THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

MINNESOTA MEDICINE

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Retired family medicine physician and cofounder of the St. Peter Community Free Clinic.

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Family medicine physician at the Mayo Clinic Health System in Mankato.

Caring for rural and small-town neighbors

Volunteer physicians help remove barriers to healthcare by operating free clinics.

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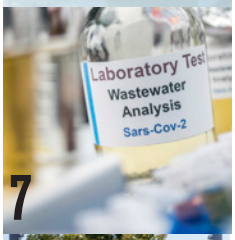

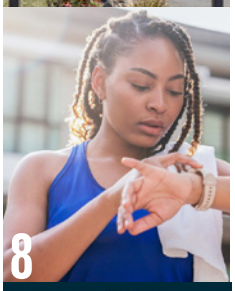

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Christopher J. Wenner, MD

Rural medicine in two words

"Hey, doc." It is the preferred greeting given to me by patients and nonpatients alike in my rural community. Certainly, I am addressed in this fashion in my clinic, but more often, it is when I am out-and-about.

"Hey, doc. There are easier ways to get your groceries home!" (When seen on a noontime ruck with a loaded backpack.)

"Hey, doc. When are you planting your tomatoes? (They know that I planted them before last week's frost.)

"Hey, doc. Get your deer yet?" (Anytime between September 15 and December 31).

I think people like to say it: "Hey, doc!" It is playful and uplifting, one can't help but smile a bit while uttering the words. I've never had anyone ride by on their bicycle and yell: "Hey, doc. You're an asshole!" (At least not with a frown on their face.) I rather enjoy the banter, the jocularity. With those two words, any pretense, formality or social hierarchy is immediately dispensed with. Respect is implied, but no deference given.

I rather enjoy the banter, the jocularity. Any pretense, formality, or social hierarchy is immediately dispensed with those two words. Respect is implied, but no deference given.

Being the recipient of a "hey, doc" highlights one of the many joys of being a small-town doc. (It is also infectious—using the shortened form of doctor). Yes, our urban cohorts are beneficiaries of this salutation; however, I would argue that rural folk are much more generous with this affable moniker, largely a product of the regular interactions with our patients outside of clinic. I may not be known formally by all members of my community, but most are aware of my profession, hence, the easy "hey, doc" when passing on the street.

Rural medicine is difficult. Obstacles in obtaining specialty care. An aging population. Declining Medicare and Medicaid reimbursements. Staffing shortages. My rural colleagues who still have a hospital practice are doubly challenged. Waiting for the radiology tech at 0300. Waiting for the surgeon to return the page. Waiting for the helicopter. Spouses understand that curbside consultations are often a part of going to the grocery store or to church with their physician partners. Anonymity is absent.

Yet despite these challenges, the career of a rural physician is singular and immensely rewarding. The profound gratitude of patients who can be treated locally. The great esteem and value placed on the profession and the professional. The interplay of office and community. The casual conversations on the price of a hundredweight of milk or if the sunnies are biting (but certainly not where). Spouses understand that curbside consultations often end with a proffering of garden produce, baked goods, or advice on the best time to plant tomatoes. Anonymity is absent.

Of the many intangible benefits of rural medicine, one stands alone, bearing joy and demonstrating familiarity, unity and trust: "Hey, doc." **MM**

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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Telemedicine's climate bonus

Telemedicine has remained popular with physicians and patients, even as the danger of COVID-19 has waned. Although not appropriate in every circumstance, virtual visits save time and trouble and solve problems for patients who don't have ready transportation.

Now, researchers have quantified another meaningful benefit: reducing the climate change impact of healthcare.

In a study reported in the *American Journal of Managed Care* in April, researchers from California, Washington, and Michigan used claims data and modeling to characterize the greenhouse gas emissions savings due to travel avoided by substituting telemedicine for in-person appointments. Extrapolating from data gathered for insured patients during a three-month period in 2023, they estimated that telemedicine saves 21.4–47.6 million kilograms of CO_2 per month—the equivalent of CO_2 emissions from some 61,000–130,000 conventional cars.

"The prime directive is always patient-centered, what is going to be best for that individual patient clinically, and there are times when virtual visits can be quite appropriate," says study co-senior author John Mafi, MD, MPH, associate professor of medicine at the University of California, Los Angeles. "If all things are equal, and it doesn't make a big difference whether the visit is in person or video, then there's a small benefit, which is that there seems to be modest reduction in carbon emissions."

Mafi and colleagues undertook the study because the COVID-era policy that expanded Medicare reimbursement for, and reduced restrictions around, telemedicine is in jeopardy. Legislation that broadened coverage was set to expire in March 2025, but Congress extended its provisions through the end of September. When it comes up for consideration once again, the paper's findings can offer one more reason to extend it.

"The debate has focused on how does this affect patient care, access, quality, and costs, but there's been really little attention, surprisingly, on other benefits and other consequences, such as the environment," Mafi says.

The study's authors encourage those making decisions affecting telemedicine reimbursement to "recognize the positive environmental impact of telemedicine utilization when considering future policies that might impact access to, and reimbursement of, telemedicine." In a similar vein, physicians and patients themselves could keep climate benefits in mind when choosing how and when to make telemedicine part of their healthcare relationship.

"Nine percent of the carbon emissions come from the healthcare system, and transportation is a big part of that," Mafi says. "There is compelling evidence that climate change affects the health of the public, and that affects all of us, really. So I think any little way in which we can find ways to deliver care that's more carbon neutral or more carbon efficient that doesn't harm patient care is a good thing."

Nearly one-third of Minnesotans used telehealth services during a 2021–23 study period, according to the Minnesota Department of Health. One in five primary care visits took place remotely in the state in 2021–22, up from 3% in prepandemic 2019, similar to the rest of the nation. Because Minnesota reflects nearly 2% of private registered vehicles nationwide, Mafi's back-of-the-envelope calculations suggest that telemedicine at 2023 levels could translate into greenhouse gas emission savings equivalent to taking roughly 1,000–2,000 conventional cars off the road.

Studies in Minnesota and elsewhere suggest that increased use of telemedicine since the COVID-19 pandemic hasn't increased healthcare costs or decreased patient satisfaction or quality of care. MDH continues to encourage payment parity and equitable access. The Minnesota Medical Association also advocates for insurance coverage for telemedicine.

– Mary Hoff

Wastewater surveillance accurately predicts community COVID-19 infections

Measuring SARS-CoV-2 in wastewater continues to accurately predict COVID-19 infections in a community, according to a University of Minnesota research study published in *The Journal of Infectious Diseases*.

Between January 2022 and August 2024, the research team examined the correlation between symptomatic COVID-19 in healthcare employees and levels of the virus that causes COVID-19 in wastewater. They found that virus levels in wastewater accurately predicted subsequent COVID-19 case counts the following week in the community.

"We learned during 2020 that rising SARS-CoV-2 virus in wastewater provided a two-week heads up of coming COVID visits to hospitals and clinics," says Timothy Schacker, MD, a professor at the University of Minnesota Medical School and an infectious disease physician with M Health Fairview. "This ongoing work demonstrates the continued importance of wastewater surveillance to public health planning for our state's hospitals and clinics."

The University of Minnesota continues to monitor COVID-19, influenza, RSV, mpox, and measles in the wastewater through its Wastewater Surveillance Study.

–University of Minnesota Medical School

Minnesotans broadly support Medicaid in new survey results

Most Minnesotans support Medicaid (known in Minnesota as Medical Assistance) and providing health insurance to people in need, according to a new statewide survey by the Health Economics Program of the Minnesota Department of Health. Nearly three quarters of respondents (72%) said that Medicaid was "very important" to people in their local community. Support for Medicaid was seen across all demographics and all areas of the state.

The Minnesota Opinions about Medical Assistance (Medicaid Opinions) survey was completed by about 2,000 people in the spring of 2025. The survey reconnects with participants of the Minnesota Health Access Survey (MNHA), which is conducted in partnership by the Minnesota Department of Health (MDH) and the Statewide Health Access Data Assistance Center (SHADAC) at the University of Minnesota.

Key findings from the survey include:

- A strong majority of respondents (93.3%) supported providing coverage through the government to people who lose job-related coverage.
- Eight of 10 respondents opposed reducing the amount of money the federal government currently puts toward Medicaid expansion.
- Respondents were split on whether they supported requiring everyone who is working age on Medicaid to be working or looking for work. Opinions shifted somewhat when people were told more about the potential impacts of this kind of policy. This includes evidence showing work requirements are expensive to administer, have little impact on employment, and result in eligible people losing insurance because the process is confusing.

–Minnesota Department of Health

10,000 steps a day? Maybe 7,000 will do, according to study

The common adage that people should aim to take 10,000 steps a day for good heath is based on marketing, not medical research. But the advice isn't far off, according to a recent meta-analysis in *The Lancet*, which reported that 7,000 steps per day is associated with clinically meaningful improvements in health outcomes and might be a "more realistic and achievable target."

The study synthesized the prospective dose-response relationship between daily steps and health outcomes including all-cause mortality, cardiovascular disease, cancer, type 2 diabetes, cognitive outcomes, mental health outcomes, physical function, and falls. According to the report, "for all-cause mortality, cardiovascular disease incidence, dementia, and falls, an inverse nonlinear dose-response association was found, with inflection points at around 5,000–7,000 steps per day. An inverse linear association was found for cardiovascular disease mortality, cancer incidence, cancer mortality, type 2 diabetes incidence, and depressive symptoms."

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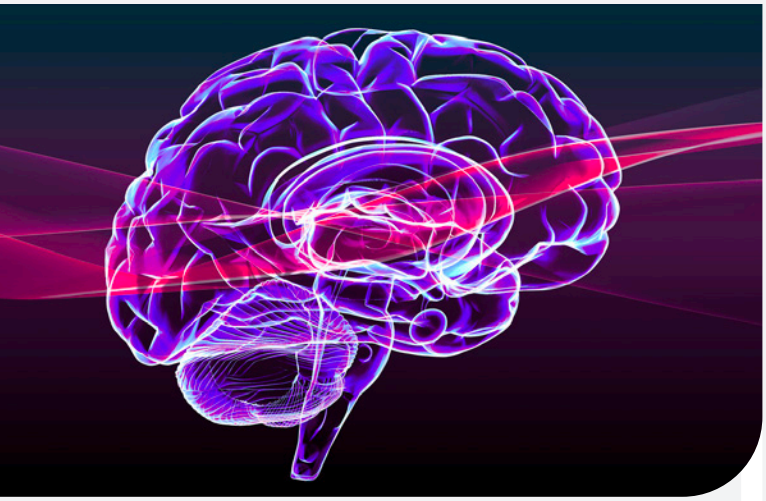

Mayo Clinic AI tool identifies 9 dementia types with one scan

Mayo Clinic researchers have developed a new artificial intelligence tool that helps clinicians identify brain activity patterns linked to nine types of dementia, including Alzheimer's disease, using a single, widely available scan.

The tool, StateViewer, helped researchers identify the dementia type in 88% of cases, according to research published online on June 27, 2025, in *Neurology*, the medical journal of the American Academy of Neurology. Researchers trained and tested the AI on more than 3,600 scans, including images from patients with dementia and people without cognitive impairment.

This innovation addresses a core challenge in dementia care: identifying the disease early and precisely, even when multiple conditions are present. As new treatments emerge, timely diagnosis helps match patients with the most appropriate care when it can have the greatest impact.

Dementia affects more than 55 million people worldwide, with nearly 10 million new cases each year. Alzheimer's disease, the most common form, is now the fifth-leading cause of death globally. Diagnosing dementia typically requires cognitive tests, blood draws, imaging, clinical interviews, and specialist referrals. Even with extensive testing, distinguishing conditions such as Alzheimer's, Lewy body dementia, and frontotemporal dementia remains challenging, including for highly experienced specialists.

StateViewer was developed under the direction of David Jones, MD, a Mayo Clinic neurologist and director of the Mayo Clinic Neurology Artificial Intelligence Program.

The tool analyzes a fluorodeoxyglucose positron emission tomography (FDG-PET) scan, which shows how the brain uses glucose for energy. It then compares the scan to a large database of scans from people with confirmed dementia diagnoses and identifies patterns that match specific types, or combinations, of dementia.

–Mayo Clinic

Report: More docs working at practices owned by hospitals or private equity groups

Physicians continue to move away from private practices and increasingly work at practices owned by hospitals or private equity groups, according to the latest AMA analysis.

