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Rx

Prescriptions for healthy living

Can physicians' directives for healthy living or provision of healthy food improve patient well-being? PAGE 16

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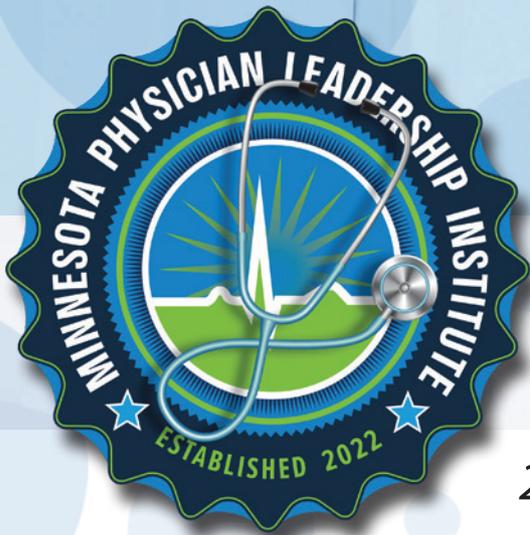
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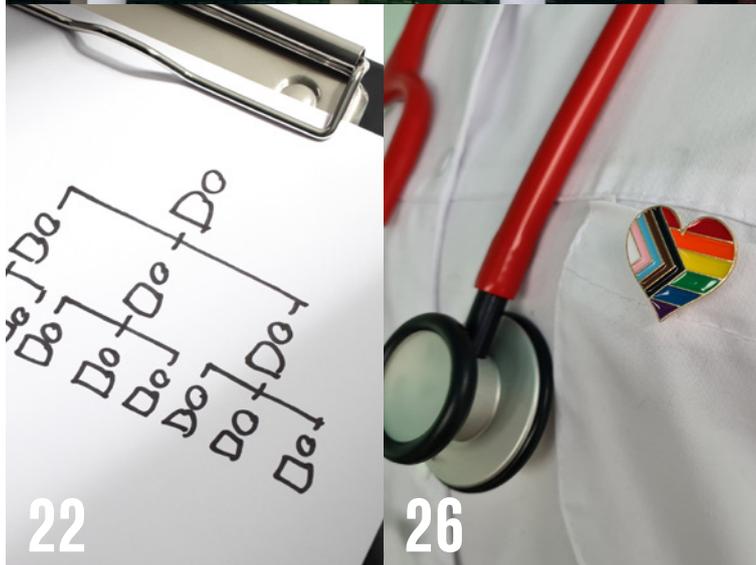
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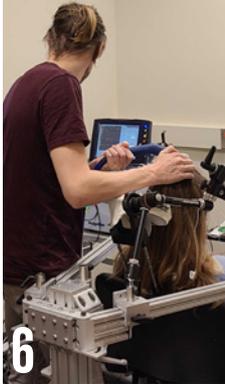
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Colin West, MD, PhD

I remind myself to encourage my patients as I try to help them take whatever steps they can toward healthier and happier lives. As credited to Sir William Osler but dating to folk sayings centuries earlier, our task is “to cure sometimes, to heal often, and to comfort always.”

Meeting patients where they are: A recipe for health and happiness

Our goal as physicians is to help our patients live better lives. One way we hope to do this is by recommending healthier behaviors, including physical activity and better nutrition. These recommendations are well-intended and can certainly yield positive outcomes. However, we also need to remember the many barriers patients may face in their attempts to live healthier lifestyles. In addition, we must keep the ultimate goal of these recommendations in mind. After all, what good is a healthier lifestyle if the patient isn't actually happier? In other words, what if the operation is a success but the patient dies?

This lesson was brought home to me during my residency training one afternoon when I saw a local farmer in clinic for follow-up after hospitalization for his second heart attack. He was effusive in his gratitude for the cardiologists and other healthcare professionals who had cared for him, and he credited them with saving his life. His words were joyful—yet his tone was anything but. In fact, he spoke in a low monotone with a flat expression on his face. At first I thought perhaps this was just the stoic nature common among so many in our farming communities, but as his demeanor persisted I asked if I could pose a question to him. I said I couldn't help but notice that although his words expressed happiness he didn't actually *seem* happy. Was there anything else going on?

As you might expect, his initial response was to apologize for not appearing more grateful. He assured me that nothing else was the matter. This didn't add up, so I gently pressed him for anything at all that I might be able to help with. Finally, he broke down a bit and despite insisting that he had no right to complain and that he owed the physicians his best efforts to fol-

low all their recommendations, he admitted, “It's the food, Doc.”

He was doing his best to follow the strict cardiac diet prescribed upon dismissal from the hospital, but the steamed vegetables, skinless unsalted chicken breast, rice cakes, and absence of any butter at all made him feel like “maybe it would have been better if the heart attack had done me in quickly, because this food is doing it slowly.” Certainly he needed to do better than the steak and egg breakfasts “and two servings on Sundays” he had enjoyed prior to his cardiac events, but this man was truly miserable. So we struck a balance between a healthier lifestyle and a happier lifestyle. Some may tut, but we discussed adding low-salt seasonings in moderation among other compromises, and we decided together that adding a single serving of a well-trimmed small steak and an egg on Sundays would be a worthy celebration of another healthy week. Oh, and we agreed with conspiratorial winks that we wouldn't tell his cardiologist. I think this shared secret may have been the most therapeutic part of our plan, actually.

As I reflect on this experience, I remind myself to encourage my patients as I try to help them take whatever steps they can toward healthier and happier lives. As credited to Sir William Osler but dating to folk sayings centuries earlier, our task is “to cure sometimes, to heal often, and to comfort always.” Healthier lifestyles are wonderful, especially when we make sure our patients are actually reaping the benefit of happier lives. **MM**

Colin West, MD, PhD, is professor of Medicine, Medical Education, and Biostatistics, Mayo Clinic. He is one of three medical editors for *Minnesota Medicine*.

Use your voice

The article “Rx for an ailing Earth” in the March–April issue of *Minnesota Medicine* does an excellent job of highlighting the very significant progress in sustainability made by healthcare organizations around the country. These efforts, and the work of climate champions like those mentioned in the article, are to be applauded. The “Doctor’s orders” outlines actions that we can take to help protect our patients and communities from the dangers of uncontrolled climate disruption. A point I would like to emphasize is healthcare’s role in affecting public policy.

The extraordinary extent of disruption of our planet’s climate-hydrologic systems cannot be overstated. At this point industry efforts, such as those outlined in this article, are essential but not sufficient to encourage necessary changes in regional and national environmental and energy policy.

We can use our voices, individually and collectively as board members, leaders of professional societies, and health experts to advance the public conversation about climate change. We can publicly express deep concern over the climate crisis and its implications for public health. We can work with policy makers, office holders, and candidates to prioritize effective responses to the climate crisis.

There is unfortunately still much denial surrounding climate issues. The public voice of healthcare can help bring dangerous realities into sharper focus.

—Bruce D. Snyder, MD

Push harder

Regarding Dr. Wenner’s editor’s note in the March–April issue: Thank you for pointing out some of the flaws in Medicare Advantage. I only wish you had been more assertive.

- Prior authorization allows the insurance company to practice medicine. This should be forbidden.
- Allowing Medicare Advantage plans to create networks should be forbidden.
- The physicians and the voters have allowed the pursuit of profits to overtake society’s need for affordable healthcare for everyone.

Major reform is needed. Let’s design what we want and implement it. Trying to make a 1960s vehicle work in a 2020s world is not going to work.

—Mark Brakke, MD

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Something on your mind? Email us at mm@mnmed.org. We’ll edit for style and length.



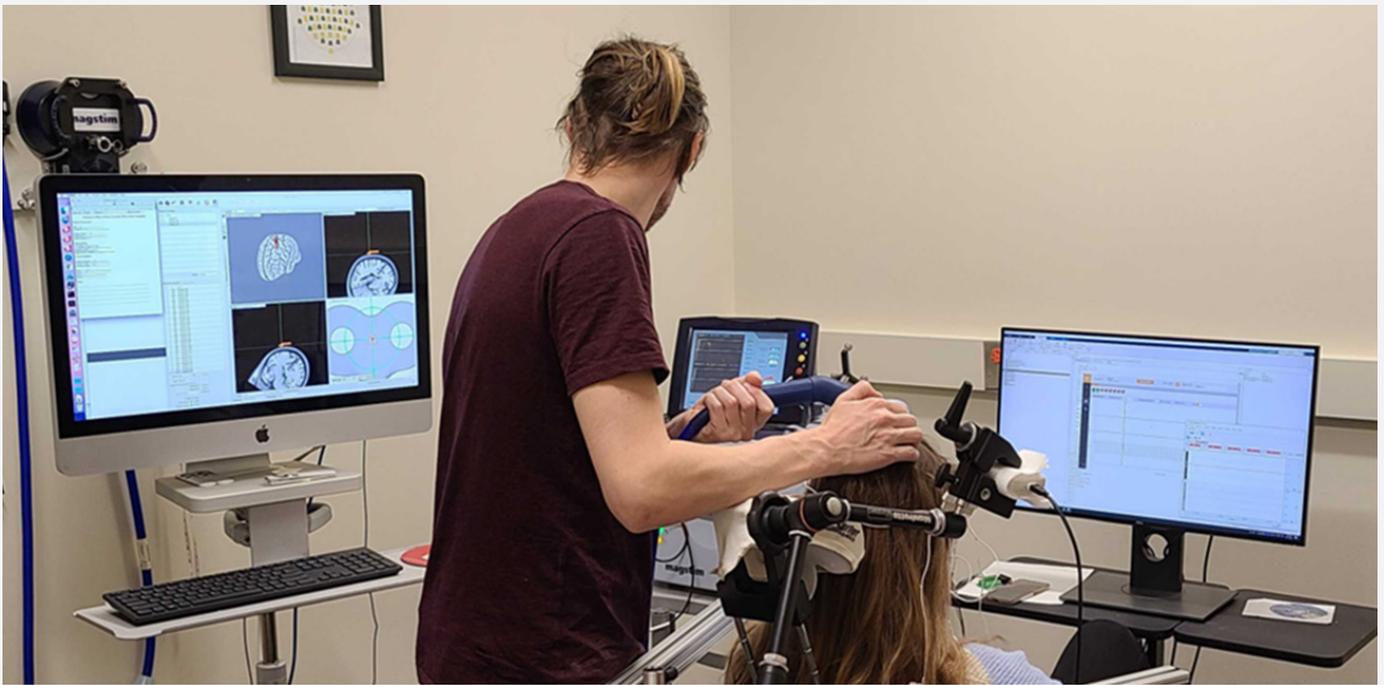
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University neural stimulation discovery may open door to psychiatric therapies

University of Minnesota researchers have shown for the first time that noninvasive stimulation with a mild alternating current can modulate human brain wave activity in a way that enhances “neuroplasticity” and may open pathways to treating disorders from Parkinson’s disease to depression to attention-deficit/hyperactivity disorder.

The effect is called “neural phase precession,” when brain oscillations shift over time in response to an external pattern, in this case, stimulation of the motor cortex.

The study was published in February in *Nature Communications*. According to the authors, stimulation of a different area of the brain, the prefrontal cortex, might have clinical applications: “The prefrontal cortex is associ-

ated with various cognitive functions and abnormal plasticity in this region relates to psychiatric disorders.”

Brain waves, or oscillations, which may range from a cycle per second to dozens, “have been associated with behavior,” says Miles Wischnewski, who participated in the study as a post doc in the College of Science and Engineering and is now an assistant professor at the University of Groningen in the Netherlands. “So we have particular brain waves in a

particular spot of the brain that seem to be correlated positively with a certain task—let’s say cognition and another with motor performance. We found that we indeed can manipulate those oscillations. So we have a suggestion that it may induce what we call neuroplasticity or basically strengthening of the connections in the brain.”

The finding suggests possibilities for treatment of Parkinson’s and depression. In Parkinson’s, for example, a relatively fast wave called beta is excessively strong. In invasive deep-brain stimulation of Parkinson’s patients, “the goal is to modulate this beta wave activity,” Wischnewski says. Even better would be to modulate it noninvasively, “which, of course, is a lot cheaper and less of a burden for the participant,” he says.

