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PRIVATE EQUITY IN MEDICINE

HELPING HAND OR IRON FIST?

As more private equity firms invest in healthcare entities, Minnesota considers banning the practice

PAGE 18

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Many in medicine are concerned that private equity firms are buying up clinics, contributing to a healthcare system where a significant portion of facilities are owned to make a profit. But what to do about it?

ON THE COVER

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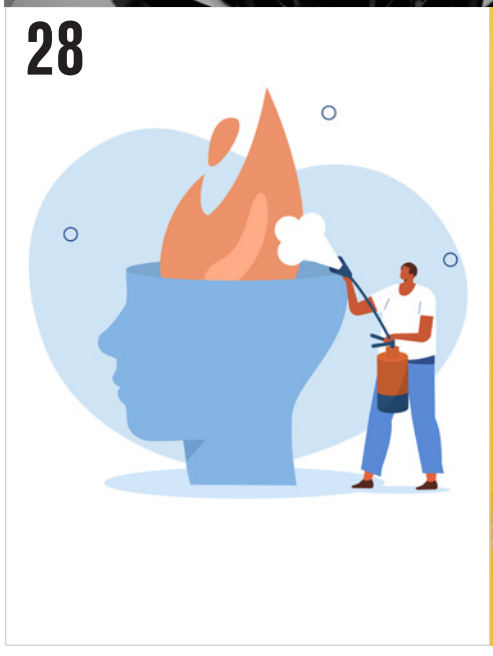

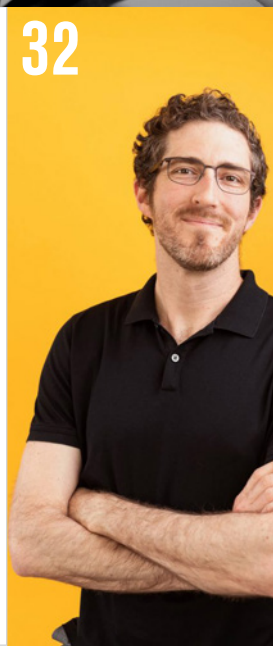

CORRECTION
Because of a typo, the byline to Charles Oberg's article on providing trauma-informed care to children from war zones failed to indicate he is an MD.

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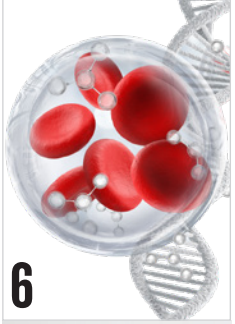

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CONTACT US
Minnesota Medicine
3433 Broadway Street NE, Suite 187
Minneapolis, Minnesota 55413-2199
PHONE: 612-378-1875 or 800-DIAL-MMA
EMAIL: mm@mnmed.org
WEB AND DIGITAL EDITION: mnmed.org

OWNER AND PUBLISHER
Minnesota Medical Association

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Greg Breining

DIRECTOR OF COMMUNICATIONS
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CIRCULATION/WEB CONTENT
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Christopher Wenner, MD

Vote "yes" for the environment and health

Election Day is two short months away. One can only hope that the next president will be decided forthwith. While many are tired of the rancor and drama associated with the presidential election, we have the opportunity to positively affect the health of our state by showing up at the polls.

The Minnesota state ballot will contain a vote for a constitutional amendment, continuing and enhancing what was established in 1991, the Environmental and Natural Resources Trust Fund. The state lottery provides the revenue for the fund and since its inception, over $1 billion has been distributed to projects statewide.

The stakeholders are numerous but the health of our state's populace remains the fund's primary beneficiary. Biking and hiking trails have been created and clean water has been ensured. Inner-city youth have been taught to canoe. Perennial, resource-sparing crops are being developed. Fishing piers have been built. Natural resource conservation and safekeeping are promoted. The list goes on. It is hard to overemphasize the positive physical and mental health effects garnered over the past 33 years that the fund has been in effect.

Promoting a healthy lifestyle is the foundation of good health. Offering safe, easily accessible, and free options for being active outdoors sets the lifestyle table well. Our climate does not always beckon us outdoors, so every opportunity to remove barriers and enhance the uptake of outdoor actives should be lauded. Additionally, the preservation of our state's trees, rivers and lakes, wildlife, and open spaces have incalculable benefits to the well-being of Minnesotans.

The amendment would not only continue to provide a dedicated revenue stream to the Environmental and Natural Resources Trust Fund, it would also allocate funds for grants directed at addressing environmental issues in adversely affected communities. These grants would be earmarked for organizations that do not have the resources to navigate a complex application process. Tribal communities, inner cities, and rural areas—the "less healthy" parts of our state—would be eligible for these grants. Imagine more sacred spaces, more green spaces, more wide-open, unmolested spaces. Environmental education would foster stewardship. Better health is certain to follow.

One could argue that the state lottery used to fund the trust fund is inherently unhealthy for the state; however, the program is well ensconced and is unlikely to meet its demise anytime soon. To snub one's nose at lottery funds would simply deposit more into the general fund—vulnerable to the whims of our legislators.

The bill placing the amendment on the ballot was passed in 2023 with bipartisan support. I am not aware of any entities that have come out in formal opposition to this amendment, although there are murmurings among some groups that all lottery proceeds should be allocated to the general fund.

The crown jewel of our state remains its natural resources, and the health benefits of a population engaged in a natural environment are myriad. Vote "yes" November 5 to support better health in Minnesota. MM

The crown jewel of our state remains its natural resources, and the health benefits of a population engaged in a natural environment are myriad. Vote "yes" November 5 for the Environmental and Natural Resources Trust Fund to support better health in Minnesota.

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

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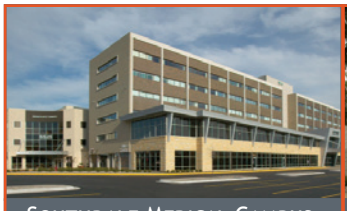

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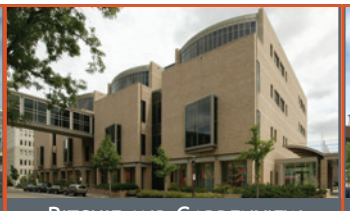

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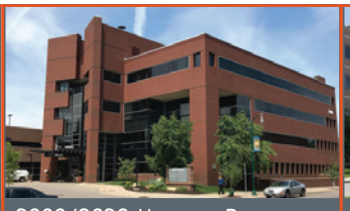

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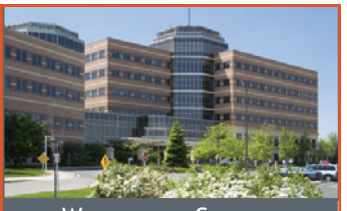

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Teenagers growing more dependent on nicotine, data shows

Minnesota students who vape are becoming increasingly dependent on nicotine, according to new data released by the Minnesota Youth Tobacco Survey.

About seven in 10 students who vape want to quit, and nearly two-thirds have tried to stop, with some trying to quit 10 or more times.

Youth and young adults can show signs of nicotine dependence quickly. Increasing dependence on nicotine leads to stronger withdrawal symptoms, which cause mood fluctuations and negative mood, and can amplify or exacerbate stress, anxiety, and symptoms of depression.

Up until about age 25, nicotine can negatively affect learning, attention and memory. It also increases risk for addiction to other substances.

Nearly all Minnesota teens who use e-cigarettes report suffering dependence on the devices, which can provide high levels of nicotine.

Minnesota Youth Tobacco Survey data shows 79.6% of students who vape reported having experienced one or more signs of dependence, such as intolerable cravings and reaching for their e-cigarette without thinking about it.

Among students who vaped in the past 30 days, 49.5% vaped on at least 20 of the past 30 days, a 47% increase in frequent vaping since 2020 and a 165% increase since 2017.

Although data shows that dependence is increasing, there is good news. After the implementation of public health measures and vaping restrictions, data shows youth vaping has started to decline in Minnesota. In 2023, 13.9% or about one in seven high school students reported having vaped in the past 30 days, a significant decline from 19.3% in 2020. Many cities and counties have enacted policies to protect youth in their community. About one in four Minnesotans are now covered by a local ordinance that restricts or prohibits the sale of flavored commercial tobacco products, including e-cigarettes.

New study finds cell donor's socioeconomic status shapes cancer treatment outcomes

A research team led by the University of Minnesota Medical School demonstrated that the socioeconomic status of cell donors affects the health outcomes of blood cancer patients who underwent hematopoietic cell transplantation (HCT).

The study, published in the Proceedings of the National Academy of Sciences, examined the health outcomes of 2,005 blood cancer patients treated with HCT across 125 hospitals in the United States. The research team found cancer patients who were transplanted with cells from donors of greatest socioeconomic disadvantage experienced a 9.7% reduction in overall survival and 6.6% increase in transplant-related mortality at three years compared to those transplanted from donors of high socioeconomic status—regardless of the cancer patient's socioeconomic status.

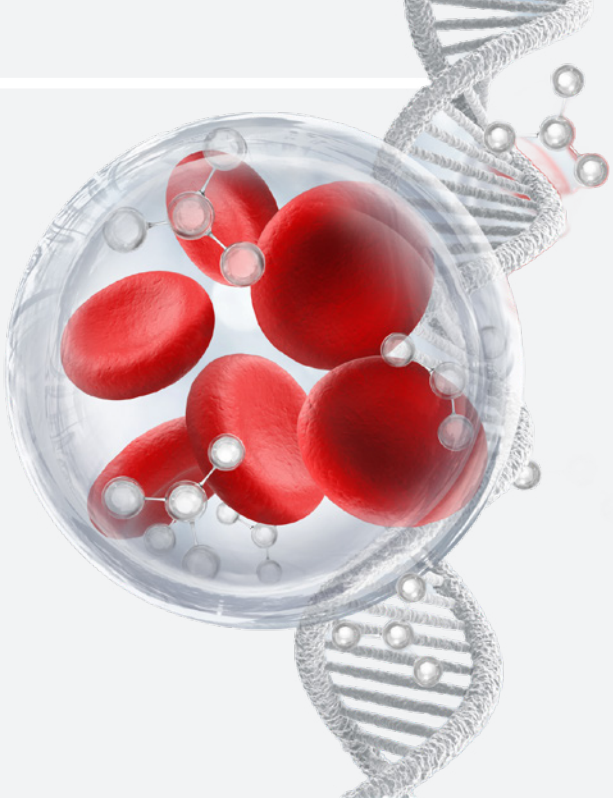
"Our findings are quite remarkable. We have shown that social disadvantage penetrates so deeply that it is actually transplantable into a new host, and its effects persist over time," said Lucie Turcotte, MD, MPH, MS, an associate professor at the University of Minnesota Medical School and pediatric hematologist and oncologist with M Health Fairview.

The results show the striking biological impact of social disadvantage and how it can alter health outcomes, specifically in

the setting of cancer and hematopoietic cell transplantation. The research team plans to conduct further research to investigate the underlying biological and physiologic drivers of these findings in order to develop interventions to mitigate the adverse health outcomes introduced by socioeconomic disadvantage.

"The importance of these findings reach far beyond cancer and bone marrow transplant care—they demonstrate the profound health effects of social inequality and highlight the critical need for public health interventions," said Turcotte.

—University of Minnesota Medical School



Minnesota AG takes on pharmacy benefit managers

In early June, Minnesota Attorney General Keith Ellison announced that he is leading a bipartisan coalition of 32 attorneys general from across the country asking the U.S. Supreme Court to rule on states' authority to regulate pharmacy benefit managers (PBMs).

In an amicus brief, Ellison and the coalition asked the court to grant Oklahoma's request that the court review a decision from the U.S. Court of Appeals for the 10th Circuit, which held that federal laws preempt Oklahoma laws that regulate pharmacy benefit managers.

The challenge to Oklahoma's laws is the latest in a string of lawsuits by the PBM industry's national lobbying association, Pharmaceutical Care Management Association (PCMA).

Ellison and the coalition seek to protect consumers by assuring that all states can regulate PBMs. Ellison and the coalition write in their amicus brief that "states have a compelling interest in preserving their traditional authority to protect their residents' access to healthcare and to regulate business practices in their states. To advance these interests, all states regulate [PBMs] to some degree." PCMA's and the 10th Circuit's broad approach to federal preemption, however, would "severely and unduly impede states' abilities to protect their residents and regulate businesses."

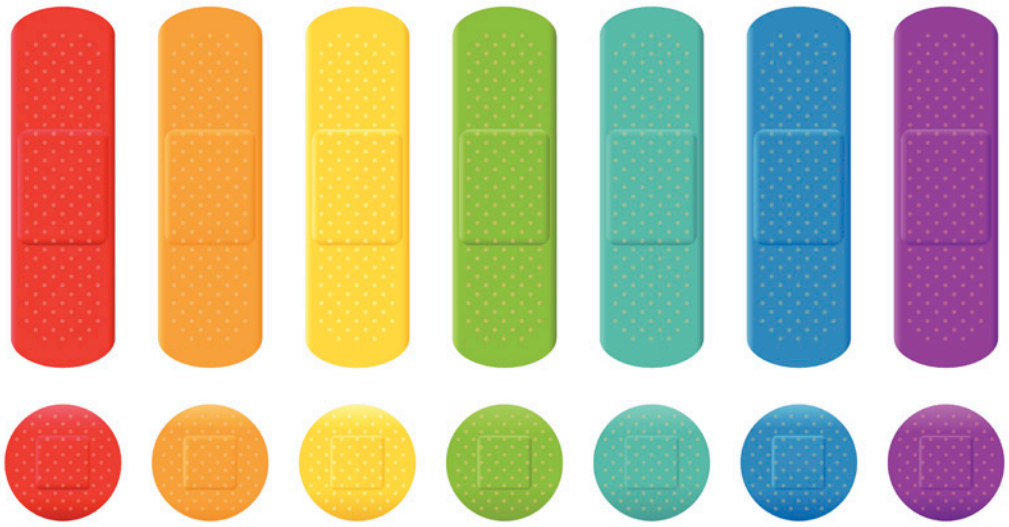
"No one should have to choose between affording their lives and affording to live, but the high cost of pharmaceutical drugs forces too many people to do just that—and the abusive practices of PBMs are one of the main reasons people are having to make that terrible choice," Ellison said.

It is the third time Ellison has led bipartisan, multistate coalitions of attorneys general in defense of states' ability to regulate PBMs: He led a coalition of 34 attorneys general in October 2022 in an amicus brief to the 10th Circuit in this same case in defense of Oklahoma's laws. He led a similar bipartisan coalition in July 2021 in an amicus brief to the 8th Circuit to defend North Dakota's laws regulating PBMs.

