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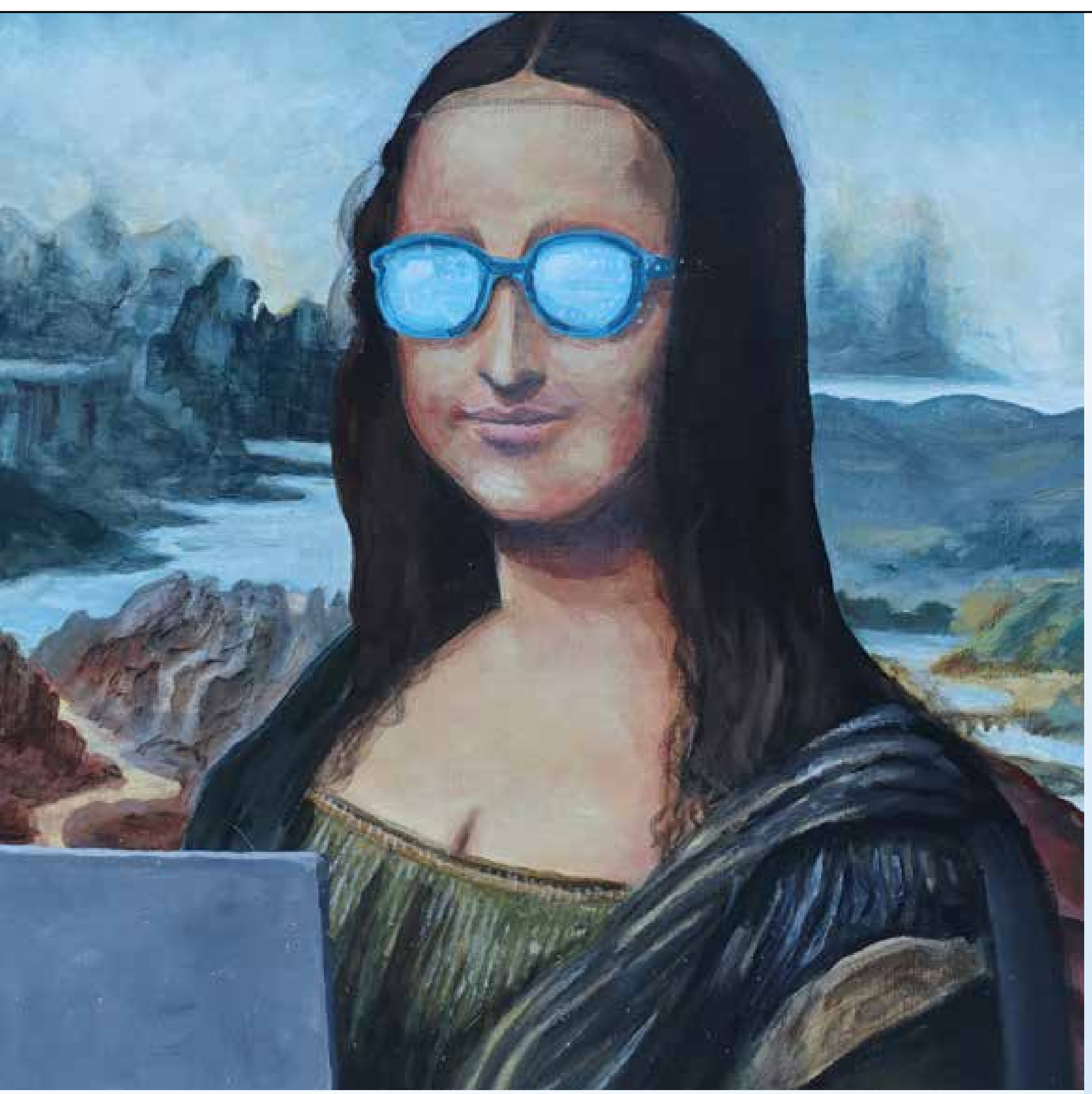

