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CHANGING HOW
HEALTHCARE
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THE CHALLENGE
OF PERSONAL
WELL-BEING.

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Academic and healthcare institutions as well as policymakers can indeed break this cycle if they are truly committed. Having true representation in those rooms is critically important in addressing inequities in healthcare.

Who is—and isn't—in the room?

Surround yourself with people who fight for you in rooms you aren't in."

I recently read this anonymous quote, which got me thinking how profoundly this statement gets to the core of our conversations around equity. Imagine a world in which all of us, not just some of us, have people who genuinely fight for us in those rooms we aren't in. Could this be a world in which real equity can indeed be possible?

When you come from a long lineage of poverty or social disempowerment, it is difficult to surround yourself with people who fight for you in rooms where consequential decisions are made. This is because the people who truly share your background and understand the circumstances that affect your life aren't usually in those rooms. And if they are, they are far too few to have a truly empowered voice.

Take our own privileged profession for example. I recently read that one of the best predictors of becoming a doctor is having family members who are doctors. Most people don't have family members who are doctors. That is especially true of people of color. In a recent publication on *JAMA Network* in 2022 by University of Minnesota researchers, high-income households are overrepresented among medical students—not just overall, but within respective ethnic and racial groups. This has great implications on who gets to be in "those rooms" representing our patient's needs. It is extremely difficult to get in those rooms when you don't have the requisite intergenerational social and economic capital. These are not insurmountable challenges. Academic and healthcare institutions as well as policymakers can indeed break this cycle if they are truly committed.

Having true representation in those rooms is critically important in addressing inequities in healthcare. Let's take maternal

health for example. Globally, one woman dies every two minutes from pregnancy and childbirth-related causes with 95% of those who die living in low- and middle-income countries. In Minnesota, as described in the maternal mortality report by the Minnesota Department of Health for 2017–18, Black Minnesotans made up 23% of pregnancy-associated deaths while they represent only 13% of the birthing population, and American Indian Minnesotans made up 8% of pregnancy-associated deaths while they represent only 2% of the birthing population. Together these two demographic groups make-up almost one-third of the maternal mortality in Minnesota from primarily preventable causes. This in a place touted to be one of the healthiest states in the nation. Healthiest state for whom?

The good news is that we know what the solutions are. Addressing these disparities calls for making pregnancy, childbirth, and extended postpartum care not only available but also accessible, affordable, and acceptable. But this calls for a commitment to dismantling systemic barriers and bias. It also means addressing social determinants of health such as trauma, housing and food insecurity, transportation, and behavioral and mental health.

In order to accomplish these, we need to make an intentional effort to build the pipeline for more socially and economically diverse healthcare and health industry leaders and champions who can be in those rooms fighting for those communities on important health, policy, and resource allocation decisions. **MM**

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Health professionals and neighborhood activists meet in North Minneapolis to tour environmental sites.

PHOTO BY ANDREW TYAN, MD, MPH

Aboard the environmental justice tour of North Minneapolis

Historical discrimination created environmental-related health disparities in Minneapolis' Near North neighborhood. Community organizers are fighting back, and medical professionals are supporting them.

BY VISHNU LAALITHA SURAPANENI, MD, MPH, SARAH RASMUSSEN, LAUREN VASILAKOS, ANAM HASAN, MELISSA WALSH, MADI SUNDLOF

Who can tell me what particulate matter is?" asked Princess Titus. As a bus full of medical students and health professionals listened, Titus explained how breathing in fine particulates (PM_{2.5}) generated by burning fossil fuels

can cause health impacts like asthma, lung cancer, and strokes.

This was not a medical school lecture about environmental health. In fact, despite routinely caring for patients from "frontline communities"—those hit first and worst by environmental pollution and

climate change—health professionals are seldom trained on how these issues contribute to health outcomes or how we can intervene.

Many of us don't experience environmental injustice first-hand. What's more, high-income earners such as physicians

PHOTO BY LAALITHA SURAPANENI MD, MPH



GAF Materials Corp., one of several manufacturers located near North Minneapolis residential areas.

PHOTO BY ANAM HASAN



The Hennepin Energy Recovery Center, a controversial site in North Minneapolis.

disproportionately contribute to pollution and climate change. The healthcare system itself, including hospitals, clinics, the pharmaceutical industry, and medical device companies, produces 8.5% of annual greenhouse gas emissions in the U.S.

So, for Earth Day this year, Medical Students for a Sustainable Future, a University of Minnesota student group, and Health Professionals for a Healthy Climate (HPHC), a local nonprofit, organized an environmental justice tour that enabled health professionals to see, smell, and breathe the pollution of North Minneapolis. This action-oriented tour was led by community members Titus, co-founder of Appetite for Change, and Roxxanne O'Brien, co-founder of Community Members for Environmental Justice (CMEJ). The science- and policy-based information shared on the tour was curated by Shalini Gupta, co-founder of CMEJ.

Before we boarded the bus, O'Brien set the tone. "We want you to learn, but also want you to apply it," she said. "Use your privilege and work with us."

The 55411 ZIP code neighborhood of North Minneapolis, through which we toured, is ground zero for asthma, with the rate of hospitalizations nearly five times the state average. This burden is attributable in part to PM2.5 pollution, according to the Asthma in Minnesota report from the Department of Health (MDH). PM2.5 is associated with diseases in nearly every organ system, including causal links to cardiovascular mortality and new-onset childhood asthma.

PHOTO BY SABAH RASMUSSEN



The tour concluded with a workshop at Breaking Bread Cafe, a locally owned restaurant.

Because of heavy industrialization, community members here also face toxic exposures to airborne heavy metals like arsenic, chromium, and cobalt, and carcinogenic volatile organic compounds. North Minneapolis residents, who've had their access to green spaces and the Mississippi River restricted by decades of redlining, industrialization, and the I-94 highway construction, have a tree equity score—a measure developed by American Forests based on tree canopy, surface temperature, income, employment, race, age, and health factors—in the 50s, compared with Edina's score above 95. The lack of green spaces exacerbates urban heat islands, increasing health impacts of climate change.

On the tour, we visited the site of Northern Metal Recycling, now closed. In 2017, dangerously high levels of air pollution from PM2.5 and lead near the facility resulted in a \$2.5 million settlement between Northern Metal and the Minnesota Pollution Control Agency. A fourth of this settlement was appropriated for mitigation of asthma and lead poisoning in the surrounding neighborhoods and is currently available for patients. Despite this pollution, the company continued to operate in North Minneapolis. As with most industries, Northern Metal measured and self-reported its pollution to the MPCA. Years of relentless community activism, bolstered by a whistleblower statement that the company falsified pollution reports, led Northern Metal to shut down its metal shredder in 2019. However, the company still stored scrap materials at the facility, which caught fire in 2021. The spike in pollution seen in the area following the intense fire is yet another example of health risks of living in proximity to industry. The site was sold in 2022.

"We are worn out," O'Brien said, "Businesses think about what risks they are taking for themselves, but no one is thinking about what risks they are taking on behalf of everyone else."

The tour also stopped at the Hennepin Energy Recovery Center (HERC), the



"We want [environmental justice tour group participants] to learn, but also want you to apply it. Use your privilege and work with us."

– Roxxanne O'Brien, co-founder, Community Members for Environmental Justice

largest trash burning incinerator in Minnesota. Burning trash creates energy that is sold to Xcel Energy to power Target Field and surrounding residences—you may have seen their ads on trash bins at the Minneapolis airport. Businesses and communities outside of North Minneapolis send their trash to the HERC.

“It’s like you’re throwing trash in my front yard, in the front yard of Black and brown communities,” O’Brien said. Incinerating plastics releases dioxin, a carcinogen that settles in the soil and water surrounding the facility, eventually ending up in the food chain. In 2019, HERC’s PM2.5 emissions resulted in an estimated \$11–24 million a year in health impacts, according to an independent analysis by PSE Healthy Energy. Its 2021 CO₂ emissions were equivalent to that generated by 35,000 cars in a year.

The Minnesota Environmental Justice Table is working to shut down HERC. They argue that rather than incinerate waste, or send it to a landfill, communities should “work upstream” to reduce the volume of waste. For example, up to

70% of the “trash” received by Hennepin County, including 30% organics and 40% recyclables like paper, metal, and plastic, can be diverted away from the incinerator through improved composting and recycling measures. HPHC is working with the EJ Table to persuade and organize health professionals to shut down HERC and implement zero-waste strategies.

Industries are typically regulated as a “point source” of pollution. MPCA sets limits on how much pollution each facility can emit. However, as we stopped at various sites on the tour, it was clear that residents in heavily industrialized neighborhoods, like North Minneapolis, are breathing in “acceptable pollution” from multiple sources everyday.

“We don’t breathe in just one pollutant at a time,” O’Brien says. CMEJ worked with State Rep. Fue Lee (DFL-Minneapolis), who introduced a bill this session to require the MPCA to consider the cumulative impacts of pollution before issuing an industrial air quality permit in an environmental justice community. In

“It’s like you’re throwing trash in my front yard, in the front yard of Black and brown communities.”

– Roxxanne O’Brien, co-founder, Community Members for Environmental Justice

Minnesota, the MPCA considers tribal areas, neighborhoods with 50% or more people of color, or communities where at least 40% of people are below the federal poverty level as areas of increased concern for environmental justice.

At the end of the tour, participants transitioned to a workshop at Breaking Bread Cafe, a locally owned restaurant. The workshop was designed to begin filling the gaps between knowledge and action. Using the vulnerability assessment framework from *Lancet* Countdown on health and climate, students worked through case studies of patients impacted by poor air quality and



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extreme heat. Participants learned about resources that clinicians can provide to their patients to mitigate risks, including air-quality alerts and weatherization assistance through the Department of Commerce.

O'Brien encouraged clinicians to educate patients about the city's asthma program, which identifies and reduces asthma triggers such as air pollution, mold, and pet dander in the homes of children less than 21 years of age, and provides free products like HEPA filters and mattresses. The Northern Metal settlement also allows residents of North and Northeast Minneapolis to receive payment for attending asthma education classes and in-home lead assessments.

Students also took time to reflect on what they learned during the tour. Some noted how air pollution and climate change impacts are pervasive across the state, impacting rural and tribal communities as well. The Climate Justice report released by HPHC last year cited several examples of polluting industries being located in or near tribal lands, including

nuclear waste sites and pipelines like the Enbridge Line 3.

Many students spoke about why advocacy should be an integral part of medical education and practice. "Social determinants of health is a framing that's helpful to us, not for patients. They already know what it is. They're living it!" said a third-year medical student, giving a powerful call to action to physicians to broaden our scope of practice from traditional roles of clinicians and researchers to include that of community advocates. The student continued, "If we don't pair our research with actions that directly benefit frontline communities, we are complicit in perpetuating inequities."

As health professionals, we may feel we have limited options when caring for patients affected by environmental injustice. You may have been taught that your role is only to escalate asthma therapy, advise smoking cessation, and prescribe medications for secondary prophylaxis of strokes and

heart attacks. And while there is a growing recognition that 80–90% of health outcomes are impacted by health-related behaviors, socioeconomic factors, and environmental factors, our current system rarely allows us the time or the tools to work upstream and address these issues.

So, as the next generation of health professionals, we are building a structure for our upstream work. We are organizing in groups such as HPHC or Medical Students for Sustainable Future. We are engaging with frontline communities, such as CMEJ, and advocating for solutions they are championing. For example, because of the information shared on the tour, a medical student testified at the Minneapolis City Council in support of zoning that limits exposure to environmental pollution. Through advocacy, we are practicing patient-centered medicine, and working to create a healthier and equitable future. **MM**

Vishnu Laalitha Surapaneni, MD, MPH, is an assistant professor at the University of Minnesota Medical School. Sarah Rasmussen, Lauren Vasilakos, Anam Hasan, Melissa Walsh, Madi Sundlof are students at the medical school, Twin Cities campus.