“In depression, it’s a little bit less clear, but at least in some subtypes of depression there seems to be some over or under activity of a particular brainwave in the prefrontal cortex of the brain,” he says.

ADHD might be another target. With stimulation of the prefrontal cortex, “some people would report that they have an increase in focus, so that they are a little sharper,” he says. “I think ADHD would be a very good candidate, because there we also have very strong evidence that the balance between two different oscillations, a theta wave and a beta wave, there is a mismatch there.”

But neural stimulation with alternating current is still comparatively new, says Wischnewski, “so it will need a few more years before we can say something definitive.”

Wischnewski, M., Tran, H., Zhao, Z. et al. Induced neural phase precession through exogenous electric fields. *Nat Commun* 15, 1687 (2024).

– Greg Breining



Miles Wischnewski



IMAGE COURTESY OF DEXCOM

Over-the-counter glucose monitor wins FDA nod

Starting this summer, adults who are not on insulin—who may not even be diabetic—will be able to buy Dexcom’s over-the-counter Stelo continuous glucose monitor to track their fitness around diet, exercise, and blood sugar.

“This will help a lot with their lifestyle—the way that physical activity can affect their glucose levels. I think all those things are great opportunities for people to see and

understand how their trends are going, how they spiked with different situations,” says Jose Jimenez-Vega, MD, assistant professor of pediatric endocrinology at the University of Minnesota. “They could see how as they continue to exercise and they continue to keep a close eye on their diet, how their blood sugar could trend in a better direction.”

The FDA approved the Stelo in March. According to Dexcom, the device is “intended to continuously measure, record, analyze, and display glucose values in people 18 years and older not on insulin.” The company cautions “the user is not intended to take medical action based on the device output without consultation with a qualified healthcare professional.” According to the company, price of the system will be announced when the product goes on sale.

The Stelo is similar to Dexcom’s G7, says Jimenez-Vega. “The accuracy is also very similar, at least from the data that they have shared with the public.” Unlike the G7, however, “there’s no integration with any automated insulin delivery system,” he says.

“There are studies that have shown that in patients with Type 2 diabetes that are not on insulin, the use of a CGM can help them have improvements in their A1C because they’re being more cognizant about what is going on,” says Jimenez-Vega. “I think it’s a great opportunity to have patients work in a team-based effort to attain the goals that they’re looking for.”



Jose Jimenez-Vega, MD
Assistant professor
Pediatric endocrinology
University of Minnesota

— G.B.

Report: Patients staying in hospitals longer because of gridlock

A new survey of patient care in Minnesota hospitals, released in late January, has found persistent, ongoing delays in discharges from emergency departments and inpatient care, resulting in tens of thousands of days of unnecessary hospital-level patient care and significant financial losses.

“Minnesota hospitals have gone from being a safety net, to being a catch-all for patient care,” said Rahul Koranne, MD, Minnesota Hospital Association (MHA) CEO and president. “This is a function they were never intended for, can’t afford, and isn’t good for patients. This gridlock is preventing Minnesotans from getting care that their lives depend on.”

The MHA survey of 101 hospitals follows similar data collection by the Minnesota Department of Human Services in the



first five months of 2023, which found more than 76,245 days of unnecessary hospital care. The new survey found 65,555 additional days of unnecessary patient stays June through October. (The new data reflects usual seasonal variation in hospital care, as

well as changes in administrative data collection.) These surveys represent nearly 195,000 patient days of avoidable and unpaid care. This patient gridlock not only reduces overall capacity for hospital care; it also costs Minnesota hospitals and health systems an estimated \$487 million in unpaid care.

These delays include patients stuck in hospital beds waiting for transfers to nursing homes, rehabilitation units, mental health treatment facilities, and other subacute care facilities. The latest survey also found hospitals provided 9,223 days of emergency department stays, often people stuck waiting for inpatient care or simply brought to a hospital for lack of any alternative. These stays increased waits for other patients who need care and forced some patients to find other care elsewhere, with potentially life-altering delays.

This level of unpaid care is a root cause of financial distress for hospitals all over the country, combined with payers that don't cover the full costs of care, and fast-rising costs. In the first half of 2023, 67% of Minnesota hospitals reported operating losses. Elsewhere, two hospitals have already closed in western Wisconsin in 2024, and 12 hospitals around the U.S. entered bankruptcy last year, more than the previous three years combined.

Minnesota Department of Health hires new health equity director

The Minnesota Department of Health (MDH) has hired Odichinma (Odi) Akosionu-DeSouza as its new director of the Center for Health Equity (CHE).



Odichinma (Odi) Akosionu-DeSouza

Prior to joining MDH, Akosionu-DeSouza worked at the Center for Antiracism Research for Health Equity as a project manager and research scholar. She also served as the director of operations for The Research in Color Foundation, leading efforts to support scholars who are interested in pursuing a PhD degree in economics and related fields, with the overarching goal to improve the number of underrepresented scholars within these fields.

The Center for Health Equity, created in 2013 to advance health equity, has grown dramatically, from about a dozen staff in 2020 to approximately 50 today.

The Center for Health Equity, created in 2013 to advance health equity, has grown dramatically, from about a dozen staff in 2020 to approximately 50 today.



Social isolation makes you old—even if you're young

Social isolation is bad for your health. That's no secret. Research has shown that seeing few friends, rarely visiting family, and belonging to few or no social groups put older people at higher risk of cardiovascular disease, high blood pressure, poor control of diabetes, and a higher mortality rate.

But recent research at Mayo Clinic shows that social isolation causes premature aging among all ages, driving the gap between chronological age and biological age as measured by a Mayo-developed model of artificial intelligence-enabled 12-lead electrocardiography. This age gap is correlated with all-cause mortality even after adjusting for cardiovascular risk factors.

"This study can have profound implications for public health and healthcare policies. Our findings suggest that fostering community engagement and strong social networks could potentially slow down the aging process," says Nazanin Rajai, MD, MPH, a research fellow at Mayo Clinic and first author of the study. "This information is invaluable for



designing interventions and strategies to promote social connections, especially among vulnerable populations. The impact of social determinants of health on health disparities is widely recognized. We also demonstrated that the impact of social isolation on cardiac aging is not the same among various racial and ethnic groups.”

The study appeared in the *Journal of the American College of Cardiology: Advances*.

Researchers aimed to understand the effect of social isolation on biological age, which according to previous research, “provides a better estimation of overall physiological function and well-being compared to chronological age.” A larger gap between chronological and biological age corresponds to a greater risk of adverse health outcomes, including all-cause mortality. Moreover, this age gap suggests a way to measure a subclinical effect of social isolation on young adult patients.

The study included all patients aged 18 years and older who came to Mayo Clinic between June 2019 and March 2022 for outpatient visits and who completed a social determinants of health questionnaire via the patient’s online portal and also had 12-lead ECG records as part of their medical care within one year of

completing the questionnaire. The sample totaled more than 280,000 individuals.

The questionnaire included a six-question survey that asks about belonging to and attending social organizations (including religious groups); talking and visiting with friends, family, and neighbors; and whether patients live alone or with a partner.

A statistical comparison of this social network index to the age-gap among participants showed “that in all age and sex categories, social isolation is associated with accelerated aging compared to more socially connected participants.” A follow-up with the participants also “revealed a significant association between social isolation and mortality.”

According to the authors, several mechanisms have been proposed to explain why social isolation would accelerate biological age. One suggests isolation upregulates pro-inflammatory genes, causing oxidative stress in vascular tissue. Social isolation is also associated with the dysregulation of the autonomic nervous system in a way that correlates with cardiovascular diseases and all-cause mortality. On a behavioral basis, isolation is associated with poor health habits such as smoking, drinking, eating poorly, exercising little, and skipping medications.

In contrast to previous studies of the health effects of social isolation, the recent Mayo study showed that isolation had greater effects on age gap among the young than the old.

In a secondary analysis comparing white to non-white groups, the average age-gap was higher in non-white patients across all social network index values. The difference was especially pronounced among the most isolated.

“Failing to address social isolation as a serious public concern could potentially aggravate the existing disparities in health outcomes, while tailoring interventions to address specific needs and challenges faced by different demographic groups can lead to more effective and equitable outcomes. This research may encourage community-based programs, support networks, and policies that prioritize social well-being as a key component of overall health,” says Amir Lerman, MD, a cardiologist at Mayo Clinic and senior author of the study.

REFERENCE

Rajai, N, Medina-Inojosa, J, Lewis, B. et al. Association between social isolation with age-gap determined by artificial intelligence-enabled electrocardiography. *JACC Adv.* null2024, 0 (0).

– G.B.



Study says exercise at work can sharpen cognition without inhibiting manual tasks

A recent Mayo clinic study confirms that exercise built into your work station not only enables healthful exercise but can improve mental cognition without reducing job performance. A clinical trial evaluated the performance

of 44 participants at Mayo Clinic’s Dan Abraham Healthy Living Center. Subjects’ neurocognitive scores either improved or remained unchanged, while typing speed decreased slightly without affecting typing errors. Performance increased after the first day. The study, published in April in the *Journal of the American Heart Association*, suggests it is feasible to blend movement with office work that previously would have been done during long periods of sitting,” says Francisco Lopez-Jimenez, MD, MS, a preventive cardiologist at Mayo Clinic and senior author. “Being sedentary is the new smoking when it comes to your cardiovascular health. These findings indicate that there are more ways to do that work while remaining productive and mentally sharp.”

– G.B.

Minnesota’s uninsured rate hits all-time low

Key findings from the Minnesota Health Access Survey released by the Minnesota Department of Health in early April showed—

- The percentage of Minnesotans without health insurance in 2023 remained low at 3.8%; about 11,000 fewer Minnesotans were uninsured in 2023, compared to 2021.
- Most Minnesotans without insurance in 2023 were uninsured for the whole year; however, compared to 2021, more experienced shorter gaps without insurance.
- While more Minnesotans had employer-sponsored group coverage than public coverage, the percent with public coverage increased, while the percent with group coverage fell.
- One in four Minnesotans went without healthcare in 2023 due to costs, compared to one in five Minnesotans in 2021.
- Measures of health insurance and healthcare affordability returned to higher pre-pandemic levels.



—Minnesota Department of Health

MN Community Measurement hires new leader

MN Community Measurement (MNCM) hired Liz Cinqueonce as its new president and CEO, effective in mid-March.

Cinqueonce had been serving as the organization’s chief operating officer (COO). As COO, Cinqueonce drove operational efficiency, fostered innovation, and built strong cross-functional teams, contributing significantly to MNCM’s growth and impact in Minnesota.

With more than 15 years of experience in healthcare policy, management, and strategy, Cinqueonce is positioned to lead MNCM. Her dedication to advancing the organization’s mission and vision was evident in her successful engagement of stakeholders, consensus building, and modernization efforts as COO.



Liz Cinqueonce



CentraCare introduces doula program

CentraCare–Plaza Clinic Obstetrics and Women’s Health is now offering doula services to provide emotional, physical and informational support to mothers in the St. Cloud area. Working with Everyday Miracles, a Minneapolis-based pregnancy care center, Plaza Clinic now provides seven doulas, including two who speak Spanish and three who speak Somali.

While doulas do not have medical training, like an OB/GYN physician or midwife, they are trained to provide assistance with breathing exercises and other nonmedical pain management techniques; advice on labor positions; comfort, encouragement, and a soothing voice of experience; and patient advocacy during labor and the immediate postpartum period.

“CentraCare team members are here to provide our patients with the best possible birthing experience,” says Erica A. Scott, diversity, equity, and inclusion specialist. “How a woman experiences childbirth impacts her mentally, physically, and emotionally. We want to partner with our birthing persons to be empowered. We listen, we learn, we treat the whole person.”