In 2019, the Minnesota Legislature passed the Minnesota Pharmacy Benefit Manager Licensure and Regulation Act. Since the law's passage, the Minnesota Department of Commerce has reached settlements or issued cease and desist orders in 12 cases enforcing the state's PBM laws.

The coalition includes attorneys general from Minnesota, Arizona, California, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Hawaii, Illinois, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Virginia, and Washington.

Adverse health events increased for fourth straight year in Minnesota



The number of reportable adverse health events in Minnesota hospitals, licensed ambulatory surgical centers, and community behavioral health hospitals increased for the fourth straight year in 2023, according to the latest data released by the Minnesota Department of Health.

Minnesota's mandatory adverse health event reporting system requires certain types of facilities to report whenever an adverse health event occurs and to conduct a root cause analysis to identify the causes and contributing factors that led to the event. The system includes 29 often preventable errors that could lead to serious injury or death. The goal of the system is to balance quality improvement with accountability and transparency, while developing opportunities for providers to learn from each other about how to prevent adverse health events.

Prior to 2021, the overall number of adverse health events had been stable. However, the number of reported adverse health events (610) and adverse health events that resulted in serious injury (222) both reached new highs in 2023.

The data is featured in a new chartbook format and includes adverse health event reports collected from healthcare providers from October 7, 2022, to October 6, 2023. The data for 2023 shows that total adverse health events rose by 38 compared to 2022 and have now increased by more than 166% since 2019, the last year that Minnesota reported a decrease in adverse health events.

In addition to seeing an increase in total adverse health events reported, the 2023 data also disclosed a concerning rise in events that resulted in severe injury—a recorded event that is associated with serious injury or death. After decreasing in 2022, the number of severe injuries or deaths increased in 2023 to an all-time high total of 238 and comprised nearly 40% of all recorded events.

Longer patient stays continue to be a trend since the COVID-19 pandemic, the data shows. A portion of the 2023 increase in adverse health events can be attributed to the continued growth in adjusted patient days. Prolonged periods of time in the hospital have been linked to an increased risk of experiencing an adverse health event.

Adjusted patient days during the 2023 reporting period grew to 5.9 million during the 2023 reporting period, up from 5.5 million in 2022. This increase in lengths of stay may stem from things like increased patient complexity due to delayed care and Minnesota's aging population.

However, discharge delays due to limited bed availability at the next level of care, which can result from post-acute care workforce challenges, also play a role and contributed to longer stays. This leads to patients being boarded in emergency departments and other locations within the hospital not otherwise suited for inpatient stays. Additionally, some hospitals reported that workforce shortages pushed them toward prioritizing critical care responsibilities, leaving fewer staff to assist with patient care needs, such as repositioning and mobility.

Like previous adverse health event data reports produced by the state health department, pressure ulcers and falls were the most common events reported. Falls drove much of the overall increase and rose more than 21% to 96 reported events in 2023. Lost or damaged biological specimens and retained objects from surgeries were also reported in greater numbers.

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Minnesota Medical Association

Focus on suicide

Suicide constitutes the majority of gun deaths in Minnesota. That points a way toward reducing the toll of firearms. And physicians have a role to play

BY GREG BREINING

Mass shootings and violent gun crimes get the press, but most gun deaths are due to suicide. In Minnesota, there were more than 450 firearm-related deaths in 2019, with more than 75% of these deaths being suicides. According to the Harvard T.H. Chan School of Public Health, about 85% of suicide attempts nationwide with a firearm end in death. Firearms are the leading method of suicide for adolescents aged 15 to 19.

"We thought that it was time for the MMA and physicians to address the increasing number of suicides," says Juliana Milhofer, JD, MMA public health and policy engagement manager. "That's what's really happening in our state."

The decision to focus on suicide-by-firearm also had a political aspect. The MMA had been advocating at the State Capitol for years for various gun safety laws, background checks, and others. "A few years ago, we understood that there wasn't movement at the Capitol," says Milhofer. "We needed to focus on something else. And we thought addressing suicide was an important role for both the MMA and physicians to play."

To reduce the use of firearms in suicide, the Minnesota Medical Association helped form the Minnesota Firearm Safety and Suicide Prevention Coalition. The coalition began in 2022 with a conversation between Milhofer and Thomas Kottke, MD, MSPH, medical director for well-being at HealthPartners, an MMA member, and a board member of Protect Minnesota, a gun safety advocacy organization.

"He came to me—we've been working for many years together—and said, medicine and gun safety don't talk," says Milhofer. "Physicians don't really have the conversation about firearm safety in the clinic. So if you go for a physical, that's not what gets asked often. There's no time. There's a lot of stigma around a physician asking if you have a gun. They might get pushback from the patient, so it's a conversation that is often overlooked."

The partnership has grown now to include the MMA, Protect Minnesota, NAMI Minnesota (National Alliance on Mental Illness), Minnesota Academy of Family Physicians, Minnesota Chapter of the American Academy of Pediatrics, Minnesota Chapter of the American College of Physicians, Minnesota Department of Veterans Affairs, Minneapolis VA Health Care System, as well as researchers from the University of Minnesota, and others interested in addressing firearm safety.

"They wanted to be action-based," says Milhofer. "So we had the idea of hosting pilot programs within clinics to give out trigger locks and other firearm safety resources. So that's kind of where this group decided that this isn't just a coalition. It's something more than that. It's a community wanting to change the narrative around firearm safety that are empowered

"Physicians don't really have the conversation about firearm safety in the clinic. So if you go for physical, that's not what gets asked often. There's no time. There's a lot of stigma around a physician asking if you have a gun. They might get pushback from the patient, so they don't do that that often."

JULIANA MILHOFER, JD, MMA PUBLIC HEALTH AND POLICY ENGAGEMENT MANAGER.

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If we can put any time and space between that veteran or any individual and their lethal means, specifically guns, we can save lives. Part of this is safe storage for a firearm."

ANDREA PERRY, RN, MN, MINNEAPOLIS VA HEALTH CARE SYSTEM

to come together to make a difference in Minnesota."

A primary objective is to encourage physicians to ask patients about their access to firearms and whether those firearms are safely stored. The coalition promotes handing out trigger locks or cable locks (which prevent the action of firearms from closing) to their patients who need them.

Andrea Perry, RN, MN, of the Minneapolis VA Health Care System, who participates in the safety coalition, urges physicians to ask if their patient has served in the military. While asking about military service is a way to help ensure that patients who are veterans get access to VA services they may be unaware of, "it's so tightly related to suicide prevention," says Perry. That's because vets are 1.5 times more likely than civilians to die by suicide and are more likely to use a firearm if they do. (According to recent Defense Department data, military members who have trained with heavy artillery and other powerful explosives are nearly 2.5 times as the nonmilitary population to die by suicide.)

"Knowing that they're working with a veteran, it's just maybe more poignant or more obvious to them, hey, we really have to talk about suicide, because in the data, we find that veterans die by suicide at a higher rate," Perry says. "And if they start having this conversation with the patient, and find out, yes, the patient is depressed or struggling, the provider can find out more information to help keep them safe. This includes a discussion about firearm safety."

Discussing firearm safety with veterans in this setting is part of lethal means safety. "What that means in the context of suicide prevention is creating time and space between an individual who's in crisis and their lethal means of choice," says Perry. "Part of this is safe storage for a firearm." Whether that means asking a patient to consider locking up guns or even storing them elsewhere during time of personal crisis, "whatever the case is, if we can put any time and space between that veteran or any individual and their lethal means, specifically firearms, we can save lives." (VA cable gun locks with Veterans Crisis Line information will be provided to veterans as part of this project.)

In the interest of safe storage, members of the safety coalition are working on what they call the Firearm Safety Storage Map Project, with a grant from The Doctors Company Foundation that was provided to a partner of the coalition—Protect Minnesota. Members of the coalition, including several researchers at the University of Minnesota and Protect Minnesota, developed the pilot project, which involves providing firearm locks to patients through three clinics in central Minnesota, as well as a firearm safety storage map of facilities in the area, such as police departments and gun shops, that are able to temporarily store firearms for patients who feel the need to put firearms beyond immediate reach. The project also provides information for physicians on how they can access training that will enable them to discuss firearm injury prevention with their patients. The pilot project began April 2024.

Suicide prevention is the primary objective of the firearm safety storage map pilot project, says Milhofer, but "it's also about ensuring the safety of all those in the home, which may include children, the elderly, or even friends visiting."

Another initiative is the coalition's Firearm Safety Physician Interview Study involving Milhofer, Kottke, and several researchers at the University of Minnesota. So far they have interviewed more than a dozen physicians who commonly discuss firearms with their gun-owning patients. The purpose of the study is to learn through the series of interviews and create a set of tools and best practices for discussing firearms and safe storage with patients. The interviews were recorded and transcribed, transcripts analyzed, and themes identified.

The goal, says Milhofer, is to make these kinds of conversations a routine part of healthcare visits.

"We've learned that physicians are doing this. Not all of them are doing it, but some of them are doing it really well," she says. Despite the politicization of gun issues, they found physicians who seem to have little trouble addressing the issue with their patients. Said one physician, "I'm a gun owner, my husband's a gun owner, and we talk about guns within our clinic spaces, and people don't defend themselves. They understand it's a safety question. And we as physicians have a role to play in keeping communities safe."

Says Milhofer, "So what we're learning from these doctors who live in rural Minnesota is that it's not a taboo topic. It's a normal part of their lives and asking about firearms should be a routine part of preventive healthcare." MM

Greg Breining is the editor of *Minnesota Medicine*.

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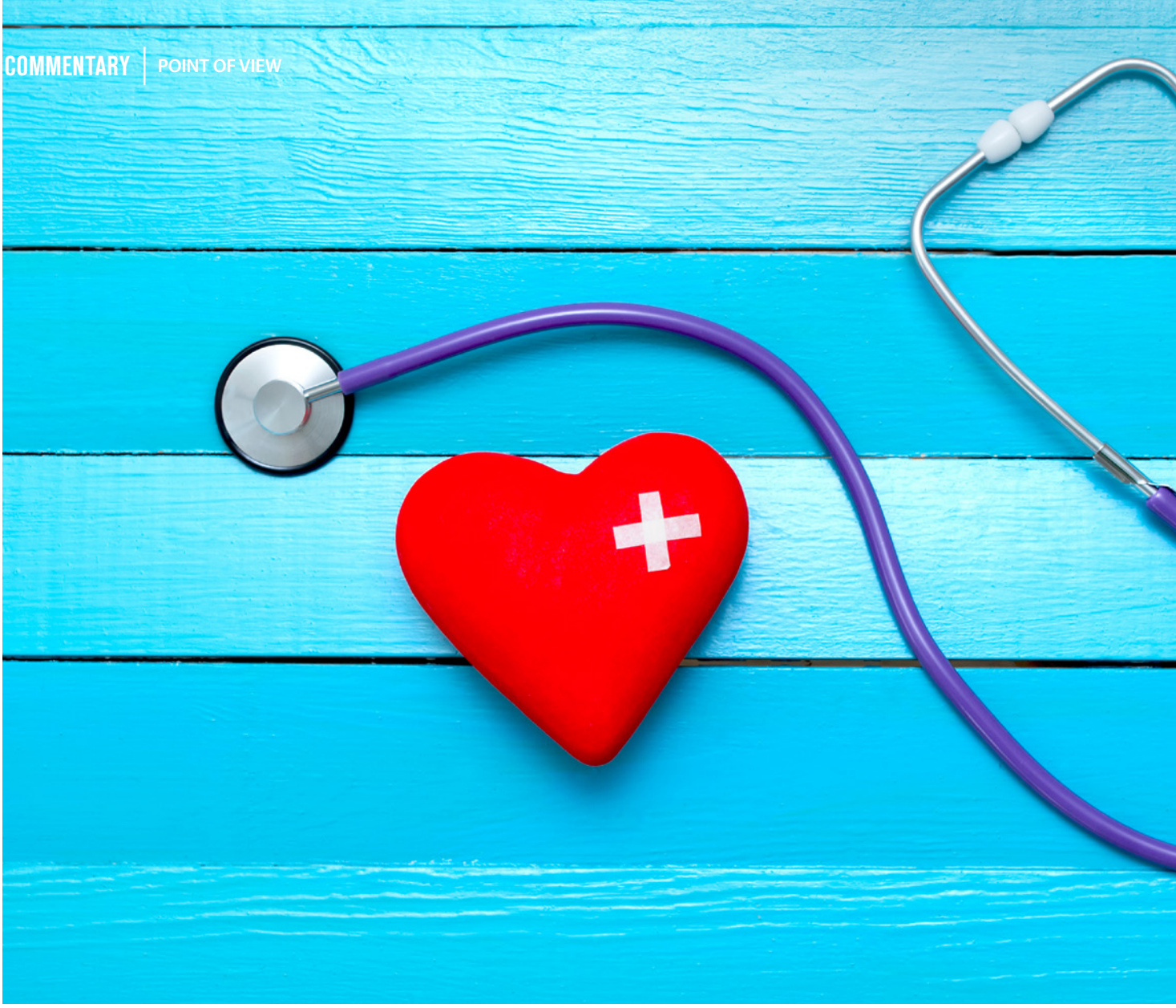

Minnesota caring safely: A safer future, together

Gains in patient safety have plateaued. Minnesota will need new strategies to resume progress in preventing patient harm.

KAREN BRILL, MHA, RN; CARA HULL; VENKAT IYER, MD; ABRAHAM JACOB, MD, MHA; BETSY JEPPESEN, RN, BS, CPHQ; LISA JULIAR; MALLORY KOSHIOL, MHA; JOSEPH MERCURI, MD, MBA, CPPS; JANE PEDERSON, MD, MS; ANDREW OLSON, MD; KANNAN RAMAR, MD, MBA; ASHLEY SWANSSON, MA, BAN, RN-BC, PHN; KIERSTEN TRNKA, RN, MSN; KARA TOMLINSON, MD, MBA MD; DIANE RYDRYCH, MA; RACHEL JOKELA, RRT, RCP; CHELSIE BAKKEN, MBA, BSN, RN

Patient safety became a core strategic focus once preventable patient harm was identified as the leading cause of morbidity and mortality in U.S. healthcare delivery in the 1999 publication *To Err Is Human: Building a Safer Health System* by the National Academy of Sciences. Today, the central tenet remains that there are not bad people in healthcare; rather, there are good people working in flawed systems.