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The devastating effects of racial disparities in acute stroke management: where we stand now

New treatments have dramatically reduced stroke-related disability, but the benefits are not being equally shared with Black patients.

BY EVAN BANKS, CODY J. RASNER, ALISON LESLIE, HAITHAM HUSSEIN, MD

Recent advancements in medical intervention for cerebrovascular disease, specifically the advent of intravenous thrombolytics and mechanical thrombectomy, have allowed for monumental reductions in stroke-related disability. Despite such advancements, there continue to be racial inequities in stroke management.

To evaluate potential discrepancies in thrombolytic therapy based on racial identity, we performed a single-center study evaluating the use of thrombolytic therapy for ischemic strokes within an urban, academic institution. The rates of IV thrombolytic use in people who self-identified as white or Black were calculated and statistical analysis was performed using a Z-test of proportions.

We demonstrate significant discrepancies in patients receiving IV thrombolytics by race, with 5.1% of Black people and 11.1% of white people who presented with

an acute ischemic stroke receiving IV thrombolytics.

Such discrepancy may be due to a variety of social, cultural, and economic factors. The persistence of disparate outcomes in stroke management based on race should incite a call to action to promote antiracist interventions at a local and national level to mitigate stroke-related morbidity and mortality in people of color.

Monumental reductions

In recent decades, significant advancements in medical intervention for stroke care have led to monumental reductions in stroke-related mortality and are acknowledged as one of the 10 great public health achievements for the United States in the last 50 years. By 2008, age-adjusted annual death rates from stroke were only one-fourth of the historic rates measured from 1931 to 1960 (40.6 vs. 175.0 per 100,000). Preventative measures, such as improved blood pressure control, antithrombotic medications, and decreased smoking rates have lowered stroke risk. Additionally, IV tissue plasminogen activator (tPA) and the life-saving mechanical thrombectomy procedure have played an essential role in improving functional outcome and decreasing acute ischemic stroke mortality.

Intravenous thrombolysis with tPA was first approved for acute stroke management by the FDA in 1996, and an abundance of research and clinical data have



TABLE 1

University of Minnesota and Fairview report of the proportions of patients receiving intravenous thrombolytic therapy during the management of an acute stroke.

Data was acquired from January 2021 through October 2022.

THROMBOLYTIC THERAPY ADMINISTERED?	BLACK	WHITE	OTHER	TOTAL
Yes	4 (5.1%)	170 (11.1%)	16 (7.69%)	190 (10.42%)
No	74 (94.9%)	1368 (88.9%)	192 (92.3%)	1634 (89.58%)
Total	78 (4.2%)	1538 (84.3%)	208 (11.4%)	1824

since supported the safe and efficacious use of tPA in all eligible stroke patients. As great as this intervention may be, there are sustained challenges such as strict eligibility criteria and a narrow treatment window (within 4.5 hours of symptom onset), risk of intracerebral hemorrhage, perceived lack of efficacy in certain high-risk subgroups, and a limited pool of neurological and stroke expertise in the community.

Mechanical thrombectomy, or the physical extraction of a clot, is another reperfusion therapy indicated for acute large artery occlusion, particularly within the anterior circulation with a longer therapeutic window of eight hours after symptom onset, which can be extended to 24 hours using advanced perfusion imaging for patient selection.

The advent of tPA and thrombectomy have improved health outcomes for many stroke patients; however, benefits from these life-saving interventions have not been received equally. Disparities among people of color with regard to acute stroke management persist, and structural racism has direct, well-documented detrimental health outcomes. As the United States is projected to become increasingly diverse, unrelenting disparities will impact an even greater proportion of the population. Racial and ethnic disparities in healthcare are particularly evident when evaluating outcomes in cardiovascular disease, breast cancer, melanoma, and systemic lupus erythematosus. Structural racism unequivocally influences the quality of care and health outcomes for people of color, including within the field of neurology.

Research on racism in healthcare has primarily focused on assessing the quality of care, access to preventative care, and disparities in more prevalent chronic illnesses like cardiovascular disease, diabetes, and cancer. Acute stroke management may carry a high burden of disease and long-term detriment to a person's quality of life, yet there is a paucity of data on the effects of structural racism in acute stroke intervention and outcomes. We aim to bring awareness to historic and ongoing structural racism in stroke management and provide evidence-guided and culturally competent interventions for ameliorating these disparities within our local Minnesota communities.

Methods

This is a retrospective study with data obtained from nine Fairview hospitals investigating the impact of race on the utilization rate of IV thrombolysis. Patients were identified and data was obtained from our local Get with the Guidelines stroke database. All patients discharged with a primary diagnosis of ischemic stroke from any of the nine hospitals of our healthcare system (one comprehensive stroke center, one thrombectomy capable stroke center, one primary stroke center, three stroke-ready hospitals, and three undesignated hospitals) January 2021 through October 2022 were selected for this analysis. Anonymized data was provided by the stroke centers' coordinators without patient identifiers other than age, sex, and race to permit this analysis. Data on thrombolytic administration were organized by race (American Indian or Alaska Native, Asian, Black, Hispanic or Latino, Native Hawai-

ian or Other Pacific Islander, or white) to determine racial disparities in IV thrombolytic administration. IV thrombolytic administration was compared between races within our local data. The primary outcome measure was the percentage of individuals with an acute ischemic stroke who received IV thrombolytics. This analysis is part of a large quality improvement project conducted at our institution aiming to address racial disparity in acute stroke care. Our University of Minnesota institutional review board has allowed the quality improvement project to proceed without requiring full board application or patient consent.

The following null hypothesis was tested: There is no difference by race in the proportion of people receiving thrombolytics. The primary statistical analysis utilized was a Z-test of proportions. P value of ≤ 0.05 was the threshold for statistical significance. All analysis was done using Microsoft Excel.

Results

We identified 1,824 patients (mean age 71 ± 14.9 years; 50.7% female) who were discharged with an acute ischemic stroke diagnosis between January 2021 and October 2022. Of those, 1,538 were white and 78 were Black patients. The overall rate of IV thrombolysis utilization was 10.4% ($n=190$); however, the rate was higher in white patients (11.1%; $n=170$) compared to Black patients (5.1%; $n=4$) and the difference was statistically significant ($p < 0.001$); (Table 1 and Figure 1).

Increased awareness

Over the last few decades, there has been an increased awareness of racial disparities within the medical field. Specifically, in the field of neurology, race-related gaps in acute stroke interventions have been of particular interest. A national study from Otter et al. 2021 highlights the progress we have made in eliminating racial discrepancies in IV thrombolytic use. They found that increases in the rates of tPA and mechanical thrombectomy are more pronounced in individuals 80 years or older compared with young patients, as well as in Black and

Hispanic patients compared with white patients, demonstrating a decline in age- and race-associated treatment disparities.

Despite the global movement to mitigate racial disparities in acute stroke care, our local Fairview data demonstrate a significant difference in IV thrombolytic utilization rate by race, which is more than twice as high in white-identifying patients compared to Black-identifying patients. Our results are similar to a systematic review of disparities in stroke care by Ikeme et al. 2022, which reported a greater proportion of white patients receiving tPA as compared to Black patients.

While we do not yet have the answer about the causes of racial disparity in our sample, the Institute of Medicine has developed a framework for possible causes that include both provider-level and health system-level contributions to structural

The persistence of disparate outcomes in stroke management based on race should incite a call to action to promote anti-racist interventions at a local and national level to mitigate stroke-related morbidity and mortality in people of color.

racism. Provider-level factors include prejudice, unconscious bias, lack of cultural competency, and patient-provider racial discordance. Health system-level factors include access to care and quality of care. Policy-level factors include health insurance, resource allocation, policies at the macroeconomic, social, and health levels, cultural and societal norms and values.

Successful interventions

Many successful interventions that address racial disparities in stroke have been employed at both a local and national level. National programs like REACH, administered by the CDC, aim to understand the impact of racial bias and work to bridge healthcare gaps through local, culturally tailored approaches. Within the field of stroke, successful interventions include those that both increase awareness of stroke symptoms and access to care. Interventions to increase stroke awareness in economically disadvantaged communities include the HipHop Stroke intervention, which is three-hour culturally tailored programming for children to share stroke information with their parents. Strategies that have successfully reduced obstacles to care include improved coordination of emergency medical services and hospital-based systems through the development of a standardized EMS-led network. Additionally, emergency department-based stroke education in the forms of a video,

written brochure, and verbal counseling can result in improved knowledge among Black patients.

Racial disparity in healthcare is a frequent topic discussed in our clinical operations meetings, case conferences, and other academic activities. We expected to find some difference between Black and white patients but not to find a difference of such magnitude, which demonstrates the need for the large quality-improvement project that is currently underway to understand the community-specific and organization-specific causes of this disparity and possible interventions to address it.

Expansion of the above-mentioned programs would promote further research investigating racial disparities within the health system and permit improved access to community-level resources which directly address some of the barriers contributing to disparate outcomes. In addition, community-based and culturally sensitive educational materials are shown to be effective at informing the public about stroke risk factors, symptoms, and action plans. Utilizing already existing communities, such as religious organizations, may serve as a vital tool in secondary stroke prevention. Furthermore, home blood pressure monitoring and advancements in technology enabling telehealth visits may also serve as important, community-level interventions that are relatively low-cost yet provide great stroke prevention benefits.

Culturally sensitive programs

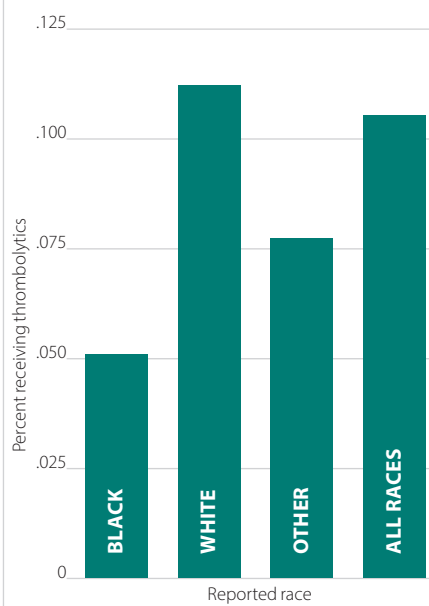
Our single-institution data reflect the vital need for increased funding, awareness, and implementation of culturally sensitive stroke prevention programs to help mitigate racial disparities in acute stroke management. These data serve as a call to action for the neurology community and the medical community at large to identify racial disparities within their local institutions to encourage actionable steps that may be taken to address such disparities. We know that racially driven disparities may effectively be addressed. It is time that we come together and eliminate such dangerous inequities and promote safe, ef-

FIGURE 1

Local proportions of thrombolytic administration in acute stroke by reported race

Data were acquired from January of 2021 through October of 2022. The race categories are based on patient-reported race as collected from the electronic medical record system. A Z-test of proportions was employed to determine potential significant differences in the proportion of Black patients receiving IV thrombolytics as compared to white patients. "Other" is categorized as American Indian or Alaska Native, Asian, Hispanic or Latino, Native Hawaiian, or other Pacific islander.

* indicates significance with a $p < 0.01$



ficacious, and equitable healthcare for all Americans.

Limitations

This study is not without limitations. First, our data is limited to data collected from nine Fairview hospitals, in which the demographics may not represent the surrounding community. Importantly, while 18.9% of the Minneapolis population identified as Black on the most recent census data, only 4.2% of our study population identify as Black. This difference could also be attributed to the demographic composition of the hospitals' catchment area or to certain barriers to presenting to the emergency department during an acute cerebrovascular event. The lower IV thrombolytic utilization rate may be due to factors that were not examined, including but not limited to health literacy, ZIP code of residence, delay in emergency department presentation, presence of infarction on CT, and other social factors or medical contraindications. Another limitation is that our data is collected in a limited timeframe which does not allow the examination of temporal trends. Future research should utilize institutional data collected over a number of years to better predict future trends.