Physicians reported that the key factors driving this change include inadequate payment rates, costly resources, and burdensome regulatory and administrative requirements.

"After adjusting for inflation in practice costs, Medicare physician payment has fallen 33 percent over the past quarter century, which has severely destabilized private practices and jeopardized patients' access to care," says AMA President Bruce A. Scott, MD. "Payment updates are necessary for physicians to continue to practice independently."

According to the analysis, the share of physicians working in private practices in 2024 was 42.2%, compared with 60.1% in 2012. Private practices now account for less than half of physicians in most medical specialties, ranging from 30.7% in cardiology to 46.9% in radiology. Exceptions included orthopedic surgery (54%), ophthalmology (70.4%), and other surgical subspecialties (51.2%).

In contrast, the share of physicians working in hospital-owned practices in 2024 increased to more than one-third (34.5%), compared with 23.4% in 2012. Twelve percent of physicians were employed directly by a hospital (or contracted directly with a hospital), double the share (5.6%) in 2012.

In 2024, 6.5% of physicians characterized their practice as private equity-owned, higher than the shares in 2020 and 2022, which were both around 4.5%, the report notes.

Among independent physicians who sold their practices in the last 10 years to a hospital, private equity firm, or insurer, the most cited reason was inadequate payment rates (rated as important or very important by 70.8% of physicians). Next was the need to improve access to costly resources (64.9%) and better manage payers' regulatory and administrative requirements (63.6%).

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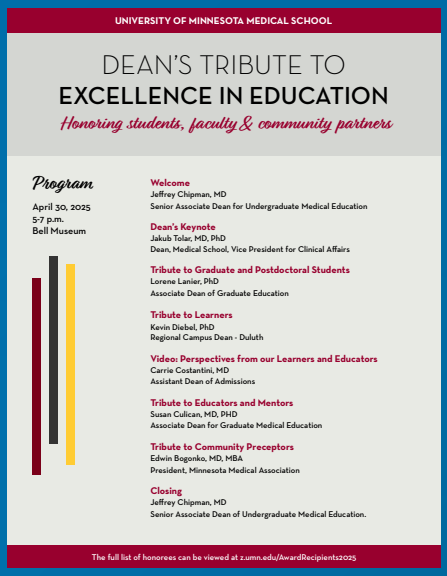
A Thank You to Our Dedicated Community Preceptors!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Tribute to Community Preceptors
Edwin Bogonko, MD, MBA
President, Minnesota Medical Association

Closing
Jeffrey Chipman, MD
Senior Associate Dean of Undergraduate Medical Education.

The full list of honorees can be viewed at z.umn.edu/AwardRecipients2025

In 2025, the MMA, in partnership with the University of Minnesota Medical School, once again sponsored the "Exceptional Primary Care Community Faculty Teaching Award" at the Dean's Tribute to Excellence in Education Event.


Ryan McFarland, MD


Sarah McFarland, MD

2025 Exceptional Primary Care Community Faculty Teaching Award Recipients

From the MMA

"The role of teacher is one of the most important roles that a physician can take. Thank you, Dr. Ryan McFarland, and Dr. Sarah McFarland, for inspiring the next generation of physicians to go into a career in primary care, and for serving as a model of professionalism for so many."

EDWIN BOGONKO, MD, MBA, MMA PRESIDENT

From the University of Minnesota Medical School

"Health education can't be done without the dedicated service of community partners. We honor and greatly appreciate the contributions of these faculty members. Teaching the next generation of physicians is a testament to their profession and undoubtedly reflects the care they provide for patients. "

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Community Preceptor Toolbox

The MMA, in partnership with the University of Minnesota Medical School, has created a set of tools and resources to improve the training and support for clinical preceptors. **Visit our Community Preceptor Toolbox to learn more!**

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Presented by the **MMA Preceptor Initiative**, a partnership between the MMA and the University of Minnesota Medical School.

Adverse health events increase slightly in latest MDH data

The latest adverse health events data issued by the Minnesota Department of Health (MDH) in late June showed a small increase in preventable errors.

After recording unprecedented increases that saw the number of annually reported adverse health events jump more than 66% from prepandemic levels between 2020 and 2023, Minnesota hospitals and ambulatory surgery centers reported a total of 624 events in 2024, up 14 from 2023. It is the smallest increase in preventable errors since adverse events actually fell between 2018 and 2019.

"We are glad to see the rate of increase in the number of adverse health events beginning to slow," says Minnesota Health Commissioner Brooke Cunningham, MD, PhD. "Thankfully, these types of patient harms continue to be rare when viewed against overall volume. However, we believe many, if not most, of these events are preventable, and we are committed to working with providers through education and analysis to advocate for patient safety."

MDH's adverse health events data report includes records collected from healthcare providers from October 7, 2023, to October 6, 2024. In addition to the modest rise in total adverse health events, the data also revealed that preventable errors that resulted in severe injury or death remained steady at 238. It is the same total recorded in 2023; however, there were two fewer deaths (14). This marked a second straight year with a decline in deaths, which peaked at 21 in 2022.

A portion of Minnesota's adverse health events in 2024 can be attributed to the elevated level in the length of patient hospital stays that Minnesota continues to experience, which increase the risk of experiencing an adverse health event, and a rise in the number of surgeries performed. The high level of lengths of stay can stem from things like increased patient complexity due to delayed care, Minnesota's aging population, systemic issues with discharge delays, and limited bed availability at the next level of care due to continued workforce challenges. Minnesota also reported an 8.5% jump in the number of surgeries performed in 2024, with procedures rising to 621,205 from 572,031, which may have impacted the rise in the number of wrong body part and wrong procedure errors.

As with previous adverse event data reports produced by MDH, pressure ulcers and falls were the most common events reported and were reported in similar numbers to 2023.

Minnesota's mandatory adverse health event reporting system requires hospitals, licensed ambulatory surgical centers, and community behavioral health hospitals 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.

CMS warns physicians of fraud schemes

The Centers for Medicare and Medicaid Services (CMS) is warning physicians and practices about fraud schemes that are increasingly targeting Medicare providers.

Bad actors are impersonating CMS officials and sending phishing fax requests for medical records and documentation, falsely claiming to be part of a Medicare audit.

Email phishing attacks are still a common occurrence, but CMS is now hearing about more fraudulent fax requests being sent out to medical practices.

CMS emphasized that it does not initiate audits by requesting medical records via fax. Physicians and practices are urged to take steps to protect their data. If physicians receive a suspicious request, do not respond. CMS encourages you to work with your Medical Review Contractor if you receive a questionable or suspected fraudulent fax request to confirm its validity.

Up for interpretation

One physician's enthusiasm for in-person medical interpretation led to a research study.

BY ANDY STEINER

Katie Freeman, MD, says that one of the best things about her job is the community she serves in St. Paul's Frogtown neighborhood. "It's an awesome neighborhood with deep history, good diversity, access to services and programs," says Freeman, a physician at M Health Fairview Bethesda Family Medicine Clinic.

Half of Freeman's patients have arrived in the United States within the last 15 years. For many, English is a second language, and some 40% request a medical interpreter during their appointments. Some patients bring along English-speaking family members or friends to interpret during their visits.

Freeman particularly enjoys working with this population and feels like it gives her an opportunity to connect to a community outside of her own. "What I love about serving refugees and immigrants is you get to know the whole family and help everyone learn about where they can get the help they need," she says. "In family medicine, I serve everyone from birth to grave."

Medical interpreters have always played a critical role at Bethesda Family Medicine, Freeman says. Before COVID-19, those interpreters nearly always worked in person. Then, when the pandemic hit, M Health Fairview, like other health networks across the state, began providing most medical interpretation services remotely—with interpreters working offsite, joining the visit by telephone or video platform like Amwell.

While she appreciated this pandemic-driven switch, Freeman held out hope that once the world returned to normal, the way her clinic worked would return to normal, too, going back to in-person medical interpreting—an approach she felt was more useful and safer for patients—since she felt that when interpreters are in the room and can clearly see what's happening, they are less likely to misinterpret what is going on between the doctor and the patient.

But, after COVID's most acute risks subsided, and patients returned to the clinic for face-to-face appointments, the number of in-person medical interpreters never returned to prepandemic levels, Freeman says. While her clinic is required by law to provide medical interpreters for all patients who request the service, she says the lower cost of remote medical interpreting means that system and health plan leaders still encourage the use of remote interpreting during most clinic visits. "Because interpreters don't have to travel and can quickly jump from patient to patient when they are remote, it is cheaper," Freeman explains. "When they are remote, you can pay interpreters by the minute instead of by the hour."

Freeman, who also sees patients and attends births at Woodwinds Hospital in Woodbury, says that remote medical interpreting feels inferior to an in-person approach. While she still has access to in-person medical interpreters at Bethesda clinic, nearly

all medical interpretation at the hospital is remote, she says. "You see a stark contrast in how it feels to interact and communicate with people in the hospital in Woodbury versus how it feels in the clinic in St. Paul."

And it's not just what Freeman sees as the inconvenience of working with a remote medical translator. She says that there are times, as in the delivery room, when having to rely on remote translation feels risky—for herself and her patients.

"In certain situations, it can be very scary and dangerous," Freeman says. "Fortunately we haven't yet had a bad outcome when a patient is doing very poorly, but it could be bad."

Making the case

Freeman believes that in-person medical interpreting makes such a difference in patient care that she decided to take her argument to system and hospital administrators. The response, she says, was less than enthusiastic.

"When I tried to ask for better support for in-person interpreters, I was told that the data said that remote interpreters, especially with a video, are just as good as interpreters in person," Freeman says. She looked into the research, but still felt skeptical. "I didn't really believe it, because it didn't match the reality of what I see every day."

Because she is a scientist by training, Freeman decided to create her own research study that would take a deeper look into the benefits and drawbacks of in-person versus remote medical interpreting. "I wanted to do this because I'm biased and I think we provide better healthcare when interpreters are here in person. I wanted to see if this is really the case," she says.

Freeman designed a qualitative research study, which she conducted with a team of six researchers, including University of Minnesota faculty, working physicians, medical students, and public health professionals, all whom she'd met while working on a health-equity group.

Freeman says that her team felt that while the research in the earlier study was sound, they agreed that the researchers weren't asking the right questions: "The data collected looked at patients who spoke specific languages and worked with consistent interpreters."

She explains that researchers conducting the earlier study asked patients to rank their experience on a 1-to-5 scale, which she feels didn't offer enough room to capture the nuance of the situation. "The patients ranked both the in-person and remote interpreters equally, but I don't think that's the best way to measure the importance of that interpreter and the complex work they do."

Freeman's team instead wanted to focus their research on interviews with patients who speak a range of languages and have worked with multiple interpreters. But hurdles, such as the cost of translation for research, made the team instead decide to focus their research on the experience of medical interpreters, a subject group that did not require translation.

They conducted five virtual focus groups that included three to six interpreters per session. Researchers asked study participants about what medical interpreting was like during COVID and about the differences between interpreting in-person and virtually. They also asked about ways to improve the patient experience and how healthcare systems could better serve interpreters.

"Our focus groups on the whole felt that in-person interpreting was superior to remote interpreting in most situations," Freeman says. But there were some situations, she continued, including those when patients have histories of trauma and prefer that their experiences feel more private, or when the weather is bad and travel is a concern, when, she said, "remote is a really good option."

This insight, Freeman admits, came as a surprise. "I thought I'd find that in-person interpreting is always best," she says. But study subjects helped open her mind: "I learned from interpreters, who think that remote, though not as good as in-person, is still super-important."

The team's research was summarized in an as-of-yet unpublished paper, titled, "Virtual and In-Person Interpretation: A Qualitative Study from the Perspective of Professional Medical Interpreters." The paper is undergoing peer review for the journal *Family Practice*. The team plans to write two more papers about their research, one about the interpreter experience during COVID, and another about the scope of the interpreter role, including how it's defined and integrated within healthcare systems.

Freeman and her team hope their work will spark discussion about the key role medical interpreters play in patient care. "I want more people having conversations about how they can support interpreters and how important they are to medicine," she says. MM

Andy Steiner is a Twin Cities freelance writer and editor.

"When I tried to ask for better support for in-person interpreters, I was told that the data said that remote interpreters, especially with a video, are just as good as interpreters in person. I didn't really believe it, because it didn't match the reality of what I see every day."

