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Non-Emergency Medical Transportation

A hidden variable in patient care

BY DAVID BEARD, PhD

Helping patients receive the best care doesn't end when the patient leaves the hospital or clinic. In fact, once they leave, your patients begin a different, and often arduous, process. Many patients struggle with planning how to return to the clinic for their next appointment, or how to arrive at the hospital or treatment facility for follow-up care or procedures. Missed patient appointments are a major concern throughout the entire health care delivery system.

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Navigating Lupus Diagnosis

Historical foundations to novel biomarkers

BY BRITTANY PARTAIN, PhD, AND TYLER ALEXANDER, PhD

Systemic lupus erythematosus (SLE) is a chronic, complex autoimmune disease affecting multiple organ systems. SLE disproportionately affects women, who account for approximately 90% of cases, and is more prevalent and severe among individuals of color. In particular, Black and American Indian and Alaska Native women face a two- to three-fold higher risk of developing lupus than White women. Among patients with lupus, Black women are more likely to experience organ damage and lupus-related complications compared to White women. These demographic patterns are directly relevant to clinical vigilance and equitable diagnostic practice.

Since its earliest descriptions, the diagnostic landscape has expanded significantly. The term "lupus" is a Latin word meaning "wolf," which was first used to describe the erosive facial lesion associated with the disease resembling a wolf bite. Initial reports have been somewhat variable, but the Italian surgeon Rogerius Frugardi is most often credited as the first to report the condition in the thirteenth century. Early on, lupus was considered a skin condition and not a systemic disease with both cutaneous and subcutaneous manifestations. Since then, many additional clinical features have been introduced to support lupus diagnosis, including serologic biomarkers. Early biomarkers included lupus erythematosus (LE) cells first reported by Malcolm

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Navigating Lupus Diagnosis
Historical foundations to novel biomarkers
by Brittany Partain, PhD, and Tyler Alexander, PhD

An overview of Lupus with special consideration of recent scientific advances involving enhanced biomarker identification allowing much earlier and more accurate diagnosis.

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Hospital Association Shares Troubling News

A recent report from the Minnesota Hospital Association (MHA) noted that Minnesota's hospitals and health systems are facing a severe financial crisis. Thirty-one hospitals, nearly 25% of all hospitals in the state, currently meet formal financial distress criteria. Statewide, hospitals are losing services, staff and the ability to serve their communities. Nineteen hospitals have been forced to discontinue labor and delivery services, leaving patients in Greater Minnesota with up 70 mile drives for basic services. Hospitals are facing a systemic crisis and numerous factors point clearly to a worsening situation.

A recent report from the Kaiser Family Foundation (KFF) cited the number of Americans without health insurance rose by more than 1.3 million in 2024, reaching 26.7 million people — the first increase in more than five years. Worsening this trend, the Congressional Budget Office projects that over 14 million additional people will lose coverage by 2034 due to changes to Medicaid and the ACA Marketplace that were included in the 2025 reconciliation law-related federal administrative changes. KFF data show that over 80% of uninsured Americans are in low-income working families, nearly four in 10 delay or forgo needed medical care due to cost and 62% carry health care debt.

"Every person who loses coverage is a patient who will still need care — but will arrive at our hospitals sicker and without the ability to pay," said Rahul Koranne, MD, MHA president and CEO.

As federal policies continue to deepen this crisis, Minnesota is being disproportionately penalized for having expanded Medicaid and uncompensated care at safety-net hospitals. The MHA has issued several recommendations to policymakers to address this crisis These include:

- Pass SF 3769 to protect the 340B drug pricing program.
- Establish a statewide hospital support pool.
- Address the chronic underfunding of public health programs.
- No new mandates on hospitals already in crisis.

Despite irrefutable evidence of a system in crisis, not unexpectedly these potential stop-gap measures face political challenges. "We need lawmakers to have the will to act now — before more hospitals reach the breaking point and more Minnesotans lose access to the care they need." said Koranne.

Fairview Proposes 189,600 - Square-Foot St. Johns Hospital Expansion

MHealth Fairview recently submitted a proposal to the city of Maplewood that detailed a 189,600-square-foot expansion to its existing 370,000-square-foot St. John's Hospital at 1575 Beam Ave. E. The project features a new four-story addition that will connect to the current building. To ensure uninterrupted care during construction, the hospital's main entrance and emergency department entrance will be temporarily relocated. The loading dock will also be expanded with an extra door to support increased deliveries and material flow. The exterior design will incorporate brick, metal and stone panels that complement the existing structure, while both interior and exterior lighting will be upgraded to energy-efficient LED systems designed for safety and dark-sky compliance.

In addition to the building expansion, the project will include removing the existing parking structure and relocating a portion of the existing surface parking spaces, replacing a deteriorating retaining wall and improving pedestrian circulation along St. John's Boulevard. Existing access points to the site will remain the same, and post-construction entry

points to the emergency department and the hospital main entrance will be in the same general location. During construction, temporary changes will be made to both the emergency and main entrances to facilitate portions of the project. Additional sidewalks will be constructed to improve access throughout the campus. The proposed addition is focused on the southwest corner of the campus, and the overall design is in keeping with the existing campus, and neighboring buildings. The Maplewood City Council is scheduled to review the request in mid-April and will post meeting minutes when available. Numerous documents, such as storm water management, landscape plans, parking and traffic studies, floor plans, etc., were submitted with the proposal. Presumably, construction timelines will be made public pending approval.

Trump Policies Reducing Government Public Health Workforce

A recent study conducted by University of Minnesota School of Public Health (SPH) showed a disturbing increase in the number of government employees leaving the public health care workforce. Using data collected by the U.S. Census Bureau and the Bureau of Labor Statistics, the study tracked employment patterns and trends among health care and behavioral health workers at local, state and federal agencies. It examined more than 25,000 individuals in government positions between 2015 and 2025 and followed whether they remained in government roles, moved to jobs in other sectors or left the labor force altogether.

At a time when the United States faces an expanding array of public health challenges — from an aging population and rising mental health needs, to chronic disease, the opioid crisis, infectious disease threats and persistent health disparities — the study shows that the public health workforce responsible for responding to many of these challenges is losing workers at increasing rates.

Government-employed health professionals play a crucial role on the front lines of the U.S. public health system and deliver care to millions of people at public hospitals, local health departments and major federal systems such as the Veterans Health Administration. The government public health workforce faces mounting pressure from federal workforce reductions and program cuts.

Key study findings included:

- Departures are increasing. Exits from government employment rose noticeably in the most recent data from October 2024 through July 2025, which ties growing workforce instability to the beginning of the second Trump Administration.
- Federal workers saw the biggest change. Historically, federal health care and behavioral health workers had the lowest exit rates. Their likelihood of leaving government employment recently, however, climbed to about 8%.

"Reducing the government health workforce threatens the ability of public health systems to meet the needs of people across the country," said Nichole Fusilier, MPH, a researcher with SPH's Center for Public Health Systems. "Government health workers provide essential services in communities nationwide, and when that workforce becomes less stable, it can ultimately affect access to care, especially for vulnerable populations. At a time when demand for health care and behavioral health services is expected to grow, policymakers should be thinking about how to strengthen and expand these jobs, rather than see further reductions in the workforce."

Blue Cross Posts $353 Million 2025 Loss

In its annual report, released April 1, Blue Cross and Blue Shield of Minnesota (Blue Cross) claimed a combined $353 million

in operating losses on $10.4 billion in fully insured premium revenue for 2025. This represents an operating margin loss of approximately 3%. Blue Cross paid $9.8 billion for members' medical and pharmacy services in 2025, or nearly $27 million in claims on a daily basis. This represents an increase of $1.7 billion in claims spending over the year prior.

Unfavorable performance in federal and state government health programs — particularly in Medicare Advantage and Medicaid — were the primary drivers of the operating losses. Contributing factors include increasing costs and utilization of specialty medications (including GLP-1s) and hospital inpatient services. In the Medicare market, ongoing federal regulatory challenges — including reimbursement levels where rates for payers have not kept pace with rising cost and usage trends — intensified financial pressures and market volatility.

At the local level, ongoing cost pressures led to multiple carriers in Minnesota either reducing benefits and geographic service areas, dropping plan offerings or withdrawing from Medicare completely. Due to this unprecedented market disruption, Blue Cross experienced a significant influx of Medicare enrollments in 2025. This rapid expansion in membership came with additional requirements to expand operational and administrative capabilities.

The same volatility existed in Medicaid, where large enrollment gains contributed to operational losses in the administration of PMAP (state Medicaid) and MinnesotaCare claims.

"While I have the utmost confidence in our ability to provide financial stewardship in a very challenging environment, it is imperative for us to make significant changes in how we fulfill our nonprofit mission over the long term," said Dana Erickson, president and CEO of Blue Cross and Blue Shield of Minnesota. "For nearly a century, Blue Cross has been here for Minnesotans. That history shows how we can successfully navigate challenges and deliver long-term stability for our state, our communities and all of our stakeholders."

Total enrollment for the year exceeded 3 million, the highest level of membership in the 93-year history of the organization.

Allina and Winona Health form Heart Care Partnership

Winona Health and the Allina Health Minneapolis Heart Institute recently announced a new partnership that will expand cardiovascular expertise in Winona and surrounding southeastern Minnesota communities. Minneapolis Heart Institute cardiologists are now seeing patients on the first floor of the Winona Clinic. Appointments are available on the second and fourth Monday of each month, making it easier to get comprehensive heart care in Winona. The partnership is designed to meet the needs of Winona Health's patients by delivering in-person clinic days supported by a full spectrum of cardiovascular services and care coordination.

"This collaboration strengthens our commitment to keeping high-quality care in our community," said Amanda Ciszak, MSN, BSN, RN, associate vice president of primary care clinics, Winona Health. "Working with Allina Health Minneapolis Heart Institute enables our patients to see cardiology specialists right here in southeast Minnesota. This collaboration helps your Winona Health care team stay connected to your care."