Decades of systematic oppression that people of color have endured unsurprisingly resulted in mistrust in the American healthcare system. A mismatch between nonwhite patients and predominantly white physicians and other medical personnel may make some patients reluctant to consent to high-risk but lifesaving therapeutic interventions. Hence, ensuring an equitable demographic representation in the physician workforce is crucial to ensure that the diverse needs of various patient populations are met. However, there exists a severe lack of racial diversity in vascular neurology fellowship programs, with only 3% of vascular neurology fellows identifying as Black or African American. Organizations like the Society of Black Neurologists are working to promote the diversification of neurology fellowship programs.

This study implores other institutions to closely analyze their local data for possible racial inequality and to address these disparities to make access to stroke care more equitable at their institutions. **MM**

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BALMS FOR burnout

RESEARCH REVEALING THE CAUSES OF BURNOUT AND EFFECTIVE SOLUTIONS IS CHANGING HOW HEALTHCARE APPROACHES THIS CHALLENGE.

BY SUZY FRISCH

Michelle Chestovich, MD, knows why nearly two-thirds of physicians have burnout. She experienced the pervasive stress and daily craziness of life as a family medicine physician for 20 years. As a certified life coach, she regularly hears from other physicians that they are at their breaking point.

It comes from spending up to 20 hours a week doing patient notes at night and on the weekends, when physicians already are exhausted and depleted. It's the steady thrum of patient questions and requests that come in 24/7, with the expectation that they will answer them quickly. Then there are directives to fit in more patients each day or shorten visits with complex patients. And as a group of people who tend toward perfectionism and strive to always go above and beyond for their patients, physicians find it very difficult to say no, Chestovich says.

There's a reason 20% of physicians report that they plan to leave the profession, according to a 2022 American Medical Association survey. Even before COVID-19 made all of these existing challenges worse—and piled on more misery—physicians were struggling. Many contend with

unmitigated burnout symptoms including unrelenting physical and emotional exhaustion, as well as depression and anxiety.

Burnout hit Chestovich in waves during different phases of her career. After getting coaching herself, she became a certified coach to support other doctors and offer a path to feeling better. She retired from clinical practice in 2021 to focus on coaching women physicians through her company MamaDoc and the Re-Mind Yourself podcast. Then her sister, radiologist Gretchen Wenner Butler, MD, died by suicide after experiencing untreated burnout and depression—one of the 300 to 400 physicians who die by suicide every year.

“We’ve been socialized to people-please and make everyone happy. A lot of the socialization we’ve had helps us be excellent physicians, but it makes it hard to set boundaries, which leads to utter exhaustion and burnout,” Chestovich says. “We’re working in a broken medical system and it’s running on the backs of hard-working, altruistic physicians.”

The scale of the problem—building for years but exacerbated by the pandemic—has prompted a systemwide focus on pre-



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MICHELLE CHESTOVICH, MD
RETIRED PHYSICIAN, COACH,
PODCASTER, AND OWNER
MAMADOC



“THE PANDEMIC HAS LAID BARE THE EXCESSIVE DEMANDS ON HEALTHCARE WORKERS, AND IT’S FORCED ORGANIZATIONS TO TAKE A LONG, HARD LOOK AND SAY, ‘IS THIS THE BEST WAY FOR US TO WORK AS A HEALTHCARE ORGANIZATION?’”

COLIN WEST, MD, PHD
INTERNIST AND DIRECTOR
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WELL-BEING
MAYO CLINIC

venting and easing burnout in medicine. The traditional view, that physicians just need to be more resilient and find ways to cope individually, is ebbing in the face of significant evidence that work conditions play a major role in burnout.

Research about how to measure burnout, identify its root causes, and implement meaningful changes to alleviate it has been occurring in Minnesota for decades. And healthcare systems are paying attention. These days, it’s common for institutions across the state to have a physician focused on well-being or a chief well-being officer who guides organizations and leaders in best practices and making systemic changes that truly help.

“The pandemic has laid bare the excessive demands on healthcare workers, and it’s forced organizations to take a long,

hard look and say, ‘Is this the best way for us to work as a healthcare organization?’” says Colin West, MD, PhD, an internist at the Mayo Clinic and director of its Program on Physician Well-Being. “That’s where well-being leadership, advocacy around well-being, and the push to embed well-being into decision-making at the structural level becomes so critically important.”

Healthcare systems facing worker shortages are realizing that returning to the pre-pandemic status quo won’t fly, West says, making it the right time to rethink their approach to caring for the caregivers. “We need to elevate the experience of our healthcare workers. The best way to take care of patients is to make sure that the people who take care of patients are well taken care of,” he adds. “We need to recommit to that because that’s the pathway to meeting our mission.”

Chestovich agrees. She knows that coaching individually or in groups is one way to alleviate physician suffering, and research backs her up. A 2022 *JAMA* study showed significant reductions in physicians’ burnout symptoms like emotional exhaustion after regular coaching. Not only does coaching provide concrete steps for abating sources of workplace stress, it also normalizes doctors’ struggles. “It’s high time that organizations step up and do something,” she adds. “As a family physician I believe in prevention. How about we give opportunities for docs to feel better before they are crispy and burned out?”

The role of work conditions

Mark Linzer, MD, an internist at Hennepin Healthcare and director of its Institute for Professional Worklife, has been raising alarms and doing pioneering research about physician burnout since 1995. His first study, with the Robert Wood Johnson Foundation, surveyed 5,000 physicians and found that 27% overall were experiencing burnout—with 50% higher odds in women. “When we started, no one was very interested in the findings, and we didn’t get a lot of invitations to give talks,” Linzer says. “Now it’s just so much different.”

Over the years, researchers identified three components of burnout: emotional exhaustion, depersonalization/cynicism, and lacking a sense of personal accomplishment. Linzer and his team found that key elements leading to burnout include time pressure and the three Cs—chaos, control, and culture. Work overload also plays an outsize role (ahem, pandemic).

There is growing recognition that challenging work conditions also play a significant role, Linzer says. Some key problems include time-sucking electronic medical records systems, overflowing schedules, poor communication from management, bureaucratic red tape that steals physicians’ autonomy in patient care, and less time spent with patients—usually a highlight for physicians.

Then add worker shortages to other pressures on healthcare such as increased labor costs, supply chain disruptions, economic instability, and lower insurance reimbursement. That creates a perfect storm for burnout to skyrocket to crisis levels, says Nancy Sudak, MD, an integrative medicine physician and chief well-being officer at Essentia Health in Duluth.

In 2021, Institute for Professional Worklife researchers published a paper in *The Lancet eClinical Medicine* about workload and work overload and the impact across the healthcare workforce. “It becomes a worrisome cycle,” Linzer says. “Everyone is suffering from work overload, and then staff will leave because the workload is too high and there’s not enough staff. Then nurses and advanced practice providers and physicians leave, and there is more work for everyone who remains.”

Elizabeth Goelz, MD, an internist and chief wellness officer at Hennepin, says that identifying the specific factors causing burnout is key to implementing system-wide solutions. “We know that burnout is a long-term reaction to stress,” she says. “The good news is that we now know the predictors of stress, and therefore the predictors of burnout. Research-proven predictors include things like control over one’s workload, chaos or the pace of work, time to complete one’s work, values alignment with leadership, teamwork, and

MMA initiatives counter burnout

PHYSICIAN-LED PROGRAMS CAN HELP OTHER PHYSICIANS STAY ON TRACK

The Minnesota Medical Association is advancing several complementary initiatives to improve physician well-being and reduce burnout.

The MMA's Physician Well-being Advisory Committee, which includes physician well-being leaders and champions from across Minnesota, will team up with members of the MMA's Policy Council over the summer and fall to develop recommendations for high-priority advocacy topics the MMA can advance to further improve physician well-being. This advocacy agenda will be led by Natalia Dorf Biderman, MD, and Colin West, MD, PhD.

The MMA hosts the Minnesota System Well-being Leaders Consortium and provides space and staff support to offer many of Minnesota health systems' chief well-being officers an opportunity to meet and discuss ideas that elevate the well-being agendas of each. This model of collaboration includes Natalia Dorf Biderman; Colin West; Elizabeth Goelz, MD; Nancy Sudak, MD; Mary Beth Lardizabal, DO; Wendy Laine, MD; and Heather Spies, MD.

With the help of a significant grant from The Physicians Foundation, the MMA Foundation is developing physician peer support and other physician well-being resources for MMA members. The development work is underway now.

Since 2019, the MMA has sponsored the annual Reclaim the Joy of Medicine Conference (formerly known as the Bounce Back Project conference) to provide MMA members with access to national and local subject matter experts including J. Bryan Sexton, PhD; Kristin Neff, PhD; Corey Martin, MD; Dawn Ellison, MD; Michael Maddaus, MD; Jacquelyn Fletcher Johnson, and many others. Watch *Minnesota Medicine* for information about the next Joy of Medicine conference, which is planned for 2024.

The MMA partnered with the University of Minnesota's Carlson School of Management to design and deliver the Minnesota Physician Leadership Institute. The curriculum is uniquely designed by and for physicians and led by program co-chairs, Corey Martin, MD, and Cindy Smith, MD.

— Kristen Gloege, MMA Foundation CEO

feeling valued by one's organization. Lack of trust in the organization as well as race and gender inequity are also themes we see contributing to stress and burnout."

On top of these components, pandemic conditions brought a new element to burnout. Clinicians were lauded as heroes during the first six months, and many felt energized by the work. Then disinformation and vaccine skepticism set in, leading to patient mistrust, workplace conflict and violence, and a widespread discounting of physicians' expertise, says Natalia Dorf Biderman, MD, a hospitalist at Methodist Hospital in St. Louis Park and chair of the HealthPartners clinician well-being task force.

"The increase in challenging exchanges with our patients, the loss of trust from our communities and our individual patients erodes the capacity of physicians to sustain our energy for what we do every



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INTERNIST AND DIRECTOR
THE INSTITUTE FOR
PROFESSIONAL WORKLIFE
HENNEPIN HEALTHCARE

day,” Dorf Biderman says. “We always had the gratitude of our patients and relationships with our patients to give us meaning. Even though the work has always been emotionally and physically taxing, you could count on those relationships to feed our soul, and a lot of that has been eroded.”

Burnout Rx

To make inroads with burnout, healthcare systems need to have a robust infrastruc-



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NANCY SUDA, MD,
INTEGRATIVE MEDICINE
PHYSICIAN AND
CHIEF WELL-BEING OFFICER
ESSENTIA HEALTH

ture for improving work conditions, Linzer says. It should include a chief wellness officer, a wellness committee, and wellness champions spread throughout an organization. It's integral to do an annual wellness survey, with results broken down by unit and then shared with its leaders. Then the team, including the unit's wellness champion, can develop a site-specific action plan.

Hennepin Healthcare has had such a system for 10 years, and “it's remarkably successful in carrying out a systematic, empathic, and effective wellness agenda,” Linzer says. The Institute developed its free Mini Z (zero burnout program) surveys to take the temperature of conditions for healthcare workers in 10 areas, including work control, chaos, and satisfaction. Then efforts to improve these conditions can be measured, demonstrating their impact.

Institutions across Minnesota and the country have caught on to the importance of embedding a well-being leader on their executive teams, West says. It indicates to employees that well-being is a visible priority, with influence on decision-making for the broad organization. As leaders debate operational changes, chief wellness officers weigh in on how those decisions might affect clinician burnout and well-being.