KATIE FREEMAN, MD
M HEALTH FAIRVIEW BETHESDA FAMILY MEDICINE CLINIC

Carolyn Stelter, MD
Retired family medicine physician and co-founder of the St. Peter Community Free Clinic.

Keith Stelter, MD
Family medicine physician at the Mayo Clinic Health System in Mankato.

PHOTO BY RICH RYAN PHOTOGRAPHY

Caring for rural and small-town neighbors

Volunteer physicians help remove barriers to healthcare by operating free clinics.

BY SUZY FRISCH

People struggle to get access to healthcare for many reasons, from a lack of insurance to sky-high deductibles to costly medications. In rural communities across Minnesota, physicians help operate free clinics to remove some of these barriers for neighbors.

Along with the satisfaction of assisting people in need, many of the volunteer physicians enjoy providing medical care without the hoops they must jump through in more conventional settings. Free clinics often run leaner without electronic medical records, prior authorizations, and other insurance roadblocks that impede physicians' ability to treat people.

"It boils down to why you became a doctor in the first place," says Carolyn Stelter, MD, a retired family medicine physician and co-founder of the St. Peter Community Free Clinic. "On a very basic level you don't have all of the bureaucracy. You are seeing one patient at a time, helping out one person at a time. That can be very refreshing."

Stelter and her husband, Keith Stelter, MD, started the clinic in 2019 inside St. Peter's food shelf. Keith Stelter, a family medicine physician at the Mayo Clinic Health System in Mankato, was inspired to help people who lost control of their chronic diseases because of lapses in insurance coverage. After patients were laid off and uninsured, they had to take multiple steps to get vital medications restarted, including costly lab work and an office visit. This delay—and the expense—often caused conditions like diabetes and high blood pressure to run rampant.

"I had patients in my practice where their medical conditions were controlled when they had medication and access to insurance, and without medication their diabetes fell out of control," Keith Stelter says. "I thought there should be a different way that people can have a safety net clinic or a place to go when they are between insurance or their Medical Assistance paperwork hasn't come through yet. We could at least bridge them for a while and maintain their chronic disease in a controlled state."

Across the state, volunteer physicians at free rural clinics play a critical role in ensuring that people don't go without basic medical care. They serve as providers for uninsured, underinsured, and underserved people, both filling pressing needs and connecting individuals to additional resources. The clinics are typically run by volunteers, including practicing and retired physicians, advanced practice providers, nurses, phar-

macists, dentists, mental health counselors, interpreters, and other area residents.

By and for the community

Red Wing's CARE Clinic got started in 2010, offering residents of Goodhue and Wabasha counties a broad range of free services. "Our vision is to be a clinic for the community provided by the community," says Executive Director Julie Malyon, RN-BSN, a cofounder. "Our main goal is to help people improve their health, and we're able to accomplish that. It's a very welcoming and inclusive place. Our patients are very grateful for this care, and the volunteers love the clinic so much—everyone is very happy to be here."

The idea came from a group of southern Minnesota physicians, nurses, nurse practitioners, psychologists, a pastor, and others who went on a mission trip to Mississippi after Hurricane Katrina. While there, they volunteered at a free clinic. During the trip, they started brainstorming about opening a similar clinic in Red Wing. Pediatrician Dann Heilman, MD, enjoyed the volunteer work but was skeptical that Red Wing had a sustained need for free services. A needs assessment found that about 3,000 people in Goodhue County lacked insurance.

Then the case of a single father with chest pains convinced Heilman to help launch CARE Clinic. The father wouldn't go to the emergency room out of fear about the cost and later died from cardiac arrest. "The lesson was that even though emergency rooms are available, many people are too proud to build up a debt they can't pay," Heilman says. "I was on board with the whole idea after that."

Now retired, Heilman initially took on the role of medical director and reduced his hours as a pediatrician at Fairview Red Wing to 75%. CARE began with walk-in medical services one evening a week, with a commitment to providing free care and medications. "It's not great to be diagnosed with diabetes and then get handed a prescription for $1,000 that people can't afford," Malyon says. A partnership with a local pharmacy for discounted prescriptions, paired with patient assistance programs through pharmaceutical companies, made that possible. Fairview Health Services provided the clinic with medical space, as did Mayo Clinic after it bought the building.

In some rural communities, established health systems provide free care to residents. That's the case with CentraCare's Project H.E.A.L. (Health, Education, Access, Link). CentraCare started Project H.E.A.L. in 1999, acknowledging that it's important to reach people outside of hospital and clinic walls and offer care that targets specific needs in a community, says Dani Protivinsky, DrPH, MPH, MBA, senior director of health equity and community health improvement at CentraCare.

Project H.E.A.L. now has many access points and sites in St. Cloud, plus locations in Melrose and Long Prairie, where it provides free monthly outreach services. It also offers care at other locations like

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Keith Stelter, MD
Family medicine physician
Mayo Clinic Health System, Mankato

PHOTO BY RICH RYAN PHOTOGRAPHY

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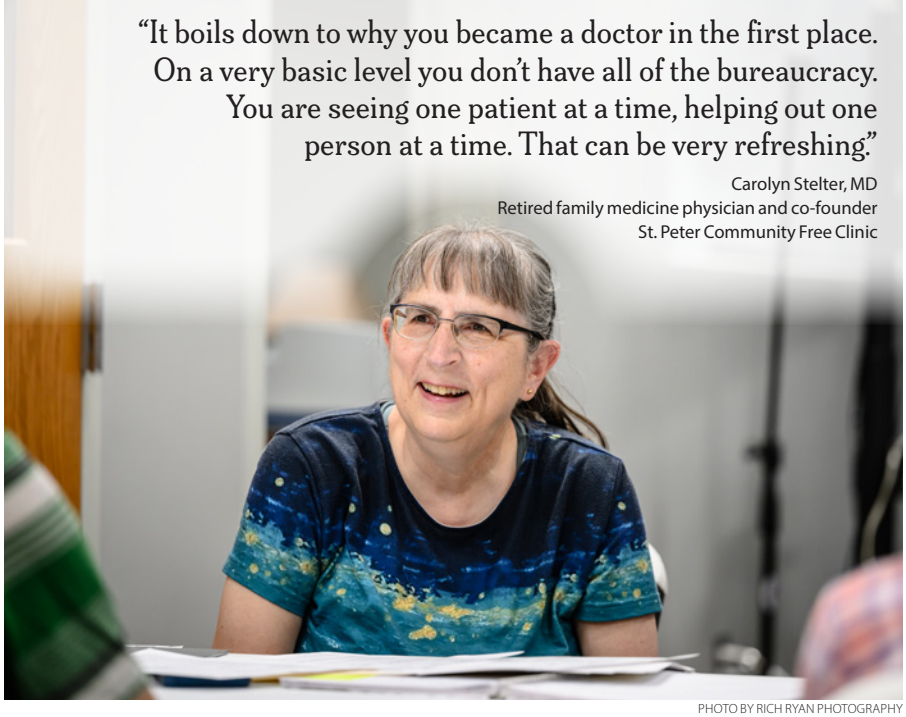

PHOTO BY RICH RYAN PHOTOGRAPHY

Abdi Jibril, MD (left), and Feisal Yussuf, MD (right), residents in Mayo Clinic Family Medicine Residency, meet with a patient and interpreter at St. Peter Community Free Clinic.

PHOTO BY RICH RYAN PHOTOGRAPHY

pop-up events and health fairs, and it partners with public health departments in nine central Minnesota counties stretching from Monticello to Redwood Falls.

"Project H.E.A.L. is designed as an equitable access point for individuals and families across all the rural areas we serve," Protivinsky says. "The primary goal is to break down barriers to care for underserved communities and help address the challenges when individuals have barriers that are impacting their care."

That might mean offering basic care and health screenings where many residents don't have connections with primary care providers. It also involves helping people navigate the healthcare system to find the services they need, whether that's medical care, social work, mental health treatment, or financial assistance.

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Julie Malyon, RN-BSN
Executive Director and co-founder
CARE Clinic, Red Wing

CentraCare uses population health data and community needs assessments completed every three years to understand the urgent challenges in its region. Then Project H.E.A.L. determines how it can help most effectively. These approaches identify high rates of health conditions or community-specific needs, including language barriers or limited access to medical or mental health services. "We continue to evolve to meet the needs of the community," Protivinsky says.

Through Project H.E.A.L., CentraCare has connected people with insurance and other internal and external services, including transportation to appointments and community paramedic medication management—a common service in rural areas that assists with chronic disease monitoring and ensuring that people are properly taking their prescriptions. Project H.E.A.L. has provided care to about 500 people, with 38 CentraCare employees volunteering their services in the last year, Protivinsky says.

Connections and care

Free clinics provide a range of services, often taking care of patients' immediate needs and finding resources to address other contributors to poor health. Soon after CARE Clinic opened, its leaders recruited Spanish-speaking psychologists to provide therapy. Next CARE began providing dental care with its extraction services. When it moved to a new building in 2019, the clinic added other treatments like cleanings, X-rays, fillings, fluoride, and sealants. Paid staff provides dental care four days a week.

It was important for CARE to add dental services because Goodhue County previously was ranked the third-worst in Minnesota for providing at least one annual visit for people on Medical Assistance, Malyon says. Many people on Medicaid struggle to find dentists that accept their insurance, so they often forgo care. CARE accepts Medical Assistance and MinnesotaCare for dental services and charges low fees for others who qualify. A mobile dental unit also treats school-age children and group-home residents. "Many people don't realize that good dental care is part of overall health," Heilman says.

The St. Peter and CARE clinics have volunteers who help people enroll in insurance programs. When patients have more complex conditions, the clinics connect them to other free clinics with broader services or community health centers, like Open Door Health Center in Mankato. The St. Peter clinic also has a strong relationship with River's Edge Hospital in town. With a referral from the free clinic, the hospital provides a complete set of lab work for patients as part of its community outreach, Keith Stelter says.

The Stelters purposely located the clinic at St. Peter's food shelf to make it convenient for people to access a range of resources. The clinic sees a 50-50 mix of regular patients and walk-ins, with providers taking care of about 25 to 30 people with chronic conditions like diabetes who don't qualify for insurance. Every year, the clinic helps more than 100 people. "It's not a lot, but the ones we help, we really help," Carolyn Stelter says.

The St. Peter clinic offers health exams and treats patients for minor injuries and acute illnesses, testing and care for chronic conditions like high blood pressure and depression, labs, and either free medicines through Roundtable Rx or coverage for half the cost of medications (patients pay the rest). Similarly, CARE patients receive

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Dani Protivinsky, DrPH, MPH, MBA
Senior director of health equity and community health improvement
CentraCare

preventive screenings and treatment for acute problems including upper respiratory or skin conditions, chronic diseases, musculoskeletal problems, and mental health concerns. When the clinic has at least four patients in need of a specialist, CARE hosts an evening targeted for that care, such as orthopedics, OB-GYN, optometry, and podiatry, Malyon says.

Another benefit of free clinics is that they provide training for college students, medical students, and residents. Project H.E.A.L. soon will offer clinical rotations to medical students at the University of Minnesota Medical School's CentraCare Regional Campus in St. Cloud, which opens its doors this fall. Members of the medical careers club at Gustavus Adolphus College volunteer at the St. Peter clinic, staffing the front desk and putting their Spanish skills to use. In addition, residents from Mayo's family medicine residency in Mankato help staff weekly shifts in St. Peter to get more hands-on experience in a community setting. CARE has a Dual-Training Pipeline Program in partnership with the Minnesota Office of Higher Education and Department of Labor and Industry that provides $6,000 a year in tuition support for each employee to build a more diverse clinic workforce; patients of the clinic have become staff at the clinic. CARE also provides weekly clinical rotations for Augsburg Doctor of Nursing Practice students.

Keith Stelter had asked residents if they would be interested in volunteering at the clinic, and he got an enthusiastic yes. "It's really a learning opportunity. We're a team and we work together and talk about the best therapy or how we can meet patients' needs," he says. "They get to see unique challenges in people who don't have good access to care when we're not working in a Mayo facility that has almost everything under the sun."

Why volunteer?

