THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

MINNESOTA MEDICINE

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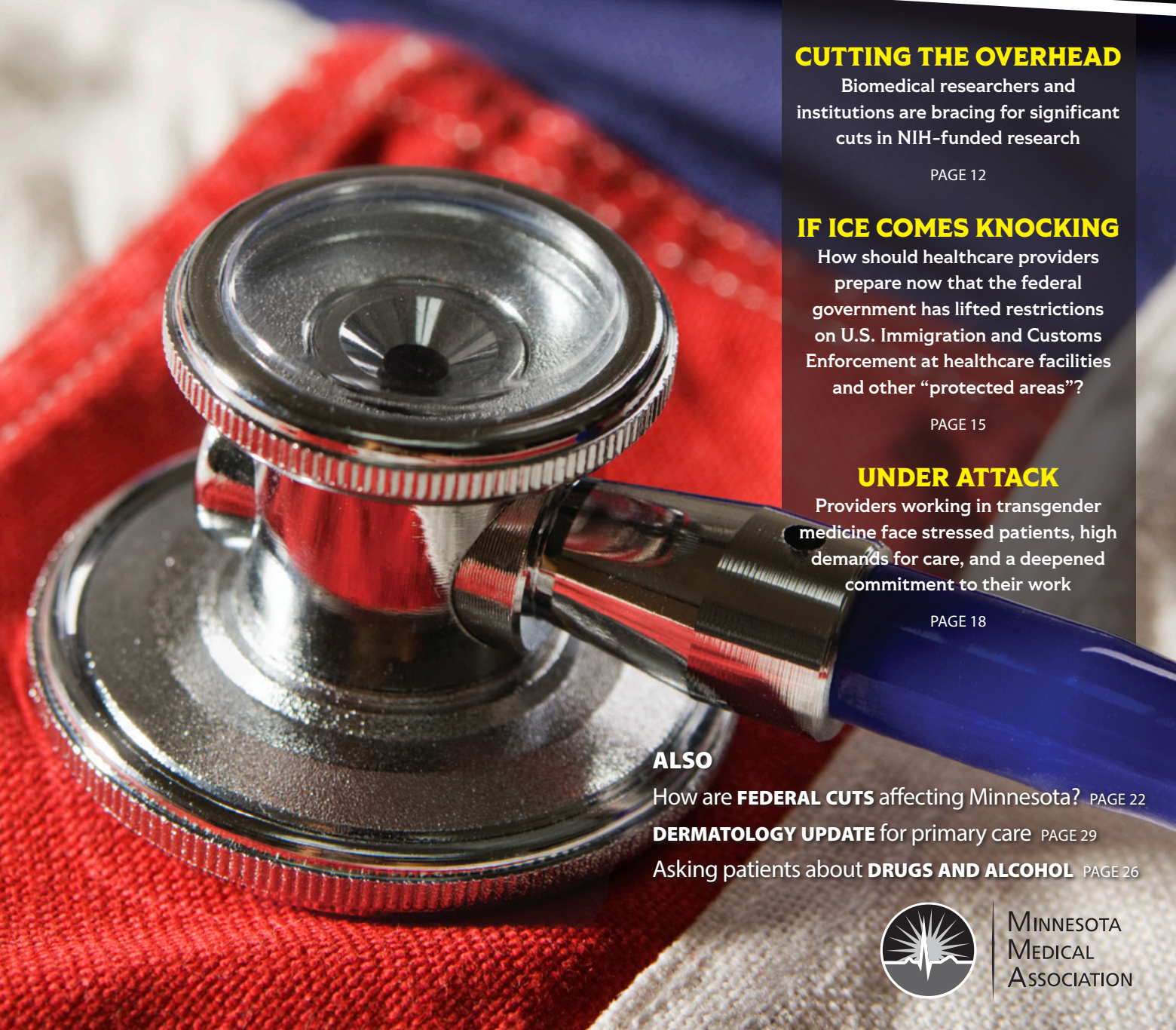
CHANGES IN WASHINGTON



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Minnesota Medical Association

NEW DEA CERTIFICATE RENEWAL REQUIREMENTS ARE YOU READY?

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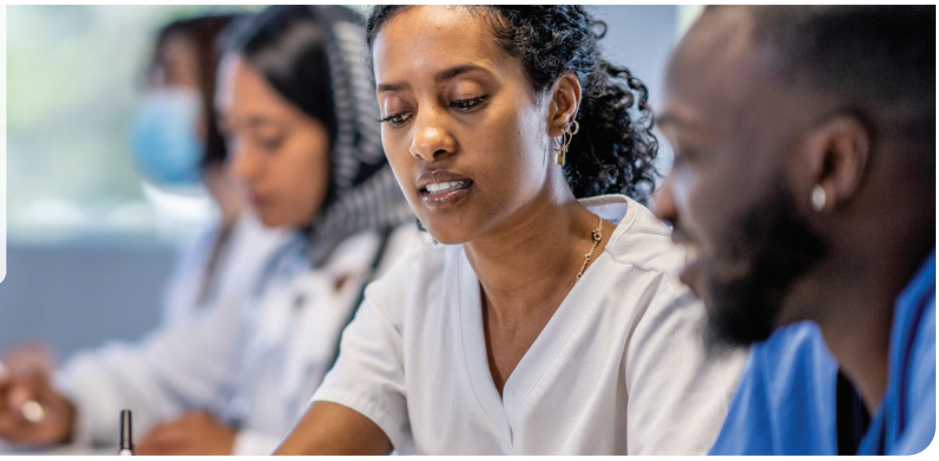
WHAT IS IT?

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.

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

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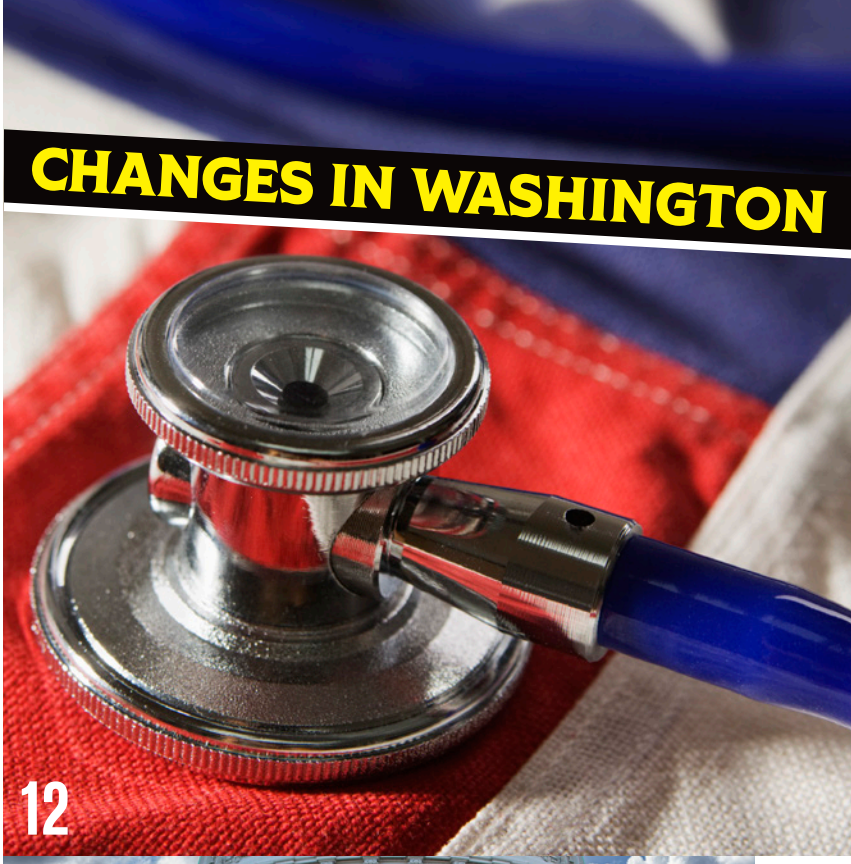

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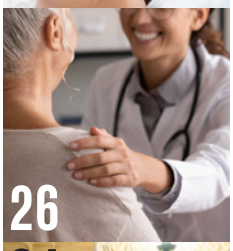

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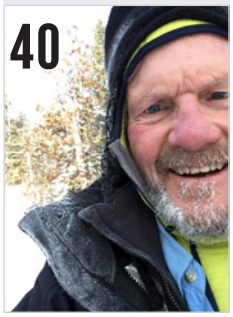

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Colin West, MD, PhD

Staying on course in stormy times

For centuries, sailors used the North Star to guide their ships as they navigated the globe. Its constancy as a reference point offered a reliable tool for staying on course, or adjusting to get back on course if storms or other challenges occurred. We face turbulent times today across our society, and certainly within medicine. What North Star can we rely on to guide us through these storms?

I have found reassuring anchoring in what I call the "MVPs" of well-being in medicine—meaning, values, and purpose—playing off the common abbreviation for Most Valuable Player. These MVPs are not only helpful in promoting well-being, though. They also provide a guide for aligning our work in medicine with what fundamentally matters most for those who choose to serve others in healthcare.

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Meaning is the value and personal significance we place on our work from an internal perspective. It is the fundamental why for the work we do, and the personal fulfillment we derive from our work. Every physician wants to help their patients, but we often lose sight of the positive effects we have. As we struggle to understand and navigate the barriers to health our fellow citizens, leaders, and society often seem to accept, we don't recognize the healing aspects of listening, empathizing, and caring we offer regardless of the other factors we cannot immediately control. To stay on course, we can remind ourselves of the intrinsic meaning in the work we do and the key roles we play as partners in our patients' lives.

Values reflect the core principles we bring to our work on behalf of our patients, colleagues, and organizations. Sometimes our individual values may seem in conflict with organizational or societal values, but every one of us can commit individually to principles such as compassion, respect, integrity, and excellence. These are constant no matter what happens around us. Mindful and intentional alignment with these values also serves to connect physicians with meaning, as living our values supports professional fulfillment.

Finally, purpose represents the externally visible ways in which we fulfill meaning. Meaning and purpose are closely related, differing mainly in their internal or external focus, respectively. Purpose in medicine commonly revolves around improving patients' lives, alleviating suffering, and bringing excellence to deliver high-quality care to our patients. When larger societal directions seem misaligned with these goals, it can feel like achieving them is impossible. As individuals, though, we can always strive for these objectives through our own responsibility for how we engage with each patient in front of us. Reflecting on our purpose and how it is supported by our core values and aligned with meaning may further sustain our ability to connect with the uniquely fulfilling opportunities we have as physicians to help others.

It is easy to feel lost at sea amidst the chaos all around us. Rather than drifting further away from our course, it is more essential than ever to identify and honor our individual missions in medicine. Leaning on meaning, values, and purpose, the MVPs in medicine, can be our North Star to help us stay true to our missions through any storm. **MM**

Colin West, MD, PhD, is professor of Medicine, Medical Education, and Biostatistics, Mayo Clinic. He is one of three medical editors for *Minnesota Medicine*.

DEI is essential to being a good physician

Dr. Tjaden, thank you for bringing much needed joy and hope to me as I read your strong words in support of the efforts of the MMA in promoting diversity, equity, and inclusion (Jan–Feb issue).

I recently retired as a family doctor after practicing in Minneapolis and St. Paul for 45 years. I grew up in St. Cloud, graduated from St. Johns and then the University of Minnesota Medical School. DEI—diversity, equity, and inclusion—has guided me in becoming a better physician over my entire career.

DIVERSITY. Diversity is at the core of daily practice. My patients were men, women, gender queer, white, Black, Native, Latinx, recent immigrants, past immigrants, native Americans, Catholic, Jewish, Muslim, Buddhist, Christian. Each person is different, each person has their own health story and health practice. Diabetes is a very different disease for a middle-class professional person, a pregnant immigrant from Africa, and an unhoused man living on the street. My job is to listen, learn, and help find the best care amidst all the diversity.

EQUITY. Life does not treat people equally. Life has not been easy for many of my patients. Many come with a backlog of health problems. Many have ongoing obstacles to good health—no insurance, low wages, often under-resourced neighborhoods, racism. Our clinical challenge is to work with our patients to address those obstacles and bring their health to the fullest potential.

INCLUSION. Many of my patients have been left out of the full benefits of western medicine. Some have not been treated well. Some speak languages other than English. Some have felt disdain from medical providers because of their cultural practices. Many have had minimal education on how the body and mind work. Our job at our clinics is to welcome everyone—and to offer them service in their language and to be respectful of their culture. To be inclusive, we employ people of different languages and backgrounds, and honor each patient's journey to health.

Simply put, to be a good physician, I need to be good at DEI. For my patients to achieve their best health, my clinic needs to offer the best DEI. For our students to become good doctors, we need to model and teach professional DEI. Our professional organizations need to lead as champions of everyday DEI.

Minnesota has great health opportunities—now we must ensure just and caring health for every person and every community.

Again, thank you Dr. Tjaden and MMA for your strong, compassionate leadership.

– Chris Reif, MD

Write to us

Something on your mind? Email us at mm@mnmed.org. We'll edit for style and length.

Injustice persists

Recent strategies to remove bias and discrimination haven't worked. Our colleagues deserve better.

BY PAUL H. WAYTZ, MD; MISSY C. FLEMING, PHD; ABDI MAHAMED, MBA

"My co-resident, an extremely competent Hispanic woman, was continuously verbally abused as well as accused of being a janitor when cleaning surfaces in the ICU during the early stages of Covid. The powers that be were too powerful, so she quit the program and left medicine."

"While a med student, I saw a Black woman vascular surgery resident repeatedly joked about behind her back by other residents, fellows, and attendings, even though she was just as intelligent and capable as anyone else."

"I [a woman] was sexually harassed."

"I saw a doctor of color being discriminated against but was afraid to say anything."

Personal stories teach and shape us, guide us toward career choices, and are essential for growth. They are compelling because they also form the basis of our dignity. As noted in the physician comments above (acquired through individual interviews), for some of our colleagues, the most essential stories can be painful, hurtful, demeaning, and an indicator that unfairness and bias persist.

The concept of physicians as victims rarely engenders sympathy. Yet, discussions with caregivers who are women or who are races and ethnicities other than white confirm that discrimination has been occurring in our ranks for years and continues up until the present.

