If I demonstrate that I know something about them, that's demonstrating respect," Walker says. "In turn, they are more likely to be willing to open their hearts and minds to trust us—if they know I really am interested, curious, and respectful of them."

Showing cultural humility is an important way to show trustworthiness, says Mark Wieland, MD, MPH, an internal medicine physician at Mayo who researches health interventions in collaboration with newcomer communities. "At the interpersonal level, it's having curiosity: Tell me your story. Over time, you'll weave a health narrative for individual patients, whether it's cultural or contextual based on their journey. Be curious and open to that and be there on a longitudinal basis. Continuity of care is very important in immigrant and refugee populations, especially early on."

Cultural humility also means asking about people's perspectives and beliefs, such as how religion informs their view of vaccines, Walker says. And when providers have a new patient from another country, especially a recent arrival, take extra time to get to know them. "It might take more time to get done what you want to get done. Take the long view," she adds. "Sitting down and asking about them, asking about their family, builds rapport and will help build a long-term relationship."

Breaking down barriers

At HealthPartners Center for International Health, which opened in 1980 at St. Paul Ramsey Medical Center, then the county hospital, the entire staff is devoted to removing as many barriers to quality care as possible. Newcomers often struggle with transportation, so having a clinic where families can make one trip for adult and pediatric healthcare, mental health services, and social worker support removes one obstacle, Walker says.

Small steps make a big difference in helping people feel welcome, like hanging

Blain Mamo
Refugee health coordinator
Minnesota Department of Health

"When we have a new community, we need to be very open-minded and listen to them and see what's going to work best for them. Then we work with the healthcare system to adapt to the communities we're seeing."

Patricia Walker, MD
Internal medicine physician and medical director
HealthPartners Center for International Health

"Don't separate the immigrants and refugees from other patient populations. Keep your patients and their outcomes at the center. We should have the same goals for them, that we want them to have high-quality care and be satisfied with their care."

art that reflects different patient populations. Hiring staff that looks like patients or speaks their language, also makes people feel at home, Walker says.

Quadri can attest to this. When she walks into a patient's hospital room, she notices that many people visibly relax upon seeing a physician of color, whose name they might recognize as originating from their corner the world. "I have noticed that there are these identity factors that have been super important in bridging that trust gap," she says. "For folks who have not necessarily seen physicians from a more diverse background, I notice a deep breath that has been taken and that they feel like they can potentially connect to me, even if I'm not from that same community or speak the same language. It builds bridges."

A focus on language services is vital to any clinic or provider that sees newcomers. There are barriers to accessing care when a health system or physician's office has a phone tree that is only in English and Spanish, or its online health portal operates in limited languages.

Moreover, Ann Settgast, MD, an internal medicine physician at the Center for International Health, believes it's essential to bring an interpreter to the exam room. "When someone is interpreting on the phone, the patient may have trouble hearing them. And there is the issue of patients' body language and eye contact that you lack on the phone," Settgast says. "Having that person in the room is so important because so much nonverbal communication happens. It's more personal and feels more comfortable for patients."

Providers should universally ask patients what language they prefer to use when interacting with their office, Quadri says. Even if newcomers speak English, they might prefer to use their native language for complex or sensitive topics such as a life-limiting diagnosis or end-of-life care.

Even with interpretive services, communication still can be difficult. The nearly 14,000 residents of Worthington speak 70 different languages, says Mark Gundersen, MD, a family medicine physician at Avera Health. Many of these languages are dialects—say Mexican Spanish compared to Honduran Spanish, which makes it difficult to find interpreters who

Resources for immigrant health

The Minnesota Department of Health offers these resources to help clinicians caring for newcomers:

Minnesota's domestic refugee health screening guidance
Healthcare providers who perform the Minnesota initial refugee health assessments can access resources covering the recommended components at https://www.health.state.mn.us/communities/rih/guide/index.html and watch videos at https://www.youtube.com/playlist?list=PLnv1INVkmxmtFx-Ms5AyolICY5mmwteLR

CareRef
This interactive tool at https://careref.web.health.state.mn.us/ guides clinicians through conducting a routine post-arrival medical screening of a newly arrived refugee to the U.S. The clinician enters basic demographic information such as country of birth, country of departure, date of birth, and any known predeparture treatments. The output will include a list of labs and tests that they need to complete, based on current Minnesota and CDC domestic refugee screening guidance.

VaxRef
This free tool at https://forms.web.health.state.mn.us/form/vaxref helps newcomers and bilingual service and healthcare providers translate their vaccination records to English from French, Portuguese, Spanish, Russian, Spanish, and Ukrainian.

Center for Excellence in Newcomer Health.
The site, https://www.health.state.mn.us/communities/rih/about/coe.html, provides extensive resources to clinicians seeking current information on newcomer health issues and needs.

Demographic and health summary dashboards.
https://www.health.state.mn.us/communities/rih/stats/index.html#primary.

Mark Wieland, MD, MPH
Internal medicine physician
Mayo Clinic

"At the interpersonal level, it's having curiosity: Tell me your story. Over time, you'll weave a health narrative for individual patients, whether it's cultural or contextual based on their journey."

match. The clinic uses a phone service where people do interpretation between clinicians and patients, plus other options like a tablet with translation programs, Gundersen says.

Other times, differences in cultural practices require clinicians to work harder to build relationships with patients. For instance, some patients' adult children attend every appointment and translate or act as the decision-maker. "It might be an older patient, and you're talking to the daughter or son. You don't get to talk directly to the patient—it goes through the family filter," Gundersen says. That requires him to ask the same question in different ways until he gets a clear picture of what is happening with the patient.

As newer groups have arrived over the years, Gundersen then works to build connections and gain understanding of various cultural nuances. It could entail learning that people from a particular region strongly emphasize modesty, or discovering which cultural groups are reluctant to share mental health challenges. Then he adjusts his approach from there.

It's also important, especially in rural areas, to be visible in the community and show patients that their physicians are accessible, Gundersen says. At Worthington's summer international festival, Avera staff host a booth where they publicize the clinic's many services. And when Gunderson sees patients in the community, he makes a point of saying hello. He finds that it helps build rapport that extends to the clinic.

Evolution of care

One difference Settgast has noticed during 17 years at the HealthPartners clinic is that refugees now usually arrive in the United States having received predeparture health screenings and presumptive treatment. This means that most refugee patients are treated for major parasites or common infections before they arrive, so physicians here see far fewer people with these conditions. Once here, patients are treated for common problems like hypertension, diabetes, and musculoskeletal concerns, similar to a U.S.-born population. Immigrant medicine clinicians do, however, see a higher rate of people with hepatitis B, latent tuberculosis, and *Helicobacter pylori* infections.

Physicians will help patients catch up on any immunizations that they might be missing and start conversations about preventive care, including having mammograms, Pap smears, or colonoscopies. Often newcomers are unfamiliar with these kinds of screenings, Settgast says, because it's a different approach from their medical care at home.

"It's not that they are unwilling to have them done. But we have patients that come from places where their only access to care was for acute illnesses," Settgast says. "The idea of doing a test or procedure when you feel good is a novel concept. Often, we will use an analogy to vaccinations—that it's something we do when we're healthy to keep us healthy. We explain early detection and that we can keep you from getting sick."

Community health workers are a key resource that can help clinicians remove roadblocks to preventive care, says Wieland, who does community-based participatory research to develop and test interventions that eliminate disparities. Across Minnesota, community health workers play an important role in connecting newcomers to culturally appropriate health services, assisting people with understanding their health conditions, coordinating care, and helping patients navigate often-confusing areas like insurance.

In addition, tapping into the knowledge and connections of respected community leaders and organizations helps providers better serve newcomers and improve their health, Wieland says. Over time, many refugees and immigrants begin to develop some of the same chronic conditions as long-time Americans, such as diabetes and cardiovascular disease. That often stems from lifestyle changes like not walking as much as they did in their native country. Or they

Ann Settgast, MD
Internal medicine
Center for International Health

"When someone is interpreting on the phone, the patient may have trouble hearing them. And there is the issue of patients' body language and eye contact that you lack on the phone," Settgast says. "Having an interpreter in the room is so important because so much nonverbal communication happens. It's more personal and feels more comfortable for patients."

lack access to healthy food, have persistent stress from transitioning to a new country, and face barriers to obtaining care.

A recent Mayo study with local Somali and Hispanic communities found that when people from newcomers' social networks deliver a cardiovascular risk reduction intervention, they experienced significant improvements in weight, blood pressure, physical activity, and diet. Building trust—or calling on existing trusted relationships— translates to greater success, Wieland says.

Addressing mental health

Linking people with mental health services is a vital aspect of providing care for newcomers, especially refugees. True Thao, a licensed social worker who has operated True Thao Counseling Services in St. Paul since 1997, is fond of the saying that refugees come with their bodies first and their minds later; immigrants come with their minds first and their bodies later.

Mark Gundersen, MD
Family medicine physician
Avera Health

Some patients' adult children attend every appointment and translate or act as the decision-maker. "It might be an older patient, and you're talking to the daughter or son. You don't get to talk directly to the patient—it goes through the family filter."

Typically, refugees leave their countries abruptly, usually in wartime and after experiencing significant trauma. While they have physically arrived in a place a safety, it takes their minds time to adjust. On the other hand, immigrants might have been dreaming of leaving their countries and mentally preparing for years, and it took getting visas, green cards, or other approvals to finally move to the United States.

Many of Thao's refugee clients share a traumatic past, but they often don't have the vocabulary to explain their mental health struggles. Often, those from Southeast Asia describe their concerns as a spiritual or biological problem. So, it often takes several sessions to connect with patients and understand what they are experiencing and why.

"They might say, 'My physical health is okay, but I don't feel well.' If the person comes from a culture without psychological services, they might have a hard time understanding the role of therapy, and the role of the psychologist compared to the physician," says Thao, who came to the United States from Laos after the Vietnam War. "It's a delicate balance to teach them information to help them understand, 'What are you doing with me and why am I here?' It's more complex than my work with mainstream clients."

It is essential for all clinicians, whether focused on mental or physical health, to take time to learn about patients' cultural perspectives on care. "Good providers are good detectives, and it's about piecing the puzzle together," Thao says. "We need to make sure we ask, 'What does this mean in your culture?' We need to integrate the best of the two worlds. Our job is to solve how we do that."

Thao's clinic devotes significant energy to helping meet clients' basic needs as well as their mental health. He understands the difficulty of adjusting to a new country and culture—including finding a job, a place to live, schools for their children, and vastly different weather. Thao's clinic operates as a community center where people can get help with things like food, clothing, and cold weather gear. As they feel the warm welcome and build trust

True Thao
Social worker
True Thao Counseling Services

"Good providers are good detectives, and it's about piecing the puzzle together We need to make sure we ask, 'What does this mean in your culture?' We need to integrate the best of the two worlds. Our job is to solve how we do that."

with Thao and his team, they become more willing to engage in counseling.

Health clinics that serve a significant population of immigrants and refugees should pair medical and mental health services under one roof, Walker says. Refugees often arrive with post-traumatic stress disorder, anxiety, and depression. When a patient needs psychological or psychiatric care, Walker works to eliminate reluctance or barriers. If it's okay with the patient, she will page an in-house clinician to drop in, meet her patient, and do a smooth handoff.

Along with caring for patients, Walker aims to teach the next generation of physicians such best practices. She knows this expertise will always be needed. "The sad thing about refugee and immigrant health is that you have guaranteed job security," she says. "People will always migrate for a better life for their children, or to escape a war, or to escape climate change. The field will always evolve in terms of what kinds of diseases and cross-cultural issues you are seeing. But the basic tenets of good immigration medicine don't change." **MM**

Suzy Frisch is a Twin Cities freelance writer.

Resources for and barriers to maternity services for racial and ethnic minority patients in rural Minnesota

BY JENNIFER PEARSON, MD; ELIZABETH EDLUND, MS3; GWYNETH HANSON, MS3; SARA RICHTER, MS; SANDY STOVER, MD

How well are rural healthcare facilities meeting the healthcare needs of minority maternity patients in the many Minnesota communities that are becoming ethnically and racially more diverse?

Doing our best to serve these diverse communities is important because, as other authors have discussed, there are correlations between the diversity of patients and several maternity care challenges. Among these are decreased empowerment with decisions during labor and delivery, less prenatal education, increased medical interventions during labor, and increased adverse birth outcomes such as preterm and low birth weight infants.

Our research project identified rural Minnesota counties where racial and ethnic minorities made up more than 5% of the population and numbered more than 500 individuals. We conducted phone surveys with providers and hospital administrators in these communities to explore the nuances of resources used and care offered to this diverse population of residents. We aimed to (1) identify what resources are being utilized and working well to help aid different communities in creating more support for pregnant, laboring, and postpartum minority patients; (2) identify barriers and gaps faced by ethnic and racial minority patients when seeking maternity services in rural Minnesota counties; and (3) identify potential actions that can be taken by healthcare systems and providers to reduce barriers and address gaps.

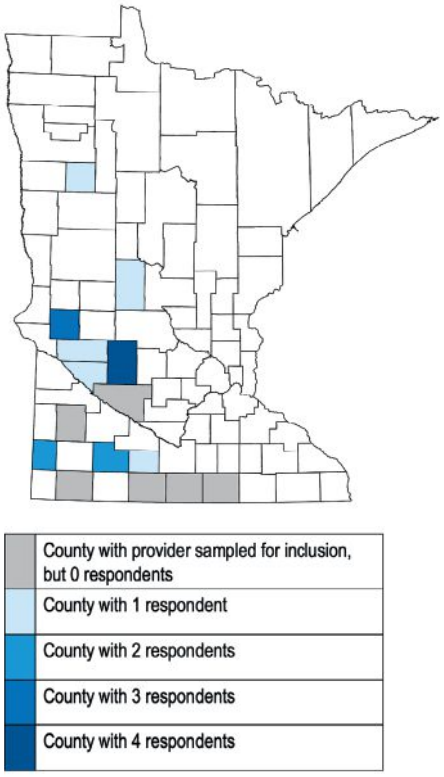
Results identified several resources that are effectively being utilized in many communities, such as printed material, and vaccine and lactation information in a language other than English.