Cancer Care in 2025

Where we came from, where we are going

BY ERIC LANDER, MD

To me, as a medical oncologist, the most common question I'm asked at family gatherings and social events after getting reacquainted is, "Eric, when are we going to find the cure to cancer?" The more that I learn and practice oncology, the more challenging the question becomes to answer. Most of my family and friends perceive oncology as it was 30 years ago: intensive chemotherapy pumps attached to patients in hospital beds for two to five days with associated vomiting that lasts well beyond hospital discharge. They recall their loved ones who never felt well and were bed bound. This is a very fair perception. It was only 30 years ago that ondansetron (Zofran™) received its first FDA approval to usher the movement of patients receiving chemotherapy from hospital bedside to infusion clinic chairside.

My typical response to my family is to be expected from an eternally optimistic medical oncologist: "Well…we have found some cures and we are using less chemo than ever before, but some cancers remain really stubborn to treat."

Cancer Care in 2025 to page 12

Artificial Intelligence in Medical Practice

Something is finally working

BY RYAN MCFARLAND, MD

As early as the 1960s, when a computer able to accomplish only fairly minimal tasks took up an entire room, early users figured they would develop applications for medical practice. The Mayo clinic started working on the concept of the electronic health record (EHR). As time went on, computers became smaller and could do more. Surely we could figure out how use them to store patient records, streamline billing and save time and money. By the 1990s the internet had left the realm of academia and the military

Artificial Intelligence in Medical Practice to page 10

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COVER FEATURES

Artificial Intelligence in Medical Practice
Something is finally working
By Ryan McFarland, MD

Cancer Care in 2025
Where we came from, where we are going
by Eric Lander, MD

CAPSULES 4

INTERVIEW 8

Creating Positive Change
Sue Abderholden, MPH executive director, NAMI Minnesota

PUBLIC HEALTH 14

Forever Chemicals
What Physicians Need to Know
By Alexander Bogdan, PhD, and Mohamed Mohamed, MD

PUBLIC HEALTH 16

Closing the Gap
Strengthening HPV Vaccine Confidence
By Lauren Dybsand, MPH; Kylie Hall, MPH; Maeve Williams; and Tracie Newman, MD, MPH

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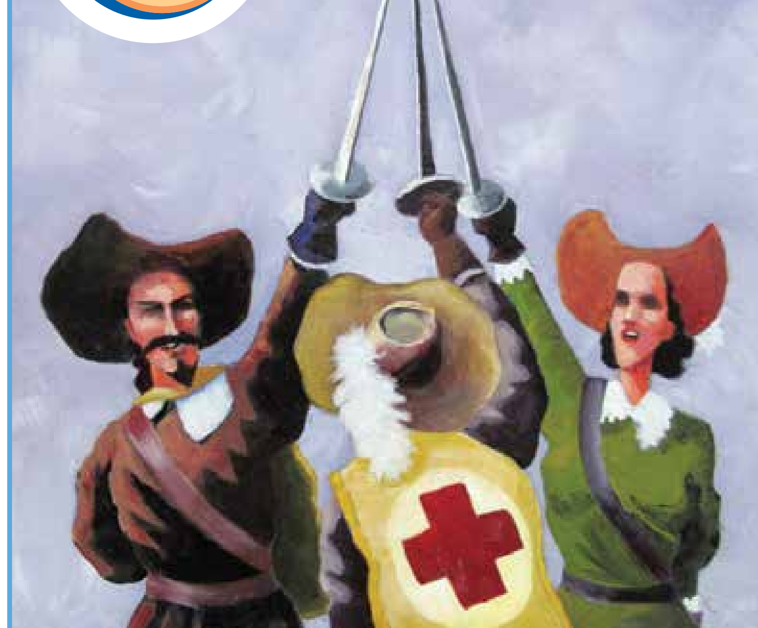
Minnesota Health Care Roundtable 61ST SESSION



DEFENDING SCIENCE

Evolving new partnerships –

Publishing this winter

BACKGROUND AND FOCUS:

It would be difficult to find a more concise definition of inmates running the asylum than the one playing out before our eyes. Science is being redefined as tool of political agenda. In the name of cost savings and efficiency, billions are slashed from research funding ultimately costing trillions. Tens of thousand of highly trained health care providers and researchers are being forced to leave the field or the country. The shortsightedness and betrayal of ethics touch every element of health care. To address these challenges, new pathways and partnerships must emerge.