Though physicians are highly educated professionals, they still may harbor negative perceptions leading to intolerance, marginalization, and directed prejudice.

Sharing and listening to stories has the potential to open doors of empathy and civility and shape newer stories and actions that address problems of injustice. Effecting change should not be elusive. Training and subsequent caregiving is rigorous enough. The social burden of someone having to defend themself is an unconscionable obstacle.

Along similar lines, studies have established that the number of physicians from underrepresented groups remain remarkably low and without significant change for the foreseeable future. Underserved communities already suffer because of the lack of this specific group of physicians. One worries—and it would be extremely difficult to prove— if potential candidates perceive bias in both the application and acceptance process and become discouraged by concerns of discrimination.

Over 20 years ago medical schools, training programs, and other healthcare organizations initiated diversity, equity, and inclusion activities that addressed knowledge and respect for patient's and colleague's cultures. Courses vary in intensity and scope, but the obvious question is if they have changed any attitudes or behaviors or if they are just boxes to be ticked by institutions. When questioned about this, a dean at the University of Minnesota Medical School asked the pertinent question: "How would you measure this?" And therein lies an essential issue.

Interviews conducted by the MMA reveal that racism and sexism persist and that physicians from underrepresented groups feel they are often held to higher standards (www.mnmed.org/RacismTruths/videos). Additionally, several of the physicians from this dialogue ask that their peers take stronger positions supporting diversity. In recognition of this, what are possible steps to effect change on both individual and institutional levels?

Seminars and courses have been going on for years; the statements from those interviewed indicate little has changed.

If solutions or answers were simple to come by, conversations and exchanges should have already made a difference. The medical field still appears to need improvement, and discussions leading to actions are necessary if we are to make any further progress. Readers of *Minnesota Medicine* as well as thought leaders might consider the following:

> "Nothing has changed. It just makes me work that much harder. You need to be treated with dignity and respect or you need to acquire dignity and respect."
>
> ABDI MAHAMED, MBA

- The authors have developed a short questionnaire that asks questions related to bias and discrimination during and following training. This instrument can be expanded and include personal interviews and follow-up to provide insights and guidance as to how to effect positive change (author Paul Waytz can be contacted for details of the questionnaire).
- Beginning in medical school and continuing through postgraduate training, ensure that DEI classes and forums are mandatory, but simultaneously determine ways to obtain and evaluate conclusions and efficacy—and act upon those results as indicated.
- Without further burdening underrepresented groups, invite physicians to opportunities at every level of our discipline so they can better be heard, seen, represented, and assume leadership roles.
- Encourage the MMA to develop programs for high school and college students from underrepresented groups to pursue medical careers with the knowledge that they will be treated fairly and respectfully.

As formal programs evolve, outcomes need to be measured. We need to do better. Perhaps, a critical component is simple: Listen on a very personal level and then ask questions and work on specific issues together. Just as no one should have to defend their identity, we need to maintain an environment where no one feels vulnerable.

With a final thought, one of the authors (Abdi Mahamed, a young man born in Somalia), with a smile and a shrug of his shoulders, stated it this way: "Nothing has changed. It just makes me work that much harder. You need to be treated with dignity and respect or you need to acquire dignity and respect." It shouldn't have to be this way for anyone. In an atmosphere that cannot get past cultural differences among colleagues, it's still happening. **MM**

Paul Waytz, MD, is a retired rheumatologist and previous partner at Arthritis and Rheumatology Consultants (pwaytz@aol.com). Missy Fleming, PhD, most recently served as an executive director at the Accreditation Council for Graduate Medicine and has spent over 20 years in child and adolescent health. Abdi Mahamed, MBA, has worked in direct healthcare and management.

New dashboard gives data on Minnesota's healthcare workforce

The Minnesota Office of Rural Health and Primary Care (ORHPC) has launched a new and improved Minnesota Healthcare Workforce Dashboard.

The dashboard features data on licensed providers in a range of healthcare fields, including physicians, nurses, mental health professionals, dentists, respiratory therapists, and many others.

The data will provide industry partners and stakeholders, including government agencies, researchers, students, educators, medical professionals, professional organizations, media, legislators, and more with the latest information on Minnesota's healthcare workforce landscape.

The dashboard provides answers to frequently asked workforce questions, such as: who are Minnesota's healthcare providers and where do they work.

ORHPC will update the dashboard to address user needs and interests. For data requests or additional information, contact health.workforce@state.mn.us.

New report describes state's 2023 healthcare performance

A new MN Community Measurement (MNCM) report reveals that childhood immunization continues to show a decrease in statewide rates from year to year. This measure has not shown improvement since the Covid-19 pandemic.

This is just one of the findings of the report, released in late February, called *HealthCare in Minnesota: Summary Report on Quality, Disparities, and Cost*. It provides a comprehensive analysis of the state's healthcare performance in 2023. It also highlights trends in healthcare quality, disparities, and costs—offering valuable and actionable insights for community partners including medical groups, payers, policy makers, public health agencies, researchers, and community-based organizations.

Report highlights include:

- **HEALTHCARE QUALITY.** Colorectal cancer screening rates for the newly eligible 45–49 age group have improved. While the 2023 rate for all age groups has significantly increased compared to 2022, it remains significantly lower than 2021. Significant gaps remain in asthma control and depression care, with thousands of patients needing improved care to meet statewide benchmarks. There were modest improvements in breast cancer screening, controlling high blood pressure, and diabetes eye exams.
- **HEALTHCARE DISPARITIES.** Black, Indigenous, and Hispanic patients experienced the most disparities across multiple measures, particularly in colorectal cancer screening. Patients speaking Hmong, Karen, Somali, and Spanish, as well as those from Laos, Mexico, and Somalia, had lower rates of preventive care and chronic disease management compared to statewide averages.
- **COST AND UTILIZATION.** The total cost of care increased by 8.4% in 2023, primarily driven by a 15.3% rise in pharmacy costs and higher outpatient hospital service utilization. All categories of medical services saw increased use, except for inpatient admissions. Women aged 36–64 had the highest number of claims, while men aged 18–35 had the lowest number of claims.

The new results come from data reported to MNCM in 2024, covering services received by patients in 2023. The report includes measures across preventive health, chronic conditions, mental health for adults, adolescents, and children, total cost of care, and utilization.

Minnesota starts screening newborns for two additional disorders

The Newborn Screening Program at the Minnesota Department of Health (MDH) has begun screening newborns for Duchenne muscular dystrophy (DMD) and guanidinoacetate methyltransferase (GAMT) deficiency. The MMA is a long-time supporter of the newborn screening program.

Early identification and treatment of these disorders is key to slowing the progression of symptoms, as well as extending and improving the quality of children's lives.

DMD is a disorder that causes muscle breakdown. It affects legs and arms first, eventually leading to loss of mobility and weakness of internal muscles needed for breathing. If not identified in newborns, symptoms of DMD can go unrecognized for years. DMD often goes undiagnosed until children are 5 years old, at which point their muscles may already be severely damaged.

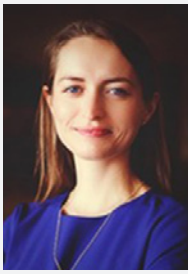
Based on the birth rate in Minnesota, as many as nine newborns are expected to need DMD treatment each year. Screening for DMD among newborns allows families and medical specialists to tailor care, such as physical therapy, based on approved treatments available for children at certain ages. Treatments do not cure DMD, but symptoms and muscle breakdown are less severe.

GAMT deficiency is a lifelong metabolic disorder causing a toxic buildup that, if left untreated, results in learning and behavioral challenges, as well as serious brain and muscle problems. GAMT deficiency symptoms include late sitting, walking, speaking, and growth. These symptoms typically begin before children reach their first birthday, and as late as age 3. Based on Minnesota's birth rate, and the rareness of the disorder, MDH expects to identify GAMT deficiency in no more than one child a year.

Since 1964, when Minnesota started screening for PKU (phenylketonuria), blood samples from all Minnesota newborns have been sent to MDH's Public Health Lab for screening, unless their parents opt out. As technology and treatments have improved in recent decades, Minnesota has expanded its newborn screening panel to help detect more disorders. In collaboration with hospitals, labs, midwives, and medical professionals across Minnesota, newborns are screened soon after birth for more than 60 serious conditions.

MDH continues to be a national leader in newborn screening. In 2023, the MDH lab screened more than 60,400 newborns from across the state, and recommended early intervention and treatment for conditions detected in about 400 of them. When a condition is detected, MDH contacts the child's healthcare provider to discuss the result, educate them about the condition, and review the recommended follow-up.

State hires director for new Center for Health Care Affordability



The Minnesota Department of Health's (MDH) new Center for Health Care Affordability (CHCA) has hired its first director.

Alex Caldwell, who started in her new position in late January, will lead the CHCA's efforts to build on our holistic understanding of the key drivers of healthcare costs in Minnesota, engage the public on the impact of rising healthcare costs, and collaborate closely with the MDH Health Economics Program to identify related research priorities and propose data-driven policy solutions.

Caldwell worked at the Colorado Health Institute for seven years, including five years as a director. In that capacity, she led teams focused on complex policy research and planning projects involving extensive stakeholder engagement. Her work in Colorado included developing a strategic plan for primary prevention of substance abuse; a guide to inform Colorado's Opioid Settlement investments; a financial map of the children's behavioral health system; and a comprehensive statewide needs assessment related to early childhood.

Caldwell has also worked with The Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva, Switzerland, as well as the Tulane University Cancer Center in New Orleans. She most recently worked in Minnesota as an associate director for FSG, a global nonprofit consulting firm, designing and executing systems change strategies for complex projects with large corporate, nonprofit, and philanthropic clients.

Business is booming, but so are UCare's losses

After a loss on operations of $504 million last year, UCare is putting a hold on new Medicare Advantage plan enrollment, and layoffs could follow, according to the *Star Tribune*. The financial losses have piled up even as the company's Medicare health plan business grew 20%.

"Last year's financial results reflect continued challenges of rising medical and specialty medication costs, and higher use of services outpacing government payments," UCare chief executive Hilary Marden-Resnik said in a statement. "We are implementing a multiyear strategic plan to ensure long-term stability for our members, providers, and partners."

UCare employs more than 1,600 Minnesotans.

Settlement ends investigation of Mayo Clinic charity care

A settlement with the Minnesota Attorney General's office will require that Mayo Clinic change its charity care and debt collection practices, according to a statement from the attorney general's office.

According to the terms of the settlement, Mayo Clinic must provide charity care to certain presumptively eligible patients and streamline their charity care application process. The settlement also prohibits Mayo Clinic from suing to collect medical debt in other than extraordinary circumstances.

The settlement resolves the attorney general's investigation, announced in December 2022 after allegations reported in the *Rochester Post-Bulletin* that Mayo had sued patients who may have qualified for charity care to collect medical debt. The investigation found that, among other things, Mayo Clinic's policies included barriers to patients' access to charity care and Mayo Clinic engaged in aggressive debt-collection practices in contravention of the Minnesota Hospital Agreement and its charitable mission and values. As a result of the investigation and Mayo's cooperation, the percentage of Mayo's operating expenses provided to charity care in 2024 rose to the highest level in more than five years.

Caregiving burdens exacerbate menopause symptoms

Women 45–60 years old who are managing family caregiving and menopause face nearly double the risk of moderate to severe menopause symptoms, according to a recent study in *Mayo Clinic Proceedings*.

Ekta Kapoor, MBBS, a coinvestigator of the study, says women providing 15 or more hours of care per week are especially affected, with half of them experiencing moderate or worse symptoms. Many of these women are in the "sandwich generation," caring for children and older adults at the same time.

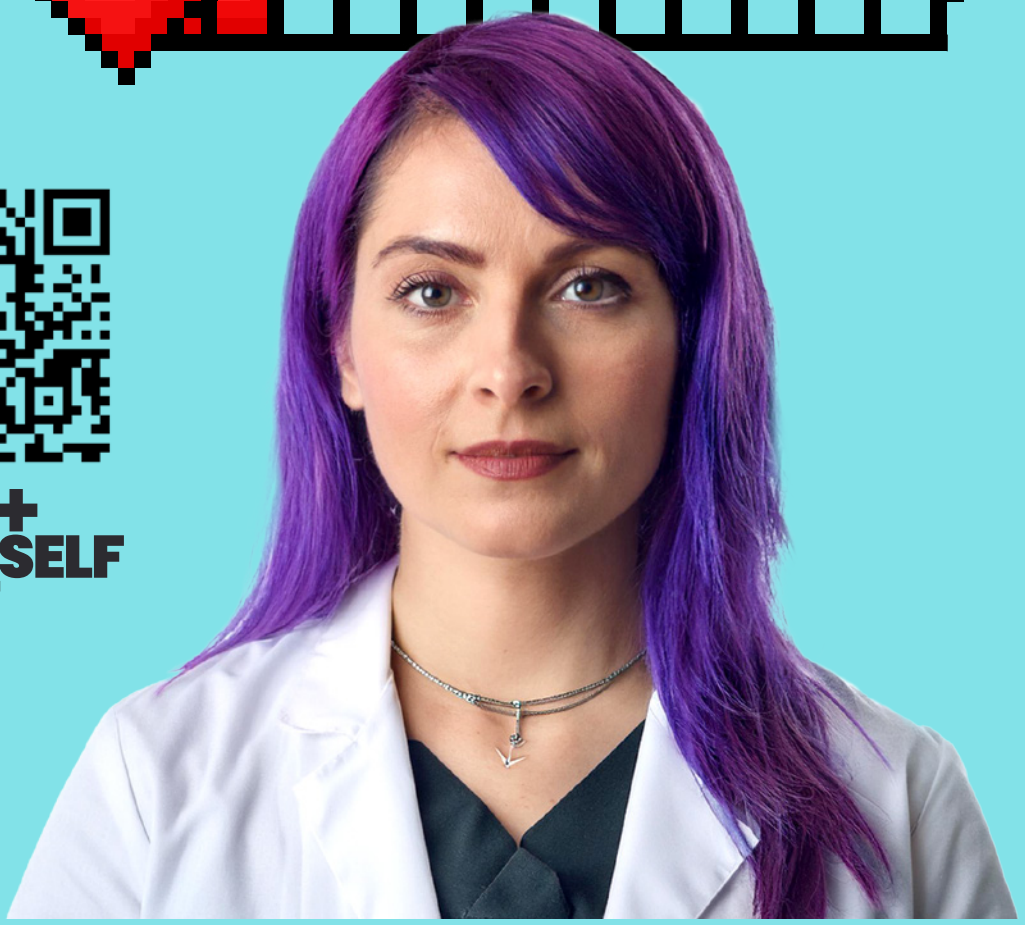
Kapoor says more menopause conversations are crucial to help women understand and navigate this life transition. "It can take a toll on their physical health. It can take a toll on their mental health. And the same can be said about menopause symptoms also, which can significantly impact the quality of life in some women," she says.

