A valued partner

Have you ever wondered what it would be like if the MMA didn’t exist? Who would work on the important issues facing the medical profession? What would the state of medicine be like in Minnesota?

Imagine the possible headlines:

“Lung cancer deaths continue to rise”

“More Minnesotans denied health care coverage”

“Minnesota physicians spending even more time with paperwork, less with patients”

“Legislature mandates opioid prescribing guidelines”

If the MMA weren’t around, who would make decisions about these matters? Non-clinicians?

If the MMA weren’t around, who would fill the podium at legislative hearings or the seats on the state committees and boards? Would individual physicians themselves do this? Clinics, large systems, health plans and specialty organizations certainly could speak to some of the issues, but would they speak for all?

Only the MMA can speak for 10,000 physicians, residents, fellows and students with a single voice. And we do speak out—on issues that affect the health of your patients, on the administrative burdens you contend with in your practice, on the big problems that are plaguing our state—such as opioid abuse and the primary care physician workforce shortage.

Take a few minutes as you read this Annual Report to consider all that the association has accomplished this year and plans to address in the future. And then, if you are not already a member, join us. Together, we can overcome our challenges and work to ensure that Minnesota once again becomes the healthiest state in the nation. With the MMA around, we can be confident that medicine in Minnesota will continue to thrive.

Thank you for being on our team.

DAN MADDOX, M.D.

DAVID THORSON, M.D.

ROBERT MEICHES, M.D.

PRESIDENT, 2012-2013

CHAIR, BOARD OF TRUSTEES

CHIEF EXECUTIVE OFFICER
Volume, Value and Victory

The MMA’s value to its members is not just measured by the volume of its victories. But if it were, members certainly received their money’s worth this past year.

At the Capitol, in state organization boardrooms, at special events and on the campaign trail, the MMA netted a number of triumphs in 2013. This is nothing new. We are always working on behalf of Minnesota’s physicians; this year just turned out to be more productive than expected.

During the 2013 legislative session, we set out to:

1. expand Medical Assistance;
2. establish a Minnesota-based health insurance exchange;
3. ensure the continued phase-out of the provider tax;
4. increase the tobacco tax to reduce smoking rates;
5. restore medical education funding; and
6. promote collaborative care delivery as opposed to independent practice for advanced practice registered nurses (APRNs).

We accomplished the first five of these goals and were able to convince lawmakers to postpone discussions on the sixth issue. We were also able to convince lawmakers to either ignore or vastly improve legislation that would have increased administrative burdens for physicians.

National Influence

On a national level, one of our members, Maya Babu, M.D., a neurosurgery resident at Mayo Clinic, won a two-year term on the American Medical Association’s board as the Resident Fellow Section representative. Her involvement will give Minnesota physicians a direct pipeline to one of the most influential health care advocacy bodies in the country.

Tackling Tough Issues

Our physician-led task forces are hard at work addressing the growing misuse of prescription opioids and the primary care physician workforce shortage. In addition, member Kathryn Duevel, M.D., assumed a seat on the eight-member board of MNSure, Minnesota’s health insurance exchange. She is one of several members who represent the MMA on influential task forces and groups such as the Minnesota Board of Medical Practice, MN Community Measurement, Minnesota Alliance for Patient Safety and the Institute for Clinical System Improvement.

Engaging Members

In an effort to increase member engagement, we began hosting policy forums throughout the state on topics such as the expansion of public programs and the misuse of prescription opioids. We attracted more than 100 physicians, students, residents and clinic managers to events in Minneapolis, Rochester and Duluth.

We also launched listening sessions that reached more than 250 physicians where they work. Our members told us of their concerns with prior authorization as well as a myriad other issues they contend with in their practices.

On the campaign trail, MEDPAC, the MMA’s political action committee, endorsed and financially supported 47 pro-medicine candidates for state office on both sides of the aisle. Eighty-seven percent of them were elected.

“Each of these ‘victories’ stands on its own as a great accomplishment but when you look at them as a whole, you really see how much the MMA does for Minnesota physicians every day,” says MMA President Dan Maddox, M.D.

It was a very valuable year indeed.
One of the MMA’s strategic initiatives is to improve access to health care for all Minnesotans. This past year, the MMA was involved in advancing legislation for one of the most influential policies supporting that goal—the expansion of Medical Assistance (MA) in Minnesota.