"We're excited to partner with Winona Health to make heart care more convenient for families across the region," said William Katsiyiannis, MD, president, Allina Health Minneapolis Heart Institute. "From prevention and diagnosis to advanced treatment, our goal is to

deliver excellent cardiovascular care locally and provide seamless access to the broader Allina Health Minneapolis Heart Institute network when needed."

The Institute is a leader in cardiovascular innovation, research and care delivery through clinical trials and publications. It trains 4,000+ providers annually, and is consistently rated "High Performing" by U.S. News & World Report. Allina Health is a network of more than 90 clinics, 12 hospital campuses, 13 retail pharmacies, specialty care centers, home care and emergency medical transportation, providing care from birth through end-of-life. Winona Health is an independent, community-owned, nonprofit health care system. For more than 130 years, it has cared for individuals and families through all stages of life from birth through end of life. Services include primary and specialty care, hospital care, senior living and hospice. Guided by a local volunteer board, Winona Health is committed to providing high-quality, patient-centered care for the community it serves.

Essentia Health Breaks Ground on Fosston Emergency Department Expansion

Essentia Health has recently broken ground on new construction that will add more than 5,500-square-feet to the existing emergency department at its hospital in Fosston, Minnesota. Essentia Health-Fosston is a Level IV trauma hospital that provides 24/7 emergency care in a rural region. The $12 million project will include additional treatment space, rooms designed for behavioral health patients, and a new ambulance bay to improve patient flow and access.

"As a critical access hospital serving a rural region, Essentia Health-Fosston plays an essential role in providing timely, high-quality care close to home," said Dr. Stefanie Gefroh, Essentia Health West Market president. "This new emergency department will help us better meet the needs of patients and families in Fosston and the surrounding area. We are proud to continue investing in this community and the people who depend on us every day."

Essentia Health-Fosston was recently named a 2026 Top 100 Critical Access Hospital by the Chartis Center for Rural Health. The redesigned department will address space constraints and improve privacy and safety for patients and staff. The facility currently supports emergency services alongside walk-in care and same-day primary care access, in addition to more than 20 specialty services.

"This is an exciting day for our hospital and for Fosston," said Mike Curtis, Essentia Health-Fosston administrator. "Our team cares for patients around the clock, and this project will give them a larger, more efficient space designed to support excellent care."

Kraus-Anderson is serving as the project's construction partner. The company said it will coordinate work to limit disruptions to hospital operations during construction. "Kraus-Anderson is proud to partner with Essentia Health on the Fosston Emergency Department expansion, a project centered on improving patient care, supporting staff, and strengthening access to critical services in the region," said Tracy Pogue, Kraus-Anderson director of business development. "Our team is committed to engaging regional trades while delivering this work with thoughtful planning, clear communication and a focus on maintaining uninterrupted hospital operations throughout construction." The project is scheduled for completion in summer 2027.

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Advancing Public Health Outcomes

Damōn Chaplin, MBA, Commissioner, Minneapolis Health Department

Please tell us about the kinds of work you do to promote public health.

Our work spans a wide range of public health priorities — all grounded in strong partnerships with our communities to advance equitable health outcomes and eliminate disparities. We do this through a combination of education, prevention, regulation and policy change—whether we're strengthening emergency preparedness, addressing chronic disease or reducing risks through home hazard mitigation, such as lead and radon prevention.

Our efforts also include commercial tobacco prevention, substance-use response and supporting maternal, childhood, and adolescent health. We oversee safety in food, lodging, pools, tanning and tattoo services, while also advancing sexual and reproductive health, communicable disease prevention and climate equity.

We're working to strengthen our local food system and expand access to care through School Based Clinics in Minneapolis high schools, ensuring that health and wellness are accessible to residents at every stage of life. The Minneapolis Health Department budget over the coming year is approximately $46 million, which is funded by the city's general fund (56%), grants (40%) and opioid settlement dollars (4%).

What can you tell us about how the Minneapolis Health Department started and how it has evolved over its 150+ years in existence?

The Minneapolis Health Department has a long history rooted in the city's response to rapid urban growth and the public health challenges that came with it. Like many cities in the late 1800s, Minneapolis began with the creation of an informal board of health in 1867, focused primarily on controlling infectious disease outbreaks and improving basic sanitation. Early efforts centered on issues such as cholera, smallpox, unsafe drinking water and poor housing conditions, which were major threats in a densely growing urban environment.

> “Social and economic conditions strongly influence health outcomes.”

In 1872, this evolved into a more formalized public health department under the City Charter, developing stronger governance and expanded responsibilities, including food and milk inspection, tuberculosis control and broader environmental health protections. This period also saw the establishing of Minneapolis General Hospital, managed by the Minneapolis Health Department until it was transferred to Hennepin County in the 1960's.

During the mid-20th century, we shifted focus to address chronic diseases, maternal and child health, immunizations and community-based prevention programs. Public health also became more closely integrated with health care providers and social services as the understanding of health expanded beyond disease treatment to include prevention and wellness.

To meet community needs, the health department is now a modern public health agency focused on health equity, recognizing that social and economic conditions strongly influence health outcomes. We work across the city to address disparities, support vulnerable populations, manage public health emergencies and promote healthier communities through partnerships and data-informed strategies.

How do you interact with other city departments of health, both in Minnesota and nationwide?

Our work is deeply collaborative, built on strong partnerships across local, state and national public health systems to advance shared funding and policy priorities. We actively engage with peer agencies through the local public health association to help shape state legislation while also contributing to national efforts through the National Association of City and County Health Officials (NAACHO) — where I serve as president — and the Big Cities Health Coalition.

Regionally, we partner with Hennepin County and neighboring city health departments to lead a joint Community Health Assessment and Improvement Plan. We also work alongside the Minnesota Pollution Control Agency to advance our shared goals around climate and environmental health, ensuring a comprehensive and coordinated approach to protecting community well-being.

What are some of the ways you work with the Minnesota Department of Health?

Our work is supported by a combination of state and federal funding, much of which is distributed through the Minnesota Department of Health (MDH), including important federal pass-through resources. One key example is the Local Public Health Grant, which provides foundational funding to health departments across the state to strengthen public health infrastructure and respond to emerging health issues.

We also work closely with the MDH for strategic planning and guidance. Our collaboration extends to implementing grant-funded initiatives, including emergency preparedness efforts that are fully supported by federal and state funding, where we coordinate trainings, exercises and drills with a wide range of partners.

Through delegations from both the United States Department of Agriculture (USDA) and the MDH, we are also able to directly conduct inspections of food, lodging, pools, tanning and tattoo establishments. Additional funding from the MDH supports our cannabis - and substance-use prevention efforts, while our opioid response work, including naloxone (NARCAN) distribution and strategies tied to opioid settlement funds, ensures we are addressing substance-use challenges with targeted, evidence-based approaches.

You provide a range of mental health support resources — please discuss some of this work.

Much of our mental health work is centered in our School Based Clinics, where we provide counseling services to students in Minneapolis public high schools, ensuring young people have access to care where they are. We are also expanding access through an upcoming Request For Proposal (RFP) for nontraditional mental health services that will be offered at the future South Minneapolis Community Safety Center, alongside efforts to support those on the front lines, such as providing healing and mental health resources to contractors involved in Operation Metro Surge.

To strengthen and coordinate this work, we recently welcomed a mental health and well-being coordinator who is leading these initiatives and helping connect broader community resources. In addition, we work to reduce stigma through public awareness efforts like It's OK to not be OK and provide referrals through our Mobile Medical Unit, helping ensure residents can access the mental health support they need in a variety of settings.

What are some of the goals you have for the Minneapolis Health Department?

Our department's work is guided by several key priority areas that shape how we serve the community and advance public health outcomes across Minneapolis. These include ensuring a healthy start to life and learning, supporting thriving youth and young adults and promoting healthy weight and smoke-free living.

We also focus on creating healthy places to live and ensuring residents and visitors have safe places to eat, swim and live, all while protecting and advancing a healthy environment. Our commitment is to maintain a strong urban public health infrastructure that can respond to both ongoing and emergent needs. At the same time, we work to stabilize our funding during this period of reduced financial resources in order to continue delivering essential services to the community.

What are some of the things you do that physicians might find the most surprising?

People are often surprised by how much public health work extends well beyond traditional clinical care. For example, the Minneapolis Health Department is actively involved in climate change mitigation and working to reduce environmental health risks that directly impact community health outcomes, such as heat-related illnesses and addressing air quality concerns. We also carry out regulatory enforcement for noise, air, water quality

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For example, when an expecting mother misses prenatal care appointments, the risks of premature birth rise with surgical births and complications becoming more likely. Mortality rates also rise.

On the other side of the lifespan, as we age, doctor's appointments become more important for managing chronic conditions. For example, a missed dialysis appointment becomes a visit to the emergency room, one of the most expensive forms of medical care possible.

> The nonemergency medical transportation system is overwhelmed.

Treatment of a single condition may require trips to multiple sites and specialists. After all, health care is fragmented and oftentimes not delivered under the same roof. For example, a cancer patient must get to their oncologist and then will likely require chemotherapy at an infusion center, rehab at another location and perhaps evaluations from other medical professionals (a plastic surgeon or a neurologist, for example). Having cancer can almost be a full time job and involve social workers, nutritionists and others — all in different locations. This does not even take into account trips to the pharmacy for various medicines, including ones just to reduce nausea as a side effect of the chemotherapy.

A Deeper Look

Some problems in health care are clear. It's easy to see that health care is expensive and that the private insurance system makes it difficult for patients to receive care. It's easy to see that Medicaid and Medicare reimbursements are too low, making it difficult for rural hospitals and clinics to survive.

The problems in the system of nonemergency medical transportation (NEMT) in Minnesota are harder to see, but they are there, and they affect nearly all of your patients. NEMT includes a web of professionals working hard to get a patient to the doctor or home from the hospital. It includes social workers or care coordinators whose job is to help secure transit (often calling a dozen companies until they find one with capacity who accepts the relevant insurance, Medicaid, or private pay). The NEMT system also includes professional transportation companies who struggle to keep licenses up to date, drivers trained and vans rolling. It includes volunteers working through community centers picking up some of the more mobile Minnesotans. The NEMT system also includes regional planning agencies and local governments, writing grants to fund innovations and policy briefs advocating for change. They need to — there are more patients needing service than the system can handle.