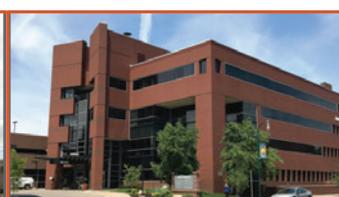
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A passing grade for the academic health task force

Recommendations to strengthen academic health win approval—but will they get the approval of the Legislature? BY GREG BREINING

State Rep. Robert Bierman is vice chair of the House Health Committee and the primary author of legislation to prevent an out-of-state entity from owning the University of Minnesota medical center—legislation that sprung from an effort by Fairview Health, which owns the University teaching hospital, to merge with an out-of-state company.

Despite his rather pivotal involvement in University health-related issues, Bierman notably did *not* serve on the governor's task force that in early February released 20 recommendations to strengthen academic medicine in Minnesota. Instead, he sat on the outside looking in. But he expresses no regrets.

"I listened to almost every single hearing, either attending or tuning in," he says. "It was a very useful exercise in that we had this sustained series of meetings with some of the most experienced players in the healthcare field in the state. I learned a lot just sitting and listening to them."

The controversy over the proposed merger between Fairview and Sanford Health stalked the meetings "like a big shadow over the whole thing," Bierman says. The members of the task force—in their first recommendation—emphatically and unanimously urged the University and Fairview to negotiate a resolution to their relationship pronto.

The remaining recommendations aimed at some of the more amorphous and difficult improvements to a major academic medical program that must do its best to succeed in the fractured environment known as the U.S. healthcare system. They included—

- Develop a strategic plan for the University's six health professional schools.
- Request and fund a comprehensive needs assessment of health system facilities.
- Establish a legislative oversight committee to monitor appropriations to the University.
- Support the University's five-point plan for its academic health system's facilities, including planning for new state-of-the-art academic health facilities.

- Maintain without disruption existing private sector labor agreements, pensions, and other benefits.
- Undertake comprehensive health professions workforce planning.
- Increase funding for effective workforce development strategies.
- Use workforce data to coordinate and plan future investments.
- Encourage multi-system integration and broader relationships and collaboration with health systems across the state to best leverage Minnesota's healthcare assets.

According to the governor's order creating the task force, the recommendations are meant "to support world-class academic health professions education, research, and care delivery [and]... advance equity, center primary care, and ensure that Minnesotans can continue to receive the highest-quality care in a financially sustainable way."

So, did the task force accomplish its mission?

Minnesota Medicine asked Bierman and two participants on the task force, MMA member Julia Joseph-Di Caprio, MD, MPH, and Jakub Tolar, MD, PhD.

Jakub Tolar

If any one participant on the task force was in the hot seat, it may have been Jakub Tolar, dean of the University of Minnesota Medical School and vice president for clinical affairs. He, after all, has been the face of academic medicine.

Tolar, one of five physicians who sat on the task force, says he welcomed the spotlight. "I'm delighted and grateful for the focus and attention that the academic health enterprise and the university has received from the state, the community and the leaders in the state."

Despite the squabble that burst into public view when Fairview proposed a merger with Sanford, Tolar says Fairview and the University are back at the negotiating table. In fact, just days after the task force issued its report, the University and Fairview signed a "nonbinding letter of intent that outlines the process of how we can resume control, autonomy, and ownership of the hospitals on our campus,

and ... make sure that the public interest is a part of how we consider our clinical service," says Tolar.

The partnership, he says, is "going to be different," says Tolar. "That's not necessarily bad, or not necessarily worrisome. This is a process, that this is a way how we can maximize the potential of academic health and academic medicine in the state, and

JAKUB TOLAR,
MD, PHD
DEAN
UNIVERSITY OF
MINNESOTA
MEDICAL SCHOOL
VICE PRESIDENT
CLINICAL AFFAIRS



Among the most important of the task force's recommendations has been the stated "need to support the public impact of academic health through public investment," says Tolar. "That theme has been running through some of the recommendations that talked about the fact that the university educates and trains 70% of physicians that practice in the state. That research, that innovation that happens at the university, is not only increasing the quality of care, but also it *decreases* the cost of care."

how we can live up to broader responsibilities to the state.”

In the midst of these developments, the University selected Rebecca Cunningham as its new president. Says Tolar, “She’s an emergency room physician so she speaks the language of healthcare. She speaks the language of medicine.” It is yet to be seen how she will bring her ideas and experience to bear not only on the University-Fairview relationship, but also on the longer-term aspects of managing academic health in Minnesota. Says Tolar, “I very much look forward to see where her leadership is going to take us.”

Among the most important of the task force’s recommendations has been the stated “need to support the public impact of academic health through public investment,” says Tolar. “That theme has been running through some of the recommendations that talked about the fact that the university educates and trains 70% of physicians that practice in the state. That research, that innovation that happens at the university, is not only increasing the quality of care, but also it *decreases* the cost of care. And it has enormous economic impact on the state economy,” he says.

“The funding is fundamental. The state bonding investment in our clinical facilities will help us achieve the final broad goal of ensuring that the facilities that deliver the critical clinical training to our students are top-notch. Our Minnesota future workforce needs to be trained in facilities that reflect the future—not the present, not the past models of care.”

Tolar says he has led legislators through the East Bank hospital “so they can actually see it. They do see our boarders in the emergency room. They do see that we have patients in the ambulance bay, the garage. They see that we are bursting at the seams,” he says. “And simultaneously, I serve with the most committed group of physicians and nurses and other practitioners that I have ever worked with. They are loyal to the mission. The reason why they are with the University is because they do want to serve the people.”

Julia Joseph-Di Caprio

As a member of the task force, Julia Joseph-Di Caprio saw the work of the group less as problem solving and more as “an opportunity.”

“One of the most important things about the work of the task force was recentering, or really acknowledging, the role that the schools in the academic health center play in the health of the citizens—from research, to training, to clinical care,” says Di Caprio, an MMA member, graduate of the University Medical School, and president and founder of Leap Pediatric and Adolescent Care. “I was really heartened that the task force recognizes and affirms the central role that the University of Minnesota academic health center has, not only in its unique research, education and clinical care role, but how it collaborates with others. And there’s the potential for it to even deepen and expand that work in the future with the right investment,” she says.

“I always knew the figure that 70% of the physicians who work in Minnesota trained at the University of Minnesota,” she says. But she didn’t realize the importance of the University to other healthcare science disciplines, such as veterinary medicine, which has only the single school in Minnesota—the College of Veterinary Medicine at the University. “I didn’t know how critical the other schools were to the workforce.”

Joseph-Di Caprio says she was impressed by another theme that emerged from the meetings—“what needs to be done particularly in terms of public support. Not only the need for facilities—that was a huge part of our discussion—but the need to support the continued work around the development of new knowledge.” While other institutions are doing that kind of work, “without the University of Minnesota leading in that effort, we won’t see the continued development of new knowledge that we need.” The task force made several recommendations that supported that need.

Another important group of recommendations addressed the University’s need for new facilities, “particularly related to a state-of-the-art hospital. That was a critical recommendation—that we need to

begin the work to get that accomplished. The work has to begin right now, particularly when thinking about the funding of it,” she says. “Planning needs to begin now. I describe it as the race to the starting line.”

One of the charges to the task force was to examine the funding and management of academic health centers in other states that might provide a good model for Minnesota. “We did not find one best model for academic health,” she says. “There are so many variables that go into a model that works. Now there are successful models across the country. But there’s not one best model that we would suggest for the University of Minnesota.”

Like other task force members, Joseph-Di Caprio found it difficult to recommend improvements to a system of academic medicine in Minnesota that had to operate in the larger environment of an inadequate U.S. healthcare system.

“That is the frame for all of our discussions,” she says. “Healthcare as it’s cur-

**JULIA
JOSEPH-DI CAPRIO,
MD, MPH**
PRESIDENT AND
FOUNDER
LEAP PEDIATRIC AND
ADOLESCENT CARE



“We framed recommendations for academic health at the University of Minnesota in terms of supporting innovation, in the short term—but building a system that looks to new ways of providing care. So the way that you might have a facility now will not be the facility that you need even in 10, 15, or 20 years.”

rently functioning, if you look broadly across the United States, doesn't work for so many people. You've heard that for many years—healthcare is broken. And for many reasons."

So task force members had to have one eye on the near term, and the other on the more distant future. "That's why we framed recommendations for academic health at the University of Minnesota in terms of supporting innovation, in the short term—but building a system that looks to new ways of providing care. So the way that you might have a facility now will not be the facility that you need even in 10, 15, or 20 years."

Rep. Robert Bierman

Like everyone on the task force, Bierman said it is imperative to clear up the University-Fairview relationship. He says he's "thrilled... they're talking about their continuing relationship with this partnership and trying to find ways to continue it."

Bierman says that as a legislator he wanted to see which recommendations gathered support, especially from the University. "I have my own thoughts and concepts, too, about what I would like to see as the future of the healthcare system in Minnesota," he says. "From a legislator's standpoint, it's a matter of seeing which ones come to the fore from the University's perspective and which ones they may bring to the Legislature with serious proposals. That's sort of what the legislators need—*What is it that you want?*"

He does suspect the University will bring proposals to spend for major upgrades to the medical center. "Looking at where the U is today, to be the world-class institution that we need to continue to support, they do need some facility and infrastructure. It needs some improvement. One of the things that they talked about was the operating rooms of the hospital. That's a really pertinent, direct thing that I think we could get our heads around to do some proposal for that particular need."

Bierman welcomed recommendations such as the one that called for a "statewide comprehensive health professions workforce plan" to align "training programs with a vision for the future of healthcare delivery."

"We do need a real comprehensive plan that we could get to understand better the needs of the state as a whole," Bierman says. "But we also need a more comprehensive look at the state's whole training, its whole education system, and what are those facilities that need more attention now? Not only infrastructure, maybe through bonding, but how many specialists are we producing in the certain areas where we need them? And what does that look like even in the next 10 years? We need to have that information so that we can design a better education component to that, whether it's grant programs, loan programs, so we get the clinical specialists we need from top to bottom."

He also favored the recommendation for "multi-system integration between UMN and other health entities." The University, says Bierman, "can have a partnership with Fairview, but that shouldn't limit in any way, shape, or form how they might relate to every other medical institution in the state of Minnesota—certainly Mayo but broader than that, too." There has been among healthcare organizations a "proclivity to hold onto your patients and not... have an open network where you can find the real specialists in certain areas. I think we should be thinking about an open network system."

Bierman says the University is "already world-class in a lot of areas. I do think they lead in a lot of areas as far as research. Right now with CAR-T cell and gene therapy, they are leading in that."

But to achieve the kind of excellence that people seem to be demanding now—"when you're thinking about world-class from top to bottom, that's a bigger challenge. It's going to take a different method of supporting it," he says.

"Other states do it somewhat differently. Where the state needs to step in and cover a lot of the cost for training medical providers—that was talked about as state funding for that." But other ways were mentioned, including wringing more out of Medicaid. "One is to maximize that Medicaid funding and there are programs apparently that we could do more with. Other states do more than we do. I think that further study on that is warranted as well."

In the long run, says Bierman, "I would like to see the University of Minnesota be a destination medical center for the country in areas that we are leading in research and treatment."

Did the task force succeed at its task? "Time will tell because task forces are notorious for creating a book that goes on the shelf and people go on with their business. Looking at the task force list and keeping it in front of us as legislators is critically important," he says. "The minor detail of needing to get reelected before I can continue looms ahead of me as well. I hope to get that done and be back to work on this. It's not going to be on a shelf in my office; it's going to be on my desk." MM

Greg Breining is editor of *Minnesota Medicine*.

ROBERT BIERMAN
HOUSE OF
REPRESENTATIVES
STATE OF MINNESOTA



"I have my own thoughts and concepts, too, about what I would like to see as the future of the healthcare system in Minnesota. From a legislator's standpoint, it's a matter of seeing which ones come to the fore from the University's perspective and which ones they may bring to the Legislature with serious proposals. That's sort of what the legislators need—*What is it that you want?*"

Prescriptions for healthy living

Can physicians' directives for healthy living or provision of healthy food improve patient well-being?

BY ANDY STEINER





Ten years ago, Kurt Hager was working at Second Harvest Heartland, a Minnesota food bank and food distribution nonprofit, when he met Diana Cutts, MD, chair of pediatrics at Hennepin Healthcare.