“This was a victory for physicians, no matter what side of the political spectrum you might come from,” says Donald Jacobs, M.D., chief of clinical operations with Hennepin County Medical Center in Minneapolis. “My vantage point as a provider within a safety net health care system is this change is much needed to even the playing field and give us a fighting chance to actually drive health care costs lower for a particular segment of the population.”

The MA expansion also directly supports the MMA’s goal of making Minnesotans the healthiest in the nation. Populations that have been underserved in the past now will have the opportunity to receive more preventive care and care for chronic conditions. “With legitimate insurance coverage and access to care, the lives and health of citizens who have been outside of our health care system for a long time will improve,” Jacobs says. “We are trying to make sure we get the right care—and I’d include prevention in that—to the right person at the right time. And we believe over time that will lower the utilization of health care in favor of a healthier population.”

Jacobs views the expansion of Medical Assistance as an opportunity to improve care delivery as well as insurance coverage. “If anything, it’s driving us to be very conscious of our competitiveness,” he says. “To not only give patients great care in a welcoming way, but also to give them care that’s affordable and has value.”
Stamping out smoking

The MMA has been a leader in the effort to increase the tobacco tax, but this year’s legislative outcome surprised even those close to the issue. The Minnesota Legislature and Gov. Mark Dayton approved increasing the tax on a pack of cigarettes to $1.60. In terms of tobacco taxes, Minnesota went from 28th in the nation to seventh.

For Richard Hurt, M.D., founder and director of the Mayo Clinic Nicotine Dependence Center, it was a victory that exceeded expectations. “The magnitude of the increase was quite striking and very encouraging,” he says. “We know that these public policies have an impact on cigarette use in three ways: reducing consumption, increasing the number of smokers who choose to quit, and decreasing the number of children who start smoking. In racing terms, it’s a trifecta.”

Hurt has a long, storied history of advocating for smoking cessation in Minnesota. He was the first medical witness to be called in the state’s historic tobacco trial in 1998, and he founded a revolutionary smoking treatment program at Mayo Clinic that is now in its 25th year.

Hurt believes the MMA is uniquely positioned to enlist and organize support among other professional organizations when addressing health-related issues such as smoking—and that can prove to be a powerful approach. “Associations and societies can join with the MMA to have a symphony rather than a cacophony of voices,” he says. “Together, we are poised to do more, and as the smoking prevalence continues to go down, we can accelerate that trend, and at some point it is going to drop off dramatically.”

Hurt believes even bolder moves lie ahead. “There are places in the world where they are actively considering ending cigarette use period. For example, New Zealand plans to be a country without cigarettes by 2025. If they can do it, others will do the same.”

Changing the mindset of politicians and citizens will require continued work on the part of the MMA and physicians. “As a health community, we need to be much more outspoken and much more persuasive of our political leaders,” Hurt says. “We have to help politicians have the courage to take serious steps to eliminate smoking. And they need to know we are going to back them and hopefully save future generations.”
Helping physicians just say no

It is the fastest-growing drug problem in the nation, and Christopher Johnson, M.D., of the Emergency Physicians Professional Association has seen the problem spread firsthand.

“We were getting a lot of patients coming into the ER with a chief complaint of chronic pain exacerbation,” says Johnson, who works at Park Nicollet Methodist Hospital in St. Louis Park. “They would come into the emergency department, be given an IV and then given fairly substantial doses of opiates. And then they would come back the next month.”

After witnessing the cycle of abuse for a couple of years, Johnson decided to do something about it. He worked with others at the hospital to create a policy around prescribing opioids in the emergency room and established a chronic pain committee. “Our policy has been very successful at decreasing admissions for chronic pain patients,” he says. “We don’t spend four hours with a patient requesting dose after dose. Now we tell them right away what will happen unless we find a new injury.”

Given his experience with the issue, Johnson was interested when the MMA launched its Prescription Opioid Management Advisory Task Force this past year to study and find solutions to addiction and abuse. For Johnson, one of the main areas of focus needs to be establishing guidelines that go beyond the emergency room and into the primary care setting. “Primary care providers are desperate for help and feel overwhelmed trying to manage these patients. You need to have an overall system so everyone acts the same way, otherwise we incentivize patients to shop around to get what they want,” he says. “Hopefully, the MMA can create a policy statement so physicians who want to do the right thing don’t feel they are left out there on their own.”