OBJECTIVES:

Our panel of diverse stakeholders will discuss the carnage in terms of costs, lives lost and damage inflicted by our own government. We will explore opportunities to challenge, slow and reverse the ongoing attacks on science, medicine and education. Navigating a path back to progress and sanity will require the evolution of new partnerships between health care entities, state government, the judicial system and the public at large. We will discuss what this might look like and what an effective response to the carefully orchestrated chaos might be.

JOIN THE DISCUSSION

We invite you to participate in the conference development process. If you have questions you would like to pose to the panel or have topics you would like the panel discuss, we welcome your input.

Please email: Comments@mppub.com and put "Roundtable Question" in the subject line.

CIDRAP Launches New Public Health Information Hub

To address the accelerating rate of health care misinformation coming primarily from sources behind the recent federal funding cuts and restrictions around the dissemination of public-health related scientific research, the Center for Infectious Disease Research and Policy (CIDRAP) recently announced the launch of the CIDRAP Information Hub (CIH). CIDRAP is located within the University of Minnesota and funds to launch the new hub were provided through a generous grant from the Bentson Foundation, which since 1956 has actively supported higher education and public health.

Part of the CIDRAP mission has always focused on providing evidence-based research and agenda-free data on infectious disease threats that families, health professionals, organizations and the public can access. CIH will exponentially expand this work. “The Information Hub will serve as an online, completely free-of-charge clearinghouse of reliable news, podcasts, commentaries and authoritative updates on infectious diseases, outbreaks, vaccines, and other key public health information for the public, scientists and policymakers,” said Michael Osterholm, PhD, MPH, CIDRAP director.

“The Bentson Foundation has long supported the work of CIDRAP, believing that nonpartisan, research-based information regarding public health is a valuable asset to practitioners and the general public alike,” said Judi Dutcher, CEO of the Bentson Foundation. “We increased our financial support so people around the globe are guaranteed a reliable source of information that empowers them to make informed health care choices.” CIH will provide visitors with reliable, scientifically based strategies for infectious diseases response, with a strong focus on advancing public health. Specifically, CIH will enhance and add substantial new content to the information currently available on the CIDRAP website by including peer-reviewed updates, timely public health reports and analyses of relevant and reliable sources. CIH will also expand CIDRAP’s outreach and social media presence across different platforms to increase visibility of public health topics for the public and the scientific community.

“We thank the Bentson Foundation for making this incredible effort possible. We look forward to leveraging the expertise of a range of public health experts to provide the world with a one-stop shop of infectious disease information and advice,” said Osterholm.

HealthPartners Addresses Reduction in Hospitalizations

HealthPartners recently released updates from its new Advanced Care Primary Care (ACPC) Clinic. Located inside the Park Nicollet Specialty Center in St. Louis Park, it is designed to help patients avoid costly emergency department visits and hospital admissions though coordinating care for patients with complex needs who may be at risk of needing hospitalization. Initial feedback has been promising, showing a 60% reduction in avoidable ED visits among patients who were admitted last year.

“We believe health care should be simple, affordable and focused on helping people live their healthiest lives,” said HealthPartners CEO Andrea Walsh. “ACPC is one of the ways we’re doing that – delivering a value-based care solution where quality, affordability and experience come together to make a meaningful difference for those we serve.”

