THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

MINNESOTA MEDICINE

JUL/AUG 2025 • $9.99

MISSED SHOTS

DESPITE ITS REPUTATION AS A HEALTHCARE LEADER, MINNESOTA RANKS NEAR THE BOTTOM OF ALL STATES IN ITS CHILDHOOD VACCINATION RATE.

PAGE 8

ALSO

MINNESOTA MEDICAL ASSOCIATION

Minnesota Medical Association

REGISTER NOW!

EMPOWERING PHYSICIANS

A NIGHT OF LEARING & CONNECTION

FRIDAY | 4 to 9PM

SEPTEMBER 26, 2025

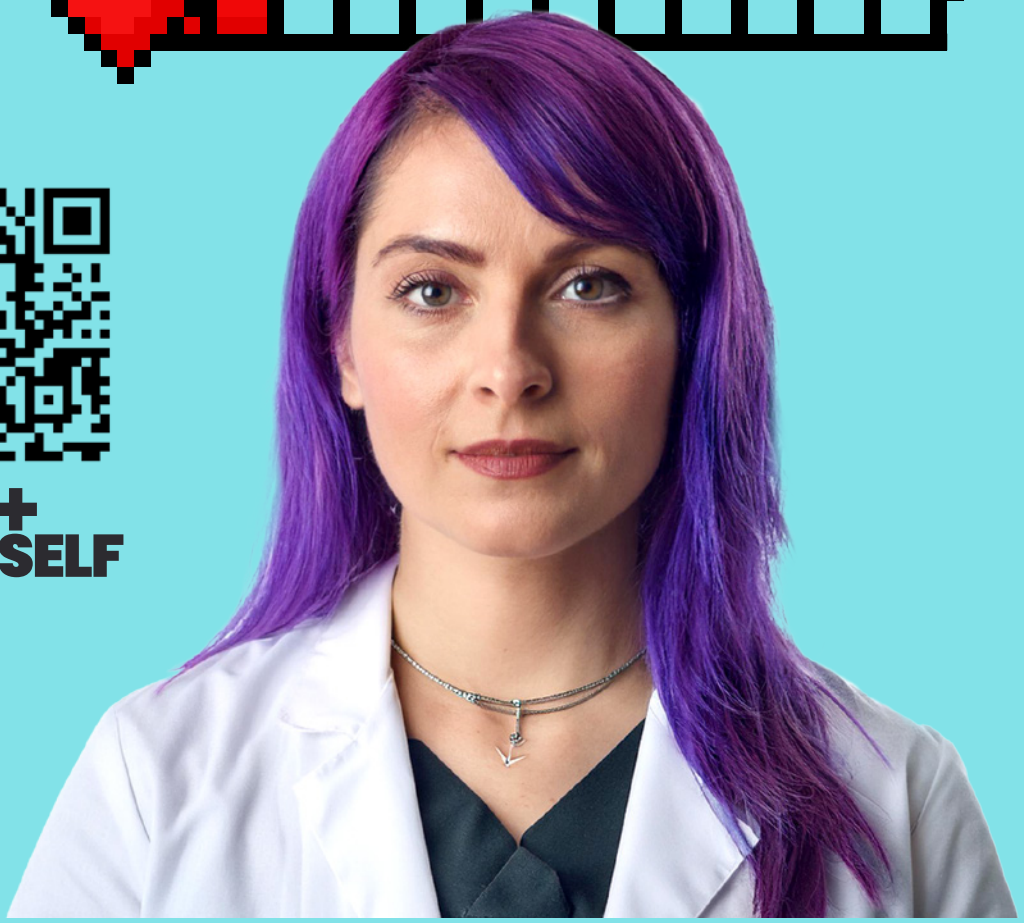
HEWING HOTEL, 300 N. WASHINGTON AVE., MINNEAPOLIS

*Best-selling author **Elisabeth Rosenthal, MD,** will discuss how physicians are at the crossroads of U.S. healthcare.*

FOR MORE INFORMATION

www.mnmed.org/EPC25

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



TREA+ YOURSELF FIRST

Minnesota Medical Association | Minnesota Academy of Pediatrics Foundation | ACP Minnesota Chapter | Minnesota Academy of Family Physicians | MPhA | APRN | MNACEP | MNNP Minnesota Nurse Practitioners | MNA | MAPA | Minnesota Psychiatric Society | Minnesota Dental Association

CONTENTS

Jul/Aug 2025 | VOLUME 108 | ISSUE 4

IN THIS ISSUE

Despite its reputation as a healthcare leader, Minnesota ranks near the bottom of all states in its childhood vaccination rate.

8

ON THE COVER

FEATURES

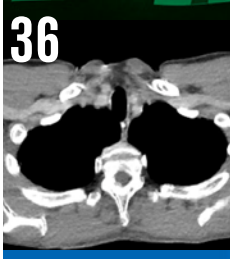
14

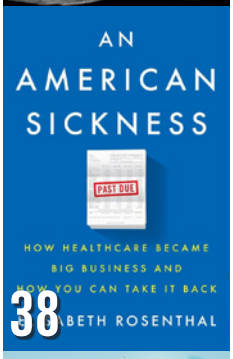
22

30

DEPARTMENTS

Minnesota Medicine is intended to serve as a credible forum for presenting information and ideas affecting Minnesota physicians and their practices. The content of articles and the opinions expressed in *Minnesota Medicine* do not represent the official policy of the Minnesota Medical Association unless this is specified. The publication of an advertisement does not imply MMA endorsement or sponsorship.





MINNESOTA **MEDICINE**

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

OWNER AND PUBLISHER
Minnesota Medical Association

EDITOR
Greg Breining

DIRECTOR OF COMMUNICATIONS
Dan Hauser

ART DIRECTOR
Kathryn Forss

CIRCULATION/WEB CONTENT
Mary Canada

MEDICAL EDITORS
Rahel Nardos, MD
Christopher Wenner, MD
Colin West, MD, PhD

SUBSCRIPTIONS
Annual subscription: $45 (U.S.) and $80 (all international)

MISSING ISSUES AND BACK ISSUES
Missing issues will be replaced for paid subscribers at no additional charge if notification is received within six months of the publication date. Replacement of any issues more than six months old will be charged the appropriate single back issue price. Single back issues of *Minnesota Medicine* can be purchased for $25 (U.S.) and $30 (Canada, Mexico, and other international). Send a copy of your mailing label and orders to Mary Canada, 3433 Broadway Street NE, Suite 187; Minneapolis, Minnesota 55413-2199 or fax it to 612-378-3875.

To submit an article
Contact the editor at mm@mnmed.org.
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents.

Rahel Nardos, MD

Global is local

"I have lived enough," my patient said without hesitation. "I am already 40, so from now on, I should think about my death." Sinedu (alias name) was my patient at the Addis Ababa Hamlin Obstetric Fistula Hospital in Ethiopia where I was working as a surgeon in 2007. She had a devastating childbirth injury from prolonged labor resulting in obstetric fistula, a hole in her bladder causing her to leak urine continuously. Like most women in her rural community, she had labored for days without access to emergency obstetric care. According to the United Nations Population Fund, half a million women and girls are thought to be living with obstetric fistula in 55 countries in sub-Saharan Africa, Asia, the Arab states, Latin America and the Caribbean. My patient is one of the lucky ones who survived childbirth—although surviving childbirth comes with long-term physical and psychological consequences for many women.

According to the World Health Organization, a woman dies every two minutes from pregnancy and childbirth-related causes, with nearly 95% of those deaths occurring in low- and lower-middle-income countries. Up to 80% of maternal deaths are preventable. Just over a century ago, maternal mortality in the United States and other high-income countries was just as high (and even higher) than what we are seeing in low-income countries now. But major healthcare transformation such as access to midwifery care, discovery of medications to prevent infectious and hemorrhagic morbidities of childbirth, and overall improvement of team-based patient care drastically cut maternal mortality and morbidity. Despite our tremendous success in transforming maternal care (albeit with tremendous disparities within our own population), we have failed to successfully scale this up on a global scale. Patients like Sinedu have a lot to offer and they should never feel like life is over at age 40.

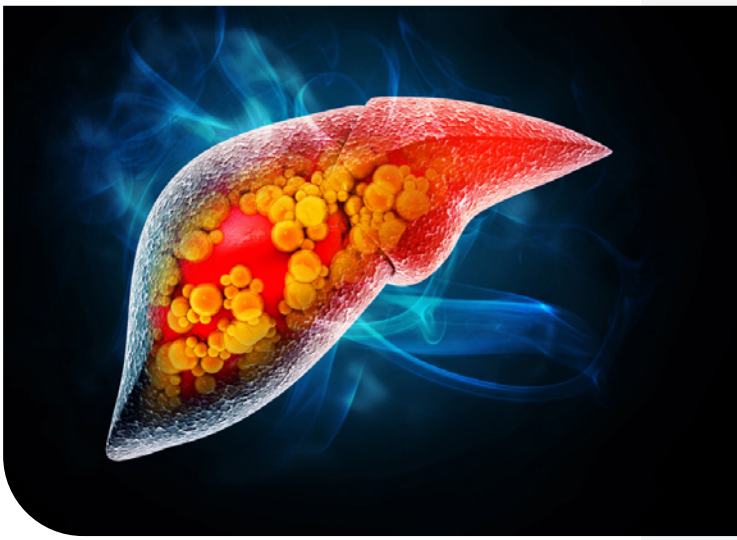
Our lack of bold vision to work towards the well-being of our global community and to scale breakthroughs in healthcare to benefit the whole of humanity has less to do with lack of resources and capacity and more to do with our failure to recognize that our fate is intertwined. If a woman in Kenya did not have timely and safe obstetric care, the United States of America may not have had its first black president in history. The truth is that even in our own community, we depend on many from immigrant and refugee communities whose health journey in their own countries or the refugee camps where they came from significantly affects their ability to fully contribute to our society. Some of us healthcare professionals who are immigrants ourselves or who collaborate with health systems in countries where our patients come from recognize this interconnectedness more acutely and have a responsibility to bring awareness to everyone else.

Our lack of bold vision to work towards the well-being of our global community and to scale breakthroughs in healthcare to benefit the whole of humanity has less to do with lack of resources and capacity and more to do with our failure to recognize that our fate is intertwined.

The reason to think global is not to save others who are less fortunate or to establish some sort of dependency that gives us a sense of superiority. Instead, we should think global because global is local, because our own well-being and ability to solve our planet's most persistent problems such as the safety and well-being of our families, the climate crisis, economic instability, and the threat of war, depends on everyone else being healthy. The World Health Organization defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. When we commit to this version of global health, we are committing to a better world for ourselves and our children. No one captures this sentiment better than the indigenous Australian activist, Lilla Watson, who is credited with the quote, "If you have come here to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, then let us work together." MM

Rahel Nardos, MD, MCR, is associate professor, Department of Obstetrics, Gynecology and Women's Health, and director, Global Women's Health, at the University of Minnesota. She is one of three medical editors for *Minnesota Medicine*.

New University of Minnesota research sheds light on better treatments for liver disease



New research from the University of Minnesota Medical School reveals how the liver may try to protect itself from serious liver damage, called metabolic dysfunction-associated steatotic liver disease (MASLD). The condition affects over a third of U.S. adults and is expected to impact 122 million Americans by 2050, and is a leading cause of cirrhosis and the requirement for liver transplant.

Published in *The Journal of Clinical Investigation*, the study found that in humans, a liver process called ketogenesis—the body's way of breaking down fat—may actually help fight off severe liver damage. In a related study from the research team, published in *Science Advances*, they found that ketone bodies—substances made by your liver when it breaks down fat for energy—may also play a role in supporting the production of healthy fats that optimize the function of cells within our organs.

"These studies show unexpected connectivity between the nutrients we eat and the products of our body's own metabolism," says Patrycja Puchalska, PhD, an assistant professor at the University of Minnesota Medical School and co-lead researcher on both studies. "Our newest data suggest that this connection might not be limited to the liver—it could also potentially influence brain development in newborns."

The study used preclinical models that were genetically unable to make ketones and got sicker when fed a high-fat diet. However, when ketogenesis was active, the fat burned off efficiently and the liver built healthy fats called polyunsaturated fatty acids. These healthy fats are known to protect the liver from damage and are commonly found in fish oils.

"Our findings suggest that interventions that stimulate ketone body production, such as low-carbohydrate diets and intermittent fasting, should be considered for treating MASLD," says Eric Queathem, a graduate student at the University of Minnesota Medical School.

This new understanding could open the door for more targeted treatments. Rather than just focusing on burning fat, future therapies could support or mimic ketogenesis to help counter the progression of liver disease.

"These studies provide quantifiable biomarkers of our healthy feeding and fasting cycles, which should allow us to predict, at a personalized level, when our feeding and fasting patterns are optimizing our health, and when they are not," according to Peter A. Crawford, MD, PhD, a professor at the medical school and co-lead author of the two studies.

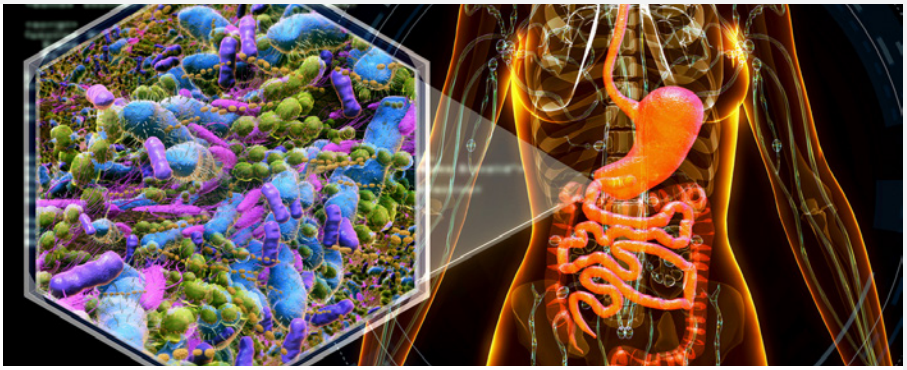
—University of Minnesota Physicians

Copic Medical Foundation awards metro-based community health initiative

This spring, the Copic Medical Foundation awarded St. Mary's Health Clinics a grant that will support its Community Health Empowerment Initiative (CHEI), which aims to reduce healthcare fragmentation for 1,200 uninsured, Spanish-speaking immigrants in the Twin Cities metro area.

CHEI integrates bilingual community health workers, medication therapy management technology, and culturally tailored education to create a seamless "medical home" model for those at high risk for chronic diseases.

The St. Mary's grant is just one of several that the Copic Medical Foundation has awarded to healthcare entities that address reducing fragmentation across care settings. Grant funding focused on initiatives that contribute to a solution by supporting scalable or replicable solutions, the testing of new ideas or growing existing solutions, and then seeing avenues for larger application.



Stool may yield clues to microbiome's role in cancer treatment

At Mayo Clinic's Center for Individualized Medicine, scientists are investigating stool samples to uncover new insights into cancer treatment. Stool may provide valuable information about the microbiome—a complex ecosystem of microorganisms, including bacteria, fungi and viruses in the gut.

Growing evidence shows the microbiome plays a significant role in health, including how the body responds to diseases like cancer and how it influences treatment outcomes.

A key part of the team's research is the oncobiome project, which includes a large collection of stool samples from Mayo Clinic cancer patients. These samples, collected before patients began treatment, are helping researchers identify microbial patterns that predict how well a patient will respond to treatments. The work may pave the way for more personalized cancer care strategies.

What sets the oncobiome project apart is its strategic design, which bridges research and clinical practice. This approach makes it easier to translate scientific discoveries into personalized treatments for cancer patients.

"Ultimately, we hope to individualize treatment plans that provide the right drug at the right time based on a person's unique microbiome and genetics," says Purna Kashyap, MBBS, the Bernard and Edith Waterman director of the Mayo Clinic Microbiomics Program.

At the heart of the project is the collection and analysis of more than 2,000 stool samples. This extensive biobank allows Kashyap and his team to examine whether the microbiome composition correlates with specific types of cancer. They also are investigating whether the microbiome can predict the likelihood of event-free survival for patients with cancers such as lymphoma who are undergoing various treatments.

Additionally, the project explores whether enzymes and metabolites produced by the gut microbiome can offer insights into how patients will respond to cancer immunotherapies and help identify potential adverse reactions.

"We included a diverse group of patients at various stages of different cancers and undergoing various treatments. This allows us to identify microbial patterns that forecast optimal cancer outcomes, independent of the underlying cancer," Kashyap says.

Ruben Mars, PhD, a research scientist at the Center for Individualized Medicine, is playing a key role in leading several studies within the oncobiome project to understand the impact of microbes on cancer risk, treatment efficacy, and the underlying mechanisms of any treatment side effects.

"Although a diverse and balanced gut microbiome is widely recognized as beneficial for our health, pinpointing specific microbial changes that enhance treatment outcomes remains challenging," Mars says. "Through the oncobiome project, we're optimistic about developing innovative methods to manipulate the microbiome and ultimately improve cancer care for patients." – Mayo Clinic

Long-time NAMI Minnesota leader announces retirement

After 24 years at the helm, Sue Abderholden, MPH, is retiring as executive director at NAMI Minnesota, effective October 15.

The NAMI Minnesota Board of Directors has hired an executive search firm to find her replacement.