Cutts has been at the forefront of activism around child food insecurity for more than 25 years, since she joined Children's HealthWatch, a national network of children's health experts focused on achieving health equity for young children and their families. She knew that access to healthy food was important for overall child health, but she also understood that actually getting this kind of food was difficult for the families she served at her busy clinic, many of whom were low-income and lived in urban "food deserts," where grocery stores offering healthy options were few and far between.

When she came up with the idea of establishing a food pantry in the clinic, Cutts reached out to Second Harvest.

"Dr. Cutts," recalls Hager, now an instructor at UMass Chan Medical School, "felt like starting the food pantry was the least she could do." With healthy food available at no cost, families could go home with a bag of food that would last for a few days.

The program was successful, Hager says, but Cutts and her colleagues wanted something that was more sustainable, a program that could grow and offer more lasting benefits to participants. They asked Hager if he could help design a program that would not only provide free groceries but also connect families with community food resources and federal nutrition programs.

Excited—and daunted—by the project, Hager was all in: Weaving together these multiple elements in a way that worked for participants felt "hard," he says, but also inspiring. In the end he created a program where staff members from Second Harvest referred patients from Hennepin County Medical Center and connected them with organizations and agencies that could help them have easier access to good, affordable food on an ongoing basis. Says Hager, "That project was really exciting to me. It was that experience that drew me to graduate school."

Eventually, Hager earned a PhD in food programs and policy. Much of his academic research has focused on ways that physicians and other healthcare providers can help food-insecure patients access healthier foods—and on the benefits of such programs—particularly those known as "prescriptions for healthy living," where providers write prescriptions that allow needy patients to access healthy foods at no cost, financing the program with donations or public assistance funds.

Recently, the results of Hager's research on prescriptions for healthy living, increasingly known "food-as-medicine

programs,” was published in the American Heart Association’s journal *Circulation: Cardiovascular Quality and Outcomes*.

He found that people at increased risk for cardiovascular disease who participated in produce-prescription programs increased their consumption of fruits and vegetables, which is associated with improved body mass index, as well as lowering blood-sugar and blood-pressure levels.

The study gathered data from some 22 different produce prescription programs in 12 U.S. states including Minnesota. “Participating individuals were lower income or food insecure and were at risk for poor cardiometabolic health,” Hager says, explaining that all had at least one of three health conditions—obesity, high blood pressure, or diabetes. “These issues are very responsive to changes in diet.”

With easier access to healthy food options, Hager said, study participants saw measurable changes in their overall health, including clinically relevant improvements in glycosylated hemoglobin, blood pressure, and BMI.

“Our study found that, as we would expect, the daily consumption of fruits and vegetables increased. Food insecurity rates were cut in half,” he says. “The adult population with diabetes had improved blood sugar control. Adults with hypertension had notably improved blood pressure, and adults with obesity had weight loss.”



“[Patients] are thinking, ‘I don’t have the money to buy the foods I need.’ Unfortunately, healthy foods might not be accessible. That’s why these kinds of programs can really help.”



ANNA MILZ, MD
VICE PRESIDENT
MEDICAL
PRACTICE OF
PRIMARY CARE
M HEALTH
FAIRVIEW
PEDIATRICIAN
TAMARACK
CLINIC
WOODBURY

Advocates of so-called medically tailored meals have pushed for expanding the practice to Medicare. Hager’s research, published in *JAMA Network Open* in 2022, estimated that providing healthy prepared meals could save the program \$3.4 billion in just one year. Early this year Rep. Jim McGovern (D-Mass.) and John Rutherford (R-Fla.) introduced legislation to remove barriers to such a program for patients for whom specific nutrition is needed for treatment of their diseases.

Healthy living prescriptions in practice

While Hager’s findings are encouraging for advocates of prescriptions for healthy liv-

ing, do they actually work to improve the health and well-being of participants long term in the real world?

Several Minnesota healthcare networks and insurers have developed such programs, including M Health Fairview, whose VeggieRx program features, among other offerings, a free weekly box of locally grown produce that participants—all low-income and food insecure—can use to make healthy, veggie-filled meals for up to six family members.

The VeggieRx program, explains Terese Hill, M Health Fairview supervisor of community advancement food system strategy, is designed to meet the needs of a



“We use [EMR] technology to send electronic referrals to SNAP (Supplemental Nutrition Assistance Program) outreach for families who are food insecure. The families are contacted within usually 48 hours and screened for their eligibility for assistance programs. They’re also given resources for the food shelves and feeding programs that are relevant to their geographic location.”



DIANA CUTTS, MD
CHAIR, PEDIATRICS
HENNEPIN
HEALTHCARE



“Our study found that, as we would expect, the daily consumption of fruits and vegetables increased. Food insecurity rates were cut in half. The adult population with diabetes had improved blood sugar control. Adults with hypertension had notably improved blood pressure, and adults with obesity had weight loss.”



KURT HAGER
INSTRUCTOR
UMASS CHAN
MEDICAL
SCHOOL

diverse population, with a focus on partnering with farm-owners of the cultures that make up much of the patient population, including Hmong, Karen, Somali, and Latino. There is also an emphasis on community buy-in and collaboration. “We are working on increasing access to healthy food and the community building that can be such an important part of that,” Hill says.

The program has some measurable results. An internal 2021 study of 296 VeggieRx participants showed encouraging outcomes for participants, including a 13% increase in self-reported health, a 9% decrease in food insecurity and a slight trend decrease in ER visits and utilization for three years in a row.

Because the program is community and health-equity centered, Hill explains that she and her colleagues want to create something that helps everyone—participants and providers included.

“We are really thinking with VeggieRx, how we do our food-as-medicine work is just as important as the food in the boxes themselves,” she says. “The way we run this work is just as important in the impact we’re having on the community as the decrease in food insecurity we’re bringing with these foods.”

This care extends to the local farmers who grow the foods as well as the workers who pack and deliver them. “We partner with youth organizations and have a strong youth workforce development aspect,” Hill says. “We provide well-paying jobs to the people who pack the boxes,

offer market rate contracts to the farms, and distribute them to the community.”

Some Minnesota physicians see a clear, lasting benefit from prescriptions-for-healthy-living programs.

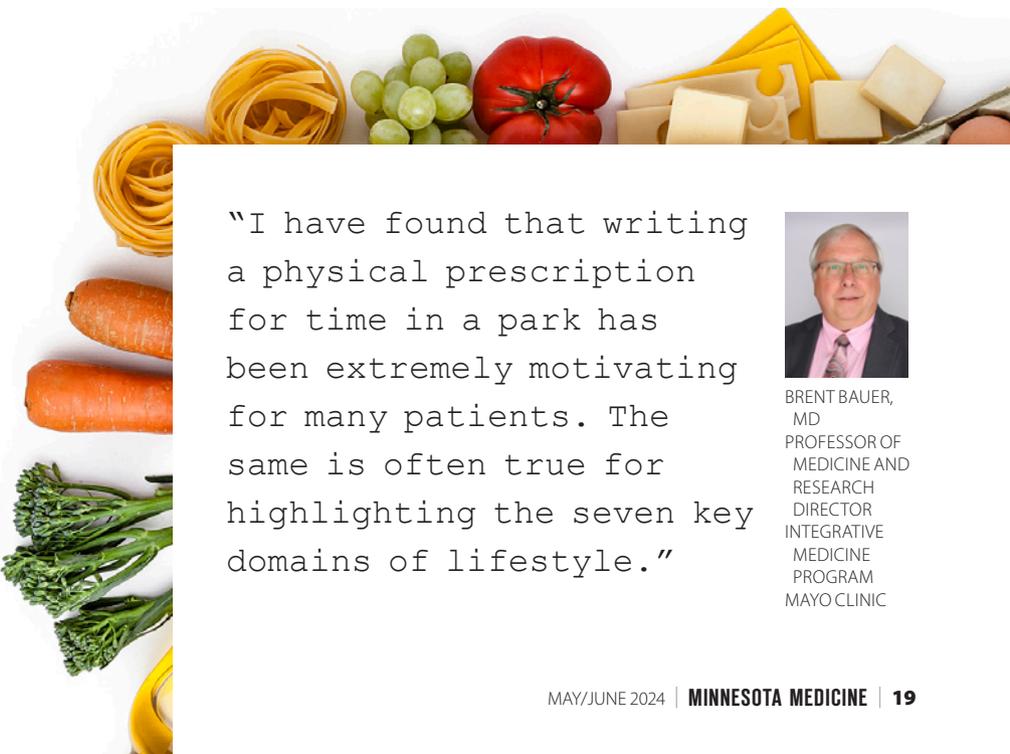
Anna Milz, MD, M Health Fairview vice president of medical practice of primary care and a pediatrician at Tamarack Clinic in Woodbury, says she has used the VeggieRx program for patients who, “have challenges with access to healthy food or have underlying conditions like diabetes.”

Understanding that having access to affordable, healthy food is key to overall health, Milz explains that her clinic screens patients at least once a year for, “food insecurity, housing needs, transportation needs. If we identify a food-

insecurity need, we try to connect them to resources.”

During the growing months, Milz explains, participants in Tamarack Clinic’s VeggieRx program can pick up free weekly boxes of fresh produce at M Health Fairview Woodwinds Hospital. “It’s been very well received by our patients,” she says. “They are very grateful and appreciative.”

Brent Bauer, MD, professor of medicine and research director at Mayo Clinic’s integrative medicine program, hasn’t used specific food prescriptions with his patients. But he includes recommendations for what he calls the seven “key domains” of health—nutrition, exercise, mind-body practice, social connection, sleep, spirituality, time in nature—in patient visits. “The goal is to make lifestyle foun-



“I have found that writing a physical prescription for time in a park has been extremely motivating for many patients. The same is often true for highlighting the seven key domains of lifestyle.”



BRENT BAUER,
MD
PROFESSOR OF
MEDICINE AND
RESEARCH
DIRECTOR
INTEGRATIVE
MEDICINE
PROGRAM
MAYO CLINIC

dational,” Bauer says, “even as we are often addressing specific problems with other therapies.”

In addition to including this lifestyle strategy in his notes, Bauer also frequently uses ParkRx, an online program that, he explains, “allows me to identify parks near the patient’s home location and actually write a ‘prescription’ for frequency and duration of activities in that park. It has been a great way to get patients engaged with nature, which we know has many critical health benefits.”

Bauer believes that ParkRx prescriptions send an important message about the importance of spending time outdoors on his patients’ overall health. “I have found that writing a physical prescription for time in a park has been extremely motivating for many patients,” he says. “The same is often true for highlighting the seven key domains of lifestyle.”

When she’s not prescribing healthy food, Milz says, she works with patients to explain strategies for using food to improve their general health. “In residency I learned a few tricks to keep it simple for patients and offer ideas with goals that they can build on.” One of those tricks includes the “5-4-3-2-1 rule,” she explains: “That’s five servings of fruits and veggies a day, at least four glasses of water, three servings of dairy, less than two hours of screen time per day, and one hour of activity. Then I add a 0 for zero sugary drinks like juice or pop.”

Tricks like these help remind patients of how even little dietary changes can make a difference. Milz backs that up in materials she provides at the end of a visit.

“I usually put in the written summary of the visit the prescription part of it,” Milz said. “I say, ‘This is the goal we agreed on today.’ Many families are eating just one or two servings of fruits and vegetables per day. I suggest moving it up to maybe four.”

“We are working on increasing access to healthy food and the community building that can be such an important part of that.”



TERESE HILL
SUPERVISOR OF
COMMUNITY
ADVANCEMENT
FOOD SYSTEM
STRATEGY
M HEALTH FAIRVIEW

‘Coloring outside the lines’

No matter how you measure it, it is clear that limited access to healthy food has a negative impact on people’s overall health.

In Milz’s experience, it does no good just to tell a patient to change their diet. Programs like VeggieRx help to make these changes feel more doable. “It can be very hard to make a change if you feel stuck,” she says. “You are thinking, ‘I don’t have the money to buy the foods I need.’ Unfortunately, healthy foods might not be accessible. That’s why these kinds of programs can really help.”