The clinic brings together a team of experts from many specialties to support the patient’s entire care journey. Each day, the care team reviews recent visits and prepares for

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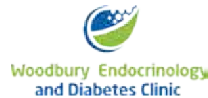

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upcoming ones. If a patient goes to the ED or is hospitalized, the team follows up quickly to understand why and provides the right next steps to support the patient. Patients are referred to the clinic by their primary care clinicians and often have existing health conditions or other factors, such as inadequate social support or food insecurity, that can lead to more serious health issues. Schedulers help patients set up appointments, and clinic-support teams resolve issues that may prevent a visit. Video visits and telephonic support also help ensure easy access to care.

Care is coordinated across settings and may include primary and specialty care, home care, pharmacy, palliative care, care management and coordination, social work and behavioral health. Enhanced care coordination includes support for transferring patients between care settings. The team also works with a patient's health plan care coordinator to ensure they receive all eligible benefits and services.

"Our collaborative team focuses care on the whole person and thinks creatively about how to meet their needs," ACPC Medical Director Dan Albright, MD, said. "Every connection is a chance to remove a barrier to care and close a gap." Access to the clinic is available through a wide range of insurance options.

AMA Addresses Latest Federal Public Health Threats

In response to statements from U.S. Health and Human Services Secretary Robert F. Kennedy Jr. that he intends to remove all 16 members of the U.S. Preventive Services Task Force (USPSTF) because they promote a too "woke" agenda, the American Medical Association (AMA) issued a statement expressing deep concern. In a recent letter to Kennedy they stated. "USPSTF plays a critical, non-partisan role in guiding physicians' efforts to prevent disease and improve the health of patients by helping to ensure access to evidence-based clinical preventive services."

USPSTF makes recommendations that dictate coverage policies for health insurers nationwide that include access without cost-sharing to services such as screenings for colon, breast, and lung cancer; screenings for anxiety and depression in children; and screenings and preventive services for cardiovascular disease. USPSTF members serve on a volunteer basis, are selected through an open, public nomination process and are nationally recognized experts in primary care, prevention and evidence-based medicine. Established in 1984, the USPSTF plays an essential role in making evidence-based recommendations for clinical prevention of disease.

Beyond the allegation that USPSTF promotes a "woke" agenda, HHS had nothing more to say of the decision to remove the members than "no final decision has been made on how USPSTF can better support the HHS mandate to Make America Healthy Again." A recent Supreme Court ruling has given Kennedy the authority to make these decisions.

The AMA letter concluded, "The most important role physicians play is improving the health of patients. Given the essential role USPSTF members play in weighing the benefits and harms of preventive services such as screenings, behavioral counseling, and preventive medications, and making evidence-based recommendations for implementation in primary care settings, we urge you to keep the previously appointed USPSTF members and continue the task force's regular meeting schedule to ensure recommendations are put forth, updated, and disseminated without delay."

Allina Announces Four Clinic Closures

In a recent statement, Allina Health announced that effective November

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1, 2025, it would be closing its clinics in Inver Grove Heights, Maplewood, downtown Minneapolis and Oakdale. The health system cited underutilized clinic space and a need to better align its resources with patient care models that continue to shift away from traditional in-person visits. "This decision balances maintaining access to care with more efficient use of space and resources," the statement said. "We are taking steps to prepare for the future, where care models driven by patient preferences will continue to evolve… and finances of nonprofit health care systems will be even more challenged." Reacting to Allina claims that fewer than 150 employees would be affected, union officials expressed alarm, having recently organized a first-ever physician picket protesting labor policies.

Allina noted, "Care team members will be provided with transition resources, and can apply for other positions that they are qualified for and interested in within Allina Health." The system further stated it will assist affected patients in transitioning their care to other locations and will provide information on provider availability, new clinic options and further updates in the coming months.

In somewhat related news, Allina Health closed its Kidney Transplant and Living Kidney Donor Program at Abbott Northwestern Hospital on June 27. An Allina spokesperson issued the following statement: "Allina Health has made the difficult decision to close the Kidney Transplant and Living Kidney Donor Program at Abbott Northwestern Hospital. This decision was made after careful consideration of our ability to fully staff the program. We will continue to care for patients who have recently had a kidney transplant, and we will continue to offer a robust variety of expert nephrology services."