The fact that the NEMT system is overwhelmed impacts physicians and their patients. This is true whether you practice in the middle of the metro or in Warroad, Minnesota. If we don't act soon, the problems will get worse.

NEMT Precarity

Problems in NEMT are easier to visualize if we begin in rural Minnesota. If you serve patients living in a rural area, far away from the large hospitals, clinics and health care systems found in Minneapolis, St. Paul, Rochester or Duluth, your patients may not be able to get to the doctor easily.

The Accessibility Observatory at the University of Minnesota studies how accessible health care is, from the perspective of transportation systems. They have calculated travel times from homes to (for example) federally qualified health clinics (FQHCs) in rural northeastern Minnesota. From some rural Minnesota counties, travel time is well over an hour one-way.

FQHCs serve the poorest Minnesotans, so it should be no surprise that many patients have a difficult time making the trip from home to the clinic for routine care. It can be difficult to secure a ride from friends and family. If the patient uses Medicaid or other social services, it may be difficult to secure a ride from the approved providers. If the patient is able to drive themselves in most conditions, a few inches of snow or that wintry mix that leaves black ice can make travel too difficult to begin. Furthermore, some FQHCs in rural areas are open for very limited hours — one in northeastern Minnesota is open for four hours a week.

The Accessibility Observatory has determined that travel to critical access hospitals is just as difficult. On nearly every dimension, for nearly every service, rural Minnesotans have a difficult time accessing health care. The problem is also faced by Minnesotans in cities. A patient in Duluth might live a short distance from their doctor, but they may live away from mass transit. They might require a vehicle that can haul their wheelchair — a trip to the doctor becomes a major obstacle to receiving care.

Addressing the Challenges

Minnesota's NEMT system is in crisis. On February 6, 2026, a group of more than thirty professionals met with members of the state legislature, the Minnesota Rural Health Association and members of the Arrowhead Regional Transportation Coordinating Council, a group of planners, policy workers and advocates working to coordinate and improve transportation in

the Arrowhead region of northeast Minnesota. This meeting produced several insights including the following.

There aren't enough vehicles or drivers

For many Minnesotans, making a doctor's appointment is only the beginning of the challenge in receiving health care. Scheduling a ride can require multiple phone calls to multiple agencies, hoping for available drivers and vehicles. Professional providers, with vehicles and drivers certified by the state, provide thousands of rides each month. It's still not enough to meet demand.

In northeastern Minnesota, multiple professional providers are supplemented by committed volunteers working for organizations like Elder Circle in Grand Rapids. Volunteers for Elder Circle will drive elders in Grand Rapids anywhere, statewide, for medical care — all the way, sometimes, to the Mayo Clinic in Rochester.

Volunteers provide hundreds of rides a month; professional providers provide thousands. Still, we don't have enough vehicles and drivers to meet the needs. We lose capacity every year as commercial providers find the margins unfeasible, leaving us on the precipice of a transportation crisis.

Severely Limited Transportation for the Disabled

Programs like Elder Circle and even more experimental programs, like goMarti in Grand Rapids, are also trying to fill the gap in transportation services. There is a limit to what these volunteer and grant-funded programs can do, especially when transporting patients with vision and mobility challenges.

The goMarti (Minnesota's Advanced Rural Transit Innovations) program is a microtransit program that allows users to schedule an autonomously driven vehicle for pickup for multiple purposes — from tourism to medical transit to grocery shopping. The project is grant-funded, intended as "proof of concept," in a way that will encourage investment by state and local governments to invest in programs like goMarti in other communities. Since 2022, goMarti has moved more than 46,000 riders. It's still not enough to meet demand.

And goMarti, by using autonomous vehicles, cannot help mobility or sight-impaired patients to board and exit the vehicle. Similarly, the elders who are transported by Elder Circle must be mobile, too. Volunteers are not allowed to help patients board or disembark the vehicle. The risk for injury to the patient or to the volunteer is too great. Patients who need help with moving on and off the vehicle need to rely on the already overburdened professional providers. All carefully planned doctor's visits fall apart if you can't leave your driveway.

Transportation Issues Turn Small Problems into Crises

Regular care of chronic conditions prevents them from becoming crises. For example, an annual blood draw on a prediabetic patient can prevent a crash from undiagnosed diabetes. Regular dialysis prevents complications and expense. When transportation is provided by professional services instead of by family, friends, or the patients themselves, the odds of missing an appointment go up. If more than an inch of snow falls, the odds of missing an appointment go up even higher.

If we can help people get to the doctor for preventive and for chronic care, we keep them out of the hospital for emergency care. This is important for the health of the patient. It's also important for the health of the health care system. Emergency care is one of the most expensive and, in these cases,

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inefficient forms of health care. A better transportation system would be a better use of funds as well as better care.

A Two Way Street

Many trips to the hospital are one-way. An ambulance transports a patient to the emergency room and then drives off. When the patient is discharged from the hospital they need to get home.

They call a cab or an Uber — but the ride might be prohibitively expensive. In Duluth, for example, patients sometimes are transported from Ironwood, at the tip of the Upper Peninsula of Michigan, two hours and two states away — an impossibly expensive cab ride home. Furthermore, on discharge they may need a vehicle that can haul a new wheelchair and are left to the tenuous contingencies of the transportation providers discussed above.

> Recognize potential transportation challenges as part of providing health care.

Anna Solem, MBA, BSN, RN, CMGT-BC and manager-system acute care coordination & transition management for Aspirus St. Luke's Hospital and Lakeview Hospital, explained what happens in these situations. Sometimes the patient remains in the hospital until transportation can be arranged. This is incredibly expensive for the patient and can become expensive for the hospital if the patient is unable to pay. If the hospital must bear the costs, eventually, all patients will bear the costs through higher charges for patients services.

A patient who cannot leave the hospital bed also creates a real risk for future patients. Your patient may need that hospital bed for an emergency or just for a scheduled elective surgery. Until the current occupant can get a ride home, that room and its services are not available. This is important because as we seek the levers to make positive change, we need everyone on board — rural, metro and suburban, poor and affluent alike. We need doctors, clinic managers, social workers and patients, working together to advocate for change.

Looking for Solutions

The problem is profound and its impact reaches wider than most imagine. But the problem is not intractable and we have opportunities to advocate for change. Researchers at the University of Minnesota are working in partnership with the Arrowhead Regional Transportation Coordinating Council (RTCC) to better describe the problems in the nonemergency medical transportation system. We are also looking for solutions.

Research tells us that one of the problems patients face when arranging transit is that the conversation begins after they leave the doctor's office. The appointment is made, and now the patient, often alone, begins to figure out transportation. We can't expect a physician to assume the challenge of arranging transportation, but we can recommend action steps that will make a big difference.

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Start by recognizing potential transportation challenges as part of providing health care. Acknowledge that transportation can be a problem. This may give a timid patient the permission they need to let your staff know about the challenges they face as they schedule a referral or a follow-up appointment. Acknowledging transportation challenges also minimizes shame or stigma related to these travel challenges — which may make it easier for your patient to seek help.

Make a discussion of the challenges in transportation part of scheduling an appointment. Although your office may be open from 7:45 a.m. to 4:30 p.m., some patients without easy transportation might find making an appointment before 10 a.m. very difficult. Some patients with easy transportation may also find 8 a.m. appointments hard to make, because they work late or they have responsibilities to children, or a hundred other reasons. Create an environment where you recognize that getting to the appointments may be complex.

It would be far better to schedule appointments with certain patients after 10 a.m., because you understand the pressures single parents face in getting themselves and their kids around the city on the bus, than to schedule them for 8:30 a.m. and see them miss their appointment. Similarly, it would be far better for a patient needing care from fifty miles away to schedule a January appointment for noon, in case the roads need plowing, making an 8 a.m. appointment an impossible goal.

You and your staff may or may not be able to solve your patient's problems, but acknowledging them brings them to mind for the patient so they can begin the problem-solving process.

Another important action step in addressing these issues is to maintain resources that point patients toward transportation options in your area. You can keep these resources in two forms: — in paper forms such as brochures, handouts and printouts that your staff can manage; the other option includes electronic data access, such as a template email with links to resources.

Circulate these resources easily and comfortably along with appointment reminders. At an in-office visit, distribute them to patients who might benefit from the information. These strategies may decrease no-shows and increase individual patient satisfaction. They are, however, bandaids, short term fixes that do not address the systemic problem.

At the level of the large practice, or the practice attached to a hospital system, small changes can make a big difference. For example, hospitals across Minnesota are adding "discharge lounges," where patients may await transportation home, freeing resources for incoming patients.

The nonemergency medical transportation system is overwhelmed by demand and undercompensated by the state and by the insurance industry. Deeper, structural solutions are needed, and physicians and their clinic managers must have a role in advocating for the needed changes.

David Beard, PhD, specializes in scientific and technical communication and is a professor at the University of Minnesota Duluth.