Goelz has lived this evolution. She joined Hennepin's provider wellness committee in 2013, eventually becoming vice chair and chair, and got involved with research through the Institute for Professional Worklife. She became skilled in advocating to Hennepin leadership about burnout and wellness matters.

Then in 2019, presidents of the Association of American Medical Colleges, the Accreditation Council for Graduate Medical Education, and the National Academy of Medicine recommended that all healthcare organizations appoint a chief wellness officer, and Goelz urged Hennepin to follow suit. She found herself in the job. However, she says, there wasn't a lot of structure behind the position, influence, or buy-in from leadership at that time.

After a yearlong road trip with her family in 2021, Goelz applied to again serve as chief wellness officer. Since her return, Goelz has tracked an increase in interest and support for well-being work, coupled with more motivation at the top to build the organizational structure to carry it out. She meets regularly with people up the leadership chain to provide well-being and burnout updates.

“We're seeing top-level leaders say, ‘We know this is important,’ or ‘How will this decision affect employee wellness?’” Goelz says. Leaders are more willing to ease growth or productivity goals for a department that is struggling with burnout. And there is more recognition that wellness should be part of Hennepin's strategic plan. “We are moving in a direction where everyone is thinking about wellness instead of just having one person think about wellness all the time.”

Personal burnout

Experiencing burnout herself about seven years ago steered Dorf Biderman to engage in well-being work. She always planned to be a lifelong doctor like her father, but odds for her career longevity were dropping based on her undercurrent of discontent and an uncharacteristic lack of enthusiasm for work.

Dorf Biderman regained her zest for her profession by starting roles in well-being and as medical director of clinical documentation integrity. Gaining a wide perspective of the healthcare system and contributing to big-picture change helped ease her burnout. “It gives me a sense of hope, both for the patients and the organization and the communities and my colleagues,” she says. “Reclaiming that sense of agency within the system I'm working in was pivotal for me as a clinician. A lot of the healthcare workforce feels a loss of agency and autonomy. Hopefully, by changing the environments we are working in, that sense of agency can be reclaimed.”

From working on well-being, Dorf Biderman has discovered the complexity and variety of contributing factors in different clinical settings. That means a one-size-fits-all approach just doesn't work, nor

does a top-down system where administrators make decisions without input from clinicians. Burnout at one clinic might stem from issues with leadership, while at another the root cause is team dynamics. Plus, burnout manifests in diverse ways, she says, even among physicians within the same specialty or practice group. Each case is different. “When you see one person with burnout, you’ve seen one person with burnout,” she says.

That means methods for addressing burnout must be multifaceted and tailored to the teams that are affected. HealthPartners has been addressing burnout from a quality-improvement standpoint, working with executive sponsors like its chief medical officer and chief people officer and the nonprofit Institute for Healthcare Improvement. Quality improvement is nothing new at HealthPartners, but more recently it has been undertaking this work both in local settings and system-wide, all in collaboration with front-line clinicians, Dorf Biderman says. Ideally, a local team—including front-line workers—works together to identify a problem area, design a potential fix, implement it, evaluate whether it’s working, and adjust if needed. “We want to bring that rigor and understanding of the quality-improvement structure and system to local teams to improve their work environment,” she adds.

For example, some of HealthPartners’ well-being and quality improvement work includes cultivating a broad network of peer support, including more opportunities to build community and camaraderie. It also focuses on improving communication between frontline staff and decision-makers, and between local leaders and senior executive leaders.

“We want to empower and equip local teams to find the solutions that they feel are more of a priority because it gives back the autonomy to the teams,” Dorf Biderman says. “They can prioritize the areas of improvement that are needed so that their work environment improves.”

Such efforts can be effective in mitigating burnout. Linzer and team published a paper in the *Journal of General Internal Medicine* in 2015 involving a randomized

trial of 34 clinics. Initiatives like workflow redesign reduced odds of burnout by a factor of five, while communication improvements between clinician groups improved satisfaction odds by a factor of three. “Satisfaction and burnout are both linked to retention, so we are optimistic these evidence-based strategies will be successful in strengthening our workforce in multiple ways,” he says.

In addition, recent research shows that not feeling valued by one’s organization, not trusting in one’s organization, or feeling a lack of trust in return are predictors of stress and burnout, Linzer says. With this knowledge, the Institute for Professional Worklife has focused much of its work on measuring these elements and then acting on them.

Anti-burnout initiatives don’t need to be complicated to make a big difference. Linzer highlights how Hennepin eliminated a source of burnout that was causing high turnover in a department. The culprit was standardized scheduling that slotted complex patients at the end of the day. And because these patients’ medical needs were complicated, the visits often ran long. That made physicians late to pick up their children from daycare, and they racked up steep fines. After navigating the Hennepin bureaucracy and advocating to leadership, Linzer secured a change. Scheduling complex patients earlier in the day became the rule, and, along with some other modest, supportive changes, burnout in that department went down by half.

Pillars of well-being

When making decisions about how to broach burnout solutions, it’s important to discern whether they help physicians connect with the foundational aspects of well-being, what West calls the “MVPs of well-being”—meaning, values, and purpose. Start with physician workload—a major burnout driver. Solutions could include bringing in scribes to reduce the burden of documentation, allowing physicians to focus on their patients instead of the computer. Or making schedules more flexible so that physicians can have more control over their day.



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ELIZABETH GOELZ, MD
INTERNIST AND
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NATALIA DORF BIDERMAN, MD
HOSPITALIST, METHODIST HOSPITAL
IN ST. LOUIS PARK AND CHAIR,
CLINICIAN WELL-BEING TASK FORCE
HEALTHPARTNERS

Studies have shown that it's most effective to offer a menu of choices to promote well-being. "If a solution is going to connect people with what's more meaningful most effectively, that's always patient care and working in an environment that allows us to prioritize patients," West says. "If we can provide a support mechanism so that physicians can make the most of their time with patients, they feel like they are honoring the values that attracted them to medicine in the first place."

One way Mayo has addressed burnout over the years is through its voluntary COMPASS (Colleagues Meeting to Promote and Sustain Satisfaction) groups. Meeting every two to four weeks over a meal sponsored by Mayo, the groups of six to 10 colleagues discuss a rotating menu of topics while sharing their experiences and building connections. Participants might discuss making major medical errors or an especially satisfying workday, releasing some of the bottled-up experiences and emotions that many keep to themselves.

"COMPASS groups help people reconnect with their meaning, values, and purpose, and it restores their sense of community and connection with a common cause," West says. He notes the COMPASS program eases burnout, improves job satisfaction, and brings more meaning to participants' work.

In 2021, Sudak made a business and ethical case to Essentia that the system should have a chief well-being officer, and her proposal was adopted. During the pandemic, Essentia created a few resources that have stuck, including training 40 peer supporters. It also started an employee support line to connect employees in distress with mental health services, well-being resources, or employee assistance programs.

Essentia has twice partnered with Linzer's team to conduct the Mini Z survey, seeking to identify burnout hotspots and strategies for addressing the root causes. Sudak uses the Mini Z process as one way to engage the Office of Well-being executive steering committee and a group of executives about Essentia's major drivers of burnout and potential ways to ameliorate them.

Elevating the chief well-being officer to the executive level has made a significant difference at Essentia, Sudak says. At high-level meetings, she has a seat at the table and can share the perspective of wellness in decision-making. Combined, all of this work is vital to help physicians and other healthcare providers heal from burnout—and prevent future problems. "When clinicians feel cared for, they are less likely to

feel burned out and less likely to express an intent to leave," she says.

While healthcare employers have made progress, there is still work to be done to relieve physician stress and burnout. "With the healthcare professional staffing crisis, the issue of staff well-being is of paramount importance. Most local well-being efforts and teams remain under-resourced—even in the biggest organizations," Dorf Biderman says. "There are some health systems that don't even have a dedicated effort, team, or representation at the highest level of the organization. There is wide variety and disparity on how organizations are tackling the problem and what attention, endorsement, and resources are dedicated to making an impact."

West agrees that the work is far from over. "Despite these efforts, the well-being leaders across Minnesota generally feel undersupported, and institutional investments remain fairly weak," he says. For example, national recommendations are for the chief wellness officer role to have at least a half full-time equivalent, but "to my knowledge only one person in Minnesota actually has that. In addition, only one or two actually sit on an institutional C-suite-level committee, despite that being the national recommendation."

Such investments are critical because the stakes, especially in the wake of the COVID epidemic, are huge.

"We can't afford to lose more clinicians to burnout. We've already suffered incalculable losses that have changed the healthcare landscape," Sudak says. "We're shy on people power and the workforce is exhausted. When a high percentage of clinicians and other healthcare colleagues are suffering from burnout, that's an occupational hazard that is associated with a higher likelihood of medical error. Tension between the finances of a healthcare organization and the well-being of its workforce has been an issue in the U.S. for many years. But I don't believe we can afford not to invest in our clinical teams so that we can take care of them." MM

Suzy Frisch is a Twin Cities freelance writer.



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Minnesota's healthcare labor shortage is an acute issue, with some solutions in the pipeline

BY ANDY STEINER



An organism needs each of its parts to be in good working condition to operate efficiently. That is particularly true of Minnesota's healthcare system, where serious shortages in several vital

sectors have been causing difficulty for employers, workers, and patients state-wide.

Even before the pandemic, healthcare in Minnesota was facing a hiring crisis, with

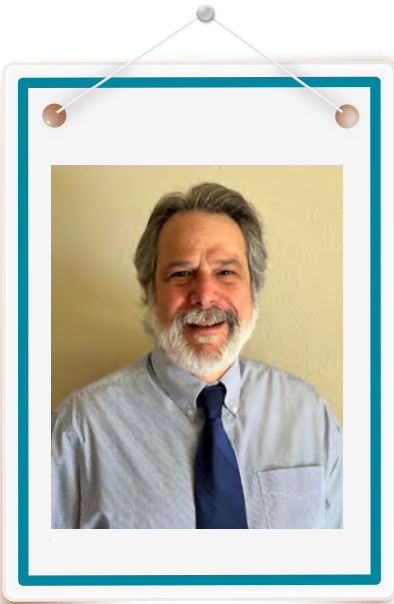
open positions looming for small and large employers alike. The global pandemic emphasized healthcare providers' key role, but the emotional and physical stress it created across the system exacerbated the

crisis when many workers chose to retire or look for different jobs with higher pay and fewer demands.

Anthony Schaffhauser, senior research analyst at the Minnesota Department of Employment and Economic Development, studies the state's healthcare workforce. In a paper titled "Critical Condition: The Health Care Workforce in Minnesota," he and colleague Cameron Macht analyzed the shortage and suggested possible ways to address it.

Among the biggest issues impacting all elements of the healthcare system, they suggested, are worker shortages in some of the lowest-wage—and most essential—jobs.

For instance, Schaffhauser explained, much of nursing and residential care is staffed by nursing assistants: "If you can't hire enough people to fill those jobs, a patient can't get released from the hospital.



"If you can't hire enough people to fill [nursing assistant] jobs, a patient can't get released from the hospital. There is no way to get a safe discharge because no one is there to send patients home. When that happens, the system gets thrown into crisis. All the pieces influence all the other parts."

Anthony Schaffhauser

Senior research analyst
Minnesota Department of Employment
and Economic Development

There is no way to get a safe discharge because no one is there to send patients home." When that happens, the system gets thrown into crisis, Schaffhauser said. "All the pieces influence all the other parts."

Laura Reed, Fairview Health chief operating officer, said that the pandemic put strain on all levels of nursing and medical practice. "It also created a lot of fatigue. Many clinicians left the profession or retired early. This exacerbated the provider shortage even more."