Abderholden "led the way in transforming Minnesota's mental health system—helping pass laws to bring mental health awareness and treatment into schools, separate out children's mental health from the child protection system, increase the diversity of our mental health workforce, expand crisis services statewide, expand Medicaid to cover mental health care, and fight for mental health parity protections," says Jessica Gourneau, PhD, LP, president of the NAMI Minnesota board.

"When I first walked through the doors of NAMI Minnesota, we were a small and scrappy team, but we had a big dream: to make sure no one navigating a mental illness had to do it alone," Abderholden wrote in a May 1 email.

"In the years since, together we built something extraordinary," she wrote. "We changed laws to build our mental health system. We raised awareness, fought discrimination, and grew our programming to meet the communities' needs. We didn't just dream about change—we made it happen."

Abderholden, a longtime advocacy partner of the MMA, says she plans to spend more time with her family and friends, travel a little, and catch up on a huge stack of books.

New residency program at Grand Itasca expands rural physician pipeline

The University of Minnesota Medical School and Fairview are expanding rural physician training in the state with a new residency program. The Grand Itasca Clinic and Hospital Rural Family Medicine Residency was recently approved by the Accreditation Council for Graduate Medical Education (ACGME).

"This approval is an important step in building the program," says Shailey Prasad, MD, MPH, associate vice president for global and rural health at the University of Minnesota Medical School. "Working with the team at Grand Itasca has been an amazing experience. The site has been hosting Rural Physician Associate Program students for many years, and this program will add to the educational experience in Grand Rapids."

Residents will start the three-year program with one year of training with the University Woodwinds Hospital Residency Program at M Health Fairview Woodwinds Hospital in St. Paul, followed by two years at Grand Itasca in Grand Rapids. The program will train two new family medicine physicians per year.

"Our community is extremely excited to grow this new program," says residency program director Tim Pehl, MD. "We will be training the next generation of doctors in the unique challenges of rural primary care by fully integrating them into our local hospital."

Students can start applying to the program in September 2025, with the first cohort set to begin in July 2026.

This new program joins the Willmar Rural Residency Program as the only rural family medicine training programs in Minnesota—creating new opportunities for medical students seeking specialized training in rural healthcare.

–University of Minnesota Medical School

CIDRAP launches Vaccine Integrity Project

The University of Minnesota's Center for Infectious Disease Research and Policy (CIDRAP) has launched an initiative dedicated to safeguarding vaccine use in the U.S. The Vaccine Integrity Project and its steering committee will engage professionals across the U.S. immunization landscape to gather feedback on how nongovernmental entities may be able to help protect vaccine policy, information, and utilization across the U.S.

The Vaccine Integrity Project is supported by an unrestricted gift from Alumbra, a foundation established by philanthropist Christy Walton. CIDRAP's long-standing mission is to "prevent illness and death from targeted infectious disease threats through research and the translation of scientific evidence into real-world, practical applications, policies, and solutions."

"This project acknowledges the unfortunate reality that the system that we've relied on to make vaccine recommendations and to review safety and effectiveness data faces threats," says Dr. Michael Osterholm, regents professor and director of CIDRAP. "It is prudent to evaluate whether independent activities may be needed to stand in its place and how nongovernmental groups might operate to continue to provide science-based information to the American public."

The Vaccine Integrity Project has established a steering committee of eight leading public health and policy experts to make recommendations for how vaccine use can remain grounded in the best available science, free from external influence, and focused on optimizing protection of individuals, families, and communities against vaccine-preventable diseases.

Across a series of information-gathering sessions, the Vaccine Integrity Project will engage professional medical associations, public health organizations, state public health officials, vaccine manufacturers, medical and public health academia, health insurers, healthcare systems, pharmacies, health media experts, and policymakers. Based on feedback collected during the sessions, future activities may be established, such as: establishing a network of subject matter experts to conduct vaccine evaluations and develop clinical guidelines based on rigorous and timely reviews; strengthening the evidence base by identifying knowledge gaps and recommending studies to enhance vaccine-related evidence, practice, and policy; and reviewing government decisions and messaging to provide clear, evidence-based information, where needed. MM

– University of Minnesota's Center for Infectious Disease Research and Policy

MISSED SHOTS

DESPITE ITS REPUTATION AS A HEALTHCARE LEADER, MINNESOTA RANKS NEAR THE BOTTOM OF ALL STATES IN ITS CHILDHOOD VACCINATION RATE.

BY SUZY FRISCH

Not a day goes by that family medicine physician Laurel Ries, MD, doesn't counsel patients about getting themselves or their children immunized. She understands that people have many reasons for not completing the recommended vaccinations, and she does her best to share information and answer their questions. But Ries knows that the work to boost vaccination rates in Minnesota is an uphill battle.

That's because Minnesota has some of the most lenient immunization laws in the country. As an M Health Fairview physician in St. Paul and immediate past president of the Minnesota Medical Association, Ries is doing all she can to make sure that patients and the public are getting immunized. Yet time and again, Ries sees the effects of these lax policies.

Though Minnesota typically ranks highly for its top-quality healthcare systems and overall healthy population, it's an outlier in immunization rates. It ranks 42nd in the country for percentage of children who have completed their vaccine series by age 35 months, according to 2024 U.S. Centers for Disease Control and Prevention data. The rate of children completing their vaccine series in Minnesota has generally declined since 2012, long before well-known anti-vaccine advocate Robert F. Kennedy Jr. took the helm at the federal Department of Health and Human Services.

"Many other states are experiencing the same thing. What's unique to Minnesota is that we have a particularly weak vaccine law that allows patients to decline vaccines for school just based on any conscientiously held belief. That big exemption is causing a lot of gaps in immunization," Ries says. "Then everything affecting everyone else is there, too, like vaccine misinformation paired with people's lack of trust in public health."

MMA'S VACCINE HESITANCY CHEAT SHEET

In 2023, 63% of Minnesota children ages 35 months were immunized, a drop from 67.8% in 2018, the Minnesota Department of Health reports. When Minnesota children entered kindergarten in the 2022–23 school year, 89% were fully vaccinated, according to MDH, compared to 93% nationally. Before the COVID-19 pandemic, the national rate held steady at 95%, the CDC reports.

There are many underlying factors explaining why Minnesota is lagging with immunizations. Those born in 2019 and 2020 are still catching up from pandemic-era clinic lockdowns, followed by several years of difficulty getting appointments when medical providers were swamped and understaffed, says Robert M. Jacobson, MD, FAAP, a pediatrician and researcher at Mayo Clinic.

During this time, some patients avoided bringing their children to the doctor for fear they would test positive for COVID-19 and then need to stay home from school or day care. That meant missed opportunities for getting patients vaccinated, Jacobson says. As other viruses started raging in 2022, it became common for physicians to see children only if they were ill—not the best time to get immunized.

Laurel Ries, MD, physician
M Health Fairview

> "What's unique to Minnesota is that we have a particularly weak vaccine law that allows patients to decline vaccines for school just based on any conscientiously held belief. That big exemption is causing a lot of gaps in immunization. Then everything affecting everyone else is there, too, like vaccine misinformation paired with people's lack of trust in public health."

Minnesota also is no stranger to vaccine hesitancy fueled by misinformation. Though opposition to vaccines has existed here for decades, the debunked 1998 *Lancet* study that linked autism with the measles, mumps, and rubella (MMR) vaccine ignited the anti-vaccine movement. As misinformation spread on social media, the World Health Organization in 2019 listed vaccine hesitancy as a major public health threat. Then COVID and fear about its newly developed vaccine heightened people's hesitancy.

Jacobson points out another factor coming into play in Minnesota: waning pushback from educators and clinicians. When students come to school with their childhood vaccines incomplete, school officials are more reluctant to address it. "They don't want to have a fight with a parent or the school board. They are not necessarily treating the missed vaccines as aggressively as you might imagine, where they contact the parent and keep the child out of school until they are vaccinated," he says. "That lack of confrontation has slipped into clinic offices, too. Providers give up early with making a vaccine recommendation, or they use language that our research shows encourages or expands parents' vaccine hesitancy."

Robert M. Jacobson, MD, FAAP
Pediatrician and researcher
Mayo Clinic

> "EDUCATORS AND CLINICIANS DON'T WANT TO HAVE A FIGHT WITH A PARENT OR THE SCHOOL BOARD. THEY ARE NOT NECESSARILY TREATING THE MISSED VACCINES AS AGGRESSIVELY AS YOU MIGHT IMAGINE, WHERE THEY CONTACT THE PARENT AND KEEP THE CHILD OUT OF SCHOOL UNTIL THEY ARE VACCINATED. THAT LACK OF CONFRONTATION HAS SLIPPED INTO CLINIC OFFICES, TOO. PROVIDERS GIVE UP EARLY WITH MAKING A VACCINE RECOMMENDATION, OR THEY USE LANGUAGE THAT OUR RESEARCH SHOWS ENCOURAGES OR EXPANDS PARENTS' VACCINE HESITANCY."

Health disparities, often fueled by social determinants of health, also play a role in low immunization rates, Ries says. Layers of barriers often prevent people in both rural and urban areas from accessing healthcare, including vaccines. "Ordinary Minnesotans are dealing with challenges every day," Ries says. "When you have a family working two jobs and they are still struggling to make ends meet and then their car breaks down, sometimes preventive care doesn't rise to the top of the necessities list."

Extra exemptions

Along with these factors, there is another major culprit in Minnesota that physicians, legislators, and public health experts agree should be eliminated: the broad personal exemption. On top of medical exemptions, Minnesota allows parents to sign a form stating that they do not want their child immunized for any reason. It must be notarized, but it does not need to be reviewed or signed by a physician. Minnesota also does not require documentation of vaccine status to be signed off by a healthcare provider, says Minnesota State Sen. Alice Mann, MD, an emergency medicine physician.

Fixing these loopholes would make a big difference. "We have some of the most lenient vaccination laws in the country. We essentially allow people to not get vaccinated for any reason they want. Our laws have not kept up with the level of misinformation that's out there," Mann says. "There has been an anti-vaccine movement for a long time, and I don't think we've adequately met this issue head-on. We have not spent the extra time and resources to educate the public."

Ries agrees, noting that the MMA advocates for Minnesota to remove the personal belief exemption. "A law that allows people to not follow it if they don't want to ends up being not a very strong law," she says. "Vaccinations are in the best interest of public health, and getting vaccinations is similar to not driving drunk or not smoking. Getting immunized is protecting not just you but the people around you and the greater community."

A legislator since 2018, Mann wants Minnesota to require that students' immunization records be signed off by a healthcare provider to boost their accuracy. Forty-seven states do this. She also champions withdrawing Minnesota's permanent medical exemption. Many states offer a temporary medical exemption that needs to be reevaluated periodically. In addition, Mann wants to consider requiring people to talk with a physician or watch a video about vaccinations to break through the misinformation barrier. Some states require people to be vaccinated during a disease outbreak—something Minnesota could adopt, too.

Minnesota State Sen. Alice Mann, MD
Emergency medicine physician

> "We have some of the most lenient vaccination laws in the country. We essentially allow people to not get vaccinated for any reason they want. Our laws have not kept up with the level of misinformation that's out there. There has been an anti-vaccine movement for a long time, and I don't think we've adequately met this issue head-on. We have not spent the extra time and resources to educate the public."

Public health attorney and State Rep. Mike Freiberg has been working on vaccine policy since he was elected in 2012. Freiberg notched a win in 2024 with a new law that he believes will make a difference in the state's immunization rates. It allows childcare facilities and licensed family providers to require that children in their care over 2 months old meet certain vaccination requirements.

"Private businesses wanted the ability to set their own policy related to vaccines," Freiberg says. "Day cares had been under the same exemption requirements as schools, whether they are privately owned or a public day care facility. They had to admit any child whose parents submitted the notarized form. That's a problem in day care because infants are too young to be vaccinated against many diseases."

In the current political climate, Freiberg thinks it's unlikely that Minnesota will eliminate its nonmedical exemption. But he has tried other approaches, such as introducing a bill requiring parents to have their healthcare provider sign a certificate of exemption for religious, philosophical, and medical reasons. It did not pass. "It's sound public health practice so it shouldn't be controversial," he adds. "But the anti-vaccine people have only grown louder in their objections since COVID, and a lot of legislators are responsive to that."

Freiberg believes that other surgical legislative strikes, like the day care bill, are more feasible. He recently introduced two bills. The first would eliminate the nonmedical exemption for just the MMR vaccine, especially as measles spreads anew. Freiberg also introduced a bill to fund outreach to communities with low vaccine rates, providing them with culturally appropriate and targeted scientific information. However, those efforts would require additional funding for MDH, which already is reeling from $220 million in recent federal budget cuts.

Mann is dismayed that the Minnesota Immunization Information Connection (MIIC)—the state's repository of electronic immunization records—might be impacted by the cuts. MDH announced it might not be able to upgrade and keep its technology current, which is very concerning for physicians who need to know their patients' vaccination status, she says.

To tighten the state's vaccination laws, it would make a big difference for physicians to share their professional opinions with legislators, Mann says. "Physicians should be calling their representatives and senators and saying, 'Pay attention to this measles outbreak and pay attention to the avian flu that is coming and pay attention that our immunization rates are some of the lowest in the country,'" she adds. "We're going to be in trouble if we don't do something. Who better to do that than physicians who are on the front lines?"

When talking to legislators or patients or parents, Mann says, the overriding message should be: "Immunizations are safe, they are effective, and they were one of the most incredible discoveries in our lifetimes to prevent illness and unnecessary death and suffering."

Boosting the rates

The doctor's office is an important place to move the needle on immunizations. To start, primary care and specialist physicians all should make themselves aware of patients' vaccination status before their appointments, Jacobson says. They should know what vaccines patients have had and what might be coming due, talking with people about recommended immunizations. Otherwise, an opportunity is lost.

To improve reporting, physicians also should use an electronic health record that links to the MIIC. That way, healthcare providers and pharmacists have an up-to-date record on what immunization patients need, Jacobson says. Finally, anyone seeing patients under the age of 18 should sign up for the Minnesota Vaccines for Children program to gain access to resources, including information and reduced-cost or free shots for patients.

Another resource to counteract hesitancy comes from Voices for Vaccines, an organization launched by two Minnesota par-

ents and now is a national resource for parents, physicians, and nurses everywhere, Jacobson says. It offers free, self-paced, evidence-based training in becoming a trusted messenger about the safety, efficacy, and necessity of immunizations, and how to best have conversations about it.

A critical way to reduce vaccine hesitancy relates to these physician-led conversations. Based on Mayo Clinic research, Jacobson notes that using presumptive language about the vaccines is highly effective compared to participatory language. "Instead of saying, 'You can get this vaccine if you want it. What are your thoughts?' you should say, 'You're due for this vaccine and my nurse or I can give it to you now,'" he says. Jacobson hears from trainees and physicians regularly that this approach makes a big impact on patients' vaccine uptake. "It's a subtle difference, but you're making it clear that you want the patient to get the vaccine, and it takes away a lot of their anxiety."

It helps to understand that one-third of people are vaccine hesitant, and just 1.3% of 2-year-old children are unvaccinated in the United States because their parents refused all shots, Jacobson says. That provides opportunities to turn hesitancy into action through motivational interviewing. He believes that this approach helps people open up about their concerns and allows clinicians to address them.

The Four-A method is a big part of it: ask open-ended questions, active listening, acknowledge what's right, and affirm the journey. Clinicians can note why people's questions make sense, explain what parts are true, and share what the provider has learned differently. "You're making sure parents or patients know that they are the decider. And you can get them information in a way that's not combative or confrontational," Jacobson says.

When interacting with families about vaccines, Ries assures parents that they are on the same team and acknowledges that their questions come from a place of wanting what's best for their child. "We all want kids to be healthy," she says. "I'm there to provide information and expertise and try to explain something that can be really hard to understand."

Ries explains the risks and benefits of immunizations, noting her belief that the benefits outweigh the risks. "I tell them that I have children, and this is what I did with my children. That goes a long way because we know everyone cares about their children. I'll offer them recommendations and honor them when they say, 'I'm not ready. I need to think about this.' Then I will give them information and welcome them back if they should decide they want the vaccine.

"As a physician and scientist, I encourage people to ask questions," Ries says. "I like when people ask whether it's safe, because that is the right question to ask when getting healthcare. Questioning is a good thing. Then we can have a positive dialogue, and then we can all get on the same page." MM

Suzy Frisch is a Twin Cities freelance writer.

State Rep. Mike Freiberg

"Private businesses wanted the ability to set their own policy related to vaccines. Day cares had been under the same exemption requirements as schools, whether they are privately owned or a public day care facility. They had to admit any child whose parents submitted the notarized form. That's a problem in day care because infants are too young to be vaccinated against many diseases. Vaccination is sound public health practice so it shouldn't be controversial, but the anti-vaccine people have only grown louder in their objections since COVID, and a lot of legislators are responsive to that."

NEW DEA CERTIFICATE RENEWAL REQUIREMENTS ARE YOU READY?

Special Discount Available for Minnesota Medical Association Members!

Use MNMED100 for $100 Off

HTTPS://CLINICALOPTIONS.COM/CONTENT/DEA-RESOURCE-CENTER

LEARN MORE

WHAT IS IT?