Kapoor says two findings stood out. First, the caregiving burden affected a broad range of menopause symptoms, from physical symptoms such as hot flashes and joint pain, to psychological symptoms such as mood problems and anxiety, and urogenital symptoms such as vaginal dryness.

Second, "when we tried to adjust for stress and the overall mental health of the women, this association between caregiving and menopause symptom burden persisted," says Kapoor.

The research, she says, emphasizes the need for better support for caregivers going through menopause and for better education of caregivers and their healthcare professionals regarding treatment options for menopause symptoms. MM

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



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Cutting the overhead

Biomedical researchers and institutions are bracing for significant cuts in NIH-funded research

BY SUZY FRISCH

As a nephrology researcher for 30 years, Kirsten Johansen, MD, has seen some downturns in federal support for scientific research over the years. But it's nothing like the planned pullback in funding occurring since the Trump administration took over in January. It's left researchers at the Hennepin Healthcare Research Institute wondering how they will complete their studies if the National Institutes of Health grants cuts go into effect.

"I have never seen anything on this scale," says Johansen, HHRI president and director of nephrology at Hennepin Healthcare. The NIH announced the cuts to biomedical research on a Friday night with an effective date of Monday, putting researchers into a panic about work currently underway. "That is incredibly disruptive. Everyone is budgeted for ongoing projects in a certain way—and now that all changes. That has never happened while I've been a researcher. This feels very different."

Though the cuts are now tied up in court (a federal judge in April barred the cuts and the administration is almost certain to appeal), biomedical researchers in Minnesota at universities, research institutes, and hospitals are reeling from potential reductions to the indirect cost portion of their funding. Indirect costs would be capped at 15%, down from an average of about 30%, according to the NIH. The institution awarded $32 billion for nearly 60,000 grants in fiscal year 2024, with $9 billion of that spent on indirect costs. A 15% cap would decrease indirect cost spending to $4 billion, *The New York Times* reports.

In Minnesota, the University of Minnesota and the Mayo Clinic would bear the brunt of the cuts, but other institutions like HHRI, the HealthPartners Institute, the Minneapolis VA Health Care System, and life science companies would lose significant grant funding. In 2024, Minnesota received $715 million total in NIH funding for biomedical research.

The University of Minnesota—the state's biggest grant recipient—secured 768 NIH grants worth $380 million in 2024. The university alone would lose $97.5 million if the 15% cap was applied to 2024, says Peter Crawford, MD, PhD, vice dean for research at the medical school. Going forward, the university would face a loss of $100–130 million per year over the next five years, Crawford says.

Mayo Clinic received 439 grants totaling $278.6 million in funding in 2024. It stands to lose about $54 million, according to an estimate by analyst James Murphy from Education Reform Now. Mayo Clinic would not comment for this article.

"These cuts would be devastating," Crawford says. "The funding is not just supporting the university. The loss of clinical trials would be substantial. The opportunities for developing modes of care would be lost and the best treatments

for the most vulnerable people would be lost, jobs would be lost, workforce development would be lost, the development of technology would be lost. This affects clinical trials that offer opportunities for therapies for vulnerable patients who have exhausted the standard of care," he adds, pointing to the university's promising research areas like immunotherapy for cancer.

Biomedical research is an important industry in Minnesota. NIH funding awarded to local institutions and companies supports 7,700 jobs and $1.76 billion in economic activity, according to United for Medical Research. Minnesota's life science industry has 7,400-plus businesses, about 326,300 employees, and contributes 10.3% or $48.5 billion to the state's GDP, reports the Minnesota Department of Employment and Economic Development.

Though many medical device manufacturers don't receive NIH research grants, much of the innovation occurring in Minnesota is built upon discoveries supported by the funding, says Michael Morton, interim senior director of government affairs and policy for Medical Alley, a network of 800 health technology and healthcare entities in Minnesota. As scientists make and confirm discoveries, many eventually partner with companies like Medtronic, 3M, Boston Scientific, and start-up businesses to translate these discoveries to devices or medications.

"The big picture is that the uncertainty is really causing some problems," Morton says. "There is concern that there is going to be less innovation coming out of these research facilities if labs are shutting down—if they are not getting the fully funded grants that they have been anticipating, then there certainly can be a disruption" in lifesaving innovation.

Indispensable support for research

Many academic and medical leaders are emphasizing that the indirect cost portions of grants are vital to completing the research. Indirect costs pay for crucial aspects of studies, such as utilities, safety, equipment and materials, data security for participants, regulatory compliance, and personnel who oversee these functions, Crawford says. Often, such facilities and administration resources are shared among funded studies.

Every three to four years, the university negotiates its indirect cost rate. The current rate is 54%, though many studies like training grants are awarded much lower rates, Crawford says. In 2024, the university spent 27% of its total NIH pool of grant funding on indirect costs.

Reductions in indirect costs for Hennepin's Institute would have a big impact on ongoing and future research. "Fifteen percent overhead is not enough to support what we do," Johansen says. "Cutting overhead is not cutting fat—it's cutting research money. We already struggle to be fully staffed and provide timely service. If indirects are cut drastically, it could come to a point where you can't support the research at all."

In 2024, HHRI obtained $25.08 million in NIH grants, supporting studies on addiction medicine, smoking cessation, trauma and acute care, and spinal cord and traumatic brain injury, and more. The bulk of HHRI's research reflects its patient population, Johansen says. As a safety net hospital, many of its patients have lower socioeconomic status and contend with numerous health disparities. Much of the institute's research seeks to identify and investigate diseases that disproportionately impact residents.

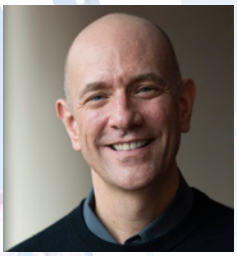
"We're addressing disparities in those diseases and adapting care for a high resource-need community. Together with the Hennepin Healthcare system, our mission is to improve patient care and the health of the community through research and education," Johansen says. "For example, our infectious disease group is absolutely phenomenal and is investigating sexually transmitted disease, HIV, and malaria in sometimes challenging populations to treat."

The university hasn't yet announced any formal changes like furloughs or hiring freezes to respond to the cuts. But if they get enacted, "there will be consequences. Everything is on the table," Crawford says, including increasing tuition, reducing graduate school admissions, and shrinking training programs. The central administration, colleges, medical school, and departments "will have to make difficult decisions about what they will do with the resources available. There's no stash of funds just sitting there."

At the Minneapolis VA, NIH-funded research projects have not yet been affected by cuts at the time of our inquiry, according to Chief of Staff Michael Armstrong, while the proposed reductions are tied up in court. The VA received $4.4 million in NIH grants in 2024 out of $37.4

"If you're stopped in the middle of a clinical trial, it's not like you get half of the information. You don't get enough people through the study to get results and get answers. That's both a threat to the research and a loss of money that's already been spent. If that happens on a large scale, that will be a big problem for us and other institutions."

Kirsten Johansen, MD
HHRI president and director of nephrology
Hennepin Healthcare



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Peter Crawford, MD, PhD
Vice dean for research
University of Minnesota Medical School

million in overall research funding. One of the largest research programs in the VA system, the Minneapolis VA has more than 150 investigators focusing on 500 projects ranging from dementia and cancer to PTSD and rehabilitation medicine.

Other research impediments

Several other factors are adding to researchers' uncertainty. In the spring, there was a slowing of the approval process for continuing and new NIH awards. Regularly scheduled grant review panels that assess applications and make funding recommendations were paused, rescheduled, or canceled. If this integral part of the NIH funding cycle gets off track, it's another way research could be hampered, Johansen says. NIH grants often support multiple-year projects, but researchers don't receive all of the funds upfront. They must submit annual progress reports and be approved to receive the next year's award.

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In addition, the NIH rescinded funding for nearly 20 research studies focused on transgender people, gender identity, and diversity, equity, and inclusion in the scientific workforce. The agency was preparing letters to claw back funds from hundreds more studies, according to *Nature*. Morton points to mass layoffs at Health and Human Services agencies like the Food and Drug Administration. This may slow companies' abilities to get approvals for all devices and products, whether or not they were developed based on NIH-funded research.

Medical Alley representatives visited members of Congress in March, underscoring the consequences of research cuts in Minnesota. "Our board members representing research organizations were talking about the dramatic impact they are seeing and will see. They were talking about the significant financial impact on their organizations and tying that to an impact on innovation," Morton says. "There is going to be a real slowdown on the sort of innovation that happens. It's not only a challenge for the state of Minnesota but for the nation in general." **MM**

Suzy Frisch is a Twin Cities freelance writer.

"The big picture is that the uncertainty is really causing some problems. There is concern that there is going to be less innovation coming out of these research facilities if labs are shutting down—if they are not getting the fully funded grants that they have been anticipating, then there certainly can be a disruption" in lifesaving innovation.

Michael Morton
Interim senior director of government affairs and policy
Medical Alley

If ICE comes knocking

How should healthcare providers prepare now that the federal government has lifted restrictions on U.S. Immigration and Customs Enforcement at healthcare facilities and other "protected areas"?

BY ANDY STEINER

Things have changed since Donald Trump took his second oath of office. One significant change that may affect the way physicians and other healthcare providers care for their patients is the lifting of federal restrictions around immigration enforcement actions in healthcare facilities.

Under the Biden administration, healthcare facilities along with other institutions, like churches and schools, were designated as "protected areas," meaning that in those places, Immigration and Customs Enforcement (ICE) officers were asked to refrain "to the fullest extent possible" from conducting enforcement actions or arresting people they considered to be in the country illegally.

Under the rules, ICE agents are now free to conduct immigration enforcement actions in these formerly protected places. This news raises concerns among leaders of healthcare organizations about the possible impact these changes could have on patients and providers alike.

Minnesota Medicine contacted several hospitals and clinics serving both urban and rural Minnesota communities, including CentraCare, Hennepin Healthcare, Allina Heath, and Sanford Worthington Medical Center. These organizations either did not return calls, declined to comment on this topic, or supplied a prepared statement.

In immigrant communities, concerns about immigration actions in healthcare settings run deep. Carolina Ortiz, associate executive director of the Minneapolis-based immigrant rights nonprofit Communities Organizing Latino Power in Action (COPAL), recalled her own childhood concerns around seeking medical help.

"Growing up undocumented there are always are fears and doubts," Ortiz said. "Should we go in to see the doctor or not? In the past, there was no access to resources for medical insurance or to have any sort of coverage. Community members tried to avoid coming for medical care as much as possible." The new lifting of regulations makes the fears around seeking medical attention run even higher, Ortiz added: "In the first and now in the second Trump terms, there has been an increasing fear about what does it mean to go in for medical help. Many of our members ask themselves, 'Is it ever safe to see a doctor?'"

Minnesota healthcare facilities and providers have tried to emphasize their commitment to the health and safety of patients in the face of these changes. At Community-University Health Care Center (CUHCC), a Minneapolis clinic that serves a largely urban, low-income patient population, Roli Dwivedi, MD, chief executive officer and chief clinical officer, took a reassuring tone.

"The Community-University Healthcare Center's focus remains on providing compassion and care for our patients, staff, learners, and community," she said in a statement. "CUHCC has protocols to maintain a safe environment and ensure our physicians can serve patients with minimal disruption, whether through in-person or telehealth visits."

The Minnesota Hospital Association also released a statement emphasizing its commitment to serving patients despite the policy changes.

"Our members are aware of a change in federal procedures regarding immigration enforcement that rescinds previous policy that limited immigration enforcement near hospitals and other public service facilities considered 'sensitive areas,'" the statement read, in part. "Regardless of federal policy, active immigration enforcement at our facilities has been rare in the past. The policy of our members however, has not changed: Our hospitals treat the patients that seek their care."

How should Minnesota hospitals and clinics and the physicians who work in them respond to these policy changes? How should staff and administrators react if ICE agents come to their doors? *Minnesota Medicine* asked Elizabeth Streefland, a Twin Cities immigration attorney with decades in private practice, for her advice. Her responses have been edited for length and clarity.

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Carolina Ortiz
Associate executive director
Communities Organizing Latino Power in Action (COPAL)

Minnesota Medicine: How would you advise healthcare facility administrators to prepare for a possible visit from ICE officers?

Streefland: The first thing is to be proactive, to be prepared for it and be prepared in a real way. I'd advise people to establish a response team. The response team should have a few people on it. It should be a proactive team designed to create a plan for the organization because I absolutely believe that an organization has to have a plan. They have to practice the plan because if Immigration comes in there will be a high level of anxiety. I would say this team should draft procedures, and one thing the procedures should include would be to train the front desk about how to respond when ICE comes knocking.

Who should be on this team?

You want someone probably in security. Security usually knows how to deescalate tension. There could be a lot of tension if ICE comes in, especially if they are coming in armed. That freaks everybody out. You should also have someone in the legal department and probably someone in HR, a manager of some type, on your team. Another important part of the team could be the record-keeping department. The team should discuss, "Do we keep immigration status in our electronic records? Do we need to?" That's an important question. Some organizations keep track of that kind of information for funding or insurance purposes. Do you need to keep that information in the electronic records? Do you need that at all? That's a policy question.

What else should be included in the response team's policy?

Your policy needs to be clear what is the public area and what's the private area of your building. ICE can legally come in the public areas, so that is probably the lobby, the cafeteria and likely the parking lot. I think the response team should figure out what areas are public and what areas are private. This should be detailed in your policy. We have fourth amendment rights that say that the police can't just come into your house. That's private. But they can meet you in front on the street. That's public. Public and private spaces in a medical building are often separated by a front desk. That would be a natural demarcation line. But putting a front-desk person in charge of that would be a big ask.