In addition to preventing abuse, Johnson believes having a standard treatment policy will help relieve pressure on physicians confronted by patients seeking opioids. “For these patients, getting the drug is the most important thing,” Johnson says. “They are going to stop your clinic for the day, they are going to argue, bring in their kids and put pressure on you. Saying to a physician ‘Just do the right thing’ puts the burden on the physician to argue for 40 minutes. It also tells the physician they have to risk complaint. No clinic or system wants to get complaints about their physicians.”

Johnson believes the creation of the MMA task force is a victory in that it is speaking to a problem that can no longer be ignored. “Prescribing is controllable. We need a sensible plan that is better for the patient, better for our own functioning, better for the hospital,” he says. “The number of deaths from prescription opiate overdose is still going up, so people are still getting the medications from somewhere. The next victory will be to see the corner turn on that stat, see the number of deaths decrease. With continued support and attention from groups like the MMA we hope to see that (happen).”

“Hopefully, the MMA can create a policy statement so physicians who want to do the right thing don’t feel they are left out there on their own.”

CHRISTOPHER JOHNSON, M.D.
Leading with quality

His first foray into the world of quality improvement began with a sequestration. Tim Hernandez, M.D., recalls how in the mid-1990s, he was sent out east for quality training. “It was three days of training where I was locked in a college dorm somewhere outside of Boston. Literally. With no transportation,” he says with a laugh.

Before attending the conference, Hernandez, as did most physicians at the time, viewed his profession one-dimensionally: “We looked at our job as taking care of people one patient at a time, giving them personal service, trying to use our best tools to do that.” But after three days in lock-down, Hernandez says his eyes were opened. He realized that there was more to the business of medicine than caring for individuals. “Creating a quality agenda was really going to involve some system changes,” he says.

Nearly two decades later, Hernandez is still advocating for system change. He heads up the quality efforts at Entira Family Clinics, an independent 12-clinic practice in the St. Paul area that employs about 60 family physicians. In addition, Hernandez sits on the board of MN Community Measurement (MnCM), serving as a co-chair of its measurement and reporting committee. He has also been active with the Minnesota Alliance for Patient Safety (MAPs).

It’s difficult to have a conversation on health care these days without bringing up the Q word, as it plays into a wide range of activities. The key element, Hernandez says, is to keep physicians at the center of the conversation.

“The most important thing is that you have physicians deeply involved (with your quality efforts),” he says.

In 2013 and continuing into 2014, the MMA is working on several quality initiatives including:

**Choosing Wisely®**
Choosing Wisely is an American Board of Internal Medicine Foundation initiative focusing on encouraging physicians and patients to think and talk about medical tests and procedures that may be unnecessary and, in some cases, cause harm. On the patient side, Consumer Reports, a Choosing Wisely partner, is developing and distributing materials that will help them engage their physicians in determining what tests and procedures are right for them. The MMA received a two-year grant to help raise awareness and educate Minnesota physicians about the campaign.

**Provider Peer Grouping**
The MMA has actively engaged in working to shape the state’s Provider Peer Grouping Project, an effort to compare the cost and quality of care provided by clinics and hospitals. The Department of Health initiative is initially focusing on total cost of care. Data on primary care practices is expected to be released in early 2014. Although physicians are concerned with the fact that the information will be three years old by the time it is made public, Hernandez says he hopes it will reveal patterns. “When you do it for a while you at least start to see which way the dial is going and that’s valuable,” he says. “The key is finding measures that are relatively easy because the burden on clinics is significant. We are constantly balancing that unquenchable thirst for knowledge that the payers and the community want with how much we can ask the clinics to do.”

**Prescription Opioid Misuse**
In late 2012, the MMA created a task force to tackle the issue of prescription opioid abuse, addiction and misuse. This year, the MMA held a series of forums throughout the state to discuss the issue and explore solutions. The MMA has also partnered with ICISI to develop clinical tools for opioid prescribing. Work will continue on this issue through 2014.
Wanted: **Primary Care Physicians**

The shortage of primary care physicians is not a new problem. In fact, it has been a concern for decades. But today there is a new sense of urgency, as it is estimated that one-third of primary care physicians will be retiring in the next 10 years.