Effective June 27, 2023, the US Drug Enforcement Administration (DEA) requires all DEA license holders to take at least 8 hours of training on opioid or other substance use disorders, as well as the safe pharmacologic management of dental pain, to apply for or renew their DEA certification.

HOW CAN I FULFULL THIS REQUIREMENT?

In partnership with Clinical Care Options (CCO), MMA now offers a comprehensive, DEA-compliant CME course, Controlled Substance Prescribing and Substance Use Disorders. Learn at your own pace on-demand—with expert-led sessions that can be taken whenever, wherever.

TAKING IT TO THE STREET

With help from the MMA and Mayo Clinic medical students, University of Minnesota med students work to build a 'street medicine' elective.

BY ANDY STEINER

A ZVMS Street Medicine team delivers winter care kits to homeless people in Rochester.

Like most future physicians, Katie McLaughlin went to medical school with the goal of helping others. So it only made sense that when she learned about a volunteer "street medicine" program cofounded by students at the Mayo Clinic Alix School of Medicine in partnership with the Zumbro Valley Medical Society (ZVMS), McLaughlin began thinking about ways that she and her fellow students at the University of Minnesota Medical School could replicate the project on the Duluth and Twin Cities campuses.

"Through my training so far, I've been most inspired by the reality that physicians who both care for and advocate for their patients also run toward the most pressing and complex challenges in healthcare and society," McLaughlin said. Homelessness, she believes, is one of those challenges, so the opportunity to help provide healthcare for people without stable housing seemed like a meaningful way to put her beliefs into action.

During her first two years of medical school, McLaughlin—like many of her Minnesota Medical Association Medical Student Section peers—was involved in clinical outreach with organizations like the HOPE Clinic and the University of Minnesota Mobile Health Initiative. "That's how I was getting involved in the Duluth community," she said, "and I was meeting many community members who were experiencing homelessness."

Interested in finding ways to expand the medical school's outreach to homeless people, McLaughlin had been meeting with a group of other med students interested in bringing street medicine to the University medical school. So, with her medical school classmate Christopher Prokosch, she reached out to Juliana Milhofer, JD, MMA public health and policy engagement manager.

Milhofer, who staffs the MMA's Medical Student Section, said she was inspired by the students' enthusiasm for this project. She, McLaughlin, Prokosch, and other students discussed what was happening in Rochester.

ZVMS Street Medicine, now in its fifth year, had started as a student-developed training series and grew into a "selective," the Mayo Clinic medical school's version of an elective. Milhofer and the group of interested med students decided that there was enough interest that they might be able to do the same thing at the University medical school.

ZVMS Street Medicine community clinics bring together a variety of volunteers to serve the Olmsted County community.

> "WE STARTED BY LISTENING [TO COMMUNITY ORGANIZATIONS]. THEY WELCOMED US. WE ATTENDED MEETINGS AND HEARD ABOUT THE WORK THAT IS ALREADY GOING ON AND TRIED TO IDENTIFY HOW WE AS STUDENTS CAN PARTNER AND SUPPORT THE WORK THAT THEY HAVE ALREADY BEEN DOING."
>
> Katie McLaughlin, student
> University of Minnesota Medical School

"We thought, how can we bring this kind of program to the biggest medical school in the state?" Milhofer said. "We thought about what we needed to make this happen, and we decided to start small. We wanted this to be something that was organically taking place." The project quickly began taking shape, and before long, a student-led street-medicine program was up and running—on the University's Duluth and Twin Cities campuses.

"The level of student interest was exciting," Milhofer said. The momentum was real, and the MMA was committed to helping University students make this change a reality at the medical school.

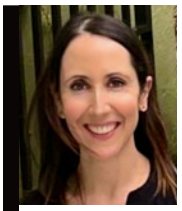
Origin story

The source of the UMN medical students' inspiration, ZVMS Street Medicine, began during COVID-19, when ZVMS created an online training series that invited homelessness service partners to discuss things they'd like future physicians to know about the people they serve. During the seven-part series, Mayo Clinic medical students took a deeper dive into seeing medical care from the patient perspective, Beth Kangas, ZVMS executive director, explained: "We learned about issues like the importance of building trust and things that doctors can do to be tolerant of missed appointments."

The series culminated in a presentation by Jim Withers, MD, FACP, the founder of the Street Medicine Institute. The presentation inspired one medical student to find a way to start a street medicine program in Olmsted County, where the Mayo Clinic is located. "We decided the best way to do that was to start with what Mayo Clinic calls a 'selective,'" Kangas said. "We saw this as a way to train mainly first-year medical students in street medicine, how to provide care to people experiencing homelessness where they are."

Grant Welk, a third-year medical student at Mayo Clinic, said that a small cohort of students at the time began reaching out to community organizations that were already serving the city's homeless population to learn about ways they could contribute. The 20-hour selective, which is optional, has proven widely popular. "The majority of students now participate in this program," Welk said. (Kangas estimates about 70%.)

As part of their participation in the street medicine selective, Mayo Clinic medical students are trained in crisis de-escalation and communication strategies, said Kathryn Xu, a third-year medical



> "WE THOUGHT, HOW CAN WE BRING THIS KIND OF PROGRAM TO THE BIGGEST MEDICAL SCHOOL IN THE STATE? WE THOUGHT ABOUT WHAT WE NEEDED TO MAKE THIS HAPPEN, AND WE DECIDED TO START SMALL. WE WANTED THIS TO BE SOMETHING THAT WAS ORGANICALLY TAKING PLACE."
>
> Juliana Milhofer
> Public health and policy engagement manager
> Minnesota Medical Association

student. The program, which is based in part on street medicine programs in larger cities, has adapted to meet Rochester's unique needs.

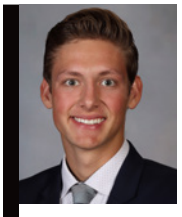
"Since we are in a smaller community," Xu said, "instead of doing street runs," where students go into the streets to bring unhoused people food, water, and supplies, "our program focuses more on holding free community clinics. We hold biannual eye-care clinics and dermatology and foot-care clinics." At the dermatology and foot-care clinics—which Xu founded—students help with foot soaks, as well as with education about ways to keep feet and other extremities as clean and dry as possible.

ZVMS Street Medicine held its first community clinic in December 2022, focusing on foot care.

Mayo Clinic medical students volunteer at ZVMS Street Medicine's biannual eye-care clinics.

In addition to medical care, guests to the ZVMS Street Medicine dermatology and foot-care clinics receive socks and footwear.

ZVMS Street Medicine community clinics provide guests with medical care and additional supplies.

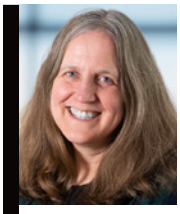


A SMALL COHORT OF STUDENTS AT THE TIME BEGAN REACHING OUT TO COMMUNITY ORGANIZATIONS THAT WERE ALREADY SERVING THE CITY'S HOMELESS POPULATION TO LEARN ABOUT WAYS THEY COULD CONTRIBUTE. THE 20-HOUR SELECTIVE, WHICH IS OPTIONAL, HAS PROVEN WIDELY POPULAR. "THE MAJORITY OF STUDENTS NOW PARTICIPATE IN THIS PROGRAM."

Grant Welk, third-year student
Mayo Clinic Alix School of Medicine

Kangas said that the ZVMS is proud of the way its street medicine program so quickly became an integral part of the experience for students, especially for first-years. By providing direct care to marginalized members of the community, they are learning what it takes to truly serve patients.

"Our Street Medicine selective participants are brand new, they're becoming doctors. In the first-year of medical school, they're learning the science, but not much



"OUR STREET MEDICINE SELECTIVE PARTICIPANTS ARE BRAND NEW, THEY'RE BECOMING DOCTORS. IN THE FIRST-YEAR OF MEDICAL SCHOOL, THEY'RE LEARNING THE SCIENCE, BUT NOT MUCH OF THE ART OF MEDICINE. THE FIRST POTENTIAL PATIENTS THEY'RE COMING IN CONTACT WITH ARE PEOPLE EXPERIENCING HOMELESSNESS. WE LIKE TO THINK THIS EXPERIENCE IS HELPING TO DEFINE THE KIND OF CARE THAT THEY WILL PROVIDE: COMPASSIONATE AND MEETING PEOPLE WHERE THEY ARE.

Beth Kangas, executive director, ZVMS

of the art of medicine," Kangas said. "The first potential patients they're coming in contact with are people experiencing homelessness. We like to think this experience is helping to define the kind of care that they will provide: compassionate and meeting people where they are."

'We started from the ground up'

With ZVMS Street Medicine so well-established, it made sense for University medical students to reach out to Mayo Clinic medical students for their advice on how to get their own program started. In 2022, McLaughlin and her fellow student volunteers met with Kangas and a group of Mayo Clinic students. "They were really generous with their time and the work they've been doing and the curriculum they developed for Mayo students," McLaughlin said.

At first, Milhofer said, University medical school organizers, with the goal of starting small, planned to launch their street medicine program in Duluth, because the community was similar in size to Rochester. But when medical students on the Twin Cities campus got wind of its development, they pushed to get the program started in their part of the state as well.

"It ended up sprouting very quickly," Milhofer said. "In the Twin Cities, we had students staying, 'We should do it here, too. Why just do it in Duluth?'"

Once momentum gathered around organizing street medicine programs in Duluth and the Twin Cities, it was hard to tamp it down, said Elizabeth Breitbach, a third-year University medical student and one of the street medicine program's

The 20-hour ZVMS Street Medicine selective for first-year Mayo Clinic medical students includes training with community partners and people who have experienced homelessness.

A LASTING IMPACT ON STUDENTS

Curious about the impact that ZVMS Street Medicine training has had on selective participants' perceptions of clinical practice, a ZVMS research team of five medical students, a physician, and Kangas conducted a qualitative study with 23 past participants. The findings from the interviews were presented in April at the Society of General Internal Medicine's annual meeting in Hollywood, Florida.

Anjie Ge, a fourth-year student at Mayo Clinic Alix School of Medicine who presented the findings, stated that the interviews highlighted what students had learned from the selective, skills they'd continued to use in their practices, and how the experience impacted the way they see themselves as physicians.

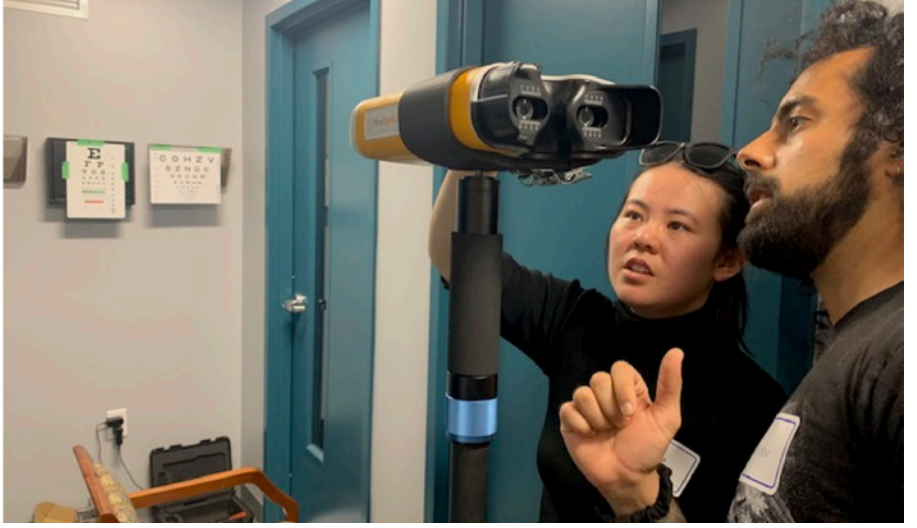
Anjie Ge
Fourth-year student
Mayo Clinic Alix School of Medicine

Many of the students interviewed said they'd learned practical skills during the street medicine selective that they now apply to clinical situations, Ge said. They reported that some of the most important skills they'd learned from the selective were communication skills, including how to more effectively speak with patients and build relationships. "They found that people just wanted to be listened to," Ge said. "That was an important takeaway."

Study participants also said their experience with street medicine helped them to feel more comfortable and empowered in challenging situations. They added that working in street medicine helped them to truly realize the gaps that exist in medical care.

"Something I go back to often is one of the participants saying that treating people as people is not something that is consistently taught in medical curriculum," Ge said. "They thought that street medicine helped them to understand that fact and to learn how to put it into practice—something that they felt made them better physicians."

– ANDY STEINER



Mayo Clinic medical school students play a pivotal leadership role in ZVMS Street Medicine community clinics.

"SINCE WE ARE IN A SMALLER COMMUNITY, INSTEAD OF DOING STREET RUNS, OUR PROGRAM FOCUSES MORE ON HOLDING FREE COMMUNITY CLINICS. WE HOLD BIANNUAL EYE-CARE CLINICS AND DERMATOLOGY AND FOOT-CARE CLINICS."

Kathryn Xu, third-year student
Mayo Clinic Alix School of Medicine

student leaders. While the conversations with the Mayo Clinic medical students were helpful ("We've learned a lot from the Mayo group," she said), they quickly realized that getting the University medical school programs going would require more than just a simple cut-and-paste.

"The landscape is so different between the Twin Cities and Duluth and Rochester. We had to figure out ways to build connections in each location and how to best partner with existing organizations doing this work," Breitbach said. "When we were getting started, we knew that the first thing we needed to do is to listen to the community."

Jessica Crosson, a first-year med student on the Duluth campus, said that student organizers are "working with established and trusted organizations in the Duluth area to see where medical students can help." For example, Crosson explained, she and other Duluth students have been in contact with Loaves and Fishes, a Duluth organization that operates houses of hospitality for people experiencing homelessness, a free bike shop, and a street outreach team that provides free burritos in the wintertime at the city's warming shelters.

"THE LANDSCAPE IS SO DIFFERENT BETWEEN THE TWIN CITIES AND DULUTH AND ROCHESTER. WE HAD TO FIGURE OUT WAYS TO BUILD CONNECTIONS IN EACH LOCATION AND HOW TO BEST PARTNER WITH EXISTING ORGANIZATIONS DOING THIS WORK."

Elizabeth Breitbach, third-year student
University of Minnesota Medical School

Building bridges to community organizations takes time and patience. "We started by listening," McLaughlin said. "They welcomed us. We attended meetings and heard about the work that is already going on and tried to identify how we as students can partner and support the work that they have already been doing."

In the Twin Cities, University medical school students have been working alongside professionals in established organizations like the UMN Mobile Health Initiative and Hennepin Health Care for the Homeless that already serve the city's unhoused population. "These organizations are already doing the work," said Hannah Maher, a third-year med student on the Twin Cities campus. "Our goal is to work alongside them, to let them lead, to not get in the way."

Moving toward elective status

The next step for the University medical school students is to turn the street medicine program into an elective, where students can earn credit for their time volunteering with the program.

Students, in collaboration with Milhofer and medical school faculty, are already developing a curriculum for the program. McLaughlin said she and her student colleagues are working on submitting an official curriculum proposal. "We've met with really great enthusiasm and support," she said.

The range of topics that would be covered in the proposed elective are focused on issues central to housing and homelessness in Minnesota, such as "housing insecurity, looking at the housing-first model of healthcare, understanding lived experiences, letting people direct their own healthcare, trauma-informed care, harm reduction and substance use, building trust, and women's shelter victim advocacy," Breitbach said.

"THESE ORGANIZATIONS ARE ALREADY DOING THE WORK. OUR GOAL IS TO WORK ALONGSIDE THEM, TO LET THEM LEAD, TO NOT GET IN THE WAY."

Hannah Maher, third-year student
University of Minnesota Medical School

The elective would last from two to four weeks. "We'd be going out with existing local organizations doing personal learning about what street medicine is," Maher said. "This is real-world exposure."

With their partners and the support of preceptors, the street medicine team is working to provide a range of services to patients, McLaughlin said, including basic health assessments, chronic disease screening (blood pressure and A1C checks), STI testing, wound and foot care, community health education, and help with finding ongoing healthcare services and resources.

"But effective healthcare doesn't happen unless there's trust," McLaughlin said. "As

"WE'D BE GOING OUT WITH EXISTING LOCAL ORGANIZATIONS DOING PERSONAL LEARNING ABOUT WHAT STREET MEDICINE IS. THIS IS REAL-WORLD EXPOSURE."

Hannah Maher, third-year student
University of Minnesota Medical School

students, we've learned the most important thing we can do in street medicine, like all medicine, is show up consistently, be genuine, listen, truly get to know the person in front of us."

Additionally, the street medicine team works to connect with community members through nonclinical services, too, like distributing food and essential supplies such as over-the-counter medications and wound-care kits, McLaughlin said. This has been possible thanks to support from the UMN Mobile Health Initiative, MMA Foundation, preceptor M. Daisy Braaten, MD, and the UMN Medical School Class of 1966 Grant.

Lately, talk has begun about expanding the street medicine program to St. Cloud, where the University medical school is slated to open a third campus in fall 2025. "The initial conversations are really exciting," McLaughlin said.

After St. Cloud, the next step, she and her fellow student organizers agree, is to move beyond the campuses and expand these programs statewide.

"Homelessness affects people in communities throughout the state," McLaughlin said. "We are starting where our med school campuses in Minnesota are located, but our student group wants to continue to build this momentum. We want to be great collaborators in communities and organizations around the state to increase access for all people." MM

Mayo Clinic medical students Matt Gish and Kathryn Xu check in guests for the June 2024 ZVMS Street Medicine eye-care clinic.