So how do you train front-desk staff in the best ways to respond if ICE agents enter your healthcare facility?

ICE can't just willy-nilly come into the private areas of your facility, so they will normally have a warrant. If the warrant is signed by a judge or magistrate, it is a court document, a judicial warrant. If your organization is presented with that kind of warrant, you have to comply. It has to be specific as to date, address, and time of day. If you are presented with an administrative warrant, which is a document issued by the Department of Homeland Security, it is an administrative order or a deportation order. You do not have to respond to those. ICE usually comes hoping that they will be let in and that they can get a whole bunch of people. They rarely have a judicial warrant.

Elizabeth Streefland
Immigration attorney

They should be trained to walk this line between being cooperative in a sense that you're acknowledging them and you're also contacting somebody to come out and help respond. You're not sending people out the back door or hiding records. The front-desk person should say, "I've been trained to contact certain people in this event and I will contact them now. Please wait here." That's their sole responsibility.

In a perfect world, the person the front desk is trained to call in this situation will be sitting upstairs with nothing else to do and they will just pick up the phone and take over. But that's not going to be the case. That's why I suggest you have a team of people who are trained to respond to this. The person who comes out to respond to officers ideally will be calm, confident, and will maybe have security with them. That person is going to have to be reviewing the documents that are presented to them by officers and saying yes or no to their request to enter the private areas of the building.

Are there legal limits on how and when ICE agents can enter a healthcare facility?

If you are willingly opening doors to immigration, word is going to get out quickly that you aren't a safe space to bring your family. The plan of not allowing ICE into your facility based on an administrative warrant is fully within the law. It is not harboring anybody. All you're doing is basically saying, "I'm following the law."

Elizabeth Streefland
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ICE can't just willy-nilly come into the private areas of your facility, so they will normally have a warrant, but there are two kinds of warrants. That's why this person who comes down to respond should have some training and confidence and be cool under pressure. Then they can read the warrant and see if it is a judicial warrant or an administrative warrant. If the warrant is signed by a judge or magistrate, it is a court document, a judicial warrant. If your organization is presented with that kind of warrant, you have to comply. It has to be specific as to date, address, and time of day. If you are presented with an administrative warrant, which is a document issued by the Department of Homeland Security, it is an administrative order or a deportation order. You do not have to respond to those.

ICE usually comes hoping that they will be let in and that they can get a whole bunch of people. They rarely have a judicial warrant. That requires convincing a judge or a magistrate of a whole bunch of things before they will sign it. The person who responds could say, "Come back with a judicial warrant." They could say, "You do not have permission to come in." An administrative warrant does not authorize ICE to come into the private areas of your facility.

This seems like it could feel really confusing and stressful—even for the best-prepared professional.

It is. Many years ago when I was a young attorney, I had the FBI show up and ask for documents in one of my clients' cases. I was like, "Yikes!" Once I calmed down I realized I don't have to hand that over and I didn't. That's why everyone needs to be trained.

Is taking the approach you're suggesting, of insisting on a judicial warrant, a politically motivated approach?

I suppose it could be seen as political, but I think that as medical professionals you have a duty to your patients. You could also look at it in a business sense: If you are willingly opening doors to immigration, word is going to get out quickly that you aren't a safe space to bring your family. The plan of not allowing ICE into your facility based on an administrative warrant is fully within the law. It is not harboring anybody. All you're doing is basically saying, "I'm following the law." MM

Andy Steiner is a Twin Cities freelance writer and editor.

MMA policy on providing healthcare to undocumented patients

The Minnesota Medical Association is committed to ensuring that all Minnesota patients, regardless of immigration status, have access to safe, timely, high-quality healthcare. State and/or federal policies that seek to target healthcare facilities as part of immigration enforcement actions have the potential to undermine the public's health if individuals in need of care avoid care due to fear and/or misinformation. The MMA supports designating medical treatment and healthcare facilities, such as hospitals, doctors' offices, accredited health clinics, and emergent or urgent care facilities, as sensitive locations, at which there would be limits to enforcement actions made by the U.S. Department of Homeland Security. The MMA encourages clinics and healthcare systems to create protocols to ensure that patients, regardless of their immigration status, feel safe accessing healthcare routinely or in an emergency. To ensure the delivery of safe and confidential health care, the MMA opposes any policies, regulations or legislation that would criminalize or punish physicians and other healthcare providers for the act of giving medical care to patients who are undocumented immigrants; opposes any policies, regulations, or legislation requiring physicians and other healthcare providers to collect and report data regarding an individual patient's legal resident status; and opposes proof of citizenship as a condition of providing health care.

UNDER ATTACK

Providers working in transgender medicine face stressed patients, high demands for care, and a deepened commitment to their work

BY SUZY FRISCH

The anxiety and fear is palpable every time Erik Haugland, MD, walks into the exam room to see a patient for gender-affirming care. People of all ages and family members are deeply worried that access to transgender services and treatment might go away at a moment's notice.

On top of that, there is sky-high demand for care from within the state, from people who travel to Minnesota from states that have banned gender-affirming care for youth, and others who have moved to Minnesota because of its status as a trans refuge. Then add in patients and providers' stress from executive orders and other policy changes from the Trump Administration targeting transgender people, and it makes for busy, taxing days for clinicians.

"I'll say my job has been really challenging lately. Everyone is really worried," says Haugland, a family medicine physician who practices gender care integrated into primary care at North Memorial Health Clinic in Brooklyn Center and gender care at Family Tree Clinic in Minneapolis. (Haugland was not speaking as a representative of North Memorial.)

The barrage of anti-trans campaign ads and comments from political candidates and the president "has been really emotionally difficult. There's been a lot of anxiety in my patients and worsening mental health, having to live in a country where the federal government is targeting them," Haugland adds. "These stressors can be especially profound for youth and their families who have had to travel from or move from other states in order to access care in Minnesota and they often have to worry about once again losing access to this essential form of healthcare after they have come here."

On his first day in office, Trump issued an executive order that took a range of actions regarding trans and gender-nonconforming people. It declared that male and female are the only two sexes and that federal money will be stripped from programs that "promote gender ideology." The order also calls for the federal government to eliminate research and education grants to institutions—including hospitals and medical schools—that provide gender-affirming care like puberty suppresants and hormone therapy to people under 19. In addition, the Centers for Disease Control and Prevention removed or edited references to transgender people, eliminated information about topics like preventing or testing for HIV in trans

populations, and stopped including data about transgender people in federal health monitoring mechanisms like the Youth Risk Behavior Surveillance System, which serves as a resource for researchers.

Today, 26 states ban gender care for youth, impacting 118,300 people or 39.4% of transgender youth in the United States, according to the UCLA Williams Institute, a think tank that researches sexual orientation and gender identity law and public policy. Minnesota became a trans refuge state in 2023, meaning that people can continue accessing gender-affirming care across the state. The laws protect the privacy of patients and clinicians who provide gender care, and providers are shielded from complying with subpoenas from states that ban transgender care.

It's been heartening to Haugland that Attorney General Keith Ellison's office has reached out numerous times to make sure physicians and other healthcare providers aren't experiencing any barriers from the federal government or states that ban transgender care. Minnesota also joined a multistate lawsuit fighting the ban on gender-affirming care for youth and the removal of federal funding.

Still, a climate of fear has impacted healthcare systems in Minnesota. Many would not make staff available for an interview—including Mayo Clinic, University of Minnesota, HealthPartners, and Essentia—but they noted that nothing has changed with their gender care services.

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>
> Christine Hill
> Media relations manager
> Hennepin Healthcare, Minneapolis

"Like healthcare systems throughout the state, we are monitoring any proposals or changes that may impact patients and their access to care," says Christine Hill, media relations manager at Hennepin Healthcare in Minneapolis. "As Minnesota's largest public safety-net hospital and healthcare system, we remain committed to serving anyone seeking care. Our healthcare professionals and those who support them at Hennepin Healthcare are unwavering in this commitment."

Staying the course

Children's Minnesota has worked in recent years to accommodate more gender care patients and reduce long waiting lists as demand increased from across Minnesota and outside the state. On top of adding two new physicians and another mental health provider in 2023, Children's also expanded nursing and support staff to pare down its waiting list. Then as other states banned gender care for youth, families turned to Children's in even greater numbers, says Kade Goepferd, MD, chief education officer and a pediatrician in the gender health program.

Goepferd stresses that Children's continues to provide high-quality, evidence-based care to gender-diverse patients. But that doesn't mean it's easy. "The landscape seems to be changing pretty rapidly and that's intended to create a lot of chaos and fear and confusion for people," Goepferd says. "Those of us in healthcare are spending so much time in clinic with families and between clinic visits and on the phone answering questions, reassuring families their child can continue to access the healthcare they need." An added burden is helping families navigate out-of-state health insurance and ensuring that care is covered.

A big aspect of providing care to transgender and gender-diverse youth involves mental health. Already experiencing higher rates of depression, anxiety, and thoughts of suicide, more than 90% of trans youth note in national Trevor Project surveys that the current political climate negatively impacts their mental health. Goepferd sees that in the clinic every day.

"Patients are more anxious and experiencing more depression, and they are hopeless about the future and what is to come for them," Goepferd says. One of patients' biggest fears is being made to stop medications like puberty blockers or hormone therapy that treat gender dysphoria. That's especially frustrating as a physician

> "There's been a lot of anxiety in my patients and worsening mental health, having to live in a country where the federal government is targeting them. These stressors can be especially profound for youth and their families who have had to travel from or move from other states in order to access care in Minnesota and they often have to worry about once again losing access to this essential form of healthcare after they have come here."
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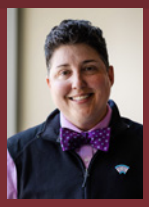
> Erik Haugland, MD
> Family medicine physician who practices gender care integrated into primary care
> North Memorial Health Clinic, Brooklyn Center
> Gender care physician
> Family Tree Clinic, Minneapolis

"Patients are more anxious and experiencing more depression, and they are hopeless about the future and what is to come for them." One of patients' biggest fears is being made to stop medications like puberty blockers or hormone therapy that treat gender dysphoria. That's especially frustrating as a physician and scientist who knows from seeing patients and from substantial research that gender medicine protocols are safe and highly effective. "All of the research we have for kids and adults shows amazing outcomes. This is well-studied, long-standing care and we know it changes lives and saves lives."



Kade Goepferd, MD
Chief education officer and a pediatrician
Children's Minnesota Hospital, St. Paul

and scientist who knows from seeing patients and from substantial research that gender medicine protocols are safe and highly effective. "All of the research we have for kids and adults shows amazing outcomes," they add. "This is well-studied, long-standing care and we know it changes lives and saves lives."

Contending with misinformation is another difficult aspect of transgender medicine, says Kelsey Leonardsmith, MD, a family medicine physician and assistant professor at the University of Minnesota who also sees patients at Family Tree Clinic, where she is director of the child and adolescent transgender hormone care department. Gender care is a slow, iterative process that doesn't jump from someone presenting with gender dysphoria to walking out of the door with hormones. Care for gender nonconforming people is highly individualized and consultative, intervening as minimally as possible to make sure patients are happy, healthy, and thriving, she adds.

Before patients see a transgender medicine clinician, they have typically spent significant time in therapy. The standard of care is that youth do not take any medications until they reach puberty, Leonardsmith says. Then, some youth opt to take puberty blockers to suppress the physical changes that don't align with their gender. If they choose to stop or take a break, then puberty begins anew. Same thing with hormone therapy. "Hormone therapy is partially reversible and so is not started until patients are mature enough to demonstrate capacity, and we start dosing low and slow," says Leonardsmith. Most healthcare providers also do not perform gender-care surgeries on people under the age of 18, she says.

If Trump's executive orders succeed, it will put physicians in a difficult position. "Deciding not to intervene for a trans young person who needs care is not benign because puberty causes irreversible changes to the human body. Those changes are going to cause harm when we have safe, fully reversible medication that can delay those changes to the point where a young person is more developmentally advanced to be able to make decisions," Leonardsmith says. "Now the government wants us to withdraw evidence-based care from our trans youth patients, and that is asking me to betray my oath as a physician. It's overtly harmful."

Expanding the ranks

To meet the demand for gender care, physicians and organizations have been working to train more clinicians. Family Tree Clinic started the Midwest Trans Health Education Network (MTHEN) with funding from the Bush Foundation to offer a cohort-based training program for providers. The virtual course prepares physicians, trainees, clinician educators, and others to provide hormone therapy to patients in rural and suburban communities in Minnesota and the Dakotas, Leonardsmith says.

Started two years ago, the six-session program is on its fourth cohort of providing education and peer support. MTHEN also offers weekend workshops for clinicians already caring for older adolescents

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Kelsey Leonardsmith, MD
Family medicine physician and assistant professor
University of Minnesota
Director of the child and adolescent transgender hormone care department
Family Tree Clinic, Minneapolis

and adults who want to learn how to provide puberty suppressing medications to younger youth.

One way physicians have been getting through this challenging time is by supporting each other. Gender care providers from across Minnesota and health systems formed a group that meets regularly to talk about the changing environment, ask questions, and share information. Family medicine resident Lily Ward, MD, who provides gender care as part of their practice, finds these connections helpful.

"As primary care doctors, part of the job is helping carry things with patients and be there with them. I find myself spending more time with my queer provider community and providers that do gender-affirming care, talking and supporting each other, and trying to focus on resilience and hope and helping with grief," Ward says. "We're focusing on what we can do, but it's pretty hard right now with more and more reports of harassment, discrimination, and open transphobia."

"We're focusing on what we can do, but it's pretty hard right now with more and more reports of harassment, discrimination, and open transphobia. When a young person has gender dysphoria it can cause difficulty with their mental health and have negative impacts on their ability to form peer relationships. Kids are really strong and resilient and smart, but it's just this extra burden on them and an extra hurdle that they have to wait all this time."