Making large-scale change in the way food is delivered to families takes more than an occasional visit to a clinic food pantry, Cutts says. She’s leaning into the use of electronic medical records, continuing Hager’s earlier work, as a way for her patient population—where approximately 40% of families and 20% of children in their clinic are food insecure—to get access to affordable, healthier food.

“We use that technology to send electronic referrals to SNAP (Supplemental Nutrition Assistance Program) outreach for families who are food insecure,” Cutts said. “The families are contacted within usually 48 hours and screened for their

eligibility for assistance programs. They’re also given resources for the food shelves and feeding programs that are relevant to their geographic location.”

Continuing to make these kinds of connections is important, Cutts says: Her goal is to work toward a society where no children face hunger. To do that, she’s willing to try any strategy to stop the cycle of poverty, and prescriptions for healthy living programs are an “outside-the-box” way to meet that ambitious goal.

“For years and years I’ve heard, ‘This isn’t what we do. You are coloring outside the lines,’” Cutts says. “But I think that mentality is changing and for some has already changed. As we look at our largest challenges in healthcare, which I think are about disparities in care, there is no way we are going to be able meet those challenges successfully without looking beyond what can be done in the clinic. That’s why programs like these are so important.” MM

Andy Steiner is a Twin Cities freelance writer and editor.



THE ANNUAL MMA AWARDS

Recognize Your Peers

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We are now accepting
nominations for the annual
MMA Awards

Award categories include:

Distinguished Service Award

Given to a physician who has made outstanding contributions in service to the MMA and on behalf of medicine and the physicians of Minnesota during his or her career.

President's Award

Designated for individuals who have made outstanding contributions in service to the goals of the MMA.

Medical Student Leadership Award

Presented to a member of the MMA Medical Student Section who demonstrates outstanding commitment to the medical profession.

Resident & Fellow Leadership Award

Presented to a member of the MMA Resident & Fellow Section who demonstrates outstanding commitment to the medical profession.

James H. Sova Memorial Award for Advocacy

Given to a person who has made a significant contribution to the advancement of public policy, medical sciences, medical education, medical care or the socio-economics of medical practice. Sova was the chief lobbyist for the MMA from 1968 until the time of his death in December 1981.

Eric C. Dick Memorial Health Policy Partner Award

Given to an individual, group of individuals, a project or an organization that demonstrates their commitment to pursuing sound public policy, building coalitions, creating and/or strengthening partnerships with the goal of improving the health of Minnesotans or the practice of medicine in Minnesota.

COPIC/ MMA Foundation Humanitarian Award

Presented to physicians who volunteer medical services and contribute to their community, specifically to MMA members who go above and beyond to help address the healthcare needs of underserved populations in Minnesota.

Visit the MMA website (www.mnmed.org/about-us/mma-awards)
to make a nomination by **June 28.**

LEADERSHIP TRAINING BY PHYSICIANS, FOR PHYSICIANS

The MMA's Minnesota Physician Leadership Institute teaches essential skills that will help physicians become effective leaders in many settings.

BY SUZY FRISCH

One physician took charge during a disciplinary meeting with a co-worker instead of letting the staff lawyer handle it. Another negotiated a better outcome when her employer told her to be a team player and move into a role she didn't want. When a different physician became a department leader, he saw a lack of fairness in scheduling that gave some physicians holiday-free schedules while others worked the brunt of the difficult shifts. He stepped up to make scheduling more transparent and equitable.

A group of 18 physicians has been meeting monthly to learn the essential leadership skills that empowered them to make these bold decisions. They are

enrolled in the first Minnesota Physician Leadership Institute (MNPLI) cohort, a curriculum developed by the Minnesota Medical Association in collaboration with the University of Minnesota Carlson School of Management. Launched in fall 2023, the 10-month program aims to enhance leadership skills for physicians with varying levels of leadership capabilities and experience.

At a session in March at the Carlson School, group members shared recent leadership situations and how they applied lessons learned through MNPLI. The day focused on leading through change and the legal and ethical responsibilities of leaders, including several exercises. In a Harvard Business School simulation, two groups ascending Mt. Everest had to weigh data and varying goals to make cascading decisions about individuals and the team, aiming to safely summit the mountain without anyone needing a rescue.

The simulation revealed common challenges facing leaders—that individuals sometimes have hidden agendas and withhold information from the group, and that individual and group goals aren't always aligned. It allowed instructor Mary Zellmer-Bruhn, PhD, Carlson School associate dean of MBA and MS programs

and professor of organizational behavior, to open a conversation exploring effective decision-making in groups. She engaged participants in a discussion about the challenge of having ambiguous information when leading, as well as strategies for creating environments of psychological safety that foster discussion among people with varying levels of power.

For Nick Esala, DO, the institute and training have helped him develop leadership skills at just the right time. A sports medicine physician at Tria, Esala has taken on increasingly more responsibility in recent years as an orthopedic urgent care site director.

Esala enrolled in MNPLI "because I want to be the best leader I can be. The program is very pertinent to what I'm doing now in my role," he says. "I've been learning better skills as a leader and learning to be a good voice for my department and colleagues. It's made me realize the importance of having physicians take on leadership roles when it comes to health-care and healthcare management."

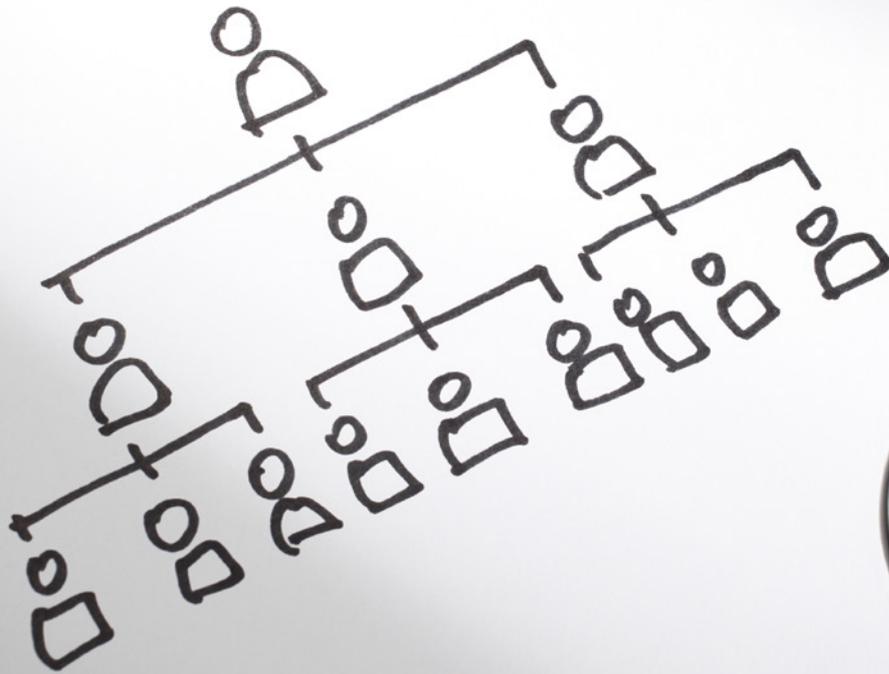
OB-GYN Amanda Zehrer, MD, hadn't previously considered pursuing leadership roles, aiming instead to focus on patient care. But when she joined Stellis Health, a private practice serving patients in Monticello and Buffalo, her employer encour-



"MNPLI HAS MADE ME REALIZE THE IMPORTANCE OF HAVING PHYSICIANS TAKE ON LEADERSHIP ROLES WHEN IT COMES TO HEALTHCARE AND HEALTHCARE MANAGEMENT."

Nick Esala, DO
Sports medicine
Tria





aged her to get involved as a physician leader. Zehrer is vice chief of staff for CentraCare Monticello Hospital, a position that becomes chief of staff and then post-chief of staff.

Zehrer says she has gotten a lot out of the institute, and it has helped her start off strong in leadership. She appreciates learning skills like negotiation and how to run effective meetings that result in action—empowering her with tools she could use right away. At each MNPLI session, “the small group discussions are great,” Zehrer adds. “It helps to hear from others about their barriers and how they are similar, and then how they solved them.”

Physician-designed course

The MMA launched MNPLI to provide leadership training specifically for physicians. This was not a new MMA idea. In the 1990s, then MMA CEO Paul Sanders, MD, helped lead the launch of what would become the University of St. Thomas Phy-

sician Leadership College, which proved very popular among physicians but closed in 2017. Current MMA CEO Janet Silversmith saw value in providing leadership training for physicians and aimed to fill the gap left when St. Thomas ended its program.

“There was a void in the community. As we think about leadership development for our organization and the value of physician leaders throughout healthcare, we believed there was an opportunity to create something really unique by physicians for physicians,” Silversmith says. “All physicians can benefit from leadership training. This is an accessible and affordable program that introduces them to the specific skills they can apply in their daily lives while exploring other leadership interests.”

The program is suited for leaders of all stages and abilities. Overall, MNPLI’s curriculum aims to provide skills and resources for growth in “leading self, lead-



“THE SMALL GROUP DISCUSSIONS ARE GREAT,” ZEHREER ADDS. “IT HELPS TO HEAR FROM OTHERS ABOUT THEIR BARRIERS AND HOW THEY ARE SIMILAR, AND THEN HOW THEY SOLVED THEM.”

Amanda Zehrer, MD
OB-GYN
Stellis Health

ing people, leading change, and leading organizations.” It’s geared toward early and midcareer physicians seeking essential leadership skills and those wanting to

develop their capabilities to expand career opportunities. In addition, MNPLI supports current physician leaders who want deeper expertise to continue to grow.

Silversmith envisions MNPLI participants absorbing practical skills and applying them daily, whether it's with colleagues, in their workplace, community, or as health policy advocates. "We were not simply looking to create the next C-suite of physician leaders," she says. "We want to democratize leadership skills for all physicians because we believe these are skills that can help them lead their clinical team, a committee in their practice, or help them be effective advocates for their patients. It gives them exposure to leadership to decide whether more formal roles are part of their career journey."

MNPLI's curriculum covers a lot of ground in a mix of in-person and virtual sessions. Participants delve into assessing and reflecting on personal leadership strengths and opportunities, strategies for making improvements in medicine or other settings, driving change, and embracing a leadership mindset. The programing, held at 10 daylong sessions from September to June, exposes participants to



"ALL PHYSICIANS CAN BENEFIT FROM LEADERSHIP TRAINING. THIS IS AN ACCESSIBLE AND AFFORDABLE PROGRAM THAT INTRODUCES THEM TO THE SPECIFIC SKILLS THEY CAN APPLY IN THEIR DAILY LIVES WHILE EXPLORING OTHER LEADERSHIP INTERESTS."

Janet Silversmith, CEO
Minnesota Medical Association



"OUR FACULTY CAN BE VERY PRAGMATIC IN THE WAY THEY TAKE RESEARCH AND APPLY IT TO THE BUSINESS SECTOR AND COME UP WITH REALLY SOLID BEHAVIORAL OUTCOMES THAT PEOPLE CAN PUT INTO PRACTICE ON A DAY-TO-DAY BASIS."

Carmen Eide
Director, business development
Carlson Executive Education

varied aspects of leadership in healthcare, such as emotional intelligence, coaching, negotiation, advocacy, finance, and strategy.

A key part of MNPLI is its partnership with the Carlson School. MMA leaders developed a vision for what MNPLI would deliver, hiring Carlson Executive Education to bring that plan to life. Then Carlson aligned its professors with expertise in each topic to teach that session, says Carmen Eide, director of business development at Carlson Executive Education.

Faculty share their knowledge, research, and real-world experience with MNPLI participants, weaving in experiential learning and case studies to keep the sessions compelling. "When you think about our faculty, they do a lot of research and consulting in the real-world business environment, and they have worked in the business world," Eide says. "They can be very pragmatic in the way they take research and apply it to the business sector and come up with really solid behavioral outcomes that people can put into practice on a day-to-day basis."