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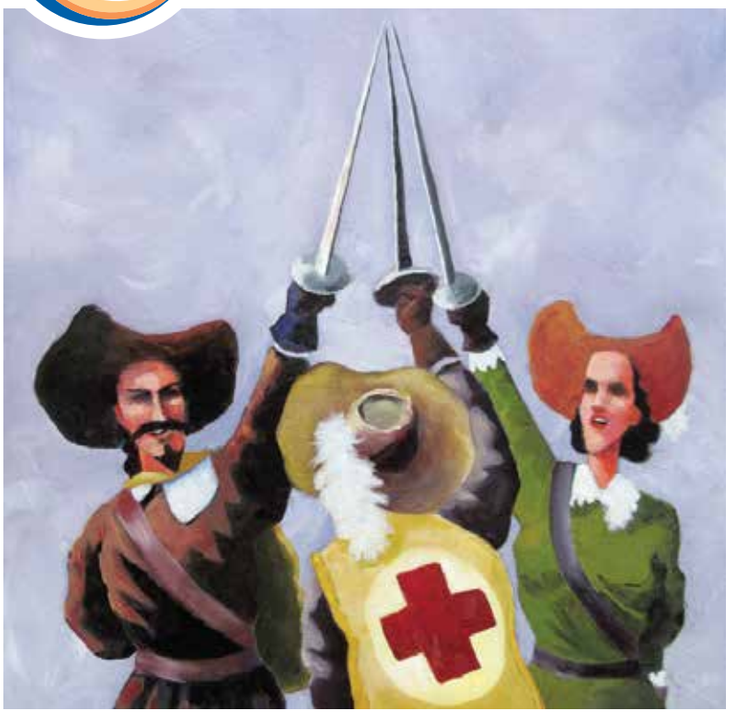
Minnesota Health Care Roundtable 61ST SESSION



Defending Science

Evolving new partnerships —

The following report from the 61st session of the Minnesota Health Care Roundtable addresses important issues posed by recent changes in federal health care policies. Our panel shares insights into the effects of these new policies and offers constructive suggestions for addressing them. Speaking from what are essentially the front lines in an effort to maintain the difference between science and ideology, several important and challenging outcomes of these new policies are discussed. Our panel offers hope and firm guidance toward maintaining the efficacy of research, public health and medical science.

We extend our special thanks to the participants and sponsors for sharing their perspectives and expertise. This winter we will publish the 62nd session of the Minnesota Health Care Roundtable on the topic of artificial intelligence and the peptide tsunami. We welcome comments and suggestions.

What are some of the biggest problems recent federal health care policy changes have created for your industry sector?

JP: Governmental public health has faced an incredibly challenging year and a half. With the end of financial support for emergency operations at the end of COVID-19, we were supposed to have time to recharge and rebuild. That really has not happened. There is very little political support felt at the federal level, coupled with communication and policy changes that can be very hard for state and local practitioners to accept. It is coming from all angles: funding cuts, policy shifts, attacks on public health workers and the questioning of science and vaccines. After substantial voluntary turnover, we've moved into a period of involuntary turnover in the field. It is a very challenging time to work in public health.

JESSE: Medicare, Medicare/Medicaid and Medicaid are utilized by people with disabilities at approximately 69% compared to the general population at 31%. Reductions by the federal government to domestic spending on health care are having a destabilizing impact on the lives of people who rely upon these federal and state programs.

BROOKE: As designed, our public health system relies on a strong federal partner for funding, communication and coordination. The Minnesota Department of Health is 50% federally funded. When there are major shortfalls in or recissions of that funding, our ability — and that of our partners — to provide public health services suffers.

During and directly following the pandemic, we started to see more investment in public health with federal funds flowing to states to recruit, retain

THE PANELISTS:

TODD ARCHBOLD, LSW, MBA, is CEO of PrairieCare, a division a Newport Healthcare, the nation's largest provider of specialty mental health services for youth and young adults. He leads the statewide Psychiatric Assistance Line (PAL) and Mental Health Collaboration Hub — services designed to increase collaboration and support between psychiatry and primary care.

DAVID BEARD, PhD, specializes in scientific and technical communication and is a professor at the University of Minnesota Duluth.

JESSE BETHEKE GOMEZ, MMA, is a member of the leadership team for Disability Hub MN and Executive Director of Metropolitan Center for Independent Living, a provider of comprehensive services assisting people with disabilities in the seven county Minneapolis–St. Paul area. He has worked in leadership roles in behavioral health care at CLUES, the American Red Cross and the United Way.

BROOKE CUNNINGHAM, MD, PhD, was appointed in January 2023 as commissioner for the Minnesota Department of Health (MDH). MDH is the state's lead public health agency, responsible for protecting, maintaining and improving the health of all Minnesotans. Dr. Cunningham is a general internist and sociologist. She received her doctorates in medicine and sociology from the University of Pennsylvania.

JP LEIDER, PhD, is the director of the Center for Public Health Systems at the University of Minnesota School of Public Health. He is a senior fellow in the Division of Health Policy and Management and on the affiliate faculty at the Center for Bioethics.

and train the public health workforce, advance disease surveillance, modernize data systems and improve our overall public health infrastructure. Then the federal government suddenly and unilaterally cut grant funds to states in late March 2025. The funds were then restored to the states that sued to retain them, including Minnesota, but we have still not recovered from the disruption of that initial loss of funds.

With the passage of the federal budget for Health and Human Services this February that maintained 2025 levels of public health funding, we'd been hopeful that the threat to public health funding from the federal government was passed. Unfortunately, sudden cuts of federal public health grants continue to be a reality. The latest round of cuts included the termination of about $38 million for the Public Health Infrastructure Grant in Minnesota. Three other states (California, Illinois and Colorado) also had their grants terminated. Canceling grants to states affects all projects, staff and partners funded by those monies, including allocations to local public health departments, Tribes and community-based organizations. We have again sued to maintain access to these funds, but even the uncertainty itself makes it more difficult for us to do our jobs.

DAVID: One of my teaching assignments at the University of Minnesota Duluth is a course in grant writing and project management. In typical years, I have shepherded students through successful crafting of grants to support rural farms (a new compost system), to support veterans (through equine therapy) or to support eldercare services (the repair of a van to transport residents of an eldercare facility). In the last year, the ecology of grantwriting has been thrown into turmoil. Federal funders are no longer reliable. State funders are struggling to establish a new normal as federal funding evaporates and state economies shrink. Foundations are cautiously attempting to determine the ways that they will need to pick up the slack.

I have long told students that grantwriting is about leveraging resources, pairing the goals of the state or the foundation supplying a grant with the goals of the nonprofit. Well-matched, we can achieve the aims of both. With the changes in the current administration, the ecology of grantwriting is unstable and it may be years before it settles — if it ever does. In the meantime, people will hurt.

TODD: Recent federal health care policy changes have thrown a wrench into the gears of an already clunky mental health care system in Minnesota. The most glaring issue is the gutting of longstanding funding for proven mental health services and infrastructure. For instance, the Minnesota Department of Human Services has faced budget cuts that directly affect community mental health programs, which are vital for serving low-income and marginalized populations. This isn't just about dollars and cents; it's about caring for our most vulnerable citizens who now have even fewer resources. It's frustrating to see mental health services continually undervalued while headlines highlight the increasing rates of anxiety and depression in people of all ages. We must advocate fiercely for policies that prioritize mental health, ensuring that funding is restored and expanded to support community-based services. Additionally, providers can help by demonstrating the effectiveness of mental health care through data and outcomes to help advance practices and secure necessary funding.

Please share some examples of how health care misinformation can affect health care delivery.

TODD: Health care misinformation exacerbates existing health disparities, particularly among marginalized populations who already face structural barriers to care. Vulnerable groups, including youth in rural areas or minority communities, are disproportionately affected, complicating their access to necessary mental health services. The rise of digital platforms and social media has intensified the spread of false narratives, leaving the public confused and mistrustful of legitimate health information. To combat this, we must prioritize health literacy and advocate for evidence-based communication. By promoting accurate information and dismantling stigma, we can ensure mental health care is recognized as a vital component of overall well-being, encouraging individuals to seek the help they need without fear.

Additionally, misleading claims about mental health treatments can deter individuals from seeking care, leading to increased suffering and tragic outcomes. One of the best examples is the misconception that antidepressants are addictive, a myth that can prevent people from accessing a treatment that could significantly improve their quality of life. These medications are scientifically proven to help people with depression and anxiety by altering brain chemistry to enhance mood and emotional regulation.

DAVID: My experience with disinformation is primarily in mental health care. Access to mental health care depends on destigmatization. For every person who believes that exercise and diet can "fix" mental health issues, there are many, many others for whom these solutions just cannot work. Medical and pharmaceutical solutions have a place as we seek help, and asking for that help should be socially acceptable.

We typically think of disinformation as the process that pushes us toward the wrong solutions, but my fear is that disinformation in mental health will just make people who need help feel shame for asking. They will suffer in silence.

JP: You don't need to look any farther than the United States losing its measles eradication status. We are now at a point where vaccine-preventable diseases are not just on the rise but are causing outbreaks across the country, and the official expectation from our federal policymakers and experts is that this trend will continue. We should expect to see more, not less, infectious disease among children, the elderly, and other populations in the United States. This consequence of federal policy represents a substantial shift in how the federal government approaches misinformation and disinformation. They no longer fund research in that space and generally forbid personnel from working in those areas.

BROOKE: When evidence-based public health information is challenged or obscured, misinformation about topics such as vaccines, substance-use risks or chronic disease prevention can spread rapidly. Over the last few years, we have seen declining rates of vaccination, which leads to the spread of vaccine-

preventable diseases in the community, increasing hospitalizations for those conditions and the exposure of other patients and health care workers. Misinformation can also cause people to ignore medical advice or seek out alternative remedies that may cause more harm than good. We saw this happen when people, often on social media, touted ineffective therapies like ivermectin or hydroxychloroquine as treatment for COVID-19 during the pandemic. During the measles outbreak in Texas in 2025, misinformation about using vitamin A to treat or prevent measles led to instances of vitamin A toxicity, which can cause vomiting, headaches, joint pain, liver damage and other problems. There's also been misinformation about the safety of tap water, specifically the safety of fluoride in tap water. People who are worried about their tap water may choose to drink bottled water, which is more expensive than tap water and stored in plastic containers that can leach chemicals or contaminate the environment, or they may choose sugary beverages instead, increasing their risk of cavities and other chronic conditions such as diabetes.

Mental health treatments backed by rigorous research are being dismissed in favor of ideologically driven narratives.

—Todd Archbald

Almost every element of health care delivery is developing new strategies to address funding cuts. What are some examples of this that you have seen?