This survey also identified barriers to care for ethnic and minority patients that are primarily related to language and socioeconomic challenges. Language barriers include shortage of interpretation services, unstable internet connection for interpretation services, and insufficient time for high-quality interpreter utilization, with hospital care posing greater challenges than clinic care. Socioeconomic barriers include transportation and insurance limitations, inability to leave work for healthcare needs, and limitations in access to devices for online resources or follow-up care. Additional barriers voiced were distrust of U.S. healthcare systems and fear of deportation.

Providers surveyed in these communities are clearly committed to meeting the needs of these increasingly diverse patient populations. Most feel that patients' cultural norms and expectations are being incorporated into their maternity care and that language needs of limited English–proficiency patients are being addressed.

FIGURE 1

Map of Respondents



Study methods

This was a prospective telephone-administered interview survey study that aimed to collect data from physicians and hospital administrators in 16 rural counties in Minnesota.

Counties in Minnesota were selected for inclusion if their Rural Urban Commuting Area classification was "entirely rural" or "town/rural mix," and they had a racial and ethnic minority population that made up at least 5% of the population and exceeded 500 individuals based on 2020 census data. The 16 identified counties were the following: Renville, Stevens, Kandiyohi, Nobles, Watonwan, Mahnomen, Todd, Freeborn, Faribault, Martin, Nobles, Pipestone, Cottonwood, Lyon, Chippewa, and Swift. Mahnomen's ethnic minority population is largely American Indian and Alaskan Native. Nobles' and Lyon's ethnic minorities are primarily Hispanic or Latino and Asian. All other counties' ethnic minority are primarily Hispanic or Latino.

All hospitals and clinics in each of the 16 selected counties were identified. One hospital administrator from each hospital and one provider from each clinic were recruited for participation. Telephone surveys were administered by two medical students.

Data from the interviews were entered into REDCap and exported into Excel/CSV for analysis.

Included within the phone survey was the following information:

- Demographics for the hospital or clinic and the provider completing the survey

(role, job title, degree, number of hospital beds, Critical Access Hospital designation, if labor and delivery services are provided, etc.).
- Whether the hospital/clinic provides a variety of materials in various languages.
- If any community programs provide maternity education.
- Frequency of assessing and incorporating maternity patients' cultural norms and expectations.
- Whether needs and services were being adequately provided for these patients.
- Open-ended questions related to additional resources and barriers for these patients.

The survey instrument was finalized in the spring of 2022, with the institutional review board determining "not human research" designation. Data was gathered during the summer of 2022 by phone surveys. Data analysis was performed in the fall of 2022.

TABLE 1

Participant demographics and institution information

	N	%
Place of work (check all that apply)		
Hospital	2	12.50
Clinic	1	6.25
Both	13	81.25
Role (check all that apply)		
Physician	10	62.50
Administration/leadership	3	18.75
Advanced practice practitioner	3	18.75
Nursing	3	18.75
Other	0	0.00
Degree(s) (check all that apply)		
Doctor of allopathic medicine (MD)	8	50.00
Registered nurse (RN)	3	18.75
Doctor of osteopathic medicine (DO)	2	12.50
Certified nurse practitioner (CNP)	2	12.50
Other	2	12.50
Certified nurse-midwife (CNM)	1	6.25
How long have you been working at your current institution?		
< 1 year	1	6.25
1–5 years	4	25.00
6–10 years	4	25.00
11–20 years	2	12.50
21–30 years	4	25.00
> 30 years	1	6.25
Do you use one or more languages beyond English with your patients?		
Yes	4	25.00
No	12	75.00
Do any of your colleagues or staff members use one or more languages beyond English with their patients?		
Yes	10	62.50
No	6	37.50

Descriptive statistics were calculated for all survey items (means and standard deviations where appropriate as well as frequencies and proportions). Additionally, survey items were summarized by two groups: hospital administrators and providers. The results were compared descriptively given the small sample size.

Qualitative data from open-ended questions were analyzed for resources and barriers using a grounded theory approach in which the data provided the themes organically, rather than coming in with a predetermined set of themes by which to categorize the data. Open coding was done by question to look for similar/repeated responses across participants. Then, axial coding was done to identify relationships within questions and across related questions. SAS v.9.4 (SAS Institute Inc., Cary, North Carolina) was used for descriptive summaries.

Results

A total of 97 people were invited to participate—81 providers and 16 hospital administrators. Of the 97, 16 interviews were completed (response rate=16.5%). Participant location is shown in Figure 1 and further participant demographic information is outlined in Table 1. These 16 participants represent 10 unique facilities with five facilities represented by one respondent, four facilities represented by two respondents, and one facility represented by three respondents.

All of the respondents provide direct patient care. Four participants (25%) said they use one or more languages other than English with their patients, and all four indicated they used Spanish. While few use another language themselves, 10/16 (62.5%) report a colleague or staff member using another language with patients (10 Spanish; 1 French).

Out of the 15 providers that work in a hospital setting, 11 (73%) said their institution was a federally designated Critical Access Hospital. The average number of beds is 45 (range: 12–150). Almost all of them (13/16 or 87%) currently provide and intend to continue providing labor and delivery services, delivering an average

of 320 babies each year (range: 100–700). Two of the three that do not have labor and delivery say the nearest hospital with those services is 20 to 30 miles away (the third was missing this information). Out of the 14 providers that work in a clinic setting, all of them said they provide prenatal and postpartum care. Almost all of them (12/14 or 86%) provide labor and delivery care. One respondent provides only gynecology services, and one other participant provides only maternity education.

As for resources available, see Table 2. In summary, the top three resources offered in a language other than English for hospitals and clinics are printed materials, vaccine information for infants, and lactation resources. Group classes and audiotapes are least available. The languages used in these resources are tailored to the specific patient population with Spanish, Somali, Hmong, and Mandarin being the most common. Printed materials developed by the hospital/clinic were often available only in one or two other languages while resources provided by external sources, like EPIC or WIC, can be printed in a wide array of languages.

Other resources such as interpreter services, classes, or home visits that rely on in-person or virtual interpreters may be limited by interpreter availability. Most hospitals and clinics can access interpreter services through tablets, in person, or family members; many through telephone, and a few by smartphone app. One respondent specifically mentioned American Sign Language was available through interpreter services. Clinic providers more often agree they have sufficient time to effectively use interpreter services during appointments compared to hospital providers during labor and delivery (78% versus 60%).

Both types of providers agree they are familiar with the cultural norms of minority patient populations that may affect maternal health, with clinic providers expressing strong agreement more often than hospital providers (29% vs 13%). About 20% of providers in both settings did not think they had enough time to ask questions related to cultural practices and beliefs related to maternal health.

Barriers by setting

When asked about barriers to using the resources above, 15 respondents identified barriers. The most common barrier was identified by over half of the respondents (53.3% or 8/15) as limited availability of interpreters, especially in the hospital setting where care can be more acute (versus a scheduled clinic visit). One respondent elaborated by saying, "Currently no one in the building speaks Spanish. We have to call or text our interpreter if someone walks into the building or calls and only speaks Spanish. We only have one interpreter, and she works a full-time job outside of the clinic, so her availability is limited."

Other common barriers include connection trouble for virtual interpreter services (phone, tablet, and app; 46.7% or 7/15) and the amount of time it adds to the appointment (40.0% or 6/15). One respondent said, "Interpretation triples the time of the appointment." Less common barriers included interpreters no-showing for appointments (n=2), dialect mismatches between the patient and interpreter (n=2), the cost involved (n=1) and lack of knowledge on how to access interpreter services (n=1).

Respondents were also asked what barriers their maternity patients face in accessing culturally adapted care. The two most frequent responses were transportation and distrust of the healthcare system/Western medicine, with roughly 40% of respondents mentioning each. Transportation barriers were not elaborated on beyond "lack of transportation." A couple of examples related to distrust were given. For example, "Some distrust comes from having limited interpreter availability and not having many bilingual staff members. This decreases the comfortability of patients in the clinic/hospital." Another example cited distrust regarding C-sections and inductions. However, it should be noted that transportation and distrust were included as examples within the question text, so their frequency may be higher than if responses were spontaneous.

Other less frequent responses included barriers related to navigating the U.S. healthcare system (n=4), not being able to get time off work (n=4), not having insurance (n=3), and additional barriers related to communication (e.g., not having an interpreter available to answer phone calls or messages getting lost in translation, n=3). Respondents were then asked what additional barriers their patients with limited English proficiency face. The main item was lack of integrated interpreter services (n=4). They specifically noted that interpreters are not available for scheduling appointments or lab visits. They also mentioned that community programs like WIC and other prenatal classes aren't offered in languages other than English. Even when written materials are available in other languages, patients may not have enough literacy in their written language to follow complicated instructions like driving directions or fasting glucose tolerance test directions. Two respondents mentioned lack of financial resources as patients may not come in for care due to cost or may not have internet service or cell phones for follow-up communication. One respondent mentioned the lack of services available to patients that are not documented.

Additional reflections

Just over half of the respondents (9/16 or 56%) indicated they always or often inquire about maternity patients' cultural norms or expectations. Over 80% (13/16) say they always or often incorporate the norms and expectations into their care. Generally, respondents feel like the language needs (88%) and cultural needs (68%) of maternity patients are being met. About 60% (10 of 16) feel like there are either additional culturally adapted resources and/or improved access to resources that could better support racial and ethnic minority patients during maternity care.

When asked what culturally adapted resources would better support racial and ethnic minority patients, 60% (6/10) indicated having more resources available in the patient's native language would be beneficial. This includes written resources in more languages, having easier access to in-person interpretation services, and having resources in more formats (e.g., videos

TABLE 2

Resources available in hospital and clinic settings

	HOSPITAL (N=15)		CLINIC (N=14)	
	N	%	N	%
Which of the following, if any, are offered in a language other than English for maternity patients at your hospital/facility? (Words separated by a slash indicate different wording used in hospital versus clinic settings.)				
Printed materials	15	100.00	13	92.86
Vaccine information for infants	14	93.33	11	78.57
Lactation resources	10	66.67	9	64.29
Tour of birth center	7	46.67	2	14.29
WIC (Women, Infants, and Children program)	7	46.67	6	42.86
Home visit by patient educator	6	40.00	1	7.14
Intimate partner violence screening	6	40.00	6	42.86
Videotapes	6	40.00	1	7.14
One-on-one childbirth education	5	33.33	3	21.43
Web-based programs	4	26.67	3	21.43
Group healthcare system-based prenatal classes	2	13.33	1	7.14
Group community-based prenatal classes	2	13.33	0	0.00
Audiotapes	1	6.67	0	0.00
Other	1	6.67	0	0.00
I don't know	2	13.33	0	0.00
None	0	0.00	1	7.14
What interpreter services are available for you to use at your hospital/facility with limited English–proficiency maternity patients?				
Tablet	15	100.00	13	92.86
In-person interpreter	14	93.33	11	78.57
Family member or visitor with patient	11	73.33	12	85.71
Telephone	11	73.33	8	57.14
Smartphone application	4	26.67	3	21.43
Other	1	6.67	1	7.14
What languages are supported by interpretation services?				
Somali	15	100.00	14	100.00
Spanish	15	100.00	14	100.00
Hmong	14	93.33	14	100.00
Mandarin	14	93.33	13	92.86
Arabic	13	86.67	13	92.86
Bengali	13	86.67	13	92.86
French	13	86.67	13	92.86
Hindi	13	86.67	13	92.86
Russian	13	86.67	13	92.86
Other	7	46.67	5	35.71
Interpretation services are readily accessible for labor and delivery/prenatal appointments.				
Strongly agree	5	33.33	4	28.57
Agree	7	46.67	9	64.29
Neither agree nor disagree	0	0.00	0	0.00
Disagree	1	6.67	1	7.14
Strongly disagree	0	0.00	0	0.00
Not applicable	2	13.33	0	0.00
My colleagues and I/I have sufficient time during labor and delivery to use interpreter services effectively.				
Strongly agree	4	26.67	3	21.43
Agree	5	33.33	8	57.14
Neither agree nor disagree	2	13.33	1	7.14
Disagree	1	6.67	2	14.29
Strongly disagree	0	0.00	0	0.00
Not applicable	3	20.00	0	0.00
I am familiar with cultural norms of major ethnic minority communities in my area that may affect maternal health.				
Strongly agree	2	13.33	4	28.57
Agree	13	86.67	9	64.29
Neither agree nor disagree	0	0.00	0	0.00
Disagree	0	0.00	1	7.14
Strongly disagree	0	0.00	0	0.00
Not applicable	0	0.00	0	0.00
My colleagues and I/I have sufficient time during labor and delivery/appointments to ask questions related to cultural practices and beliefs regarding maternal health.				
Strongly agree	1	6.67	2	14.29
Agree	9	60.00	9	64.29
Neither agree nor disagree	2	13.33	0	0.00
Disagree	2	13.33	3	21.43
Strongly disagree	0	0.00	0	0.00
Not applicable	1	6.67	0	0.00
Does your hospital/facility have any culturally adapted resources available for racial and ethnic minority patients seeking maternity care?				
Yes	4	26.67	5	35.71
No	8	53.33	5	35.71
I don't know	3	20.00	4	28.57
Are there any plans to add resources?				
Yes	2	13.33	2	14.29
No	6	40.00	6	42.86
I don't know	7	46.67	5	35.71
Missing	0	0.00	1	7.14

and audiotapes). Three respondents (30%) said having staff members that share the same cultural and ethnic background as the patients would be helpful. One respondent mentioned more staff education and meeting with community members to better understand the needs and expectations of these patients.

Some respondents mentioned additional resources for patients with limited English proficiency. The resources identified included community organizations (Conexiones, local food shelf, and community education), local government and its programs (county public health, WIC, local school system), and other translation resources (YoMingo app, and EPIC/EHR).