Volunteers are a key component of successful free rural clinics. CARE currently has 100 volunteers, including providers, lab technicians, and administrative staff. Together, the clinic had nearly 8,200 patient encounters in 2024, and 42,000 total since it started 15 years ago. In St. Peter about nine volunteers—including doctors, nurses, and interpreters—attend weekly, contributing a total of 400–540 hours per year, Keith Stelter says.

Many physician-volunteers report enjoying being able to talk at length with patients about their needs, then providing care and education, Malyon says. It's a bonus that they are helping people who lack access to health services. Some doctors are retired and like being able to continue using their skills. "I think it also allows them to practice medicine without all of the administrative trappings that go along with their daily work," Heilman says. "It's more gratifying knowing that the services they are providing are free of charge. That has a certain amount of positive feedback for them, and that's key."

Keith Stelter appreciates being able to provide streamlined care with simple charting and spend time with each person. "You feel like you are making a real difference in someone's life," he says. "Also, patients are extremely grateful, and it's very refreshing that way."

For information on volunteering at clinics for underserved people, go to: https://www.mnmed.org/about-us/mma-foundation/our-initiatives/physician-volunteerism

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Dann Heilman, MD
Pediatrician
CARE Clinic, Red Wing

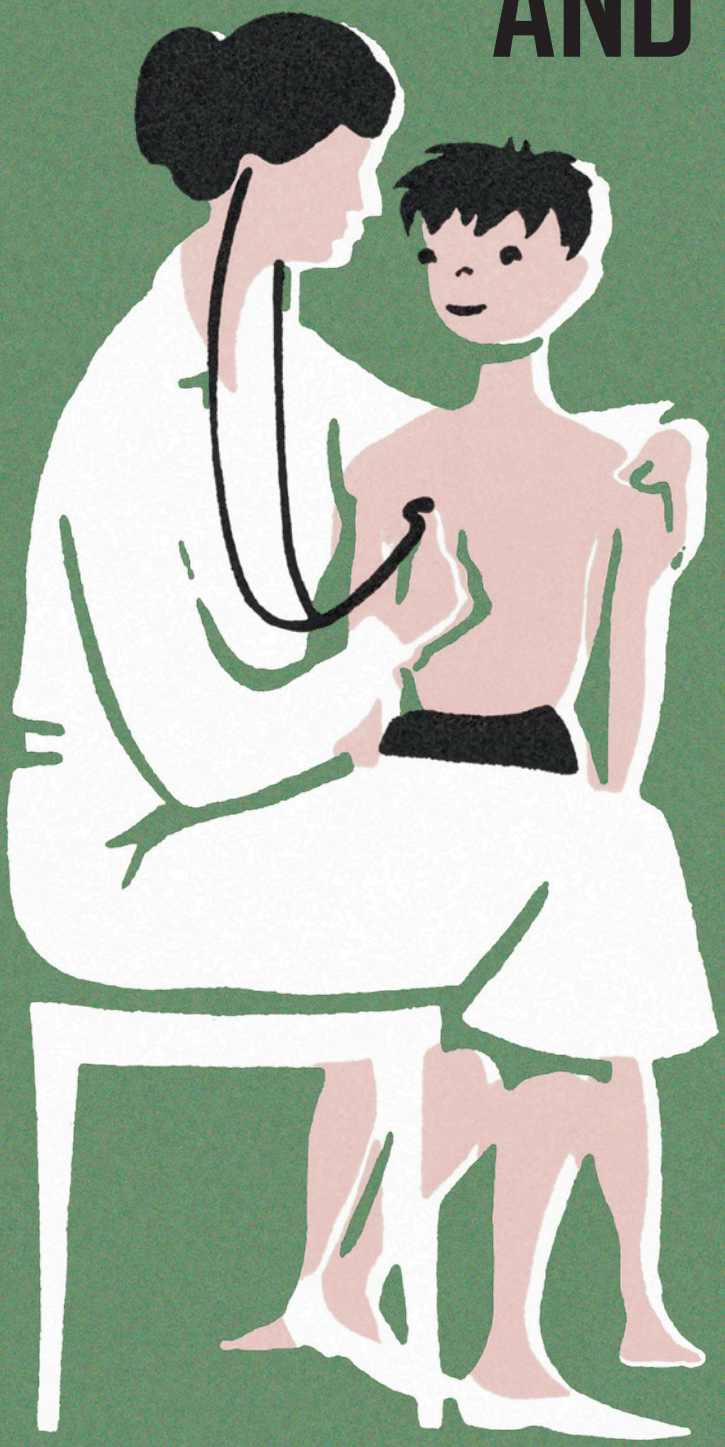
Project H.E.A.L. volunteers include retirees and current practitioners who want to give back to the community. Many serve at community sites because they are passionate about health equity, Protivinsky says. "We have individuals who want to be more visible in their community rather than just being in a clinical setting," she adds. "And in the last five years at CentraCare, we've really seen this shift in our workforce—a real yearning to be culturally aware of the patients they are seeing. When they see more patients from a population, they want to know more about them."

For physicians intrigued by the idea of providing free care to people in need, the Stelters encourage them to consider contributing their talents. "Starting the clinic was a lot easier than I ever imagined. It does take some work to maintain it, but it doesn't have to be grand," Carolyn Stelter says. "It can be having a weekly blood pressure–diabetes check. You don't have to provide all of these services. If there is a need in the community, just do it."

Keith Stelter adds that running a free clinic mainly involves developing a base of volunteers who are committed to helping on a regular basis. "It's not as hard or onerous as one might think," he adds. "If you're looking for a direct way to help your community that's really rewarding, you should think about starting a free clinic." MM

Suzy Frisch is a Twin Cities freelance writer.

Rural rigors AND rewards



The challenges facing physicians in rural communities are many and growing, but help is on the way.

BY SUZY FRISCH

Family medicine physician Jan Baldwin, MD, is steeped in the challenges—and opportunities—of providing full-spectrum care to residents on the Iron Range. Wait times to get appointments with her in Hibbing are long, even with Baldwin routinely taking more patients than available schedule slots. Yet despite high demand for care, it's a constant struggle to recruit more doctors to the area.

Having practiced in the region for more than 30 years, Baldwin exemplifies what it means to have a longitudinal practice. It's not uncommon for her to see patient families with four or five generations represented, giving her intimate knowledge of their histories and preferences. She also knows that when medical students, residents, and physicians get a taste of rural medicine, they often find it as appealing and gratifying as she does.

"I love what I do. What I really like is the connectedness," says Baldwin, an Essentia physician who provides family medicine with obstetrics at its Hibbing clinic and Fairview Range Medical Center. "Some of the babies I now deliver are the babies of the babies I delivered many years ago. A couple patients this morning said, 'You feel like part of our family.' It's because I've been there for births, for deaths, for tragedies, and for joys, and you walk with these people. They don't have to explain themselves anymore."

Even with its rewards, the work of providing medical care in rural areas can be difficult and unrelenting, with intersecting, complicated factors woven into the landscape. From providers who are stretched too thin caring for unhealthier patient populations to steadily declining financial pictures, rural health care is in a precarious position. Many in healthcare fear the financial and other pressures in rural areas will only get worse if Congress approves its proposed cuts to Medicaid—estimated to cost Minnesota $500 million annually, according to John Connolly, deputy commissioner of the Minnesota Department of Human Services. Such cuts could lead to fewer places for people to get healthcare as hospitals and clinics close locations to stem their losses.

Raymond Christensen, MD, associate dean for rural health at the University of Minnesota Medical School Duluth Campus, has been steeped in family and rural medicine for more than five decades. To him, many of the challenges of rural medicine—like not having enough physicians—are timeless while other obstacles have emerged more recently.

"When we say today that it takes two new people to replace each physician, that has not changed. What has changed is that every time there is healthcare reform, there is a new layer of bureaucracy," such as changing the way reimbursements are handled or pouring resources into doing numerous studies that don't lead to improvements, Christensen says."For those on the front lines, those layers of bureaucracy chew up a lot of providers' time. Another factor is electronic medical records. You're never done with charting, and it just goes on forever."

In rural areas, the need for more physicians is a constant pressure. The United States faces a projected shortage of 87,150 full-time primary care physicians by 2037, reports the federal Health Resources and Services Administration. This shortfall will have an outsize impact on rural communities. In Minnesota, a disproportionate number of physicians practice in rural areas—just 4.4% of the state's physicians treat the 15% of Minnesotans living there, according to the Minnesota Department of Health (MDH). That results in widespread physician shortages, particularly in primary care, pediatrics, OB-GYN, general surgery, and psychiatry.

Residents of rural areas trend older and sicker. Rural physicians trend older, too—a median age of 56.5 compared to 47 in urban areas. Factor in physician shortages and "it puts a lot of stress on the physicians who are there," says Shailey Prasad, MD, MPH, associate vice president for global and rural health at the University of Minnesota Medical School.

"There has been a shortage all over the country of primary care physicians, but that becomes much more dramatic in rural areas," Prasad says. "If you can't see a family physician in an urban area, you can go to another part of the city to find someone else. In rural areas, that distance becomes an added burden to access to care and an overburdened physician workforce."

This demanding environment increases physicians' risk for burnout, paired with a desire to leave the profession. In fact, the MDH 2025 Minnesota's Physician Workforce survey found that double the number

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Jan Baldwin, MD
Family medicine physician
Essentia Hibbing clinic and Fairview Range Medical Center

Shailey Prasad, MD, MPH
Associate vice president for global and rural health
University of Minnesota Medical School

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of rural physicians plan to leave the profession in the next five years—36% for rural physicians and 18% for urban doctors. Of rural physicians who plan to leave, the majority plan to retire, but 14% of those who are leaving the profession are quitting because of burnout and career dissatisfaction.

"We're always losing our seasoned professionals from rural areas and we're having to figure out how to replace them," says Teri Fritsma, PhD, MDH lead healthcare workforce analyst.

Part of that challenge is the work-life balance that younger physicians emphasize, often requiring employers to hire two young physicians to replace one veteran doctor. Baldwin notes that finding relevant employment opportunities in rural areas for nonphysician spouses is a difficulty that has intensified over the years, making recruiting even more arduous.

Medicaid fallout

States and healthcare providers are bracing for the fallout from potential Medicaid cuts, which would deeply impact rural areas, says Zora Radosevich, director of the MDH Office of Rural Health and Primary Care. About 54% of rural Minnesota residents access healthcare through public sources like Medicare, Medicaid (called Medical Assistance in Minnesota), and MinnesotaCare, for people with incomes that are low but not low enough to qualify for Medical Assistance.

Rural physicians already contend with continually declining reimbursements from Medicare and Medicaid, a lifeline of income for them, says Christopher Wenner, MD, a solo family medicine physician in Cold Spring. "When you have limited commercial payment because over half of the patients are Medicare or Medicaid beneficiaries, it's really challenging to make that pencil out," he says. "It's a threat to rural primary care when they aren't keeping up with inflation and there are cuts in reimbursement on an annual basis."

The financial picture is always a challenge for rural hospitals, but Joel Beiswenger, president and CEO of Astera Health in Wadena, observes that now is the most difficult time he's experienced in 40 years in the industry. The current financing model for the sector, including the confluence of low reimbursements and high inflation, is not tenable, he says.

Another complication is Medicare beneficiaries' shift to Medicare Advantage plans—about 60% in rural Minnesota—and the difficult financial position it presents rural providers, Beiswenger says. Mainly, Medicare Advantage, unlike traditional Medicare, does not reimburse hospitals and clinics for the gap between the true cost of providing care and Medicare's set fees. That leaves Astera absorbing losses of about $2 million in 2024. "The model is just not working," he says. "The financial pressures are pretty substantial."

Rural Minnesota's workforce challenges are compounded by Medicare Advantage requirements for prior authorizations and medication formulary changes. It's part of insurance companies' attempt to restrict care, Beiswenger says: "We see them as delay and deny tactics to manage the outflow of costs. To manage that, we spend an extreme amount of administrative staff and physician resources to do prior authorizations, which take a lot of time. It takes physicians away from patient care."

The centralization of care through larger healthcare systems is another change that has complicated rural practice. Wenner notices it most when patients require specialty services like colonoscopies. There aren't enough independent local specialists, and the slots available often go to in-network patients seeing physicians in

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Teri Fritsma, PhD
Lead healthcare workforce analyst
Minnesota Department of Health

Zora Radosevich
Director, Rural Health and Primary Care
Minnesota Department of Health

"A goal of mine is that every education healthcare training program has a rural rotation component to it. Even if clinics and hospitals do a two-month training program, they start to develop relationships with education providers and give students opportunities to see what it is like out in these communities,"

the larger systems. That requires other patients to delay care or travel far distances. "It can be relatively monopolistic in specialty care, and that can be quite challenging," he adds.