In response to this data around preventable harm, the Minnesota Alliance for Patient Safety (MAPS) was established in 2000 as an independent, inclusive, nonprofit organization to support the efforts

of collaboration in Minnesota to improve patient outcomes for safe care everywhere. In 2001 efforts began in the state to support greater transparency around medical errors and to create a culture where collaborative learning from medical errors can occur. In 2003 the Minnesota Legislature passed the first-of-its-kind Adverse Health Events (AHE) Law that required hospitals and ambulatory surgery centers to report to the Minnesota Department of Health whenever one of 27 (now 29) serious adverse health events occurred. Significant progress in advancing the science of patient safety and interventions to error-proof care delivery occurred during the first 20 years.

Despite these gains, progress has plateaued in Minnesota and nationwide as the current rates of preventable harm challenge the very foundation of our oath "to do no harm" (Bates et al, N Engl J Med 2023;388:142-153). In response, MAPS convened a network of safety leaders from across Minnesota in 2023. This article is a review of themes from those discussions and recommendations for the way to do better together.

The impact of COVID-19

Over the past four years, during the COVID-19 pandemic, new patient safety risks have emerged, such as the impact of restricting patient partners at the bedside on both the patients and families as well as the moral injury for those delivering care. There has also been an exacerbation of patient safety risk factors that were known prior to the pandemic: high rates of healthcare worker burnout; turnover of experienced care providers; long-standing staffing gaps; existential financial stressors, especially for those that care for our most vulnerable patients such as in nursing facilities and mental healthcare settings; as well as worsened access to primary and specialty care. Patient safety metrics worsened in almost all categories. Overall trust in public health and healthcare has been in a downward slide since the start of the pandemic.

Equity and healthcare disparities

Minnesota consistently ranks at the top nationally for overall healthcare quality and system performance, and yet we have some of the worst healthcare disparities in infant and maternal mortality, and prevalence of and death due to asthma, diabetes, heart disease, and stroke. The evidence is clear that there are disparities in the rate of safety events when analyzed by age, race, ethnicity, disability, and language. The journey to improve the safety for all Minnesotans must include a better understanding of why harm or risk of harm may be disproportionately experienced by vulnerable, minority, or marginalized populations.

In the wake of the murder of George Floyd in Minneapolis, the lived experience of BIPOC (Black, indigenous, and people of color) and other marginalized communities was placed in the national spotlight. These communities as well as our vulnerable populations such as the disabled, aging, and non-English speaking individuals experience much higher rates of unfair or disrespectful treatment in the healthcare system, and have lower levels of trust in healthcare providers. There are a number of root causes for these disparities including access to healthcare, socioeconomic factors, transportation, language barriers, structural racism, cultural bias, diversity in the workforce, and distribution of resources. Providing safer care in Minnesota must include approaches to address these healthcare disparities. If we care well for the most vulnerable, we will care well for all.

Complicated versus complex care

Besides the issues that surfaced during the pandemic, it is also important to differentiate between complicated care and complex care.

Complicated care is care that, although difficult, is linear by nature and may often have best practices to achieve better outcomes. Evidence has shown that many patient safety events are complicated but often have a root cause, where simplifying and standardizing processes lead to better outcomes, and zero harm is possible. Examples of complicated and preventable

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patient harm include central line–associated bloodstream infections, catheter-associated urinary tract infections, and wrong-site surgeries. Noteworthy progress has been made with simplifying processes in healthcare through leveraging checklists, standardization of best practices, and workflow redesign. Organizations such as the Minnesota Hospital Association, Minnesota Department of Health, and Minnesota Medical Association have been invaluable to leading these efforts.

However, much of healthcare is complex, where root causes of defects are nonlinear, have irreducible complexity, may not have a root cause, and where zero harm may not be possible. For example, it may not be possible to prevent every pressure injury in critically ill patients where mobilizing them creates other safety risks. These are safety events that require a different approach and skillset, focused on risk reduction and mitigation. These skill sets may include industrial engineering, systems resilience engineering, human factors, and ergonomics—and, importantly, acknowledgement that zero harm may not be possible. Our accountability may be to focus instead on harm mitigation and reducing risk.

To truly envision a safer future in Minnesota, we must equip teams to manage both complicated and complex care. We must continue to build on the success harm reduction experienced in hospital-acquired conditions using standardization and best practice processes of care or "bundles." However, to address complex care, we will need to redesign systems that anticipate and act on threats to patient safety in real time while creating adaptive capacity across our teams. As studied by Weick and Sutcliffe in their analysis of high-risk organizations [Weick, KE, and Sutcliffe, KM (2001). *Managing the unexpected: Assuring high performance in an age of complexity]*, highly reliable organizations are sensitive to operations. In other words, they understand and adapt to the needs of front-line staff and workflow. For example, attributing safety events to individuals or teams not adhering to system policies may require us to ask if our policies are optimally supporting our staff. If compliance with a best practice of care or bundle is only 50%, do we need to adapt our processes to meet the workflow needs of our staff?

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A focus on care gone wrong

For over four decades, the healthcare industry has utilized root-cause analysis to investigate patient harm events and develop solutions to prevent recurrence. That process has been a cornerstone of safety improvements utilizing retrospective analysis to drill down to the recommendations for action that will address the root cause or causes of the patient safety event to prevent or markedly decrease the likelihood of recurrence. Examples of interventions range from enhanced organizational learning to modifications in technology, simplifications in process or policy, leadership involvement, and culture improvements required to sustain future outcomes of success.

Besides learning from defects in care, we must also learn from excellence—when care goes well despite barriers to care delivery and complexity of patients. Our healthcare teams are our greatest asset and resource. In addition to focusing on specific types of errors retrospectively, we must also do a multifaceted analysis of when care goes well. We can proactively learn from and replicate tools, processes, and safety cultures that enhance and improve our systems of care.

Strategies going forward

To continue being a leader in patient safety, Minnesota will need to lead the way in redesigning systems to address today's risks and care delivery realities. We must learn how to care safely in all aspects of healthcare across the continuum, equitably. Minnesota can create safer systems by the following strategies:

Building and learning from quality and safety improvement collaboratives. Improvement collaboratives have long demonstrated an ethos of "all share, all learn." These collaborations focus on developing and sharing best practices based on data-driven decision-making and implementing evidence-based interventions.

Embedding a health equity lens in patient safety metrics to identify disparities in patient safety events in age, race, disability, ethnicity, language, sexual orientation, and gender identification. Understanding statewide disparities in patient safety outcomes is the first essential step to eliminating them.

Including patients and families in their care and in the work. Patients and families play a vital role in making care safe and should be considered valued experts on the care team. Their experiences and outside perspectives can help organizations learn and improve through coproduction and codesign. We must continue to expand the role of patients as partners in the critical work of safety, including root-cause analysis and improvement efforts.

Building systems around proactive safety. The positive impact of daily safety huddles on improving situational awareness, patient outcomes and safety culture is widely acknowledged by patient safety experts and organizations. Models of proactive safety help to identify and prevent threats in real time by engaging teams in dialogue about safety concerns and esca-

lating these concerns to all levels of the organization.

Managing complicated care and complex care. Clinical variation reduction or embedding best practices for common conditions and processes can lead to significant reduction in harm where standardization has not been implemented. But what happens beyond the standardization? The next iteration of safety and high reliability must include the science of human factors, systems engineering, ergonomics, and industrial engineering to adapt and redesign our systems based on the needs of our patients and staff. Understanding how to better support our staff will also help to mitigate the risk of burnout and moral injury.

Training early and often. Integrating health systems safety science education into allied health science curriculum is vital to equip future healthcare professionals with a holistic understanding of team-based healthcare delivery, high reliability, and safety science. This prepares current and future healthcare workers to work effectively within complicated and complex healthcare systems and deliver team-based care.

Building systems designed for success. People are at the heart of providing care through human touch and interpersonal connection. Patients ultimately experience the outcomes all systems are trying to improve. As leaders, we must nurture building relationships among and across our teams and patients and co-design processes with healthcare workers and patients to achieve shared outcomes.

A call to action

Minnesota's approach to patient safety must adapt to meet the complex care delivery requirements patients present with today. Patient safety must be reprioritized in Minnesota. Patients are getting older with more diseases and comorbidities than ever before and being cared for in a wide spectrum of environments including hospitals, rehabilitation facilities, nursing homes and at home. Treatments and potential cures have higher risk. Given the increased complexity of the patients we care for, we must reinforce what has worked in harm reduction and redesign our systems around caring safely. With the right leadership, investment, and collaboration, we will re-establish trust with those we serve and codesign innovative ways to provide safe care that removes silos and is scalable and sustainable.

We invite organizations, healthcare professionals, patients, and patient partners to join us in creating a safer healthcare future by participating and contributing to improvement collaboratives, codesign care delivery systems with patients that address healthcare disparities, staffing, and financial constraints; building skills around complex care as well as complicated care; and commit to ongoing education and training for the current and future workforce.

Doing better by doing better together

To join us in this collaborative work, please reach out to Lisa Juliar, ljuliar@mnpatientsafety.org, or Ashley Swansson, aswansson@mnpatientsafety.org. MM

Karen Brill, MHA, RN, is a Minnesota healthcare senior leader and patient safety advocate. Cara Hull is chief quality officer, HealthPartners. Venkat Iyer, MD, is chief quality and safety physician officer, Allina Health. Abraham Jacob, MD, MHA, is chief quality officer, M Health Fairview. Betsy Jeppesen, RN, BS, CPHQ, is senior vice president quality and safety, Stratis Health. Lisa Juliar is director of patient and family engagement, Minnesota Alliance for Patient Safety. Mallory Koshiol, MHA, is vice president of safety, quality and experience, Allina Health. Joseph Mercuri, MD, MBA, CPPS, is physician section director, quality and safety, CentraCare. Jane Pederson, MD, MS, is chief medical quality officer, Stratis Health. Andrew Olson, MD, is associate professor of medicine and pediatrics, University of Minnesota. Kannan Ramar, MD, MBA, is professor of medicine, patient safety and mortality officer, Mayo Clinic. Ashley Swansson, MA, BAN, RN-BC, PHN, is senior safety advisor, Minnesota Alliance for Patient Safety and principal healthcare consultant with Selah Health Consulting. Kiersten Trnka, RN, MSN, is director of safety and quality, Glencoe Regional Health. Diane Rydrych, MA, is director, Health Policy Division at the Minnesota Department of Health. Rachel Jokela, RRT, RCP, is director, Adverse Health Events System at the Minnesota Department of Health. Kara Tomlinson, MD, MBA, is vice president, High Reliability, M Health Fairview. Chelsie Bakken, MBA, BSN, RN, is senior director quality and patient safety, CentraCare.

PRIVATE EQUITY IN MEDICINE

HELPING HAND OR IRON FIST?

As more private equity firms invest in healthcare entities, Minnesota considers banning the practice

BY SUZY FRISCH

To Alice Mann, MD, MPH, the steady increase of private equity investments in Minnesota medical practices signifies an ailing healthcare system. It's something she has observed from her dual perspectives as a practicing physician and state senator.

Mann has been unhappy to see evidence that care quality decreases in hospitals purchased by private equity, including increased readmissions, hospital-acquired infections, and falls. Then there are situations Mann observes at work in emergency medicine, including how consolidation of clinics and closed nursing homes affect patients' access to care.

"When hospitals or healthcare entities are now owned by private equity companies, they have a different focus in mind. Their end goal is not great patient care—it's turning a profit for their stakeholders," Mann says. "To me, it doesn't make sense to have private equity companies that don't know how to take care of patients own healthcare entities, and it will worsen already worsening patient care outcomes."

Mann and Rep. Jessica Hanson sponsored legislation in the 2024 session to halt the trend of private equity firms purchasing clinics and other healthcare entities. House Bill 4206/Senate Bill 4392 would ban private equity firms and real estate investment trusts (REITs) from investing in or purchasing a wide swath of healthcare providers, including medical and dental clinics, hospitals, ambulatory surgery centers, nursing homes, and integrated health plan and provider systems. If it were enacted, the bill also would prohibit private equity firms and REITs from adding on to their existing direct or indirect ownership, or expanding their operational or financial control of healthcare entities.

The House held an informational hearing but neither chamber's committees considered the legislation. Mann and Hanson plan to bring it back next session. Other states have been considering similar laws to ban or regulate private equity in medicine, including Indiana, Oregon, New Mexico, and California.

Private equity involvement in medicine is one aspect of the macro challenges facing healthcare in Minnesota, encompassing consolidation, financial stress, and smaller, independent organizations' struggles to operate in this market. Private equity is a complex issue that warrants additional discussion and perhaps a more nuanced approach than a total ban, says Dave Renner, director of advocacy for the Minnesota Medical Association.

"We've had a couple initiatives come through MMA committees for us to support outlawing or prohibiting private equity

investment in healthcare," Renner says. "We agree there is a concern when profit is the only motive, but it's not as simple as saying private equity shouldn't be here."

Mann agrees. "The purpose of the bill is really to start conversations and bring stakeholders to the table to discuss what private equity in Minnesota looks like, how it is impacting patient care, and what are potential solutions or pathways forward," she says. "I don't want it to seem like I believe that an outright ban on private equity investment is the only solution."

Understanding Minnesota's landscape of private equity will be key to resolving this issue. There's no question that the trend has been increasing recently, even though Minnesota is later to the private equity party because of its strong roots in nonprofit healthcare, says Stephen Parente, PhD, MPH, a professor and Minnesota Insurance Industry Chair of Health Finance at the University of Minnesota Carlson School of Management.

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"Physicians value their autonomy and don't want to be bought out. But the reality is, the market has changed," Parente says. Providers are struggling with capital requirements to maintain practice insurance, electronic health records, and pressures like wage increases postpandemic.

"You can't easily run a small, independent practice anymore or a larger practice cashless," Parente says. "For better or for worse, private equity solves a problem, and investors want to come in and provide new resources. The flip side is that there will

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State Sen. Alice Mann, MD, MPH

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be expectations that it runs more like a business, and transparency is a lot harder to find."