As last comments, three respondents discussed the need for administrative support to better care for these patients, including supporting longer appointment times and providing more staff education on culture, language, and immigration issues faced by these patients. One respondent discussed how community interpreters can help maternity patients receive better care: "The WIC office and Help Me Grow program hired full-time Spanish interpreters that help get patients' maternity care. These interpreters also help patients and families understand their families' and children's conditions when more than printed materials are necessary. Having a well-connected interpreter from the community helps community health."

Discussion

With increasing numbers of racial and ethnic minority patients in rural Minnesota communities, providers surveyed are clearly committed to meeting the needs of these increasingly diverse patient populations. Most of these providers feel that patients' cultural norms and expectations are being incorporated into their maternity care and that language needs of limited English–proficiency patients are being addressed. In aiming to identify resources being utilized that enhance support for pregnant, laboring, and postpartum minority women, most clinics and hospitals represented by our survey data offer resources such as printed information, vaccine information, and lactation information in a language other than English. Some but fewer locations have been able to partner with community organizations to provide additional support.

When examining the barriers to care for racial and ethnic minority patients, language and socioeconomic considerations are at the forefront. Also noted is that hospital care seems to pose greater challenges than clinic care. Regarding language barriers, a shortage of interpretation services and unstable connection for virtual interpretation services were the most consistently mentioned challenges. In addition, insufficient time to allow for higher quality interpretation and a lack of prenatal education in languages other than English were also voiced. Even when efforts were made to overcome language barriers, many respondents felt that patients still had misunderstandings regarding their care. Socioeconomic factors also contribute significant barriers to care for racial and ethnic minority patients. These factors include a lack of transportation, an inability for patients to leave work for medical appointments, a lack of healthcare insurance, and financial instability that limits access to technology that can augment medical care (for follow up communication and access to online resources). In addition, a distrust of the U.S. healthcare system as well as fear of deportation for some individuals further prevents patients from seeking community medical care.

Clearly, the ability to provide robust and culturally nuanced maternity care to this expanding patient demographic in our state is a complex challenge, especially amid the myriad of challenges and budgetary constraints faced by rural healthcare systems. Amid many local efforts underway to support this diverse population, consideration of additional solutions could be considered at various levels.

Local health system–based solutions for minimizing language barriers might include: (1) expanding appointment times; (2) expanding access to in-person or virtual interpretation services (especially for those most-common non-English languages being spoken locally); (3) hiring providers or allied community workers who share a background and language with many racial and ethnic minority patients in the region.

Community-based solutions for increasing access to maternity services may include: (1) offering community prenatal education classes in languages other than English; (2) offering online education in languages other than English at local clinics or libraries for patients who lack devices for personal online access; (3) expanding resources like WIC to be offered in languages other than English; (4) developing ride-share programs; (5) engaging community health workers (such as lactation consultants, home health aids and others) to partner in care for these patients with attention towards efforts to engage individuals with shared background and language to fill these roles.

Furthermore, these local and community-based solutions would benefit greatly from successful advocacy for increased state and federal funding.

Of note is that there are efforts underway in urban areas of Minnesota to meet the needs of increasingly diverse maternity patients. (https://twin-cities.umn.edu/news-events/new-anti-bias-childbirth-training-courses-address-disparities-black-and-indigenous). Exploring the potential to partner and expand these types of services into rural communities may allow for improvement of care for these diverse patient populations across our state.

The authors recognize some limitations to this study. First, self-selection bias may be present given the recruitment strategies used. Second, the small sample size in this study limits statistical testing and the potential to generalize the findings. Third, American Sign Language was not included within the survey tool and could provide additional insight for the population with hearing impairments. Lastly, since providers/administrators were recruited for participation, this study lacks patient and community perspectives.

Although this study has a small sample size, providers surveyed included robust and nuanced insight into how their respective communities are working to support and care for these patients. Our hope is that these data may generate further dis-

cussion, study, and effort to continue to improve the experiences of these racially and ethnically diverse maternity patients within our rural communities. Clearly, the shared goal is to optimize care and outcome for all. **MM**

Jennifer Pearson, MD, is an associate professor at the University of Minnesota Medical School, Duluth campus. Elizabeth Edlund and Gwyneth Hanson are third-year medical students at the University of Minnesota Medical School. Sara Richter, MS, is an independent statistician with Richter Statistical Services, LLC. Sandy Stover, MD, is an assistant professor at the University of Minnesota Medical School, Duluth campus.

Financial Disclosures: The funding for this project was obtained by the University of Minnesota Medical School Student Summer Research Grant Program. There are no additional financial disclosures.

TABLE 3

Additional reflections

	N	%
How often do you inquire about your maternity patients' cultural norms or expectations?		
Always (90% or more)	6	37.50
Often (about 75%)	3	18.75
Sometimes (about 50%)	4	25.00
Rarely (about 25%)	3	18.75
Never (< 10%)	0	0.00
How often do you incorporate your maternity patients' cultural norms and expectations into their care?		
Always (90% or more)	6	37.50
Often (about 75%)	7	43.75
Sometimes (about 50%)	2	12.50
Rarely (about 25%)	1	6.25
Never (< 10%)	0	0.00
How often do you encounter instances when there may be a misunderstanding of health information because of language or cultural differences?		
Always (90% or more)	0	0.00
Often (about 75%)	3	18.75
Sometimes (about 50%)	12	75.00
Rarely (about 25%)	1	6.25
Never (< 10%)	0	0.00
The language needs of limited English–proficiency patients are being met during maternity care.		
Strongly agree	4	25.00
Agree	10	62.50
Neither agree nor disagree	0	0.00
Disagree	1	6.25
Strongly disagree	0	0.00
Not applicable	1	6.25
The cultural needs of ethnic and racial minority patients are being met during maternity care.		
Strongly agree	1	6.25
Agree	10	62.50
Neither agree nor disagree	3	18.75
Disagree	2	12.50
Strongly disagree	0	0.00
Not applicable	0	0.00
Are there any culturally adapted resources that you think would better support racial and ethnic minority patients during maternity care?		
Yes	10	62.50
No	2	12.50
I don't know	4	25.00

REFERENCES

Alhusen JL, Bower KM, Epstein E, Sharps P. Racial discrimination and adverse birth outcomes: an integrative review. J Midwifery Women's Health. 2016;61(6):707–720. doi:10.1111/jmwh.12490.

Asche K. The state of rural—2021 update. Ruralmn.org. December 2021. https://www.ruralmn.org/the-state-of-rural-2/.

Bolin J, Bellamy G, Ferdinand A, Vuong A, Kash B, Schulze A, Helduser J. Rural health people 2020: new decade, same challenges. J Rural Health. 07 May 2015. https://doi.org/10.1111/jrh.12116

Greater Minnesota: refined and revisited. MN State Demographic Center. January 2017. https://mn.gov/admin/assets/greater-mn-refined-and-revisited-msdc-jan2017_tcm36-273216.pdf

Kozhimannil KB, Hung P, Henning-Smith C, Casey MM, Prasad S. Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States. J Am Med Assoc. 2018;319(12):1239–1247. doi:10.1001/jama.2018.1830

Le Neveu M, Berger Z, Gross M. Lost in Translation: The role of interpreters in labor and delivery. Health Equity. 2020;4(1):406–409. doi:10.1089/heq.2020.0016.

Minnesota Compass. By immigrant group. Mncompass.org. 2021. https://www.mncompass.org/topics/demographics/immigration?age#1-5601-g.

Minnesota Compass. By race and ethnicity. Mncompass.org. N.d. https://www.mncompass.org/topics/demographics/race-ethnicity?diversity-index

Mueller CG, Webb PJ, Morgan S. The effects of childbirth education on maternity outcomes and maternal satisfaction. J Perinat Educ. 2020;29(1):16–22. doi:10.1891/1058-1243.29.1.16

Oachs W, Gehlen E, Moore J, Redmer R. Building community, embracing difference: immigrants, refugees, and local government outreach in rural Minnesota. Ruralmn.org. June 8, 2021. https://www.ruralmn.org/building-community-embracing-difference-immigrants-refugees-and-local-government-outreach-in-rural-minnesota/.

Richert C. Rural hospitals retreat from delivering babies; small towns pay the price. Mprnews.org. January 22, 2019. https://www.mprnews.org/story/2019/01/22/rural-clinics-end-baby-delivery-small-town-minn-pays.

Thom DH, Hall MA, Pawlson G. Measuring patients' trust in physicians when assessing quality of care. Health Aff 2004;23:124–132.

A tangled web

Minnesota's post-COVID Medicaid 'unwinding' requires patience, compassion

BY ANDY STEINER

In her role as supervising attorney for Mid-Minnesota Legal Aid in St. Cloud, Ralonda Mason has seen clients express a full range of emotions. But these days, many of the people who come into her office seeking help filling out Medicaid renewal forms are exhibiting a specific set of reactions.

"People are scared," Mason says. "They are also frustrated." Sometimes, those two emotions boil over into something else: "When people get scared and frustrated, that leads to anger. We're certainly seeing plenty of that."

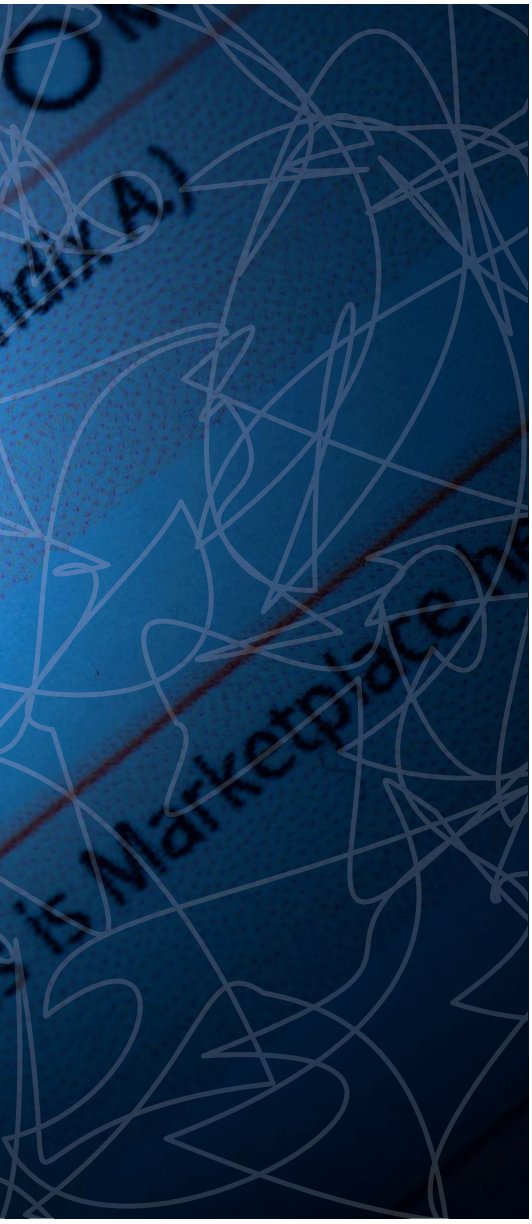
This fear, frustration, and anger come from something many are calling "Medicaid unwinding," or the complicated and cumbersome process of determining eligibility for many of the 94 million Americans who were enrolled in Medicaid and its corresponding Children's Health Insurance Program (CHIP) as of April 2023.

The number of enrollees in these federally subsidized healthcare programs increased dramatically at the start of the global COVID-19 pandemic in the spring of 2020, when, according to the Centers for Medicare and Medicaid Services (CMS), Medicaid and CHIP rolls increased by 32 percent, or more than 23 milion individuals. In Minnesota, some 1.5 million people were on Medicaid in early 2023.

This massive increase in eligibility was done, Mason explains, "for a very important reason. While we were struggling through an unprecedented health emergency in this country, having people lose coverage and access to healthcare would've been horrible for all of us."

Lynn Blewett, professor in the Division of Health Policy and Management in the University of Minnesota's School of Public Health, says that many Americans who may have otherwise lost healthcare coverage when their employers cut jobs or shut down completely were suddenly eligible for Medicaid coverage.

"Medicaid is a really important part of the U.S. healthcare system," she explains.



"It serves as a cyclical safety net program: Enrollment goes up when the economy is not doing very well. When the economy is doing well, enrollment goes down. Enrollment is based on the needs of people in the country."

When the need was high for a number of Americans, the decision to open Medicaid rolls was the right response to a terrible situation, Blewett says. "In this most recent case, it was the double whammy of COVID on the economy and people's health and the need for vaccinations and screenings and COVID tests. Thank goodness we have Medicaid. It provided a really important safety net for people through that time."

Now, with the official end of the global health emergency comes significant change for Medicaid enrollees.

Before COVID, eligibility for the program for most people was determined on an annual basis, says Allexa Gardner, senior research associate at Georgetown University's Center for Children and Families. During the three years of the COVID emergency, she explained, Medicaid recipients were instead provided continuous enrollment.

"This provision proved Medicaid's role as an important safety net program for those who were in the lowest-income brackets as we prepared for a recession, as the economy ebbed and flowed," Gardner says. During this time of crisis, she added, "people didn't have to worry about whether they had healthcare coverage. It was a good thing."

'Clean-up' time

While experts knew that this expanded Medicaid coverage would eventually end with the pandemic, many people who had been part of the benefit's rolls were still taken by surprise this spring when they learned that they could soon lose their healthcare coverage. (Some estimates say that anywhere between 100,000 and 280,000 Minnesotans could lose their Medicaid coverage in 2024, for instance.)

Fast forwarding three years from the start of COVID, Mason explains, "we have a very large number of people who were on these programs, many of whom had never been on them during the normal processing procedures that we follow under nonpandemic times and have not had to even think about their eligibility for a number of years."

When the federal government began asking states to reevaluate their Medicaid rolls, enrollees began receiving renewal packets in the mail. Many people put it aside. Many who looked at the information didn't understand it.