As healthcare has grown increasingly specialized and complex, it's especially vital for physicians to hone their leadership skills, Zellmer-Bruhn says. Often,

physicians end up in leadership roles to help clinics or healthcare systems manage this change, and leadership development can help them be effective.

"Investing in yourself and your growth is always a valuable thing to do. No matter where you think you will end up—even if it's not in a major leadership role—there are a lot of things in your day-to-day work you can think about improving and changing," Zellmer-Bruhn says. "There are a lot of ways we lead without a title, and we can make our jobs and workplaces better by going through this type of development."

Learning from each other

The cohort format is a key component of MNPLI. Together, participants share their



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Mary Zellmer-Bruhn, PhD
Associate dean of MBA and MS programs and professor
of organizational behavior
Carlson School of Management



"WHEN THE PROGRAM IS OVER, THESE ARE PEOPLE THEY CAN REACH OUT TO AND SAY, 'HERE IS WHAT'S HAPPENING IN MY PRACTICE AND ORGANIZATION. WHAT DOES THAT LOOK LIKE AT YOURS AND CAN YOU GIVE ME ADVICE THROUGH THAT?'"

Corey Martin, MD
MNPLI program co-chair and founder of Innovations in Resilience, a leadership and personal development consultancy

own work experiences and provide input based on their varied work settings, from metro area clinics to rural hospitals. A fruitful part of each session occurs when participants detail real-life work experiences and how they incorporated course learnings to navigate them, says family physician Corey Martin, MD, MNPLI program co-chair and founder of Innovations in Resilience, a leadership and personal development consultancy.

"One of the goals is that everybody who is in the MNPLI program gets to know each other and trust each other and be vulnerable with each other. They share their real face-down moments with each other and support each other in getting back up," Martin says. "When the program is over, these are people they can reach out to and say, 'Here is what's happening in my practice and organization. What does that look like at yours and can you give me advice through that?'"

In addition, MNPLI focuses on leadership styles, exposing physicians to different methods and helping them discover their own approaches. They also engage in developing communication skills and ways to work effectively with people who

have different leadership styles, says MNPLI co-chair Cindy Firkins Smith, MD, a dermatologist and physician-leader at CentraCare and past MMA president. In talking with participants, she adds, many have told her that "they are learning a lot about themselves. They have been uncovering skills that were already there and recognizing that they are already leaders."

Martin knows how helpful leadership training can be, having completed the St. Thomas program. Medical students and trainees don't get to spend much time developing and enhancing leadership skills—yet it is an important part of being a good clinician. "As we get into the real world, having those leadership skills is important in allowing our voices to be heard," he adds. "It allows us to speak up for patients and communities where we live so that we can provide the best care our patients deserve."

Smith likes to emphasize to physicians that they are leading all of the time, whether it's guiding patients through care decisions, leading by example with co-workers, or interacting with healthcare administrators. It's integral that physicians have a seat at the table and share their expertise and insights, as well as patient experiences.

"I believe that medicine needs physician leaders. By optimizing our leadership capacity and really honing our skills, it will make us all better leaders," Smith says. "It's really important that physicians lead within their organization and take the initiative to lead endeavors that will optimize care for patients."

Recent research published in the *Journal of Healthcare Management and Health Care Management Review* suggests that healthcare organizations with strong physician leaders have better outcomes and quality data. "It's really important that physicians who know the most about patient care and are in the trenches of caring for patients have a voice in healthcare policy," Smith says. "If we aren't speaking for patients, [decision-makers] don't understand the challenges of delivering the

TO LEARN MORE ABOUT MNPLI, VISIT [MNPLI.ORG](https://mnpli.org)

care and that patients have accessing the care. It's important that physicians speak for those patients."

Leadership training also can provide

relief to physicians experiencing burnout, Martin says. It's often helpful to take time away to do something that benefits them personally. Learning leadership tools helps physicians hold true to their values and work with integrity within organizations—an essential way for them to take more control over their work and ease burnout factors like moral injury, he adds.

It's not uncommon for physicians to shy away from leadership work because their primary driver is making a difference for individual patients, Smith says. But stepping in as leaders can allow physicians to make a lasting impact.

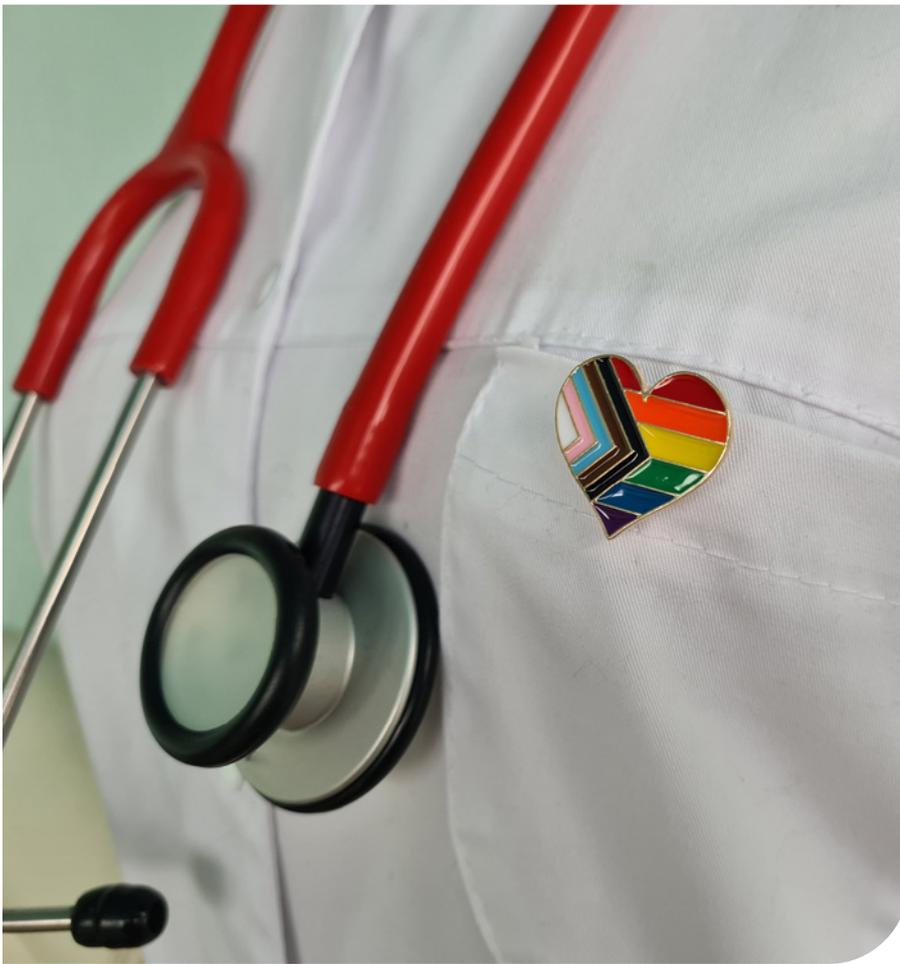
"As physicians we have the opportunity every single day to make a difference for our patients. We can do that one patient at a time. But when I step outside of the hospital or office and into a legislative office or insurance company and advocate for my patients to help pass a bill, that can result in powerful change for generations," Smith adds. "The way we can lead in medicine is really powerful." **MM**

Suzy Frisch is a Twin Cities freelance writer.



"I BELIEVE THAT MEDICINE NEEDS PHYSICIAN LEADERS. BY OPTIMIZING OUR LEADERSHIP CAPACITY AND REALLY HONING OUR SKILLS, IT WILL MAKE US ALL BETTER LEADERS."

Cindy Firkins Smith, MD,
Dermatologist and physician-leader
CentraCare



Creating a space for the LGBTQ+ community

Two Mayo physicians plan advocacy and community as chairs of MMA's new LGBTQ+ Section

Two Mayo Clinic physicians, psychiatrist Fi Fonseca, MD, and gastroenterologist Victor Chedid, MD, MS, have stepped in to chair the new LGBTQ+ Section that sprung from a session the MMA sponsored at last fall's Rainbow Health's All Gender Health conference to bring LGBTQ+ physicians and allies together.

"When we saw there was an interest from the MMA to have an LGBTQ+ Section, we got excited because we feel that we have a role in advocacy for trainees and physicians who belong to the LGBTQ+ community and their allies, as well as to patients who belong to that community," says Chedid. "Both of us stepped up and felt that it would be great to lead this as well as try to see where we go with it."

"I hadn't been as involved with MMA," says Fonseca. "This was an opportunity to start getting more involved and in a way that is close to my heart."

Minnesota Medicine asked what plans they have for the new section and how they plan to engage LGBTQ+ physicians.

Victor, you suggested this goes both ways—toward the physicians in the LGBTQ community, as well as patients that you might serve. So describe for me how this section might affect each of those groups.

CHEDID: Absolutely. I believe this section would benefit the MMA members and also physicians from Minnesota who belong to the LGBTQ+ community, because they would know that there's support from the MMA as a big medical association in this state. They would know that there is representation that looks like them, and that's a place for them to have their voice heard. So whether it is related to things pertaining to how to advance your career, or navigate your career while being from the LGBTQ community, or finding mentorship or people who are more senior than you. Growing up in medicine, I believe both Dr. Fonseca and I did not have folks who looked like us or belonged to the LGBTQ community who we could look up to—because we didn't know where to look. Having such a section

would help younger folks who are going in training know that there's this group of folks who could be either mentors or colleagues or people you can bounce ideas off of and get advice on how to navigate your career.

At the same time, it would benefit patients because as providers, we see patients from all walks of life and we see a lot of patients who belong to the LGBTQ+ community. We recognize that they have a lot of specific care needs. Many times a person who belongs to the LGBTQ community goes to their doctor and feels they're not heard, or they feel that they're not understood. So by creating such a section, we can set a lot of groundwork for policy that will ensure patients are getting the care they deserve. So let's give an example. In states around us transgender folks might not be able to get the care, the gender-affirming care they need, but Min-



VICTOR CHEDID, MD, MS
GASTROENTEROLOGIST
MAYO CLINIC



FI FONSECA, MD
PSYCHIATRIST
MAYO CLINIC

nesota does have sanctuary for transgender folks who are seeking gender-affirming care. So part of our role would be to ensure that we maintain the policies that Minnesota has in place and also help with making the patient's voice heard as well.

FONSECA: I think it comes down to two things—community and connection. How do you as a physician, as a queer physician, feel connected to your community of other queer physicians? And then how long do you feel connected to the larger queer community in your role as a physician serving the community? So, connecting with other physicians, yes. But also space for those who are not queer to be there and to learn so that they can better serve.

So tell me, how can people get involved? What ideas do you have for reaching out to people? How do you get the ball rolling?

FONSECA: I think starting with getting connected with MMA, reaching out to MMA administrative leadership, like the membership team. That would be one way to get connected. I don't think that we have a presence on the website yet. So there's a few areas for us to work on. I think we're still so new that we don't have a clear protocol.

CHEDID: We're gonna start our formal meetings [about the time this issue is published]. We've been figuring out a good time for us to meet. We'll figure out a better way of how we can get members to sign up and join, and we are going to

have a social event that we will be planning around Pride [Month] in June that would be sponsored by the MMA. So those will be venues for folks to know about us further and to join.

Tell me a bit more about the meetings you have planned. You've got presumably statewide interest here. We're talking about Zoom meetings?

CHEDID: For convenience for everybody it will be virtual meetings. And usually later at night when everybody's done with work. So after people finish their clinics or



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And then how long do you feel connected to the larger queer community in your role as a physician serving the community? So, connecting with other physicians, yes. But also space for those who are not queer to be there and to learn so that they can better serve."

FI FONSECA, MD



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VICTOR CHEDID, MD, MS

whatever they do. We will meet in the evenings mainly to plan our year and different aspects, whether it pertains to social events or mentee-mentor relationships, or figuring out other things pertinent to patient advocacy and trainee advocacy. So we will have agendas for every meeting.