“The statistics nationally are more concerning than they have been before,” says Kathleen Brooks, M.D., director of the Rural Physician Associate Program (RPAP) at the University of Minnesota Medical School.

But an aging physician workforce isn’t the only challenge. “We also have an aging population needing more care, plus physicians today are less likely to work 80 to 90 hours per week in order to have professional and personal life balance,” Brooks says. “Those pieces plus the Affordable Care Act and new models of health care promoting access for all are creating a new demand and increasing the concern.”

Earlier this year, the MMA formed a Primary Care Physician Workforce Expansion Advisory Task Force to explore this issue. Part of the initial work has been to understand what’s happening, review the available data, and begin to discuss the challenges around addressing this complex issue.

“If we say we really are interested in nurturing interest in trainees for going into primary care, then what are the challenges? For example, the University of Minnesota Medical School has difficulty finding training practices, physicians or places to take our students and teach them,” says Brooks, who is a member of the task force. She attributes the difficulty to the fact that practices have become much more productivity-driven. “Having a student to teach adds another obligation to a physician who already has a busy day.”

Brooks believes the MMA has a real opportunity to bring about change. She sees value in bringing together physicians from all disciplines to look at this issue and carrying forward the physician perspective to other key players such as local and state governments, universities and community organizations. “The MMA can’t change the economics of salaries and reimbursement disparities,” she says. “But the MMA can be at the table in a very informed way to represent physician concerns.”

“**We have an aging population needing more care, plus physicians today are less likely to work 80 to 90 hours per week in order to have professional and personal life balance.**”

**KATHLEEN BROOKS, M.D.**
Helping secure education funding for Minnesota’s future

The education and training required to become a physician doesn’t come cheap. So when funding for the state's Medical Education and Research Costs (MERC) fund appeared to be in jeopardy at the Legislature again, the MMA knew it was time to stand up for future physicians. As a result of the MMA’s work, lawmakers agreed in a last-minute move to provide $12.8 million in funding for MERC.

“MERC funding is a source of support to our graduate medical education programs at many of the institutions where our residents work,” says John Andrews, M.D., a pediatrician and associate dean for graduate medical education at the University of Minnesota. “It is critical to preserving the educational experience for residents. So there was a strong interest from a consortium of hospitals in seeing the funds restored to the previous level.”

In 2011, lawmakers cut MERC funds by 50 percent to help balance the state’s budget, with the promise of restoring the funds once dollars became available. “We were motivated this year by the fact that at the time the funds were cut, the message was that it was temporary,” Andrews says. “But as the 2013 legislative session progressed, there was concern that the funds wouldn’t be restored, and if the funds were restored they might not be restored to serve the same purpose they had been earmarked for in the first place.”

There was significant debate about the use of the MERC funds, specifically around the need to educate more primary care physicians in rural areas of Minnesota. “I was concerned there was a misunderstanding of where providers in rural areas are educated and how the funds could be applied to meet the gap,” Andrews says. “I didn’t want to see someone say ‘Yes, let’s restore MERC funding, but let’s send it all to hospitals in greater Minnesota because those hospitals have a primary care shortage and need doctors.’ The truth is, the training programs for people in primary care disciplines are in hospitals in the metro area.”

The challenge for lawmakers who represent rural communities was how to defend the distribution of funds to organizations in the Twin Cities. To help address that concern, the Legislature approved an additional $2 million in MERC funding dedicated to primary care physician residency programs in rural communities.

Andrews believes a “perfect storm” is forming around the financial costs of becoming a physician, and that is why getting the additional MERC funding was a critical victory this year for physicians and the MMA.

“There is a lot of concern that funding for graduate medical education could be reduced or could, at least at the federal level, go away completely. If that’s the case, we are going to have to come up with a really novel way of paying for the education of physicians.”

But what can seem insurmountable can become doable when physicians work together. “I think the MMA can make sure issues are being debated in a way that benefits physicians, other providers, health care facilities, and the patients throughout the state of Minnesota. Their ongoing interest in these issues is really important,” Andrews says.
Legal support system

In the clinic and hospital, physicians wield power. They write prescriptions and perform surgery, lead teams and often help their patients contend with life-or-death situations. However, when it comes to the courts, physicians often say they feel powerless.