JESSE: At the Minnesota Center for Independent Living (MCIL) we have advanced a new model called the 7 Life Sustaining Dimensions that identifies needed realities for families, children and individuals to stabilize their lives. All sectors of society must work together to improve and address the needs of families, children and individuals. For example, the health care sector that focuses solely on health intervention and prevention needs to innovate, to answer the question what else is needed to stabilize the patient, the client, the individual, the child, the family? This framework is based on a constitutional society in which the context of all sectors leads to better coordination and integration in stabilizing families, children, individuals and older adults.

We are living in an era of higher costs for people and doing more with less. Yet such an era of crisis can also be one of opportunity to build on the knowledge of why stabilizing families, children and individuals including older adults is the focus of a constitutional society. At the same time we have the opportunity to build upon technological advances in bringing integrated resources to stabilize people within the 7 life sustaining dimensions.

JP: Health care delivery within governmental public health is narrower, of course, than the broader health care delivery sector. Health departments sometimes provide primary care, but much more often, they focus on STI treatment, clinical disease prevention, or maternal and child health services. There are a number of rural jurisdictions that operate clinic-like facilities and are particularly concerned about forthcoming effects from the cuts to Medicaid. Prior to the Affordable Care Act (ACA), many of those services were provided by state grants, but those grants largely no longer exist and aren't coming back. So, unless states decide to spend scarce general fund dollars to restore these supports, health departments will have a very hard time replacing federal funds. It seems much more likely that services will simply be cut.

DAVID: I'm recently fascinated by the commitment small, rural Minnesota communities are putting into "upstream" mental health resources. These "upstream" resources include support groups like GLAD (the Group Living w/Anxiety & Depression in Silver Bay, Minnesota) or less direct resources, like hiking clubs and church communities. These community programs support those with mental health needs now. These groups also help connect those who might face challenges in the future with community and with resources.

TODD: In Minnesota, mental health organizations are getting creative in response to funding cuts, adopting innovative strategies to ensure continued access to care. The rapid adoption of telehealth and online services has been a game changer, allowing providers to reach clients in remote areas where mental health resources are scarce. For example, organizations like NAMI Minnesota have expanded their virtual support groups and educational programs, making it easier for individuals to access help from the comfort of their homes. Additionally, mental health providers are leveraging technology, including mobile apps that offer self-help tools and resources, to augment traditional treatment. Collaborative partnerships are also emerging, with mental health providers teaming up with schools and law enforcement to focus on early intervention and crisis prevention. These adaptive strategies are essential not just for survival but for thriving in an evolving landscape where mental health care is increasingly critical.

BROOKE: Public health has never had the resources it needs to fully serve its mission. While I'm proud of what our smart and resourceful public health workforce can do, I hope the day comes when we have more than a shoestring budget. In the meantime, the best new strategies to address funding cuts strengthen coalitions and identify new partners (e.g., private sector, foundations) with shared interests. For example, counties in Minnesota have started coming together at the regional level to explore how working together can save time and money. Using a regional data model, local health departments share the staffing, knowledge, expertise, and infrastructure to increase an entire region's ability to collect and use population health data. In health care, rural providers are also working together in clinically integrated networks to share costs, enhance care coordination, and negotiate more sustainable reimbursements from payers. For example, a new Children's Mental Health Initiative is being developed that will allow counties to reduce costs and improve outcomes by coordinating care across the region. A few states (e.g., Michigan, Mississippi) have worked with philanthropy to create investment funds or trusts specifically for public health. While the origins and operations of the models differ, they enable ongoing investment in high-impact, high-priority initiatives. Finally, schools of public health and local public health departments have also been developing new programs for students to gain hands-on experience in public health for academic credit. These programs

provide valuable training, meet degree requirements, improve readiness for public health practice after graduation and help meet local workforce needs.

In light of diminishing health care resources, how could new community-based partnerships help extend access to health care delivery?

TODD: Community-based partnerships have the potential to be innovative and highly effective safety nets at a time when resources are dwindling. By collaborating with local organizations, mental health providers can create a web of support that extends far beyond traditional care settings. Imagine a scenario where mental health providers, schools, faith-based organizations and community centers come together to address mental health needs. A great example is the Mental Health Collaboration Hub, a community of more than 400 organizations that help youth in mental health crisis who are boarding in hospitals. Other programs aim to integrate mental health services with community resources, breaking down barriers and making it easier for individuals to seek help without fear of stigma. Integrated care models, where mental health services are offered alongside primary care, can ensure that patients receive holistic support. These partnerships can also open doors to funding opportunities that might otherwise be out of reach or unrecognized. In Minnesota, the collaboration between mental health organizations and local governments has led to innovative funding solutions that prioritize mental health care. Ultimately, our communities will pay one way or another; investing in mental health is essential for fostering healthier, more resilient populations.

We are being asked whether we trust individuals as they recommend fewer vaccines and other changes that just don't make sense.

—David Beard

JESSE: Twenty years ago I worked on a plan that addressed a multi-payer framework to better stabilize inpatient mental health clients who transitioned into community settings. It involved Rule 29 outpatient mental health clinics and needed community supports. We learned that the health care sector is highly inelastic and that innovation is difficult. The conversation needs to go beyond health care delivery and focus on health care outcomes and beyond that to answer the question: "How can our health care system leverage what we do with needed resources and supports to stabilize our patients?" Ultimately the context of health care is to advance the health and well-being of a society as a throughline to a constitutional based society.

BROOKE: Community-based partnerships are no longer optional, they are essential. By moving some care out of hospitals/clinics and into the heart of the community, we can meet people where they are. This reduces cost and overcomes barriers that keep our most vulnerable communities from care. Multi-sector partnerships, community-based organizations (CBOs), like recreation centers, faith-based organizations and libraries can help. They could become "community care hubs" with community health workers (CHWs), pharmacists, clinicians and counselors offering services to individuals or groups. CHWs or health navigators could help community members (re)enroll in public programs, such as Medicaid. CBOs could be supported to expand programs focused on community connectedness, improving mental health and well-being.

These organizations could create dedicated space to help community members securely connect with their health care providers via telehealth, which would be particularly beneficial for Minnesotans who do not have broadband access, have difficulty navigating virtual platforms, or have transportation barriers. Health care organizations, in partnership with local public health departments, could expand mobile health —currently used in Minnesota for mammography, dental screenings, vaccine access, and some preventative care — to include other clinical services. Mobile health is especially important to address care needs when people live or work in health care deserts or people are highly mobile, such as seasonal workers and people experiencing homelessness.

JP: It's more important than ever for primary care providers and community public health professionals to be in contact with each other. This is crucial both to ensure reasonable continuity of care for shared patients and to target population-based prevention efforts that are very hard to address independently. Additionally, there is an opportunity to better leverage technology to enhance public health surveillance and communicable and chronic disease reporting. However, this entails overcoming technical hurdles and building partnerships between healthcare entities that may not see an immediate improvement to their bottom line. We are very lucky in Minnesota to have incredibly robust electronic health information exchanges; our hospital systems, private practitioners, and public health departments have all benefited from this. I hope other states can follow our model.

Health care initiatives that involve diversity, equity and inclusion have recently been identified as part of an anti-American agenda and have experienced significant negative repercussions. Please share some examples of this.

BROOKE: At the Minnesota Department of Health, we believe everyone should have what they need to be healthy. Both science and common sense tell

us that "one size does not fit all," that the path to optimal health looks different for different people. Yet recent federal funding disruptions have created significant uncertainty for many programs that support addressing that diversity of need. In response to this uncertainty, many organizations have scaled back, discontinued, or delayed the implementation of services that seek to focus on those most affected by health inequities, especially racial, ethnic, sexual or gender minorities. The impact will be felt well into the future as institutions cut programs that prepare clinicians to respond to the diversity of patient background and circumstance. Community-based organizations, which have historically filled some of the gaps for people, have also experienced significant negative repercussions as funding streams disappear, including those from foundations that have changed course in response to this new climate. While individuals, families, and communities bear the immediate consequences of "one size fits all" approaches, when care needs go unmet for a prolonged period of time, we all pay. The population overall is less healthy than it could be, which adversely affects the quality, cost, experience and accessibility of services, even beyond health care. We cannot have vibrant communities with thriving connections, resilient families and strong economies if we neglect or dismiss the needs of large segments of the population.

The United States of America is among the few western nations that lacks a national public health policy.

—Jesse Bethke Gomez

TODD: Many of the initiatives aimed at promoting diversity, equity and inclusion are often mischaracterized as divisive, despite their fundamental importance in enhancing cultural competence and access to care. Given our state's cultural richness, it is imperative that our mental health providers understand unique cultural differences and provide both empathy and appreciation for diverse backgrounds. The intent of these initiatives aims to ensure that mental health services are culturally relevant and accessible to all communities. Backlash against these initiatives can create an environment where providers feel hesitant to engage in necessary conversations about race, identity, and mental health. This is not a threat to our systems or something that should be controversial; it is essential for achieving quality-based outcomes. The reality is that these initiatives are not just ethical imperatives, they are crucial for creating a health care system that works for everyone. By fostering an inclusive environment, we can ensure that all individuals receive the mental health care they need, ultimately leading to better outcomes for our communities.

JESSE: The basis of the United States of America is known as the "natural laws," that which is immutable, self-evident and endowed by a Creator in all humanity. We also need to remember that who we are in the richness of the mosaic of society of people is that our human nature for all is one and the same as Homo sapiens. Euclid of Alexandria around 300 B.C. had first among his five general axioms: Things which are equal to the same thing are equal to each other. With these realizations we have organized a society that entrusts these natural laws into our constitution. Our constitution gives greater context with the amendments to the constitution and the three co-equal branches of government. The 13th, 14th and 15th amendments to the U.S. Constitution are foundational to the Civil Rights Act. It is the Civil Rights Act that identifies protected classes against discrimination. Additional federal regulations, federal laws and state laws also prohibit discrimination based upon protected classes. Through the arc of our history as a constitutional society, every generation has worked to advance that which we uphold as the natural laws in further advancements about the U.S. Constitution and the laws in the fair and equal treatment of all humanity: the encompassing of diversity, equity and inclusion.