FONSECA: I think the biggest thing is—How can we join our voices with the MMA to continue to support LGBT healthcare initiatives? And how can we build a network statewide so that clinicians can feel connected through the MMA to each other in the sense of community and can collaborate with each other on research, maybe writing, a mentorship like Victor was saying. And maybe a sense of down the road, as Minnesota is now a sanctuary state, how can we work together across institutions to smooth out care for our patients, especially trans patients? I'm working here at Mayo in the Transgender and Intersex Specialty Care Clinic, and I see patients who are in the Twin Cities who maybe would be better served by seeing a clinician there, but I don't know what their wait lists are like, compared to our wait list. How could we work in a way that optimizes outcomes for the patients.

In recent years, we've seen far more acceptance of gay people, gay issues, gay marriage. On the other hand in the last couple of years, we've seen a tremendous backlash against transgender people. How does that figure into this? I would imagine it in some ways makes this kind of effort, especially on the political front, a bit more imperative, does it not?

FONSECA: Absolutely. I wouldn't say that they're kind of opposite things. I would say actually, the challenges that the trans community is facing actually puts some of the progress that the gay community has made kind of in peril. That's more how I see it—kind of steps backwards for everyone. I see these folks having a rough time; that means these folks are next. That's what I'm seeing—a precarious position for everyone. So I definitely think this is important, especially because we're a sanctuary state.



How can we continue to protect that for our community, for our patients, for our



“The challenges that the trans community is facing actually puts some of the progress that the gay community has made kind of in peril. That's more how I see it—kind of steps backwards for everyone. I see these folks having a rough time; that means these folks are next. How can we continue to protect that for our community, for our patients, for our clinicians, all of that and keep pushing forward instead of undoing all of these gains that have been made.”

FI FONSECA, MD

clinicians, all of that and keep pushing forward instead of undoing all of these gains that have been made.

CHEDID: I 100% agree with what they said [Fonseca uses the pronouns they/ them/their]. I view it the same way—that the attack is now on the transgender community, but I don't see that the lesbian and gay community is that much more privileged. That's why our unity is very important. The unity within our community is very important for advocacy for all. I'm a strong believer that when somebody's rights are being stripped from them, that means that everybody's rights are in danger. And when we speak up for one group's rights, that means we speak up for all groups' rights.

FONSECA: Especially with like homophobia, transphobia. They're so interwoven that it's really hard to talk about one without addressing the other.

CHEDID: 100% agreed.

In terms of mentor-mentee relationships, I realize you haven't had a long time to think about this and put it together, but do you have any plans to foster those relationships?

FONSECA: I can speak a little bit to that. Before moving to Minnesota, I was in Michigan, and I was very involved with the Michigan Psychiatric Society. I actually set up a mentorship program for that state organization. So I think we could use some of those materials to adapt for MMA and the LGBT Section. Mentorship

is something that folks need at every stage of the career, whether they are premed or midcareer or even later career.

CHEDID: I agree and I've had experience myself as well with the same topic with mentorship and training as part of the American College of Gastroenterology and as part of the American Gastroenterology Association. I belong to training committees there and I've developed programs and worked on developing programs for aligning mentors with mentees based on their research interests and career focus. And I also am part of an advocacy group within gastroenterology. We developed a group together that is a whole group of LGBTQ+ gastroenterologists, a national group called Rainbows in Gastro. We are working together on doing a mentorship-mentee program for Rainbows in Gastro. I will apply these skills in the MMA section.

The way I envision it is that mentorship is either you have a mentor who will be mentoring you along the way for a long period of time, or sometimes you need mentorship for a small period of time. We will be surveying the capacity of the mentors versus the need of the mentees and we will try to match them along those lines.

FONSECA: It wouldn't necessarily be a one-to-one kind of thing. Because you might need a different person for a different thing. And it's not just one mentor, even if it is a longitudinal mentor that you have.

I presume this is a work in progress....

FONSECA: We haven't quite started yet.

CHEDID: This is vision.



“I think it’s just so important that there is a space, that the space exists, because without an open declaration of the space existing, it’s something that would have to be kind of addressed sideways in a lot of different directions. And this was really an opportunity to join voices and join forces. That’s where the organization MMA is so critical and why it’s so important for us to work through the organization.”

FI FONSECA, MD

Then regarding political issues and dealing with those issues at the Legislature, again, I presume we’re at a nascent stage here. But tell me how that might unfold.

FONSECA: To me, it would be starting by joining with what the MMA is already doing. And I know there were several kinds of bills that we were asked to weigh in on, chime in on. So I think starting with that, sharing our thoughts with the MMA, encouraging membership to do the same. Then if there are areas that are missed, in the MMA's consideration as they respond to views on bills being proposed, we could then fill in that gap, and say, hey, this is what we're hearing from the members of the section. This is something that is of concern that we need to start thinking about addressing as an organization. So

very much working through the MMA is how I envision our role with the section.

CHEDID: Yes, I second all what they said. One thing I know from the MMA is we will be aligning with their key initiatives that are for 2024. And I know they focus on advocacy, so advocating engagement and connection, empowering and transforming healthcare, and then informing. I think we will be doing part of that work with the MMA, too, but from an LGBT perspective.

Is there anything else you'd like to add in terms of getting people involved in the section?

FONSECA: I think it's just so important that there is a space, that the space exists, because without an open declaration of the space existing, it's something that would have to be kind of addressed sideways in a lot of different directions. And this was really an opportunity to join voices and join forces. That's where the organization MMA is so critical and why it's so important for us to work through the organization.

CHEDID: I just would add that I want to make it clear that although both of us are Mayo physicians, we just want to make sure that the word spreads out to all the medical centers in Minnesota. Everybody's welcome to join and we would love all the diversity from all the different medical centers across the state to be part of our group. Because the more voices we have, we get different perspectives from different healthcare centers and how it is done in different places. It'll enrich our experience and enrich the agenda and plans that we have in the future.

FONSECA: That is a really important point. We need others on board. **MM**

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

Urachus remnant

A rare cause of colovesical fistula

BY ZACHARY J ANDERSON, DO; SIMRANJIT KAHLON, MBBS; CASSIANO SANTIAGO, MD; SAMUEL IVES, MD

The urachus is a canal that connects the allantois to the fetal bladder and will typically atrophy in the fetal period. If the process of involution fails, this can lead to inflammatory changes causing a spectrum of anomalies including bladder diverticula, neoplasia, and colovesical fistulas (CVFs). Although CVFs account for an estimated 1 in 3,000 surgical admissions, it is exceedingly rare that the inciting factor is remnant urachus tissue.

Case report

A 52-year-old man presented for dysuria and malodorous urine. The patient had no history of tobacco use, prior abdominal surgeries, or significant family history. On examination, there was some suprapubic tenderness. Genital, prostate, and rectal examinations were normal. Testing for urinary tract infection and sexually transmitted illness were negative, and PSA was not elevated. The patient was treated on levofloxacin for four weeks.

He returned to clinic after four weeks now reporting the sensation of air in his urine. He was subsequently sent for computed tomography (CT) of the abdomen and pelvis.

Findings demonstrated a large hypervascular mass at the bladder dome consistent with remnant urachal tissue with features for concerning for malignant

transformation (Figure 1). This was associated with air in the lumen suggesting formation of a CVF (Figure 2). The patient was referred for colonoscopy and there was no fistula or abnormality appreciated throughout the visualized intestinal tract.

He underwent a sigmoid colectomy, robotic-assisted partial cystectomy, and urachus excision with umbilectomy. The tumor was successfully removed without incident. His genitourinary symptoms resolved with the surgical treatment of the CVF.

Discussion

The urachus is a canal that connects from the fetal bladder to the allantois and serves to empty the bladder. Throughout the fetal period, the urachus will typically atrophy, leaving a fibrous strand that becomes the median umbilical ligament. The estimated incidence of urachal anomalies in the adult population is 1 in 5,000. In the pediatric population, the incidence is estimated to be closer to 1 in 500, suggesting there is a component of resolution naturally.

Fistulas are abnormal connections between two body parts or organs that do not normally connect. One such type is a colovesical fistula, an irregular connection between the bladder and a part of the colon. The sigmoid is the most commonly affected segment of the colon. The most

common symptoms seen in CVFs are pneumaturia, fecaluria, and urinary tract infections. The exact incidence of CVFs is unknown, but it is estimated that 1 in 3,000 surgical admissions are due to symptomatic CVFs. The most common etiology of CVFs is diverticulitis, followed by malignancy and Crohn's disease.

For patients with symptoms including lower abdominal discomfort, a palpable suprapubic mass, or recurrent

unexplained urinary symptoms—urachus remnant should be on the differential. Visualization with ultrasound or computed tomography of the abdomen and pelvis can support the diagnostic conclusion.

Urachal remnants should be monitored for structural or malignant transformation, and surgical removal should be discussed. Management of CVFs with surgical approach is considered safe and effective with good perioperative and long-term outcomes.

Our patient had an unremarkable surgical course and resolution of symptoms within six weeks. **MM**

Zachary J. Anderson, DO, and Simranjit Kahlon, MBBS, are internal medicine residents at Hennepin County Medical Center. Cassiano Santiago, MD, is a diagnostic radiology resident at the University of Minnesota. Samuel Ives, MD, is an internal medicine physician at Hennepin County Medical Center.

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FIGURE 1

Sagittal view of bladder tumor



FIGURE 2

Axial view of colovesical fistula





Physicians and physicians-in-training from across the state gathered to advocate on behalf of medicine.

White coats take over Capitol to advocate for medicine

PHOTOGRAPHY BY RICH RYAN

More than 170 physicians, residents, and medical students flooded the hallways and legislative offices at

the Capitol complex February 28, as part of Physicians' Day at the Capitol.

Physicians and physicians-in-training heard from Sen. Kelly Morrison, MD, and met with legislators to discuss MMA's top legislative priorities: prohibit prior authorization for critical services; stop insurers from forcing patients to switch medications midyear; promote well-being in Minnesota's healthcare workforce; ensure patient treatment wishes are followed and respected; and reduce substance use disorder morbidity and mortality.

Following Morrison's keynote, Dave Renner, MMA's director of advocacy, and Chad Fahning, MPP, MMA's manager of state legislative affairs, reviewed the MMA's top legislative priorities. Then, attendees proceeded to meetings with their legislators. Members shared information with them on the MMA's priorities or other issues that were important to them.

"What a fantastic day for healthcare advocates," said MMA President Laurel Ries, MD, who served as emcee for the event. "So much energy. So much passion. It's always great to see our members getting involved and educating lawmakers on how laws affect them and their patients." **MM**



It was a beautiful day to meet with lawmakers.



Jasmine Kamboj, MBBS, and Amrit Singh, MBBS, listen to staffers review the MMA's top legislative priorities.



Sen. Kelly Morrison, MD, addressed the group.

News Briefs



An award-winning night, from left: MMA CEO Janet Silversmith; MMA President Laurel Ries, MD; Michael Osterholm, PhD, MPH; Jan Malcolm; Minnesota Health Commissioner Brooke Cunningham, MA, MD, PhD; and MMA Board Chair Kim Tjaden, MD, MPH.

Osterholm, Malcolm honored by AMA

The AMA awarded six individuals with its prestigious awards for outstanding government service. Among the recipients were two Minnesotans, Michael T. Osterholm, PhD, MPH, who received the award for Outstanding Member of the Executive Branch Serving by Presidential Appointment, and former Minnesota Health Commissioner Jan Malcolm, who received the award for Outstanding Career Public Servant at the Local Level.

The awards were presented in mid-February at the AMA National Advocacy Conference in Washington, D.C. The MMA nominated Osterholm for the honor.

Osterholm, the director of the Center for Infectious Disease Research and Policy (CIDRAP) at the University of Minnesota, is a renowned epidemiologist who warned for years that the United States was ill-prepared for a pandemic. He was appointed to President-elect Joe Biden's COVID-19 transition advisory board, and previously served as science envoy for health security on behalf of the State Department.

"Having worked directly with Dr. Osterholm for many years, the Minnesota Medical Association was honored to nominate him for this prestigious award," said MMA President Laurel Ries, MD. "Minnesota physicians recognize his vast and deep expertise and value his ability to communicate threats to public health in a way that penetrates through so much noise. We are particularly grateful for his collaboration and genuine empathy for the individuals and families harmed by infectious diseases."