“Physicians are certainly interested in what’s happening with the legal aspects of the profession,” says Todd Brandt, M.D., a urologist with Metro Urology in Woodbury. “It impacts our day-to-day lives pretty significantly. My impression is that it’s one of those things we don’t have that much control over.”

Brandt and 19 other MMA members weigh in on and discuss a variety of legal and ethical matters as part of their work on the MMA’s Ethics and Medical-Legal Affairs committee.

In the past year, the committee has focused on four key topics:

- “Loss of chance” malpractice – The state Supreme Court reversed a law that had previously held that a physician may only be liable for harm a patient actually incurs. With the ruling, a medical malpractice claim may prevail if a patient merely establishes that the physician’s negligence made survival or recovery less likely – even if survival is unlikely in the natural course of the disease.

- Medical staff autonomy – A Minnesota Court of Appeals ruled in late July in the case of Avera-Marshall medical staff v. Avera Marshall Regional Medical Center that a medical staff is not considered a legal entity in the eyes of the law and therefore cannot sue. The court also ruled that the bylaws between a medical staff and a hospital are not a binding contract for both parties. The MMA supported the medical staff, which is determining what recourse it has following the ruling.

- End-of-life decisions – In late July, a Court of Appeals reversed a lower court’s ruling regarding the scope of a legal guardian’s powers in determining a ward’s medical care, and whether those powers extend to termination of life support. In the case, the MMA supported the rights of the guardian, in consultation with a physician, to make end-of-life decisions rather than let a judge decide.

- Restrictive covenants – Not tied to a particular case, this debate is over whether physicians can be held to non-compete clauses in contracts when they are hired by an organization. The committee has not taken a position yet. It is likely that the state Legislature will address this topic in 2014.

“As a physician you just don’t have time to keep up with all that is happening,” Brandt says. “You need an advocate.”

And that advocate is the MMA.
Value in allegiances

The MMA partners with a number of organizations both to work on issues that affect the practice of medicine and to offer services to its members.

External Partners

Institute for Clinical Systems Improvement (ICSI)
The MMA has worked closely with ICSI on several projects including the Reducing Avoidable Readmissions Effectively (RARE) program, which has prevented more than 5,400 readmissions in the last two years. More than 100 Minnesota hospitals participate in the program. We are also collaborating with ICSI on the Choosing Wisely Minnesota campaign. ICSI works to develop collaborative relationships that improve health care quality and value. www.icsi.org

Member Advantage
A discounted package of products and services is available to MMA members through MemberAdvantage, a joint venture of the MMA and the Twin Cities Medical Society. Each offering has been carefully selected to meet the needs of physicians in their practices and in their personal lives. Products and services include temporary staffing help, office products and medical/surgical supplies, revenue cycle management and collection services, professional liability insurance, and personal and business insurance. www.memberadvantagenow.com

Midwest Medical Insurance Company (MMIC)
The MMA has a strong partnership with MMIC Group, Inc., the leading carrier of medical professional liability insurance for Minnesota physicians, with a 92 percent market share. Minnesota’s current medical professional liability rates are the second-lowest in the nation, thanks to the MMA’s work with MMIC. The MMA will continue to work closely with MMIC to maintain a sustainable malpractice insurance rate for all physicians in the state. www.mmicgroup.com

Minnesota Alliance for Patient Safety (MAPS)
MAPS was founded in 2000 by the MMA, the Minnesota Hospital Association and the Minnesota Department of Health to promote patient safety across all health care settings. The MMA has worked with MAPS to develop and implement a Patient Safety Culture Roadmap that offers an evidence-based process for improving safety. www.mnpatientsafety.org

Minnesota Community Measurement (MNCM)
As one of the founding members of MNCM, the MMA works to ensure the physician’s voice is heard in quality measurement discussions. The MMA also works with MNCH to educate physicians about the Minnesota Statewide Quality Reporting and Measurement System. Several MMA members serve in MNCH leadership and technical positions. MNCM works to improve the health of Minnesotans by developing and reporting quality measures. www.mncm.org

Minnesota Credentialing Collaborative (MCC)
The MMA helped create and now helps direct the MCC, which provides a secure, centralized, web-based platform for collecting, submitting and storing credentialing data and supporting documents. These documents include licenses, attestations and privilege forms. The MCC is owned by the MMA, the Minnesota Council of Health Plans and the Minnesota Hospital Association, and has been endorsed by the Minnesota Medical Group Management Association. www.mncred.org