"Many states give 30 days from the time that renewal packet is mailed to the time information is due, resulting in someone being terminated from coverage," Gardner says. "Not providing clear information on what's required by beneficiaries to maintain coverage or the information not being provided in someone's spoken language can add up to why someone cannot get their renewal forms in on time."

"Many states give 30 days from the time that renewal packet is mailed to the time information is due, resulting in someone being terminated from coverage. Not providing clear information on what's required by beneficiaries to maintain coverage or the information not being provided in someone's spoken language can add up to why someone cannot get their renewal forms in on time."

ALLEXA GARDNER
SENIOR RESEARCH ASSOCIATE
CENTER FOR CHILDREN AND FAMILIES
GEORGETOWN UNIVERSITY

Mason says that people who come into her office don't know how to respond to these packets: "For the last three years, people were told to ignore notices, not report changes, not to provide information. That was necessary to be able to keep so many people enrolled." Now enrollees are being told to act quickly if they want to keep their coverage.

Add language barriers and a highly mobile population to the mix, and you've got a recipe, if not for disaster, at least for plenty of confusion, Mason says. "When everything changed all of a sudden, the state doesn't have a good way of getting that information out reliably to the people who need it. In many cases, the addresses, the information that was on file is no longer good. People have moved. Their phone number has changed."

While Mason believes that officials in Minnesota have tried to be conscientious about evaluating eligibility of Medicaid enrollees, she says the process has been clunky, to say the least. "I do think that the state tried to be thoughtful, and I think they recognize the challenge. I think they tried to develop a way to get information out," but the sheer number of enrollees that need to be reached is daunting: "The problem is there's not a good single way to disseminate information when you need about a quarter of the population to hear and understand what you are trying to ask them to do. It's been a tough job, and I'm seeing every day just how challenged people are feeling by the process."

"For the last three years, people were told to ignore notices, not report changes, not to provide information. That was necessary to be able to keep so many people enrolled." Now enrollees are being told to act quickly if they want to keep their coverage.

RALONDA MASON
SUPERVISING ATTORNEY
MID-MINNESOTA LEGAL AID
ST. CLOUD

Look for the helpers

While the process of establishing Medicaid eligibility can be stressful, there are plenty of people in Minnesota who have been trained to help folks understand the system and determine if they are still eligible for coverage.

At Mid-Minnesota Legal Aid, for instance, Mason says that teams of Medicaid navigators, provide "free assistance to people to apply for coverage, and to do what they need to do to stay covered. Our navigators go through a fairly extensive training process to understand the questions they are supposed to ask."

Medicaid navigators don't work just in the St. Cloud office, Mason adds. They have been dispatched to meet with consumers in 14 different locations across the region. "We try to spread through the 12-county area and be in communities that are closer in distance to the people we are serving so they don't have to travel all the way to St. Cloud."

Bilingual navigators are stationed in public libraries, health clinics and social service agencies. "People bring us documents and say, 'I got this in the mail. Can you tell me what they say? I don't understand.'" Mason says. And for clients with transportation barriers, "we also meet with people on the phone and do virtual appointments. We try to be as available as we can."

Mason says her office is the only legal aid program in the state that provides this service to clients. It's a relatively costly and time-consuming decision, she admits, but she and her colleagues think the help is that important. "We've worked hard to make sure people know that we are providing these services. It is part of our job and our mission." She wishes the process didn't have to be so complicated: "You shouldn't need to go to a lawyer to get to see your doctor."

"Not very many states got specific funding to help with Medicaid unwinding. That was a big help. There are now three or four states that are doing that, which has been shown to be so important for childhood vaccinations and well-child prevention visits. Minnesota has also recently added coverage for undocumented adults and children."

LYNN BLEWETT, PROFESSOR
DIVISION OF HEALTH POLICY AND MANAGEMENT
UNIVERSITY OF MINNESOTA SCHOOL OF PUBLIC HEALTH

Julie Marquardt, interim Minnesota state Medicaid director in the state Department of Human Services, says that her office has tried to focus on making the unwinding process as painless for qualified Medicaid recipients as possible. "We're

working with community organizations and other partners to make sure that assistance is accessible to everyone. We want people who need assistance to be able to easily contact someone to get help in a language they understand. People can find navigators and assisters in all of the communities in Minnesota."

State Medicaid workers also tried to cut through the confusion and clutter in the renewal and eligibility letters that were sent out to enrollees, affixing bright blue dots to the envelopes to make them more visible so that people were less likely to throw them away, Marquardt says. "Our goal has always been that everyone who remains eligible for Medicaid keep their coverage.'

How Minnesota compares

Blewett says that while some states—including Arkansas, Texas, and Florida—have been "culling their Medicaid rolls more aggressively," other states have been moving more slowly and carefully. "Minnesota is one of those states," she says.

Moving slowly and carefully means striking a balance between, Marquardt says, "just keeping everybody on regardless of whether they are eligible or not" and finding those Minnesotans who no longer meet the eligibility requirements for Medicaid coverage. With an eye to making sure that every Minnesotan who is eligible for Medicaid stays enrolled, she explains that her department is in the process of "changing the technology that helps us to do the work, making adjustments so we can identify as many eligible people as easily as we can."

Nonetheless, the U.S. Department of Health and Human Service announced in September that it was requiring Minnesota and 28 other states to restore coverage for a large group of Medicaid enrollees who may have mistakenly lost benefits. According to the federal government, states may have erroneously decided eligibility across entire households when children might qualify for coverage when their parents do not.

"A technology glitch put everyone on notice," says Blewett of the University of Minnesota. "One of the automative programs used by many states was determining eligibility for entire households even when children, who have higher income eligibility limits, might still be eligible for Medicaid and/or the Children's Health Insurance Program. Minnesota responded by placing a pause on eligibility determinations and a reinstatement of almost 12,745, mostly children. They are learning of problems and fixing them as they go along."

According to Marquardt, the state Department of Human Services submitted a mitigation plan to CMS and is implementing the plan, which includes the "reinstatement of coverage for some enrollees—nearly all individuals impacted have been reinstated." In addition, deadlines for renewing have been extended, and there have been ongoing improvements to auto-renewal processes. "These steps help ensure more enrollees, the majority of which are children, retain coverage. Minnesota's objective throughout this renewal process is to keep all Minnesotans who remain eligible covered," Marquardt says.

"It is clear that DHS is struggling to meet the federal requirements," says Mason of Mid-Minnesota Legal Aid. "The result has thus far been a patchwork of efforts and processes that is leaving Minnesotans confused and frustrated."

The Minnesota Legislature has provided funding to support Medicaid unwinding efforts. "Not very many states got specific funding to help with Medicaid unwinding," Blewett says. "That was a big help."

Special attention has also been paid to providing Medicaid coverage for the youngest Minnesotans, by passing legislation last session for continuous coverage to children up to age 6 and for two years for older children.

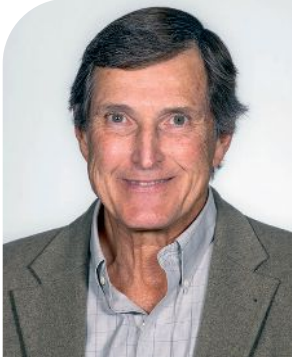
"There are now three or four states that are doing that," Blewett says, "which has been shown to be so important for childhood vaccinations and well-child prevention visits. Minnesota has also recently added coverage for undocumented adults and children."

While not all of the Minnesotans who were on Medicaid during the pandemic will remain on the rolls after the unwinding, Marquardt says that she and her staff have been working "at breakneck speed to get things implemented. It has been challenging, but ultimately it aligns with our vision, the goals we've always set. And in the long run more children and adults who are eligible will be able to keep their coverage." **MM**

Andy Steiner is a Twin Cities freelance writer and editor.

Will an MD come with a union card?

Allina physicians just voted for a union.
Is their vote a sign of things to come?



PAUL CLARK, PROFESSOR
THE SCHOOL OF LABOR AND EMPLOYMENT RELATIONS
PENN STATE

In October, more than 500 primary-care and urgent-care physicians working in more than 50 clinics in the Allina Health System in Minnesota and Wisconsin voted on the question of whether to form a labor union. An overwhelming majority voted for the union.

According to an organizer with the Doctors Council in New York City, the union has been formed and the clinicians have started the bargaining process; the average first union contract settles in about 18 months.

The campaign was the second involving Allina. In March, about 150 physicians at Allina's Mercy Hospital in Coon Rapids took steps to form a union.

Not long ago, physicians tended toward conservative politics, opposing Medicare in the 1960s and national healthcare more recently. The Allina vote represents a political turnaround that many in the industry find startling.

What has caused the change in attitude? Is Allina unique? Or a sign of things to come? *Minnesota Medicine* asked Paul Clark, professor in the School of Labor and Employment Relations at Penn State and widely recognized as a national expert on labor issues in healthcare. The interview has been edited for brevity and clarity.

"What I think we're seeing is an almost universal desire on the part of people who are employed to have a greater voice in their workplace, in their work life, to have some modicum of control over where they spend a great deal of their time every week practicing medicine."

In the 1960s, the American Medical Association vehemently opposed Medicare as "socialized medicine." Now, Allina Health System physicians just voted to form a union. What happened?

What I'm hearing is how private capital is coming in and buying up an awful lot of physician practices and clinics. And many physicians are stuck in the position of moving from having their own practice, being self-employed, to now being employees of someone, whether it's a hospital or a health system. What I think we're seeing is an almost universal desire on the part of people who are employed to have a greater voice in their workplace, in their work life, to have some modicum of control over where they spend a great deal of their time every week practicing medicine. I have studied workplaces and workers for decades now. This trend doesn't surprise me.

We haven't seen this much in the past for a couple of reasons. One is the reason you mentioned. There was this view of medicine—single payer medicine being "socialized medicine"—and doctors didn't want to be a part of that. I have several physicians in my family, and I'm very aware that unions just have not historically been part of that profession. The majority of doctors—I think they have a very difficult time seeing themselves as union members. That's for blue-collar workers. That's for workers without significant higher education and very sophisticated and advanced skills.

I think we've got to remember our country is a little bit of an exception when it comes to unions. American management has always been an outlier in terms of how aggressively they oppose unions. You know, employers in other parts of the world accept unions. It's just a reasonable part of the workplace relationship. Physicians in the U.K. National Health Service are basically wall-to-wall unionized. So physicians' organizing is not a new phenomenon at all in many parts of the world. This seems like a radical thing in the U.S. It's not in the rest of the world.

Also, as a footnote, interns and residents in this country have had somewhat of a history of organizing, at least in major urban areas. There's long been—I think it's called the Committee of Interns and Residents. They've been around a long time. But, of course, I think in the medical profession an intern and resident is seen as very different from a practicing physician.

I wanted to circle back to something you'd said earlier about the changing economic landscape that is putting more doctors into the position of being labor rather than capital. In 2020 for the first time in this country the proportion of doctors who are employees is now greater than the number who are in private practice. And in Minnesota, physicians are far less likely than in other parts of the country to own their own practice—just 15% work in a physician-owned practice.

That's absolutely at the heart of it. Physicians who have their own practices are basically self-employed. They make deci-

sions, the very critical decisions about how they're going to practice their profession, how they're going to go about their work, when they're going to work. They have a great deal of control over their work lives.

When it shifts and you become an employee of an organization, and I think particularly when you become an employee of a large organization, you lose that control over how you're going to practice medicine—or, at least, about a lot of the decisions about practicing medicine. I think that physicians, in many cases, think this does not allow them to practice medicine in a way that most benefits patients, or the way they believe they should practice.

I spent many years studying nurses' unions, and working as a consultant with nurses' unions. And 25 or 30 years ago, nurses began to organize on a very much more significant basis than they have in the past. Unions had not been a part of the nurse culture. To have a union suggested to them that you were putting your interests, particularly your financial interests, before the patients—that a union was about, well, maybe being a little greedy and getting more money. Nurses are so committed to their patients. They put their patients first. That didn't square with their culture.

But over time, I saw nurses come to understand that in organizations where decisions about how to provide care are being made increasingly by administrators, by people who are using financial bases for making their decisions, organizing a union would give them a greater voice in the workplace. That was something that would benefit patients. Organizers would argue that it's almost irresponsible for nurses not to try to organize so that they could increase the leverage and input they had into how care was delivered, because they believe their decisions will be much more centered on the patient's well-being. And I've read a few articles where physicians are arguing the very same thing—that as their voice diminishes in these organizations, patients are disadvantaged. And so I think that's what you see behind an awful lot of this. Again, it gets back to having a voice in their own work.

"I think that it's logical and rational for physicians to look around and say, 'How can we regain some control over how we practice medicine? We think we're the best people to make judgments about how to practice medicine, not administrators.' "

It sounds as though the nurses led the way in the field of healthcare toward unionization. Did that influence doctors to be more interested in or accepting of unionizing?

Well, you know, I spent some time trying to figure out the relationship between nurses and physicians. It is a very complicated relationship with different levels. You know, I don't think physicians generally look to nurses for leadership on a lot of issues. Again, that's something that goes way back in terms of the culture of medicine.

But I'm sure doctors are beginning to understand why nurses over the last couple of decades have organized. And I think they're seeing that nurse organizing has been an effective way for nurses to retain or even increase the voice they have in the workplace.

Most of the time when you hear about the issues in nurse bargaining, it's generally not about pay and benefits. The nurses do want better pay and benefits. But the real sticky issues in nurse bargaining, the issues over which strikes occur, are things like understaffing in hospitals, nurses being forced to work mandatory overtime, nurses forced to float to parts of the hospital where they don't feel adequately trained or competent. And each of those issues in their view threatens the safety of patients. It reduces their ability to provide care of the highest quality, care that they're committed to provide. And so if physicians are seeing nurse organizing in that light, it's quite different from organizing in blue-collar industries and unskilled industries.