Andy Steiner is a Twin Cities freelance writer and editor.

Advertorial

Caring for our healthcare professionals who care for us

WeCare is a new nonprofit organization started by Christa Rymal, Registered Nurse and former healthcare administrator and leader.

WeCare was founded in response to the urgent and often invisible crisis facing our healthcare workforce—a profession filled with heroes who are suffering in silence. These caregivers face relentless emotional, physical, and moral burdens, often without the support or resources they need to sustain their own well-being. By offering a spectrum of whole-person wellbeing opportunities that provide continuing medical education, support and appreciation are provided to our compromised healthcare workforce.

WeCare offers innovative solutions to a long-standing problem.

The organization's resources provide something new in a space with a true deficit; addressing reported healthcare professionals' pain points and the impact these burnout symptoms have on both professionals and their patients. The organization's resources provide something new in a space with a true deficit; addressing reported healthcare professionals' pain points and the impact these burnout symptoms have on both professionals and their patients.

Under WeCare's umbrella model, a variety of service lines foster healthcare professionals' personal, professional and integrative wellness needs.

Two of WeCare's entities were acquired; WeCare Conferences (formerly known as the MNCares Conference) and the Minnesota Holistic Medicine Group (MHMG). In addition, WeCare's other entities include WeCare Boxes, WeCare Retreats (The Point Retreats), Rebel & Be Well Podcast (Returning in 2025) and WeCare Mobile Clinic and In-Patient Services (Coming soon).

WeCare's newest offering, WeCare Boxes, features clean and impactful wellness products coupled with expert-led CME education. These innovative wellness boxes advance both clinical knowledge as well as an individual's own health, in a safe and comfortable way. With boxes themed to address every major healthcare provider painpoint, WeCare boxes provide solutions to improve whole person health. Boxes are curated and products are chosen by licensed medical professionals. WeCare's innovative boxes can be privately purchased or donated.

products | conferences | retreats | services | professional membership | provider directory

Advertorial

WeCare understands the need to provide tangible and significant solutions to help solve healthcare professionals' unique pain points

WeCare's annual conference is taking place this year on November 12, 2025 at the Heritage Center in Brooklyn Center. This single-day conference offers whole-person wellbeing via an all-inclusive day with keynote speakers, morning and afternoon workshops, lunch, vendor booths and giveaways. Keynote speakers include Dr. Corey Martin and Giovanna Navarro.

Dr. Corey Martin is a Yale-trained family physician driven to change the delivery of healthcare and improve the mental and physical health of our communities. He is a founder of the Bounce Back Project, practicing private group physician, former Bush Fellow, Chief Medical Officer, and lead physician in response to clinician burnout.

Giovanna Navarro, RN, BSN is Dr. Joe Dispensa's lead research nurse and is a catalyst for change, seamlessly blending cutting-edge neuroscience, nursing wisdom, leadership skills, and her own intuition. Especially attuned to doctors, Giovanna equips them to conquer stress, anxiety, burnout, and the rigors of their field, infusing resilience and grace into their journey.

Additionally, on September 22nd WeCare will be hosting its inaugural "Stayin' Alive" fundraising gala at 7 Vines Vineyard in Dellwood, MN.
This elegant event promises an exciting mix of entertainment, philanthropy, and community, all in support of WeCare's mission. This event is open to the public and WeCare welcomes you to join them.

Connect with us @wecare_nonprofit_foundation

Physician well-being recommendations: A 2025 PERSPECTIVE

The intersection of rising rates of physician burnout and new developments in medicine require new recommendations for well-being.

BY CIARA C. O'SULLIVAN, MB, BCH, BAO; KATHRYN J. RUDDY, MD MPH; AMYE J. TEVAARWERK, MD; SAVANNAH LIDDELL, MD; ANDREA E. WAHNER HENDRICKSON, MD; BRITTANY L. SIONTIS, MD; KATHARINE A. PRICE, MD; BRIAN A. COSTELLO, MD; ARIELA L. MARSHALL, MD; LAURA E. RAFFALS, MD; COLIN P. WEST, MD, PHD

Physician burnout, which adversely impacts physician quality of life and patient care, is alarmingly prevalent nationally and globally. Burnout contributes to attrition manifested by physicians reducing clinical hours as well as leaving the medical workforce entirely, which costs the U.S health system about $4.6 billion annually. A scarcity of physicians can also make it more challenging for patients to access quality care locally, potentially increasing healthcare disparities.

Given the potentially devastating consequences of burnout for medical professionals, patients, and healthcare systems, urgent efforts to improve physician well-being are imperative. Physician well-being recommendations are an important way to assist healthcare leaders to optimally support their employees, with the goals of reducing physician burnout and attrition while maintaining excellent and accessible patient care.

Through the years, Mayo Clinic has worked to promote physician well-being in multiple ways, including by publishing the original Mayo Clinic Department of Medicine Guidelines in 2008, targeting individual physicians, institutions, and organizations. Specific well-being offerings currently include well-being index self-assessment tools, virtual coaching groups, and resilience training. Physician Engagement or Colleagues Meeting to Promote and Sustain Satisfaction (COMPASS) groups that have reduced burnout in randomized controlled trials are also well established. Several other academic medical institutions also provide access to online resources that empower physicians and institutions to enhance well-being at the personal, leadership, and organizational level.

As the medical landscape continues to evolve, we present updated 2025 physician well-being recommendations and discuss unmet needs and ongoing challenges more broadly.

The multiple aspects of well-being

Well-being, as defined by Mayo Clinic, is a holistic state encompassing multiple aspects of health, a sense of purpose, happiness, and positive functioning. Unfortunately, poor physician well-being is a global epidemic which adversely affects physicians, patients, and healthcare institutions[1]. Other health professionals and scientists struggle with burnout as well, but this article will focus on physicians, as they are often ultimately responsible for patient management and outcomes, which can confer additional stress.

Although self-sacrifice, prioritizing patient needs, and "doing more with less" have been a way of life for generations of physicians, the demands were often offset by a fulfilling clinical or academic practice[2]. However, ever-increasing workloads and administrative tasks, decreasing

autonomy, and increased professional scrutiny eroded physician well-being, resulting in endemic levels of burnout, an occupational phenomenon characterized by physical and emotional exhaustion, cynicism, depersonalization, and a perceived low sense of professional accomplishment[3]. Notable stressors include electronic health records (EHR), complexity of medical care, regulatory requirements, and performance assessments[1,4,5]. As the issues are multifactorial, and beyond the ability of individuals to address in many cases, broader efforts are essential.

Organizational factors that contribute to burnout include work overload, lack of autonomy, insufficient reward, breakdown of community, lack of fairness, and employer-employee values mismatch[1,6–9]. Burnout is also associated with depression, risky alcohol consumption, and suicide in physicians[10, 11]. Further, physicians experiencing burnout are more likely to make medical errors, be involved in medical malpractice litigation suits, behave unprofessionally, and leave medicine entirely[1, 10]. Physician burnout is a barrier to affordable patient care and a healthier population. Specifically, the cost of physician burnout-related job turnover alone adds about $4.6 billion to the U.S. healthcare system annually[12]. Therefore, it is imperative to advocate for reform to protect physician and patient well-being.

In 2008 Tait Shanafelt, MD, then a hematologist at Mayo Clinic, was the lead author of a review outlining principles to promote professional satisfaction and work-life balance for physicians[13]. The recommendations were intended to help align institutional policies and guide other healthcare organizations. The original manuscript addressed seven areas fundamental to physician well-being[13]. These included meaningful work, challenges commensurate with skills, interests and resources, opportunities for professional development, autonomy and flexible scheduling, and a culture that (1) cultivates professionalism and professional satisfaction, (2) values and encourages life outside of work, and (3) promotes wellness.

In 2012, Shanafelt et al. published the first large national prevalence study on physician burnout, noting that almost 50% of U.S. physicians were at high risk of burnout[3]. The results contributed to growing awareness of the link between work-life balance and physician burnout, but the misperception that burnout was primarily due to individual factors and it fell to physicians to fix their own problems remained common[14]. Mistakenly viewed as another burden on already overworked physicians, the well-being movement was sometimes regarded with skepticism in medical circles[2].

The well-being movement led to multiple individual interventions and pilot studies, some of which modestly improved physician well-being[15], but large randomized interventional studies were not conducted. Following the Accreditation Council for Graduate Medical Education (ACGME) and the National Academy of Medicine (NAM) implementation of guidelines for targeting clinician burnout[16, 17], there is increasing awareness that excessive workplace stress and unhealthy work environments are major contributors. Further, studies suggested greater benefit from interventions improving workplaces and the work itself rather than individual-focused solutions[15, 18]. In recent years, much has been written about mitigating burnout and promoting well-being in physicians[19].

Recent developments, such as virtual medicine and increasing use of email with patients, as well as the continuing burden of the EHR, warrant updating physician well-being recommendations. Although virtual medicine offers increased efficiency and convenience[20], many physicians feel under pressure to address work-related and patient queries outside working hours and on weekends or vacations[21], further blurring boundaries between home and work[22].

Physician well-being

One definition of well-being is pursuing one's full potential, thriving personally and professionally. At Mayo Clinic, the Committee for Employee Well-Being promotes a workplace culture whereby individuals care for colleagues while experiencing personal and professional fulfillment[23]. This is reflected in a values-aligned culture, where employees can thrive and provide exemplary care for patients and colleagues. The Mayo Clinic Program on Physician Well-Being conducts research specifically on physician well-being, assisting physicians to find greater meaning in their work. Other priorities include optimization of staff performance and retention. They have demonstrated that physician burnout reduces quality of patient care and satisfaction, limits access to medical care, and adversely affects the lives of healthcare workers. Specifically, Physician/Scientist

Although self-sacrifice, prioritizing patient needs and "doing more with less" has been a way of life for generations of physicians, the demands were often offset by a fulfilling clinical or academic practice. However, ever-increasing workloads and administrative tasks, decreasing autonomy, and increased professional scrutiny eroded physician well-being, resulting in endemic levels of burnout, an occupational phenomenon characterized by physical and emotional exhaustion, cynicism, depersonalization, and a perceived low sense of professional accomplishment.

Engagement Groups (PEG) or Colleagues Meeting to Promote and Sustain Satisfaction (COMPASS) groups reduced burnout in randomized controlled trials[1, 15, 24–27]. Physicians and healthcare leaders nationally regularly consult with the program on ways to mitigate burnout and increase well-being.

Five focus areas

In 2023, Mayo Clinic identified five focus areas central to employee well-being, specifically, a healthy work environment, personal enrichment, community at work, being valued, and meaningful work[23]. These serve as background for the 2025 physician wellness recommendations and are broadly applicable.

Healthy work environment

This area ensures that employees feel physically and psychologically safe at work. Workload challenges are addressed, and employees are provided with resources to promote well-being. Leaders are encouraged to uphold Mayo Clinic values and implement strategies to address employee-related concerns, and to invest in policies that promote well-being.

Personal enrichment

This area permits employees to support Mayo Clinic's mission and advance professionally, with adequate emotional, financial, physical, and mental support. Leaders are advised to check on colleagues and model healthy work-life balance behaviors. Mayo Clinic in turn invests and provides professional development opportunities while supporting efforts to increase well-being and recognition.

Community at work

This area aims to promote a sense of belonging among employees. Opportunities for physicians at Mayo Clinic include groups, which encourage participants to regularly share a meal and conversation regarding their professional experiences. Every faculty development program in the Mayo Clinic Department of Medicine includes a community building element, to promote opportunities for relationship building and strengthening of community. Across the enterprise, the expectation is that all colleagues and patients are treated in a respectful and compassionate manner.

Being valued

This area aims to ensure employees are respected, heard, and valued, as demonstrated by appropriate compensation and benefits, professional development opportunities, and recognition. At the organizational level, this includes creating opportunities for employees to voice concerns to leadership.

Meaningful work

This area is based on the premise that employees find fulfillment in performing work aligned with their values, interests, and professional skillset. Whenever possible, physicians should work at the top of their license (that is, use their full scope of training to provide the highest level of needed care), delegating tasks which can be completed by other healthcare professionals[28]. At the organizational level, this is reflected by leaders providing career guidance along with resources to enhance employees' skills, and by making institutional decisions with their welfare in mind. Critically, organizations should mitigate burnout for all members of the healthcare team by developing staffing models and implementing process improvement initiatives to match workload to expectations and regulate work intensity so meaningful work can be sustainable[29].

Physicians have varying views as to what constitutes meaningful work, but participating in activities that employ their unique talents may meaningfully reduce burnout. In one study, engaging in meaningful work prevented burnout. Ensuring physicians are working to the top of their scope to meet patient needs increases the proportion of time engaged in duties perceived as meaningful, which decreases burnout.

Physician well-being recommendations for 2025

Given the increasing prominence of virtual medicine (including video, email, and EHR use), and in the aftermath of the COVID-19 pandemic, our group suggested updating physician well-being recommendations for a 2025 audience. The original manuscript by Shanafelt et al. addressed seven areas the department considered fundamental to physician well-being[13]. These areas were each retained and refreshed with guiding principles, current supporting context, and recommendations. The updated areas are described below.

1. Meaningful work

GUIDING PRINCIPLE: Leadership should ensure that physicians spend most of their clinical hours engaged in meaningful work.

BACKGROUND: Meaningful work is the physician's perception that they are using their professional skillset in the most appropriate way. Physicians have varying views as to what constitutes meaningful work, but participating in activities that employ their unique talents may meaningfully reduce burnout. In one study, engaging in meaningful work prevented burnout[30]. Ensuring physicians are working to the top of their scope to meet patient needs increases the proportion of time engaged in duties perceived as meaningful, which decreases burnout[31].

Further, ongoing efforts to streamline EHRs and maintain physician EHR skillsets should be prioritized, as minimizing EHR time can improve the user experience[32–35]. Ensuring each physician has the necessary support staff allows appropriate delegation of requests not requiring physician input. Technologies such as ambient listening tools can significantly reduce documentation burden[36–38]. Further, effective strategies to eliminate redundant, time-consuming tasks within physician workflows are critical[39]. Nonetheless, it is important not to overburden other healthcare and administrative personnel, as they should also work at the top of their license. Therefore, institutions should develop and implement strategies to improve teamwork, manage pace and volume of work, streamline technology, and reduce administrative tasks[29, 40].

RECOMMENDATION: Clinical workflows should be developed and streamlined to reduce overall burden for all staff, delegating tasks not requiring a medical degree to other personnel.

TABLE 1

Physician well-being recommendations 2025

NUMBER	PRINCIPLE	GUIDELINE
1	Meaningful work	Physicians should spend the majority of their working hours engaged in meaningful work.
2	Challenges commensurate with skills, interests, and resources	When assigning professional responsibilities to aspiring physician-leaders, it should be ensured they have the interest, ability or potential, and resources to successfully execute same.
3	Opportunities for professional development	The physician's desired career trajectory should be supported, identifying and providing opportunities for those interested in emerging areas of institutional need.
4	A culture that cultivates professionalism and professional satisfaction	Ongoing efforts to increase workplace satisfaction should focus on addressing pain points, encouraging input from all faculty, and regularly rotating leadership roles.
5	Autonomy and flexible scheduling	Whenever possible, physicians should have professional autonomy and the ability to personalize their working schedule.
6	A culture that values and encourages life outside of work	Institutions should mitigate burnout by addressing barriers preventing physicians from disconnecting entirely from work when out-of-hours or on vacation.
7	A culture of well-being	A culture of wellness should be promoted, by encouraging open discourse regarding physician burnout, and providing tangible, nonjudgmental support for physicians with mental health struggles.

2. Challenges commensurate with skills, interests, and resources

GUIDING PRINCIPLE: When assigning professional responsibilities to aspiring physician-leaders, leadership should ensure they have the interest and resources to successfully execute same.

BACKGROUND: Thoughtfully selecting individuals to assume work-related responsibilities is imperative to ensure that the candidate feels empowered to perform the role. Therefore, at the leadership level, choosing physicians with the greatest interest and training, or willingness to train, for the role is essential, as well as providing appropriate resources and practical support. Overall, appointing individuals with the potential and enthusiasm for the role increases the likelihood of professional success and career advancement. It is also imperative that talented, albeit less qualified, individuals receive training and opportunities to realize their potential.

RECOMMENDATION: Adequate mentorship, training, and practical support should be provided for emerging physician-leaders commencing new roles.

3. Opportunities for professional development

GUIDING PRINCIPLE: Leadership should support and facilitate the physician's desired career trajectory, as well as identify and provide growth opportunities for those interested in emerging areas of institutional need.

BACKGROUND: As physician faculty are recruited to academic institutions given their clinical and scientific expertise, leadership must ensure that individuals have continued opportunities to refine their skillsets and develop interests in administration, leadership, teaching, and research, as applicable. Providing appropriate supports can enable physicians to more easily satisfy time-consuming external recredentialing requirements as career development evolves. Nurturing a propensity for lifelong learning and encouraging ongoing professional development can also mitigate burnout. Departmental leadership must also provide the time, resources, and tailored mentorship to ensure the physician's optimal professional success and satisfaction with their career trajectory. Further, identifying physicians interested in developing skills in emerging areas can complement the evolving needs of the institution. This is relevant for both junior and later-career faculty seeking to pivot or diversify research interests.