DAVID: There is a positive dimension possible as we rethink our approaches to "health equity" in light of recent federal changes. In 2025, a Duluth nonprofit (Ecolibrium3) began speaking about Health Equity by census tract, instead of demographic data, noting that census tract 156, or Lincoln Park's lower neighborhood along the highway and harbor, has one of the lowest life expectancies in the entire state. In that geography, life expectancy is just 69 years, meaning 99.5% of Minnesotans can expect to live longer than the neighborhood's residents. Just a few miles away, in other census tracts, life expectancy is more than 80 years.

By speaking about health equity in terms of geography, we can speak to intersectionality in new ways. Everyone in census tract 156 is at risk, across diverse demographic categories and identities — and that neighborhood is diverse. By speaking in terms of geography, we have an opportunity to think about health equity for that entire community.

Similarly, my research emphasizes rural Minnesota. Rural Minnesota is far more diverse than we think it is. Rural areas include Indigenous community members, migrant communities pursuing labor opportunities, and more – as well as individuals of all backgrounds who are aging fast.

We have been asked to transition our vocabulary for talking about health equity. We have not lost the ability to examine and respond to challenges in health equity — we have instead been forced to rethink them in a way that may serve all Minnesotans better.

JP: As the saying goes, elections have consequences. New policies are in place that dramatically reverse the federal administration's position on the importance of diversity, equity, and inclusion. Furthermore, executive orders actually go a step farther to bar these activities in large part. This has substantial implications for the health workforce in Minnesota and nationally. A number of programs had been established to fund residents, fellows, and early-career staff from underrepresented communities. Representation largely encompassed race and ethnicity, but also, importantly, geography. Because many of these programs could not simply be generalized or have the offending language removed, they were terminated. Effectively, this means less funding for workforce development, recruitment and retention in the health sciences. It is reasonable to expect that workforce shortages will be deeper than anticipated. Additionally, with changes to student loan policies and Public Service Loan Forgiveness, there will be less

financial incentive for professionals to work in underrepresented communities or in public service more broadly. There is every reason to think this will lead to not just shortages, but a health workforce that does not look like the community it serves.

Numerous recent actions undertaken through new federal policies seemingly undermine the empirical scientific process. Please share some examples of this with some consideration of the potential repercussions.

JP: Professionally, I was raised on the idea that we should always be skeptical about a particular study or finding. It is deeply concerning, however, to see the fundamental notion of empiricism questioned in favor of anecdotes or "doing one's own research." To me, there are some obvious early outcomes: less trust in science has made us less safe, and our children are less equipped to compete in a global environment. But there are less obvious outcomes too, which are perhaps just as concerning. Over the last hundred years, much of the power of the United States has been soft power. One important way we project that is through our global scientific leadership. Abdicating that position — by leaving the WHO, making our colleges and universities less appealing to international students, or changing our health science funding model to make it harder for junior scientists to secure funding — is alarming. Any one of these actions would be concerning on its own, but combined, these structural challenges to our scientific investments mean we are in for a very difficult time on the global stage.

The danger today is not that science is becoming political – it always has been – but that it is becoming ideological.

—Brooke Cunningham

TODD: We're witnessing a troubling trend where political differences can undermine the very foundation of the scientific process. When political agendas take precedence over empirical evidence, we're playing a dangerous game. For instance, certain mental health treatments backed by rigorous research are being dismissed in favor of ideologically driven narratives. This not only erodes trust in the scientific community but also delays care, creates stigma, and ultimately puts lives at risk. Funding cuts to research initiatives stifle innovation, leaving us with outdated practices that fail to meet the needs of patients. This is a critical juncture. We must advocate fiercely for policies that prioritize scientific integrity, ensuring that our approaches to mental health care are grounded in solid research. The repercussions of ignoring this are dire; we risk losing the progress we've made in understanding and treating mental health conditions.

BROOKE: Over the past year, we've seen significant changes at the federal level that affect how immunization recommendations are made. For decades, providers have relied on the Advisory Committee on Immunization Practices (ACIP) to issue recommendations to the Centers for Disease Control and Prevention (CDC) that were based on the best available data and scientific evidence. In June 2025, all 17 members of ACIP were dismissed and replaced — without good cause. Since then, the reconstituted ACIP and acting CDC leadership removed or downgraded recommendations for several vaccines. In multiple cases, these decisions were made without the full, transparent evidence review that providers have traditionally expected from the ACIP process. A preliminary injunction was recently issued that stops or reverses actions that this new ACIP has taken (at least for the time being), but confusion over these policy changes can contribute to vaccine hesitancy.

JESSE: While federal policies have recently seemingly undermined empirical research, we are moving into an era of Artificial Intelligence (AI) that is quickly becoming integrated into care models of delivery. We enter an era of hyper empirical evidence that will become a powerful means that better aligns federal policies with real-time science-based evidence.

DAVID: Science proceeds best when scientists are invisible; this is why we teach students to craft lab reports using the passive voice. It doesn't matter who conducted the experiment; what matters are the results and their implications for health care.

Science may work best when the scientist is invisible, but we have entered a time when trust in science has become hard to disentangle from trust in scientists, physicians and public health leaders.

During the pandemic, we saw this crisis in trust play out in multiple ways — we saw Dr. Osterholm become a nationally trusted figure in pandemic response. At the same time, a candidate for governor advised Minnesotans to be skeptical of the advice of doctors and public health professionals concerning masks — a claim that depended on our trust in him.

Historical trauma also complicates trust in medical professionals — people of color are pressed to trust medical institutions that harmed them in the past. As a result, local leaders like Arne Vainio shared their own pandemic vaccination on the nationally syndicated TV show "Native Report." Viewers might not trust "medicine," as an institution or cultural construct, but they could trust Dr. Vainio. During the pandemic, in complicated ways, we learned to trust people, instead of institutions.

The fallout from this shift, however, is that the current leaders in public health are calling for our trust and we don't want to give it. We are being asked whether we trust individuals as they recommend fewer vaccines and other changes that just don't make sense if you've lived long enough to remember polio or if you lived in an urban area in 2020.

Please share some of your thoughts on how these policies can affect public health.

JP: To me, public health is just as much a public safety function as fire or police. We are trying to prevent infectious diseases and ensure that our air, water, and food are safe. We accomplish this through direct inspection/regulation, clinical treatment and population-based prevention. Each of these pillars of public health is being eroded in the current federal environment. Some of this is framed as a difference in policy that explicitly aims to change the status quo for public health in the United States. Reasonable people can disagree about the role of government in our lives, but I genuinely believe we are less safe now, and I'm not sure we talk about that as much as we should.

JESSE: The United States of America is among the few western nations that lacks a national public health policy. On the American journey of discovery to become a more perfect union, we must recognize that public health is concerned with the well-being and health of society. In the context of a constitutional society we must recognize the inalienable rights and human dignity of all as the basis for guiding our actions. What is most important is that as we have endured through a generational impact due to the COVID-19 pandemic, we are making discoveries beyond the role of public health and health care, whereby both become concerned for stabilizing families, children, individuals and older adults as well as all other sectors that lead to the context of a constitutional society in assuring even greater relevancy to the Preamble of the U.S. Constitution: We the people of the United States, in order to form a more perfect union, establish justice, insure domestic tranquility, provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and our posterity, do ordain and establish this Constitution for the United States of America.

It is deeply concerning to see the fundamental notion of empiricism questioned in favor of anecdotes.

—JP Leider

TODD: Some policy changes assume that things are "good enough," but in reality, they are far from it. Mental health research is years behind the rest of medicine, and when innovation and access to mental health services are restricted, we're not just talking about individual suffering; we're looking at a public health crisis in Minnesota. Untreated mental illness can lead to increased rates of substance abuse, homelessness, and even suicide, creating a domino effect that destabilizes entire communities. The stigma surrounding mental health, fueled by misinformation and negative narratives, only compounds the issue, keeping people from seeking the help they need. For example, Minnesota has seen a rise in youth suicide rates, particularly among marginalized communities, highlighting the urgent need for effective mental health interventions. We need to advocate for policies that recognize mental health as a cornerstone of overall health, ensuring that everyone has access to the care they need to thrive. If we don't, we risk creating a society where mental health issues are swept under the rug, with devastating consequences for individuals and communities alike.

BROOKE: Federal policy changes may lead to people forgoing important care or preventative services, or insurers not covering them. For example, if federal policy shifts some vaccines away from universal recommendation status, even if patients have insurance, it's not clear insurers will continue to cover vaccines. If clinics are unsure whether a vaccine will be reimbursed, they may limit which vaccines they stock or refer patients somewhere else. Over time, that can create real access gaps for patients.

The upcoming changes to Medicaid eligibility and enrollment are also worrisome. According to data from the latest Minnesota Health Access Survey, the state's uninsured rate increased from a historic low of 3.8% in 2023 to 5.8% in 2025. This means almost 120,000 more Minnesotans are going without health insurance compared to 2023. Much of this increase in uninsurance is due to the unwinding of continuous coverage provisions set up during COVID-19.

Federal funding is also crucial for us to maintain efforts like the Health Care Preparedness Coalitions in Minnesota that provide essential regional coordination across health care systems, long-term care, emergency medical services (EMS), emergency management and local public health. These coalitions lead critical response efforts, including evacuating long-term care residents during fires and floods, responding to infrastructure failures such as roof collapses in medical facilities, troubleshooting supply chain disruptions after natural disasters, and managing large-scale medical surge events like the 2007 I-35W bridge collapse. Cuts or instability in funding weaken our ability to respond to these emergencies.

How might we best move through these challenging times and preserve the integrity of scientific research and the value it brings to health care delivery?