I think also nurses are seeing a number of nurses leaving the profession. This becomes a real crisis for our healthcare system—the nurses that are burning out, quitting, going into other fields. If the conditions that nurses work under aren't improved, our entire healthcare system is in jeopardy. And my guess is that that's not far afield from what a lot of physicians are sort of feeling about the increased growth of private capital in healthcare, and the conglomerization of healthcare systems. I don't think they're way behind nurses.

We're only talking about a relatively small number of situations where physicians are organized. It's not a wave that's sweeping the country. But it's a new direction that we're seeing. Years ago you just didn't hear about this. It happens in the context of a real resurgence to the labor movement in general. I don't know if it's coincidence or cause and effect, but the condition for workers' organizing unions in this country right now are about as good as they've been in maybe half a century. A lot of stars have aligned to get us where we are in terms of this issue.

Not to sound too cynical about this, but conditions in which nurses and physicians are seeking other careers, dropping out of the field, retiring early, do create the circumstances, set the table, for an easier time to unionize, do they not? I mean, when there's a shortage of labor, that's a pretty strong lever to use in a situation like this.

It's probably the strongest lever. And we're at a point in time where workers and employees in this country face conditions that are as good as they've been for half a century.

The number one factor is the labor market. Because when you have unemployment of any significance—that disciplines workers. Most people understand that organizing a union is something employers are going to vehemently oppose and that you might be putting your job on the line. But when every employer you can think about has a help-wanted ad in their window [U.S. unemployment is under 4%], people become a little braver. And, as you say, it does give them much more leverage if you do form a union and go into bargaining. The leverage you have is threatening to withdraw your labor to strike. If there's 10% unemployment out there, in a whole lot of scenarios, the employer is going to say, "Well, go ahead, you ungrateful SOBs. For every one of you, there're 10 people out there looking for a job." And, of course, the labor laws in this country make it perfectly legal for employers to replace striking workers. But if you look at the UAW strike, if you look at the UPS strike, workers are much more willing to go on a strike because there just aren't people that employers can hire to take their place. And that gives them much more leverage in bargaining. And so I think your point is on target.

"We have a president in the White House who said he is the most pro-union president in American history. And if you look at labor law, the way he is making an impact is by appointing people to the National Labor Relations Board, and that board in virtually every case is interpreting labor law in a way that benefits workers. That hasn't happened to the degree it's happening now for decades."

Plus a couple other things. We have a president in the White House who said he is the most pro-union president in American history. And if you look at labor law, the way he is making an impact is by appointing people to the National Labor Relations Board, and that board in virtually every case is interpreting labor law in a way that benefits workers. That hasn't happened to the degree it's happening now for decades.

And there's also a public opinion poll that Gallup does every year where they ask the public, do you support unions? And last year, 2022, it hit its highest level in 50 years: 71% of the American public said they approve of unions, they support unions. So you've got a public that's much more open to unions and supportive. You've got a political situation that's much more sympathetic to unions. And you've got an economy that very much gives workers leverage.

You wrote a book, *Building More Effective Unions*, that builds on behavioral science to describe how unions can attract more members and build engagement. Does that have relevance to healthcare?

Well, I'd like to think so. The sort of things I talked about in that book are sort of universal. It's interesting, it's where we started this conversation. Most every worker, no matter unskilled, skilled, professional, nonprofessional, wants a voice in their work lives. We spend so much time at work.

You know, we're a democratic society in which we believe that every person should have a voice in our government in terms of how we organize and run our society. But that's not the case at work. Our system is a system where employers, at least in the private sector, make all the decisions about what workers are going to do, when they're going to do it, what they're going to be paid. We have a system of employment-at-will in this country where you can fire a worker for a good reason, a bad reason, or no reason at all—the exception being you can't violate discrimination laws. In a democratic society, people have this idea that they should have a modicum of voice and control over their lives. People have that same innate desire for a need for a voice in the workplace. And that's sort of what that book is. Everything in there is built around the idea of how can unions give workers a bigger voice in their workplace. Because that's what's gonna get them committed to their union, that's what's gonna get them participating in their union.

"Workers right now that are 18 to 30, there's a lot of research that shows that they have a very different attitude about work. They expect more out of their work life. They expect more balance in their work life. They expect their work to be more meaningful and rewarding. And they don't seem to be willing to put up with things that prior generations have put up with."

So where does this all go? Is Allina a one-off? Or will we see more groups of physicians pursue collective bargaining?

If I had a crystal ball, I could answer that question. But I don't.

I understand, I think, exactly what's going on at Allina—exactly what's going on with a lot of the experience of physicians in the workplace. And I think that it's logical and rational for physicians to look around and say, "How can we regain some control over how we practice medicine? We think we're the best people to make judgments about how to practice medicine, not administrators." Physicians think they're in the best position to make these decisions. And they are, and they're going to do what they can to regain greater control over how medicine is practiced.

The only caveat I would say that I do worry about—if we suddenly go into a recession and unemployment starts growing. We know from long experience that it's going to discipline workers. Workers are not going to be quite as bold about trying to change their workplaces, about trying to organize a union.

So the big question in my field, labor and employment relations, is what's going on a fundamental change in how people view work? And is it the case that people are just not going to put up with what they put up with in the past? Or is this just a function of all of a sudden the cost of doing this, you know, is much less than it would be if we had 8% unemployment. You know, I mentioned the factors we sort of identify, which is labor market, public opinion, the political realm. The fourth thing that gives us some hope that maybe this is something that has legs is generational.

The generation of workers right now that are 18 to 30, there's a lot of research that shows that they have a very different attitude about work. They expect more out of their work life. They expect more balance in their work life. They expect their work to be more meaningful and rewarding. And they don't seem to be willing to put up with things that prior generations have put up with. You see it in the vast majority of new organizing we're seeing around the country right now. It's young people. It's Starbucks, it's Amazon, it's Trader Joe's, it's Whole Foods, it's REI, it's social media companies and platforms. You know, that makes one wonder whether employment is going to fundamentally change in the next decade going forward. I think that theory will be tested if we slide back into a recession. We'll learn the answer then.

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

MMA
Mentorship
Program

Connect with a mentor today!

The MMA Mentorship Program connects pre-med students, medical students, and residents/fellows, with mentors who help answer questions, provide advice, and offer career guidance.

mnmed.org/mentorship

Minnesota Medical Association

Cannabinoid pharmacogenomics concepts and strategies for the practicing clinician

Clinicians should be aware of the clinical implications of patients' cannabis use.

BY JESSICA WRIGHT, PHARMD*; LINDA HUANG, PHARMD*; BASANT EL-FETOUH KATAMESH, MBBCH; SIDDHANT YADAV, MD; ABHINAV SINGLA, MD; ANN VINCENT, MD *CO-FIRST AUTHOR*

Effective August 1, 2023, Minnesota legalized recreational cannabis for use by individuals 21 years and older. The resulting ease of access and availability may escalate cannabis use both recreationally and medically, based on the experience of other states that legalized cannabis.

Cannabis products affect individuals differently and can alter the metabolism of pharmaceutical agents. Clinicians should be aware of the clinical implications of patients' incorporating cannabis into their medication or recreational regimen. The purpose of this article is to raise awareness of the issues that may arise from cannabis use, particularly the major cannabinoids, cannabidiol (CBD) and tetrahydrocannabinol (THC), as it relates to side effects based on an individuals' pharmacogenomic profile and the potential for drug-cannabinoid interactions.

Cannabinoid pharmacology

Much of the data regarding CBD and THC are derived from studies (see References) on the two FDA-approved cannabinoids: dronabinol (brand name: Marinol) and cannabidiol (brand name: Epidiolex). In addition to the major cannabinoids CBD and THC, the cannabis plant produces many minor cannabinoids including cannabinol, cannabigerol, and Δ9-tetrahydrocannabinolic acid, most of which are not well studied. Cannabinoids differ in their therapeutic effects depending on the binding affinity of the cannabinoid receptors CB1 and CB2 within the endocannabinoid system (Figure 1) and mechanisms independent of these receptors. Cannabinoids are highly lipophilic; thus, their bioavailability varies based on their route of administration. Inhalation is reported to have higher bioavailability compared to ingested and topical forms. Despite the popularity of medical cannabis and indications approved by state cannabis programs, there is a deficiency of high-quality evidence supporting cannabinoid use. At the current time, indications that have moderate evidence include epilepsy, appetite stimulation, neuropathic and cancer pain, and spasticity related to multiple sclerosis.

CYP450 pharmacogenomics of cannabinoids

Predicting the pharmacologic effects of cannabis in individual patients can be complex. One of the factors that contributes to interindividual variability and response to medications and cannabinoids is an individual's cytochrome P450 (CYP450) enzyme genetic make-up and variation. CYP450 is a superfamily of enzymes that metabolize drugs and other compounds. CYP phenotype categories include poor, intermediate, normal, rapid, and ultrarapid. Whereas poor and intermediate represent decreased function (reduced metabolism of drugs), rapid and ultrarapid represent increased function (faster metabolism of drugs) compared to normal metabolizers. The likelihood of carrying particular variants of CYP genes is associated with biogeographical population (Table 1).

Additionally, both cannabinoids and drugs can independently induce or inhibit CYP450 enzymes, potentially impacting each other, further complicating the clinical picture. Although the pharmacokinetics and pharmacodynamics of cannabis pharmacology is complex, we have dis-

TABLE 1

Prevalence of altered genetic CYP activity across major biogeographical populations

BIOGEOGRAPHICAL POPULATION	REDUCED CYP2C9	REDUCED CYP2C19	INCREASED CYP2C19
Central/South Asian	40%	49%	21%
Near Eastern	39%	25%	29%
European	37%	28%	32%
African American/Afro-Caribbean	24%	35%	28%
Sub-Saharan African	27%	34%	24%
American (Native to the Americas)	17%	23%	14%
East Asian	16%	59%	3%
Pacific Islander	9%	94%	2%

tilled the information into the most salient points for the practicing clinician.

Cannabinoids are metabolized by the CYP450 superfamily. THC is primarily metabolized by CYP2C9 and CYP3A4 while CBD is principally metabolized by CYP2C19 and CYP3A4. Epidemiology reports show that patients will have more CYP2C9 and CYP2C19 genetic variants compared to CYP3A4. Rates of atypical CYP2C9 and CYP2C19 phenotypes are described in Table 1. Therefore, if an individual with a clinically significant variant in CYP2C9, CYP3A4, or CYP2C19 consumes cannabis, they may experience altered efficacy and adverse effects. For example, a patient who is a CYP2C19 ultrarapid metabolizer may have increased clearance of CBD and therefore may require larger doses to produce a therapeutic effect. Conversely, a CYP2C9 poor metabolizer who consumes an otherwise typical dose of THC could have decreased clearance of THC, resulting in prolonged exaggerated adverse effects compared to most individuals. Finally, drug-cannabinoid interactions can also alter CYP450 enzyme function, thereby impacting blood levels of cannabinoids. For example, a patient taking fluoxetine, a CYP2C19 inhibitor, who decides to start CBD (metabolized by CYP2C19) may experience adverse effects related to increased levels of CBD.

Cannabis and pharmacogenomics are both relatively new fields for investigation. Clinical grade data regarding the relevance of CYP activity as predicted by pharmacogenomics testing are still forthcoming. Until the evidence is published, it is still important to be aware of the potential for these genetic interactions.

CBD and THC inhibit many CYP450 enzymes, influencing commonly used medications in clinical practice. For example, according to Stout and Cimino, CBD and THC can increase the levels and risk of side effects of some beta blockers (metoprolol, bisoprolol), some calcium channel blockers (amlodipine), select antidepressants (paroxetine, vortioxetine, tricyclic antidepressants), select anticoagulants (apixaban, warfarin), some nonsteroidal anti-inflammatory agents (ibuprofen, celecoxib, meloxicam), and certain sulfonylureas (glyburide). Other drugs may have decreased efficacy when used concurrently with cannabinoids (antiplatelet agent clopidogrel and the opioids tramadol and codeine). The medications mentioned here are not a comprehensive list; consulting with a pharmacist is recommended for an individualized review when drug-cannabinoid interactions might occur.

TABLE 2

Medical cannabis qualifying medical conditions in Minnesota

- Alzheimer's disease
- Amyotrophic lateral sclerosis
- Autism spectrum disorder
- Cachexia
- Cancer-associated pain
- Chronic motor or vocal tic disorder
- Chronic pain
- Crohn's disease
- Glaucoma
- HIV/AIDS
- Irritable bowel syndrome
- Nausea/vomiting
- Obsessive compulsive disorder
- Obstructive sleep apnea
- Post-traumatic stress disorder
- Seizures
- Severe muscle spasm associated with multiple sclerosis
- Sickle cell disease
- Terminal illnesses with less than one year life expectancy
- Tourette syndrome

Practical guidance for clinicians

The changing landscape of cannabis access in Minnesota has created some unique scenarios for the practicing clinician. Information typically available during pharmaceutical development including safety, adverse effects, and drug-drug interactions is currently deficient for cannabis products. Further complicating the matter is the lack of standardization of the over-the-counter products, including newly available recreational formulations and cannabis that the patient can grow at home. With these challenges, we propose practice-related suggestions for clinicians to keep in mind.