Plus, there are other risks to vertical integration, Christensen says. When leaders and institutions located in another area make decisions about and for another community, it doesn't always reflect the needs and wants of the local population. This centralized decision-making often leads to the loss of services for communities, typically obstetrics and elective surgery.

Rural areas have been experiencing this obstetric pullback in recent years, with 22 hospitals in Minnesota stopping scheduling deliveries from 2011 to 2021, according to the Chartis Center for Rural Health. Since 2024, Mayo Clinic Health System closed its maternity units in New Prague and Fairmont, while Essentia ceased its maternity services in Fosston. Today, 45 percent of rural hospitals in Minnesota no longer provide maternity services, reports the Center for Healthcare Quality and Payment Reform.

Baldwin lives this gap in coverage all the time. She understands that it's expensive to keep maternity services running. "Even if there is no one in the hospital having a baby, we still have to keep that unit open and staffed and have the right equipment," she says. Yet the closures mean patients commonly travel from cities like International Falls because there aren't services nearby. "I have patients who are a couple hours away, so if there are complications, or it's someone's fifth or sixth baby, that's a hazard to the rural population" (because labors tend to be much shorter after multiple births).

On the plus side, Baldwin now benefits from advances like tele-NICU services for rural hospitals. If babies are born in distress, someone on the care team pushes a button to connect on camera with a Twin Cities neonatologist. The physician advises her on stabilizing the infant for transport. "The connectiveness we have with telemedicine has made some things easier," she says. "That's a capability we didn't have before, and I think it's helped improve rural healthcare."

Boosting the rural ranks

To tackle workforce gaps in rural areas, medical schools, training programs, state government, and employers are working together on fresh approaches. They are expanding ways to immerse students and trainees in rural areas so they can understand their challenges and opportunities. Much of that work starts with the premise that when people get exposed to the daily life of practicing medicine in small communities, it's meaningful and impactful, Prasad says. Plus, data show that people tend to practice close to where they trained.

That was the objective of the University's Rural Physician Associate Program (RPAP), launched in 1971 to provide third-year medical students with nine months of training in rural areas. The program places students in communities across the state ranging from 300 to 30,000 people. Students complete their traditional clinical rotations in one rural location.

"We're trying to put some rural genetics in each of these students. There are rural competencies you need to learn, and one is being comfortable with uncertainty," Christensen says. "If you've never been a student out there in a snowstorm working with a preceptor when things aren't going well, you have to make do with what you've got and practice with competence in specialties that aren't your own. When

Christopher Wenner, MD
Family medicine physician
Cold Spring

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President and CEO
Astera Health in Wadena

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That experience in rural communities truly sticks with RPAP students, helping them envision careers in smaller towns, says Kirby Clark, MD, a family medicine physician and director of the Rural and Metropolitan Physician Associate Programs. RPAP contributes a healthy pipeline of medical students to primary care—70% of participants compared to 17% of nonparticipants. RPAP alums are four times more likely to practice in rural areas, he says.

"The secret sauce is students have continuity in a community, where they develop trust in their teachers, patients, and community, and the teachers, patients, and community get to trust them," Clark says. "They have more autonomy in their relationships with patients. They might identify and see the challenges of a rural practice, but they also enjoy the continuity of care and meeting those challenges."

The University has several efforts underway to bring more students to rural areas for medical school and residencies, Prasad says. This fall, the Medical School opened its CentraCare Regional Campus St. Cloud with 24 first-year medical students; by 2029, three more classes will have started, leading to 96 students across the four years. It also expanded its Duluth program so students can complete their entire medical degree there instead of moving to the Twin Cities for their final two years.

Having students steeped in these communities will enhance their understanding of rural medicine, as both campuses emphasize rural care, Prasad says. In addition, Duluth will continue focusing on Native American communities and St. Cloud will concentrate on immigrant populations. "When we talk about primary care training, we emphasize the importance of context, the community in which they serve," he adds. "There is a need for us to emphasize place-based learning. That is a critical part of helping solve the issues in rural areas."

Medical students at the Mayo Clinic Alix School of Medicine now have the option to explore rural medicine through a new course. Called the Rural Medicine Selective, the elective introduces students to common health challenges facing people in rural communities and gives them a first-hand perspective on practicing in rural areas. Mayo kicked off the program in 2024 in partnership with the Zumbro Valley Medical Society. In 2025, 16 first-year students participated in the three-day course. They shadowed physicians working in rural areas, met with emergency responders and farmers about common medical health concerns in the agricultural sector, and participated in a Q&A session with Mayo Clinic physicians who practice in rural areas.

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Raymond Christensen, MD
Associate dean for rural health
University of Minnesota Medical School Duluth Campus

As part of its efforts to ensure a vibrant healthcare workforce, MDH has been involved in efforts to increase rural graduate medical education opportunities, Radosevich says. The department partnered with healthcare providers and the University to develop three training sites to train more residents in rural communities. In June, two residents started training through the University of Minnesota/CentraCare Willmar Rural Family Medicine Residency Program. Trainees will spend much of their first year in St. Cloud and the other two years at CentraCare's Lakeland Clinic in Willmar.

In July 2026, two residents will begin training in the Grand Itasca Clinic and Hospital Rural Family Medicine Residency. Similarly, they will spend their first year at M Health Fairview Woodwinds Hospital in Woodbury, followed by two years in Grand Rapids. The University is waiting for accreditation approval for a third rural site in Staples. Residents seeking family medicine with obstetrics qualifications would complete one year with the North Memorial Family Medicine Residency program before finishing two years at Lakewood Health System.

The University of Minnesota Medical School is offering other opportunities for students to get a taste of rural family medicine, providing three five-day stints in their first 16 months of rotations, Christensen says. Students see patients in their homes, clinic, hospital, and long-term facilities, learning from preceptors who often host students in their homes.

Other residency programs have been adding rotations to rural areas to give trainees the experience of practicing in smaller communities, Christensen says. Hennepin Healthcare and Sanford Health recently kicked off a partnership to provide one-month rotations in Bemidji for emergency medicine and psychiatry residents. The University's surgery residency program includes one designated rural resident each in the fourth and fifth year who train in Duluth; second-year residents also can opt for an elective rotation there to gain rural experience.

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Kirby Clark, MD
Family medicine physician and director of the Rural and Metropolitan Physician Associate Programs

Sustaining rural care

In 2026, Minnesota will be able to put seasoned physicians, who were often sidelined by not having completing residencies in the United States, to work in rural areas. In June, the Legislature passed a bill that will provide two-year limited licenses to international medical graduates who worked in another country for at least five years in the past 12 years. They must find a willing employer in rural or underserved urban areas. State Sen. Alice Mann, MD, co-sponsor of the bill, estimates that 220 to 300 physicians will benefit from the limited licensure program. After mastering a range of requirements under the guidance of a collaborative physician, participants can be granted a standard license.

Aiming to improve the health of rural providers, 17 independent hospitals and clinics across Minnesota came together in 2024 to form the Headwaters Network. A key component of Headwaters is building strength in numbers at the negotiating table with insurance companies on value-based care agreements and finding efficiencies in operations and clinical care, Beiswenger says. For example, Headwaters used its large size as a collective group of providers instead of individual entities to negotiate new arrangements with physician staffing companies and telehealth services for its members.

Another way that Wadena-based Astera works to stay healthy in the current financial climate is through growth. This summer, it opened a full-service cancer center in Wadena, in partnership with CentraCare, to offer more cancer treatments in northwestern Minnesota. Previously, area residents would need to travel about 90 minutes each way to Bemidji or Fargo to get daily radiation or chemotherapy care. They now can turn to Astera instead.

This summer, MDH is conducting focus groups across Minnesota to understand the barriers and challenges to opening even more rural training opportunities, Radosevich says. "A goal of mine is that every education healthcare training program has a rural rotation component to it. Even if clinics and hospitals do a two-month training program, they start to develop relationships with education providers and give students opportunities to see what it is like out in these communities," she adds. "It also reminds people that all of us have a responsibility to train the next generation of the healthcare workforce, and everyone has a role in working on it and making it available." MM

Suzy Frisch is a Twin Cities freelance writer.

Can physicians and patients fix US healthcare?

The keynote speaker at Empowering Physicians event takes the temperature of American medicine.

Elisabeth Rosenthal, MD, is a one-time emergency room physician, former healthcare reporter for *The New York Times*, senior contributing editor for KFF Health News, and author of *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back*. She will be the keynote speaker at the MMA's 2025 Empowering Physicians: A Night of Learning and Connection event September 26 at the Hewing Hotel in downtown Minneapolis. She spoke with *Minnesota Medicine* about the dysfunction in U.S. healthcare. The interview has been edited for clarity and brevity.

First of all, I wanted to talk to you a bit about your personal story, because it strikes me as unusual. How and why did you transition from being a physician to a reporter for *The New York Times*?

I was practicing in the New York Presbyterian ER. I really enjoyed it, but I had always loved writing on the side. All through medical school, during residency, and when I was working in the ER I was freelancing, up to and including the *Times*. In the early '90s, a bunch of things happened. I had two kids. The night shifts were getting pretty overwhelming. And if you remember, this was the era of the HIV/AIDS epidemic in New York City, and it was emotionally pretty difficult.

Now I'm going to sound like a dinosaur. You remember the Clinton health reform effort, right? *The New York Times* said, "Do you want to come write about this?" And I really thought, "Oh, sure, I'll write about it. This is going to pass, and then I'll go back to being a doctor." And of course, it didn't pass, and I got hooked on journalism. I kept thinking for years I would go back, because I loved being an ER doc, but life happens. As I made the transition, I worked rather than three shifts, two shifts, and then one shift as I was writing more. At one shift, I realized I wouldn't want me as my ER doctor. The kind of skills that you need to keep up were fading.

People say, "Oh, it's a really weird transition." In some ways, it's a really natural transition, because as a physician, particularly in an ER, you go into a room and talk to a person you've never met and try to put together a story about what's wrong with them. And that's the fundamental skill of journalism—the same kind of listening to a person, often at a stressful point in their lives, and trying to make a story up.

Your background as a physician and a reporter and book author must give you an unusual perspective. How have those twin threads of being a writer and a physician informed your opinion of U.S. healthcare?

I feel like I've watched a kind of ongoing train wreck, where caring and the physician's ability to care for patients has in many cases been corporatized. That's the theme of my book—the logic of business has taken over our healthcare system. The logic of medicine is, inherently, not always efficient. It takes time with patients. The doctors are not running the show anymore. They were when I trained.

We do a short feature in every issue of the magazine that we call

On Call. It's a profile of an MMA member, and one of the things we always ask is, "What's the greatest surprise that your medical education left you unprepared for?" And so I'm going to ask you that question: What's the greatest surprise that you were unprepared for?

I think it didn't really apply then, but it would apply if I was still practicing: I thought nothing about what things cost and what patients were being charged in my name. You prescribe a drug; you don't know how much it's going to cost your patient. You ask for an MRI, and you're not sure how much that's gonna cost. Everyone says, "Oh, patients should be good shoppers and doctors should be good stewards of healthcare dollars." But the way our healthcare system runs, that just can't happen. And I think that's a fundamental problem. It's hard for me to see how either of those groups can change that on their own. You want doctors to say, "We're going to take back medicine," but you know, they're not in the C-suite anymore for the most part.

In your book, *American Sickness*, you offer suggestions to patients about how they can take greater control of their healthcare. I thought they were good, but one by one, they won't reform the healthcare system.

Yeah, exactly. What we can do as patients is limited. I'm the patient who's always on guard. When my kid needed a hernia surgery, I'm like, is the anesthesiologist in network? Instead of having my doctor send my lab work to the hospital where it's going to be expensive, I have him send it to Labcorp, which he can now do from his computer. But you know that's a lot of responsibility. I do think the solutions are not up to the problem. I asked the first economist I talked to in the book, "What can we do about the system?" He's a marketing economist, and he said, "I think you have to blow it up and just start all over again."

I think it's a system nobody likes, and yet it's very hard to change. And that's why I've been beating my head against the wall for 30 years about it.