RECOMMENDATION: Institutions should facilitate ongoing training and maintenance of certification for physicians to practice at the top of their skill sets and in their areas of interest.

4. A culture that cultivates professionalism and professional satisfaction

GUIDING PRINCIPLE: Ongoing efforts to increase workplace satisfaction should address pain points, encourage input from all faculty, and regularly rotate leadership roles.

BACKGROUND: Physicians who report professional satisfaction provide more optimal patient care, and their work environment is an important factor. Therefore, institutions should continually identify, change, or eradicate problematic workflows or workplace components. Notably, the leadership skills of physician supervisors significantly impact the well-being of physicians working in healthcare

organizations[6]. For example, in a study of physicians evaluating the impact of organizational leadership on professional satisfaction and burnout, each 1-point increase in composite leadership score (higher scores indicating more effective leadership) was associated with a 3.3% decrease in the likelihood of burnout (P<0.001) and a 9.0% increase in the likelihood of satisfaction (P<0.001) of the physicians supervised[41]. Physicians' ratings of their supervisors' leadership abilities were also associated with subsequent levels and changes in burnout and professional satisfaction two years later[41]. Imposing limits on major leadership position duration, as in term limits to ensure rotation of leadership, cultivates professional satisfaction by allowing more staff to experience being leaders in the organization. Physician leaders and their administrative partners can improve satisfaction by encouraging input from multidisciplinary stakeholders and conveying desire for all to succeed.

RECOMMENDATION: Optimizing workplace satisfaction and careful selection of physician leaders should be an institutional priority to ensure optimal physician well-being and superior patient care.

5. Autonomy and flexible scheduling

GUIDING PRINCIPLE: Whenever possible, physicians should have professional autonomy and the ability to personalize their working schedule.

BACKGROUND: Having autonomy at work as well as flexibility regarding scheduling are key contributors to physician satisfaction. This should be balanced with avoiding excessive variation in physician working practices, which can impact other team members and increase their workload. Although most clinical practices have predefined productivity thresholds, physicians should be permitted some degree of control over their calendar (including flexible working hours for clinical, research, and administrative duties). This may include the ability to work from home during research or administrative time, especially if meetings will largely be held virtually to accommodate collaborations across sites. Given the popularity of telemedicine for second opinion consultations and e-consultations, when appropriate, virtual clinics offer a good way to facilitate medical care, with greater convenience and flexibility for patients and physicians alike. Implementing these arrangements fairly is imperative, and should be done on a rotating basis so that all interested physicians can benefit. To optimize equitable and flexible work processes, institutions should support the conceptualization and evaluation of novel scheduling tools and approaches.

RECOMMENDATION: Physician autonomy should include some control over one's working hours and professional schedule.

6. A culture that values and encourages life outside of work

GUIDING PRINCIPLE: Institutions should mitigate burnout by addressing barriers preventing physicians from disconnecting entirely from work when out of hours or on vacation.

BACKGROUND: Cultivating a healthy balance between one's professional and personal life is important to promote well-being. This has become increasingly difficult as modern physicians can be easily contacted at any time via email, phone, pager, or EHR, including out of hours and on weekends off. Being unable to disconnect from work entirely, even on vacation, can significantly contribute to burnout. Although varying degrees of clinical and in-basket coverage are typically provided, it is common for physicians to perform work-related duties while on vacation[42]. Poor work-life balance can negatively affect physician well-being, including that of individuals close to them. Therefore, enabling physicians to set clear boundaries between life in and out of the workplace is essential. The institutional expectation should be that physicians completely disconnect from work-related activities when out of office. Further, institutions should implement appropriate coverage so that messages or questions are not held for the physician's return unless absolutely necessary, which also ensures patients are not negatively impacted. Employers should support physicians' dedicating time to family, friends, hobbies, community, and spiritual practices, if applicable, as all these measures enhance well-being. A potential example would be to discourage work-related meetings outside standard working hours (such as 8 a.m.–5 p.m., Mondays–Fridays). In addition to the intrinsic value of a fulfilling life for each individual, happier physicians provide higher-quality patient care, which ultimately ensures the success of the organization.

RECOMMENDATION: Institutions should support physician well-being by ensuring out-of-hours and vacation coverage.

7. A culture of well-being

GUIDING PRINCIPLE: Institutions should promote a culture of well-being by encouraging open discourse regarding physician

Overall, appointing individuals with the potential and enthusiasm for the role increases the likelihood of professional success and career advancement. It is also imperative that talented, albeit less qualified, individuals receive training and opportunities to realize their potential.

burnout and providing tangible, nonjudgmental support for physicians with mental health struggles.

BACKGROUND: The vast majority of staff physicians are motivated and committed to putting the needs of patients first. However, these same traits can make it challenging for individuals to address their own well-being. Obstacles include the tendency of medical professionals to avoid "bothering" others, the perceived stigma associated with requesting mental health support and lack of access to same, overwhelming workloads and administrative burdens, long working hours (including on-call duties), inability to control or flex work schedules, high productivity targets, insufficient compensation, systemic pressures from healthcare systems, the fear of medical litigation or losing one's medical license due to admission of mental health issues, and the opinion that prioritizing well-being could negatively affect professional advancement.

RECOMMENDATION: By acknowledging that physician burnout is a widespread problem, institutions can reduce the stigma and shame impacted individuals may experience. Motivated, transparent physician and administrative leaders can work together to achieve meaningful, sustained change.

Discussion

Medicine is a demanding profession, and if physician well-being is suboptimal, this may lead to burnout, depression, anxiety, and strained personal relationships[43]. In 2024 the prevalence of burnout in physicians was estimated to be about 50%[44]. Extensive evidence shows that physician burnout can negatively impact patient care and is associated with increased medical errors and decreased care quality, leading to reduced patient satisfaction, career attrition, and increased likelihood of medical litigation[10]. Therefore, the well-being of patients nationally and globally is at stake.

Even prior to the COVID-19 pandemic, physicians were demoralized and felt micromanaged due to increasing administrative tasks and physician performance assessments that detracted from their professional autonomy, meaning, and purpose[1]. The pandemic placed additional burdens on physicians and the entire healthcare system, elevating burnout to crisis levels[45]. Post COVID-19 and to the present day, physician burnout and attrition levels remain alarmingly high (although modest improvements have been noted recently)[46].

During and post COVID-19, many physicians reassessed their priorities, with a substantial number deciding to retire early, work less, or leave clinical medicine entirely[47]. Additionally, when compared with their predecessors, modern-day medical students and newly-qualified physicians are increasingly prioritizing work-life balance and well-being[48]. As society changes and attitudes toward well-being evolve, medical systems will need to adapt to ensure the retention of these talented individuals.

Having autonomy at work as well as flexibility regarding scheduling are key contributors to physician satisfaction. This should be balanced with avoiding excessive variation in physician working practices, which can impact other team members and increase their workload. Although most clinical practices have predefined productivity thresholds, physicians should be permitted some degree of control over their calendar (including flexible working hours for clinical, research, and administrative duties).

Sustained, large-scale organizational and institutional efforts to improve work-life integration will be critical to reduce physician burnout and attrition as well as potentially negative patient outcomes. The current recommendations complement the recent report from the Minnesota Medical Association summarizing opportunities to impact the well-being of Minnesota's physician community[49].

Despite notable efforts to identify and implement changes to improve physician well-being over the last decade, numerous challenges remain. Nationally and globally, there is need for interventions at both the individual and systems level. Although substantial reform is urgently needed to ameliorate physician burnout and moral injury, existing problems within healthcare systems are often difficult to resolve. Endeavors to improve and transform healthcare for the benefit of patients everywhere will be largely dependent on the optimal performance of all staff members, including physicians. Therefore, larger-scale efforts to improve and prioritize physician well-being nationally and internationally will be critical. **MM**

Ciara C. O'Sullivan, MB, BCh, BAO, is an oncologist at Mayo Clinic, Rochester. Kathryn J. Ruddy, MD MPH, is an oncologist at Mayo Clinic, Rochester. Amye J. Tevaarwerk, MD, is an oncologist at Mayo Clinic, Rochester. Savannah Liddell, MD, is a hematology-oncology fellow at Mayo Clinic, Rochester. Andrea E. Wahner Hendrickson, MD, is an oncologist at Mayo Clinic, Rochester. Brittany L. Siontis, MD, is an oncologist at Mayo Clinic, Rochester. Katharine A. Price, MD, is an oncologist at Mayo Clinic, Rochester. Brian A. Costello, MD, is an oncologist at Mayo Clinic, Rochester. Ariela L. Marshall, MD, is a hematologist at the University of Minnesota, Minneapolis. Laura E. Raffals, MD, is a gastroenterologist at Mayo Clinic, Rochester. Colin P. West, MD, is a general internist and quantitative health sciences researcher at Mayo Clinic, Rochester.

Statements and declarations

Funding: This work was supported by personal research funds (O'Sullivan).

Competing interests:

C. O'Sullivan has research funding to Mayo Clinic from Pfizer and AstraZeneca.

K. Ruddy—no relevant disclosures.

A. Tevaarwerk— a family member works for Epic Systems.

S. Liddell—no disclosures.

Andrea E. Wahner Hendrickson—no relevant disclosures.

B. Siontis—no relevant disclosures.

K. Price—no relevant disclosures.

B. Costello—no relevant disclosures.

A. Marshall—no relevant disclosures.

L. Raffals has consulted for Bristol-Myers Squibb Company, Fresnenius Kabi USA, Geneoscopy, Janssen, Takeda, and Boomerang.

C. West—no relevant disclosures.

REFERENCES

1 West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. J Intern Med. 2018;283(6):516-29.

2 Sinskey JL, Margolis RD, Vinson AE. The wicked problem of physician well-being. Anesthesiol Clin. 2022;40(2):213-23.

3 Shanafelt TD, Boone S, Tan L, Dyrbye LN, Sotile W, Satele D, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med. 2012;172(18):1377-85.

4 Holmgren AJ, Hendrix N, Maisel N, Everson J, Bazemore A, Rotenstein L, et al. Electronic health record usability, satisfaction, and burnout for family physicians. JAMA Netw Open. 2024;7(8):e2426956.

5 Yan Q, Jiang Z, Harbin Z, Tolbert PH, Davies MG. Exploring the relationship between electronic health records and provider burnout: A systematic review. J Am Med Inform Assoc. 2021;28(5):1009-21.

6 Shanafelt TD, Gorringe G, Menaker R, Storz KA, Reeves D, Buskirk SJ, et al. Impact of organizational leadership on physician burnout and satisfaction. Mayo Clin Proc. 2015;90(4):432-40.

7 Grow HM, McPhillips HA, Batra M. Understanding physician burnout. Curr Probl Pediatr Adolesc Health Care. 2019;49(11):100656.

8 Ryan E, Hore K, Power J, Jackson T. The relationship between physician burnout and depression, anxiety, suicidality and substance abuse: A mixed methods systematic review. Front Public Health. 2023;11:1133484.

9 Lacy BE, Chan JL. Physician Burnout: The hidden health care crisis. Clin Gastroenterol Hepatol. 2018;16(3):311-7.

10 Menon NK, Shanafelt TD, Sinsky CA, Linzer M, Carlasare L, Brady KJS, et al. Association of physician burnout with suicidal ideation and medical errors. JAMA Netw Open. 2020;3(12):e2028780.

11 Soto-Moreno A, Martínez-López A, Sánchez-Díaz M, Martínez-García E, Buendía-Eisman A, Arias-Santiago S. Anxiety, depression, and alcohol use disorder in dermatologists: relationship with burnout and associated risk factors. Int J Dermatol. 2024;63(8):e171-e7.

12 Han S, Shanafelt TD, Sinsky CA, Awad KM, Dyrbye LN, Fiscus LC, et al. Estimating the attributable cost of physician burnout in the United States. Annals of internal medicine. 2019;170(11):784-90.

13 Shanafelt TD, West CP, Poland GA, LaRusso NF, Menaker R, Bahn RS. Principles to promote physician satisfaction and work-life balance. Minn Med. 2008;91(12):41-3.

14 Vermilion P. Wellness gone awry: how helpful hints might be harmful. J Gen Intern Med. 2022;37(12):3166-7.

15 West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet (London, England). 2016;388(10057):2272-81.

16 Sullivan AG, Hoffman A, Slavin S. Becoming AWARE: ACGME's new suite of well-being resources. J Grad Med Educ. 2020;12(1):122-4.

17 National Academies of Sciences E, Medicine, National Academy of M, Committee on Systems Approaches to Improve Patient Care by Supporting Clinician W-B. Taking action against clinician burnout: a systems approach to professional well-being. Washington (DC): National Academies Press (US). Copyright 2019 by the National Academy of Sciences. All rights reserved.; 2019.

18 Panagioti M, Panagopoulou E, Bower P, Lewith G, Kontopantelis E, Chew-Graham C, et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. JAMA Intern Med. 2017;177(2):195-205.

19 Ungur AP, Bârsan M, Socaciu AI, Râjnoveanu AG, Ionuț R, Goia L, et al. A narrative review of burnout syndrome in medical personnel. Diagnostics (Basel). 2024;14(17).

20 DePuccio MJ, Gaughan AA, Shiu-Yee K, McAlearney AS. Doctoring from home: physicians' perspectives on the advantages of remote care delivery during the COVID-19 pandemic. PloS one. 2022;17(6):e0269264.

21 Sinsky CA, Trockel MT, Dyrbye LN, Wang H, Carlasare LE, West CP, et al. Vacation days taken, work during vacation, and burnout among US physicians. JAMA Netw Open. 2024;7(1):e2351635.

22 Hall CE, Brooks SK, Mills F, Greenberg N, Weston D. Experiences of working from home: umbrella review. J Occup Health. 2024;66(1).

23 Wieneke KC, Berkland BE, Kruse GC, Priestley MR, Teal DM, West CP. Charting a new path forward in addressing employee well-being in health care. Mayo Clin Proc. 2025;100(3):501-13.

24 West CP, Dyrbye LN, Sloan JA, Shanafelt TD. Single item measures of emotional exhaustion and depersonalization are useful for assessing burnout in medical professionals. J Gen Intern Med. 2009;24(12):1318-21.

25 West CP, Shanafelt TD, Kolars JC. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. Jama. 2011;306(9):952-60.

26 West CP, Dyrbye LN, Satele DV, Sloan JA, Shanafelt TD. Concurrent validity of single-item measures of emotional exhaustion and depersonalization in burnout assessment. J Gen Intern Med. 2012;27(11):1445-52.

27 West CP, Dyrbye LN, Satele DV, Shanafelt TD. Colleagues meeting to promote and sustain satisfaction (COMPASS) groups for physician well-being: a randomized clinical trial. Mayo Clin Proc. 2021;96(10):2606-14.

28 Bacigalupo A Md MPH. Clinical workflow efficiencies to alleviate physician burnout and reduce work after clinic. Fam Pract Manag. 2023;30(3):21-5.

29 Thomas LR, Ripp JA, West CP. Charter on physician well-being. JAMA. 2018;319(15):1541-2.

30 Shanafelt TD, West CP, Sloan JA, Novotny PJ, Poland GA, Menaker R, et al. Career fit and burnout among academic faculty. Arch Intern Med. 2009;169(10):990-5.

31 Tendulkar RD. In search of joy and meaning in modern medicine. JCO Oncol Pract. 2024;20(12):1550-4.

32 Dymek C, Kim B, Melton GB, Payne TH, Singh H, Hsiao CJ. Building the evidence-base to reduce electronic health record-related clinician burden. J Am Med Inform Assoc. 2021;28(5):1057-61.

33 Sloss EA, Abdul S, Aboagyewah MA, Beebe A, Kendle K, Marshall K, et al. Toward alleviating clinician documentation burden: a scoping review of burden reduction efforts. Appl Clin Inform. 2024;15(3):446-55.

34 Lagasse J. Optimized EHR flowsheets found to reduce clinician burden, burnout. Healthcare Finance (March 2021). Available at:https://www.healthcarefinancenews.com/news/optimized-ehr-flowsheets-found-reduce-clinician-burden-burnout.

35 Medical practice efficiencies and cost savings. Official Website of the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT. Available at:https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/medical-practice-efficiencies-cost-savings.

36 Shah SJ, Devon-Sand A, Ma SP, Jeong Y, Crowell T, Smith M, et al. Ambient artificial intelligence scribes: physician burnout and perspectives on usability and documentation burden. J Am Med Inform Assoc. 2025;32(2):375-80.

37 Ma SP, Liang AS, Shah SJ, Smith M, Jeong Y, Devon-Sand A, et al. Ambient artificial intelligence scribes: utilization and impact on documentation time. Journal of the American Medical Informatics Association. 2024;32(2):381-5.

38 Tierney AA, Gayre G, Hoberman B, Mattern B, Ballesca M, Kipnis P, et al. Ambient artificial intelligence scribes to alleviate the burden of clinical documentation. NEJM Catalyst. 2024;5(3):CAT.23.0404.

39 Ashton M. Getting rid of stupid stuff. The New England Journal of Medicine. 2018;379(19):1789-91.

40 Linzer M, Jin JO, Shah P, Stillman M, Brown R, Poplau S, et al. Trends in clinician burnout with associated mitigating and aggravating factors during the COVID-19 pandemic. JAMA Health Forum. 2022;3(11):e224163.