At Fairview, Reed said, the record-setting number of openings in all staffing levels is most evident in acute-care settings—"our 24/7 operations where we need to cover off-hours and holidays." Staff are realizing, she explained, that "there are a lot of job opportunities beyond healthcare. Salaries have increased across the board. So people see that they don't have to work in life-or-death situations in hospitals to make a decent living. They can work retail and have an almost similar starting wage without the demands of clinical care."

To compete with these wage shifts, Fairview and other healthcare employers statewide have had to increase starting wages for employees at all levels, but particularly in entry-level roles. This emphasizes the reality that all parts of an organization have to be seaworthy to keep the ship afloat.

This new approach requires significant financial investment, Reed said. "We have had to do a lot of adjusting our base salaries to make sure we can actively compete with other industries."

It's the same in Greater Minnesota, where overtaxed healthcare workers are letting employers know they can find decent-paying jobs in lower-stress industries, said Mark Jones, executive director of the Minnesota Rural Health Association.

"It is taking more money just to stay competitive," he said. It wasn't always the case, Jones added, recalling his own youth in small-town Minnesota. "When I was



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Laura Reed

Chief operating officer
Fairview Health

growing up, the doctor in town was one of the highest-regarded professionals in the community. With that came a very nice salary. "

If community standing is largely measured by salary, Jones said, that sense of regard has changed. "These days, physician salaries don't compare with salaries of many other professions, especially the tech and social-media world." If communities all over Minnesota want to keep attracting physicians and other key healthcare staff, further investments have to be made: "We've got to come up with new ways to draw folks in if we want to keep the system working."

Just how bad is it?

One way to measure the extent of the state's healthcare worker shortage is to take a look at the numbers. At the Department of Employment and Economic Develop-

ment, Schaffhauser has those figures at his fingertips and quickly gives a true measure of the problem.

“The whole healthcare and social assistance industry has the most job vacancies,” he said. “In 2022, there were 45,000 openings in the healthcare and social services industry in Minnesota. That’s more than in 2021, where there were 39,727.”

Some of those openings can be explained by demographic shifts driven by baby boomers now retiring en masse. This is something that experts have seen coming for years. Add increased anxieties around healthcare careers, and you’ve got a recipe for a workforce crisis, Schaffhauser said.

“I think that situation has led to a lot of burnout and people wanting to leave healthcare because of that. Also those

stories and perceptions get passed along,” he explained. This shortage extends all the way back to the worker training: “Some of the state’s nursing programs, especially in rural areas, have continued to have empty seats past the pandemic.”

It’s almost as if nursing home quarantines and hospital health risks have short-circuited the traditional pathways that people took into healthcare, Schaffhauser said. “There used to be this career ladder where a lot of young people would get experience in nursing and residential care as nursing aides and then enroll in nursing school. The faculty in these schools are now concerned that the experience they were getting in the pandemic is turning students off to continuing on in their education.”

M Health Fairview has a large number of open positions in its hospitals and clinics, Reed said, but it’s important to put those numbers in context with its massive workforce: “Right now we have about 2,500 open positions. That sounds outrageous, but it’s important to remember that we have an employee base of 33,000.” While this number of open positions represents a relatively small percentage of all employees, it still is a massive hurdle,” she said. “We have to stay on top of our current vacancy rate.”

One of the things that Joe Kalkman, CentraCare chief administrative officer, finds most disturbing about the employment situation is watching physicians, the most highly trained and compensated workers in the field, just step away from jobs that they’ve worked so hard to attain.

“A physician makes that choice to leave the profession knowing what it takes to become a physician,” Kalkman said. “It’s an indication of how extraordinary the times are that someone who’s worked so hard to attain that skill and ability to impact patients in such profound ways would make the decision that it’s no longer worth it and go do something else. That to me is one of the hardest workforce challenge elements of the current situation.”



“From doctors to professional staff to nurses to technologists, the employment crisis is nearing dire in some areas. I think that it has probably hit in our independent rural hospitals and clinics the hardest. They don’t have a health system that’s helping to support their workforce needs.”

Mark Jones

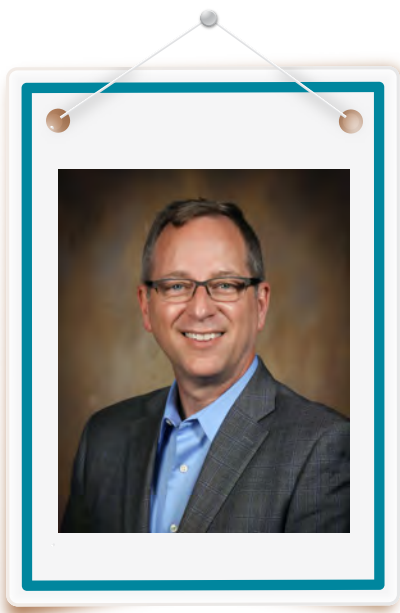
Executive director
Minnesota Rural Health Association

Rural providers face more challenges

Jones said the Minnesota Rural Health Association’s members often tell him the same thing: Finding qualified staff to work in smaller hospitals and independent clinics is especially tough—and it’s not going to get easier anytime soon.

“From doctors to professional staff to nurses to technologists, the employment crisis is nearing dire in some areas,” Jones said. “I think that it has probably hit in our independent rural hospitals and clinics the hardest. They don’t have a health system that’s helping to support their workforce needs.”

Kalkman said that at CentraCare, with its network of hospitals and clinics based outside of the metro area, human resources staff tell him it’s hard to recruit and retain workers when they’re already dealing with a smaller pool of potential employees.



“A physician makes that choice to leave the profession knowing what it takes to become a physician. It’s an indication of how extraordinary the times are that someone who’s worked so hard to attain that skill and ability to impact patients in such profound ways would make the decision that it’s no longer worth it and go do something else. That to me is one of the hardest workforce challenge elements of the current situation.”

Joe Kalkman

Chief administrative officer
CentraCare

“Rural healthcare, rural locations have a greater challenge when it comes to workforce shortages,” he said. Twin Cities-based employers, he added, “are fishing in a bigger pond with more folks with the skills that you’re needing. You don’t have that as easily in rural settings.”

Kalkman said another stumbling block for healthcare employers in Greater Minnesota is the age of the region’s population.

“Rural Minnesota is a little bit older and actually a little bit sicker than the metro area when you look at health outcomes,” Kalkman said. “And in many of the rural counties of the state, we’re seeing the population itself get smaller.”

Jones agreed, adding that a declining population makes it hard to find enough people to fill jobs. And when high school populations shrink, the number of future workers shrinks alongside. Another problem is the difficulty attracting qualified healthcare professionals to an aging community with limited options like schools and daycare for themselves and their families. That’s a difficult situation with few easy fixes.

Potential solutions

Even in the midst of a hiring crisis, some experts still feel hopeful, touting ideas that could help to reverse the course and bring more workers into healthcare fields.

One step that’s needed is listening closely to existing employees, understanding their needs, and responding to them in concrete ways, Reed said. “The pandemic took a toll beyond what any of us could have anticipated, but I think in general we are focusing on how do we help meet people in making sure that they have a job that adds meaning and brings joy to their lives. As a health system, we’ve been working on making sure that we’re paying attention to what do people want in their work environment and making that happen.”

Other initiatives focus on future workers. Jones and his colleagues are collaborating with rural school districts to develop educational programs that introduce students to healthcare professions

and teach them about the benefits of these jobs.

“We want to get kids interested, get them exposed to healthcare professions,” he said. “There needs to be opportunity to see the paths to become a physician or a nurse. It needs to be very well defined. We need to make it appear obtainable for kids who want to pursue it.”

M Health Fairview has established an initiative called OnTrack, an on-site nurses training program for community members interested in moving into healthcare careers. “We pay the training wages,” Reed said. “We pay the cost of the education. The program helps remove barriers to employment for that group to come into healthcare. It helps us bring a different kind of diversity to our workforce.”


Another huge initiative is happening in St. Cloud, where CentraCare is partnering with the University of Minnesota Medical School to build a campus focused on training physicians to work in rural medicine.

“We’re doing the work right now around building out the program and the facilities,” Kalkman said. “We’ll have an explicit mission from a recruiting standpoint, all the way through graduation: Our focus is going to be on rural medicine.”

This project is exciting to healthcare advocates around the state, who hope that the new campus will attract scholars committed to serving rural communities. It could become a route for physicians ready to work in a part of the state that often struggles to attract qualified candidates. “We think it’s going to have a big impact on that talent pipeline for physicians who are interested in practicing in rural Minnesota,” Kalkman said.

Jones couldn’t be happier about this development. “It’s a wonderful approach to do it in Greater Minnesota,” he said. “It is going to help out a lot.” MM

Andy Steiner is a Twin Cities freelance writer and editor.



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The next pandemic

Think our experience with COVID-19 prepared us to respond better next time?
Think again.



Michael Osterholm, PhD, MPH



Michael Osterholm, PhD, MPH, the director of the University of Minnesota Center for Infectious Disease Research and Policy, has warned of a pandemic since long before the appearance of COVID-19.

In *Deadliest Enemy: Our War Against Killer Germs*, published three years before the COVID outbreak, Osterholm described the most pressing infectious disease threats of our era and also proposed a nine-point strategy to address them.

In November 2020, he was appointed to President-elect Joe Biden's 13-member Transition COVID-19 Advisory Board. He has continued to advise federal health officials about the coronavirus and other pathogens with the potential to cause a pandemic.

In mid-May, the day before the federal government declared the end of the COVID public health emergency, Osterholm spoke to *Minnesota Medicine* about the likelihood of a new pandemic, its possible causes, and how well prepared the nation is to respond. The interview has been edited for clarity and brevity.

I want to talk to you about the next pandemic. But I understand that you recently had some business with the old pandemic—you came down with COVID a couple of months ago. How are you feeling now?

I actually did have some long COVID symptoms for four to six weeks after my infection. It was something I'd rather avoid if I could.

The fact that we just had a pandemic—does that do anything to reduce the chances of a new pandemic anytime soon, either a radically evolved form of COVID or something else entirely?

First of all, let me add some caveats to that, OK? Most people would tell you the pandemic is over when the public thinks it's over. And the public thinks it's over. That doesn't necessarily correspond to whether there will be more surges of virus in the future. In fact, just several weeks

ago a group of virologists who really specialize in the genetics of this virus put forward to the White House a document suggesting there might be a 30 to 40% chance that we'll see one more wave comparable to what we saw with the omicron variant. I can't tell you whether that is going to happen or not. This is one of those examples where this virus keeps throwing 210-mile-an-hour curveballs at us. So I can't say that it's over with. I can say for certain that we're still seeing 1,100 deaths a week in this country, and you know that's almost 60,000 deaths a year. Clearly that means we're not over with this virus yet at all.

Some people have taken the view that it is going to go away. It's not going to go away. It's now in the permanent landscape of human infections. The question is will it become more of a seasonal virus. Will it come back from time to time as people have waning immunity, much like we see with influenza? What will happen? We don't know. This is a part of the equation that people dislike; they want someone to tell them with certainty what's going to happen. We can't.

So that's the current situation. It's not necessarily done. Then if you look at the future as you just said, that by itself is a wide-open issue, one where I think we're less prepared today than we were before this pandemic. Just for example, we have lost great trust in public health, and so much of what public health is about is trust—

whether people get vaccinated, people comply with certain recommendations to reduce risk. We have at this point, I think, greatly reduced any likelihood for Congressional support for additional research and development into new and better vaccines or drugs for future pandemics, including either influenza or coronaviruses.