It is also of note that North Memorial is closing its clinic on Nicollet Mall in Minneapolis this summer. With over 140,000 Minnesotans losing their Medicaid benefits, and great uncertainty around other health care funding sources, these kinds of responses may not be unexpected. The Allina statement addressing the clinic closings concluded, "We thank our patients who have entrusted us with their care at these locations."

St. Joseph's in Brainerd Receives 5-Star CMS Rating

The Centers for Medicare and Medicaid Services (CMS) recently released its 2025 ratings for health care facilities, and Essentia Health-St. Joseph's Medical Center in Brainerd has received the highest rating possible. For the first time ever, St. Joseph's Medical Center has earned a five-star rating, placing it in the top 10% of the more than 4,600 hospitals evaluated by CMS nationwide. The score is based on a five-star scale, with four stars signifying a better-than-average performance compared to similar health care facilities. The ratings are based on how well a hospital performs across different areas of quality, such as the patient experience, providing timely and effective care, readmission rates, mortality and safety. CMS first publicly reported data on hospital quality measures on a website called Hospital Compare, a public-private collaboration with the Hospital Quality Alliance (HQA) that began in 2002. Over the years the measurement and reporting standards have continued to evolve and improve. They currently include information on:

- Whether a health care provider gives care based on guidelines and standards of care and if the treatment gives the best results for most patients with a particular condition.
- Outcome measures designed to reflect the results of care, rather than whether or not a specific treatment or intervention was performed.

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Only data from Medicare-certified hospitals are included on Care Compare.

"Earning a five-star rating is an incredible honor that fills us with gratitude," said Todd Defreece, senior vice president of regional operations at Essentia. "This recognition reflects the outstanding talent, compassion and unwavering commitment of our providers and staff, who continually strive to deliver top-tier care to our patients in the Brainerd Lakes region. It reinforces our dedication to excellence and inspires us to keep raising the bar for the health and well-being of our community."

Stratis Health Awarded CMS 13th Scope of Work Project

Stratis Health, a member of the Superior Health Quality Alliance (Superior Health), has recently been recognized as part of the Centers for Medicare & Medicaid Services (CMS) 13th Scope of Work (SOW) award. This award affirms Superior Health and Stratis Health as trusted national leaders in health care quality improvement through their work as a Quality Innovation Network - Quality Improvement Organization (QIN-QIO). As part of this award, Superior Health will now cover 14 states and two territories, supporting health care organizations that serve Medicare beneficiaries across an expanded Great Lakes Region and a newly awarded Northeast Region. The five-year contracts run through May 27, 2030.

CMS selected Superior Health for its strong track record of delivering meaningful results — including helping avoid nearly 270,000 harms, achieving a 21% reduction in readmissions and delivering more than $1 billion in value over the past five years. Superior Health bridges the gap between CMS goals and local health care needs: delivering measurable results through person-centered, data-driven solutions. Through this new contract, Superior Health will continue providing no-cost technical assistance and leading community-driven quality improvement initiatives in hospitals, clinics and long-term care settings.

"This is a pivotal moment for our alliance," said Tania Daniels, CEO of Superior Health. "CMS's decision recognizes our proven ability to deliver results and build trusted relationships across care settings. We are honored to extend our support to even more providers and communities."

What this means for Minnesota and our region is that Stratis Health will support efforts to:

- Improve patient outcomes and reduce harm
- Strengthen care coordination and reduce readmissions.
- Advance health equity and data-driven care.
- Provide hands-on technical assistance and learning opportunities.

"Stratis Health is excited to continue and expand our longstanding service as a Medicare QIN-QIO, improving the health and care of older adults as a founding member of Superior Health Quality Alliance," said Jennifer Lundblad, president and CEO.