41 Dyrbye LN, Major-Elechi B, Hays JT, Fraser CH, Buskirk SJ, West CP. Physicians' ratings of their supervisor's leadership behaviors and their subsequent burnout and satisfaction: A Longitudinal Study. Mayo Clin Proc. 2021;96(10):2598-605.

42 Marshall AL, Elafros M, Duma N. Work patterns of women physicians during vacation: a cross-sectional study. J Womens Health (Larchmt). 2022;31(4):573-9.

43 Patel RS, Bachu R, Adikey A, Malik M, Shah M. Factors related to physician burnout and its consequences: a review. Behav Sci (Basel). 2018;8(11).

44 2024 Medscape physician burnout and depression report. Available at: https://www.medscape.com.

45 Alkhamees AA, Aljohani MS, Kalani S, Ali AM, Almatham F, Alwabili A, et al. Physician's burnout during the COVID-19 pandemic: a systematic review and meta-analysis. Int J Environ Res Public Health. 2023;20(5).

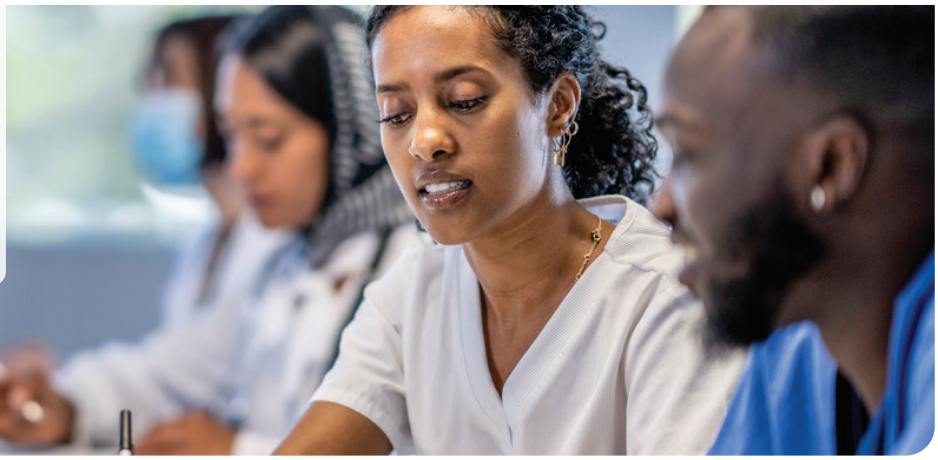
46 Shanafelt TD, West CP, Sinsky C, Trockel M, Tutty M, Wang H, et al. Changes in burnout and satisfaction with work-life integration in physicians and the general US working population between 2011 and 2023. Mayo Clin Proc. 2025.

47 Darves B. Physicians' career priorities and expectations undergoing shifts. NEJM Career Center, August 9th, 2024. Available at :https://resources.nejmcareercenter.org/article/physicians-career-priorities-and-expectations-undergoing-shifts/. Accessed on December 16th, 2024.

48 Chen, TP. Young doctors want work-life balance. Older doctors say that's not the job. The Wall Street Journal, November 3rd, 2024. Available at: https://www.wsj.com/lifestyle/careers/young-doctors-want-work-life-balance-older-doctors-say-thats-not-the-job-6cb37d48?st=zgt8ja&reflink=desktopwebshare_permalink. Accessed on January 10th, 2025.

49 Opportunities to impact the well-being of Minnesota's physician community. MMA Physician Well-being Advisory Committee's report to the MMA Board of Trustees. Minnesota Medical Association. Delivered May 18, 2024.

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**

CONTACT

Haley Brickner
Health Equity Coordinator
hbrickner@mnmed.org
612-355-9344

VISIT

www.mnmed.org/healthequity

Minnesota Medical Association

An optometrist works to obtain an accurate glasses prescription as part of the vision screening exam.

Increasing access to vision care for seasonal agricultural communities in southern Minnesota

A STUDENT-LED INITIATIVE

The University of Minnesota Mobile Health Initiative vision screening program helps bridge gaps in vision care among seasonal farmworkers in southern Minnesota by providing free eye exams, glasses, and referrals.

BY HANNAH J. HWANG, BA; MINDA LIU, BA, MPH; DIVYA R. ALLEY, BS; ANGELA A. CAO, BS; JUSTIN YAMANUHA, MD; JAFFER SHAHID, MD

Every year, between 20,000 and 35,000 seasonal agricultural workers move to Minnesota from Texas and northern Mexico to work on farms and in food processing plants.[1] In the United States, seasonal farmworkers and their families face significant healthcare disparities, including visual impairments and preventable causes of blindness, due to transitory living and working circumstances.[2,3] Notably, 50% of these workers and their families lack vision insurance and have limited access to local healthcare facilities.[4] Barriers to care that are commonly encountered include transportation challenges, limited health literacy, cultural barriers, and financial concerns.[5–7]

Mobile health programs are an innovative approach to increase healthcare access for underserved communities, including seasonal farmworkers. These programs offer a low-barrier alternative to traditional brick-and-mortar healthcare settings. Mobile vision care programs can address vision insecurity, or the unmet need of maintaining healthy vision, by providing eye examinations, distribution of glasses, access to specialized glasses prescriptions, and targeted education on eye health.[8]

In 2021, the University of Minnesota's Mobile Health Initiative (MHI) launched a mobile vision screening program developed by medical students that provides farmworkers and their families with free vision services. The MHI vision screening program helps bridge gaps in vision care in this community by providing free eye exams, glasses, and referrals to eye care professionals. The program is a prime

The Mobile Health Initiative van transports vision equipment and provides additional space for patient encounters.

The 2023–24 Mobile Health Student Interest Group executive board (left to right, back row): Angela Cao, Colin Tang-Whitmore, Sonja Knudson, Minda Liu; (front) Divya Alley, Kenny Ta, Hannah Hwang, Rashika Shetty, Rebecca AbuAyed.

REGISTRATION
Check-in
Obtain patient demographic information, fill out vision insecurity questionnaire

STATION 1
Visual acuity testing
Autorefraction, Snellen test

STATION 2
Eye "vitals" and dilation
Eye motility, pupil reaction, dilated eye exam, tonometry testing, peripheral vision

STATION 3
Appointment with OD/MD provider
Clinical eye exam, prescription, assessment for any need of referrals

STATION 4
Ordering glasses and referrals
Collect home address for eyewear delivery, gather information for referral placement

At MHI vision screenings, medical students guide patients through a sequence of stations from check-in to ordering glasses and placing referrals to outside providers as needed.

example of how students in training and providers can utilize mobile healthcare delivery models to improve care for underserved communities in Minnesota.

This study describes the development of MHI's student-led vision screening program for the seasonal farmworker population in rural southern Minnesota, the program's patient demographics, and patient and student volunteer satisfaction and feedback.

The purpose of this study is to (1) describe the development of a student-led initiative to offer vision screenings to the seasonal farmworker community, (2) describe the demographics of patients served by MHI, (3) evaluate patient satisfaction with their vision screening, and (4) assess feedback from students regarding their volunteer experience. We aim to inspire medical students and clinicians to respond to public health needs by developing innovative approaches such as mobile health care.

Starting the vision screening program

MHI comprises an interprofessional team of healthcare professionals and students affiliated with the University of Minnesota. Since 2020, MHI has been improving health equity across Minnesota by providing needed medical services in partnership with community organizations. One of these long-standing partnerships is with the Tri-Valley Opportunity Council (TVOC), a nonprofit organization that supports agricultural workers and their families in rural Minnesota.

In partnership with TVOC, MHI hosts "health fairs" for itinerant workers in Elgin and Owatonna—two towns in rural southern Minnesota. Health fairs are typically held in the summer and fall, the peak harvest seasons when farmworkers travel to Minnesota for work. Attendees can access free services, including physical exams, dental cleanings, blood pressure, hemoglobin A1C testing, immunizations, medication refills, and primary care referrals.

The MHI vision screening program was created in June 2021 after TVOC identified a lack of community access to vision care. The program was initiated by a group of medical students with oversight from a volunteer optometrist. The program has since expanded, with screenings now staffed by optometrists or ophthal-

mologists, medical students, and in-person Spanish interpreters. All members of the vision team are volunteers. Students are primarily responsible for the operation of the vision program, including completing patient registration, visual acuity checks, ordering prescription glasses, and referrals.

The total cost of screening equipment was approximately $17,000, which included the following: a handheld tonometer, an autorefractor, a lensometer, a set of trial lenses, a portable slit lamp, an indirect ophthalmoscope, condensing lenses, eyedrops, a mobile printer, and iPads used for documentation. Equipment is stored and unloaded from MHI's van for events. The cost of purchasing the vision equipment was supported by grant funding obtained by MHI from the Otto Bremer Trust.

Vision screening

Medical students conduct the initial vision screening, which includes a general eye history, pupil exam, motility and confrontational fields exam, visual acuity testing, tonometry, and autorefraction. An autorefraction prescription is obtained for vision worse than 20/25, and results are refined with a trial lens kit. For patients requiring a dilated exam, an optometrist or ophthalmologist performs slit lamp biomicroscopy and an indirect ophthalmologic examination. After the eye examination, medical students help patients select glasses using a sample set of trial frames. Patient prescriptions are submitted online through Changing Life through Lenses, a nonprofit program through the OneSight EssilorLuxottica Foundation that provides free frames and lenses to charitable organizations. Glasses are shipped directly to a patient's preferred address through the program.

If urgent follow-up or surgical care is needed, patients are referred to a facility in Minneapolis–St. Paul. For patients unable to be seen at our events, vouchers are given through a partnership with VSP Vision Care. Patients can use these vouchers to receive free exams and glasses at accepting clinics. Patient information is stored in REDCap, a HIPAA-compliant health information management system.

Study design

This study was conducted in two parts, including (1) a retrospective study of demographic and vision insecurity survey data obtained for a needs assessment, and (2) a prospective study of patient and student satisfaction obtained via surveys. A telephone interview was conducted with patients who received glasses from the health fairs to assess patient satisfaction. An electronic survey was provided after vision screening events to assess student volunteer feedback. IRB approval was waived by the University of Minnesota Twin Cities Institutional Review Board Committee.

Demographic and vision insecurity data

Demographic and vision insecurity data were collected during patient check-in at vision screening events. Data were summarized using descriptive statistics and reported as a mean +/- standard deviation. A survey on vision insecurity, measured on a five-point Likert scale, assessed how frequently vision affected quality of life. Patients were asked how often vision impaired their ability to work, read, and go about daily life (e.g., "How often does your vision affect your ability to work?"). Vision insecurity was defined as severe ("always" or "very frequently"), moderate ("occasionally" or "rarely"), or minor ("very rarely" or "never"). Answers were denoted as unspecified if the patient did not answer the survey question or if not asked due to time constraints.

Patient satisfaction

In a subgroup of patients that received glasses, follow-up calls were implemented from August 2023 through October 2023 to assess patient satisfaction regarding their clinic experience and glasses prescription. Calls were made to those who were prescribed and ordered glasses at MHI vision screenings in Elgin and Owatonna. On-demand phone interpreters and medical Spanish-speaking volunteers were enlisted to complete interviews, and questions were asked as described in Table 1.

TABLE 1

Patient satisfaction questions asked over a telephone interview

1	Did you receive your glasses?
2	On a scale of 1–10, 10 as the highest, how happy are you with your glasses prescription?
3	On a scale of 1–10, 10 as the highest, how likely are you to recommend our vision clinic to friends or family?
4	Do you have any other feedback you'd like to share?

Student feedback

Medical students were given an electronic survey to gather feedback regarding their volunteer experience with the vision screening program. The survey was sent to students in the fall of 2024 after mobile vision screening events. Students were asked to respond to statements described in Table 2 on a Likert scale of strongly disagree, disagree, neither agree nor disagree, agree, and strongly agree. Qualitative student feedback regarding their volunteer experience was also obtained through formal interviews from the University of Minnesota Office of Academic and Clinical Affairs from 2019 to 2022 to promote MHI's activities.

TABLE 2

Student feedback statements and questions given over an electronic survey

1	Volunteering with MHI was a valuable educational experience.
2	Based on my experience, I would volunteer with MHI again in the future.
3	I felt prepared to perform the tasks that were asked of me at the event.
4	Do you have any other feedback you'd like to share?

Results

Between 2021 and 2023, 184 patients were screened at 10 vision clinics in southern Minnesota. MHI sites included local community centers and churches in Owatonna and Elgin, Minnesota. The screenings were hosted primarily in the summer, between June and September.

TABLE 3

Demographic characteristics of patients seen at MHI vision screening events

DEMOGRAPHICS	NUMBER OF PATIENTS (%) N = 184
Gender	
Female	117 (62%)
Male	56 (30%)
Age	
< 18	46 (24%)
19 – 50	87 (46%)
> 51	56 (30%)

A volunteer assists a child undergoing vision screening.

Demographics and vision insecurity

The average age of all patients screened was 36.4 ± 20.8 years, and 61.4% of patients were female (Table 3). Of the patients who attended the MHI Health Fairs, 86.6% self-identified Spanish as their primary language, while 13.4% selected English as their primary language. About 79.3% of patients were autorefracted for vision impairment equal to or worse than 20/25 (n=146). Of patients autorefracted, 53.4% were provided a glasses prescription or glasses (n=78/146).

As part of the vision insecurity survey, patients were asked how often vision impacted their ability to perform daily tasks (n=184). Responses were grouped as severe ("always"/"very frequently"), moderate ("occasionally"/"rarely"), or minor ("rarely"/"never"). Patients reported that their vision severely impacted their reading (37%), with moderate impediment to daily life (38%) and minor impairment to work (27%).

Patient satisfaction

Out of 33 patients who were provided a prescription and ordered glasses from August through October 2023, 16 phone interviews were conducted successfully. Of the patients interviewed, 81.25% received glasses (n=13/16). Of those who did not receive their glasses, this was likely due to patients reporting their residential Texas address instead of their Minnesota address; glasses were reordered for these patients accordingly after confirmation of their correct address. Of 17 patients not interviewed, phone numbers were inactive or unlisted (n=6/17), patients were unreachable (n=10/17), and one patient was missing a phone number in REDCap.

Results indicated high levels of patient satisfaction, with an average rating for glasses satisfaction as 9.75/10 (n=12/16) and an average likelihood to refer the clinic to others of 9.88/10 (n=16/16). Testimonials from follow-up calls included the following remarks, which were obtained with the assistance of interpreters with minor edits for clarity:

"It was my first time going to the clinic. I had a great experience and am very

Patient testimonials

"It was my first time going to the clinic. I had a great experience and am very grateful for the services me and my granddaughters have received."

"I was very happy with clinic services and have recommended the clinic to my family and friends. We live in Texas and usually come to Minnesota around the summer. My only question is to know about upcoming clinic dates and hours to share that information."

"The service overall was very good. The clinic works very efficiently, and they do great work for the community."

Medical student volunteer testimonials

"This was my first experience at one of the migrant health fairs, and I was able to see the impact that is made on the community. It was an experience that allowed us, as first-year medical students, to dip our toes into what our profession calls us to do and hope to be in service to. . . . It was especially fulfilling to see fellow medical students find the experience as fulfilling as I did."

"Joining MHI will keep you grounded. It becomes evident how essential programs like MHI are, as they bridge gaps created by systemic and structural barriers to healthcare access. Above all, we must engage in constant dialogue with our patients to build a health infrastructure that is inclusive, responsive, and sustainable."

"Volunteering through MHI has given me the opportunity to meet people from the many vibrant communities of the Twin Cities and broader Minnesota, improved my ability to engage with patients, and offered space to wrestle with how we can evolve healthcare delivery to meet the needs of the present day."

Volunteers assess visual acuity for patients as the first step in the screening process.

grateful for the services me and my granddaughters have received."

"I was very happy with clinic services and have recommended the clinic to my family and friends. We live in Texas and usually come to Minnesota around the summer. My only question is to know about upcoming clinic dates and hours to share that information."

"The service overall was very good. The clinic works very efficiently, and they do great work for the community."

Student feedback

Seven medical student volunteers from the fall 2024 mobile screening events responded to the student feedback survey. Five students strongly agreed, and two agreed that volunteering with MHI was a valuable educational experience and that they would volunteer again in the future based on their experience. In addition, five agreed, and two strongly agreed that they felt prepared to perform the tasks asked of them at the event.

Written feedback regarding the vision screening program from students included:

"This was my first experience at one of the [MHI] health fairs, and I was able to see the impact that is made on the community. It was an experience that allowed us, as first-year medical students, to dip our toes into what our profession calls us to do and hope to be in service to…. It was especially fulfilling to see fellow medical students find the experience as fulfilling as I did."

Additional feedback emphasized that volunteering with MHI was a fulfilling and enjoyable experience and expressed appreciation for the opportunity.

Student feedback from formal interviews with the university's Office of Academic and Clinical Affairs included:

"Joining MHI will keep you grounded. It becomes evident how essential programs like MHI are, as they bridge gaps created by systemic and structural barriers to healthcare access. Above all, we must engage in constant dialogue with our patients to build a health infrastructure that is inclusive, responsive, and sustainable."

"Volunteering through MHI has given me the opportunity to meet people from the many vibrant communities of the Twin Cities and broader Minnesota, improved my ability to engage with patients, and offered space to wrestle with how we can evolve healthcare delivery to meet the needs of the present day."