Ripe for investing

Nationwide, private equity involvement in healthcare started gaining steam about a decade ago. There were 78 private equity deals in the United States totaling $5 billion in 2000. That grew to 855 deals covering a variety of healthcare entities totaling $100 billion in 2018, according to a 2020 Institute for New Economic Thinking paper. Private equity firms acquired 355 physician practices from 2013 to 2016, including 1,426 sites and 5,714 physicians, a 2020 JAMA study reported. When looking at the overall value of private equity deals in the U.S., healthcare's share of the pie jumped from 5% in 2012 to 12% in 2021, according to University of Pennsylvania research.

Private equity ownership in healthcare ballooned during 2010–2020, with about $750 billion in deals in that timeframe, according to a 2021 report by the American Antitrust Institute and Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California, Berkeley. Currently, 4–5% of physicians in the United States work at private equity-backed employers, a 2024 Health Affairs study found. In addition, private equity firms now own about 8% of hospitals in the United States, according to a California Health Care Foundation study. Such acquisitions are associated with higher costs for patients and insurers, lower patient satisfaction, mixed to worse quality of care, and worse financial outcomes for the acquired, the report notes.

The accelerating pace of private equity purchases in healthcare prompted attorneys general from 11 states, including Minnesota, to petition the Federal Trade Commission, U.S. Department of Justice, and U.S. Department of Health and Human Services about potential enforcement and regulatory action. The states seek to address the possible detrimental effects of private equity transactions, including harm to patients and a loss of physician autonomy.

Today, private equity transactions affect diverse areas of healthcare, including surgery centers, private physicians practices, emergency medicine providers, reproductive medicine and ophthalmology clinics, and nursing homes, says Pinar Karaca-Mandic, PhD, a health economist and the C. Arthur Williams Jr. Professor in Healthcare Risk Management at the Carlson School.

There are numerous reasons healthcare providers have been willing to entertain private equity investments. In an era of consolidation, many independent practices find it difficult to recruit new physicians to grow their businesses. Smaller practices also lack the bargaining power of larger or hospital-owned clinics, making it challenging to secure higher reimbursement rates, Karaca-Mandic says.

"What we're seeing so far doesn't strike me as very bad news. Some studies show minimal improvements in quality metrics, and we do see increases in utilization and new patients. Does it mean that this is overuse—the need was there, and it was not being met? Or did they recruit more physicians and can provide more volume? I think we need to learn more about private equity and scrutinize it more."

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"In this fast-changing healthcare environment, physicians might be finding it harder to keep up with the business side," Karaca-Mandic adds. "When you are acquired by a private equity firm that has 60 to 80% ownership, then physicians can focus more on the clinical side."

Private equity firms typically provide much needed capital that can fund investments in equipment, expanded locations or services, higher wages, and other spending to improve employees' and patients' experiences, Parente says. It also offers a source of capital after banks tightened up lending and made borrowing more expensive, while wages and other costs increased after the pandemic.

However, many people have concerns about what happens after private equity steps in. Investors aim to increase profit, typically seeking a return during a five- to 10-year window, Karaca-Mandic says. That can occur in a variety of ways. It might mean cutting costs, perhaps by hiring advanced practice providers instead of physicians, or emphasizing high-margin services instead of low-margin care. Studies show that when private equity owners sell an entity, usually after three to eight years, they often receive roughly 20% of the profit, she adds.

Research seeking to compare outcomes at private equity and nonprivate equity–owned healthcare entities show mixed

reviews at this point, Karaca-Mandic says. Two recent publications illustrated the cloudy picture.

One 2022 study in *JAMA Network Open* looked at six quality measures during 2001–2018, such as patient mortality, length of stay, and readmission for five common conditions including stroke and COPD. Researchers found that private equity acquisition was associated with lower in-patient mortality in acute myocardial infarction. However, a 2023 JAMA publication compared quality of care and patient outcomes in 51 private equity–acquired hospitals and 259 other hospitals. The study noted that private equity institutions had an increase in hospital-acquired adverse events like infections and falls.

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Private equity in practice

In Minnesota, varied healthcare providers are weighing the pros and cons of accepting investments or selling to private equity firms. At Minnesota Eye Consultants, the Bloomington-based practice ultimately decided in 2017 to join forces with Waud Capital Partners of Chicago. Managing partner Jill Melicher, MD, shared Minnesota Eye's experience with private equity at the MMA Physician Forum in May.

Looming difficulties with operating as an independent provider prompted Minnesota Eye to consider options like merging with a larger hospital system, consolidating with similar practices, or aligning with private equity. The primary drivers prompting Minnesota Eye to change its practice structure included market consolidation and competition from large healthcare systems, plus a need for capital to grow, said Melicher, an ophthalmic plastic and reconstructive surgeon.

"We really were facing difficulty getting a seat at the table with health plans for appropriate reimbursement for our services, both in our clinics and ambulatory surgery centers, because we were a relatively smaller practice compared to the larger healthcare systems," Melicher said at the forum. "We saw an opportunity to identify a capital partner that would allow us to continue to practice and fulfill our growth targets to provide tertiary care to the state of Minnesota without leveraging our younger partners and placing them in debt to do so."

Minnesota Eye chose Waud for its acquisition. Then the two entities launched Unifeye Vision Partners to bring Minnesota Eye's practice model to a bigger audience. Through the transaction, Minnesota Eye secured liquidity for original investors (physician partners) while retaining equity in the practice. Today, Unifeye Vision Partners includes 25 ophthalmology practices in four states, 19 ambulatory surgery centers, 1,500 employees, and 155 physicians.

"Private equity has given us the capital to build two offices and two ambulatory surgery centers that we probably would have thought twice about doing, and add new technology. It allowed us to continue to maintain the same kind of academic medicine private practice that Dr. [founder Richard] Lindstrom built 35 years ago," Melicher says, noting that Minnesota Eye also added a second fellowship position. "We have had the opportunity to see more patients and build our company the way we wanted to, which was the impetus to partner with private equity."

Taking the opposite tack, Midwest Radiology has not seriously considered a private equity buyout or funding because the practice's leaders "feel strongly that healthcare delivery should remain in the hands of physicians," says Susan Truman, MD, a diagnostic radiologist and president and CEO of the Roseville-based practice. "Physicians often lose autonomy, and many decisions regarding healthcare delivery are made by outside investors who are not rooted in the communities where the practices are located. We feel this is a significant negative. Physicians are trained to put the patient and the community first,

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Jill Melicher, MD | Managing partner | Minnesota Eye Consultants

while private equity firms' first and foremost goals are profit and growth."

Midwest Radiology has 175 physicians, making it one of the largest independently owned radiology practices in the Midwest. This size helps it withstand the financial pressures on smaller practices, such as funding the purchase of expensive equipment, Truman says. The practice has flourished by offering specialized radiology care and well-run overnight services, giving the practice an advantage over smaller practices.

Midwest Radiology avoids private equity because its physicians have seen how other firms are forced to operate under private equity ownership, says Truman. She points to investors' practice of negotiating higher reimbursement rates. Though this sounds appealing, she says, it does not always benefit physicians. Private equity owners often seek to maximize their profit and return on investment by reducing physicians' salaries, while prices increase for patients. They also cut costs and that often that means critical support staff are trimmed and quality can suffer. In addition, practices with lower physician salaries struggle to recruit and retain physicians, which ultimately limits patients' access to care.

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Toby Pearson, president and CEO of Care Providers of Minnesota, an advocacy group for post-acute and long-term care operators, sees the issue from both angles. In the past three years, nursing-home owners have eliminated 3,000 beds either by shutting down completely or temporarily closing floors.

That's because many are contending with a complicated blend of issues: staffing shortages, high rates for supplemental staffing, stagnant reimbursement rates, and delays in receiving timely reimbursements. Many facilities have needed an influx of capital to keep their doors open. Often, private equity is their last-resort source of funding when banks favor lower-risk lending, Pearson says.

Though the implications of regulating or banning private equity are worth studying, Pearson says, he believes the bigger concern is having a window into whether owners and operators are providing high-quality care. "From a public policy perspective, the state is better off looking at transparency," he adds. "I'm not sure we're concerned as much about what type of ownership they are in as long as we have access to high-quality care in the state."

So let the debate begin on whether private equity is a good thing or a threat to Minnesota's healthcare system and physicians' approach to practicing medicine. MM

Suzy Frisch is a Twin Cities freelance writer.

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Your brain on contact sports

Should young patients play sports that come with a significant risk of head injuries? It's a balancing act.

BY JOHN ROSENGREN

Several high-profile deaths of former NFL players later diagnosed with chronic traumatic encephalopathy (CTE), like that of star linebacker Junior Seau in 2012, have drawn attention to the dangers football poses to brain health. The 2015 blockbuster movie "Concussion" further underscored those dangers and elevated concerns in parents about the risks playing football posed to their children.

Perhaps not surprisingly, participation in high school football has declined significantly—by 17% since 2006, according to the National Federation of State High School Associations—yet it remains the

nation's most popular high school sport for boys, played by nearly a million nationwide.

Most of the media attention about those who have developed the memory loss, impulsive behavior, depression, and suicidal thoughts associated with CTE has focused on those who played college or professional football, yet even children playing youth tackle football can be at risk of impaired brain health resulting from repeated blows to the head. Results of a 2011 study published in the *Journal of Neurotrauma* reported that 9- to 12-year-old children playing youth tackle football experience on average 240 head impacts a season.

"There's no question that our work has shown that there is a risk to playing football, that there are structural brain changes and long-term consequences to playing football that can be very devastating to one's brain health. The hits that these children endure playing youth level sports can be as hard and as damaging as the hits sustained by higher-level athletes. One of the biggest things I need to get across to parents is it's not just professional sports, it's low-level sports. We think even youth football carries a risk. I really can't be in favor of tackle youth football under the age of 14."

Ann McKee, MD
Neuropathologist and director
CTE Center
Boston University

Another study, following youth tackle football players ages 8–14 over the course of two seasons, 2015–17, and using resting-state MRI to measure brain activity, found a single football season reduced the football players' default mode network functional connectivity—even without experiencing a concussion. Then, during the offseason, players experienced a "positive and compensatory change" in functional connectivity. The study didn't address what might happen to players long-term: "It is possible that continued participation in activities with risk for head impacts during off-season months in some players led to an attenuation of apparent off-season positive delta FC values."

Concussions are an obvious concern, but the repetitive subconcussive blows that don't present immediately identifiable symptoms may be even more insidious. A 2023 study based on data from Boston University's CTE Center, the largest to look at causes of CTE, found the best indicator of brain disease later in life was the number of hits absorbed to the head and their cumulative impact, rather than the number of diagnosed concussions. Indeed, researchers at BU's CTE Center have concluded that playing tackle football at any level for 2.6 years doubles the risk for CTE. "There's no question that our work has shown that there is a risk to playing football, that there are structural brain changes and long-term consequences to playing football that can be very devastating to one's brain health," says Ann McKee, MD, a neuropathologist and director of BU's CTE Center. "The hits that these children endure playing youth level sports can be as hard and as damaging as the hits sustained by higher-level athletes. One of the biggest things I need to get across to parents is it's not just professional sports, it's low-level sports. We think even youth football carries a risk. I really can't be in favor of tackle youth football under the age of 14."

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Anne Skemp, MD
Pediatrician
South Lake Pediatrics

At the same time, McKee agrees there are obvious benefits to youth playing football and other sports such as hockey, wrestling, rugby, lacrosse, and soccer that also carry a significant risk of concussion. On its HealthyChildren.org portal for parents, the American Academy of Pediatrics cites some of these—"playing a sport can help your child develop leadership skills, self-confidence, and teamwork and deal with success and failure"—and concludes "the dangers of inactivity surpass the dangers of playing a sport." Given this tension, it can fall upon physicians to help parents concerned about their children's health and safety navigate the risks and benefits of playing sports, especially those that carry elevated risk of brain injury.

Anne Skemp, MD, a pediatrician who practices at the Chaska and Minnetonka clinics of South Lake Pediatrics, acknowledges many sports—including those where participants don't wear helmets—can carry risk of concussion, but she believes the benefits are more widespread

than the injuries. "I'm not in the business of dissuading parents from having their kids play sports," she says. "There so many benefits, we want to make sure kids participate and do so safely."

With the emphasis on "safely," she points to efforts made to mitigate the risks, such as modified tackling techniques and equipment changes as well as recent protocols for returning to play after a concussion. "I just try to help parents frame it in the safest way possible and steer them toward the resources available," she says. Those resources include AAP's HealthyChildren.org and the Centers for Disease Control's Heads Up campaign designed to help coaches, trainers and parents recognize the signs and symptoms of concussions and know when it's safe for a child to return to school and an activity.

To find out if a program is availing itself of those safety resources, George Morris, MD, a sports medicine physician with CentraCare in St. Cloud, encourages parents to do some preliminary research. He suggests before they let their child play in a program that they ask sports program leaders and parents of other participants about the safety record and practices of those programs. For instance, are they using the safest possible equipment? Are coaches trained in emergency management or do they have an athletic trainer at events who can help with a concussion diagnosis? Are they doing proper warmups that can decrease the risk of injury? "I don't want to make people afraid of sports, but I do think parents should be asking more questions about either their schools or their local youth clubs to say, 'How safe are you?' and 'What can you do to decrease the risks for children?'" Morris says.

"I'd weigh the child's history of learning challenges and the family history of prolonged recovery from concussions. I'd ask, 'If they have academic concerns and they get an injury, what's that going to do to them?'"

George Morris, MD
Sports medicine physician
CentraCare, St. Cloud

A parent's firsthand observation of a program can also provide useful information. Morris and his wife raised five children, including a son who played tackle youth football for two seasons. They steered him toward other sports around age 11 when they became concerned about the coaches' approach. "They weren't great with technique and their main approach was just banging heads," Morris says.

He also emphasizes the importance of considering the individual child's situation and their family history. If the child has had multiple previous concussions, that could be reason to engage in sports with less risk of head impacts. A family history of migraines or prolonged recovery from concussions can be an indicator that the child might not recover quickly from concussions. Children with ADHD can also have more difficulty concentrating and be more hyperactive after a concussion, making slower recoveries. "I'd weigh the child's history of learning challenges and the family history of prolonged recovery from concussions," Morris says. "I'd ask, 'If they have academic concerns and they get an injury, what's that going to do to them?'"