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Creating Positive Change

Sue Abderholden, MPH executive director, NAMI Minnesota

What are some of the biggest changes you have seen in how we approach mental health care?

When I first came to NAMI Minnesota 25 years ago, mental health treatment was not viewed as part of our health care system. There was limited coverage of treatment and services under Medicaid, Medicare and private insurance. It wasn't unusual for a person to be allowed only a limited number of therapy visits. More intensive treatment was often funded through county dollars or grants. It wasn't until the Mental Health Action Group formed and developed (and passed) recommendations that we had a list of treatment and services that would be funded under Medicaid. People no longer had to wait for county funds to become available.

There wasn't a lot of awareness of the symptoms of mental illnesses. Over the years legislation has passed to require teachers, police and others to have training and education on mental illnesses and suicide prevention. When you see someone as experiencing symptoms instead of exhibiting behaviors, the way you interact with them changes dramatically – in a positive way.

Medicaid expansion was extremely beneficial for people with mental illness because they no longer had to wait to become certified as disabled by the Social Security Administration to be eligible for Medicaid. Especially for young adults who were experiencing their first serious symptoms of a mental illness, they could more easily access the treatment and services they needed, and our mental health system was able to decrease the amount of uncompensated care. More recently Medicare finally recognized marriage and family therapists to be seen as mental health professionals so their treatment could be paid for under Medicare.

Who have been some of the people who were inspirations in your career, and why?

It's really been the people with mental illnesses and their families. It takes determination and courage when mental illnesses impact an individual and their family. I have seen people be incredibly resourceful, amazingly strong advocates, and ever clinging to hope.

> "We have not yet fully built our mental health system. The system isn't broken, it wasn't built."

One family had a son really struggling with schizophrenia. Even with treatment the symptoms never disappeared. He was in and out of hospitals. But they never gave up. And what was inspiring is that they looked at the barriers to his care not as stumbling blocks but as policies that should be changed. They testified several times before the legislature, and their elected officials knew them by name. And several of the policies were changed thanks to their sharing their story.

The people with mental illnesses who lead our support groups or share their stories through our In Our Own Voice program also inspire me. They all struggled with their mental illness at one time. And yet they take those stories and use them to help others, and to raise awareness. For people who are currently struggling, it gives them hope to see someone who struggled giving back to their community.

And then there were the Arc women, an advocacy group for people with developmental or intellectual disabilities. In the '80s these women who volunteered were incredibly knowledgeable about the legislative process and how to create change. Darlene, Betty, Bette, Sally – they all taught me so much. The best advice they gave me is that when I look ahead and see how much needs to be done, I need to look behind me and see how far we've come.

What are some of the most significant challenges involved with addressing mental health conditions?

There are really three challenges. One of the hardest challenges is when people experience anosognosia – where people don't believe they have a mental illness. It is so difficult to get people the help they need in these situations, and families struggle with how to help them.

The second challenge is that we are really just beginning to fully understand the brain and be able to see it thanks to technology. There isn't yet a blood test or imaging test to diagnose a mental illness, and it's still difficult to know which medications will work the best. I am hopeful that diagnosis and treatment will be improved in the next few years.

The third challenge is we have not yet fully built our mental health system. The system isn't broken, it wasn't built. The institutions were not a system. President Eisenhower's mental health commission laid out a framework that if it had been funded would have resulted in having a system. What's frustrating is that we know what works – intensive first episode programs, assertive community treatment, supportive housing, mobile crisis management – we just don't fund them.

What are some of the biggest societal misconceptions around mental health conditions?

One of the biggest misconceptions is that people with mental illnesses are violent. It's unfortunate that such incidents that do occur are widely broadcast in the media. Most of the research shows that it's a very small percentage. Even with mass shootings we know that there are many other complicating factors. The reason it's important to dispel this myth is that it prevents people, especially younger adults, from seeking treatment early because they are afraid of how people will think of them.