Discussion

This paper describes a student-led initiative to establish a mobile vision screening program for the seasonal farmworker community in southern Minnesota, a community that experiences significant health inequities. Since its inception in 2021, the program has served 184 patients, with 53.4% of patients receiving a prescription and/or glasses. Based on the responses of unmet vision needs affecting quality of life, providing glasses is the first step in meeting the needs of this community.

Patients had high levels of satisfaction with their glasses prescription (9.75/10) and a high likelihood of referring MHI's vision services to others (9.88/10). Testimonials emphasized the clinic's efficiency and appreciation for the service. A high level of satisfaction may be due to our program's use of Changing Life Through Lenses, which enables the ordering of glasses and free delivery with the submission of a prescription. Given the financial and transportation barriers that the farmworker community faces, obtaining glasses for free and having them delivered directly to one's home is crucial to improving health equity.

Overall, our patient satisfaction data provides promising feedback on the quality of our mobile screening program. It corroborates our ability to provide a service deemed valuable by the community being served. This study also fills a gap in knowledge regarding patient experiences with mobile eye care. Other mobile vision studies have indicated a lack of patient satisfaction data as a limitation.[9] The mobile health delivery modality bases its work on patient-centered care, making patient feedback essential to improving community trust and strengthening our understanding of community needs.

MHI's vision screening program is a community-based initiative conceived by a small group of medical students. The screening program has since expanded and continues to be largely student-driven—both on- and off-site in improving the program. Most recently, from this initiative, a group of students created a university interprofessional student group, recruiting over 150 volunteers to support MHI's events. Members recruit volunteers and eye professionals, lead quality improvement projects, and initiate health equity research. By having students drive MHI's initiatives, our program creates a culture of advancing health equity among students in training.

Since students are the primary volunteer force leading vision screenings, their perspective is crucial to understanding the program's strengths and weaknesses. Student feedback survey responses and interview statements affirmed that volunteering with MHI was a valuable experience, whether in staying grounded in service or bringing healthcare access to the forefront of our future healthcare professionals' focus.

Limitations

The focus of the vision screening program has always been on providing excellent care rather than data collection. As a result, our data contains inconsistencies with missing responses, limiting us from making meaningful conclusions regarding vision insecurity and ocular disease. In response, we have improved the data collection process by having patients fill out survey questions before being seen. This change has increased data consistency while protecting patient-provider time.

Our patient satisfaction and student feedback surveys also had a low response rate. Patients were difficult to reach due to inactive or missing phone numbers or lack of response—potentially due to frequent relocation for work. Moreover, only a subgroup of patients was contacted due to volunteer constraints. Student feedback was similarly limited. In the future, however, we plan to incorporate a patient and student feedback process on-site immediately after volunteering.

Future directions

Our mobile vision screening program's primary service is the identification and correction of refractive error through the provision of glasses, though ophthalmic diseases are also identified through these screenings. However, apart from referring patients to outside clinics, the screening program does not provide comprehensive eye exams or coverage of ophthalmic management, surgery, or medication due to staffing and financial limitations.

One of the first steps toward comprehensive care is to create a more structured referral process for patients who need extensive eye care. Currently, patients needing referrals are referred to Hennepin Healthcare and Open Eye Clinic, which are approximately 70 miles away from Owatonna and Elgin. MHI is working to partner with local optometric and ophthalmological practices to address these transportation limitations and the costs of surgery and medication.

MHI has expanded vision screenings to include organizations across Minnesota. Just a few of these organizations include:

- Power of the People Leadership Institute (POPLI)
- Islamic Association of North America (IANA)
- Center for American and Pacific Islanders (CAPI USA)
- Hispanic Advocacy and Community Empowerment through Research (HACER)
- Community-University Health Care Clinic (CUHCC)
- The Minnesota Department of Health and Hennepin County

While the vision screening program has grown to address several of the barriers to vision care faced by underserved communities, the overall need for vision care across the state remains high.

Student involvement with MHI has extended beyond volunteering to sharing MHI's vision screening program with others. Medical students presented at the national Midwest Migrant Stream Forum in Albuquerque, New Mexico, including step-by-step instructions on creating a vision screening program for health organizations. Students also led group discussions and documentary screening of MHI's vision screening program, "We Are Here: Lowering Barriers with Mobile Health," at the national North American Refugee Health Conference in Minneapolis. By enabling students to lead discussions on healthcare access on local and national levels, we hope to create future healthcare providers who empower others to serve.

Call to action

The Mobile Health Initiative (MHI) advances health equity by partnering with local communities and offering a range of essential healthcare services. We seek interested healthcare professionals to join our team and advance health equity across the state. We would love your support if you would like to become involved in MHI's outreach work. Please contact mobilehealth@umn.edu or Shahid Jaffer, MD (jaffe019@umn.edu), for more information on volunteer opportunities and/or collaboration opportunities. MM

Shahid Jaffer, MD, is an assistant professor in the Department of Hospital Medicine at the University of Minnesota and the associate clinical director for the University's Mobile Health Initiative. Justin Yamanuha, MD, is an associate professor in the Department of Ophthalmology and Visual Neurosciences at the University of Minnesota Medical School. Hannah Hwang is a medical student at the UMN Twin Cities Medical School and founder of the UMN Mobile Health Student Interest Group. Minda Liu, Divya Alley, and Angela Cao are UMN Twin Cities medical students and part of the original student interest group board.

REFERENCES

1 Contreras V, Duran J, Gilje K. Migrant farmworkers in south-central Minnesota: Farmworker-led research and action for change. Cura Reporter. 2001;31(1).

2 Boggess B, Bogue HO. The health of U.S. agricultural worker families: A descriptive study of over 790,000 migratory and seasonal agricultural workers and dependents. J Health Care Poor Underserved. 2016;27(2):778-792. doi:10.1353/hpu.2016.0089

3 Chheda K, Wu R, Zaback T, Brinks MV. Barriers to eye care among participants of a mobile eye clinic. Cogent Med. 2019;6(1):1650693. doi:10.1080/2331205X.2019.1650693

4 Villarejo D. The health of U.S. hired farm workers. Annu Rev Public Health. 2003;24:175-193. doi:10.1146/annurev.publhealth.24.100901.140901

5 Tsui E, Siedlecki AN, Deng J, et al. Implementation of a vision-screening program in rural northeastern United States. Clin Ophthalmol Auckl NZ. 2015;9:1883-1887. doi:10.2147/OPTH.S90321

6 Connor A, Rainer LP, Simcox JB, Thomisee K. Increasing the delivery of health care services to migrant farm worker families through a community partnership model. Public Health Nurs. 2007;24(4):355-360. doi:10.1111/j.1525-1446.2007.00644.x

7 Weathers A, Minkovitz C, O'Campo P, Diener-West M. Access to care for children of migratory agricultural workers: Factors associated with unmet need for medical care. Pediatrics. 2004;113(4):e276-e282. doi:10.1542/peds.113.4.e276

8 Chen N, Hsieh HP, Tsai RK, Sheu MM. Eye care services for the populations of remote districts in eastern Taiwan: a practical framework using a mobile vision van unit. Rural Remote Health. 2015;15(4):3442.

9 Williams AM, Botsford B, Mortensen P, Park D, Waxman EL. Delivering mobile eye care to underserved communities while providing training in ophthalmology to medical students: experience of the Guerrilla Eye Service. Clin Ophthalmol. 2019;13:337-346. doi:10.2147/OPTH.S185692

Cat scratch disease: An impersonator of malignancy

A careful and thorough history of exposures and travel is especially important in clinical care.

BY MEGAN KINDOM, MD; KEITH STELTER, MD

Cat scratch disease most commonly presents with fever, weight loss, and systemic symptoms and can be a mimicker of malignancy. It is caused by the fastidious gram-negative bacteria, *Bartonella henselae*[2]. Treatment for cat scratch disease includes symptomatic care and antimicrobials[3].

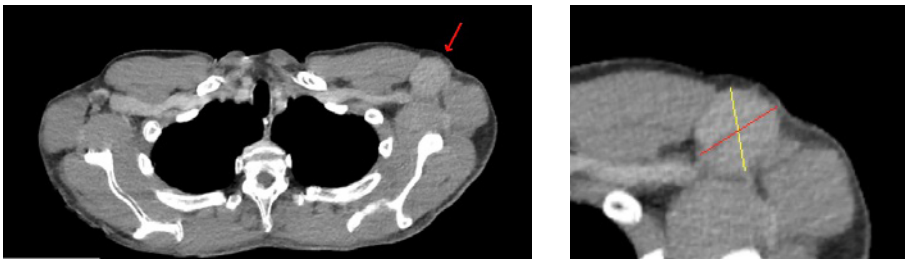


FIGURE 1

Large lymph node

Computed tomography showed large lymph node in left axillary region as indicated by red arrow on left image. The image on the right shows the dimensions of the lymph node, 3.7 cm by 3.3 cm.

Case report

The patient is a 53-year-old male with a past medical history of chronic obstructive pulmonary disease and depression who presented to the emergency department with a painful axillary mass. The mass had been present for one year but recently increased in size and became painful. He also noted episodes of night sweats, hot flashes, and a 20-pound unintentional weight loss. He denied any fevers or chills. The physical exam was notable for a large, tender protruding mass in the left axilla and measured at approximately 4 cm in diameter.

Ultrasound showed a 3.4 x 3.1 x 2.8 cm peripherally hypoechoic centrally and hyperechoic mass with moderate to significant hypervascularity. Ultrasound characteristics appeared to be solid but also could have a small cystic/necrotic or heterogeneous area within it. There were also several small to mildly enlarged lymph nodes in the left axilla. This raised the suspicion for a neoplastic process, including lymphoma.

No treatment was given at that time, and the patient was instructed to follow up with primary care. At the primary care office, the mass was determined to be 4 cm in diameter and further work-up was initiated. Laboratory evaluation showed a normal complete blood count, comprehensive metabolic panel, and a normal lactate dehydrogenase. Computed tomography of chest, abdomen, and pelvis as demonstrated in Figure 1 showed a stable 3.7 cm left axillary lymph node, grossly unchanged from recent ultrasound. CT also was notable for further mild adenopathy in the left axilla seen previously. Tissue sample was obtained with a guided core biopsy. This demonstrated necrotizing granulomatous inflammation. Phenotyping for leukemia and lymphoma from blood and tissue samples did not suggest malignancy. Because the core biopsy was nondiagnostic, and phenotyping did not rule out malignancy, an excisional biopsy was performed. Pathological analysis demonstrated follicular hyperplasia, necrotizing granulomatous inflammation, polytypic plasmacytosis, pigment deposition, and malignancy was ruled out.

The patient then saw an infectious disease specialist who performed testing for brucella, syphilis, blastomyces, cryptococcus, histoplasma, human immunodeficiency virus, *Bartonella*, and tuberculosis. Of note, *Bartonella* titers including both IgG and IgM were elevated, at 1:1024 and 1:256 respectively. This was consistent with cat scratch disease infection. Further history was obtained that about one year ago he adopted an "outdoor" cat that had fleas. Patient remembered getting flea bites at that time but never sought care.

The patient was treated with azithromycin for a five-day course that improved his symptoms. His case was also complicated by significant social determinants of health, and lack of health insurance initially. With the assistance of social services, he was able to secure health insurance.

Discussion

Cat scratch disease is an infection transmitted by cats or fleas caused by the bacteria *Bartonella henselae*. This disease should be suspected with symptoms of lymphadenopathy, fever, weight loss, and any known feline exposures. Estimated annual incidence is 4.5–9.3 per 100,000. Lymphadenitis can be mistaken for neoplasm in cat scratch disease resulting in unnecessary medical procedures, as in this case. Compared with CT, magnetic resonance imaging can be better at displaying imaging features that align with cat scratch disease. Therefore, in patients being worked up for lymphadenopathy and fever, an

MRI should be considered to prevent invasive procedures which unfortunately was not completed for this patient[1].

Diagnosis includes serology testing; IgG can be more indicative of prior infection and can stay positive longer than IgM. IgM is more indicative of an acute, recent infection[1]. In our specific case, IgM was elevated, which indicates an acute infection despite suspected source of infection was a year prior to presentation. Therefore it is possible that he developed a secondary episode of the infection causing his presenting symptoms.

Treatment can include multiple different regimens. Mild disease does not require antibiotic treatment and can be treated symptomatically. If a patient has painful lymphadenitis, a five-day course of azithromycin is the first-line treatment, as it will improve lymphadenopathy and resolve other symptoms. Other antibiotic options are clarithromycin, rifampin, or trimethoprim-sulfamethoxazole. Occasionally, the lymph nodes are painful and suppurative. In these situations, aspiration can be beneficial. Rarely is excision of lymph nodes indicated. If there is known disseminated disease to spleen, liver, or eyes, azithromycin and rifampin are indicated. Corticosteroids result in rapid resolution of systemic symptoms, including neuroretinitis, using a five- to seven-day course[3].

Conclusion

Cat scratch disease due to *Bartonella* infection is a rare zoonotic infection that can result in lymphadenitis. It is a tricky diagnosis to make and can be confused with other malignant conditions, namely lymphoma, and lead to excessive and unnecessary testing. This case also points out the fact that a careful and thorough history of exposures and travel is especially important in clinical care and can help alleviate unnecessary testing. Ideally, this case report will continue to stimulate further research and education in cat scratch disease, resulting in decreased unnecessary procedures. MM

Megan Kindom, MD, is a third-year family medicine resident at Mayo Clinic in Mankato. Keith Stelter, MD, is a core faculty member at Mayo Clinic in Mankato.

REFERENCES

1 Chen, Y., Fu, Y.-B., Xu, X.-F., Pan, Y., Lu, C.-Y., Zhu, X.-L., Li, Q.-H., and Yu, R.-S. (2017). Lymphadenitis associated with cat-scratch disease simulating a neoplasm: Imaging findings with histopathological associations. Oncology Letters. https://doi.org/10.3892/ol.2017.7311

2 Dhal, U., Hicklen, R. S., Tarrand, J., and Kontoyiannis, D. P. (2021). Cat scratch disease as a mimicker of malignancy. Open Forum Infectious Diseases, 8(11). https://doi.org/10.1093/ofid/ofab500

3 Spach, D., and Kaplan, S. (2021, December 9). Treatment of cat scratch disease. UpToDate. https://www.uptodate.com/contents/treatment-of-cat-scratch-disease

Best-selling author of *An American Sickness* to speak to MMA in September

Best-selling author Elisabeth Rosenthal, MD, will discuss how physicians are at the crossroads of U.S. healthcare, at the MMA's 2025 Empowering Physicians: A Night of Learning and Connection event from 4 to 9 p.m. Friday, September 26, at the Hewing Hotel in downtown Minneapolis.

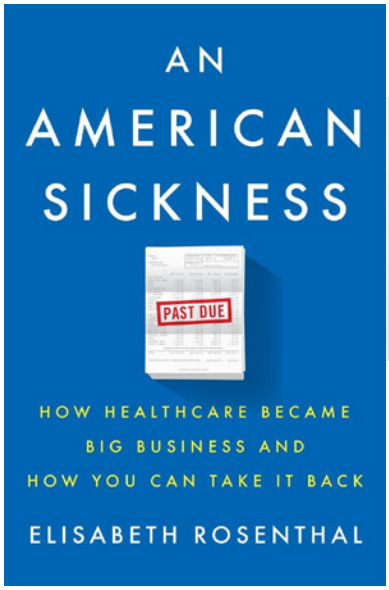
Rosenthal is the editor-in-chief of *Kaiser Health News*, a contributing opinion writer at *The New York Times*, and the author of *An American Sickness*, a revealing investigation into America's healthcare system.

A former emergency room physician, Rosenthal was an award-winning reporter at *The New York Times* for 22 years, gaining acclaim for her coverage of health and health policy issues. Drawing on her expertise, Rosenthal unpacks one of America's most complex and frustrating institutions with a humanist approach, and examines what physicians, patients, and providers can do to help repair it.

Rosenthal will present a 60-minute lecture, answer questions for 15 minutes, and then be available to sign books.

For more information on Rosenthal, please visit www.prh-speakers.com.

To register, visit: www.mnmed.org/EPC25. MM



News Briefs

MMA member running for U.S. House of Representatives seat


State Sen. Matt Klein, MD

MMA member and State Sen. Matt Klein, MD, (DFL-Mendota Heights) announced in early May that he's running in 2026 for Minnesota's 2nd Congressional District.

The seat is being vacated by U.S. Rep Angie Craig, who is running for the U.S. Senate.

Klein is a hospitalist at Mayo Clinic. Klein was elected to the West St. Paul school board in 2013, and to the State Senate in 2016, where he represents the communities of West St. Paul, South St. Paul, Mendota Heights, and Inver Grove Heights.

"It's great to see our members getting politically involved at both a state and federal level," said MMA President Edwin Bogonko, MD, MBA. "Physicians need to be at the table wherever decisions are being made about the practice of medicine."

Klein is the second physician and MMA member to run for Congress in recent years. Member and former State Sen. Kelly Morrison, MD, ran and was elected to serve Minnesota's 3rd Congressional District in 2024.