The risk of concussion or repetitive subconcussive blows may indeed be greater for some than others. The results of a study published recently in *JAMA Neurology* suggested that a genetic variant known as APOE4 (also associated with a greater risk of Alzheimer's disease) could make those who experience head trauma more susceptible to developing CTE. "There are some people that can sustain an injury and recuperate without much trouble, and there are other people that can have the same injury and have prolonged difficulty in the recovery and miss a significant amount of school," says William Qubty, MD, a pediatric neurologist with the Minneapolis Clinic of Neurology and codirector of the Pediatric Traumatic Brain Injury Program at Hennepin County Medical Center. "If someone [younger than high school age] has had a head injury with prolonged recovery that's made them miss substantial schooling, there's a higher chance of it happening again or even worse," he says.

Indeed, studies have shown that one concussion can increase the risk of an additional concussion that season or in the

"There are some people that can sustain an injury and recuperate without much trouble, and there are other people that can have the same injury and have prolonged difficulty in the recovery and miss a significant amount of school. If someone [younger than high school age] has had a head injury with prolonged recovery that's made them miss substantial schooling, there's a higher chance of it happening again or even worse."

William Qubty, MD
Pediatric neurologist

Codirector
Pediatric Traumatic
Brain Injury Program
Hennepin County Medical Center

next by three to four times, so it becomes especially important for physicians to be able to help parents monitor their child's recovery. Andrew Waititu Kiragu, MD, a pediatric critical care physician at Children's Minnesota who serves on the executive committee of the AAP's Council on Injury, Violence and Poison Prevention, says the most common question he gets from parents of children who have been severely impacted by a sports-related brain injury is when their child can return to school and their sport. "You want to be helpful but at the same time reduce the risk of further injury. It can be a difficult balance to strike," he says. "For kids who are allowed to go back too early, there's an increased risk of additional damage."

"The good thing is the increased attention of concussions and concerns about CTE in professional athletes has helped to improve our awareness. That awareness is a form of prevention."

Andrew Waititu Kiragu, MD
Pediatric critical care physician
Children's Minnesota

Executive committee member
AAP's Council on Injury, Violence and Poison Prevention

Qubty advocates for standardized baseline testing for young athletes prior to participation in contact sports that can provide a measure for when those who've experienced a concussion are ready to return to school and their sport. "It will be important to make sure we have good baseline cognitive assessments done by the right qualified individuals and for children not to [deliberately] underperform on the tests," he says.

Kiragu, like other physicians interviewed for this article, recognizes the benefits of playing teams sports and does not want to discourage children from doing so. They just want to make sure they're safe, which may be more likely given the patient-physician discussions prompted by the public discourse about brain health. "The good thing is the increased attention of concussions and concerns about CTE in professional athletes has helped to improve our awareness," he says. "That awareness is a form of prevention." MM

John Rosengren is a freelance journalist based in Minneapolis. His latest book is *The Greatest Summer in Baseball History: How the '73 Season Changed Us Forever.*

'It was finally time for me to give it a try'

MMA's SafeHaven program offers a comprehensive suite of well-being services designed for physicians

BY ANDY STEINER

The first time Kimberly Tjaden, MD, heard that her health system was offering a support program for physicians, she didn't sign up. She wasn't alone in that decision. Uptake in the self-care program, which offered online supports ranging from a concierge service to job coaching and mental health counseling, was low across the board.

"One of the reasons I and others didn't sign up for it is that we are busy and we don't always have time for extra things," says Tjaden, Minnesota Medical Association board chair and a family practice physician at CentraCare in St. Cloud. "Working with the program felt like just one more thing to do."

But last year, when she heard that the MMA was offering discounted subscriptions to SafeHaven, a full-service clinician

Kimberly Tjaden, MD
MMA board chair

Laurel Ries, MD
MMA president

Janet Silversmith
MMA CEO

well-being program founded by the Medical Society of Virginia in 2020 to provide physicians the support they need to stay well and prevent burnout, she decided to sign up.

"I joined," Tjaden says, "number one because I am board chair and I want to make sure I know what we're getting because we are advertising it, but I also joined because the things this program was offering sounded appealing. I figured it was finally time for me to give it a try."

In the beginning, Tjaden just dipped a toe into SafeHaven's offerings by signing up for the program's concierge services, which include perks like arranging car detailing, help purchasing event tickets and home-care options like window washing. "It felt appealing," she recalls. "I decided I want to get my car detailed and my windows washed and the radon in my basement mitigated."

Kimberly Tjaden, MD

"I joined because the things this program was offering sounded appealing. I figured it was finally time for me to give it a try. I decided I want to get my car detailed and my windows washed and the radon in my basement mitigated. I thought, this is great. Somebody is finally taking care of me."

SafeHaven's concierge service emailed Tjaden the names of three organizations that could tackle these jobs. Once she made her selection, the service set up the appointments and even arranged for someone to pick up her messy car and drop it off when it was nice and clean. Tjaden admits this full-service treatment got her hooked. She was ready to try more. "I thought, this is great," she says. "Somebody is finally taking care of me.'"

Janet Silversmith, MMA CEO, says that Tjaden's reaction is exactly what the MMA's board hoped for when they decided to offer SafeHaven to members. Initially, Silversmith explains, Kristen Gloege, MMA Foundation CEO, pitched a grant proposal to The Physicians Foundation requesting funds to develop an in-house peer support program. The proposal was funded, but after consulting with staff at other medical associations that had developed similar internal programs, it became clear that a subscription-based service would not only offer a more comprehensive range of physician well-being services but also be more cost-effective for the MMA and its members. The Physicians Foundation agreed and approved the request to use the grant dollars to pilot an outsourced well-being program that offered peer support along with a full suite of other well-being options from concierge services to counseling.

If MMA members started out with less intrusive options like window cleaning, Silversmith and Gloege figured, they might be more likely to eventually try out some of the program's more personal wellness services.

Laurel Ries, MD, MMA president, says that the association selected SafeHaven because it is a confidential resource developed by a medical society that physicians can use without risk to their medical license, and because it has been widely used by physicians around the country. MMA staff liked the fact that the program was road-tested and popular. The burnout crisis among MMA members was concerning enough that they knew they had to try something.

"We at MMA recognized that we needed to look at all the opportunities where we could have impact in helping our physicians be less burnt-out," Ries says. While she knows from personal experience that offering self-care strategies may feel like lip service to doctors overwhelmed by the practice of modern medicine, she and her colleagues hoped that SafeHaven could help take some of the psychological load off members while the association focused on encouraging much-needed statewide policy shifts targeted at supporting physician mental health.

Laurel Ries, MD

"The concierge service is the 'gateway tool.' The hope is that these services help to make life easier. Maybe that's all you'll ever use, but it can also be a way into requesting something more substantial than getting your windows cleaned."

"While we know that self-care alone isn't going to fix the problem," Ries says, "it is going to help us keep our heads above the water while the problem is getting fixed. What we're doing is getting people in their life vests while we work on emptying the pool."

A gateway tool

Concierge services like car detailing are just one small part of SafeHaven's offer-

ings, Ries says, a way for wary physicians like Tjaden to test the waters and gauge their comfort with trying some of the program's other offerings, like peer mentoring or mental health services.

"The concierge service is the 'gateway tool,'" Ries says. Some physicians may want to stop there, she says, but, once they get the lay of the land, others may want to take advantage of the program's other benefits: "The hope is that these services help to make life easier. Maybe that's all you'll ever use, but it can also be a way into requesting something more substantial than getting your windows cleaned."

That's how it worked for Tjaden. Once she got comfortable with SafeHaven's concierge services, she decided to give the program's other services a try. "I have used the coaching service," she says. "I have a lovely coach who is a physician in Atlanta. She and I talk about how to move health equity forward in my organization."

Laurel Ries, MD

"While we know that self-care alone isn't going to fix the problem," Ries says, "it is going to help us keep our heads above the water while the problem is getting fixed. What we're doing is getting people in their life vests while we work on emptying the pool."

Tjaden also has had individual sessions with a SafeHaven psychotherapist. "That has been focused on life transitions like being an empty nester, transitioning to parenting adult children," she says. "It's all on Zoom, and it's been extremely helpful."

Tjaden was also pleased to learn that SafeHaven's 24-7 mental health services are available free of charge to physicians' family members—a benefit she thinks many of her colleagues may find appealing.

"It's important that people understand that these services are also available to your kids and your spouse," Tjaden says. Burnout can bleed into family dynamics, and it's great to know that this service is available to everyone. "I asked the therapist I was seeing, 'How old can my kids be? Can they be 30?' She said there is no age limit. This feels amazing."

While past prejudice and current practice make many physicians hesitant to seek out or admit to using mental health services, Tjaden says she feels that it is important enough to bust prejudice that she's willing to talk openly about her own mental healthcare. She's looking forward to the day when seeing a counselor for your mental health will feel no different from seeing a physician for your physical health.

I want the word to get out there about stigma and mental health and doctors and nurses," Tjaden says. "We need to get services if we need them, instead of worrying about our licensure and trying to be perfect all the time."

Busting burnout

For years there's been talk about the crisis of physician burnout, an all-too-real problem that was only exacerbated by trauma of practicing medicine during COVID-19. Physicians like Tjaden, who have thrown themselves into a demanding career while simultaneously juggling the stressors of everyday life, know better than anyone the feeling of work just being too much. Sometimes all the self-care strategies in the world don't even scratch the surface.

"I remember," Tjaden says, "back when we were transitioning to a new electronic health record, crying to my supervisor, saying, 'I'm sleeping, I'm doing yoga, I'm meditating, and I can't do anything else.'" While employers' urging physicians to lean into self-care was well-meaning, she says, "it felt like the organizations were telling us it is our fault that we're burned out. They were saying, 'You doctors care too much. You doctors don't sleep. You don't trust anyone. You don't take vacations.'"

Kimberly Tjaden, MD

"I have used the coaching service. I have a lovely coach who is a physician in Atlanta. She and I talk about how to move health equity forward in my organization. It's all on Zoom, and it's been extremely helpful."

Ries agrees. She knows from her own experience that physicians are "very good at working really hard and being really smart, but self-care was not on the list of values we were taught. We have an entire work force of physicians who were trained to work hard, but were not rewarded for self-care."

Physicians who can't make the time or aren't given the time to step away from their work and care for themselves end up burned out, Ries says. "Sixty percent of doctors say they are burnt out. This is not good for anybody. Burnt-out physicians make more mistakes. They are more likely to leave the profession."

This conundrum speaks to the need for structural change in healthcare and

in the system that trains and employs physicians, Ries says. In the past, most physicians were men—and many had wives who stayed at home and managed the family and household. That model is slipping away: In 2021, more than 37% of the active physician workforce in the United States was female, according to the 2022 Physician Specialty Data Report of the American Association of Medical Colleges.

In acknowledgement of these demographic shifts, younger generations of physicians are demanding changes, like less-onerous residency requirements, alternative work structures, and a more open acceptance of mental healthcare. But until those major structural changes occur, comprehensive support programs like SafeHaven may be a needed response to crisis.

Laurel Ries, MD

"Burnout is part of the driving forces that are causing physicians and other people in healthcare to leave their work. They simply don't want to be in the environment that has caused them to burn out, which sounds like a reasonable response, but now we are looking at two in three rural physicians leaving the workforce in three years. These departing doctors are not replaceable. We can't pump out physicians fast enough to replace those that are leaving. Something has to be done."

"Burnout is part of the driving forces that are causing physicians and other people in healthcare to leave their work," Ries says. "They simply don't want to be in the environment that has caused them to burn out, which sounds like a reasonable response, but now we are looking at two in three rural physicians leaving the workforce in three years." These departing doctors are not replaceable, she says: "We can't pump out physicians fast enough to replace those that are leaving. Something has to be done."

To encourage more member participation, MMA has prepaid for 75 SafeHaven subscriptions using grant funding to subsidize the cost during the pilot period, Gloege says. As a result, MMA members pay only $99 for a 14-month subscription. The pilot program began in November 2023, but uptake has been slow, with only 20 members signing up so far, she admits.

Ries believes that SafeHaven's slow start may have to do with a combination of not knowing how beneficial the resources are and feeling too busy to take on additional things. "The people I've talked to who are using it say they have been really happy with it. It is meeting the things they need help with at that time. But we'd like more folks to try it out." This year, thanks to MMA advocacy, the Minnesota Legislature passed a physician wellness bill that includes confidentiality protections for physicians participating in MMA's SafeHaven program," Ries says. "Hopefully more physicians will take advantage of the offering now knowing the confidentiality protections are in place."

That's why Tjaden is stepping forward with her own SaveHaven stories. Maybe MMA members need to see a little encouragement from their peers before they decide to take the leap and sign up.

Kimberly Tjaden, MD

"It's important that people understand that these services are also available to your kids and your spouse. I asked the therapist I was seeing, 'How old can my kids be? Can they be 30?' She said there is no age limit. This feels amazing."

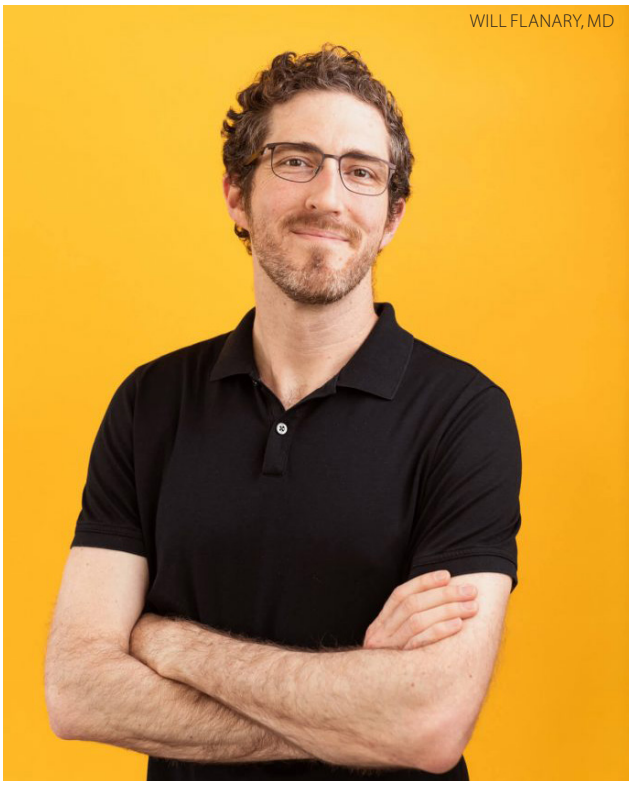
"I am a firm believer in personal invitations," Tjaden says. She and her husband lead busy lives, co-parenting young adult children while working demanding jobs. The SafeHaven suite of services has helped to make their lives feel just a bit less stressful, and she wants to encourage her fellow physicians to give this service a try.