The other misconception is related to employment. Many people with mental illnesses want to

work, and evidence-based practice shows that work helps people in their recovery. The biggest problem is that few employers know what accommodations are needed in the workplace to address mental illnesses. We have seen greater interest since COVID because so many employees – especially those working in health care, have been struggling with their mental health during and after that period.

What are the best ways to change these misconceptions?

The greatest effect on changing attitudes comes from the sharing of people's stories. It can take those with mental illnesses awhile to find the right medications and treatment and gain access to those community supports, but eventually many of them do so and they live full lives in the community.

Think of all the people who have come forward – from athletes, to actors, to elected officials, to everyday people. When we hear these stories we better understand the struggle people face but we also feel hope when we see them being better.

Identifying mental illnesses early absolutely yields the best outcomes. When clinics put out information about depression or anxiety – even psychosis – patients are more likely to discuss their symptoms and ask for help. It essentially signals to them that it's OK to talk about their mental health with the physician.

It's also important to recognize that treating mental illness is not just about taking medication. It's therapy, nutrition, moving, mindfulness, learning coping skills and connecting to others. It's also about the social determinants of health — whether people have housing, and so forth.

How can the stories of individuals be best used to affect the creation of public policy around mental health conditions?

Public policies are about people and how these policies affect people's lives. People need to share their stories and help legislators understand how a bill will either help or hurt them. Over and over again throughout my career, I have seen the effectiveness of these stories. And I would add that many people testify in favor of bills that will no longer help them but will help the people coming behind them. In the 1980s mothers of teens testified in favor of special education going down to birth, as soon as a disability is identified, because they hadn't had early access. An adult living with a mental illness shared how the evidence-based employment program (IPS) helped him get and keep a job because the job supports were provided alongside the mental health supports. A teen testified how important it was to allow 16-year-olds to consent to mental health treatment, especially when their parents didn't understand mental illnesses. I could literally provide hundreds of examples – including MMA's bringing patients to testify on the difficulties people experience with prior authorization or mid-year formulary changes.

Please share some of the most outstanding success stories you have seen whether involving individuals, policy development or both.

This past session we worked on ensuring that families are not referred to child protection when their children are in an ED and are waiting for intensive services and can't come home. These families struggle with children who have very complex mental illnesses. They have difficulty finding people to provide in-home services, they are on waiting lists for residential treatment, they have county case managers. But the services the children need aren't there, and at times the parents cannot bring their children home because they can't keep

Creating Positive Change to page 26 ▶

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- Regions Hospital (St. Paul)
- Glencoe Regional Health Services (Glencoe)
- Glenfields Living with Care (Glencoe)
- Sanford Medical Center (Thief River Falls)
- St. Luke's Hospital of Duluth (Duluth)
- Madelia Health Hospital (Madelia)
- Windom Area Health (Windom, MN)

◀ **Artificial Intelligence in Medical Practice** from cover

to present even more potential benefit to health care. By 2009 EHR was a federally mandated part of health care delivery. Unfortunately, what had been envisioned as a way to save time and money grew into an industry generating much more annual revenue than the National Football League. Small independent practices could not afford to keep pace with the ever-changing and increasingly expensive mandatory technology updates. This helped drive rampant medical practice consolidation and create a new concept – physician burnout. Intense competition between EHR vendors led to the creation of systems that did not communicate with each other and hundreds of options were available. In the end, what was envisioned to save time and money ended up driving costs up exponentially and forcing physicians to work all day and then go home to complete their recordkeeping. It is difficult to see how this improved patient care, or much else for that matter, besides the bottom lines for EHR company shareholders and executives.

Despite this bleak picture, the genie was out of the bottle and there was no turning back. Amazing advances were made in clinical science and, these continue to come at rates so fast that medical practices need to hire change-management professionals as part of their IT staff. In the meantime, among the technological advances, another innovation was emerging: Artificial Intelligence (AI). What could go wrong?