MMA board considers Minnesota physician workforce data

As part of its ongoing efforts to understand trends and changes in the Minnesota physician workforce, the MMA Board of Trustees discussed at its May meeting a recent analysis of workforce data presented by representatives of the Minnesota Department of Health's Healthcare Workforce Analysis Group.

Contrary to anecdotal stories, the number of licensed physicians in Minnesota has increased by 8,910 or 31.3% during 2010–24. There are now more than 29,000 actively licensed physicians in the state, about 23,000 of whom are involved in a direct patient care position.

The rate of increase in physician licensure has been outpaced over the same time period, however, by the increase in licensure among physician assistants (67.9%) and advanced practice registered nurses (52.9%), reported Teri Fritsma. She was joined in her presentation by fellow department staffers: Zora Radosevich and Nitika Moibi.

The geographic distribution of physicians remains a challenge, especially in the following specialties: there are .5 psychiatrists, 1.1 pediatricians, and 1.1 OB/GYNs per 100,000 people located in rural areas of the state. Overall, 4.4% physicians practice in rural parts of the state; 15% of Minnesotans live in rural parts of the state.

Nineteen percent of physicians reported that they intend to leave the workforce in the next one to five years, with nearly 10% reporting burnout or dissatisfaction as the reason. The main reason for dissatisfaction stems from "paperwork demands" being too high, followed by "management doesn't listen to my concerns."

The presentation and board member discussion will help inform ongoing MMA advocacy efforts.

MMA bestows teaching award to two family physicians

In April, MMA President Edwin Bogonko, MD, MBA, presented the Exceptional Primary Care Community Faculty Teaching Award to Ryan McFarland, MD, and Sarah McFarland, MD, at the seventh-annual Dean's Tribute to Excellence in Education event in St. Paul.

One of the students nominating the McFarlands wrote the following: "Their teaching abilities and practice truly inspired me to consider a career in family medicine—something I was not actively considering before then. I am happy to report that I am now applying to family medicine residency, and I recognize that this is largely because of my experience working with Drs. McFarland in Hudson."

Both McFarlands practice family medicine at Hudson Physicians in Hudson, Wis.

The MMA has been partnering with the University of Minnesota Medical School since 2015, the year the MMA embarked on what became the Preceptor Initiative, an effort to develop tools and resources to improve the training and support for preceptors. The partnership serves as a recognition of the important role that community preceptors play in the education of medical students, and their combined commitment to ensuring that there is a sufficient supply of community preceptors across Minnesota.

With the United States facing a shortage of between 20,200 and 40,400 primary care physicians by 2036, the need for additional preceptors to educate future primary care physicians is critical.

The teaching award stemmed from this partnership, and it recognizes those who take the time to teach the future primary care physician workforce. The award honors community faculty members and is co-presented by the MMA and the University of Minnesota Medical School.

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

MMA signs on to pro-fluoridation letter sent to Congress, HHS secretary

The MMA is among 250 healthcare organizations from across the country to sign a letter supporting community water fluoridation.

"What has been lauded as one of the 10 greatest public health achievements of the 20th century has recently become politicized and gravely misrepresented," said the letter that was sent to all members of Congress, the HHS secretary, the EPA administrator, and the CDC acting director in April. "It is our duty—as health professionals, dental experts, advocates, and

researchers—to proactively combat this misinformation being spread to the people of the United States."

Along with the MMA, other Minnesota groups signing the letter included the Minnesota Dental Association, the Minnesota Dental Hygienists Association, the Minnesota Dental Therapy Association, and the Minnesota Oral Health Association.

"Community water fluoridation remains the only way to ensure that all people—especially those who are at greatest risk for dental disease and who have the fewest resources to maintain their oral health—can reap its cavity-preventing benefits," the letter said.

State cannabis rules approved despite MMA's concerns

The Minnesota Office of Cannabis Management (OCM) announced in April that an administrative law judge has approved draft rules governing Minnesota's adult-use cannabis market.

The rules, which the judge approved without changes, will be published in the State Register and go into effect later this month. This milestone sets up the final step in launching Minnesota's cannabis market, allowing OCM to begin issuing business licenses to applicants who have completed all necessary steps in the application process.

Throughout this rule-making process, the MMA has expressed concerns about potential effects on the health, safety, and welfare of Minnesotans. These concerns went unheeded.

The MMA requested:

- Appropriate health warning labels must be included on all cannabis products.
- Cannabis products must be stored in child-resistant packaging or containers; and must be stored out of children's reach or in locked locations.
- The medical cannabis consultant, who will advise consumers on cannabis products, must be a medical professional. If the medical cannabis consultant is not a medical professional, they must be able only to provide advice on dosage, advice on the best type of cannabis product for a particular condition, etc., in consultation with a pharmacist.

Rulemaking is a multistep process involving substantial public input, where state offices propose detailed rules to implement Minnesota statutes. In drafting the rules, OCM conducted a series of surveys that focused on specific rulemaking topics and held meetings with partners and interested parties, including cannabis management offices from other states.

OCM shared a preliminary draft of the proposed rules with the public, seeking feedback during the summer of 2024. After incorporating changes based on that feedback, OCM posted its formal draft for public comment for 30 days from January 13 to February 12. After incorporating additional changes based on public comments, OCM submitted the final draft rules to an administrative law judge with the Office of Administrative Hearings on March 25. The judge approved the rules without changes on April 2. Now approved, the final rules must be published in the State Register for them to take effect.

Minnesota prior authorizations doubled between 2022 and 2024

According to an MMA analysis of publicly posted Minnesota health plan data, the number of prior authorization (PA) requests in Minnesota has more than doubled over the past two years—from 227,549 in 2022 to 460,243 in 2024.

The analysis finds that 70% of this increase is attributable to Blue Cross Blue Shield of Minnesota products, and 24% of this increase is attributable to Medica products.

The analysis also finds that in 2024:

- 87% of initial PA requests were approved.
- Only 19% of PA denials were appealed by providers or patients,.
- Of appealed requests, 84% were approved.
- Overall, 89% of PA requests were ultimately approved (either initially or upon appeal).

The analysis is based on data required by a 2020 Minnesota law that requires Minnesota health plans to publicly post annual PA data on their websites.

Starting January 1, 2026, a new set of PA regulations championed by the MMA will take effect. Most notably, state-regulated health plans will be prohibited from requiring PA for:

- Treatment of a chronic health condition that has received PA under the current insurance provider, unless the standard of care has changed. "Chronic health condition" means (a) expected to last at least one year and (b) requires ongoing medical management to prevent adverse health events or limits at least one activity of daily living.
- Outpatient mental health and substance use treatment services, excluding medications.
- Antineoplastic cancer treatment consistent with guidelines of the National Comprehensive Cancer Network, excluding medications.
- Services with an A or B rating from the U.S. Preventive Services Task Force.
- Immunizations recommended by the Advisory Committee on Immunization Practices.
- Preventive services for women as described in Code of Federal Regulations Title 45, Section 147.130.
- Pediatric hospice services.
- Services delivered through a neonatal abstinence program operated by pediatric pain or palliative care specialists. MM

FROM THE CEO

Advocacy is a team sport—are you in?

An MMA member recently contacted us to ask why we were sending them an email promoting an upcoming educational program instead of raising the alarm about the then-pending U.S. House reconciliation bill and its approximately $700 billion in Medicaid funding cuts.

Messages like this—somewhat infrequent but not rare—force staff to take a deep breath. The fact is that when that message arrived, the MMA had already been raising the alarm about potential Medicaid cuts for months and had sent a recent "Action Alert" to all members urging them to contact their member of Congress to urge them to vote against the bill. This particular member had not responded to that Action Alert on Medicaid cuts. Unfortunately, they were not alone.

The MMA has an incredible team of skilled advocacy professionals. This team collaborates with members, usually on committees or task forces, to research and inform policy development; they analyze and respond to proposed regulations; they identify legal cases that would benefit from MMA's input; they draft legislative language and amendments; and they shepherd MMA priority proposals through the legislative morass. As effective as MMA's lobbyists are, they cannot replace the power of a physician's voice in describing the impact of policy proposals on their patients, their communities, and their practices.

We know physicians are busy and, like many of us, are often overwhelmed by a seemingly endless number of emails and demands on their time. We also know that, like many of us, a limited number of physicians are inclined to get involved in public policy and legislative activities. Those are some of the reasons that the MMA is judicious in its use of Action Alerts—asking physicians to take direct action when the need is most critical or urgent.

So far this year, the MMA has asked members, via these Action Alerts, to send messages to their legislators on four specific policy proposals—two before the Minnesota Legislature and two before Congress. In aggregate, a total of 464 messages were sent; those messages matter. But more than 10,000 physicians received each Action Alert, and those 464 total messages did not come from 464 unique physicians.

Minnesota physicians—members and nonmembers alike—value the advocacy work of the MMA. That value has been consistently measured over many years in countless surveys. Minnesota physicians care deeply about how state and federal policy changes affect their patients and their ability to practice medicine. The MMA will continue to lead medicine's advocacy work in Minnesota. Yet effective advocacy cannot be entirely outsourced. Effective advocacy requires many voices, repeated messages, and—most importantly—stories of impact.

The next time you receive an MMA Action Alert, please take a minute to respond. If you have not yet done so, introduce yourself to your state legislators. If you have never contributed to MMA's PAC (MEDPAC), please consider a donation today. Although the U.S. House passed its reconciliation bill, the Medicaid cuts are not yet a fait accompli. Visit MMA's Protect Medicaid Access page to learn more and take action (https://www.mnmed.org/advocacy/protect-medicaid-access).

Click to help protect Medicaid access

We need your help. Are you with us? MM

Janet Silversmith
JSilversmith@mnmed.org

VIEWPOINT

Will we be at the table—or on the menu?

PHOTO BY KATHRYN FORSS

Edwin Bogonko, MD, MBA
MMA President

As the end of my presidential term draws near, I am both pleased by the work we have underway on behalf of Minnesota's physicians and at times overwhelmed by how much more there is to do.

We continue to engage at the local, state, and national level to ensure that physicians are well represented whenever decisions are made on the practice of medicine—decisions on such important issues as prior authorization, physician well-being, access to healthcare, health equity, and government payment reform, to name just a few.

Despite this progress, our work on improving the practice of medicine is far from complete. Physicians have to be at the table when it comes to the following issues:

Defending Medicaid. More and more of our patients depend on it for their healthcare, yet the government seems determined to cut it at all costs. This will deny access to services for many across the state and nationwide with as many as 45% of women depending on it for safe childbirth. Mental health care needs this even more. Even when politicians are not threatening to cut it, Medicaid underpays for the services we provide. Both options threaten the economic viability of clinics and hospitals across the state and should concern every one of us.

Promoting vaccinations. What once was a solid win for healthcare has become a flashpoint. Immunization skepticism continues to spread across the state and the country. Measles has stormed back. To add insult to injury, the new HHS secretary has dissolved advisory boards of the Advisory Committee for Immunization Practices and CDC, which have been beacons of safe vaccine policy. This appears to be an advocacy battle we will need to wage for some time.

Rebuilding patient trust. The skepticism associated with vaccinations and needed commonsense protections for reproductive health has hurt our reputation as a trusted resource for patients. We need to restore trust and continue ensuring that physicians remain leaders of the healthcare team.

Holding elected leaders accountable. We continue to see legislative activity that undermines patient-physician relationships and stretches the boundaries of scope of practice. We need you to keep your local elected leaders in check, and share patient stories of hardship and harm due to bad health policy legislation.

Self-care. One life is too many to lose from our ranks. So many factors push us toward burnout—administrative burdens, prior authorization roadblocks, lack of access for our patients—the list goes on and on. Let us continue to pause and take care of self and of each other so we can continue to fight for our patients and healthcare. Become familiar with the Treat Yourself First campaign and make a difference!

These are just a few of the issues we need to continue monitoring. As someone once said, "You're either at the table or on the menu." Which do you prefer? I've dedicated many hours of nonclinical time at the table of organized medicine—as a trustee, as a board chair, as an AMA delegate, and now as president.

Physicians cannot afford to focus just on patient care. Yes, that is our No. 1 priority, but if we don't effectively advocate for patients and the practice of medicine, patient care can be significantly compromised.

Physicians need to be engaged wherever healthcare policy decisions are made. At the U.S. Congress, state capitols, in the courtroom, with health plans, and in communities. Who can we depend on to monitor scope-of-practice issues, patient safety, and healthcare policy, if not us? Help us help the profession. Get involved. While we face many obstacles, together we can break them down so that Minnesota remains one of the healthiest states for the benefit of our patients and the best place to practice medicine.

Physicians need to be engaged wherever healthcare policy decisions are made. At the U.S. Congress, state capitols, in the courtroom, with health plans, and in communities. Who can we depend on to monitor scope-of-practice issues, patient safety, and healthcare policy, if not us?

Take care. It has been an absolute honor to serve you all. MM

Minnesota Medical Association

Looking to offer CME?

The MMA is your one-stop shop to get it done.

- Our customer service is unmatched in the state of Minnesota. The MMA offers CME processes that are simple and competitively priced, taking the guess work out of compliance while maintaining the highest standards of accreditation. The MMA's joint providership program is so well-regarded that our partners are referring us to other healthcare organizations across the country.
- For more information, visit www.mnmed.org/education-and-events/cme-providers.

3433 Broadway Street NE, Suite 187; Mpls, MN 55413 • PHONE: 612-378-1875 or 800-342-5662
FAX: 612-378-3875 • EMAIL: mma@mnmed.org • WEB: mnmed.org

NANCY SUDAK, MD

Nancy Sudak, MD, is the chief well-being officer and director of integrative health at Essentia Health.

"I started a service line in Integrative Health at Essentia Health with my dyad partner, Kathy Beeksma, in 2016, which has grown steadily over the years," she says. "A handful of us self-organized in 2019 to strategize how we could better support all colleagues at Essentia. The pandemic created a solid platform to escalate a case for appointing me as chief well-being officer and launching an Office of Well-Being in 2021. We've been privileged to elevate some best practices to serve the well-being of our workforce in just a few years so far."

Sudak became an MMA member in 2024, when she became involved in the MMA's Minnesota Systems Well-Being Leaders Group.

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

I grew up in Cleveland, Ohio. I was an English major at Kenyon College and then went to medical school at Case Western Reserve University. I moved to Duluth in 1989 for my family medicine residency and got hooked for life!

Tell us about your family.

My husband, Jamie, is a renaissance man who has had a varied career at the nexus of health, community, healthcare, food systems, and the environment. My kids, Emma and Nat, are delightfully funny, good-spirited humans. Emma, a nutritionist, and her husband, Deven, live part-time in Atlanta (Deven's in the film industry) and part-time in Duluth. Nat is a musician and audio engineer in Minneapolis.

Hobbies or side gigs?

The older I get, the more of a homebody I become. I love cooking for friends and family, beautifying the yard, walking in the woods, reading, sewing—and I do actually leave the house to travel. That photo is from 2022 in Peru.

Why did you decide to become a physician?

I am a highly relational person. I felt a calling to step into a service-oriented, challenging, and stimulating profession, knowing that my ability to connect with individuals would serve that purpose well.

What was the greatest lesson of your medical education?

I feel like I'm still in my medical education! What I've learned through practice is that the relationship we have with each patient is therapy unto itself, above and beyond the physical treatment we offer. This has brought me comfort in times when I've left an encounter feeling like I haven't delivered much on alleviating their physical suffering, but I've been a meaningful container to listen and show deep care.

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

The faster the pace of change occurs, the less surprises me, but I've been so struck by how much sicker the average patient is now compared to when I began my practice, and how much of medical practice really is about tending to a general state of angst, with the current era being the most notable example—despite the comforts of modern life.

What's the greatest challenge facing medicine today?

Speaking for the U.S. only, I would say that our corporatized model of healthcare delivery is the most fundamental problem, with business interests making the rules. The well-being of patients and healthcare workers hangs in the balance and puts us in a very precarious position when we're already very shy on people power. We are providing care that costs more to deliver than the revenue we receive for that care and we are treating patients in less time than it takes to provide good care for them. None of it makes any sense.

How do you keep life balanced?

Exercise and eating well have always been a priority for me, so I bake those into my day with rare exception. I have become an avid CrossFit participant like many silver-haired people these days. It's kind of thrilling to make consistent gains. I've found that when I meditate regularly, life flows better, so I find a way to do that too. I recommend all these strategies to patients routinely, keeping me practicing what I preach.

If you weren't a physician—?

Toughie. I have had such a rewarding career so far and feel so grateful for it. But if I had a clean slate, I'd probably consider a career that puts me more in touch with the natural world (plants, forests, animals), but I don't have a clear picture of how that would look. MM

Minnesota Physician Leadership Institute

Turning physicians into highly effective leaders

2025-2026 program details available soon at:

WWW.MNPLI.ORG

Providing world-class leadership skills exclusively for MMA-member physicians. Challenge yourself beyond the clinical world and learn from the best.

Minnesota Medical Association

This activity has been approved for AMA PRA Category 1 Credit™

You're not a policy number. You're a human.

We see you. And we understand your challenges. Our relationship doesn't start when there's a claim. From day one with Copic, we bring you insights designed to improve patient safety, help reduce risk, and let you focus on what you do best. We're here for the humans of healthcare.

Copic is proud to be the endorsed carrier of the Minnesota Medical Association. MMA members may be eligible for a 10% premium discount.

copic

copic.com | 800.421.1834