1. *Document patient usage of cannabinoids including dosage, frequency, and route of administration in the medical record.* Frequently, the label may have the total cannabinoid content of the entire bottle and not cannabinoid content per serving size of the product. For assistance with calculating dose or evaluation as to whether the dose is within a general therapeutic or toxic range, consider consulting with a pharmacist, preferably one with cannabis expertise. Other resources with dosages of cannabinoids include NatMed Pro (naturalmedicines.therapeuticresearch.com/) and Health Canada's website (canada.ca/en/health-canada/services/drugs-medication/cannabis/information-medical-practitioners/information-health-care-professionals-cannabis-cannabinoids.html) regarding cannabis information for healthcare professionals.
2. *Recognize that cannabis products can vary in quality.* In states such as Minnesota where cannabis is medically legal, patients can obtain therapeutic-grade products from state dispensaries (https://www.health.state.mn.us/people/cannabis/patients/locations.html). If patients are unable to utilize a state dispensary, we propose guiding patients to use a cannabis product with a certificate of analysis, which will include information regarding cannabinoid content, batch number and safety testing information on pesticide, heavy metals, microbials, and mycotoxins. These certificates may be available in package inserts of the product or available on the manufacturer's website. On a related note, the state of Minnesota is planning to create several additional cannabis-testing facilities.
3. *Familiarize oneself with indications in which cannabis has shown efficacy.* Although a few studies point to the potential for cannabis benefit in conditions such as chronic pain, anxiety, insomnia, and PTSD, conclusive data are still lacking. We also recommend clinicians

familiarize themselves with the qualifying medical conditions listed in the Minnesota Medical Cannabis program (Table 2) because patients who have one of these conditions can apply for a cannabis medical card which allows access to state resources for dosing and selection of products. Although the specific dosages of cannabinoids for many indications is currently ambiguous, we direct clinicians to a resource such as NatMed Pro and Health Canada's website regarding cannabis information for healthcare professionals for dosages of cannabinoids.

4. *Assess for potential interactions between cannabis, genetic profile, and the patient's medications to provide the patient with individualized care:*
   a. For patients who had pharmacogenomics testing, we propose taking these results into account when guiding cannabis therapy and consulting with a pharmacogenomics pharmacist specialist, if available, to assist in applying these results.
   b. For patients who have not had pharmacogenomics testing and there is concern about cannabis side effects or efficacy, we propose consideration of pharmacogenomics testing.
   c. For patients with polypharmacy or other drug interaction potential, we propose checking drug-cannabis interactions utilizing institutionally available drug interaction software. Clinicians need to be aware that current drug interaction checkers may not provide complete information about CYP450 interactions. Until tools are further developed, utilization of pharmacology knowledge regarding CYP450 metabolism can help infer cannabis-drug interactions. This can be facilitated through consultation with a pharmacist, or synthesized through resources such as Lexicomp and PDR (Physicians' Desk Reference).

TABLE 3

Adverse effects of cannabis

PSYCHIATRIC	CENTRAL NERVOUS SYSTEM / COGNITION	RESPIRATORY/ CARDIOVASCULAR	GASTROINTESTINAL
Anxiety in naive users	Dizziness/loss of balance	Tachycardia	Nausea/vomiting
Panic attacks in naive users	Cognitive impairment	Hypotension	Cannabis hyperemesis syndrome
Increased risk of psychosis in vulnerable and naive users	Hallucination	Airway inflammation (inhaled route)	Appetite changes
Potential for cannabis addiction and dependency	Somnolence	Decreased lung function (inhaled route)	Dry mouth
Euphoria	Driving impairment	Increased risk of coronary artery disease	Abdominal cramping/pain

5. *Understand the spectrum of adverse effects of medical cannabis, including effects on the cardiovascular system, respiratory system, central nervous system, cognition, and mental health (Table 3).*

6. *Recognize clinical scenarios where patients are at higher risk for cannabis-related adverse events*.
   a. All patients undergoing anesthesia should be assessed for cannabis use. Higher doses can lead to cardiovascular and pulmonary perioperative complications and increase the need for pain medications. Any perioperative tapering or discontinuation goals need to be met at least one week prior to surgery. Tapering within the week prior to surgery is discouraged due to potential for withdrawal.
   b. Patients with active cannabis use who are admitted to the hospital for any reason are at risk for cannabis withdrawal and should be monitored. Similarly, communication during transitions of care should include information regarding cannabis use.
   c. Patients who are at risk of becoming pregnant will need counseling on the effects of cannabis due to potential fetal harm and other complications during pregnancy.
   d. Patients with psychiatric disorders should be monitored when initiating or changing cannabis use. Clinicians should also be mindful that cannabis has been associated with psychiatric adverse effects despite being studied for the management of psychiatric disorders.
   e. Patients using central nervous system depressants such as opioids and benzodiazepines are at risk for additive sedative effects when taken together with cannabis.
   f. Patients with substance use disorders who use cannabis may require closer monitoring in conjunction with their substance abuse treatment plan.

Conclusion/future directions

Legalization of recreational cannabis is likely to continue nationwide, and with it patient use is likely to increase. Clinicians are treading carefully, and many are feeling unprepared as we advance into uncharted territories. It is apparent that pharmacogenomic implications and drug-drug interactions are important considerations. As clinicians, we should keep our patients safe in the current environment, participate in research, and advocate for cannabis best practices in our institutions. **MM**

Jessica Wright, PharmD, BCACP, is a pharmacogenomics pharmacist at Mayo Clinic in Rochester. Linda Huang, PharmD, BCACP, is a medication management services pharmacist specializing in general internal medicine at Mayo Clinic in Rochester. Basant Katamesh, MBBCh, is a research trainee at Mayo Clinic in Rochester. Siddhant Yadav, MD, and Abhinav Singla, MD, are senior associate consultants in general internal medicine at Mayo Clinic in Rochester. Ann Vincent, MD is a consultant in general internal medicine at Mayo Clinic in Rochester.

REFERENCES

Arellano AL, Papaseit E, Romaguera A, Torrens M, Farre M. Neuropsychiatric and general interactions of natural and synthetic cannabinoids with drugs of abuse and medicines. CNS Neurol Disord Drug Targets. 2017;16:554–566.

Canada Go. Information for health care professionals: cannabis (marihuana, marijuana) and the cannabinoids: Health Canada.

Chayasirisobhon S. Mechanisms of action and pharmacokinetics of cannabis. Perm J. 2020;25:1–3.

Connor JP, Stjepanovic D, Budney AJ, Le Foll B, Hall WD. Clinical management of cannabis withdrawal. Addiction. 2022;117:2075–2095.

D'Souza DC, Ranganathan M. Medical marijuana: Is the cart before the horse? JAMA. 2015;313:2431–2432.

Epidiolex prescribing information: Greenwich Biosciences, Inc.

Flanagan OoGTWLGP. PHOTOS: Governor Walz signs bill legalizing adult-use cannabis in Minnesota starting August 1, 2023.

Hall W, Lynskey M. Assessing the public health impacts of legalizing recreational cannabis use: the US experience. World Psychiatry. 2020;19(2):179–186.

Hayer S, Mandelbaum AD, Watch L, et al. Cannabis and pregnancy: a review. Obstet Gynecol Surv. 2023;78:411–428.

Health MDo. Medical cannabis program key dates 2023.

Ladha KS, McLaren-Blades A, Goel A, et al. Perioperative Pain and Addiction Interdisciplinary Network (PAIN): consensus recommendations for perioperative management of cannabis and cannabinoid-based medicine users by a modified Delphi process. Br J Anaesth. 2021;126:304–318.

Lee CR, Luzum JA, Sangkuhl K, et al. Clinical pharmacogenetics implementation consortium guideline for CYP2C19 genotype and clopidogrel therapy: 2022 update. Clin Pharmacol Ther. 2022;112:959–967.

Marinol prescribing information: Solvay Pharmaceuticals, Inc.; 2006.

Ortiz-Medina MB, Perea M, Torales J, et al. Cannabis consumption and psychosis or schizophrenia development. Int J Soc Psychiatry. 2018;64:690-704.

Preissner SC, Hoffmann MF, Preissner R, Dunkel M, Gewiess A, Preissner S. Polymorphic cytochrome P450 enzymes (CYPs) and their role in personalized therapy. PLoS One. 2013;8:e82562.

Sevigny EL. Cannabis and driving ability. Curr Opin Psychol. 2021;38:75-79.

Shah S, Schwenk ES, Sondekoppam RV, et al. ASRA Pain Medicine consensus guidelines on the management of the perioperative patient on cannabis and cannabinoids. Reg Anesth Pain Med. 2023:rapm-2022-104013.

Skipina TM, Patel N, Upadhya B, Soliman EZ. Cannabis use is associated with prevalent coronary artery disease. Am J Med Sci. 2022;364:304–308.

Solmi M, De Toffol M, Kim JY, et al. Balancing risks and benefits of cannabis use: umbrella review of meta-analyses of randomised controlled trials and observational studies. BMJ. 2023;382:e072348. Published 2023 Aug 30. doi:10.1136/bmj-2022-072348

Stout SM, Cimino NM. Exogenous cannabinoids as substrates, inhibitors, and inducers of human drug metabolizing enzymes: a systematic review. Drug Metab Rev. 2014;46:86–95.

Stresser DM, Mason AK, Perloff ES, et al. Differential time- and NADPH-dependent inhibition of CYP2C19 by enantiomers of fluoxetine. Drug Metab Dispos. 2009;37:695–698.

Testai FD, Gorelick PB, Aparicio HJ, et al. Use of marijuana: effect on brain health: a scientific statement from the American Heart Association. Stroke. 2022;53:e176–e187.

Theken KN, Lee CR, Gong L, et al. Clinical Pharmacogenetics Implementation Consortium guideline (CPIC) for CYP2C9 and nonsteroidal anti-inflammatory drugs. Clin Pharmacol Ther. 2020;108:191–200.

Urits I, Charipova K, Gress K, et al. Adverse effects of recreational and medical cannabis. Psychopharmacol Bull. 2021;51:94–109.

Werk AN, Cascorbi I. Functional gene variants of CYP3A4. Clin Pharmacol Ther. 2014;96:340–348.

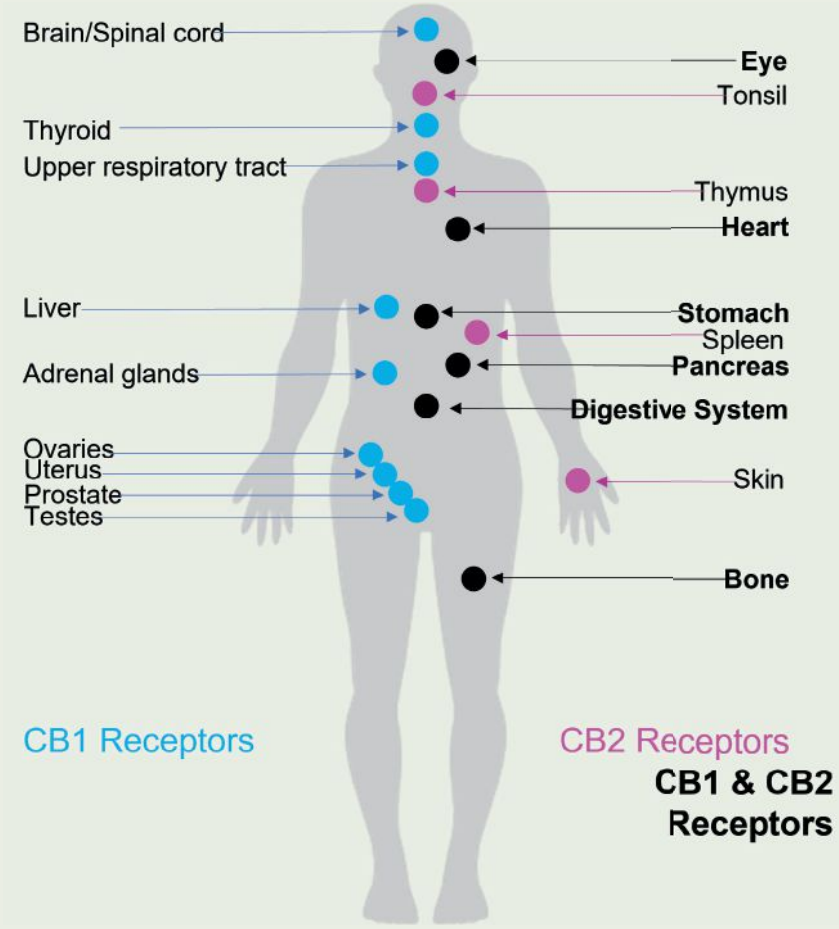
Whirl-Carrillo M, McDonagh EM, Hebert JM, et al. Pharmacogenomics knowledge for personalized medicine. Clin Pharmacol Ther. 2012;92:414–417.

Whiting PF, Wolff RF, Deshpande S, et al. Cannabinoids for Medical Use: A systematic review and meta-analysis. JAMA. 2015;313:2456–2473.

FIGURE 1

CB1 and CB2 receptor distribution

CB1 receptors are expressed in the brain, spinal cord, and peripheral nervous system both in inhibitory GABA neurons and excitatory glutamatergic neurons. CB2 receptors are expressed in the immune system, hematopoietic system, and glial cells.



MMA will lobby Legislature on prior authorization, other vital issues

Although it's not a budget year, the Minnesota Legislature is likely heading into the next session with a surplus that is projected to be at least $2.4 billion, so a supplemental budget will be debated.

"Whenever there is a surplus there are expectations among interest groups for more spending," says Dave Renner, MMA director of advocacy. "With all House seats up next fall, legislative leaders are deciding how much to spend, how much to return in tax cuts, and how much to leave for next year."

One certainty is that there will be several bills dealing with how medicine is practiced in Minnesota, and that's where the MMA comes in. This next session, the MMA's advocacy team will focus on the following five priorities approved by the MMA Board of Trustees in November:

Prohibit the use of prior authorization (PA) for services where we don't want barriers to care. This includes eliminating PA for preventive services, generic drugs, outpatient cancer treatment, outpatient mental health/chemical dependency treatment, and medication-assisted treatment (MAT). In addition, the MMA will work toward limiting PA for chronic conditions to just a one-time approval, eliminating PA for value-based contracts, and eliminating PA for providers whose approval rates are within the norm for approvals.

Limit mid-year formulary changes for prescription drugs. This ensures that patients can't be forced by their insurer to change medications until the end of their health insurance contract. It also requires that health plans use "real-time benefit tools" to inform practitioners whether a prescribed drug is covered.