We have really whipsawed the medical community and medical services in this country—the fact that we've seen so many people leave the profession just over the stress and the challenges. Right now, we're not even in a period of what one would call a crisis time, and yet we have hospitals around this country that are on divert status every day because they're full, including right here in the Twin Cities. I mean we have no elasticity for care for many individuals, even when there isn't a crisis. So imagine if a crisis now develops. You start adding this all up, it's not a pretty picture for the future.

You had mentioned that we're less likely now to fund new research. That strikes me as being really ironic, sort of paradoxical.

An example right now: The administration is proposing a program called NextGen—Next Generation—which is supposed to help spur on the kind of investment in vaccines, drugs, and diagnostics over the next 18 months that might be needed for future pandemics. Now I, for one, have not

been a big fan of that approach because what we typically do is we respond to infectious diseases like this as if it's a biennial one-budget-item event. Well, when's the last time anybody built an aircraft carrier where they funded it all in one wallop? It doesn't happen that way.

I think that a huge issue right now for us is to get people to understand these vaccines and drugs take some time to get better prepared for the future. The vaccines we had were good; they weren't great. We saw waning immunity and a need to get revaccinated—that over time they weren't effective. We don't know, for example, as new variants develop how well they're going to do against those in terms of what we call immune escape. So there really is a need for a substantial increase in research and development in this area.

At this point, it looks as if Congress is going to claw back all of that \$5 billion that the Department of Health and Human Services actually identified within their budgets that could be used that have not been spent yet for COVID-related activities. They've been appropriated and now Congress is saying, "Wait a minute, you can't use that. We want that money back." So there's a real possibility that NextGen won't even be funded. If that's the case, there's very little research and development of any kind going into new vaccines, drugs, or diagnostics.

Are you aware of other diseases on the horizon with the potential to spread to humans and become highly contagious and virulent?

I think it really focuses on influenza and coronavirus. I call these—in fact, I'm writing a new book right now about what lessons we should have learned from this pandemic, and I talk about "viruses with wings." These really are the respiratory-transmitted infectious agents that can change quickly in such a way that there is little prior human immunity to these viruses. And they're very infectious. A good example is the 2009 H1N1 pandemic that emerged in Mexico. In the first month after we first identified it in Mexico, it was confirmed in at least 127 different

I think the bottom-line message is that the science was there [on industrial hygiene aspects of respiratory protection] amongst those who would look for or understand the science ... and yet the CDC message never included that, really. So I think there were just a lot of challenges where the science did exist. People just ignored it.

countries. That's how fast it moved. We know too that that's how fast SARS-CoV-2 moved around the world.

There are a lot of other bad viruses out there—Ebola, Marburg, all the things you hear about every day—but they don't have wings. They're body-fluid contact viruses. There's not this very effective if not dynamic transmission by the respiratory tract, where just breathing air is going to do it.

So, when it comes to COVID, what did we do well?

The vaccines we were able to develop quickly literally saved millions of lives. People still got COVID, but because they had had two or more doses of vaccine, they were much more likely to have mild cases of infection, meaning they weren't hospitalized and dying. So that was important.

What people fail to realize, though, if you look at both the chimp adenovirus vector vaccines that came out of Europe, out of Oxford and so forth, and you look at the mRNA vaccines that came out of the United States' effort, these were both vaccine platforms that had been in the research environment for cancer drugs for years. On top of that, if you look at the Ebola outbreaks of 2014 through '16 in western Africa, the chimp adenovirus vector was in fact used for Ebola. So when we talk about a vector or we talk about a platform, what we mean is this is what carries the material into the human host into the cells, that then results in the immune response. Having all that work done before, particularly around cancer vaccines and so forth, we were able to adapt it quickly to deal with COVID. That's not going to be the case in the future. We don't have any new vaccine technologies just sitting out there, waiting for a crisis to happen.

Our center has led on an international level the development of what we call roadmaps. If you go to our website and look at IVR or CVR—that influenza vaccine roadmap or coronavirus vaccine roadmap—we brought together major groups of experts from around the world, 50-plus experts for each of those. Over a course of from nine to 12 months for each

Most people would tell you the pandemic is over when the public thinks it's over. And the public thinks it's over. That doesn't necessarily correspond to whether there will be more surges of virus in the future.

one we developed a very, very detailed roadmap by dates and times and so forth that would be needed to possibly see game-changing flu or coronavirus vaccines. We're actually monitoring just how well compliance is occurring with these.

What did we not do well when it comes to COVID? And what would it take to do better in that regard next time?

I think the communication issues were a huge challenge. You had a lot of people who were speaking with some authority which provided confusing and often incorrect messages. I mean, here's an example. We now know clearly—and this has been confirmed by the World Health Organization and CDC—that this virus is spread largely by aerosol airborne transmission, OK? Yet it took the CDC and WHO almost two years to come to that conclusion.

Why is that important? Because many masks that people wear—procedure masks—are useless. They're useless. They're like fixing three of the five screen doors on your submarine. To me, that is a huge challenge in and of itself—we didn't have good science, we didn't have good communication of this issue.

And that's a real challenge right here in Minnesota. I have to say I entered hospitals four times during the course of this pandemic for work-related issues, and each time I was told at the door to take my N95 off and put on a procedure mask because that is what they used. Of course, I didn't agree to do that. But I think the point being is that again communication from a science perspective was really lacking.

To what extent was that a communication problem and to what extent just an ignorance problem?

That's a very important point. It's really both. You're right. But I think the bottom-line message is that the science was there amongst those who would look for or understand the science—a lot of people with expertise in understanding industrial hygiene aspects of respiratory protection. NIOSH, the National Institute for Occupational Safety and Health as part of the CDC, had on its website the whole time that you've got to be protected against aerosol. And yet the CDC message never included that, really. So I think there were just a lot of challenges where the science did exist. People just ignored it.

Can we do better given the structure of our public health system, our healthcare system, and the present nature of our politics?

That makes it more complicated, obviously. I'm one of those who believes very strongly that we should be doing a major review of what happened so we don't repeat the mistakes of the past again in a future pandemic. I would welcome that. We do need a 9/11-like commission, I think, to go back and really review all this and to see what did we learn, what could we learn, what should we learn?

How do you rate our system of health surveillance?

I think in Minnesota it's much better because the state Health Department has had a longstanding relationship with

I think right now the most important thing that doctors can do is ask themselves how are they doing. I think the stress from the pandemic has been immense.

laboratories and hospitals and local clinics. And so I think we performed as well or better than just about any state in the country. In the country as a whole there are still huge gaps of trying to get information from laboratories. For example, I know many states will give positive test results—the only thing on a positive test result is a birth date. There's no way to get ahold of the person. There are no demographics about the person. I think that is huge.

One of the things that came to the forefront during the epidemic is the use of sewage, sewage treatment plants, to monitor the virus. Is that something we're going to see more of in the future?

I hope so. It is a very important measure of activity in a community. We're still trying to understand how to interpret it, meaning, are there some virus strains that just produce a lot more virus, so it's not more people infected, but more virus in the system? We still have a lot to learn that way, but in general it is a very important indication of what's happening in the community.

What are the implications of our worsening political relations with China given the importance of that country to some pandemics?

I think the whole world is a challenge right now. We have many countries for which the ability to work with them closely relative to pandemic activity is a real challenge. China is one, but Russia is another. When we look at countries throughout the world right now—divided into camps that make it very hard if there is an infectious disease problem. I mean, how do you respond to it? You run into that right now in Africa with diseases like Marburg and Ebola.

I wanted to ask you a couple of questions about physicians, since this is a magazine for physicians. How can physicians be better prepared? And what role do they play in surveillance in the early stages of a developing pandemic?

I think right now the most important thing that doctors can do is ask themselves how are they doing. I think the stress from

the pandemic has been immense. And I think a lot of doctors are not doing well in terms of the stress and are going to be leaving the profession soon. We have to take care of the well-being of our clinicians—nurses, doctors, orderlies, all the people. No system can be effective if the people there are emotionally and physically challenged. That's the first thing I'd say.

Second of all, I think they need to ask, how can we help you with the system? I mean why are we in a state of—for lack of a better term—challenge, when we're on divert, when nothing else is happening in the community that would cause that to happen? I mean that's a pretty significant issue.

Yeah, why are we at capacity right now?

Yeah, why are we? What's going on? I keep hearing from everybody how we have the best healthcare system in the world. Well, I beg to differ. We don't. A lot of it is just the challenge over time that from a finances standpoint, I mean we still largely fund healthcare in this country on a 1968 Medicare model. Why do we have so many people today who are occupying beds in our hospitals? They should be in step-down or long-term care beds. I mean, go through the laundry list here. These are all issues that play directly to the pandemic-preparedness of the future. MM

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


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Bestselling author Dr. Abraham Verghese will headline Empowering Physicians Conference

Bestselling author, champion of the patient-physician relationship, and a prominent voice in medicine, Abraham Verghese, MD, MACP, will be the keynote speaker at the MMA's Empowering Physicians Conference Sept. 21 at The Marquette Hotel in downtown Minneapolis.

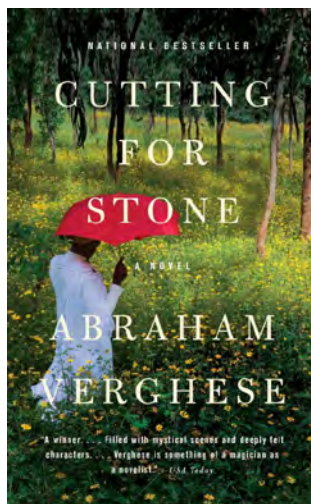
The event, which runs from 1 to 8 p.m., will also feature an opening session with Minnesota Health Commissioner Brooke Cunningham, MD, PhD; a panel discussion on "Examining the Dynamics of Physician Practice: Employment, Ownership and Private Investment"; and a skills-building workshop.

"We're putting together a great day of insightful discussions and skills-building content," says MMA President

Will Nicholson, MD. "We're so lucky to have secured Dr. Verghese. Given his past work and brand new novel, it's sure to be a talk not to be missed."

Verghese's memoirs and novels on medical themes have sold millions of copies, topped bestseller lists, and earned major movie deals, while his *New York Times* articles arguing for greater focus on the physical patient have made waves in the medical community. His warmth and vision as well as his world-class gifts as a storyteller make him a powerful speaker both to healthcare professionals and the patient in all of us.

In addition to being a deep thinker about the future of healthcare, Verghese is a successful author with great popular appeal. His novel, *Cutting*



for *Stone*, was a runaway hit, topping *The New York Times* bestseller list for more than two years and earning a movie deal.

His first book, *My Own Country*, a memoir about treating AIDS in rural Tennessee, was a finalist for the National Book Critics Circle Award for 1994 and was made into a movie. His second book, *The Tennis Partner*, was a *New York Times* notable book and a national bestseller. His latest novel, *The Covenant of Water*, came out in May and is receiving rave reviews.



Verghese has served on the faculty of many universities, including the University of Texas Health Science Center, San Antonio, where he was the founding director of the Center for Medical Humanities and Ethics. He has served on the Board of Directors of the American Board of Internal Medicine, is a Master of the American College of Physicians, and was elected to the Association of American Physicians, as well as the Institute of Medicine of the National Academy of Sciences.

In 2016, Verghese received the National Humanities Medal from President Obama, "for reminding us that the patient is the center of the medical enterprise."

For more information and to register, visit: <https://www.mnmed.org/AC23>. MM

News Briefs



MMA board approves ED boarding recommendations

At its May meeting, the MMA Board of Trustees approved a list of recommendations designed to reduce the incidence and improve the quality of emergency department boarding of patients with psychiatric diagnoses (EDBPPD) in Minnesota.

The recommendations are part of a 44-page report produced by a task force convened by the MMA and the Minnesota Chapter of the American College of Emergency Physicians.