"One of the things I plan to do is to say, 'Listen, I know you are in a two-parent working family and it is a struggle to get birthday parties planned and dinner on the table. This is something that might be helpful to you.'"

Tjaden's hoping this approach will appeal to a few of her colleagues. She knows it would to her: "I think that personal invitation is huge, so I'm willing to step forward and do it." MM

Andy Steiner is a Twin Cities freelance writer and editor.

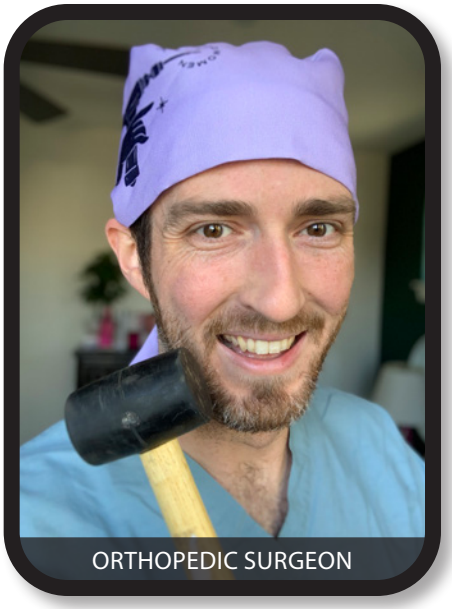
Laughter is the best medicine


WILL FLANARY, MD

William Flanary isn't just a physician. He plays one on YouTube. Several, actually. And he'll be performing for the MMA in September.

The experience of Will Flanary, MD, aka Dr. Glaucomflecken, provides a strong argument—as if any were needed—that misfortune and comedy go hand in hand.

Flanary, an ophthalmologist in Portland, Oregon, is also a humor writer, stand-up comic, podcaster, and YouTube performer who has delivered keynotes and entertained medical groups all over the world.


ORTHOPEDIC SURGEON

> I decided to start a medical comedy Twitter account, and I called it Dr. Glaucomflecken. I was telling painfully specific ophthalmology jokes to an audience of about like six people who are all vision researchers. So you can imagine how much traction all my jokes were getting.

But he also battled testicular cancer as a medical student and, more mysteriously, suffered cardiac arrest in his sleep. Says Flanary, "I just went to bed one night and I woke up in the ICU a couple days later." An alert response by his wife (and podcasting co-host), Kristen, to call 911 and perform CPR saved his life.

Flanary will perform as Dr. Glaucomflecken at the MMA Empowering Physicians Conference September 27 at the American Swedish Institute in Minneapolis. He spoke with *Minnesota Medicine* about his unusual biography of comedy and medicine. The interview has been edited for clarity and brevity.

Give me the origin story of Dr. Glaucomflecken.

I was a second-year resident at the University of Iowa, and I had just in the past few years recovered from a cancer diagnosis. I had testicular cancer as a med student and I was dabbling in some comedy writing. I did stand-up in college and high school in Houston, Texas. At that point in my life, I was writing satirical articles for different places, all about medicine. It was my first foray into medical comedy.

I was at a conference for ophthalmology called ARVO [Association for Research in Vision and Ophthalmology]. I was bored to tears. I had never been to such a boring conference in all my life. It made me realize that the research life is not for me. So to pass the time, I decided to start a medical comedy Twitter account, and I called it Dr. Glaucomflecken. And at the time, I was telling painfully specific ophthalmology jokes to an audience of about like six people who are all vision researchers. So you can imagine how much traction all my jokes were getting. So anyway, that was the beginning, and then it just gradually grew from there.


"LOYAL SCRIBE" JONATHAN

What are glaucomflecken, by the way?

It's actually a real term in ophthalmology. It's a clinical exam finding you see in people who have angle-closure glaucoma. It's hilarious!

You weren't literally writing these jokes and starting your channel during the conference itself, were you?

Yeah, of course I was. I was in these sessions hearing about, like, stem cell research and all kinds of stuff. And I was just trying to make people laugh on the internet.

You mentioned that you were involved in stand-up. I've got to ask you, is that the toughest job you've ever had, doing stand-up?

I wouldn't say the toughest. I would say it had the widest swings of emotion. Because when it's going good, it's going real good. It's so much fun. But when it's going bad, it's real bad.

The comedy stuff, though, I've never had the financial stress surrounding it, because I've always had my career as a physician. So that's been able to afford me the ability to not stress about comedy. If I was trying to make a living as a comedian, I'm sure it would feel like a much harder job.

Let's back up just a little bit. You had mentioned your two bouts with testicular cancer. More mysteriously, you suffered cardiac arrest in the very early morning, and your wife saved your life by giving you CPR. Tell me about that.

She woke up hearing me gasping for breath and called 911 and they walked her through how to do CPR. It was right at the beginning of the pandemic. So they thought I had COVID. But I did not. We actually don't know what caused the cardiac arrest. It's still a mystery. But, yeah, she saved my life. I'm fortunate that I woke her up.

Do you have any recollection of that moment?

I don't. I just went to bed one night and I woke up in the ICU a couple days later.

How did that change your life and attitude? The fact that it's a mystery—that's got to be rather haunting.

You know, we're still working through some of it as a family, right? It does have lasting effects. We talked about it with our kids, and I still think about it from time to time. But you just settle into a new normal, and I have a defibrillator that will go off if it happens again. So I have a little bit of peace of mind there. But there's always a little something in the back of my mind, like, what if it happens again?

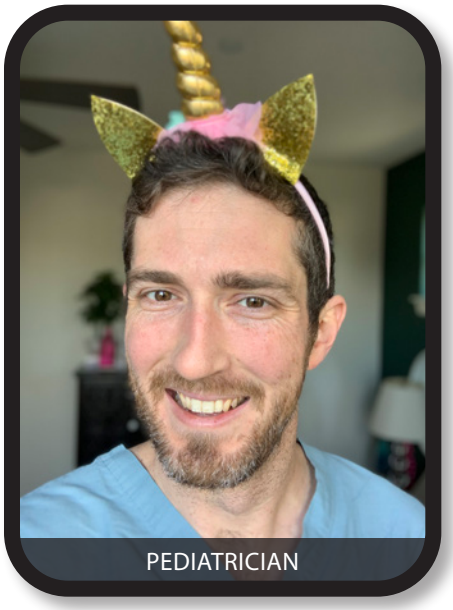
With my job as an ophthalmologist, I can relate a little bit more to my patients in a lot of different ways. A lot of our patients in ophthalmology are quite old, and so they're going through health issues and the healthcare system. So I feel like I can talk a little bit more about that stuff with them. I've tried to find the positive.

Describe your involvement with First Descents, as long as we're on the subject of your health. Why that organization and why the outdoors connection?

That was an organization that my wife, Kristen, found for me, because she recognized after the second bout of testicular cancer, I was not in a great place, and she knew I needed to talk to other young people who had been through cancer. She found that organization based out of Denver. Basically it brings young adult cancer survivors together to form a support network. The outdoor part of it is to allow you to trust your body again and to realize you're still strong and you can still do all these things, that cancer doesn't define you. It's just a part of your life. Mostly, it's just a way to bring young adult cancer survivors together, which is hard to do. There's not a lot of attention that's placed on young adult cancers.

And you've done some fundraising for them.

Over the years, we've raised probably close to $150,000. And it's all through, mostly all through social media. Just talking about it, either at conferences or online, and people donate.

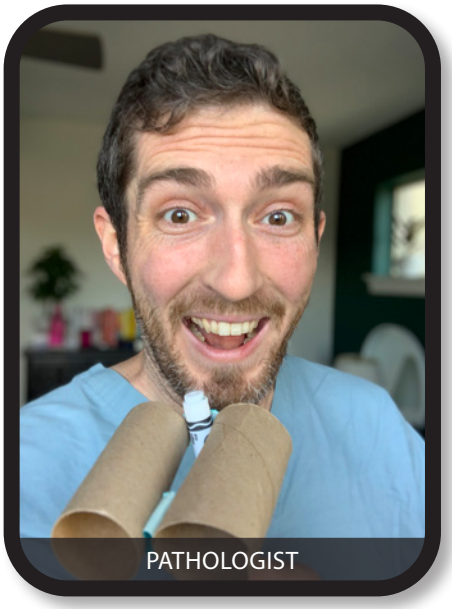

PEDIATRICIAN

Have your health challenges informed your comedy at all?

Oh yeah, I talk about it. When I talk to the Minnesota Medical Association, I'll talk all about this stuff.

So where do the Dr. Glaucomflecken ideas come from? The potential for comedy? A sense of outrage? What gets you going?

I mean, I love the interpersonal relationships between different specialties. I love all the idiosyncrasies of the different types of doctors out there, the weird things that



piss us off, or the stupid little pet peeves we have that no one really cares about. I love finding those and turning that into comedy and allowing us to laugh at ourselves and our weird personalities. That's part of it, and the other part of it is education. I love teaching people about the healthcare system and all of its pitfalls and downsides and all the ways that we fail people in this country with our healthcare system, which is kind of a depressing part of it. I joke that I trick people into learning things about healthcare by making it funny.

So what's the funniest medical specialty?

Urology is pretty far out there. For obvious reasons.

I thought you might say radiology and doctors sitting in the dark all the time.

Radiology is a good one. I would say most of the surgical fields are pretty funny. I've spoken at conferences for most of the specialties, and so I get a sense of who has got a good personality. Emergency medicine—they're pretty funny. They have such a serious job they have to have a good sense of humor about it.

How do you get so familiar with other specialties? I mean, as an ophthalmologist working in a clinic, you're somewhat siloed, and yet you seem to have all of this insight into the stereotypes of different specialties. For example, I was watching one of your clips about the conversation and body language that goes on when the surgeon walks into surgery late, and inadvertently apologizes—a hilarious bit. How do you know all about that?

I draw on a lot of it from my own past, going through medical education. And I do a lot of research. I follow on social media. I follow people in all different specialties, and so I pay attention to what they're complaining about.

Where's being Dr. Glaucomflecken taken you? Where have you performed and presented?

Oh, man, I've given dozens, probably close to 100 keynotes over the past few years all over the world. I've collaborated with the surgeon general of the U.S. and various famous doctors. I've given commencement addresses. I've gotten to explore different creative projects. My wife and I, we do a podcast together called "Knock Knock, Hi! with the Glaucomfleckens." We are now putting on our own live shows. We're going on a tour later this year.We have a live show based on our life together. It's called Life and Death. It's been really fun to just explore different creative outlets. We're putting together an animated series. So, it's really cool doing all these different things that I would never have the opportunity to do if it wasn't for social media and comedy.

Tell me about the animated series. What will that be like, and with whom?

It's still in the beginning stages. We're going to release a few episodes of it later toward the end of the year. It's based on my characters, which are all cartoonish in a way. You have more creative freedom in animation than you do in real life. So we'll see what happens. It's just a fun little passion project, and we'll see if it goes anywhere.

Tell me about your practice.

I still practice ophthalmology, private practice, EyeHealth Northwest. I practice four days a week, which gets busy because I basically have, like, two full-time jobs now. I still love it. People always ask me, would you consider quitting medicine and doing the social media stuff full time? But medicine is my connection to my comedy, so I can't really have one without the other.

You're afraid that if you quit medicine, your inspiration would sort of dry up after awhile?

I think my content would become less meaningful, less authentic. It would just lose some of its luster, I think, if I was no longer practicing medicine. Because part of how I carry such weight with my healthcare-related advocacy is because I'm in it, I'm doing it. That means something.

When did you decide to become a physician?

Junior high, I think. Middle school. It was like a little summer camp where I went to a med school and saw, you know, an anatomy lab. I don't even remember what I did, but you got to hear from doctors talking about the human body. That kind of put it in my head initially.

And why ophthalmology?

I like the anatomy. I like fast-paced outpatient-style medicine. The hospital inpatient

medicine, I just, I never—it's just not my personality. I like having a defined end to my day, like I know when it's going to be over. I wanted work-life balance. That was important to me, because I had all these other interests and things I wanted to do outside of medicine. And most of all, eyeballs just don't gross me out. That was also a big part of it.

At a commencement you gave, I believe it was this spring at the University of Michigan Medical School, you talk about the value of maintaining a connection to your creative side.

It can be anything, you know. I think it's so helpful to have something outside of medicine that you can turn to, and just turn that medical side of your brain off for a bit. I play ultimate Frisbee as well. That's another hobby of mine. And when I'm out there playing, I don't think about Glaucomflecken, and I don't think about medicine. It's something I can do where I just get a break. That's been so helpful for me. The challenge is that medicine can just take over everything, right? Your whole life can easily be medicine. And in a way that's happened with me, because even my hobby, this comedy thing, has turned into medicine as well.

Especially with young people coming up, it's kind of beaten into your head that medicine is a calling. You can't think about doing anything else. That message is a double-edged sword, because you've got to really love medicine to do it for a career. But it doesn't have to be your life.

> I love the interpersonal relationships between different specialties. I love all the idiosyncrasies of the different types of doctors out there, the weird things that piss us off, or the stupid little pet peeves we have that no one really cares about. I love finding those and turning that into comedy and allowing us to laugh at ourselves and our weird personalities.

What was the greatest lesson of your medical education?

Probably the only way to avoid surgical complications is to not operate.

When I was a resident that honestly helped me out. Because when you have a surgical complication as a resident, it's like the world is ending. It feels terrible. And then hearing one of my attendings say that to me—he didn't make that up. Every surgeon has heard that. But hearing it for the first time in the context of me actually having a surgical complication was so helpful, just to reaffirm that I'm not the first person that's ever screwed up.

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

The healthcare system. In med school and even residency, you're so focused on just learning the science, learning the medicine, learning how to do cataract surgery, learning how to be a competent physician, that you are just blissfully unaware of the hardships that the healthcare system will foist upon you and your patients. So it's a rude awakening to get out and practice. All of a sudden, you're dealing with prior authorizations for the first time. Your patients are dealing with denials. You're in private practice negotiating insurance rates so you can get paid fairly. Doing peer-to-peer reviews. There's all this stuff that we have no knowledge about, no exposure in education.

And if you weren't a physician, what would you do?

I would try to be an actor, probably.

Have you taken acting lessons? Because you seem to have the knack for acting, judging by your videos.

No, I have not taken anything formal. I'm comfortable in front of a crowd, and I've learned how to have stage presence. And part of that is acting and being compelling and engaging. But, no, I've not done any formal training. I kind of want to though.