Lily Ward, MD
Family medicine resident

Another challenge is knowing that people face long waits to access care. "It's really hard to wait another year before they meet with a provider about their dysphoria. These younger ages are so crucial for development and sense of self and self-confidence," Ward says. "When a young person has gender dysphoria it can cause difficulty with their mental health and have negative impacts on their ability to form peer relationships. Kids are really strong and resilient and smart, but it's just this extra burden on them and an extra hurdle that they have to wait all this time." MM

Whirlwinds of change

Minnesota braces for changes emanating from Washington—a Q&A with Commissioner of Health Brooke Cunningham.

PHOTO BY KATHRYN FORSS

Brooke Cunningham, MD, PhD, Minnesota commissioner of health

The Trump administration's flurry of financial cuts threaten public health, medical research, and many aspects of clinical practice in general. On March 24, *Minnesota Medicine* talked with Minnesota Commissioner of Health Brooke Cunningham, MD, PhD, for her read on the effects that rapid federal policy changes will have on public health and medical practice in the state.

Rapid, indeed. The very next morning, "the federal government had unilaterally terminated approximately $226 million in grants to the Minnesota Department of Health, effective immediately," said Cunningham. "The federal government gave us no advance notice, no close-out period, so we had to halt work that would have helped us address chronic gaps in the system and be better prepared for future threats. Abrupt cancellations of grants and contracts is unprecedented and will impact our work and that of our partners. It means layoffs for our staff that will have ripple effects on the whole public health and health care system. These layoffs impact those that support the state's response to measles, H5N1, and slower response times for other infectious disease outbreaks. It means an immediate suspension of partner-led vaccine clinics and emergency preparedness activities. Our public health laboratory will also be impacted leading to delays in lab results and patient care. There are other impacts as well, this is just a few, but the bottom line is these cuts are a tremendous loss. We are working now to figure out how much of this critical public health work we can save and continue."

Legal challenges to the cuts have whipsawed public health institutions. In early April, a federal judge, responding to a lawsuit by nearly two dozen states and the District of Columbia, issued a temporary restraining order on the grant cuts. By the time you read this, the original order will have expired, and undoubtedly new challenges will have been mounted.

"This is a bright spot amidst what have been some very dark days in public health. The evidence put forward by Minnesota, 22 other states and the District of Columbia, clearly demonstrated the harm this reckless grant termination poses for Minnesotans and our public health infrastructure," said Cunningham. "That said, this is a temporary order, so the future is not yet certain. We will once again have to take some time to figure out what this fully means for the critical services we provide, our community partners, and most importantly, the staff that have received layoff notices."

But back to the earlier conversation, which has been edited for clarity and brevity.

The administration has proposed slashing funding for medical research at universities. That's most immediately the concern of research institutions like the University of Minnesota and Mayo Clinic. But how might that affect Minnesotans more broadly?

As you may be aware, I was a researcher in medical school before I joined the Minnesota Department of Health. What we know about the strength of American medicine is its basis in fact. The main takeaway from the Flexner Report in 1910 was to move medical education to a more science- and research-based foundation, to really differentiate American physicians in that way.

We know that there are key ties between the research that goes on medical schools and in therapies and treatments that we provide patients. So certainly, I believe that research makes us healthier. Certainly we have more confidence in the advice that we give patients because of its grounding in science, and then as practitioners, research has helped us find solutions.

And even downstream from that, we live in Minnesota, a center for biotech. Those advancements that come from federal funding and research institutions often get translated by those other adjacent sectors, so that they can be distributed broadly.

So I think there are a lot of real potential impacts on our research institutions, our medical school, on patients participating in clinical trials, and more broadly, on population health and our economic well-being in this region.

Are there other things we should be aware of?

The Minnesota Department of Health, is heavily funded by the federal government. We get more than 50% of our funding from the fed, and often we pass through those monies to partners. And when we think about local public health departments, they get more than a third of their funding through the federal government.

Public health is a very broad scope of practice, a very broad scope of work. Most people know public health because of COVID-19, because of our infectious disease work, but we do a lot more. We have a drinking water program where we partner with community water systems to make sure the water coming out your tap is safe. We administer the WIC program, the Special Supplemental Nutrition Program for Women, Infants, and Children. We do chronic disease surveillance and partner with people to improve outcomes on chronic disease. And we are a healthcare regulator, CMS's designee to make sure our hospitals are safe and otherwise regulate to make sure the food that we eat, the romaine lettuce, is safe. So we have a very broad scope of work, heavily dependent on federal funding.

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I wanted to ask you about the Robert F. Kennedy Jr. effect. Are you seeing or anticipating negative effects on vaccination in Minnesota because of skepticism in the high ranks of the administration? Minnesota already has one of the lowest rates of childhood vaccination in the country.

In that last assertion, I will say, depending on what data you look at, we would get different numbers. When we look at our kindergartens, for example, 87% of kindergarteners in Minnesota were fully vaccinated with MMR as they went into the 2023–24 school year. So I think people may argue over the data, but the underlying argument is we know vaccines are one

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of our most effective resources to protect ourselves against infectious disease. We want higher vaccination rates wherever the number is less than full vaccination for the full population.

You talked about the Robert Kennedy effect. I still don't know yet that there has been a Robert Kennedy effect when we're having this conversation. But we do know that there was an effect through the pandemic. We know that a lot of this information, or intentional misinformation, circulated. There's a lot of fear. There's growing, perhaps, distrust of the government. And yet, what we always want to encourage—and I have even seen this from the administration—they are encouraging people to talk to their doctors. And I think that is the most important thing to encourage. Doctors are still trusted by their patients in that doctor-patient relationship. Doctors are a trusted voice. Sometimes you've got to have more than one conversation. We know that.

So concerns, fears, confusion from disinformation have caused fewer people to get vaccinated. I am encouraged by that kindergarten number, and I am encouraged by what my team sees as even earlier, as we look at the rate of vaccination in two-year-olds. Those numbers are going up slowly.

Robert Kennedy has been very public about being in long-term recovery from addiction to alcohol and opioids. He has some fairly set views on what worked for him, and seems to suggest that that would be a good course of treatment for other people suffering from those problems. Aside from that, are there benefits to having someone who is in long-term recovery also serving as the country's top health official?

Well, I think we have to see in terms of how those experiences play out in his policy. Time will tell whether that is virtuous and beneficial or not. What I know is we still need support for areas of substance use work, for areas of injury and violence prevention, for mental health support. My hope is that those experiences play out to continue funding in these areas that have not ever had enough funding. Last fall, we were happy to report some declines in overdose deaths in the state, particularly in greater Minnesota, where we've had greater naloxone distribution. But we still know our Minnesota Student Survey continues to show us that the slope continues to increase in terms of the incidence of students reporting coping with a long-term mental health problem. So I think my answer to that question is time will tell.

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Kennedy has expressed interest in improving food and the food system. Might any good come of this?

It's too early to say. As I mentioned, the federal funding cuts will have an impact on our ability to respond to outbreaks, and that will include foodborne outbreaks. The Special Supplemental Nutrition Program for Women, Infants, and Children that provides nutrition, health screenings, and breastfeeding support and services to eligible pregnant women, new mothers, babies, and young children is also federally funded. We worry about a loss of funding for that program that would have impacts on the health of these key populations.

Are you foreseeing problems with surveillance for infectious diseases such as H5N1?

So there's always a funding concern. I might sound like a broken record, but I do want to lift that up. Public health really has its roots in infectious disease control. Because of that, CDC has been a main funder of our infectious disease work. As a whole, our infectious disease work, more than 90% of it, is federally funded. We have lots of talent, but we also have wonderful resources in the state, like our public health lab. It's not just a state resource, it's a regional resource, and so certainly I worry about the funding. The other thing about infectious disease control is not only the funding that supports our lab, that supports our epidemiologists, that supports our contract cases, that supports our community engagement, but also critically important, of course, are the information channels. We need to know what's happening around this, not only domestically, but globally when we think about controlling infectious disease. So there are a lot of concerns around our ability to respond to infectious disease, which is dependent not only on funding, but it's dependent on information, and it's dependent on partnerships.

House Republicans, not the president directly, are talking about cutting Medicaid or Medicare to finance federal tax cuts. What preparations is Minnesota taking? Are there, in fact, effective preparations to be taken?

I think Medicaid is a huge concern. You are seeing a lot of people share those concerns. Certainly, the Department of Human Services, as our Medicaid agency, would be better positioned, perhaps, to speak to their planning around potential cuts. I know they have developed a lot of materials — a whole series called Medicaid Matters — which really is fantastic, and I would point your readers to it, because not only does it point to the impact on particular segments of Minnesota, low-income Minnesota, and certainly also low-income elderly. Over 40% of Minnesota's children

are covered by Medicaid. So those are some significant impacts. We want people to have coverage so that they get care.

We also know sort of the financial situation of many of our provider organizations, whether they be hospitals or skilled nursing facilities and there, also, many of their patients are covered by Medicaid. As a primary care provider, you know, I have seen people delay care and end up with a worse outcome because they are afraid of the bill. We don't want to put more people into that space where they don't have coverage. But also, as health commissioner, I hear from those provider organizations that already feel understaffed and underresourced and they, too, want to be able to continue to serve Minnesotans.

When you became health commissioner two years ago, one of your stated goals was to reduce health inequities in Minnesota. I'm speaking largely of inequities in class and race. Will it be possible to continue that work when much of the language concerning racial inequities is not even tolerated by the federal government now?

What I will say to you is I feel so fortunate that I live in the state of Minnesota. Because in the state of Minnesota, not only do we know and acknowledge that racial inequities exist, that inequities by income, wealth, class exist, but we know that we can still talk about it. And we can still work together to intervene. And I would say at the Minnesota Department of Health, our mission has not changed. Our mission is to protect, maintain and include the health of all people, and all means all.

Over the course of my career as a physician, physicians today are much more conscious of what public health has been doing for a long time, which is to recognize the social conditions in which we live, work, and play either promote health and well-being or inhibit it. Those social conditions—what we in public health talk about as risk and protective factors—those things are patterns. They're patterned by race, in terms of differential exposures to risk and protective factors. They're patterned by class. They're patterned by geography. And not only will we continue to talk about that, we will continue to work on that. Because investing in health equity, both in terms of time and funding, is one of the most prudent investments we can make.

"Physicians today are much more conscious of what public health has been doing for a long time, which is to recognize the social conditions in which we live, work, and play either promote health and well-being or inhibit it. Those social conditions—what we in public health talk about as risk and protective factors—those things are patterns. They're patterned by race, in terms of differential exposures to risk and protective factors. They're patterned by class. They're patterned by geography. And not only will we continue to talk about that, we will continue to work on that. Because investing in health equity both in terms of time and funding, is one of the most prudent investments we can make."

Any parting comments you would like to make?

I would just go back to being that broken record about the importance of partnerships. We have partners in healthcare. We have partnered with community-based organizations. We partner on this work, both in terms of funding, but also information sharing and thinking about public health strategy with folks at the federal level. And the governor already said this aloud, that the magnitude of anticipated cuts cannot be backfilled by the state. When we talk about all of our programs—our 90% funded infectious disease work, our work with women, infants, and children, which serves over 100,000 people monthly with nutrition support, health screenings as a health program with lactation support, mental health—my hope is that your readers help as they think about advocating for their patients' health, that they also think about advocating for community health and really foster conversations in their networks about how we best work together and what we need to make sure that everybody in Minnesota can achieve their optimal health. Physicians remain powerful voices. MM

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

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Effective engagement of patients about their alcohol and other drug use

Discussing use of alcohol and drugs requires a level of trust between physician and patient that may be a challenge to establish.

BY LEWIS P. ZEIDNER, PHD

There is growing public health awareness that even moderate use of alcohol and other drugs has a profound association with both mortality and morbidity. A recent report by the U.S. surgeon general talked about similarities between the growing awareness of the health consequences of tobacco use in the 1960s and current evidence of the impacts of alcohol use. The opiate and related fentanyl crises also trigger frequent news headlines. All of this while our communities scramble to make THC-related products more readily available. Every provider is faced with the need to find effective and efficient ways to address the role of alcohol and other drugs in the lives of their patients while maintaining a positive relationship with patients and effectively managing time in their office practice.

Identifying patients with substance use disorders or their precursors would be less arduous if there were a laboratory test or other objective diagnostic measure for providers to use, reducing the requirement for clinical judgment. While measures of the medical consequences of more advanced stages of substance use disorders are clear, early intervention and prevention of advanced disease requires a different form of diagnostic.

Unlike acute or chronic physical pain that leads to easy discussions with a provider, moderate use and initial stages of substance use are often associated with the reduction of physical or psychic

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pain and not seen as disturbing symptoms. Later, early hints of problems with alcohol and other drugs are associated with shame and fear and therefore resistance to disclosure and discussions with physicians.

As with most diseases, prevention and early intervention with alcohol and other drug use disorders leads to less suffering, fewer psychosocial challenges, and better outcomes. This article will seek to provide guidance related to methodologies for effective early intervention with patients.

A review of a large number of substance use histories from those suffering with a disorder shows that patients report three primary drivers of initial alcohol and other drug use.

- First, reduction in social anxiety and an ability to be more engaged socially is common. Reduced inhibitions in social contexts allows many people to initially feel less isolated and more accepted by peers and colleagues.
- Second, reduction of disturbing thoughts and feelings triggered by life's stresses or historic emotional traumas. Often people will reflect on "needing a drink" at the end of a difficult day or challenging interaction.
- Third, reduction of physical pain caused by injury or other medical conditions. Recent disclosures and movies about the sales of OxyContin showed the impact that drugs that are perceived to manage pain can have on addiction.

Although each of these reasons for using alcohol and other drugs initially reflects "normal behavior" in our majority culture, when it intersects with genetic factors, other mental health conditions, and different levels of life stress it can lead to disordered use. While initially effective in addressing life challenges (as noted above), alcohol and other drugs lose their effectiveness over time and become associated with growing challenges in multiple aspects of a patient's life.

Understanding the linkages between the initial role of alcohol and other drugs in helping patients solve normal obstacles in life and then later creating challenges can be a very effective tool in providing patients with the information they need to make changes. There is a concept in mental healthcare called a "therapeutic alliance." It refers to a collaborative, trust-based relationship between a patient and a therapist as a key ingredient in working toward a common goal of success in therapy.