Promote physician wellness services. This includes prohibiting credentialing applications from asking applicants about past health issues; protecting medical information disclosed as part of SafeHaven, the MMA's new confidential, physician wellness program; and funding a public awareness campaign to encourage physicians to seek care. It also would include establishing a recognition program for hospitals and systems that promote workforce wellness.

Implement and fund an electronic registry for POLST (Provider Orders for Life Sustaining Treatment) forms.

Address substance use morbidity and mortality through a public health lens by supporting the legislative work of the Harm Reduction Collaborative. This would include promoting the use of MAT in prisons, jails, and sober homes; and strengthening Minnesota's Good Samaritan law for seeking help during a drug overdose and providing safe recovery sites. MM

Save the date: Physicians' Day at the Capitol scheduled for February 28

Physicians and physicians-in-training from across the state will don white coats and gather again in-person at the state Capitol February 28 to advocate on behalf of medicine.

The annual get-together will include a presentation from a key legislator, a review of top priorities, and tips on how to interact effectively with elected officials. Most importantly, it includes scheduled meetings with your personal legislators.

"This day is so important for the MMA and the attendees," says MMA President Laurel Ries, MD. "Physicians need to meet with representatives and senators to make sure they understand how the legislation they are passing affects patients and the practice of medicine in Minnesota."

The MMA is partnering with several specialty societies to promote the event, including the Minnesota Academy of Family Physicians; the Minnesota Academy of Ophthalmology; American College of Cardiology–Minnesota Chapter; the Minnesota Chapter, American College of Emergency Physicians; District VI of the American College of Obstetricians and Gynecologists; the Minnesota Chapter of the American College of Physicians; the Minnesota Osteopathic Medical Society; the Minnesota Psychiatric Society; and the Zumbro Valley Medical Society.

News Briefs

Minnesota hospitals keep losing money

The Minnesota Hospital Association (MHA) released last month an analysis of hospital and health system finances that shows losses growing at many of the state's major healthcare providers.

Data collected from MHA members show ongoing financial losses nearly tripled in some cases. Key findings of the analysis include:

- Median hospital and health system operating margins declined from -0.5% in 2022 to -2.7% in the first half of 2023.
- 67% of hospitals and health systems in the MHA analysis had negative operating margins, which means they were losing money. This is up from 55% of hospitals and health systems that had negative margins in 2022.
- The costs of labor grew by 7%, and supply and service costs grew by 6%.

Nearly a quarter of member hospitals and health systems reported labor costs rising by double-digit percentage points, and a third of hospitals said supply and service costs had risen by more than 10% over 2022.

The losses also correspond to a rise from 62% to 64% in the proportion of Medicare and Medicaid patients reported by nearly every hospital. Those programs continue to reimburse providers well below the actual cost of providing care, routinely underpaying an estimated 27% below cost for Medicaid, and 20% below cost for Medicare.

Programs have closed and care has been cut at more than 50 hospitals across the country already in 2023 and hundreds more could follow. Nearly 30% of U.S. rural hospitals are facing closure, according to the Center for Healthcare Quality and Payment Reform, and that could include as many as a half-dozen in Minnesota if urgent action is not taken.

The nonpublic financial data referenced in the analysis is provided voluntarily by hospitals and health systems in Minnesota. It is not audited financial data but is more current than public financial reports issued by the hospitals and health systems. The data comes from more than 70 hospitals that are members of the MHA. It includes both large health systems and small rural hospitals in Minnesota.

MMA members get discount on DEA training on opioids

Since last June, DEA license holders, upon initial registration or renewal, have been required to complete at least eight hours of training in the treatment or management of patients with opioid or other substance use disorders.

The MMA has recently partnered with Clinical Education Alliance (CEA) to offer a one-stop resource to fulfill this training.

If you have already completed the MMA's Best Practices in Prescribing Opioids and Other Controlled Substances, you can apply the two hours of credit earned toward the eight-hour requirement. This course was available from January 22, 2020 through December 31, 2022. If you need evidence of completion, contact the MMA at cme@mnmed.org.

For the six remaining hours (or all eight if you haven't completed any training), open the website using the QR code at right.

Developed in collaboration with renowned experts, this comprehensive training equips healthcare professionals with the necessary knowledge and skills to optimize patient care while meeting the requirements set forth by the DEA. Dive into key topics, including substance use disorders, pain management, DEA regulations, reimbursement codes, and much more.

Gain a deep understanding of best practices and evidence-based approaches for safe and effective prescribing practices. Led by experienced faculty, the course offers an interactive learning experience with engaging lectures, case studies, and interactive discussions fostering collaboration and knowledge exchange with peers. Earn course credits including *AMA PRA Category 1*, Board MOC and MIPS improvement activity.

Learn at your own pace with the self-guided on-demand course. MMA members can apply the following code (MNMED100) to receive a $100 discount for the course cost of $299.

New training focuses on serious illness conversations

The Center for Advancing Serious Illness Communication (CASIC), a joint program of the MMA and Minnesota Hospital

The Center for ADVANCING SERIOUS ILLNESS COMMUNICATION
A JOINT INITIATIVE OF THE MMA & MHA

Association, has launched its first series of on-demand training to introduce healthcare providers and other members of care teams to serious illness conversations (SIC).

CASIC, which is sponsored by Blue Cross and Blue Shield of Minnesota, is focused on:

- Creating a dedicated statewide community standard on how to address SIC, with a focus on training, implementation, and workflow processes.
- Encouraging consistent and higher usage of SIC by providers.
- Helping normalize the practice across all healthcare organizations to the benefit of patients, their families and clinicians.

This three-module introductory training series begins the process of preparing clinicians and healthcare organizations to engage every patient experiencing a serious illness in meaningful discussions about their diagnosis, prognosis, and care choices. It focuses on the Serious Illness Communication Guide, an evidence-based tool developed by Ariadne Labs, which is a joint center for health systems innovation at Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health.

"We're excited to be launching this important training," said Janet Silversmith, MMA CEO. "Patients deserve compassionate and reliable support from their clinical team in understanding their prognosis and in prospectively defining the care that they do and don't want to receive. This program seeks to make those conversations the rule, rather than the exception."

The free training is available to all members of care teams who work with patients with serious illnesses. The modules are taken in sequence, as each subsequent module builds on the knowledge gained in previous modules. They can be accessed on the CASIC website (advancingsic.org/training-and-events).

These modules are CME-eligible for physicians. Other health professionals who participate in this CME activity may submit their statement of attendance to their appropriate accrediting organizations or state boards for consideration of credit. They will be a prerequisite for more extensive virtual classroom training launching in early 2024, which will focus on learning how to conduct these conversations effectively and with confidence using role-playing techniques, as well as how to incorporate them into day-to-day workflows.

Minnesota physician launches campaign for Congress

In November, state Sen. Kelly Morrison, MD, DFL-Deephaven, launched her campaign for Minnesota's 3rd Congressional District, a seat currently held by Rep. Dean Phillips, who launched his presidential campaign in October.

PHOTO BY KATHRYN FORSS

Sen. Kelly Morrison, MD, speaks to attendees at the MMA's Physician Day at the Capitol in 2023.

Morrison, an OB/GYN and MMA member, has served in the Minnesota Legislature since 2019 and has worked on numerous health-related legislative issues. She's championed multiple MMA legislative priorities, including issues related to prior authorization reform, reproductive healthcare, mental health and well-being, lowering costs of prescription drugs, and increasing access to affordable healthcare for Minnesotans. Morrison has also been featured multiple times at MMA's Day at the Capitol and at several MMA advocacy events.

Morrison served her first two terms in the Minnesota House before winning her Senate seat in 2022. She has historically won tightly contested elections in politically diverse districts. She won her 2018 and 2020 elections by only 216 and 313 votes respectively before winning her current seat in the Minnesota Senate by more than 6,000 votes.

Morrison is a native Minnesotan. She received her undergraduate degree from Yale University and her medical degree at Case Western Reserve University School of Medicine.

Task force on pregnancy and substance misuse starts work

The Task Force on Pregnancy Health and Substance Use Disorders, set up by the Legislature earlier this year, met for the first time in October to lay the groundwork for recommending protocols for when physicians, advanced practice registered nurses, and physician assistants should administer a toxicology test and requirements for reporting for prenatal exposure to a controlled substance.

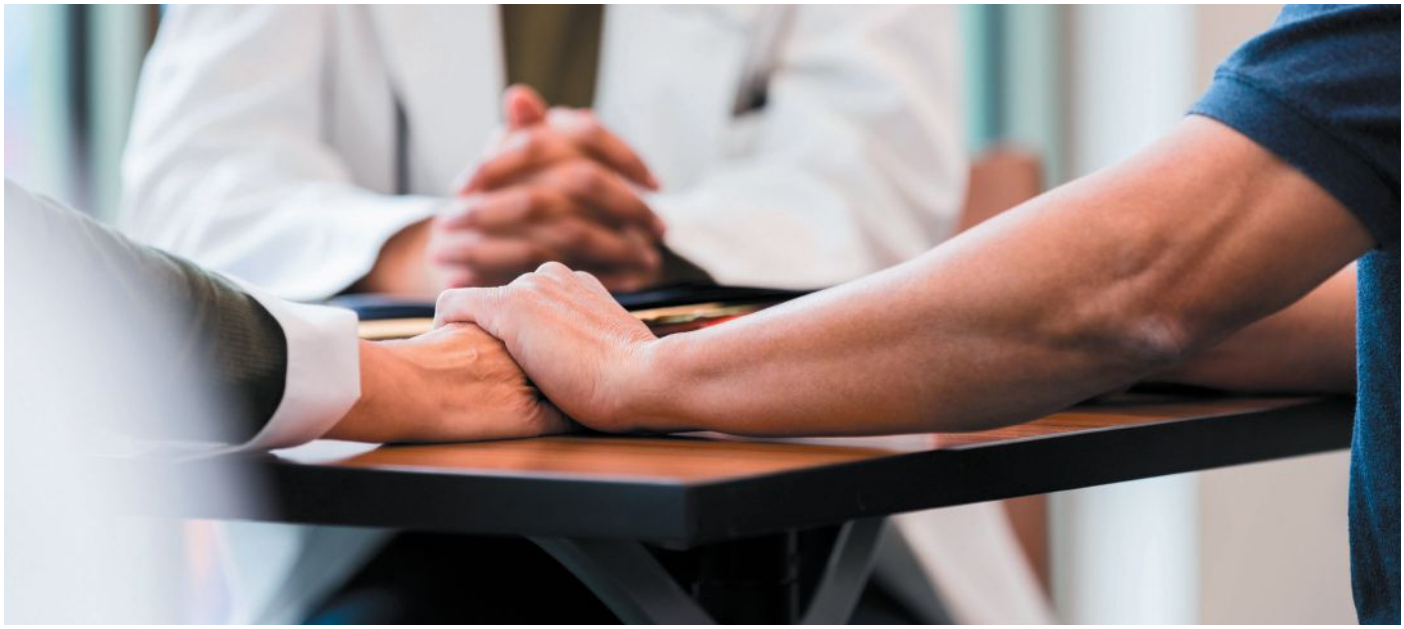
Kurt DeVine, MD, FASAM, from CentraCare—St. Cloud Hospital Addiction Services is officially representing the MMA on the task force. Two other MMA members are also serving: Cresta Jones, MD, representing the American College of Obstetricians and Gynecologists; and Chris Derauf, MD, representing the Minnesota Perinatal Quality Collaborative.

Members of the task force will develop recommended protocols for when a toxicology test for prenatal exposure to a controlled substance should be administered to a birthing mother and a newborn infant. The task force must also recommend protocols for providing notice or reporting of prenatal exposure to a

The Center for ADVANCING SERIOUS ILLNESS COMMUNICATION

A JOINT INITIATIVE OF THE MMA & MHA

www.advancingsic.org



The Center for Advancing Serious Illness Communication

invites you to participate in our three-module on-demand training series. The series will introduce you to serious illness communication and to the Serious Illness Communication Guide, an evidence-based tool developed by Ariadne Labs, which is a joint center for health systems innovation at Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health.

The training is available **at no cost** and available to all care team members serving patients with serious illness. These modules have been approved for CME credits.

The modules include:

Part 1: Serious Illness Communication—An Introduction

Part 2: The Serious Illness Conversation Guide

Part 3: Implementing Serious Illness Communication

Please visit our website at ***www.advancingsic.org/training-and-events*** to learn more and to view the training videos.

Minnesota Hospital Association

Minnesota Medical Association

The Center for Advancing Serious Illness Communication is a joint project of the Minnesota Medical Association and the Minnesota Hospital Association.

BlueCross BlueShield Minnesota

Funding for this project is provided by Blue Cross and Blue Shield of Minnesota, as part of their long-term commitment to improving the health of Minnesota communities, and ensuring that all people have opportunities to live the healthiest lives possible.

controlled substance to local welfare agencies under Minnesota Statutes, Chapter 260E.

By no later than December 1, 2024, the task force must submit a written report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services on the task force's activities and recommendations on the protocols developed.

Stay tuned to MMA's *News Now* for updates on task force efforts, as their work progresses.

MMA offers cross-cultural assessment to aid health equity

The MMA is now offering free intercultural development resources to members and member organizations with diversity, inclusion, and health equity goals.

The Intercultural Development Inventory® (IDI) is the premier cross-cultural assessment of intercultural competence. It can be used in a variety of ways, such as for individual development, for group/team training and development, or for baseline assessments and organizational development.

"It is essential that healthcare organizations are effective at engaging diversity and cultural differences, if we want to achieve equity and inclusion goals," said Edwin Bogonko, MD, MBA, the MMA's president-elect. "The IDI is a tool which can be used to build intercultural skills, in both individuals and organizations, and move us toward those goals."

Some organizations offer the IDI to physicians, while some offer it to leadership. Interested healthcare organizations can work together with the MMA's qualified administrator to determine how to best utilize the IDI to meet their needs. The MMA is offering this opportunity to a limited number of organizations.