Malcolm served as health commissioner under three governors. Her first stint, 1999 to 2003, was in Gov. Jesse Ventura's administration. Gov. Mark Dayton tapped her for health commissioner in 2018, where she stayed until 2022 under Gov. Tim Walz.

"The MMA is delighted that Jan Malcolm's exemplary and longtime leadership in Minnesota healthcare has been honored by the AMA," said Janet Silversmith, MMA CEO.



Newborn Screening Program adds to list of conditions

Minnesota's Newborn Screening Program continues to grow.

In late February, the program began universal screening for Krabbe disease one month after adding Duchenne muscular dystrophy (DMD) to the list of conditions for which Minnesota newborns are routinely screened.

Krabbe disease is a rare, genetic condition in which the newborn cannot fully break down certain fats. These fats build up in the body and can lead to damage to the nerves affecting a person's ability to eat, walk, and speak. In the most severe form, symptoms can progress to death within the first two years of life.

DMD is the most common form of muscular dystrophy. It is extremely rare for females to have it, but they can be carriers. The life expectancy for males with this condition is around 20 years.

The MMA has been a long-time supporter of the state's newborn screening program.

Since 1964, when Minnesota started screening for PKU (phenylketonuria), blood samples from all Minnesota newborns have been sent to the Minnesota Department of Health's Public Health Lab for screening unless their parents opt out. The lab now screens all babies born in Minnesota for more than 60 conditions.

MMA Mayo member wins national award

In February, A Breath of Hope Lung Foundation announced Anastasios Dimou, MD, assistant professor of medicine at the Mayo Clinic College of Medicine, as the winner of its 2023 Peg's Fight for Life Research Award.

Dimou, an MMA member, won for his project entitled: "BiTE to target EGFR peptide: HLA class I complexes in EGFR mutant lung cancers." Dimou's clinical focus includes strategies to overcome resistance



to immunotherapy in EGFR-mutant and other mutation-driven non-small cell lung cancers (NSCLC).

In a statement, A Breath of Hope Lung Foundation “expresses its gratitude to Dr. Dimou and his lab at the Mayo Clinic for their extraordinary commitment and contributions to the lung cancer field. Translational research focused on understanding mutations (and resistance) improves treatment options for lung cancer patients, allowing them to live longer and better. Funding competitive science is the road to improved lung cancer survival.”

A Breath of Hope Lung Foundation is a national 501(c)(3) nonprofit organization founded by a group of Minnesota patients and caregivers in 2008. The group’s mission is to improve survival by funding innovative U.S. research, educating the public for improved disease awareness and early detection, and providing support and education to lung cancer patients and their caregivers.

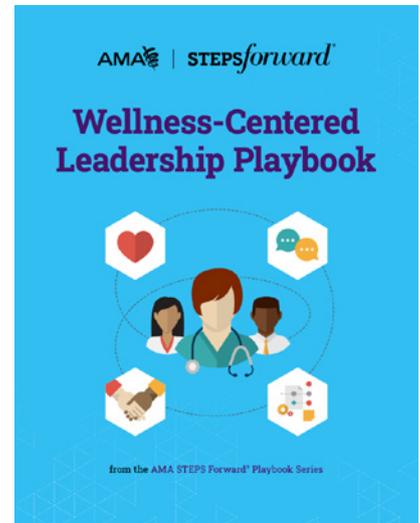
New wellness tools available from AMA

If you are considering strategies to help you thrive at work, the AMA has curated a series of toolkits, videos, podcasts, and ready-to-use tools to help you create positive change in your practice.

Physicians and leaders looking to refocus their practice can turn to AMA STEPS Forward for proven, physician-developed

strategies for confronting common challenges in busy medical settings.

The AMA’s Wellness-Centered Leadership Playbook, released in 2023, presents the reasons why physician well-being is so important and offers specific actions leaders can take to get started on developing a culture of well-being across their organization. The playbook also contains links to numerous sources to help establish an environment that creates the organizational foundation for joy in medicine. MM



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FROM THE CEO

A good investment strategy for good

The MMA is in the fortunate position to have investment assets. Based on Board of Trustees–adopted policy, these funds can be used for: infrastructure improvements; maintaining services and stability during short-term economic downturns; unique board-identified programs or activities; and some operations support. The MMA’s Finance and Audit Committee, with the guidance of professional staff and outside advisors, is responsible for the oversight and management of MMA investments.

A long-standing and key policy of the MMA is a prohibition on investing in companies that produce tobacco. As an organization whose mission includes making Minnesota the healthiest state,

that investment limitation is universally supported. Until recently, however, most other investment decisions were guided by traditional considerations of risk, return, and fees, with little additional attention paid to whether the companies and funds in which MMA invested were aligned with MMA’s mission.

In 2022, the MMA Foundation Board asked whether additional investment restrictions or considerations, beyond tobacco, should be incorporated (both organizations follow the same investment policy). In response, the MMA Board of Trustees directed staff and the Finance and Audit Committee to consider whether a more socially responsible investment strategy was appropriate for MMA.

Socially responsible investing, or ESG investing, allows organizations to invest in (or avoid) industries and companies based on assessments of their environmental safeguards (e.g., climate change impact/response), social structures (e.g., relationships with employees, suppliers, customers, and communities where they operate), and governance standards (e.g., leadership, executive pay, audits, internal controls, shareholder rights). Although ESG investing has attracted some political heat, there is little debate that ESG investing is increasing in popularity.

Importantly, a growing body of research suggests that ESG investment performance is comparable or better.

The MMA spent more than a year analyzing this issue. To help guide its consideration, the Finance and Audit Committee adopted a set of principles to guide its discussion and analysis. In particular, the committee noted that any changes to MMA’s investment strategies should:

- Provide competitive returns relative to current investment approach (i.e., must not undermine ability of investment fund performance to meet MMA needs);
- Ensure any investment screens, whether positive or negative, maintain sufficient investment choices for investment return and diversification;

- Have similar or lower internal costs/fees than currently in place;
- Limit administrative costs by limiting review of any screens to no more than once every three years, barring extraordinary circumstances;
- Only consider investment screens that clearly align with MMA-adopted policy.

After more than a year of thorough analysis and thoughtful deliberation, the Finance and Audit Committee unanimously recommended to the Board of Trustees that MMA investments be screened for highly rated ESG funds in addition to existing exclusions (i.e., tobacco). At its September 2023 meeting, the Board of Trustees unanimously adopted the recommendation. As of January 2024, all of the MMA’s investments comply with this new policy.

I’m proud that the MMA’s assets are invested in organizations that are performing well and, by best available metrics, doing good. Members of the MMA can be confident that the assets are being invested to support the MMA long into the future. **MM**

Janet Silversmith
JSilversmith@mnmed.org

VIEWPOINT

Fellow female physicians: reach out and mentor someone today

When I began working in St. Cloud more than 20 years ago, I was the third female family physician in our family medicine clinic of 35 physicians. I was, and am still, grateful for the women who went before me and those who have come after. I thank them for their support, understanding, and guidance in my early years of practice.

After the birth of our children, I remember my friends visiting to offer support and help with the major changes we faced at home and at work. One friend would watch our kids if they were sick or had a day off from school, and I would watch hers, as we had different days off.

Women like former MMA presidents Marilyn Peitso, MD, Cindy Firkins Smith, MD, Patricia Lindholm, MD, as well as current President Laurel Ries, MD, have shown that they can successfully balance a practice, a family, and leadership responsibilities. They have served as role models for many of us in medicine.

Of course, we all follow in the footsteps of such pioneering female physicians as:

- Emma Katherine Ogden, MD, the first practicing physician in Minnesota in the 1880s.
- Gertrude Booker Granger, MD, the first woman to join the Mayo brothers in practice back in 1898.
- Orianna McDaniel, MD, the first woman to work as a physician for the state of Minnesota in 1896.
- Martha George Rogers Ripley, MD, one of the first female physicians in the state, who established the Maternity Hospital in Minneapolis in 1886.

They were true leaders and paved the way for females to find their own paths as physicians.

The mentorship of younger generations is crucial to the advancement of women in medicine. Through mentorship programs and professional networks, we offer invaluable support, encouragement, and wisdom, helping to nurture the talents of tomorrow's medical leaders. Knowing that I was not alone in my struggles helped immensely in those first years of practice. Having coffee or lunch with trusted women physicians encouraged me to grow as a leader and a physician. It also gave me the opportunity to feel supported and that my struggles were not mine alone.

I am blessed to have a troop of women physicians who gather a few times each year for a short trip and other times just for coffee. These women are my friends and mentors. As we were reflecting on our times together last September, I asked our group, "Who are we mentoring?" It's important that we share our gifts of knowledge and experience with those newer in the field. Since that weekend, I have gathered a few younger and more experienced women physicians and medical students for a meal and offered to mentor them.

My fellow female physicians, I encourage you find a way to mentor a female physician. Gather in small groups and discuss challenges you've faced and your accomplishments. Share a meal and support each other.

If you want to mentor more formally, you can work through the MMA Mentorship Program, which connects pre-med



Kimberly Tjaden, MD
MMA board chair

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students, medical students, and residents/fellows with mentors who help answer questions, provide advice, and offer career guidance. You can find out more about this program here: www.mnmed.org/mentorship.

Honor those who came before you by mentoring some of our future physicians. You won't believe how rewarding it is. **MM**

GUSTAVO A. CORTES PUENTES, MD

- Currently a consultant in the Division of Pulmonary and Critical Care Medicine at Mayo Clinic in Rochester and an assistant professor of medicine and physiology at Mayo Clinic Alix School of Medicine. I also serve as the chair of the Equity, Inclusion, and Diversity Subcommittee for the Critical Care Independent Multidisciplinary Practice at Mayo Clinic Rochester.
- MMA member since 2013.
- Graduated medical school in Colombia and worked as a physician in both rural and urban communities, personally experiencing the sociopolitical challenges that surrounded medical practice in Colombia two decades ago when guerrilla groups and political unrest impacted the lives of many Colombians. Training and practicing as a doctor in Colombia was a unique life experience. Colombia is a place where cultural, racial, artistic, and musical diversity are fundamental pillars of the country's identity. That social, cultural and political contrast of Colombia undoubtedly helped me in developing my leadership skills, and practice medicine with a sharp appreciation of socioeconomic reality.
- Clinical training includes an internal medicine (IM) residency at the University of Minnesota and a pulmonary and critical care medicine (PCCM) fellowship at Mayo Clinic in Rochester. Prior to my IM residency training, my research training included a research scholar program at the University of Minnesota on physiology-based experimental animal studies evaluating pulmonary mechanics and mechanical ventilation under the mentorship of Dr. John J. Marini.
- While I studied, trained, and practiced medicine in Colombia and the United States, I learned the valuable lesson that clinical practice and applied physiological research can complement each other in improving delivery of care. These experiences, combined with my personal background as a Latino immigrant and member of the LGBTQ+ community, have reinforced the importance of promoting equity and diversity in healthcare, research, and leadership as an essential part of my identity as a physician scientist.



Cortes Puentes takes in the sights of Lucerne, Switzerland, from the Kapellbrücke (Chapel Bridge) spanning the River Reuss.

I became a physician because...

Of values instilled in me by my family. I embraced the idea of being a part of a profession focused on helping others, regardless of circumstance or socioeconomic background; one that focused on healing and improving quality of life. As early as elementary school, I developed a love for math and science. I somehow knew very early on that medicine was the career for me, and I hoped to help people by applying science.

The greatest challenge facing medicine today...

Cost, health disparities among under-represented populations, and staffing shortages—a few come to mind. I also think that with the increasing digitization of healthcare, regulatory changes should involve stricter data privacy and security requirements, so that data privacy and security do not become bigger issues.

How I keep life balanced...

By working on my ability to completely disconnect when I am “off” work. Finding alignment between clinical practice, research and advocacy efforts also helps in keeping that balance.

If I weren't a physician...

I would be an art curator. I would love to plan and organize art exhibitions at museums, galleries, and other institutions. **MM**



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