What can *physicians* do to improve the system, both for themselves and for their patients?

I don't have to do the work, so I'm being ambitious on other people's parts, but I think they can be on hospital boards and demand that they be on the board. When I speak to residents, I always tell them—and this is a big ask—right on your computer to order tests, show how much it's going to cost. I think doctors could push for that. I mean, the EMRs, which all doctors take, could tell you if you're ordering something expensive. You know the patient, you know the drug, you know their insurance, you should be able to pop up what it's going to cost.

In the ER, I ordered so many tests because I had the patient there. Why don't we just do a CT? Well, maybe we don't just do a CT because it's going to cost $10,000 in the hospital and only $300 if I tell you to go out and get it down the street. So I think you know doctors can push their institutions for more price transparency, so they at least know what's being billed on their behalf.

I think among doctors, the whole concept of unions has been kind of anathema, because doctors traditionally are independent spirits. They went into medicine to have autonomy, but now they typically have very little. So I'd like to see more unionization of doctors to kind of push back against the commercial interest, the proliferation of administrators and C-suite people who really don't add to the medicine.

And the consolidation that's going on now is not making medicine more efficient. It's just making collecting money from insurers more efficient because they're in better negotiating positions. So I think, you know, some concerted push-back would work.

In the book I talked to an orthopedist at a smaller hospital in Northern California who was really very successful at pushing back against the parent corporation for some bad things they wanted to do with his hospital. He was kind of a rebel. He made a big stink, and he was like, "What are they going to do, take away my parking space?" I think they wanted to close the maternity ward. And he said, "Until you reverse that decision, I'm taking my orthopedic surgeries elsewhere," and drove, you know, 75 miles to do them elsewhere.

I think you need someone like that to kind of lead the charge at every hospital, but that's not what doctors were made for. They didn't want to be politicians, but unfortunately, I think we're in a position where patients really don't have a voice. Doctors, you know, maybe have a voice, but I think they could use it more. Most of them, I think, still like or love doing medicine, seeing patients, and doing what they do as doctors. They don't like the huge array of business stuff that's developed around medicine.

There are some bright lights. I saw my rheumatologist at Hopkins about a month ago, and he was using an AI software while we spoke and asked, you know, if I minded, and I was pretty shocked. He's someone I know pretty well. So, you know, we talked about our kids, we talked about this, that and the other, and that AI program cut out all the nonsense and generated a good medical note at the end of it. I think that kind of thing can really help save physicians time.

But I don't think that's going to be the answer either. It will give them back some of the time suck that the EMRs have created. It kind of takes a revolution from doctors and patients. Someday maybe I'll see it. In the meantime, all I can do is write.

It seems to me, in the last six months in this country, as the new administration has taken over, we have taken some giant steps backwards in terms of improving our medical system, especially if there are cuts to Medicaid and cuts to research and chaos among research institutions. Your

thoughts about what we're facing now?

Well, it's going to be a difficult time, I think, particularly for rural hospitals. And I think the sad thing is that these big institutions with big endowments, like Harvard, they'll probably be able to make up the slack. Their research will keep going. I don't think researchers are going to close down their labs, but a lot of research is done, and important research is done, at state schools that will not be able to fill the gap. And I'm talking about research funding, and I think we'll lose a lot of important research. You don't want all the research to be at five universities. So I think that's going to be a problem.

What will happen to Medicaid? It's really hard to know with the work requirements. I think different states will impose that differently, and that will make a big difference how onerous they are, right? I'm in New York State which has a very progressive attitude towards healthcare. My guess is they'll manage to find a way to make any kind of work requirement not difficult. But in states that want to cut Medicaid, which is the whole point of the way you balance the budget, you're going to lose a lot of Medicaid income. And in a lot of rural hospitals, a huge proportion of the patients are Medicaid.

Aside from Medicaid, you know, the other thing which is kind of looming is the Affordable Care Act subsidies for the Medicaid expansion and the marketplaces are expiring at the end of this year. A whole bunch of people who are low income or didn't have job-based insurance are not going to be able to afford insurance anymore. The rates on the marketplaces without a subsidy are really high. There's going to be a big double whammy that people face—hospitals face the loss of Medicaid income, but also because there'll be a whole lot of people who are uninsured, and if they have to go to a hospital, they're just not going to be able to pay bills.

You can start putting liens on Social Security checks and taking houses, but that's a really bad look for hospitals. There is a lot of money sloshing around in the system that's not used very well. Maybe it's time to redirect some of the money we use for administrators to healthcare. But some rural hospitals may close and may not be able to survive. That's a very complicated issue in and of itself. Does every town need a hospital? Probably not, but every town needs something. People need access to a hospital. As our president said, "Who knew healthcare is so complicated?" It just gets more complicated. It's bureaucratic. There are layers of business. It needs a huge untangling.

Ultimately, the doctor-patient relationship is pretty simple. Doctors deserve to be paid well for what they do. It's hard work, and a lot of money in our system is going everywhere else but the doctor-patient relationship and all that entails. **MM**

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

IMPROVING CARE FOR ALL:
TOOLS & RESOURCES

The Minnesota Health Equity Community of Practice (CoP)

The CoP brings together health equity leaders and professionals from Minnesota medical practices to exchange expertise, resources, and ideas. It provides an opportunity for networking, cross-organizational communication, and collaboration. The CoP also guides the work of MMA by providing input on health equity priorities and identifying opportunities for collective action in support of health equity. The CoP meets quarterly and interested physicians may join at any time.

To attend a CoP meeting, contact Haley Brickner.

Intercultural Development Inventory

The Intercultural Development Inventory (IDI) is a developmental assessment which provides in-depth insights on individuals' and group's levels of intercultural competence. The IDI process empowers participants to increase their intercultural capability.

The IDI can be used by individuals to receive feedback and recommendations and by organizations for baseline assessments, organizational development, or as a pre-post assessment in program evaluation.

The MMA now offers this valuable resource, including:

- IDI Assessment
- Individual Profile Report
- Group Profile Report
- Customized Intercultural Development Plan
- 1:1 Debrief/Coaching sessions with a qualified IDI Administrator

Learn more at www.idiinventory.com and contact Haley Brickner to start your IDI process.

Best Practices for Inclusive Communications – Training and Guide

The words we use can either promote a culture of respect and inclusion or perpetuate harm toward marginalized individuals and communities. As we work to promote an anti-racist culture in medicine, we must also examine the way we speak about people and groups. As language and culture change over time, it is our responsibility to stay up to date on best practices for communicating about health equity. The MMA offers training for organizations on Best Practices for Inclusive Communication, enabling participants to use more inclusive communication by providing suggested language, guidance, and explanatory context, and encouraging them to think critically about the words they use, the meaning conveyed, and the potential impact.

The training accompanies the free Inclusive Communication Guide, which can be found at www.mnmed.org/healthequity

Implicit Bias Training (CME available)

Research suggests that implicit biases contribute to health disparities by affecting patient relationships and care decisions.

The MMA offers health care providers several ways to learn about Implicit Bias:

- Public workshops: Our live, virtual 2-hour Understanding and Mitigating Implicit Bias in Healthcare Workshop is offered to the public twice a year.
- Private workshops: Bring workshop to your organization at a time and place that works for you.
- Recorded workshops: Our Implicit Bias Workshop is available on-demand

Explore Implicit Bias resources at www.mnmed.org/IB

Racism in Medicine: Truths from MN Physicians (CME Available)

In this powerful video series, physicians of color share their stories of practicing medicine in Minnesota. Efforts toward making medicine more inclusive require an understanding of the experiences of these physicians. This project is a step toward addressing the harmful effects of racism, microaggressions, and implicit bias within the culture of medicine. Also available is a 90-minute workshop featuring critical reflcetion on, and discussion, the video series.

View the videos and symposium at www.mnmed.org/racismtruths

Conversations on Race and Equity (CME Available)

The Conversations on Race and Equity (CORE) series is a virtual space for physicians to discuss topics that relate to health equity and inclusion in healthcare.

Each session is 1 hour and includes facilitated dialogue based on curated content. The topics include:

Session 1: Anti-racism
Session 2: Cultural Humility
Session 3: Implicit Bias & Microaggressions
Session 4: Racism in Medicine
Session 5: Allyship

There are two ways to bring CORE to your organization:

- MMA Facilitated: With this option, each session will take place via Zoom with an experienced CORE facilitator
- Self-Guided: The MMA has developed a CORE Toolkit for healthcare organizations to host a CORE series on their own.

To bring CORE to your organization, visit www.mnmed.org/CORE

FOR MORE INFORMATION ABOUT ANY OF **THESE RESOURCES**

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VISIT

www.mnmed.org/healthequity

Minnesota Medical Association

A legislative session like no other

The MMA had a successful close to the 2025 Minnesota legislative session, but the road along the way was anything but smooth.

The House of Representatives was set to open with a 67-67 tie for the first time since 1979. However, two weeks before the start of session, a Democratic representative resigned because he was found to not actually live in the district in which he was elected. A special election was scheduled to replace his seat, but Republicans maintained a one-vote majority in the interim. To block Republicans from having the power of a majority, Democrats boycotted the House until halfway through session, when the results of the special election returned the House to a tie.

It was a unique session for the Senate as well. It was set to open with a 34-33 Democratic majority, but one Democratic senator passed away from cancer one month before the start of session, and a Democratic candidate filled her seat. Another Democrat awaited trial for a breaking and entering charge, but continued to govern. And a Republican was arrested and resigned. That seat went unfilled until it was won by a Republican in a special election on April 29.

In the end, legislators couldn't agree on a budget before the session closed on May 19. Gov. Tim Walz called legislators back three weeks later, and a budget finally passed on June 9.

Five days later, an armed assailant shot and killed Speaker Emerita Melissa Hortman and her husband. Sen. John Hoffman and his wife were also shot and wounded in their home. Fortunately, the Hoffmans survived.

It was a tragic ending to a very strange session.

While the MMA's legislative team juggled a variety of health-care-related bills, there are two that could greatly affect the health of Minnesotans. Here's a closer look at both.

Midyear formulary change limits

Beginning January 1, 2026, insurers and pharmacy benefit managers (PBMs) can no longer change coverage for a patient on a particular medication in the middle of a contract year. Nor can they place a drug in a category that raises the enrollee's cost for the duration of the enrollee's plan year.

The only exceptions are when:

- The drug has been withdrawn by the FDA or the manufacturer;
- An independent source or research has found the drug to cause patient harm; or
- The health plan adds a new generic or biosimilar and gives at least 60-day notice to the prescriber, pharmacist, and the enrollee.

For years, physicians across specialties have been frustrated when the medication they prescribe is no longer included in the patient's health plan formulary. This has caused the patient to change medications, pay out-of-pocket, or appeal the health plan's decision to continue coverage.

These formulary changes are not made because they benefit patients. They're usually made so that health plans and PBMs can secure better rebates from drug manufacturers.

For many patients, these midyear formulary changes are disruptive and a burden, but for some, the changes can be life-threatening.

"We are all concerned with the cost of medications," said MMA President Edwin Bogonko, MD, MBA. "But we must first be concerned that patients are getting the best treatment. Forcing a patient to change their course of treatment simply because the health plan or PBM gets a bigger 'kickback,' is not best for the patient."

The new law applies to private insurance, as well as Medical Assistance and MinnesotaCare.

"We've been working for a long time to get this into law," said Chad Fahning, the MMA's senior manager of lobbying and legislative affairs. "It's great to see that our hard work has finally paid off. This new law should alleviate a lot of frustration for Minnesota physicians."

New licensure pathway for international medical graduates

This session, Minnesota became the eighth state to pass legislation that provides international medical graduates (IMGs) with a new pathway toward licensure.

In the past, IMGs in Minnesota had to complete at least one year of residency at an accredited residency program. This proved difficult for many physicians who trained and practiced in other countries but were unable to match into an accredited residency program.

Beginning January 1, 2026, IMGs who have practiced for at least five of the last 12 years in another country can pursue this new pathway toward licensure.

To qualify, IMGs must practice for two years under a limited license in a clinic or hospital setting; in a rural or underserved urban area; and under a collaborative agreement with a supervising physician.