Internal Partners

MEDPAC
MEDPAC is the MMA’s political action committee. It endorses pro-medicine candidates for state office; contributes to the campaigns of endorsed candidates; generates grassroots action; and recommends candidates for national office to AMPAC, the AMA’s political action committee. www.mnmed.org/Advocacy/MEDPAC

MMA Foundation
The MMA Foundation provides scholarships to promising students and works with a number of partners to improve access to medical care in underserved communities in the state. www.mmafoundation.org
“I’m 35, I am making more than I ever will make again; funding is going down, my hours are going up. More forms, more telephone calls, more expectations and no compensation.”

Member response from the 2013 value survey.

Minnesota physicians face many challenges — administrative burdens, physician shortages, heavy workloads, loss of autonomy and uncertainty about the future. Many things are converging to change medical practice as we know it.

As we help physicians address these issues, MMA members and staff are keeping their eye on the goals identified in the MMA’s strategic plan, Focused for Success:

- Making Minnesotans the healthiest in the nation
- Making Minnesota the best place to practice
- Advancing professionalism

So, a year into the plan, how are we doing?

“Focused for Success is making headway on several fronts through the hard work of staff and member physicians,” says David Thorson, M.D., chair of the MMA Board of Trustees. “I am confident that our work will touch every physician’s practice in Minnesota because of the common issues we are addressing.”

Focused for Success Report Card

**Making Minnesotans the healthiest in the nation**

- **Improving the quality of care**
  - **Prescription opioid abuse task force.** The MMA convened a task force to develop a strategy for dealing with this problem. Three policy forums were held, where we gathered feedback from physicians around the state on ways to fight opioid addiction, abuse and diversion. Now, the MMA is working with ICSI to develop consistent prescribing resources for Minnesota physicians.
  - **Increasing the tobacco tax.** The MMA lobbied for raising the tobacco tax this year. The higher tax is already improving the health of Minnesotans by reducing smoking.
  - **2014 Quality Summit.** An event is planned for early next year where physicians can discuss the importance of accurately measuring physician performance and the role it should play in care improvement.

**Ensuring access to care**

- **Primary physician workforce task force.** We’ve convened leaders from across Minnesota, who are gathering information to determine the best ways to expand the primary care physician workforce. A special summit to discuss the topic had been scheduled for November 2013.
- **Expanding health coverage through MNsure and Medical Assistance expansion.** Our support ensures more Minnesotans will have health coverage and physicians will see less uncompensated care.
- **Restored MERC funding.** The MMA was successful in convincing the Legislature to restore MERC funding for Minnesota’s teaching facilities.

**Making Minnesota the best place to practice**

- **Administrative burdens/prior authorization for medications**
  - **Coordinator begins work.** A coordinator has begun interviewing health plans and documenting prior authorization processes and policies. A plan to reduce burdens is the end product of this effort.

**Preparing for new and innovative payment and care models**

- **Three-session program planned.** Watch for programs in 2014 that will help physicians navigate new payment and care models.

**Advancing professionalism**

- **Protecting the core values of the medical profession**
  - **Choosing Wisely.** Medical specialties have created lists of tests or procedures that may be overused, unnecessary and potentially harmful. The MMA is developing communications tools that physicians can use in their conversations with patients to help them make wise choices.
  - **CME Accreditation.** The MMA accredits 22 Minnesota and North Dakota organizations that provide continuing medical education and ensures they meet high standards. This provides physicians local access to high-quality CME.

**Bringing physicians together around professionalism**

- **Advisory team.** An MMA team is identifying ways to enhance professionalism and promote collegiality among the state’s physicians.
MMA leadership

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  Phalen Village Clinic, St. Paul

- **AMA ALTERNATES**
  David C. Thorson, M.D.
  University of Minnesota Physicians, Minneapolis

**AMA ALTERNATES**

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  **CHAIR** Laurel M. Ries, M.D., HealthEast Rice Street Clinic, St. Paul

- **Quality**
  **CHAIR** Carolyn McClain, M.D., Emergency Physicians Professional Association, Minneapolis