While a patient's relationship with a physician is inherently different from that with a mental health therapist, features of a therapeutic alliance can improve the outcome of a physician's approach to alcohol and other drug use. Factors that are essential include empathy, acceptance, compassion, and collaboration. Conversely, statements that sound judgmental, don't offer options, and appear to lack an understanding of the patient's worldview or social context reduce trust and tend to lead to reduced effectiveness in interactions about alcohol and other drug use.

The amount of required collaboration between the provider and patient in making lifestyle changes, including the use of alcohol and other drugs, is significantly greater than in many other medical situations. Framing the changes prescriptively is less effective than seeking a patient's perspective about what changes they are willing to make.

Balancing the need for collaboration is a need for honesty and transparency from the physician about the known risks and science behind alcohol and other drug use. In addition to a need to stay current with the literature, this requires a willingness to be direct and clear in efforts to educate a patient about the risks of

Evaluation tools and where to find them

Tobacco, Alcohol, Prescription medication and other Substance use (TAPS) Tool
https://nida.nih.gov/taps2/

CAGE (Cut-down, Annoyed, Guilty and Eye-opener) screening tool
https://www.uspreventiveservicestaskforce.org/home/getfilebyid/838

Alcohol Use Disorders Identification Test (AUDIT)
https://www.drugsandalcohol.ie/18727/1/audit.pdf

Drug Use Disorders Identification Test (DUDIT)
https://www.hse.ie/eng/about/who/primarycare/socialinclusion/addiction/national-addiction-training/alcohol-and-substance-use-saor/dudit.pdf

alcohol and other drug use. Neither understating known factors to reduce tension nor overstating risks to create motivation are effective in creating trust.

Two patient examples can help demonstrate some core challenges for the medical provider.

John is a 35-year-old male-identifying patient who upon admission to substance use disorder treatment reported not visiting his primary care physician for seven years to avoid questions about his drinking and what he perceived to be his doctor's judgment of him.

Sarah is a 40-year-old female-identifying patient who was referred to outpatient care for substance use disorder by her primary care physician as a result of misuse of prescription drugs following several family losses. She described feeling heard by her doctor and that he truly understood her struggles; thus she trusted his guidance.

When working with patients' alcohol or other drug use problems, it's important that the physician has a critical awareness of his or her own experiences with family members and previous patients around alcohol and other drug issues and how those interactions impact the response to the current patient. Awareness of the ways that past experiences shape current perception of a patient can improve a patient's experience of empathy and acceptance.

Efficiency in assessment within medical practices has led to a number of validated screening tools for several more common physical and mental health conditions from asthma to anxiety to safety in the home. They rely on patients' independent trust in the safety of the relationship with a physician since the screening tools do not inherently build trust and at the same time require honesty and vulnerability from patients for the results to be valid.

Several of the most common validated screening tools—such as the Tobacco, Alcohol, Prescription medications, and other Substance use (TAPS) Tool— use frequency and quantity of use as core measures. Although frequency and quantity are easily evaluated and frequently correlate with disordered use, they fail to address consequences of use, which is a core element of defining disorders and recommended interventions related to alcohol and other drug use.

The CAGE (Cut-down, Annoyed, Guilty and Eye-opener) screening tool is focused on consequences of alcohol use and is a common tool utilized because it is very short and quick to administer. A positive CAGE screening, however, requires a more detailed assessment to identify appropriate next steps.

The Alcohol Use Disorders Identification Test (AUDIT) and Drug Use Disorders Identification Test (DUDIT) are each 10-question patient self-administered tools that focus both on frequency and quantity of use but also on consequences of use such as missed obligations, symptoms of withdrawal, guilt, injury, and concern from loved ones. They can both trigger self-reflection for patients and provide a basis for discussion with a physician, social worker, or nurse.

For patients with alcohol and other drug use who are not seeing challenges reflected in the above screening tools, family genetic history and high-stress life events can create platforms for a discussion with a physician about risk factors.

> Balancing the need for collaboration is a need for honesty and transparency from the physician about the known risks and science behind alcohol and other drug use. In addition to a need to stay current with the literature, this requires a willingness to be direct and clear in efforts to educate a patient about the risks of alcohol and other drug use. Neither understating known factors to reduce tension nor overstating risks to create motivation are effective in creating trust.

In summary, there are three core factors that can improve the effectiveness of a physician's efforts to educate patients about the risks of their alcohol and other drug use:

- Seek to understand a patient's psychosocial dynamics that initially influenced their use, such as social anxiety, desire to become socially connected, acute or chronic stressful life situations, or physical pain.
- Work to ensure that clinical guidance, education, and intervention are likely to be heard in a context of trust, empathy, and efforts to build a collaborative plan.
- When utilizing validated screening and assessment tools, ensure that the tools identify multiple dimensions of consequence of use in addition to frequency and quantity of use.

A common recommendation for patients that test positive for problematic alcohol and other drug use is to go to an emergency department in a local hospital to access services. While those recommendations may be useful for symptoms of acute medical withdrawal or suicide risk, emergency rooms are not equipped and physicians there are not prepared to evaluate and discuss the nuanced needs of a patient. The most effective recommendations include evaluation and guidance by licensed alcohol and drug counselors and other licensed mental health professionals in private practice, or within substance use disorder treatment programs in the community. MM

Lewis P. Zeidner, PhD, serves as the CEO of Meridian Behavioral Health, one of the largest providers of residential and intensive outpatient substance use disorder healthcare to Medicaid and commercially insured patients in Minnesota. Meridian provides co-occurring whole person care to patients who have both mental health and substance use disorders, offering a full continuum of services.

Dermatology update for primary care. Part 2: Psoriasis

Psoriasis, one of the most common skin diseases, appears in many forms.

BY KAMRUZ DARABI, MD

Primary care providers manage many common skin diseases as patients frequently consult with their primary care provider first for their skin ailment.

In last issue's article we discussed several skin, nail, and hair diseases commonly seen by primary care. In this second article, I will discuss one of the most common skin diseases: psoriasis. I will provide helpful diagnostic clues, including uncommon presentations of this common disease and go over treatment strategies that can easily be applied by primary care providers and discuss new targeted systemic therapies, such as biologics, that have become available to manage severe cases of this often chronic and burdensome skin disease.

Psoriasis is extremely common. The prevalence varies among populations but is thought to range from 0.5 to 11.4% in adults and 0 to 1.4% in children[1]. Patients commonly present with scaly plaques and patches distributed in a random pattern on the scalp, inside the ear canal, on the postauricular creases, eyebrows, upper eyelids, creases of the nose and smile lines, on the torso and extremities, most commonly on elbows and knees. Rarely psoriasis may af-

Kamruz Darabi, MD

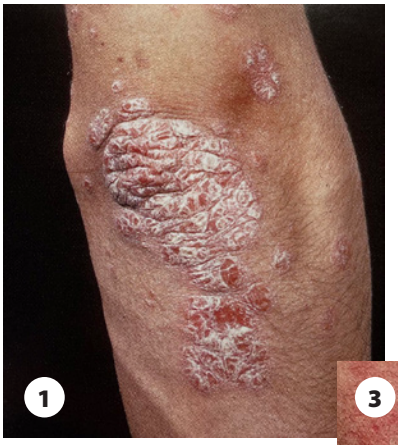
fect the palms and soles, cause nail pitting and oil drops on nails or frank onychodystrophy that resembles onychomycosis. Not uncommonly psoriasis can be found on genitals and in intertriginous areas, such as on the inframammary and inguinal folds, the gluteal cleft, perianal and scrotum/vulva.

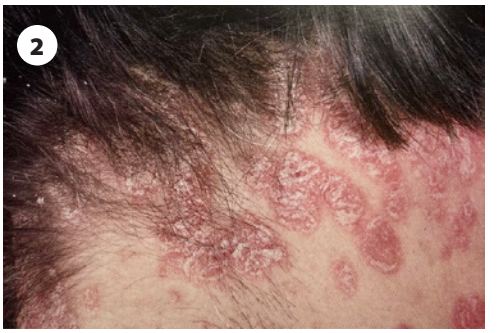
As you can see, the presentation of psoriasis can be incredibly variable. However, the common denominator is that psoriasis plaques and papules have a noticeable layer of white or silvery scale. In moist intertriginous and genital areas, the scale is less noticeable; however, if you scan the entire skin you should be able to find classic lesions elsewhere. That's why it is important to perform a complete skin inspection with the patient disrobed. This will aid tremendously in making the right diagnosis as the distribution of the rash will point you in the right direction.

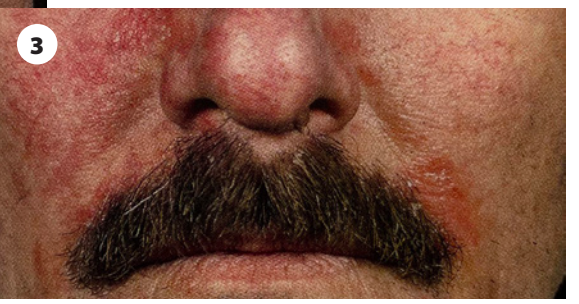
We have learned that psoriasis is not just a skin disease, but it is a systemic inflammatory disease that could present with psoriatic arthritis, with joint pain and stiffness, particularly morning stiffness, and back pain. Many different joints can be affected. Soft tissue inflammation manifesting as enthesitis (inflammation at the site of tendon insertion into bone) tenosynovitis, and dactylitis ("sausage digits") are additional common findings. The prevalence of psoriatic arthritis varies greatly amongst different studies.

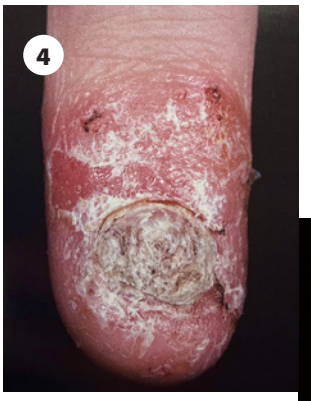
As a result of systemic inflammation psoriasis patients have higher rates of cardiovascular disease, metabolic syndrome, inflammatory bowel disease (Crohn's and ulcerative colitis) and other autoimmune disorders.

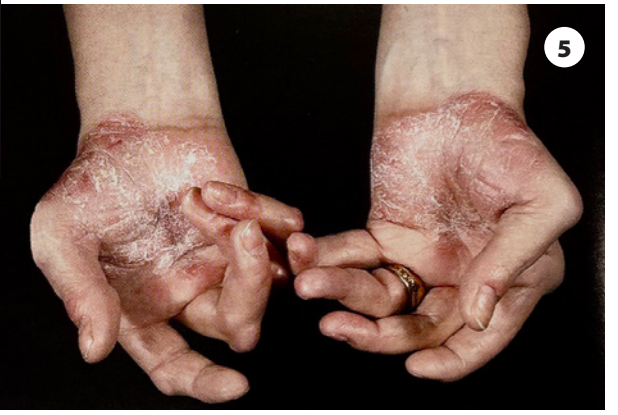
According to current research, treating psoriasis may potentially reduce the risk of heart attack and stroke in psoriasis patients, as studies suggest that managing psoriasis, particularly with medications like biologics and methotrexate, can lower systemic inflammation which is linked to cardiovascular disease; however, more research is needed to definitively confirm this link and understand the full extent of the impact on cardiovascular risk.

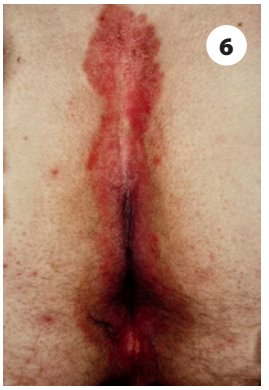


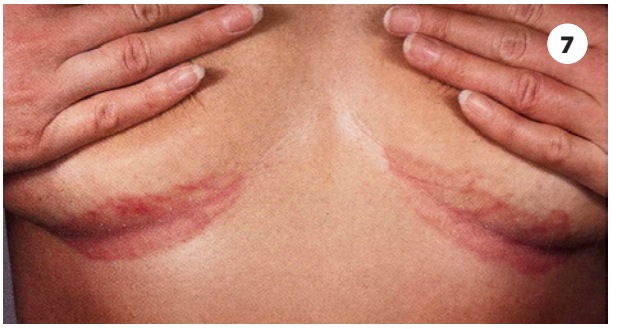


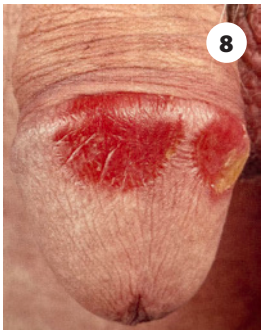


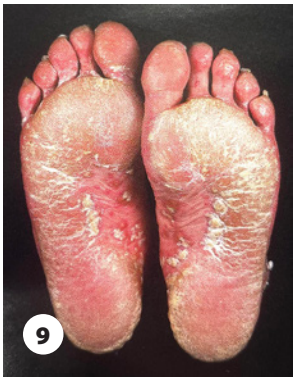












Here is a gallery of psoriasis affecting the classic body sites:
1. Classic elbow-knee psoriasis.
2. Scalp psoriasis.
3. Facial psoriasis, creases between nose and cheek, nasolabial folds, beard.
4. Finger dactylitis and onychodystrophy of fingernail.
5. Palmar psoriasis and psoriatic arthritis with swan neck deformities and ulnar deviation.
6. Gluteal cleft and perianal area.
7. Intertriginous areas, such as inframammary folds, intertrigo.
8. Genitals, such as balanitis:
9. Soles, plantar psoriasis.

It goes without saying that treating psoriasis successfully greatly improves a patient's self-esteem, personal and social performance and mental well-being. Untreated or improperly treated psoriatic arthritis can lead to permanent joint destruction and disability. Therefore, every psoriasis patient should be screened for psoriatic arthritis by inquiring about severe joint pains, swelling, morning stiffness and referred to a rheumatologist, if needed.

Treatment of psoriasis depends on the extent of body surface area involvement and location of plaques.