Other stipulations include:

- IMGs must have an employment offer to qualify for a limited license;
- During the limited license period, the IMG must submit a statement at least every six months certifying that they are still employed;
- Under the collaborative agreement, the IMG must shadow the collaborating physician for the first four weeks and include the collaborating physician in all patient encounters for the next four weeks;
- The collaborating physician must provide supervision for a minimum of two hours per week.
- Following the two-year limited license period, the IMG is eligible for a full, unrestricted license if they have:
  - Held the limited license for two years and are in good standing to practice;
  - Has practiced a minimum of 1,692 clinical hours each year;
  - Has passed Step One, Two, and Three of the United States Medical Licensing Examination;
  - Has a letter of recommendation from their supervising physician;
  - Has completed at least 20 hours of continuing medical education.

The MMA did not oppose the IMG legislation, but worked closely with its main author, Sen. Alice Mann, MD.

"We certainly need more physicians in Minnesota," Bogonko said. "We just want to make sure that they are held to the highest standards of training."

The goal of this new pathway is to allow physicians who have trained and practiced in other countries to be able to use their skills and expertise in practice in Minnesota without having to complete a residency program. The MMA advocated for additional supervisory requirements to help ensure a minimum level of competency for licensees through this new pathway.

MMA's legislative priorities and how they fared

Several of the MMA's priorities passed this session. They included:

- An increase in Medical Assistance (MA; i.e., Minnesota Medicaid) provider payments for mental health services. Specifically, MA will pay physicians 100% of the Medicare rate for psychotherapy and diagnostic assessment services and rates recommended by the Minnesota Department of Human Services (i.e., rates based on commercial payment) for community-based mental health services such as home-based care, day treatment programs, and family community support service. The MMA intended for this rate increase to apply to all outpatient physician services, but legislators narrowed the affected services during budget negotiations. The rate increase is contingent on federal approval of a new assessment on managed care organizations.
- An allocation of $250,000 of one-time-only funding to the Treat Yourself First (TreatYourselfFirst.org) campaign, which is designed to encourage healthcare practitioners to get help if they need it.
- The continuation of audio-only telehealth coverage for two more years.

For a comprehensive look at the session, read our legislative review on the MMA website:
www.mnmed.org/application/files/8817/5088/0500/MMA_LegislativeRevw061925_FNL.pdf

Looking ahead

To fill Hortman's seat and other openings that have come up, Walz will call for special elections still this year. Walz has also indicated that he may call a special session to address budget issues that now exist because of the recent reconciliation bill passed by Congress.

The next session begins at noon on Tuesday, February 17. The MMA's Physicians' Day at the Capitol will take place Thursday, March 19. MM

News Briefs

US budget bill to have big impact on Minnesota healthcare

With the passage of President Trump's budget bill in early July, many in healthcare are wondering how it will affect the practice of medicine and how it will impact the health of Minnesotans.

The narrowly passed bill is controversial for its $3.4 trillion (i.e., 9.4%) increase in the national debt over 10 years and significant cuts to healthcare and nutrition programs, including Medicaid, Affordable Care Act (ACA) marketplace subsidies, and the Supplemental Nutrition Assistance Program (SNAP).

The nonpartisan Congressional Budget Office (CBO) estimates that the bill will result in 16 million Americans losing their insurance in the next 10 years—11.9 million due to Medicaid cuts and 4.2 million due to cuts to ACA marketplace subsidies.

According to a preliminary analysis by the Minnesota Department of Human Services (DHS), nearly 140,000 Minnesotans will lose coverage. "The impacts on Medical Assistance, Minnesota's Medicaid program, will be significant and felt by all Minnesotans," the DHS said in a release. "The bill specifically targets low-income adults without children, saddling them with additional paperwork, forcing more frequent administrative hoops, and imposing medical bills."

"While we are disappointed with the final bill, the MMA is committed to educating our members as the bill is implemented," said MMA President Edwin Bogonko, MD, MBA. "We will collaborate with our Minnesota partners to mitigate the bill's anticipated harms, and advocate for corrective policy at every possible opportunity."

MMA launches big, beautiful guide for physicians

The MMA has launched "The One Big Beautiful Bill Act (OBBBA) Resource Guide for Physicians" (www.mnmed.org/OBBBA) to help Minnesota practitioners understand how key provisions of the law will affect their practice and patients.

The guide includes five sections that describe the law's impact on:

- Medicaid,
- The ACA individual market and MinnesotaCare,
- Medicare,
- Health savings accounts,
- Medical school loan access.

Scan to access the MMA's OBBBA Resource Guide for Physicians

Within each section, provisions are listed in order of effective date and explained in clear language.

The MMA encourages the sharing of the guide with all who may be interested, including nonmembers and nonphysicians. Contact Adrian Uphoff (AUphoff@mnmed.org), manager of health policy and regulatory affairs, with questions.

Vaccine experts express concern for future vaccinations

Some of the nation's top experts on vaccinations painted a grim picture of the future of immunizations in Minnesota and the United States, at a June online forum hosted by the MMA.

Michael T. Osterholm, PhD, MPH

The discussion centered around what lies ahead after HHS Secretary Robert F. Kennedy Jr. replaced members of the Advisory Committee on Immunization Practices (ACIP) with eight of his own people, six of whom are avowed anti-vaxxers, said panelist Michael T. Osterholm, PhD, MPH, director of the Center for Infectious Disease Research and Policy (CIDRAP) at the University of Minnesota.

Also on the panel were Gregory A. Poland, MD, infectious disease prevention expert and president of the Atria Academy of Science and Medicine, and Tabitha K. Hanson, DNP, MPH, RN, immunization program clinical consultant at the Minnesota Department of Health.

"We have an [HHS] secretary that's already said they don't care if they have ACIP or not," Osterholm said. "They're going to do whatever they want to do." They are choosing to make decisions based on politics, not science. "In Minnesota, we, like all the other states, are suffering through this, and we're recognizing that right now, more than any time in the last 60 years, our vaccine infrastructure and enterprise is at serious, serious risk."

"Myths and disinformation are deadly," Poland said. "Poor science equals poor public health equals poor medical and even economic outcomes for a state or for a nation."

Earlier this year, Osterholm and his associates at CIDRAP created the Vaccine Integrity Project, which is now, in a sense, taking the place of the CDC and ACIP, he said. The project has held a series of focus groups made up of a variety of healthcare individuals involved in vaccines. "We are trying to take it head-on, and I think if we can do that, it surely doesn't eliminate the mis- and disinformation that's coming out, but it offers an alternative authoritative source," Osterholm said. "And so, that we can, in fact, hopefully make it possible for payers to continue to pay for these vaccines."

While the panelists painted a negative picture, they did have suggestions for how physicians can approach the current environment.

Hanson suggested that physicians use neutral language when talking to their patients about vaccinations. "Thinking about things that might inspire people to get vaccinated might be different for different people with different political beliefs or cultural beliefs," she said. "Some examples of that might be focusing more on personal liberty or individual choice, or maybe keeping the economy open might be something that appeals to some people, versus someone who might be interested more in the common good or protecting their families, or protecting their loved ones."

Poland suggested meeting patients where they are. When a physician considers getting a vaccine, they will likely say: "'Show me the data.' Well, patients don't ask that. Rather, they have a series, often of ill-formed ideas or biased information. And so, you need to understand that. You need to understand their cognitive style, and then address your education toward them in that style."

"We're in a space where people, your patients, may care more about you caring for them than how smart you are, which is a very strange place to be, because you have so much knowledge and in-

formation and wisdom and experience to share with them," Hanson said. "But what they really want to know is if you would vaccinate your own children, or if you would get the vaccine yourself."

Hanson said MDH continues to do outreach and partner with specialty societies and community groups to promote vaccinations.

A recording of the forum, which was moderated by MMA President Edwin Bogonko, MD, MBA, is available on the MMA website (www.mnmed.org/education-and-events/physician-forums/past-physician-forums).

MMA mourns political violence on state lawmakers

The MMA continues to mourn the June 14 assassination of House Speaker Emerita Melissa Hortman (DFL-Brooklyn Park) and her husband, as well as the shootings of Sen. John Hoffman (DFL-Champlin) and his wife.

Speaker Hortman worked regularly with the MMA's advocacy team over the years to pass pro-medicine legislation. "Like many have said over the last few days, it is hard to express feelings following these shootings," said Dave Renner, CAE, the MMA's longtime lobbyist who retired in July. "Speaker Hortman was not just a remarkable legislative leader; she was a good person. She treated all with respect even if she disagreed with your position."

Hortman was first elected to the House in 2004. She served one term as a member of the House Health and Human Services Finance Committee in 2013–14. She became speaker in 2019.

"Interacting with Speaker Hortman both at the Capitol and on the campaign trail was routinely a pleasure," said Chad Fahning, MMA's senior manager of lobbying and legislative affairs. "You could not design a more effective lawmaker, nor a kinder one."

"Sen. Hoffman has been an active, passionate member in the health and human services arena since first being elected in 2012," Renner said. "He is one of the strongest advocates in the Senate for the disability community."

Hoffman served in the Senate Health, Human Services, and Housing Committee in his first term and has been a member of the Human Services Committee since 2017, chairing that committee starting in 2023. It has been reported that one of his motivating factors to enter politics was that his daughter was born with spina bifida.

"I've had to go to his office more than a few times to share concerns with legislation he was pushing," Fahning said. "Sen. Hoffman is oftentimes stubborn when challenged, but he always wrapped up those meetings making sure I knew nothing was personal and that a difference in opinion should be nothing more than just that. I think we could use more of that attitude in the world today."

MMA well-represented at feisty AMA meeting in Chicago

The AMA's annual meeting, June 6–11 in Chicago, reinforced the importance of physician advocacy efforts on behalf of their patients and the practice of medicine.

As the meeting was taking place, HHS Secretary Robert F. Kennedy Jr. removed all members of the Advisory Committee on Immunization Practices (ACIP). The AMA responded immediately with a strong rebuke, issuing a statement and emergency resolution demanding reinstatement of the ACIP members and Senate oversight. The resolution passed with wide support despite concerns over political repercussions. The MMA also released its own statement.

A major action at the meeting was a directive calling on the AMA to elevate Medicaid to an urgent and top legislative advocacy priority alongside Medicare payment reform, and to specifically advocate for maintaining and expanding Medicaid coverage, access, federal funding, and eligibility.

The AMA House of Delegates elected Willie Underwood III, MD, MSc, MPH, as the 180th president-elect of the AMA. Underwood is a urological surgeon from Buffalo, New York.

Finally, delegates were introduced to the AMA's new executive vice president, John Whyte, MD, MPH, who previously served as chief medical officer of WebMD. He replaces James Madara, MD, who is retiring after serving 14 years as executive vice president.

MMA Past-president Laurel Ries, MD (left); President-elect Lisa Mattson, MD; and President Edwin Bogonko, MD, MBA, pose for a selfie at AMA's annual meeting in Chicago.

The MMA's delegation included JP Abenstein, MD; Lauren Benning, DO; Edwin Bogonko, MD, MBA; Andrea Hillerud, MD; Lisa Mattson, MD; George Morris, MD; Dennis O'Hare, MD; Ashok Patel, MD; Laurel Ries, MD; Cindy Firkins Smith, MD. MMA staff in attendance included Dave Renner, CAE; Janet Silversmith; Stephanie Lindgren, JD; and Adrian Uphoff, MPH, MPP.

Advocacy highlights at the meeting included:

- Rural minority health: Supported further research and resources to address care challenges for minorities in rural areas.
- Combating misinformation: Called for efforts to counter medical misinformation and protect the physician-patient relationship.
- Obesity care: Recognized obesity as a chronic disease requiring priority support.
- AI and digital health: Directed a task force to develop long-term House of Delegates engagement strategies.
- Legal advocacy: Backed AMA's lawsuit against the healthcare company MultiPlan, and supported amicus briefs on key public health issues.
- Prior authorization reform: Celebrated federal- and state-level wins to streamline prior authorization and reduce care delays.
- Physician protections: Supported civil and criminal protection in states with legal physician-assisted suicide; opposition to legalization remains.
- Health system ethics and workforce: Promoted ethical guidance, staff empowerment, and transparency around private equity ownership.
- Reproductive and immigrant care: Defended Emergency Medical Treatment and Labor Act abortion protections and care for undocumented immigrants.
- Global Health: Reaffirmed support for WHO and USAID. MM

FROM THE CEO

Supporting the village that trains physicians

In his February 1972 President's Letter in *Minnesota Medicine*, then MMA President Robert T. Kelly, MD, enthusiastically heralded the expansion of medical training in Minnesota. It was in September 1972 that Mayo Medical School, now known as the Mayo Clinic Alix School of Medicine, admitted its first 40 students; it was the same year that the new Duluth campus of the University of Minnesota admitted its first 24 students.