If you are interested in learning more about bringing the IDI to your organization, contact Haley Brickner, (hbrickner@mnmed.org) the MMA's health equity coordinator and IDI administrator.

State court backs Children's Minnesota on health records

In mid-October, the Minnesota Supreme Court published its opinion in a case that pits the Minnesota Health Records Act (MHRA) against the federal Health Insurance Portability and Accountability Act (HIPAA).

Minnesota is one of only a handful of states that has a state health records law that offers more protections to patients than HIPAA. This has caused headaches for healthcare providers and facilities when they try to comply with both laws.

Parents of a patient at Children's Minnesota sued the hospital for releasing their child's health records to the Children's Minnesota foundation, without their consent. The parents argued that the MHRA allows only for the release of health records on two occasions: (1) with the proper written consent of the patient or their representative, and (2) with specific authorization in law. The parents claim that because the MHRA generally provides more protections of health records, the specific authorization in law must come from a state law and that a federal law, such as HIPAA, cannot provide authorization.

The district court, appellate court, and now the Minnesota Supreme Court have all sided with Children's Minnesota, finding that the specific authorization in law could come from a federal law such as HIPAA.

HIPAA allows for the use or disclosure of protected health information for "treatment, payment, or healthcare operations." This exception is broad and includes fundraising activities, which is the exception that Children's Minnesota and other Minnesota facilities rely upon.

The decision made by the Minnesota Supreme Court is a win for facilities and healthcare providers because it will allow them to conduct their business activities without additional burdens, but while continuing to protect patients' protected health information.

Report: Adverse health events increased in MN in 2022

The number of reportable adverse health events in Minnesota hospitals, ambulatory surgical centers, and community behavioral health hospitals increased in 2022, according to a recent report from the Minnesota Department of Health (MDH).

Prior to 2021, the overall number of events had been stable. However, for the second year in a row, MDH observed a rise in the number of incidents. The report notes that this is likely due to ongoing pandemic-related effects that continue to be felt across the state's healthcare system: "Clinicians were forced to adapt in real time as hospitals

and health systems took care of sicker, higher acuity patients with multiple health concerns and significantly longer lengths of stay."

Minnesota's mandatory adverse health event reporting system includes 29 often preventable errors that could lead to serious injury or death. The goal of the system is to balance quality improvement with accountability, while developing opportunities for providers to learn from each other about how to prevent adverse events.

As in years past, pressure ulcers and falls were the most common events reported. Pressure ulcers, which can sometimes be associated with longer stays, drove most of the overall increase noted in the report, while falls decreased slightly compared to 2021.

The report is an analysis of data collected from healthcare providers from October 7, 2021, through October 6, 2022. It includes a total of 572 events, up from the 508 recorded in 2021 and 190 more than the 383 events reported in 2020. And though the data showed a drop in the number of serious injuries, the 21 reported deaths are the most since 2006, when 24 deaths were recorded.

AMA leader addresses All Gender Health 2023 conference

New AMA President Jesse Ehrenfeld, MD, MPH, spoke at Rainbow Health's All Gender Health 2023 conference in late October in St. Paul. The MMA sponsored the event.

"It was a great meeting," said MMA President Laurel Ries, MD, who introduced Ehrenfeld. "Lots of positive, optimistic, and productive conversation."

The conference, with the theme "Beyond Barriers, Beyond Binaries: Navigating Health and Legal Landscapes," brought together a diverse community of lawyers, advocates, providers, and community members who are committed to challenging and overcoming systemic and institutionalized barriers that disproportionately impact LGBTQ+ communities.

In June, Ehrenfeld became the first openly gay president of the AMA. Ehrenfeld is a senior associate dean, tenured professor of anesthesiology, and director of the Advancing a Healthier Wisconsin Endowment at the Medical College of Wisconsin. For the past two decades, he has been a nationally recognized advocate for LGBTQ+ communities. MM

FROM THE CEO

How the MMA helps you invest in yourself

Happy New Year!

Many of us like to think of a new year as a fresh start—a blank slate upon which we can chart our plans, hopes, and dreams for the next 12 months. The turning of a page on a calendar, of course, does not erase the real challenges that remain in our world, communities, or lives. But for me it offers a time for fresh perspective, renewed energy, and rekindled optimism for progress.

One way to make progress is to make a commitment—a resolution. A new program we recently launched is a perfect choice for those of you who are resolved this year to invest more in yourself.

The MMA's SafeHaven program is a confidential and independent resource designed to help physicians promote work-life balance, relieve stress and burnout, and support overall well-being. The program, managed by national expert VITAL WorkLife, offers a variety of high-value services, including peer coaching on topics such as career growth, grief and loss support, and communication skills; counseling sessions for you and your family members with licensed behavioral health professionals; a WorkLife Concierge service that offers an all-purpose, 24-7 virtual assistant to help manage day-to-day tasks and maximize time; and, legal and financial planning resources.

Importantly, SafeHaven is confidential and independent of your practice or employment. This independent feature is what makes this program so unique. Time and again physicians have told us that despite their employer or practice offering employee assistance–type services, they are reluctant to access such services for fear of the ramifications to their privacy and career. Thanks to grant funding from The Physicians Foundation, the MMA is excited to offer SafeHaven at a discounted price of only $99 for the first 75 MMA members who subscribe. You can learn more online at www.mnmed.org; look for SafeHaven under the Resources tab.

There are many other ways the MMA helps you invest in yourself, including continuing education courses, leadership development programming, professional networking, and by providing you with a platform to have a voice in healthcare. By adding your voice to the voices of other physicians across the state, you can change the health of your community and how healthcare is delivered, financed, and accessed. And we need your help.

This year, the MMA has set a legislative advocacy agenda that continues to advance our mission to make Minnesota the healthiest state and the best place to practice medicine. Among our key priorities for 2024 are: reducing substance use morbidity and mortality through harm reduction strategies; promoting clinician well-being; securing funding for an electronic POLST (Provider Orders for Life Sustaining Treatment) registry; limiting mid-year formulary changes; and reining in prior authorization abuses.

This is an aggressive agenda, but I'm excited about our prospects. The easiest way for you to add your voice is to attend the **2024 Physicians' Day at the Capitol** on Wednesday, February 28. The MMA will schedule meetings for you with your legislators, provide you with tips for a successful meeting, and offer talking points and other resources. Please plan to attend!

The MMA is here to help you succeed and I'm proud of the ways—old and new—that we help you care for you.

Here's to a productive 2024!

Janet Silversmith
JSilversmith@mnmed.org

PHYSICIANS' DAY AT THE CAPITOL

SAVE THE DATE

Wednesday, February 28, 2024

ADVOCATE FOR YOUR PROFESSION

www.mnmed.org/education-and-events/Day-Capitol

VIEWPOINT

Our No. 1 headache needs to be cured

Kimberly Tjaden, MD
MMA board chair

Haven't we been through this before? We pass legislation that we think will help a problem, but the problem gets worse. As the new legislative session looms, the MMA is once again focused on reducing insurer interference, specifically when it involves making sure patients get the critical services they need.

If you are like me, you experience the headache of prior authorization (PA), or insurers' changing their covered drugs, regularly in your day-to-day practice. How many of these examples sound familiar?

- A patient is in critical need of an MRI and the insurer, never having seen the patient, says it isn't medically necessary.
- A patient on asthma medication for years suddenly has to change their prescription because the insurer changes its formulary. Now, the patient needs to learn how to use a new device, despite having a med that already worked for them.
- A patient stabilized for substance abuse disorder with medication assisted treatment (MAT) is required to get PA to continue on their recovery.

Insurers often require PA even with inexpensive, generic medications. Patients are forced to make a change, then we need to do labs or follow-up visits to make sure the new meds are working. This requires the patient to make another visit, lose time at work, and submit to more lab work.

Another issue is that we have value-based measures that we are required to meet for incentives for insurance companies. For example, an A1C in a diabetic should be under 7. There are amazing medications that get us to that goal within several months but are later removed from formularies or are changed. We often see patients who were in range, now go out of range again due to the difficulty acquiring medications. Insurance companies pay us based on reaching certain goals but take away the tools that help us meet those goals.

It is so frustrating. Legislation is needed to reduce hassles that get in the way of good patient care. This session, the MMA is working on two bills to address this. One bill will prohibit insurers and health plans from forcing a patient to change to a new drug mid–contract year, once a therapy begins. Patients often choose their insurance company or health plan based on the medications that work for them and whether an insurer covers those drugs. This is especially true for patients with chronic conditions such as MS, rheumatoid arthritis, epilepsy, or mental illness. When an insurance company or a pharmacy benefit manager changes a formulary for financial reasons, it can force a patient to change drugs, which can lead to serious harm.

The second bill prohibits the use of PA for services in which it is just wrong to create barriers to care. This would include basic services such as preventive care and generic drugs. We also want to eliminate PA on services in which delays of care can be very harmful, such as outpatient cancer treatment, outpatient mental health/chemical dependency treatment, and MAT. In addition, the MMA will work toward limiting PA for chronic conditions to just a one-time approval, eliminating PA for value-based contracts, and eliminating PA for providers whose approval rates are within the norm for approvals.

The MMA acknowledges the role that PA requirements and preferred drug lists play in reducing costs. But when they get in the way of ensuring patients receive the care they need, they must be stopped.

MMA is once again focused on reducing insurer interference, specifically when it involves making sure patients get the critical services they need.

safe haven™
CONFIDENTIAL SUPPORT

Rediscover meaning, joy and purpose in medicine.

MMA now offers a member benefit with MMA SafeHaven, a subscription to a suite of resources created to address career fatigue and promote work/life balance.

MMA will cover 75% of the cost of the service to the first 75 actively practicing members who enroll, offering it for **only $99 for an annual subscription.**

Scan the QR code to sign up today!

safehavenhealth.org/enroll/mma

Clinician Peer Coaching
Talk with someone like you who can help you grow both personally and professionally

Counseling
Virtual counseling sessions are available for you and your family

Support When You Need It
In-the-moment telephonic support is available 24/7

WorkLife Concierge
A virtual assistant to help with every day and special occasion tasks

VITAL WorkLife App
Mobile access to resources, well being assessments, insights, videos and more

Minnesota Medical Association

LINDSEY YOCK, MD, JD

- Pediatric hospitalist at Children's Minnesota, board certified in both pediatrics and pediatric hospital medicine. The majority of my time is spent in clinical practice. I also work as an advisor for governance and medical affairs at Children's, supporting both the employed and independent clinicians of the professional staff and the hospital's leadership.
- MMA member since 2007. Member of the Ethics and Medical-Legal Affairs Committee.
- Formerly served on the board of the Minnesota Chapter of the American Academy of Pediatrics.
- Grew up in Edina.
- Attended Harvard (biochemistry 2004); then University of Minnesota Law School (2008) and University of Minnesota Medical School (2011). My pediatrics residency was at Mayo Clinic in Rochester; I stayed there for an additional year to serve as chief resident.
- Live in Minneapolis with my husband, who is also a physician. I'm grateful for our shared language of medicine and our common experience of the highs and lows of taking care of patients.
- Teach medical students and residents at Children's Minnesota as an adjunct assistant professor of pediatrics at the University of Minnesota Medical School.

Became a physician because…

Being a doctor has allowed me to learn and apply an amazing body of knowledge and to directly benefit patients and their families on a daily basis, working with dedicated colleagues who have wonderful values and high personal integrity.

I chose the joint JD-MD program because I also wanted to better understand American institutions, governance, and social fabric through a formal legal education. I was eager to gain perspective that is useful beyond the traditional legal world. I continue to find the medical and legal disciplines to be complementary in study and in practice. Dean Kathleen Watson at the University of Minnesota Medical School introduced me to a terrific quote from physician Rudolf Virchow: "If medicine is to fulfill her great task, then she must enter the political and social life. …The physicians are the natural attorneys of the poor." Working at Children's and with the MMA provides a meaningful way to engage in political and social issues that relate to the health and well-being of our patients.

The greatest challenges facing medicine today…

The powerful socioeconomic factors that influence an individual's health, the limited access to and unaffordability of care for a large portion of the population, the intrusion into the physician-patient relationship by requirements for documentation and productivity, and the complex and cumbersome payment system.

How I keep life balanced…

Through time with loved ones, travel and new experiences, decompressing with wonderful colleagues, and witnessing the commitment and energy of medical students and residents.

If I weren't a physician…

I'm not sure what I might be doing. For all its pain points, a life in medicine presents so many opportunities to be useful, to be a perpetual student, and to collaborate with exceptional colleagues. I don't know what other field could match this combination. **MM**

NEW DEA CERTIFICATE RENEWAL REQUIREMENTS ARE YOU READY?

Special Discount Available for Minnesota Medical Association Members!

Use MNMED100 for $100 Off

HTTPS://CLINICALOPTIONS.COM/CONTENT/DEA-RESOURCE-CENTER

LEARN MORE

WHAT IS IT?

Effective June 27, 2023, the US Drug Enforcement Administration (DEA) requires all DEA license holders to take at least 8 hours of training on opioid or other substance use disorders, as well as the safe pharmacologic management of dental pain, to apply for or renew their DEA certification.

HOW CAN I FULFULL THIS REQUIREMENT?

In partnership with Clinical Care Options (CCO), MMA now offers a comprehensive, DEA-compliant CME course, Controlled Substance Prescribing and Substance Use Disorders. Learn at your own pace on-demand—with expert-led sessions that can be taken whenever, wherever. for or renew their DEA certification.

BEYOND

COVERAGE

COPIC's premier medical liability insurance offers comprehensive support built on unparalleled expertise and decades of experience. We share our knowledge through meaningful CME/CNE education, an extensive library of resources, in-depth site visits, and more. All of which help you avoid risks, improve practice protocols, and solve urgent issues quickly.
That's Value Beyond Coverage.

COPIC is proud to be the endorsed carrier of the Minnesota Medical Association. MMA members may be eligible for a 10% premium discount.

COPIC®
Better Medicine • Better Lives

CALLCOPIC.COM | 800.421.1834