A limited number of plaques can be treated with potent topical steroid ointments, such as clobetasol, halobetasol, betamethasone dipropionate, or fluocinonide under occlusion twice daily for up to four weeks if needed. Ointments are more occlusive than creams and therefore increase the potency of the active ingredient. Additional occlusion can be achieved by application of cellophane wrap (such as Saran food wrap) or film dressings such as Tegaderm. This is most tolerable overnight when the patient sleeps. After four weeks the frequency of steroid application should be reduced to two or three applications weekly to reduce the risk of skin atrophy from long-term high-potency topical steroid use. At this point the patient needs to be reevaluated to evaluate the success of the topical treatment. If the patient can be weaned off the high-potency steroid, a midpotency steroid such as triamcinolone or low-potency steroid such as desonide, mometasone furoate, or hydrocortisone 2.5% can be utilized. A nonsteroidal anti-inflammatory topical calcineurin inhibitor such as tacrolimus 0.1% ointment or pimecrolimus cream is another good option if ongoing daily topical therapy is required.

Over the last few years additional nonsteroidal topical anti-inflammatory drugs have been approved for psoriasis: Roflumilast (Zoryve) for patients 6 years and older, is a PDE (phosphodiesterase) inhibitor. Tapinarof (Vtama) is an AhR (aryl hydrocarbon receptor) agonist approved for adults. These newer topicals routinely require prior insurance authorization.

Intralesional triamcinolone acetonide injections to limited recalcitrant plaques can be very effective. Injections can be repeated every four to six weeks, as needed.

Scalp psoriasis requires the use of steroid solutions such as high-potency clobetasol or fluocinonide, or mid- to low-potency triamcinolone lotion or mometasone furoate or fluocinolone solution. Over-the-counter shampoos that contain coal tar and salicylic acid are effective adjunct treatments for scalp psoriasis. Narrow-band ultraviolet B light combs are highly effective and can be purchase online or through a medical device supplier such as National Biological or Davlin. Narrowband UV-B treatments take only one to two minutes per site and are performed every other day at home.

Intertriginous and genital psoriasis requires special attention as high-potency topical steroids can rapidly cause skin atrophy due to the thin baseline nature of skin in these areas and the physiologically occlusive nature of skin folds. In these locations I use at most a mid- to low-potency steroid such as triamcinolone and switch to a topical calcineurin inhibitor if long-term treatment is indicated at the one- to two-month follow-up.

Palmar and plantar psoriasis is challenging to treat as patients find it impractical to apply ointments twice daily. Most of my patients find it acceptable to try a month of intensive topical therapy with nighttime application of a potent steroid such as clobetasol ointment under glove or cellophane wrap occlusion. If that is ineffective, a hand and foot narrowband UV-B panel can be purchased online or through a medical device supplier (National Biological or Davlin are two examples) and used at home every other day. Improvement can usually be seen after four to eight weeks.

> According to current research, treating psoriasis may potentially reduce the risk of heart attack and stroke in psoriasis patients, as studies suggest that managing psoriasis, particularly with medications like biologics and methotrexate, can lower systemic inflammation which is linked to cardiovascular disease; however, more research is needed to definitively confirm this link and understand the full extent of the impact on cardiovascular risk.

Nail psoriasis, such as psoriatic onychodystrophy, poses a challenge to topical therapy as topicals applied to the surface of the nail are usually ineffective at penetrating through the nail plate and cuticle skin into the nail bed and nail matrix that can be found in the lunula, the white band that is covered by the proximal nail fold, or cuticle. Intralesional triamcinolone injections into the proximal nail fold and nail matrix can be effective but require ongoing injections every four to five weeks. Systemic therapies such as methotrexate and biologics are most effective for nail psoriasis.

Generalized psoriasis can affect large body surface areas and in the most extreme case lead to erythrodermic psoriasis (psoriasis of almost the entire skin, leading to a confluent red rash, giving the entire skin a red—erythro—appearance).

Total body narrow-band UV-B light therapy can be an effective treatment for generalized psoriasis. Light units with six-foot panels are available for in-office or at home use every other day and improvement is usually seen within four to six weeks, with almost complete resolution after 12 to 16 weeks of continuous every-other-day light therapy.

Methotrexate is another older drug that has been successfully used for generalized psoriasis for decades. In dermatology weekly doses of 10 to 25 mg are utilized with frequent monitoring of blood cells counts and liver function tests as methotrexate is an inhibitor of folate and nucleotide metabolism and can lead to cytopenias, and it is metabolized in the liver and can cause transaminitis and liver injury. A portion is excreted through kidneys and therefore it is

prudent to monitor creatinine as a marker of renal function as well. Methotrexate seems to also modulate several inflammatory pathways, such as JAK-STAT pathways and others. Common side effects are nausea and "brain fog" on the day of methotrexate dosing. This can be remedied by splitting the dose in an a.m. and p.m. dose to improve tolerability. Folic acid supplementation with 1 mg daily on the six days of the week when methotrexate is not administered reduces the risk of cytopenias. Long-term low-dose methotrexate therapy has been associated with liver injury, fibrosis, and cirrhosis. The risk is higher for patients with existing liver risk factors, such as excessive alcohol consumption, active chronic viral hepatitis B or C, other drugs with potential for liver toxicity such as statins, NSAIDs, and high-dose acetaminophen. Regular laboratory monitoring at least every three months is recommended to monitor for AST and ALT elevations and albumin reduction, and dose adjustments should be made to bring these laboratory abnormalities back into the normal range. Sulfa drugs, such as sulfa antibiotics, may increase the toxicity of methotrexate as they also inhibit folate metabolism. NSAIDs can reduce renal filtration and lead to accumulation of methotrexate. In my opinion, treatment with methotrexate is best left to a healthcare provider who has experience in managing this medication.

Severe acute flares, such as after streptococcal infections, can be managed with prednisone 0.5–1 mg/kg tapered over three weeks or intramuscular triamcinolone injection of 0.5–1 mg/kg or cyclosporine at daily doses of 2.5–5 mg/kg for two to three months to rapidly control a severe flare as another slower acting agent with better long-term tolerability is started simultaneously, eventually allowing steroids or cyclosporine to be tapered off. The clinician must be aware of potential side effects of systemic steroids and cyclosporine. The latter is notorious for nephrotoxicity, hypertension, ototoxicity and electrolyte imbalances and therefore requires close monitoring.

Research and discoveries of the molecular pathways of psoriasis have led to our understanding of psoriasis as a Th1-mediated autoimmune disease with TNF-alpha and interleukins 12, 17 and 23 playing a key role in the pathogenesis of psoriasis and psoriatic arthritis. This led to the development and approval of many biologic therapies that target key cytokines and checkpoints in the inflammatory cascades of psoriasis. The table above summarizes the main biologics currently used in the management of moderate to severe psoriasis recalcitrant to other treatments and highlights most relevant clinical features of each.

Main biologics currently used in the management of moderate to severe psoriasis recalcitrant to other treatments

	MECHANISM OF ACTION + ROUTE	PROS IN PSO	CONS	% PATIENTS ACHIEVING PASI 75* (90 FOR SKYRIZIÒ AND BIMZELXÒ)	FDA INDICATIONS
ETANERCEPT (ENBRELÒ)	TNF-alpha inhibitor, SQ	Age ^{3} 4 yrs	May worsen MS, CHF class III-IV, concurrent or prior malignancy	49% if dosed twice weekly 33% if dosed weekly	Pso, PsA, AS, RA, JIA
ADALIMUMAB (HUMIRAÒ)		Approved for adult + peds Crohn's		71%	Pso, PsA, AS, RA, JIA, HS, IBD, Uveitis
INFLIXIMAB (REMICADEÒ)	TNF-alpha, IV, weight-based dosing	Approved for adult + peds IBD		76% if dosed 5mg/KG 70% if dosed 3mg/KG	Pso, PsA, AS, RA, IBD
CERTOLIZUMAB (CIMZIAÒ)		Use in pregnancy, crosses placental minimally		75% if dosed 200mg q2 wk 83% if dosed 400mg q2 wk	Pso, PsA, AS, RA, Crohn's
USTEKINUMAB (STELARAÒ)	IL12, IL23, SQ, weight based dosing	Age ^{3} 12 yrs Q3 month SQ dosing		66-67% if dosed 45mg 66-75% if dosed 90mg	Pso, PsA, Crohn's
GUSELKUMAB (TREMFYAÒ)	IL23, SQ	Q2 month SQ dosing		86-91%	Pso, PsA
TILDRAKIZUMAB (ILUMYAÒ)	IL23, SQ	Q3 month SQ dosing		83% at 12 wk 96% at 52 wk	Pso
RISANKIZUMAB (SKYRIZIÒ)	IL23, SQ	Q3 month SQ dosing		PASI 90**: 75% at 16 wk 85% at 52 wk	Pso
SECUKINUMAB (COSENTYXÒ)	IL17a, SQ		All may worsen IBD Siliq: REMS suicidality program	77-82% at 12 wk	Pso, PsA, AS, NRASA^
IXEKIZUMAB (TALTZÒ)	IL17a, SQ			84% at 12 wk	Pso, PsA, AS, NRASA^
BRODALUMAB (SILIQÒ)	IL17a rec, SQ			85-86% at 12 wk	Pso
BIMEKIZUMAB (BIMZELXÒ)	IL 17a+f, SQ			PASI 90***: 85-91% at 16 wk	Pso, PsA, HS, AS, NRASA^

*Psoriasis Area and Severity Index 75 = 75% improvement of psoriasis from baseline
** PASI 90 = 90% improvement from baseline
^ Non-radiographic axial spondylarthritis
Pso, psoriasis ; PsA, psoriatic arthritis, AS, ankylosing spondylitis ; RA, rheumatoid arthritis; JIA, juvenile idiopathic arthritis ; HS, hidradenitis suppurativa ; IBD, inflammatory bowel disease.

I hope this overview equips the reader with an overview of diagnostic features and therapeutic options of psoriasis, a dermatosis commonly encountered by primary care providers who can now start treatment as the patient is referred to a dermatologist for further management, if required. **MM**

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Physicians and physicians-in-training gather for a group shot before heading out to meet with lawmakers.

White coats turn out for Physicians' Day at the Capitol

Physicians and physicians-in-training meet with legislators to air concerns and push priorities. PHOTOGRAPHY BY RICH RYAN

Physicians and physicians-in-training from across the state met with legislators February 19 to advocate on behalf of medicine as part of Physicians' Day at the Capitol.

Each year, the MMA hosts members and nonmembers from across the state at the Capitol. This year's event saw nearly 150 physicians and physicians-in-training holding more than 70 meetings with elected officials.

Kirsten Robinett, MD (left); Sibel Dikmen, MD; Rachel Newinski, MD; and Laura Hurley, MD, pause for a photo

"The MMA needs to be at the table whenever the practice of medicine is discussed at the Capitol," said Dave Renner, MMA's director of advocacy. "It means so much to have our members meeting with legislators and personally supporting the issues that matter to physicians across the state. That's what the MMA is all about."

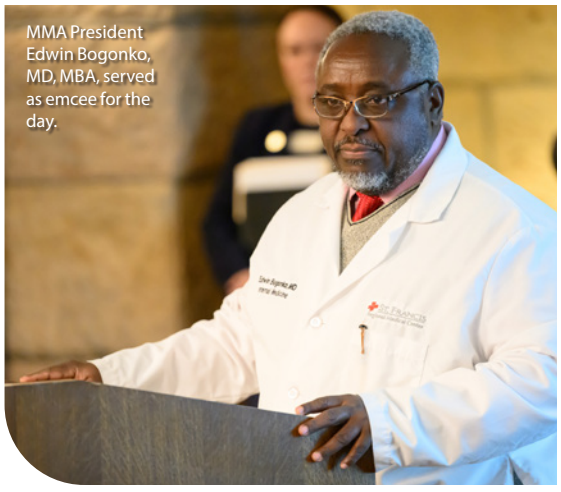
Attendees heard from Sen. Alice Mann, MD, MPH, and met with legislators to discuss the MMA's top legislative priorities:

- Increasing Medical Assistance (MA) payments. Currently, MA reimburses at a rate of between 60 and 70% of Medicare, and only 30% of commercial payers.
- Prohibiting formulary changes during a contract year by health plans and pharmacy benefit managers.
- Funding the POLST (Provider Orders for Life-Sustaining Treatment) registry that was recommended by the Minnesota Department of Health.
- Continuing efforts to address physician wellness.
- Continuing coverage for audio-only telehealth services.

Following Mann's keynote, Renner and Chad Fahning, MPP, MMA's manager of state legislative affairs, reviewed the MMA's top legislative priorities. Then, attendees proceeded to meetings with their legislators.

"Today is about either establishing or strengthening relationships with your legislators," said MMA President Edwin Bogonko, MD, MBA, who served as emcee for the event. "Your role is crucial in promoting legislation that is good for the patients you serve." MM

One attendee peruses the "advocacy board," where guests wrote what they wanted to accomplish that day on Post-it notes.



MMA President Edwin Bogonko, MD, MBA, served as emcee for the day.

Sen. Alice Mann, MD, kicks off the day with some tips on influencing legislators.

Director of Advocacy Dave Renner runs through the MMA's top legislative priorities with the group.

Alain Ret, MD (left); Amena Kazmi,MD; Allyssa Jonsson, DO; and Yusra Jangda, MD, pause for a picture.

Amy Gilbert, MD, meets with her legislator, Rep. Kaohly Vang Her.

Sen. Scott Dibble talks with a large group of physicians and physicians-in-training.

Medical student Jasmine Tatah (center), and Kaitlin McLean, MD, meet with President of the Senate Bobby Joe Champion.

THE ANNUAL MMA AWARDS

Recognize Your Peers

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We are now accepting nominations for the annual

MMA Awards

Award categories include:

Distinguished Service Award

Given to a physician who has made outstanding contributions in service to the MMA and on behalf of medicine and the physicians of Minnesota during his or her career.

President's Award

Designated for individuals who have made outstanding contributions in service to the goals of the MMA.

Medical Student Leadership Award

Presented to a member of the MMA Medical Student Section who demonstrates outstanding commitment to the medical profession.

Resident & Fellow Leadership Award

Presented to a member of the MMA Resident & Fellow Section who demonstrates outstanding commitment to the medical profession.

James H. Sova Memorial Award for Advocacy

Given to a person who has made a significant contribution to the advancement of public policy, medical sciences, medical education, medical care or the socio-economics of medical practice.