You've said that there's no temptation to become a comedian full time and ditch medicine.

No, definitely not. I put too much time into it. Not in the near future. MM

Interview by Greg Breining, editor of *Minnesota Medicine*

Less-lethal weapon injuries from the George Floyd and Daunte Wright protests: What have we learned?

Crowd-control measures continue to cause injuries and raise questions about state-sanctioned force

BY CHRISTOPHER R. PROKOSCH, MS4; ANDREA K. WESTBY, MD; DAVID P. DARROW, MD, MPH; JOEL T. WU, JD; RACHEL R. HARDEMAN, PHD, MPH; DAVID J. SATIN, MD*; ERIKA A. KASKE, MD* (*CO-SENIOR AUTHORS)

Eleven months after the murder of George Floyd by Minneapolis police in May 2020, Daunte Wright was fatally shot during a traffic stop in a Minneapolis suburb. Protests began that afternoon and continued for 10 days. Police responded with less-lethal weapons for crowd control.

The terminology "less-lethal weapons," which may be more familiar to readers as "non-lethal weapons," arose from a need to be more accurate and transparent about the potential damage these weapons can cause.[1] Less-lethal weapons were used by police across the country throughout the George Floyd protests.[2] Our previous work in Minneapolis documented the clinical outcomes of 89 people who sought medical care for injuries resulting from police use of less-lethal weapons between May 26 and June 15, 2020.[3] Twenty-three people sustained head injuries from less-lethal weapons, bringing attention to the potential safety hazards of these weapons in a crowd setting.[4] Meetings among Minnesota state lawmakers, Minneapolis city council members, and Minneapolis Mayor Jacob Frey included discussion of these results.

This study uses the same methodology to document injuries from less-lethal weapons occurring in Minnesota's Daunte Wright protests. We evaluate differences and similarities between less-lethal weapons' injury patterns in both protests. We discuss policy implications for police use of less-lethal weapons for crowd control and attempt to answer the question, "What have we learned?"

Methods

This study followed the recommended methodology for documenting injuries from less-lethal weapons in protests established in *Kaske, et al.* 2021 NEMJ report on the George Floyd protests.[3] In evaluating injuries to Daunte Wright protesters in Brooklyn Center, a suburb of Minneapolis, we included patients from the two closest Level I trauma centers and another Level III, multi-facility, hospital system with geographic proximity.[3] Initial evaluation included all patients receiving medical care from April 11 to April 20, 2021 at the emergency departments. Inclusion criteria focused on patients with ICD10 codes S00-T59 or patients with "projectile," "protest," "riot," "rubber bullet," or "tear gas" in patient notes. We excluded patients (1) who did not sustain injury, (2) if injuries did not relate to the protests, and (3) if

injuries were not related to law enforcement less-lethal weapons. The number of individuals injured served as our primary outcome. The body region(s) and organ system(s) affected were our secondary outcomes. Additional outcomes included the type of weapon causing injury and whether patients underwent surgery. Language used to describe the weapons in this paper follows recently published recommendations.[1]

This study received IRB approval from all clinical sites and the University of Minnesota.

Results

The initial search included 8,749 medical records. Seventy-seven patient records included the above keywords. On review, 14 patients (ages 13–38) met study criteria with 11 (78.6%) patients injured from police use of impact munitions, two (14.3%) from less-lethal chemical weapons, and one (7.1%) from batons.

One (9.1%) patient was hit in the neck. Two (18.2%) patients were hit in the hand, requiring surgery. Two (18.2%) patients (including a pediatric patient) experienced asthma exacerbations from less-lethal chemical weapon exposure. A summary of injuries and hospital courses is in Table 1.

TABLE 1

Detail of injury by weapon type, patient gender, age, and course of injury

GENDER, AGE (BY LIFE DECADE), WEAPON TYPE	DETAILS OF INJURY	COURSE
Gender non-binary, 20s impact munition*	Large zone III neck laceration. Left abdominal hematoma	Admitted. Neurosurgery consult and laceration repair
F, 20s, impact munition	Open fracture of the right hand; tendon rupture	Taken to OR for pinning and open reduction internal fixation, tendon repair x2
M, 30s, impact munition	Fracture of middle and distal phalanx; finger laceration	Admitted. Taken to OR for closed reduction and percutaneous pinning
M, 30s, impact munition	Contusion of the left knee and glute; erythematous tender left ankle	Supportive care and discharged
F, 20s, impact munition	Laceration of the left knee	Washout and laceration repair, discharged
F, 20s, impact munition	Laceration of the left leg	Washout and laceration repair, discharged
F, 20s, impact munition	Laceration of the left leg	Supportive care and discharged
F, late teens, impact munition	Decreased sensation and bruising on medial right foot	Supportive care and discharged
F, 20s, impact munition	Abrasion and contusion of left leg	Supportive care and discharged
F, early teens, less-lethal chemical weapon exposure**	Irritated eyes, sore throat, asthma exacerbation	Supportive care and discharged
M, 20s, less-lethal chemical weapon exposure	Shortness of breath, dizziness, and double vision	Supportive care and discharged
F, 20s, "flash bang grenade"	Four days of headache, syncopal episode, nausea, and blurry vision	Supportive care and discharged
M, 30s, baton	Acute shoulder pain and leg bruising	Discharged
M, 20s, impact munition	Laceration of the left knee	Washout and laceration repair, discharged

*Impact munitions include weapons more colloquially known as rubber/foam/sponge bullets as well as "bean bags."
**Less-lethal chemical weapons are more colloquially known as "tear gas." These naming conventions arose from a need to be more accurate and transparent about the potential damage these weapons can cause.

Discussion

The George Floyd protests saw 89 people injured—45 from projectiles, 32 from chemical irritants, and 12 from both chemical and projectile weapons.[2] In contrast, the much smaller Daunte Wright protests resulted in 14 people injured, but through a wider variety of weapons including flash-bang grenades, batons, munitions, and chemicals. One pediatric asthma exacerbation was reported from chemical irritants, where no children were reported in the George Floyd protests. Two patients at the Wright protests received surgery compared to seven at the George Floyd protests.[2] Whereas the George Floyd protests saw 23 head and neck injuries from several sources,[2] the Daunte Wright protests saw one neck injury.

International use-of-force guidelines provided by the United Nations (UN) state that less-lethal weapon injuries to the head, face, and neck are potentially unlawful because they represent unintended misuse or intentional use of less-lethal weapons in a manner for which they were not designed.[9,10,11] While local police departments are not obligated to follow UN guidelines, these guidelines are often used in studies assessing injuries because they are evidence-based and comprehensive. In addition, not all local police departments have specific policies on less-lethal weapons. In some protests, multiple jurisdictions are involved in policing protests, each with varying policies. Even when available, lawful and unlawful use can be more complex than local police department manuals describe.

Our data from the George Floyd and Daunte Wright protests can be valuable information for Minnesota's state and local leaders. The outcome data can be used in many ways. Because this study uncovered only one potentially unlawful injury per UN guidelines (projectile injury to the neck), it can highlight a challenging question for lawmakers: How many of these injuries should the state allow? We caution policymakers to not use these numbers in a strictly utilitarian calculus—trading

injuries of a certain type for undesirable outcomes of another. Leaders must reckon with at least two truths: State-sanctioned use of force must always be held to a higher moral standard than the actions of individual citizens; and the use of state-sanctioned force against its citizenry has a long, racialized history.

The public health concerns of these weapons go beyond individual harm or inherent weapons accuracy. The American Public Health Association has declared law enforcement violence to be a public health issue,[14] and less-lethal weapons–based crowd control is an important part of this concern. Recent studies show that, in terms of attitudes and policies, racial prejudice predicts police militarization in the United States.[15] Because less-lethal weapons were disproportionately used during Black Lives Matter protests "relative to other types of demonstrations,"[6] any risk/benefit policy assessment should acknowledge that members of disenfranchised communities and their supporters bear the burdens while the benefits may accrue across a more general population. So long as these weapons continue to be used in protests, there is a public health imperative for a more explicit, structured, and publicly available accounting.

Limitations of this study include that our identification of munition-type was indirect, using patient report and injury type, rather than by direct identification or police records. In comparison to the Minnesota George Floyd protest results, our data from the Daunte Wright protests are too small to draw direct conclusions about policy changes that may have altered these outcomes. Finally, our primary outcome reflects the minimum, not total, number of injuries.

Conclusions

What have we learned by following up the George Floyd protest data with the Daunte Wright protest data? One lesson from these two studies is that the safety, equity, and justice concerns of less-lethal weapons in a protest setting are more complicated than a dispassionate utilitarian calculation can address. We hope this provokes further policy conversations that go beyond what number of injuries the state should allow. **MM**

Christopher Prokosch is a fourth-year student at the University of Minnesota Medical School in Minneapolis. Joel Wu, JD, is a University of Minnesota Center for Bioethics Clinical Ethics assistant professor and a senior lecturer in the Division of Health Policy and Management at the School of Public Health. Rachel R. Hardeman, PhD, MPH, is a tenured professor in the Division of Health Policy and Management at the University of Minnesota's School of Public Health, the Blue Cross Endowed Professor in Health and Racial Equity, and the Founding Director of the Center for Antiracism Research for Health Equity. Andrea Westby, MD, is faculty at the University of Minnesota Department of Family Medicine and Community Health's Broadway Family Medicine Residency Program and director for justice, equity, diversity, and inclusion for the Department of Family Medicine and Community Health. David Darrow, MD, MPH, is an assistant professor in the University of Minnesota's Department of Neurosurgery and the Rockswold-Kaplan Endowed Chair for Traumatic Brain Injury (with Hennepin Healthcare). David Satin, MD, is the ethics, law, and policy course director in the University of Minnesota Medical School, an associate professor in the Department of Family Medicine and Community Health, and at the Center for Bioethics. Erika Kaske, MD is a second-year resident in Psychiatry at Massachusetts General Hospital and clinical fellow at Harvard Medical School. Satin and Kaske served as co-senior authors on this project.

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EMPOWERING PHYSICIANS CONFERENCE

Conference to highlight innovations, negotiating skills, and hilarious look at the state of medicine

A presentation on innovations in medicine, a negotiating skills workshop, and a hilarious look at the future of healthcare are all on the docket at this year's Empowering Physicians Conference on Friday, September 27, at the American Swedish Institute in Minneapolis.

"There really is something for everyone at this year's conference," says Laurel Ries, MD, MMA president, who will close out her term and welcome the next president—Edwin Bogonko, MD, MBA, at the event.

"The conference provides Minnesota physicians and physicians-in-training the opportunity to get together with their peers, renew friendships, make new ones, and learn about the latest trends in medicine," she says. "You won't want to miss it."

The conference kicks off with a look at innovations in medicine, beginning with Mike Pitt, MD, FAAP, the CEO and founder of Q-rounds, a virtual queue that sends real-time notifications of when to arrive for rounds—an innovation that is "taking the waiting around, out of rounds." The session will also include other innovators who will share what they are doing to improve (and maybe even change) the practice of medicine in Minnesota.

Following the innovations session, attendees will take part in a hands-on, skills-building workshop with Danielle Hansen, MBA, vice president of global sourcing—direct materials for JBT Corporation, a global food tech company. Hansen is part of the Carlson Educator Network and has taught supply chain and operations management as a senior lecturer at the University of Minnesota Carlson School of Management.

After the workshop, attendees will transition to a reception that will include remarks from Bogonko, the incoming president, and a poster symposium featuring research by medical students, residents, and fellows. During the reception, attendees will also have the chance to take a guided tour of the institute's Turnblad Mansion, built between 1904 and 1908.

The day will conclude with dinner and a keynote speech by social media star Dr. Glaucomflecken (aka Will Flanary, MD), who will offer his hilarious take on the future of healthcare. Flanary, who practices ophthalmology in the Portland, Oregon, area, has become known for his satiric medical videos on X/Twitter, TikTok, and YouTube.

The premier conference sponsor is COPIC. Exhibitors include the Minnesota Alliance on Problem Gambling, the Minnesota Rare Disease Advisory Council; MEDPAC, the MMA's political arm; the MMA Foundation; Concentra; Phathom Pharmaceuticals, and RoundtableRx. MM

Social media star Dr. Glaucomflecken (aka Will Flanary, MD)

FOR MORE INFORMATION
www.mnmed.org/EPC24

News Briefs

Group aims to ease use of opioid use disorder meds in jails

A work group organized by the Governor's Office of Addiction and Recovery in partnership with the MMA and Minnesota Sheriff's Association, has begun to meet to identify barriers and solutions to providing medications to Minnesotans experiencing opioid use disorder who are incarcerated.

One in five overdoses occur within a year of incarceration, and studies have shown that individuals with opioid use disorder in jail who get medication are less likely to be reincarcerated. "Providing access to these medications during jail or prisons is critical to reduce overdose deaths in Minnesota," said Tyler Winkelman, MD, of Hennepin Healthcare and MMA representative. "Most people with an opioid use disorder will spend time in jail or prison. Continuing treatment during incarceration can reduce overdoses and improve public safety."

A 2021 study by Minnesota Management and Budget found that less than half of Minnesota jails provided access to medications for opioid use disorder. Some of the barriers included workforce shortages, funding, and access to prescribers.

The work group brings together those working on the ground—practitioners, people working in the jails, sheriffs, local corrections, healthcare providers, and others—to identify current barriers to providing medications, possible solutions, and identify connections that can be made to support these efforts.

MMA member's son competes in Olympic trials

The son of MMA member George Morris, MD, competed in the Olympic swimming trials in Indianapolis in June.

Christopher Morris qualified for the 100 freestyle and 200 freestyle events. "He did well but didn't make the team," said proud papa Morris. Only 26 men and 26 women are selected to represent the USA Olympic swim team. "It's an honor just to make the trials," the elder Morris said.

Morris, his wife, and their four other children were in Indianapolis to cheer for Christopher on Father's Day, which also happened to be one of Morris' daughter's birthdays, making it a real family treat.

Morris, one of the MMA's AMA alternate delegates, works as a sports medicine physician at CentraCare. He also works with the ski and snowboarding U.S. Olympic teams, as well as athletes at St. Cloud State University and various St. Cloud–area schools.

The younger Morris is a senior at the University of Wisconsin–Madison. He has set state and school records, is a Big 10 Champion and College Sports Communicators Academic All-District swimmer.