TODD: Navigating these turbulent times requires a commitment to preserving the integrity of scientific research in health care. We need to champion transparency in research funding and policymaking, especially as it pertains to mental health. When decisions are made behind closed doors, it breeds distrust and fuels political influence. We must foster open dialogue among researchers, practitioners and policymakers to ensure that evidence drives our decisions. Collaboration across disciplines is vital; diverse perspectives can enrich our understanding of mental health issues and lead to more robust solutions. Education is also key — public awareness campaigns that emphasize the importance of evidence-based practices, such as those led by the Minnesota Department of Health, can help counteract misinformation. Additionally, we need to do a better job communicating practical learning from studies and research. While we have extraordinary breakthroughs in labs, the results don't always translate well to practice settings. By ensuring that scientific research remains at the forefront of mental health care, we can continue to improve outcomes for all Minnesotans.

DAVID: Charismatic and trustworthy public health leaders can be an important part of a persuasive and effective public health campaign, but they can't replace faith in science as an institution. We need to restore faith in science as a set of practices and a set of institutions that generate knowledge that we can use to make difficult decisions.

It's possible that we have lost, that we cannot restore faith in, the generations who are adults today. The generations who have funneled their trust into podcasters and political pundits may be beyond our ability to reach. So, as an educator, I am putting my faith in and pinning my hopes on the children we are educating for tomorrow.

JESSE: In every generation of American history it is often "we the people" that have worked through great challenge in seeking to advance a more perfect union. Our nation and its postsecondary sector, the health care sector, the public health sector and as important the people of our nation, recognize that it is incumbent upon each of us to contribute to the greater good and common good for all.

For example, at MCIL we are as concerned about fixed asset limitations of $2,000 for individuals and $3,000 for couples for certain federal and state services for people with disabilities and older adults that have remained at the same fixed rates for over 40 years. This astonishing reality speaks to a nation adrift from the very heart and soul of that which is foundational to who we are namely the natural laws immutable in humanity and as a constitutional society. Our work is addressing and solving the severe humanitarian crisis for individuals who rely upon direct care services for daily living. This work is needed and essential for who we are as a society and advancing our ability as a nation in advancing the ability of people to care for one another.

BROOKE: Although we should continue to talk about the scientific gains that we have made to prevent disease and to recover more quickly when an illness or injury occurs, it is much more important to talk about the process of science than to enumerate its successes. Science is valuable because of the "how" not the "what."

Science is at its best when it is fully transparent — when scientists explain their study limitations; when they embrace learning and routinely welcome critique; and when they repeat studies over time, across settings, and with different populations to see if the results hold and modify their conclusions when they do not. We should talk more about the scientific process as iterative, as always seeking to improve its measures and methods in order to test its assumptions and conclusions. The transparency, reproducibility, openness to disconfirmation and methodological rigor of science account for its value.

To move through today's challenges, we must do more than just ask the public to "trust the science." Scientists garner trust when they describe their research in plain language and are forthright about what is known versus unknown. By speaking publicly about the norms and practices that create confidence, discussing the ways in which scientists hold each other accountable, and acknowledging the harms that have occurred when checks-and-balances fall short, we can preserve the integrity of scientific research and strengthen its credibility with the public.

What are the most important things people need to do as we face ongoing efforts to turn scientific research into political agenda?

TODD: Politics need to stay out of scientific research. We need to cultivate critical thinking and media literacy; people must learn to question sources of information and seek out evidence-based insights. Engaging in open discussions about the importance of scientific research in health care can help demystify the process and counteract misinformation. We need to advocate for policies that protect the independence of research institutions, ensuring that scientific inquiry remains free from political influence. As a leader in mental health care, I emphasize the power of collaboration among professionals to create a unified voice that champions evidence-based practices. Supporting organizations that prioritize scientific integrity and promote public health initiatives can amplify our collective impact. By taking these steps, we can work together to safeguard the value of scientific research and ensure that it remains a cornerstone of effective health care delivery.

JP: Because science has become politicized, and it is not entirely obvious how to reverse that trend, people who care about these issues also need to become politically engaged. Regardless of where anyone falls on the political spectrum, I would wager that there are health care issues important to them — for example, that we all want to fight cancer and ensure better health outcomes for seniors in our communities. That means talking to your legislators about what issues you want to see addressed, and for professional physicians and other clinicians to talk about the importance of their work and what is lost when funding decreases.

DAVID: We need a next generation of citizens who understand scientific practice and scientific institutions. We need citizen scientists, as well as professional ones. If we cultivate those, maybe, in twenty years, we won't be making public health decisions based on whether we listen to one podcast guest or another.

BROOKE: Science is often presented as neutral or objective. The sociology of science shows, however, that science is shaped, at every stage, by human choices and institutional contexts — from what topics are prioritized for funding, to which populations are included, to which variables are selected (e.g., individual-level vs. neighborhood vs. policy), to whether and how data are shared, to how results are interpreted and used to support or challenge existing systems. In that sense, science is always political. The danger today is not that science is becoming political — it always has been — but that it is becoming ideological.

When results are amplified or dismissed based on fit with a pre-existing narrative, when scientists fail to test competing hypotheses or ignore contradictory evidence, and when policymakers select experts based on their adherence to a particular worldview, spaces that were once scientific have become ideological. At its core, science is a practice that embodies transparency, openness, critique, reflection and correction. To guard against the infusion of ideology into scientific practice, we must zealously safeguard the norms and practices of science. It would also serve us well to be more upfront about ways that power has always shaped science.

Navigating Lupus Diagnosis from the cover

McCallum Hargraves and colleagues in 1948. His team discovered LE cells in the bone marrow of patients with lupus resulting from phagocytosis of free nuclear material indicative of autoimmune reactivity. Biomarkers now central to lupus evaluation include antinuclear antibodies (ANA), anti-double-stranded DNA (anti-dsDNA), anti-Smith, complement C3 and C4 (C3/C4), antiphospholipid antibodies (aPL), anti-cardiolipin and anti-β2GPI antibodies. These autoantibodies are directed to discrete antigens associated with lupus pathology and are more commonly found in patients with lupus than in healthy individuals or those with other autoimmune diseases.

It takes an average of nearly six years from the onset of symptoms to receive a lupus diagnosis.

Treatment Overview

Once patients receive a diagnosis, it is imperative that appropriate treatment is implemented to reduce the risk of flares, organ damage or death. Quinine was first discovered as useful for the treatment of lupus by John B. Payne and colleagues, who documented successful management of discoid lupus erythematosus skin lesions in 1894. Chloroquine was introduced in 1953, followed by hydroxychloroquine (HCQ) in 1955. HCQ has demonstrated excellent efficacy and patient tolerability in SLE and is still considered a cornerstone in SLE treatment regimens to this day. Another hallmark of lupus therapy, corticosteroids, were discovered in 1948 by Philip Hench as a potent anti-inflammatory medication, which was initially used to treat rheumatoid arthritis but also showed favorable outcomes in patients with lupus. Shortly after, glucocorticoids were introduced for treatment of SLE and other autoimmune diseases. More recently, immunosuppressants and biologic disease modifying antirheumatic drugs (DMARDs) have become increasingly popular to treat SLE as they directly target overactive immune cells thus limiting side effects.

Immunosuppressants, such as cyclophosphamide, mycophenolate mofetil (MMF) and azathioprine, reduce hyperactivity of B and T lymphocytes to induce disease remission. The introduction of biologic agents such as belimumab (introduced in 2011) and anifrolumab (introduced in 2021) has expanded treatment options by targeting distinct immune pathways, with belimumab inhibiting B-lymphocyte stimulator (BLyS) to reduce B-cell survival and autoantibody production, and anifrolumab blocking type I interferon receptor signaling to suppress interferon-mediated inflammation.

Genetic & Environmental Factors

The causes of lupus development are multifactorial including both genetic and environmental determinants. Genetic factors include defects in self-antigen clearance, innate immunity pathways, complement pathway proteins and autoreactive lymphocyte development and maintenance genes.

The first animal model (F1 hybrid New Zealand Black/New Zealand White mouse) provided insights into autoantibody formation, immune tolerance and glomerulonephritis.

The human leukocyte antigen (HLA) region genes, specifically HLA Class II genes, have shown the strongest genetic link to lupus development. Not all lupus cases, however, are directly related to genetic predisposition.

Environmental factors such as Epstein-Barr virus infection; microbiome composition; smoking; and exposure to pollutants, silic and UV light have been linked to lupus development. No single factor has been independently associated with lupus development, but a combination of genetic predisposition and environmental exposures are most likely to cause disease.

The Diagnostic Gap

Timely diagnosis and prompt treatment initiation are important to reduce the risk of flares and organ damage, but these goals are not consistently achieved. According to a study conducted in partnership with the Lupus Foundation of America (LFA), it takes an average of nearly six years from the onset of symptoms to receive a lupus diagnosis, and many patients see multiple physicians before getting a definitive diagnosis. Patients typically undergo nearly 15 office visits and 58 lab procedures before receiving a diagnosis, and up to 70% experience misdiagnosis along the way.

Lupus flares range considerably in severity, from mild episodes of fatigue, joint pain, and rash to life-threatening complications including nephritis, cardiovascular disease and neurological involvement. Critically, the period between symptom onset and diagnosis is not clinically silent. Ongoing immune dysregulation during this interval can cause cumulative, and sometimes irreversible, organ damage that timely treatment could have prevented or substantially reduced. The six-year average diagnostic delay is therefore not merely an inconvenience, but represents a window during which disease progression may go unchecked.

Recent studies evaluating outcomes in a cohort of patients whose SLE was diagnosed early (within six months of symptom onset) and late (greater than

six months from symptom onset) provide strong evidence that earlier diagnosis is associated with fewer hospitalizations and overall cost savings. When SLE was diagnosed within six months of symptom onset, patients experienced meaningful reductions across multiple categories. Specifically, earlier diagnosis was associated with a 20% reduction in SLE-related hospitalizations. This study reinforces that earlier diagnosis is associated with fewer flares across all severity levels (minor flares, moderate flares, severe flares). Beyond acute care, the early diagnosis group had a 16% lower rate of outpatient visits during follow-up, reflecting a more stable disease course and less need for ongoing evaluation. These patients also experienced 13% fewer severe flares, likely related to earlier initiation of appropriate treatment.