Eric C. Dick Memorial Health Policy Partner Award

Given to an individual, group of individuals, a project or an organization that demonstrates their commitment to pursuing sound public policy, building coalitions, creating and/or strengthening partnerships with the goal of improving the health of Minnesotans or the practice of medicine in Minnesota.

Copic/ MMA Foundation Humanitarian Award

Presented to physicians who volunteer medical services and contribute to their community, specifically to MMA members who go above and beyond to help address the healthcare needs of underserved populations in Minnesota.

Visit the MMA website ***(www.mnmed.org/about-us/mma-awards)*** *to make a nomination by* ***June 27.***

News Briefs

Treat Yourself First campaign launched at Capitol to reduce stigma of seeking mental health care

A coalition of Minnesota-based professional associations, led by the MMA, are working together to end the fear and stigma that many healthcare professionals experience when in need of mental health services and support. The campaign was announced at a press conference (www.youtube.com/watch?v=-ZLPbeHbtMk) in St. Paul in late February.

The Treat Yourself First campaign, funded by a 2024 Minnesota Department of Health grant, is designed to build awareness of stigma around help-seeking and create a supportive environment that encourages clinicians to prioritize their mental health and seek help when needed. The campaign is also intended to create peer-to-peer messages and resources designed to amplify clinicians' voices to reduce stigma surrounding mental health and seeking mental health care, and to communicate to all Minnesota clinicians that there are effective and confidential resources available to help them battle burnout and fatigue and focus on their own well-being.

Even before the pandemic, burnout was a big deal, with 35–54% of nurses and physicians, and 45–60% of medical students and residents reporting symptoms, according to the National Institutes of Health.

"The goal of the campaign is to normalize the process for clinicians and healthcare professionals to seek help for workplace related stresses and increase clinicians' awareness of mental health issues and services," says Edwin Bogonko, MD, MBA, MMA president.

On January 30, Sen. Liz Boldon (DFL-Rochester) introduced legislation that includes a one-time appropriation to help promote the awareness and education campaign.

The coalition has also launched a website (www.treatyourselffirst.org) that includes resources for healthcare workers to use to get the help they need, and to help promote it to their fellow healthcare workers.

Founded in 2024 by the MMA, with support from the Minnesota Department of Health, the Treat Yourself First Coalition is a group of Minnesota-based professional associations working together to end the fear and stigma that many healthcare professionals experience when in need of mental health services and support.

Coalition members include Minnesota Academy of Family Physicians; Minnesota Academy of Physician Associates; Minnesota APRN Coalition; Minnesota Chapter of the American Academy of Pediatrics; Minnesota Chapter, American College of Emergency Physicians; Minnesota Chapter, American College of Physicians; Minnesota Dental Association; MMA; Minnesota Nurse Practitioners; Minnesota Nurses Association; Minnesota Pharmacists Association; and Minnesota Psychiatric Society.

Two resident groups are latest to explore unionizing

Two groups of physicians-in-training in Minnesota have started the process of unionizing.

In late March, nearly 1,000 residents at the University of Minnesota filed to unionize with the Service Employees International Union (SEIU) Committee of Interns and Residents, which is the country's largest union of trainee physicians, representing more than 34,000 interns, residents, and fellows.

This comes just days after residents at Hennepin Healthcare filed for union recognition. Both groups say they are understaffed and underpaid.

"We came to Hennepin specifically because we wanted to work in a safety net hospital caring for this community, and so all of the residents care so deeply and dive headfirst into our work," said Nicole Lund, MD, in a press release. "But we are stretched so thin, and the truth is, it doesn't have to be this way."

Both the U of M and Hennepin Healthcare released statements saying the physician trainees are valued and the organizations recognize the trainees' right to organize.

The U of M and Hennepin Healthcare residents are following a growing trend toward unionization of physicians in Minnesota.

In October of 2023, more than 500 primary and urgent care physicians, physician assistants, and advanced practice providers at Allina Health voted to unionize. At a press conference in August of that year to announce the move toward collective bargaining, several Allina physicians said they felt joining a union was needed to ensure that patients' needs were met. Physicians, they argued, were being asked to do too much, see too many patients without adequate support, and consequently many were feeling burned out and leaving the profession.

In late March of 2023, Allina physicians at Mercy and Unity hospitals held a vote to unionize with the Doctors Council SEIU. In early 2024, the National Labor Relations Board certified the results for 130 physicians.

"The MMA recognizes the right of physicians and physicians-in-training to have their voices heard, including engaging in collective bargaining, consistent with state and federal law," said MMA President Edwin Bogonko, MD, MBA. "Are physician unions the best response to current pressures and forces that are overwhelming many of us? That's a question each physician will need to make for themselves, considering their own circumstances." MM

FROM THE CEO

Measles on my mind

In late February, I was struck with a bout of spring fever; it was time for a brief escape from winter. Despite having heard much about San Antonio and its attractions, I had never been there. With a direct flight from Minneapolis, no time zone changes, and temperatures in the mid to upper 80s, it was an easy choice.

Shortly after finalizing my travel plans, I learned that some adults who were vaccinated for measles in the 1960s (i.e., those who had received the killed vaccine) may need an additional vaccine. I fit squarely in that demographic. Although San Antonio is nearly 400 miles from the current measles outbreak, which has been concentrated in and around Gaines County, Texas, I paused. Did I receive the killed vaccine? Was it safe to travel to Texas? After a call to my physician and a blood test, I was relieved to learn that I was immune.

According to the Centers for Disease Control and Prevention, as of April 11, 712 measles cases and two confirmed deaths (and one other under investigation), have been reported across 25 states, with the bulk of the cases in West Texas. The number of cases this year already exceeds the 285 cases reported in 2024 and is far greater than the 85 cases reported in 2000, when the CDC declared measles "eliminated" from the U.S.

I was shocked to read, in a March 12 article in the *Washington Post* (referencing a Gallup Poll), that only 69% of Americans believed it was very or extremely important for parents to get their children vaccinated, down from 94% in 2001. In that context, the spike in measles cases is, sadly, not at all surprising. Although there has only been one measles case reported this year in Minnesota, there is real cause for concern, given that Minnesota has the fourth lowest MMR vaccination rate among kindergartners in the nation (87%)—and one of the weakest childhood vaccination laws.

The recent confirmation of Robert F. Kennedy Jr. to the position of secretary of the U.S. Department of Health and Human Services has rattled the medical and public health community. (MMA urged Minnesota's senators to oppose his nomination.) Kennedy has a long record of openly questioning vaccines and promoting disproven links between vaccines and autism. In response to the growing outbreak in Texas, Kennedy has been widely criticized for offering muted vaccination recommendations, at best, while promoting unproven treatments such as cod liver oil.

As we mark the five-year anniversary of the COVID pandemic, I can still remember the eagerness with which nearly all of us awaited the release of the vaccine—a truly remarkable scientific achievement. Because of the intense demand, I drove more than 200 miles roundtrip for my first vaccine appointment.

Unfortunately, misinformation and fear are powerful forces that are hampering vaccination efforts. Physicians play a critical role—as trusted professionals—in answering questions and addressing fears. The MMA, too, will continue its work to champion evidence, advocate for policy change in Minnesota's vaccination laws, and address misinformation.

I had a great time in San Antonio. I will fondly remember the River Walk, the food and culture, and, of course, the Alamo. I will also remember how grateful I was to enjoy my time in that vibrant city knowing that I was safe from contracting measles. **MM**

Janet Silversmith
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VIEWPOINT

Providing the tools to take on mental health

Kimberly Tjaden, MD
MMA board chair

May is Mental Health Awareness Month. Are you aware of this? Do you talk about mental health with your colleagues? It's likely you don't, and that's why the MMA is out to change that.

For several years, we've been working to get more attention paid to physician well-being. I don't need to tell you how challenging our work is these days. We are being asked to do more with less, our patients don't trust us the way they used to, prior authorization clogs up our workflow, and on and on.

Mental fatigue is real, and it's nothing new. The National Institutes of Health found that burnout among U.S. healthcare workers had reached "crisis levels"; 35–54% of nurses and physicians, and 45–60% of medical students and residents reported burnout symptoms—and that was before the COVID-19 pandemic.

And it's not just that we feel burned out; many of us refuse to address it directly for fear of reprisals from our employers or out of pride that, as physicians, we think we need to be superhuman. A 2017 study published in *Mayo Clinic Proceedings* found that overall, about 40% of physicians reported reluctance to seek formal medical care for treatment of a medical condition.

Over the past few years, the MMA has created programs to help physicians address their well-being. In 2023, the MMA launched a suite of resources to address career fatigue and promote work-life balance. The MMA SafeHaven program (www.mnmed.org/resources/safehaven), developed in partnership with VITAL WorkLife, includes a subscription to a package of resources such as clinician peer coaching, concierge services, in-the-moment telephone support, and in-person and virtual counseling.

I've taken advantage of this program myself. A few years back, when my husband and I became empty nesters for the first time, I reached out to a counselor. I was struggling with parenting adult children—a whole new set of worries and skills. Additionally, I needed new ways to communicate with my husband, as we were the only ones at home and had to figure out new ways of being together again.

Now, with all of the turmoil in our communities, it is needed more than ever to manage the stress of challenging patient interactions, complex medical diagnoses and management, and worries about executive orders and how they will affect patient care.

All of this stress takes its toll. I found the therapy helped me reframe some of my challenges and address them in a healthy way. I have offered the program to my adult children as well. Challenges like dealing with interpersonal issues or understanding future goals and opportunities add stress to their lives. Knowing they have an opportunity to discuss opportunities and challenges with a professional gives me great peace of mind.

This past February, we also launched the MMA-led Treat Yourself First campaign, a group of 12 Minnesota-based professional associations that support physicians as well as nurses, pharmacists, physician assistants, and dentists.

It is designed to build awareness of stigma around help-seeking and create a supportive environment that encourages clinicians to prioritize their own mental health and seek help if they need it. Treat Yourself First strives to communicate to healthcare workers that there are effective and confidential resources available to help battle burnout and focus on their own well-being.

The coalition's website (www.TreatYourselfFirst.org) includes resources for healthcare workers to use to get the help they need and to promote the program to their colleagues.

For several years, the MMA has been working to get more attention paid to physician well-being. I don't need to tell you how challenging our work is these days. We are being asked to do more with less, our patients don't trust us the way they used to, prior authorization clogs up our workflow, and on and on.

I urge you to go online and learn more about SafeHaven and the Treat Yourself First campaign. Even if you don't need help, you probably know someone who does. Spread the word. Help out a peer. Let's work together to break the stigma and make the most of Mental Health Awareness Month. MM

WILLIAM G. DICKS, MD, DAAPM

William G. Dicks, MD, DAAPM (diplomate of the American Academy of Pain Management), is a specialist in pain management at Sanford Bemidji Main Clinic.

As he practiced family medicine, "I developed an interest in chronic pain by observing the misery of numerous patients and the harm, injuries, iatrogenesis, overdoses, and suicides." He studied on his own, visiting pain clinics, especially Sister Kenny Institute in Minneapolis, where he had been a polio patient himself at age 3 (and made a full recovery). "I took my boards in 2006, and have practiced pain management since," he says.

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

I was born and raised mostly in Minneapolis, ran away from home at age 14 (the cops brought me back), and attended Catholic schools and a year and a half of seminary in Holy Trinity, Alabama.

I worked back-breaking jobs—landscaping and then a moving van company. But the money was good and essential to pay for higher education.

Then to the University of Minnesota for 10 years beginning in 1962. I stretched out my education to quell a near-pathological wanderlust. I then enlisted in the U.S. Navy, spending most of my time in Vietnam on swift boats or as medevac while learning how ignorant we, Americans, could be about the world.

Upon my return, I resumed my undergraduate education.

Why did you decide to become a physician?

I had some interest in medical school and then rejected it. I went back and forth for years. After the Navy, I worked as an orderly at the old Abbott Hospital as I finished my B.A. The head of the imaging department one day suggested, "Why don't you go to medical school?" I had an immediate panic attack. Here it was, after all those years! So I jumped on my bike and pedaled to the University Medical School and met Dr. W. Albert Sullivan, who laid out a checkerboard of requirements. I finished my B.A., submitted applications, did the MCAT, and completed all the requirements in math, physics, and calculus. It was a race!

When did you become an MMA member?

In 1980, after my first year of residency at HCMC.

Hobbies or side gigs?

I rowed with the University crew and then the Minneapolis Rowing Club. After residency and before starting in Bemidji, I sailed the Atlantic with two French guys, but made it only to the Azores due to serious storm damage to our 35-foot sloop-rigged boat.

I cross-country ski in winter. Up here in Bemidji we have a long season for that!

Tell us about your family.

At age 38, I finally got married, to Suzanne, a Bemidji clinic nurse who has two daughters from her first marriage, Megan and Brook. We have three children together—Will, Anna, and Mattie K. We live on a 160-acre farm 10 miles west of Bemidji.

What was the greatest lesson of your medical education?

During my medical education, I fed on this very rich diet of facts and knowledge, which I loved, but how all this became the basis for patient care was indeed a great surprise. I think it was my B.A. in literature and the humanities that more profoundly enabled healthcare. Poetry, stories, ethics, philosophy, art, music—here be the stuff of life, the basis for the why and what and how we care.

My first fee statement at the University of Minnesota was $32. I could afford to wander and wonder through geology, botany, literature, and language on and off for 10 years. I loved it all! Education must become affordable and not rush young people to make life decisions when they as yet have no life.

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

Science, medicine, all of healthcare left out the world of pain. It took me years of self-study, experiences with chronic pain patients, trial and error. But now we have many new meds and technologies that do quiet the misery.

What's the greatest challenge facing medicine today?

We practice in a broken mess—private equity, massive profits on the backs of the poor, life-saving meds unaffordable, pharmacy benefit managers, for-profit health insurance. Why not universal health coverage?

How do you keep life balanced?

In my early practice, it was hectic. At this stage in my career, I work four days a week, with a very reduced schedule.

If you weren't a physician—?

My life in medicine has been so rewarding, so much a part of my life, it is hard to imagine what I would have done. But, I still love nature, the world of life, the sun. So perhaps the natural sciences and that wonderful green thing—botany! MM

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