MMA member representatives from left: David Thorson, MD; Cindy Firkins Smith, MD, Dennis O'Hare, MD; Andrea Hillerud, MD; Laurel Ries, MD; Lisa Mattson, MD; George Morris, MD; Ashok Patel, MD and JP Abenstein, MD, MSEE.

MMA physicians lead on issues at AMA House of Delegates

Nine physicians represented the MMA at the AMA annual meeting of the House of Delegates in June, discussing a range of issues, from prior authorization to Medicare sustainability.

MMA member representatives included: Cindy Firkins Smith, MD, delegation chair; JP Abenstein, MD, MSEE; Andrea Hillerud, MD; Lisa Mattson, MD; George Morris, MD; Dennis O'Hare, MD; Ashok Patel, MD; David Thorson, MD; and MMA President Laurel Ries, MD.

The Minnesota delegation works collaboratively with delegates from the North Central Medical Conference (NCMC), which includes Iowa, Nebraska, North and South Dakota, to address issues important to Minnesota physicians and patients. North Central is a caucus of states that work together at the AMA meetings and is known for its commitment to rural health and underrepresented patients.

Medicare payment reform. A top priority for the AMA is reforming the Medicare payment system to ensure fair and sustainable payments to physicians. The current payment system has resulted in physician payments dropping 29% since 2001, after adjusting for inflation. These unsustainable payment rates do not reflect practice costs or the value of the care provided, according to an AMA Council on Medical Service report adopted at the meeting.

The current system also benefits larger systems. While current healthcare industry trends lean toward larger physician practices, more than half of physicians still work in practices with 10 or fewer physicians. The report also focused on Medicaid payments, stressing that the viability of these small physician practices—as well as those serving patients in rural, economically marginalized, or underserved areas—may be at risk because Medicaid pays them even less than Medicare does.

The report adds that, as Medicare physician payment rates continue to either drop or fail to keep up with the rate of inflation, linking private insurance payment rates to the Medicare physician payment schedule puts small practices at a further disadvantage.

Prior authorization. Prior authorization is an issue that is impacting physician practices across the country. According to an AMA Council on Medical Service report that was adopted at the annual meeting, of particular concern is the lack of information included in denial letters.

Information needed to understand or appeal the denial itself is not included for physicians and patients. For example, patients and physicians may simply be informed that a medication has not been granted prior authorization. Beyond that, no justification as to why the denial took place or an alternative treatment option is provided.

Artificial/augmented intelligence. The AMA meeting focused a lot of discussion on artificial/augmented intelligence (AI) and its role in patient care. While there are many good uses of AI to improve patient care, it is also being used by insurers and others to deny care based on algorithms that do not consider the individual needs of a patient.

To address this growing issue, the AMA will establish a task force focused on digital health, technology, informatics, and AI. The approved policy calls for that task force to transition to a new formal council to address these issues.

Private equity. As the business side of medicine continues to grow, there is a growing concern about overconsolidation and the influence of private equity firms purchasing clinics. The House heard a report from the Council on Ethical and Judicial Affairs restating that physicians have a fundamental ethical obligation to put the welfare of patients ahead of personal financial interests. This includes seeking capital for their practice from investment firms.

Because of the pressures on clinics to consolidate, many clinics believe partnering with an investment firm is a better alternative to selling to a large hospital system or a health plan. Because of this complexity, the House asked the council to continue to study these issues and report back at the next AMA meeting in November.

Rural ER staffing. To address concerns that some emergency rooms are occasionally operating without physicians present, there was a push by emergency physicians to require that all ERs be staffed by board-certified emergency physicians. The Minnesota delegation opposed that proposal because of the strain it would put on rural ERs. The final action adopted requires that the ERs be staffed 24-7 by qualified physicians. The ruling did not define "qualified physician," nor did it state how that staffing would be achieved. The AMA is scheduled to release a formal report on the issue at its interim meeting in November.


Kelly Morrison, MD

PHOTOGRAPHY BY RICH RYAN

MMA member quits State Senate to run for Congress

Kelly Morrison, MD, an ob-gyn and MMA member, resigned from the Minnesota Senate in June to focus full-time on her bid to represent Minnesota's 3rd Congressional District in the U.S. House of Representatives.

In a social media post announcing the move, Morrison said the decision will "save taxpayers the cost of a special election and allow voters to more easily participate in choosing a new senator."

The announcement puts partisan control of the Minnesota Senate up for grabs going into the 2025 legislative session. Prior to Morrison's resignation, DFL senators held a single vote, 34-33, majority. The replacement for Morrison's seat will be decided during the general election November 5. If Morrison had waited to resign or not resigned until elected to Congress, the special election would have taken place after November 5.

Morrison has served in the Minnesota Legislature since 2019, serving two terms in the House before being elected to the Senate in 2022. She announced her candidacy for Congress last November.

In the 2024 legislative session, Morrison authored legislation severely limiting the use of prior authorization. In her time, she has also championed other MMA priorities, including legislation increasing access to reproductive healthcare, supporting physician mental health and well-being, and ensuring reimbursement for telehealth services, among many others.

Sen. Matt Klein, MD, an internal medicine physician and MMA member, and Sen. Alice Mann, MD, MPH, are now the only two physicians in the Minnesota Legislature. MM

FROM THE CEO

Having a voice in MMA is easy and needed

As a membership organization, the MMA relies not only on members' dues for financial support; we also rely on members' input to drive our direction, policy, and impact.

The opportunities for involvement are numerous. Physician and medical student members across the state serve on committees and task forces to research, deliberate, and recommend public policy positions; support our role in accrediting organizations and institutions to deliver accredited CME; serve as mentors to students and residents; learn from our educational programs; network with colleagues at social events; advocate for their patients and profession by responding to legislative action alerts; educate legislators by attending Physicians' Day at the Capitol; contribute articles for publication in *Minnesota Medicine*; elect leadership; steward the organization as leaders and fiduciaries on the Board of Trustees; and more.

We also have made it easier for members to get involved in less formal ways. In 2020 the MMA launched The Pulse, an electronic policy development and polling tool designed to capture the opinions, comments, and ideas—the "pulse"—of members. Through The Pulse, members can submit policy proposals for consideration by the Board; provide input and comment on proposed policies from MMA committees and other members; and provide feedback on final policy decisions made by the Board of Trustees. Our goals were clear: (1) make it easy for every member to have a voice in the direction of their association, and (2) increase the number of member voices that inform our work.

I'm delighted to say that our goals are being met. In 2023, 555 unique MMA members voted on The Pulse proposals—a nearly 19% increase over the number in 2022. Particularly encouraging is the consistent growth in new engagement. The success of The Pulse in engaging more voices—in an easy and dynamic way—is also spreading to other states. The MMA has licensed base features of The Pulse to other state medical societies, including Indiana, Wisconsin, Wyoming, and Oregon. Each state has customized the tool to use in ways that meet its specific needs, and all agree that it is working to increase the number and variety of voices that inform their work.

THE PULSE
Minnesota Medical Association

Explore The Pulse here

The Pulse has helped to democratize MMA policy development. But it is not enough. We are committed to ensuring that the work we do on your behalf continues to reflect the needs and interests of Minnesota physicians. What challenges do you and your colleagues face in delivering safe, timely, high-quality care? What barriers do your patients experience in maximizing their health that are beyond your control? What keeps you up at night? The MMA wants to hear from you. Please share your thoughts by contacting me directly (jsilversmith@mnmed.org) or submitting your suggestions to mma@mnmed.org. **MM**

Janet Silversmith
JSilversmith@mnmed.org

VIEWPOINT

Another day, another dollar (gone)

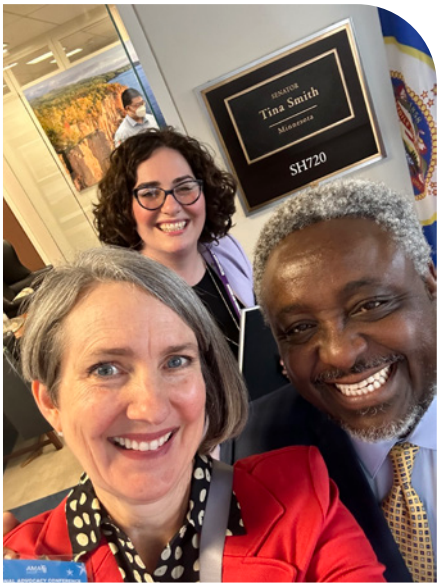
Kimberly Tjaden, MD
MMA board chair

Here we go again. Another year, another cut.

The Centers for Medicare and Medicaid Services (CMS) recently announced the new conversion factor for 2025 payments. Because of a flawed formula that requires budget neutrality, there is a scheduled 2.8% cut. This is on top of the 3.37% cut announced last year by CMS.

In the long term, Medicare physician payments have declined 29% from 2001 to 2024 when compared to inflation. Physician reimbursements are the only ones not to get at least an inflationary adjustment. In 2024 inpatient hospitals, outpatient hospitals, surgery centers, and hospice all received at least a 3% increase. The cost of practicing medicine, as measured by the Medicare Economic Index, increased 4.6%, yet reimbursements were cut by more than 3%.

This is not sustainable. Medicare physician payments are not keeping up with the increasing cost of providing care. And our work is certainly not diminishing or getting easier in any way.



MMA Board Chair Kimberly Tjaden, MD (left), President Laurel Ries, MD, and President-elect Edwin Bogonko, MD, MBA, lobbied for MMA priorities including higher reimbursement rates at Sen. Tina Smith's office in Washington earlier this year.

How are medical clinics expected to survive? Complex billing and documentation requirements can create significant administrative burdens for physicians, leading to increased overhead costs. Yet our patients covered by Medicare need clinics to provide their care.

It's not like this issue is going to fix itself. As baby boomers get older, there will be increased pressure on Medicare to adapt and ensure that payments are adequate to support the growing number of beneficiaries.

So, what are we to do? We need to continue lobbying Congress to stop yet another scheduled cut. We need to convince lawmakers to replace the flawed formula that results in physicians being the only group that does not receive an inflationary increase.

Work continues as the MMA partners with the AMA to urge Congress to fix this problem. In fact, I and other MMA leaders were in Washington, D.C., this past February speaking with members of the Minnesota Congressional delegation about this and other important topics that affect the practice of medicine in Minnesota. The voice of physicians matters!

You can find out more ways to influence legislators by visiting AMA's Fix Medicare Now website at https://fixmedicarenow.org. And then send a note at https://fixmedicarenow.org/take-action?vvsrc=/Campaigns/108965/Respond or use your phone's camera to scan the codes below.

AMA's Fix Medicare Now website

Send a note to members of Congress

Medicare physician payments are not keeping up with the increasing cost of providing care. And our work is certainly not diminishing or getting easier in any way. How are medical clinics expected to survive?

AMRIT B. SINGH, MBBS

Based in Mankato, Amrit B. Singh is an assistant professor of oncology, College of Medicine and Science, Mayo Clinic; a consultant, medical oncology and hematology, Andreas Cancer Center, Mayo Clinic Health System; chair, hematology-oncology, Mayo Clinic Health System Minnesota. He is president, Minnesota Society of Clinical Oncology.

When did you become an MMA member?

2012. I have served as trustee representing southwestern Minnesota since 2018 and have been secretary-treasurer since 2023.

Where did you grow up, do your undergraduate and grad work, medical degree?

I grew up in India and completed high school in 1973 at Mayo College Ajmer, which in those days was a boys-only boarding school. Did my medical school at Armed Forces Medical College Pune. Passed out of medical school in 1979, was awarded a bachelor of medicine and bachelor of surgery (MBBS) degree in 1980, and completed my post-grad in ophthalmology in 1989.

Joined the Indian Army in 1980 and served until 2001, including on multiple occasions at sites on the India-Pakistan and India-China borders that could be reached only by seven days of walking over mountainous terrain. Served in the Kargil War with Pakistan and was awarded multiple medals. Last served in the rank of lieutenant colonel.

I arrived in New York in 2001, worked as a "sandwich artist" in a Subway shop, moved on to work as a technician for a retina practice in New York while I studied for my United States Medical Licensing Examination.

Did my residency in internal medicine from 2005 to 2008 at Brookdale University Hospital and Medical Center in Brooklyn, where I was also the chief resident. Subsequently did my fellowship in hematology and oncology from 2008 to 2011 while I moonlighted in the hospital's ER.

Joined Mayo Clinic at Mankato in 2011.

Tell us about your family.

I married my wife, Rita, in 1984. In addition to being a strong, steadfast support to me (especially during my residency and fellowship) and our children, she has been an entrepreneur and has had multiple small businesses—most recently a UPS store at Mankato. We have two sons: Ustat in information technology with British Petroleum in Houston, along with his wife, Promita, and their daughter (our granddaughter), Nyla. Our second son, Jap, runs the UPS store.

Hobbies or side gigs?

Traveling, fish keeping, stamp collecting, and in my younger days, papier-mâché.

Why did you decide to become a physician?

I always had a fascination for the human body and its functions, and a deep desire to help others. In the 1970s in India, most children took either medicine or engineering. I always found science interesting, but physics was not my cup of tea.

What was the greatest lesson of your medical education?

The realization that the practice of medicine is as much an art as a science. I have realized how little we know about our human body. My practice in oncology has taught me the importance of empathy and understanding the patient beyond their symptoms.

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

Neither my medical education in India nor in the U.S. prepared me for the business of medicine, which encompasses reimbursement, insurances, pre-auth, etc., etc.

What's the greatest challenge facing medicine today?

Several—

- Healthcare access and equity: Disparities persist, influenced by factors such as social economic status, geography, and race.
- Burnout and workforce shortages: Increasing demands on healthcare professionals along with systemic inefficiencies have led to burnout, which contributes to workforce shortages.
- Healthcare costs: Containing costs while maintaining or improving quality of care is a complex and ongoing challenge.
- Aging population: This is leading to a higher prevalence of chronic conditions, increasing the burden on healthcare systems. This requires a shift towards geriatric care and chronic disease management.
- Integration of technology: Integrating new tools into everyday practice poses challenges, including ensuring data privacy, maintaining the human element of care, and addressing the digital divide.

How do you keep life balanced?

Taking time off. Luckily at Mayo my vacation time is based on age and can't be cashed. I use it to travel to meet friends and family.

If you weren't a physician—?

I cannot think of any other profession that I would have pursued. I find myself very comfortable talking and listening to patients. When patients do well, it always gives me a sense of satisfaction I cannot describe. It just keeps me going. This is the main reason I have not yet retired and continue to dedicate myself to the practice of medicine. MM

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