Now, 53 years later, there is similar palpable enthusiasm about the opening of the University of Minnesota's CentraCare Regional Campus in St. Cloud. As in 1972 in Duluth, the new campus welcomed 24 new medical students this fall.

The physician shortage, both nationally and in Minnesota, particularly in rural areas, is real and expected to worsen. Survey data collected by the Minnesota Department of Health indicate that 19% of all Minnesota physicians—and one in three rural physicians—intend to leave the workforce in the next one to five years. Fittingly, the St. Cloud campus is eager to train and retain students with a commitment to practicing in rural areas.

Training future physicians takes a village—at medical schools, in residency programs, and at clinical sites across the state. President Kelly acknowledged the role of practicing physicians in this important work in 1972 when he wrote, "The private practicing physician in Minnesota must also assume an active role in helping to provide opportunities for these medical students and residents. He must be willing to participate in new programs as well as educational programs already established."

Kelly's words remain true today—current physicians can and should support the training of future physicians. One essential role that a physician can play is as a clinical preceptor for medical students.

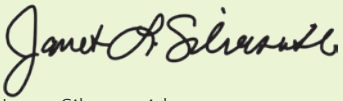
To support this essential role, the MMA, in partnership with the University of Minnesota Medical School, has created a robust set of tools and resources to prepare and support preceptors—whether rookie or veteran.

The "Community Preceptor Toolbox" includes simple and accessible tip sheets and video modules covering topics such as providing effective feedback, managing time, precepting in the presence of a patient, as well as documentation of the personal and professional benefits associated with precepting. You can access these resources from the "Resources" tab on the MMA website (www.mnmed.org, see "Preceptor Tools").

In further demonstration of the critical role that community preceptors play in medical education, the MMA and the University of Minnesota Medical School established an award to recognize preceptors as part of the Dean's Tribute to Excellence in Education annual event. This year, the MMA was honored to present the Exceptional Primary Care Community Faculty Teaching Award to Ryan McFarland, MD, and Sarah McFarland, MD, both from Hudson Physicians.

To those of you who serve as preceptors, thank you. For those of you looking to share your experience and knowledge with future physicians, please consider doing so. The MMA is here to help you succeed, and the future physician workforce looks to you for support.

Finally, congratulations to all those involved in the planning, development, and launch of the CentraCare Regional Campus in St. Cloud. What an amazing and exciting achievement! I also offer a sincere welcome to the class of 2029 from all of Minnesota's medical schools! The MMA and Minnesota physicians are here to support you now and throughout your professional journey. **MM**



Janet Silversmith
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VIEWPOINT

Perhaps call it the Big Backwards Bill?

Kimberly Tjaden, MD
MMA board chair

This past Independence Day seemed anything but freeing for healthcare in Minnesota.

That's when the president signed into law what he calls his "Big Beautiful Bill." It's big and it's a bill, but it's hardly "beautiful" to the millions of patients who will lose their health insurance in the years ahead.

While experts continue sifting through the nearly 1,000-page bill and determining how it will affect Minnesota patients, we know this for certain—it will not improve access to healthcare in the North Star State or anywhere else in the country.

The new budget package calls for increased spending on our military, plus border security and immigration control, while cutting a variety of healthcare-related items such as Medicaid and Affordable Care Act (ACA) marketplace subsidies. It also significantly cuts the Supplemental Nutrition Assistance Program (SNAP), which offers sustenance to the youngest of Americans.

The nonpartisan Congressional Budget Office estimates the bill will result in 16 million of our fellow citizens losing their insurance over the next decade—11.9 million due to Medicaid cuts and 4.2 million due to cuts to ACA marketplace subsidies.

Some items in the new law that take effect immediately include:

- The prohibition of new and heavy restrictions on existing Medicaid provider taxes, which states like Minnesota depend on to draw down critical federal matching funds. There is a three-year grace period for states with active taxes to allow for the transition.
- The limiting of states' ability to use state directed payments—a mechanism through which states can force insurers to pay providers certain rates for care provided to Medicaid patients—to no more than 100% of Medicare. The law allows for gradual implementation in grandfathered states.

Other aspects of the law impacting Medicaid take effect in 2027:

- The imposition of work requirements (i.e., 80 hours per month) for certain Medicaid recipients.
- The tightening of eligibility renewal requirements from every 12 months to every six months.
- The limiting of retroactive coverage from 90 days prior to application to only 30 days prior to application for expansion enrollees and 60 days for traditional enrollees.
- Reductions in federal matching fund rates for states that provide gender-affirming healthcare or public healthcare programs to people with undocumented status.

The MMA has opposed the Medicaid cuts since Congress first started drafting the bill earlier this year. We published a "Protect Medicaid Access" landing page on our website, sent two Action Alerts prompting members to send emails and secure texts to their members of Congress, and joined more than 40 other state medical societies in sending a letter to Congressional leadership.

In the end, it wasn't enough. The bill narrowly passed the Senate and the House.

Now that the bill is law, the MMA is committed to educating members on how it will affect you. We will collaborate with our Minnesota partners to mitigate the bill's anticipated harms, and advocate for corrective policy when possible.

Minnesota has a history of progressive policies to improve the health of our residents. This is an unfortunate step backwards for healthcare in the state. The MMA will continue to do what we can to keep moving forward for the health of our patients and the practice of medicine. MM

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EDWARD P. EHLINGER, MD, MSPH

Edward P. Ehlinger, MD, MSPH, board certified in pediatrics and internal medicine, is no longer employed but volunteers as a board member and committee member for various professional and civic organizations. He mentors medical students, advocates for public health policies, writes Substack posts, and consults on maternal and child health issues. "Since I'm no longer employed and 'retired' doesn't seem to fit what I'm doing, I created a title—public health metaphysician," he says. "A public health metaphysician views health from a medical and public health perspective and is concerned with the conditions that create health for individuals, a community, and society." He was a paid MMA member from 2003 through 2011 and a retired member from 2019 to present.

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

I was born in Green Bay, Wisconsin, and, as expected by every boy in the city, played high school football. Our coach was a member of the Packer Hall of Fame, so we got to use a lot of used Packer equipment. As a senior I wore Bart Starr's helmet, Ray Nitschke's shoes, and Max McGee's shoulder pads. Because of that I was sworn to be a Packer fan for life.

I went to St. Norbert College for one year and finished my undergraduate education at the University of Wisconsin—Madison, earning a BA in English and stayed at Madison for medical school.

To finance my education, I worked in a cheese factory (packing cheese slices for McDonald's), served as a park attendant (play leader), umpired baseball, and sold beer at Packer games.

I was a Robert Wood Johnson Clinical Scholar at the University of North Carolina at Chapel Hill and received an MSPH in maternal and child health while I was there. I interned at Penn State Health Milton S. Hershey Medical Center and did internal medicine and pediatric residencies at the University of Utah.

I spent 2 years providing medical care in Montana as a member of the National Health Service Corps. In Minnesota I ran the Maternal and Child Health Program for the Minneapolis Health Department for 15 years, directed Boynton Health Service at the University of Minnesota—Twin Cities for 16 years, and served as Commissioner of Health for seven years.

Tell us about your family.

My dad was a machinist and my mother was a teacher. I'm the third in a family of 10 children. Education was a family priority, so all my siblings ended up with advanced degrees in various fields. I was married for 48 years. My wife died in 2017. I have two daughters and four grandchildren.

Hobbies or side gigs?

I play multiple musical instruments (none of them well), write musical doggerel, carve stone, cross-country ski, and bicycle to maintain my mental and physical health.

Why did you decide to become a physician?

When I was 8 my dad took me to my first Packer game, and I noticed a Black player. My dad told me that he could only be in town during the season and had to live on the outskirts of town. When I said, "That doesn't seem fair," my dad said, "You are right, and I hope your generation does something about it." Ten years later my high school football coach suggested I read Michael Harrington's *The Other America*, which highlighted the health, social, and economic inequities in our country. Becoming a physician seemed the best way to meet my father's hopes and address the needs of the "other America."

What was the greatest lesson of your medical education?

Physicians are part of a large team that is needed to provide effective care and to protect and improve health. I also learned that the humanities, liberal arts, and science are all integral to creating healthy individuals and a heathy society.

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

Society believes that having access to medical care and making good choices about diet, exercise, and substance use are the major determinants of health. My medical education reinforced that notion. I was surprised to discover that living conditions and belonging to a supportive community are just as important—maybe more.

What's the greatest challenge facing medicine today?

Healthcare is seen as a commodity and not as a right. This makes healthcare a business, not a vocation, and undermines the reasons why most people go into medicine. The profit motive behind healthcare transfers leadership to businesspeople rather than caregivers.

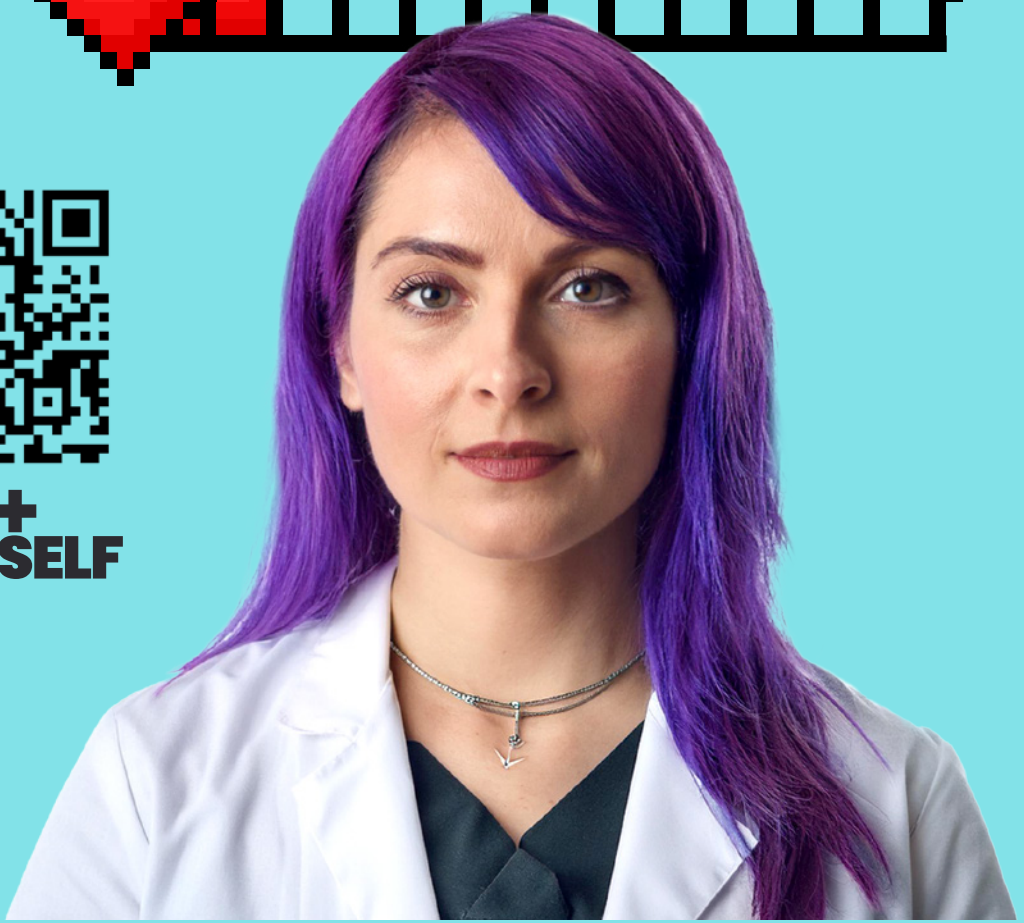
How do you keep life balanced?

My personal and professional values are similar—how to create a healthy and vibrant community. So, my challenge is how can I use my nonmedical skills to enhance healthcare and my medical skills to improve my community. To meet that challenge I look for interesting, new, and fun opportunities to use all my skills.

If you weren't a physician—?

I'd be a snow climatologist. MM

Your patients' well-being starts with your very own.



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