- **ISSUE-SPECIFIC MMA TASK FORCES**
  **GOVERNANCE 2.0**
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  **CHAIR** Jeremy S. Springer, M.D., Park Nicollet Clinic Creekside, St. Louis Park

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- **CHAIR** Jeremy S. Springer, M.D., Park Nicollet Clinic Creekside, St. Louis Park

**Choosing Wisely**

- **CHAIR** Thomas E. Kottke, M.D., Regions Hospital, St. Paul

**Prescription Opioid Management Advisory Task Force**

**STANDING MMA COMMITTEES**

**Administration and Finance**

- **CHAIR** Paul B. Sanford, M.D., St. Luke’s Internal Medicine Associates, Duluth

**Ethics and Legal Affairs**

- **CHAIR** Todd D. Brandt, M.D., Metro Urology, Woodbury

**Health Care Access, Financing and Delivery**

- **CHAIR** Lisa Mattson, M.D., University of Minnesota - Boynton Health Service, Minneapolis

**Membership and Communications**

- **CHAIR** Keith L. Stelter, M.D., University of Minnesota Physicians/ Mayo Clinic Health System, Mankato

**Minority and Cross-Cultural Affairs**

- **CHAIR** Dionne A. Hart, M.D., Federal Medical Center, Rochester
2013 Financial highlights

How your dues are used
1 GOVERNANCE 30%
   MMA Board and House of Delegates, AMA delegation
2 ADVOCACY 27%
   Legislative and regulatory lobbying, payer relations, quality, public health
3 COMMUNICATIONS 24%
   Minnesota Medicine, MMA News Now, website, special reports
4 MEMBERSHIP 14%
   Member relations, outreach, education, events
5 PRODUCTS and SERVICES 5%
   Accreditation, joint sponsorships, contracted lobbying

Total MMA Revenue: $4,100,000
1 DUES 57%
   Dues payments from members
2 ROYALTY INCOME 27%
   Royalty payments made from MMIC
3 ADVERTISING INCOME 7%
   Revenue earned from the advertising sold in Minnesota Medicine and on the MMA website
4 ADMINISTRATIVE AND LOBBYING SERVICES 5%
   Revenue earned by the MMA for accreditation, co-sponsorships and lobbying support for other related organizations
5 ALL OTHER REVENUE 4%
   Including income from investments, grants and events
State-wide Value

As the 12th largest state in the country, Minnesota covers a lot of ground. In order to be a truly representative association, the MMA needs to consider the diverse opinions of physicians from Becker to Zumbro Valley. Six trustee districts with 31 Component Medical Societies represent that breadth. Below, you’ll find a breakdown of our membership.

**NORTH CENTRAL TRUSTEE DISTRICT** | **547**
---|---
East Central | 44
Park Region | 80
South Park Region | 58
Stearns-Benton | 177
Upper Mississippi | 154
West Central | 18
Wright | 16

**NORTHEAST TRUSTEE DISTRICT** | **539**
---|---
Lake Superior | 438
Range | 101

**NORTHWEST TRUSTEE DISTRICT** | **226**
---|---
Clay-Becker | 62
Headwaters | 100
Red River Valley | 64

**SOUTHEAST TRUSTEE DISTRICT** | **3,632**
---|---
Freeborn | 42
Goodhue | 61
Mower | 17
Rice | 32
Steele | 70
Wabasha | 4
Winona | 14
Zumbro Valley | 3,392

**SOUTHWEST TRUSTEE DISTRICT** | **410**
---|---
Blue Earth | 65
Blue Earth Valley | 22
Brown | 13
Camp Release | 22
Lyon-Lincoln | 23
McLeod-Sibley | 43
Mid-Minnesota | 151
Nicollet-Le Sueur | 20
Southwestern | 42
Waseca | 9

**TWIN CITIES TRUSTEE DISTRICT** | **4,562**
---|---
Twin Cities | 4,562
At Large | 4

**TOTAL:** | **9,920***
---|---

Includes: regular/active, retired, students, residents/fellows
Note: Resident and student numbers can fluctuate significantly throughout the year.

**MEMBERSHIP OVERVIEW**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Members</th>
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<td>2000</td>
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<td>10,347</td>
</tr>
<tr>
<td>2013</td>
<td>9,920*</td>
</tr>
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</table>

*Numbers as of July 31, 2013
The unified voice of the medical profession