The task force met for nine, two-hour meetings over four years to research, discuss, and develop recommendations on EDBPPD, taking a one-year break during the height of the COVID-19 pandemic.

“This is a critical issue. Many Minnesotans have to spend days and sometimes weeks in emergency departments waiting for available hospital or residential treatment beds,” says task force co-chair Dionne Hart, MD. “Taking action is long past due.”

“The recommendations that our task force developed offer up a game plan on addressing this complex issue,” says task force co-chair Drew Zinkel, MD. “It’s a big lift but desperately needed.”

The task force’s recommendations include the following (an asterisk denotes actions that the MMA and MNACEP, as medical associations, are positioned to leverage best):

1. Recommendations spanning the ED boarding continuum:

- Publicize and circulate the report to inform and empower leaders.*
- Support the creation of a Minnesota ED boarding database.*
- Collaborate to improve the usefulness of mental healthcare search tools in Minnesota.*
- Strategize to improve the size, distribution, and diversity of the mental healthcare workforce in Minnesota.
- Protect and expand the use of telehealth for mental health services.*

2. Recommendations for inflow factors (that lead to high ED utilization by patients in mental health crises):

- Support the financial sustainability of 988 call centers in Minnesota.
- Explore emergency transport diversion to EDs in hospitals with patient-appropriate inpatient mental health beds.
- Leverage healthcare workers and facilities to educate the public about mental resources.*
- Support legislation to require Minnesota health plans to reimburse for collaborative care model services.*

3. Recommendations for stalling factors (that potentially worsen the mental and physical health of boarding patients):

- Support the development and evaluation of alternative emergency facilities for patients with psychiatric diagnoses who await disposition.
- Advocate for an increase in ED-designated mental healthcare workers.*

4. Recommendations for outflow factors (why mental health patients get stuck boarded in EDs):

- Advocate for more inpatient mental health hospital beds in Minnesota.
- Advocate for more residential treatment beds in Minnesota.
- Monitor and engage in the development of locked Intensive Residential Treatment Services (IRTS) facilities in Minnesota.
- Support legislation to require Minnesota health plans to cover Psychiatric Residential Treatment Facilities and IRTS.*
- Collaborate to reduce the burdens of corporate foster care on ED boarding.

Telehealth controlled substances prescribing extended

The U.S. Drug Enforcement Administration is extending the ability for physicians to prescribe controlled substances based on telehealth visits through Nov. 11, 2023. This method had been set to expire when the COVID-19 public health emergency ended May 11.

On March 1, the DEA and the Department of Health and Human Services sent out notices of proposed rulemakings to generate feedback on proposals to continue allowing the prescribing of controlled medications via virtual visits with patients. More than 38,000 public comments came in.

“These medications, including those used to treat opioid use disorder, are a vital form of care for millions of Americans who have come to rely on safe and effective telemedicine appointments,” said the AMA in a statement. “Patients being treated with these medications often have challenges securing and traveling to in-person appointments.”

MMA recognizes exceptional primary care physician

MMA President Will Nicholson, MD, on May 3 presented the Exceptional Primary Care Community Faculty Teaching Award to Michael N. Stiffman, MD, at the fifth annual Dean’s Tribute to Excellence in Education event at Coffman Memorial Union at the University of Minnesota.

Stiffman, an MMA member, has provided comprehensive primary care for more than 25 years, and has spent much of his career managing patients with HIV with compassion and empathy.

In 2015, the MMA and the University of Minnesota Medical School embarked on what would become the Preceptor Initiative, an effort to develop tools and resources to improve the training and support for preceptors. This partnership recognizes the important role that community preceptors play in the education of medical students, and helps to ensure that there is a sufficient supply of community preceptors across Minnesota.

The teaching award stemmed from this partnership, as a way to recognize those who take the time to teach our future physician workforce. The award honors community faculty members and is co-presented by the MMA and the University of Minnesota Medical School.

Nicholson was joined at the event by Janet Silversmith, MMA CEO, and Juliana Milhofer, JD, MMA's public health and policy engagement manager.

MMA, others object to Cigna's office note policy

The MMA and 107 other healthcare advocacy groups signed on to a letter sent April 18 to Cigna leadership expressing concerns with its forthcoming policy that requires the submission of office notes with all claims including evaluation and management services, and modifier 25 when a minor procedure is billed.



"We urge Cigna to reconsider this policy due to its negative impact on practice administrative costs and burdens across medical specialties and geographic regions, as well as its potential negative effect on patients," said the letter signed by 41 state medical associations and 67 specialty groups.

The letter-writers suggested collaborating with Cigna on different ways to ensure the correct usage of modifier 25 that do not unfairly punish the majority of physicians and other healthcare professionals that code appropriately.

"There is a growing problem with physician burnout, and policies like these are adding to that burnout," said MMA President Will Nicholson, MD. "This proposed requirement adds hassles and burdens that don't improve patient care."

MMA now offering cross-cultural assessment tool

The MMA is now offering free intercultural development services to member organizations to help them achieve their diversity, inclusion, and health equity goals.

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

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

Some organizations offer the IDI to physicians, while some offer it to leadership. Interested healthcare organizations can work together with the MMA's qualified administrator to deter-

mine how to best utilize the IDI to meet their needs. The MMA is offering this opportunity to a limited number of organizations.

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

MMA launches webpage to help with DEA licensing

With the signing of the Consolidated Appropriations Act of 2023 last December and the subsequent removal of the DATA Waiver (or X-Waiver) requirement, physicians seeking an initial or a renewed DEA license are required to complete at least eight hours of training for the treatment and management of patients with opioid or other substance use disorders.

The MMA has created a webpage (www.mnmed.org/OpioidTreatment) to help Minnesota physicians comply with this new requirement.

The deadline for the training is the date of a physician's next scheduled DEA registration submission, whether it is an initial registration or a renewal.

State creates campaign to combat teen vaping

To combat the tobacco industry's use of marketing tactics like celebrity endorsements and the use of flavors that appeal to youth, the Minnesota Department of Health has launched "Hey Norm," (HeyNorm.org) a marketing campaign intended to engage teens about the issue of vaping.

According to the 2022 Minnesota Student Survey, about 14% of Minnesota's 11th grade students and more than 2% of middle school students use e-cigarettes. This use exposes students to the potential for a lifelong nicotine habit.

The MMA has long advocated for measures to reduce and eliminate teen vaping.

"Teens know some of the harmful side effects [of vaping], but they may not actively seek out information, and they may not feel comfortable talking about nicotine use with friends or trusted adults," said Minnesota Commissioner of Health Brooke Cunningham, MD, PhD. "We hope this campaign prompts them to learn more and share that knowledge with their friends."

Picking up on the popular "low-budget infomercial" approach, the campaign encourages teens to call or text Norm at 1-833-HEY-NORM to get advice about how to start "the vape talk" with their peers.

There's also a website, Room to Breathe (aroomtobreathe.org), with relevant data and resources about the harms of nicotine and vaping, ways to get involved, and access to quit support tailored for teens. The anti-vaping campaign is featured in mobile billboards, bulletins, posters, transit system signage, online videos, social content, and streaming audio. **MM**



FROM THE CEO

A pause to celebrate

This is the season of celebrations—graduations, weddings, family gatherings, school reunions. The MMA is also taking a moment to celebrate the completion of an incredibly successful legislative session and the marking of a significant historical milestone—the 170th anniversary of the MMA’s founding.

I’m very proud to report that the MMA’s influence at the Capitol led to positive outcomes on four of five defined MMA priorities:

- Passage of legislation recognizing an evidence-based model known as CANDOR (Communication and Optimal Resolution) to improve administrative transparency and patient safety by protecting from discovery discussions that are held between physicians and patients following an adverse event;
- Funding for a planning process to develop a registry for POLST (Provider Orders for Life Sustaining Treatment) forms;
- A two-year extension of audio-only telehealth coverage and payment;
- And expansion of Medical Assistance coverage for recuperative care services for patients experiencing homelessness.

The only MMA priority that did not pass this year was prohibiting insurers and pharmacy benefit managers from forcing a patient to change to a new drug in the middle of a contract year. Advocates for the bill faced opposition chiefly because of how much it would cost to implement.

Special recognition is owed the MMA’s legislative lobbying team, Dave Renner and Chad Fahning; MMA leadership, including Will Nicholson, MD, president; and Laurel Ries, MD, president-elect, both of whom testified before numerous committees; and the many physicians who attended Physicians’ Day at the Capitol.

Healthcare-related bills were, of course, among many of the 2023 Legislature’s headline-grabbing outcomes—from preserving access to reproductive health services, to expansion of MinnesotaCare

for undocumented individuals, to new investments in early childhood, to new oversight of healthcare mergers and acquisitions, to new firearm safety provisions, to the legalization of recreational marijuana. The MMA remained actively engaged in all of these items, and more. Although there will be lingering and legitimate debate over the merits of some of the policies enacted, the MMA’s involvement proved pivotal in shaping key proposals and advancing improvements for patients and physicians alike. You can read more about the scope of MMA’s 2023 legislative activity in our legislative review in this issue.

Another cause for celebration this summer is the MMA’s 170-year anniversary. Other than a brief hiatus in activity during the Civil War, the MMA has been actively involved in supporting physicians, improving public health, advancing medical education, and promoting professionalism during nearly two centuries of dramatic churn and change.

Yet the future of the organization is not guaranteed. Like medical care itself, organized medicine is increasingly specialized and fragmented. Physician employment and other practice arrangements have changed the ways in which physicians interact. Social media and other tools have made it easier for physicians to advocate for specific causes and to find like-minded interests.

Yet I believe there is still value and power in the collective of medicine—of physicians, without regard to specialty, geography, practice type, or ideology—to deliberate, support, collaborate, and advocate for the medical profession and for patient health. The MMA continues to make a difference. May it continue to do so for many more years to come.

Janet Silversmith
JSilversmith@mnmed.org

VIEWPOINT

Folks, we can fix this

The MMA is about physicians helping physicians. And today we need each other more than ever. We need to team up and look out for each other. We are the solution we've been looking for.

Covering each other's backs has not always been a dominant part of our professional culture. The power physicians have to manage our practices and guide our institutions has changed.

The core values and the sustainability of our profession were once built into our institutions and practices—we didn't have to fight for them at every turn.

Bit by bit those conditions have changed. We're spending more time swim-

ming upstream and trying to pull our patients against a growing current. It's harder work and it's long past time that our profession resolved to take better care of each other. No one else is going to. Our profession can and must band together. Our employers, fellow healthcare professionals, and regulatory bodies cannot protect physicians as well as we can protect each other.

Together we can restore balance. Physicians know how to fix the 20% physician workforce shortfall. Physicians know how to prevent the next pandemic. Physicians know the cures for the burnout crisis. Physicians can prevent healthcare worker suicides. And physicians know the prescription for a healthcare system that works for every Minnesotan.

To me, bringing physicians together starts by simply helping every MMA member get the most out of their membership. Every member who votes on the Pulse makes the MMA's voice stronger and more informed. Every member who does continuing medical education with us strengthens the quality of care they deliver. Every member who joins a committee or forum helps build meaningful connections. Every member who joins us at the Capitol or nominates a colleague for an award or writes for *Minnesota Medicine* escalates our voice as a profession.

Our nation may be addicted to martyrs and throw-away heroes but let's not go there. Together, we can break that cycle in healthcare. Our voice can lead Minnesota to better health. Our voice can drown out the pundits and the political spin. Our voice can restore facts, science, and basic human decency to our public discourse. Our voice can tame the nation's addiction to fictional quick fixes and false cures. Our voice can keep healthcare focused on helping patients—because we too are patients. Yes, working together as a profession, we are the solution we've been looking for. **MM**



Will Nicholson, MD
MMA President

Together we can restore balance. Physicians know how to fix the 20% physician workforce shortfall. Physicians know how to prevent the next pandemic. Physicians know the cures for the burnout crisis. Physicians can prevent healthcare worker suicides. And physicians know the prescription for a healthcare system that works for every Minnesotan.