Laboratory Testing & Novel Biomarkers

To enhance the likelihood of timely diagnosis, new diagnostic tests have recently been introduced, and additional biomarker assessments are currently under development. Laboratory testing is an important part of the lupus evaluation. Physicians often start with tests that assess autoantibody levels. One of the most common screening tests is the ANA test, or antinuclear antibody test. This test is very sensitive for lupus, and nearly every patient with SLE will have a positive ANA.

The challenge is that ANA is not specific and up to one-third of healthy individuals can also have a low positive ANA. While it is a useful starting point, it does not provide a definitive answer on its own. Antibodies that are highly specific for lupus including anti-Smith and anti-dsDNA are tested as well, but they are seen in only a subset of patients with SLE. Anti-Smith is detected in only 14% of patients, and anti-dsDNA in approximately one-third.

AVISE® Lupus was designed specifically to address these limitations. Developed by Exagen Inc., a San Diego-based diagnostics company specializing in autoimmune disease testing, it is a multianalyte diagnostic test that combines novel cell-bound complement activation products (CB-CAPs) with standard serologic testing in a validated two-tiered algorithm. This approach generates a lupus risk score that reflects the likelihood of disease across a gradient rather than a binary positive/negative result.

CB-CAPs were first described in 2004 and incorporated in AVISE Lupus testing in 2014. CB-CAPs include erythrocyte-bound C4d (EC4d) and B lymphocyte-bound C4d (BC4d), which represent complement activation fragments deposited on the surface of red blood cells and B lymphocytes, respectively. CB-CAPs have the added benefit of detecting complement products on the cell surface, such that they remain detectable for longer periods of time than traditional complement measures. CB-CAPs remain detectable for the duration of the cell's life cycle, which enhances their ability to detect ongoing inflammation rather than a single signal at the time of evaluation. This elongated detectability allows for enhanced sensitivity (66%) and specificity of CB-CAPs over standard complement, anti-Smith, and anti-dsDNA. To further enhance diagnostic accuracy, AVISE Lupus combines these novel CB-CAPs with standard serology components (ANA, anti-Smith, and anti-dsDNA) in a two-tiered method to provide a serology-based gradient of likelihood for SLE.

Combining standard serology markers with CB-CAPs provides improved sensitivity (80%) and specificity against other autoimmune rheumatic diseases

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(86%) and healthy individuals (98%). In addition, AVISE Lupus uses a proprietary algorithm to assign a lupus risk score with the ability to classify the likelihood of lupus even in early disease stages.

Multianalyte testing approaches, including AVISE Lupus, represent one category of emerging diagnostic tools designed to address the sensitivity and specificity limitations of standard serology alone. Building on these advances, additional markers have become available to improve the sensitivity for SLE. In 2025, T lymphocyte-associated markers including T cell-bound C4d (TC4d) and T cell-bound autoantibodies (TIgG and TIgM) were introduced for clinical use. These markers capture complementary aspects of the immune response not fully reflected by B cell-focused or traditional serologic markers.

Published data specifically characterizing the sensitivity and specificity of TC4d, TIgG, and TIgM in SLE populations are emerging and further validation studies are ongoing as clinical use expands. Notably, CB-CAPs and T cell biomarkers are present in patients who test negative for standard serology, marking an important step forward in improving the ability to diagnose lupus.

Disease Activity Monitoring

Beyond diagnosis, CB-CAPs can evaluate lupus disease activity. In a recent investigation, erythrocyte-bound complement C4d (EC4d) levels were independently associated with SLE disease activity, as measured by clinical SELENA-SLEDAI scores, enabling improved monitoring capabilities beyond the current standard of care. For instance, treatment efficacy could be evaluated by monitoring the presence of CB-CAPs in the context of serum complement levels.

A patient with normal complement measures without the presence of complement activation products could indicate adequate disease control. Further, EC4d remained associated with disease activity regardless of fluctuations in C3/C4 status, suggesting evidence of a more reliable indicator for disease activity over time.

Barriers to Diagnosis & Access

While the validity and utility of novel diagnostic approaches have been established, barriers to clinical implementation can limit patient access to these diagnostic technologies. In a report from the Addressing Lupus Pillars for Health Advancement (ALPHA) project (an independent multistakeholder initiative) representatives from academia, industry, regulatory agencies, clinicians, researchers, patient advocacy organizations and patients were queried about the most significant barriers to lupus diagnosis. Survey respondents indicated the lack of understanding by government payer/insurers about lupus, access to clinicians familiar with lupus and development of diagnostic and prognostic biomarkers as significant barriers to lupus diagnosis.

In a separate collaborative study of patient perspectives from Exagen and the LFA, patients reported long wait times to see providers, high out-of-pocket costs for testing and insurance not covering costs of needed services as factors contributing to diagnostic delays.

Broader engagement with rheumatology providers and payers on newer diagnostic approaches, including multianalyte assays like AVISE Lupus, can improve uptake and ensure providers have the tools needed to strengthen diagnostic capabilities.

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Regulatory & Guideline Context

Currently, laboratory developed tests (LDTs) like AVISE Lupus are not subject to FDA medical device-level approval requirements (21 CFR 809). LDTs are instead regulated under the Clinical Laboratory Improvement Amendments (CLIA) program, administered by the Centers for Medicare and Medicaid Services (CMS), which sets standards for laboratory quality and accuracy. Insurance coverage for LDT-based diagnostics like AVISE Lupus varies by payer and plan. While some commercial insurers and Medicare Advantage plans provide coverage, others do not. This remains a prominent barrier patients and providers frequently encounter, as reflected in the access challenges described above.

In the context of diagnostic guidelines, the American College of Rheumatology (ACR) and the European Alliance for Associations of Rheumatology (EULAR) endorse classification criteria for lupus centering around a combination of serology and other clinical features to standardize clinical trial eligibility and uniformity among comparison groups. These classification criteria are, however, often used clinically to diagnose lupus in patients. This contributes to diagnostic uncertainty as patients with lupus often present with diverse clusters of symptoms and serology that may not always align with established classification criteria.

In academic medical centers, classification criteria may perform reasonably as these patients are likely to exhibit more severe or advanced disease stages. Community centers that may see patients with early-stage disease or uncommon symptomatology, however, may struggle to meet existing criteria. Therefore, it is imperative that the complete clinical picture is considered when evaluating a patient with suspected lupus. Diagnostic approaches that include additional biomarkers beyond standard serology help to widen the landscape to support a diagnosis, especially in ambiguous cases.

Conclusion

Timely lupus diagnosis enables earlier intervention with targeted therapy to reduce the risk of disease flares and associated morbidity. Current diagnostic standards rely on clinical features, including serologic biomarkers. Low sensitivity and/or specificity of conventional serology (including anti-dsDNA, anti-Smith, and complement) can delay diagnosis and treatment initiation, increasing the risk of lupus-related organ damage. Novel testing approaches, including CB-CAPs, T cell autoantibodies, and the AVISE Lupus multianalyte test, can enhance the clinical picture to substantiate diagnosis, thereby reducing the diagnostic journey for patients and opening the door for appropriate management strategies.

Incorporating expanded biomarker panels in evaluating patients with clinical features suggestive of lupus, particularly those who do not fully meet ACR/EULAR classification criteria, represents a practical and evidence-supported step toward earlier, more confident diagnosis.

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Advancing Public Health Outcomes
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and erosion control, ensuring that our community's environmental conditions support, rather than undermine, community health.

Emergency preparedness and response is a major focus of our work. We plan for and respond to public health emergencies such as disease outbreaks, extreme weather events and other crises that require rapid coordination across multiple public health and other response systems.

We also engage in policy development at the local level, shaping regulations and initiatives that prevent illness before it occurs, and address the root causes of health disparities. Together, these functions highlight how public health complements clinical medicine by focusing upstream — preventing illness, protecting environments and strengthening the systems that keep entire populations healthy.

Recent federal government policies have created significant challenges for anyone involved with public health and safety. How has this affected your work?

Recent changes in the federal funding and public health landscape have created significant challenges for local public health departments. There have been attempts at the federal level to reduce or eliminate key grant programs, including targeted cuts to initiatives such as the Public Health Infrastructure Grant and Racial and Ethnic Approaches to Community Health (REACH) program that impact states like Minnesota, Colorado, Illinois and California. This uncertain and diminished funding environment has contributed to lower morale and uncertainty among staff, particularly those whose positions are supported through federal grants.

> "Instability and uncertainty within the CDC landscape have affected vaccine outreach efforts."

We also experienced the loss of our Public Health Associate Program in early 2025, along with reductions in AmeriCorps opportunities. The Public Health Corps program, previously a critical pipeline that introduced young people to local public health careers and supported staffing capacity, has since been disbanded. In addition, instability and uncertainty within the CDC landscape have affected vaccine outreach efforts locally, contributing in some areas to increased vaccine hesitancy and associated outbreaks.

Is there anything else you would like physicians to know about your work?

We invite your readers to partner with us to improve health for your patients and the community. For example, we can help a family struggling with asthma or lead poisoning through our Lead and Healthy Homes program. We can help students with mental health challenges through our School Based Clinics.

Damōn Chaplin, MBA, is the Commissioner, Minneapolis Health Department.

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In Alexandria, MN, the community knows the best place to get well and gather is at Alomere Pavilion. At the home of the new Alomere Rehabilitation Services Center, JLG's Healthcare Studio designed for unity of community, creating 10,000 SF of upper-level tenant space, with 18,000 SF of specialized main-floor space – helping an integrated team of therapists expand their services and practice their passion. Just steps from the main hospital, patients are empowered to build skills, strength, and the capabilities to lead vibrant, active lives.

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The six-week program provides motivation and tips to help people safely increase their walking pace and make physical activity part of everyday life. This program is for anyone who can be on their feet for 10 minutes—even if they use a walker, cane, or other aid.

Walk with Ease can help people with arthritis or other health conditions:

- Reduce joint pain
- Learn how to walk safely at their own pace
- Increase balance, strength, and stamina

DEPARTMENT OF HEALTH

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