2023 Legislative Session in Review

MMA comes out with big wins during fast-paced session

The MMA had a very successful session at the Capitol this year with four of its five top priorities becoming law. In addition, we passed other key items for Minnesota’s physicians and patients, and defeated some proposals that would have impacted how medicine is practiced in the state.

At his swearing-in ceremony on Jan. 2, Gov. Tim Walz previewed the session saying, “Minnesotans spoke clearly this last election, and they expect all of us to get things done. The era of gridlock in St. Paul is over.”

And that’s pretty much what occurred. The DFL-controlled Legislature, working with a \$17 billion budget surplus, was very productive—protecting Minnesotans’ reproductive rights, expanding access to affordable health coverage, enacting firearm safety measures, passing paid family and medical leave, and adopting a state budget for the next two years.

Here’s a review of the session, including reports on MMA priorities as well as other healthcare-related legislation:

MMA’s priority issues at the Legislature

ISSUE	RESULT
Ensure patient treatment preferences are followed and respected (POLST)	Passed The MMA supported legislation to develop a statewide electronic registry for Provider Orders for Life Sustaining Treatment forms.
Improving patient safety through open and honest communication (CANDOR)	Passed The MMA supported legislation that: (1) improves patient safety by encouraging open and honest communication with a patient and their family following an adverse event and (2) protects those communications, and any documents created for resolving an adverse event, from discovery in any lawsuits.
Increase access to care through expanded telehealth coverage	Passed The MMA advocated for the continued coverage of audio-only telehealth services to ensure that all individuals have access to high-quality healthcare. This coverage will continue for two more years. The MMA supports continued coverage of these services for all Minnesotans.
Support recuperative care for those experiencing homelessness	Passed The MMA supported expanding Medical Assistance (MA) to include coverage for recuperative care. This allows Minnesotans experiencing homelessness to receive needed short-term care in their recovery following hospitalization.
Stop insurers from forcing patients to switch medications mid-year	Did not pass The MMA pushed for legislation to prohibit insurers and pharmacy benefit managers (PBMs) from forcing a patient to change to a new drug in the middle of a contract year.

Other healthcare legislative issues

ISSUE	RESULT	ISSUE	RESULT
Adult-use recreational cannabis	<p>Background: Beginning Aug. 1, 2023, Minnesotans aged 21 and older will be able to use recreational cannabis. The law establishes regulations for the sale and marketing of the product and establishes a new tax of 10%. Warning labels are required to inform of the risks for use before age 25 and the drug's effect on brain development. Retail sales are not expected until 2024.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Neutral</p>	Family planning grants	<p>Background: Renamed as Sexual and Reproductive Health Services Grants, these grants received \$1.156 million per year to increase access to sexual and reproductive health services for people who experience barriers, whether geographic, cultural, financial, or other, in access to such services.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>
All Payer Claims Database (APCD) update	<p>Background: This legislation updates the state's APCD to ensure the collection of non-claims-based payments such as quality payments, infrastructure investments, care coordination and other patient support services.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>	Gender-affirming care	<p>Background: This legislation makes it clear that gender-affirming care for minors is legal in Minnesota and that physicians and patients cannot be prosecuted for providing these services for a patient from a state where services have been banned or limited.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>
Center for Health Care Affordability	<p>Background: What started as the Healthcare Affordability Commission, with the authority to set and enforce healthcare spending limits, became the new Center for Health Care Affordability in the Health Department, with the purpose of future healthcare planning.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Neutral</p>	Grants to reduce violence against healthcare workers	<p>Background: This legislation allocates \$4.4 million for grants to increase safety measures in healthcare settings. The funds will also establish or expand programs to train staff in healthcare settings on de-escalation and positive support services. The grants cannot exceed \$50,000 per facility.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>
Conversion therapy ban	<p>Background: This legislation bans the practice of trying to change a minor's sexual preference. The practice, also known as "conversion therapy," has been debunked by medical organizations as lacking scientific credibility and clinical usefulness.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>	Increased investments into early childhood services	<p>Background: The Legislature approved \$1.17 billion for early childhood initiatives, such as childcare, and early education programs. This is an increase in public investments into these programs.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>
Extreme risk protection orders—"red flag" laws	<p>Background: Law enforcement is now authorized to temporarily remove firearms from a person who has been determined to be a harm to themselves or others by receiving an Extreme Risk Protection Order from a judge.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>	LARC reimbursement	<p>Background: Medical Assistance (MA) will now cover the insertion of a long-acting reversible contraceptive (LARC) immediately post-partum. Previously, a patient would have to return one to two weeks after delivery for a LARC to be covered.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>

Other healthcare legislative issues

ISSUE	RESULT
<i>Mandatory reporting of lost/stolen firearms</i>	<p>Background: This would have required all gun owners to report to law enforcement if their gun was lost or stolen. This bill passed the House but not the Senate.</p> <p>Legislative Action: Did not pass</p> <p>MMA Position: Supported</p>
<i>Opioid Prescribing Improvement Program changes</i>	<p>Background: The Department of Human Services Opioid Prescribing Improvement Program can sanction prescribers who prescribe large doses of opioids. This has resulted in patients with chronic pain being forced to taper off their prescription drugs, even if it is not in their best interest. Because the program has made it difficult for chronic pain patients to find physicians to treat them, the Legislature voted to sunset the program no later than December 31, 2024.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>
<i>Oversight of mergers/acquisitions</i>	<p>Background: Legislation provides increased authority for the attorney general (AG) to review healthcare mergers and acquisitions and intervene if it is determined that the transaction will result in over-consolidation that harms patients. The MMA worked to limit the scope of the AG's authority to entities with annual revenues greater than \$80 million (it was \$10 million as introduced). For entities with revenues between \$10 million and \$80 million, there are additional data reporting requirements to the Department of Health.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Neutral</p>

ISSUE	RESULT
<i>Prior authorization</i>	<p>Background: Legislation would have required all insurers to report annually to the Departments of Commerce and Health: how often they use prior authorization (PA), how often PAs are approved, and how often they are denied. This legislation directed the department to use this data to develop recommendations to reduce the administrative burden of PA and focus its use only on areas where there is significant over-utilization.</p> <p>Legislative Action: Did not pass</p> <p>MMA Position: Supported</p>
<i>Public option</i>	<p>Background: MinnesotaCare will be expanded to allow all Minnesotans to purchase MinnesotaCare through MNSure as a "public option" to commercial insurance. The MMA worked to ensure that additional actuarial analysis is completed, and that reimbursement rates are at a level that will ensure provider access and sustainability before implementing a buy-in program in 2027.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>
<i>Reproductive healthcare access</i>	<p>Background: Several bills passed to ensure access to reproductive care, which was a top priority of the DFL-controlled Legislature. One clarifies the right to reproductive services in Minnesota, another repeals outdated restrictions from law, and a third clarifies that a physician or patient cannot be prosecuted for delivering the services to a woman from a state that outlaws abortions services.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>



Other healthcare legislative issues

ISSUE **RESULT**

<p>Restrictive covenants ban</p>	<p>Background: For all employment contracts signed on or after July 1, 2023, the use of a restrictive covenant, or a “non-compete clause,” is prohibited. This applies to all employment contracts, except those that include trade secrets. This also applies to physicians who have employment contracts but does not void contracts signed before the effective date.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>
<p>Rural clinical, workforce training and primary care residency grants</p>	<p>Background: Funding is provided for a new rural primary care residency program, additional rural clinical training rotations, and increases in loan forgiveness for the healthcare workforce.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>
<p>Safe storage of firearms and ammunition storage</p>	<p>Background: This would have required firearm owners to store their guns, unloaded and in a locked safe or with a locking device. This passed the House, but not the Senate.</p> <p>Legislative Action: Did not pass</p> <p>MMA Position: Supported</p>
<p>Universal background checks</p>	<p>Background: This expands laws that require a criminal background check prior to the purchase of a firearm to include private sales and gun shows. These two areas were exempt from current law.</p> <p>Legislative Action: Passed</p> <p>MMA Position: Supported</p>



How does an issue become an MMA priority?

The MMA Board of Trustees determines MMA legislative priorities based on the input from our physician members through their participation in committees, task forces, forums, the Policy Council, The Pulse, member events, surveys and online discussions. MMA policies serve as the foundation for our legislative, regulatory and administrative advocacy efforts during the legislative session and throughout the year.

To get involved in MMA legislative and grassroots efforts, contact our legislative team or someone from our member relations team.

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HEATHER BELL, MD, FASAM, FAAFP

- MMA member since 2013.
- Grew up in Cottage Grove. My mother, a single mom and registered nurse at St. John's in Maplewood, was diagnosed with myelodysplasia and died in 1999. As a result, younger sister, Molly, and I were separated. As an emancipated minor at age 16 I learned the value of hard work, perseverance, resilience, and just how hard it can be when you are disregarded as "less-than" because of having "less-than."
- Double-majored in biology and English at Gustavus Adolphus College. Worked for the athletic department, managing the weight room for the football team, announcing junior-varsity home football and baseball games, and getting the stadium ready for home varsity games. Threw hammer and shot put in track and field.
- MD from the University of Minnesota Medical School in Duluth. I participated in the Rural Physician Associate Program in Owatonna.
- Have represented the MMA on the state Opioid Epidemic Response Advisory Council since 2020. Was honored to receive the MMA Advocacy Champion recognition in January 2020, as well as the MMA President's Award in 2020. Worked with the MMA on projects concerning opioids and addiction.
- Practiced family medicine in Little Falls.
- Educate professionals on addiction topics with Project ECHO and mentor colleagues with the Tackling Overdose with Networks (TOWN) program, a Minnesota Department of Health approach that includes multiple strategies to reduce opioid overdose within communities.
- Provide medications for opioid use disorder treatment in county jails with a "jail grant" from the state Opioid Epidemic Response Advisory Council.
- Launching a new podcast, Addiction2Recovery, with certified peer recovery support specialist Josh Solem.
- Writing a memoir.
- Living in Little Falls with four amazing kids—Isaac, 13; Emmitt, 11; Kilie, 8; and Jaycee, 6. Days are taken up with travel soccer, travel baseball, figure skating, and taekwondo. Marcy, the sweetest 2½-year-old labradoodle in the world, loves baseball as much as the boys.

I became a physician because...

My mom was a nurse so that is what I was going to be—until she told me no! I "settled" on being a doctor. My favorite medical memories from my childhood, where my nurse-doctor dream blossomed, were the take-your-child-to-work days at the St. John's Med-Surg floor with my mom. Just seeing how she was with patients and the energy of the hospital had me hooked!



Bell with children (right to left) Emmitt, Kilie, Jaycee, and Isaac.

If I weren't a physician...

I'm not sure what I would do, but I might be a writer—an author or magazine editor or poet. (I was published in *Minnesota Medicine* my first year of medical school for writing the poem "To Be a Better Doctor.")

The greatest challenge facing medicine today...

Complete inequity and lack of true care, compassion, and desire to help people. Medicine is currently overrun with people trying to make money and "look the part" at the expense of what is best for the community they are meant to serve and the individual patients who, unfortunately, end up being simply numbers. When finances drive healthcare as they do now, those who truly need good care are the ones who are the most negatively impacted. This then further perpetuates discrimination and inequity.

How I keep life balanced...

My kids definitely balance my life! I love seeing through their eyes what the world looks like. It brings me so much hope for the future seeing the world that way, as this very young generation is so accepting and compassionate. And with all of their activities, color-coded calendars are a must to keep things organized! **MM**



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