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AI in health care is developing in many directions simultaneously. It is being used as a diagnostic aid, to improve and operate medical devices, to develop new pharmaceutical products based on genetics, to enable patients to seek out medical advice directly, and more. Generative AI is emerging as a term for AI that can recognize, summarize, translate, predict and generate text and other content based on knowledge gained from large datasets. Generative AI tools in health care are covering a growing, diversified range in their use and acceptance, including assistance with administrative functions involving interface with EHR, such as generating office notes, responding to documentation requests and billing matters and generating patient messages. This article focuses primarily on work done in this area of health care AI.

AI in health care is developing in many directions simultaneously.

Here at Hudson Physicians, we are ideally positioned to be in the vanguard of this new development. We are large enough, with multi-specialty practices, but small enough to retain agile decision-making processes. Also we can quickly and effectively share or collect information around how this new tool can best be developed and implemented. We participated in a program involving a dozen other health care groups around the country, and the results are now at the point of being able to be shared.

Addressing the Problems

As the capabilities of AI developed to the point of being able to offer meaningful benefit to medical practice, we looked at current problems. Thanks to documentation concerns physicians often needed to interrupt patient communication to navigate through drop-down menus or scroll through screens. No doctor wants to divert their attention to operate a keyboard during a patient visit, where making eye contact is an important part of providing care. Building relationships is essential to understanding my patients and how best treat to them; it's difficult to do that sitting behind a computer screen.

Furthermore, while some of our providers used scribes, the majority did not. In terms of documentation completion we had a handful of docs who were routinely two to six weeks behind. Putting in "pajama time," finishing documentation at home, is a widely acknowledged part of the recipe for physician burnout. As if this isn't enough, there are significant concerns related to how this documentation relates to billing. Overlooking small data entry details can create lower or delayed reimbursement or potentially lead to making data such as imaging or lab results more difficult to access in future patient visits.

According to some research, physicians spend 44.9% of their time on EHR, with 20.7% on EHR input alone. Clinician burnout is at an all-time high, and one of the reasons for that is the burden of administrative work. The overburdened health care provider is also a risk to patient safety and is one of the causes of workforce shortage in the health care industry.

In the work we did to help adapt the potential of AI to solve these concerns, we found that the other practices had very similar experiences and challenges. In order to address them meaningfully, a major hurdle involved voice activation. How could a machine recognize every voice in the practice, accurately interpret idiosyncratic verbal shorthand, and then accurately transpose the data into the EHR? It is a big challenge.

Creating the Solution

What was needed was to combine generative AI, clinical intelligence, multimodal voice- and screen-driven assistance and simplified workflows into a

single, unified solution that enables providers to give their full attention to the needs of their patients.

These data would need to integrate the EHR and combine clinical automation, conversation-based note generation and proposed clinical follow-ups directly at the point of care. AI would need to instantly access critical elements of a patient's medical history, such as the latest blood test results, simply by asking. It would need to capture comprehensive notes with the preferred templates the provider uses currently in the patient's EHR. Data generation would need to be fast (minutes not hours), and it would need to support next-step actions, such as drafting referrals and prescription orders for approval, and scheduling follow-up labs and appointments.

More than just eliminating clicks, AI can automate the entire documentation process and synchronize it back to the patient's individual medical record without copying and pasting. This automation significantly reduces manual work. To ensure oversight and control, providers must still complete the interaction by reviewing, modifying and approving the notes and next-step actions, but again this is a minutes not hours process. Physicians maintain complete oversight and control and though AI synchronizes data, it does not copy and paste it, ensuring valuable data is not overwritten.

Another important element to consider is cybersecurity. If AI takes such an increased role in documentation, how can it be protected from outside attack? Recent events in health care have exploited system vulnerabilities around the world. Recognizing this, security protocols need to be simple and easy to use, deploy and operate. Cyberattacks are an imminent and existential threat to health care. Keeping patients safe from the debilitating impacts of cyber-terrorism is now part of health care delivery. In the study in which we participated to develop clinical applications, the company we worked with provides the same military-grade security that is used to protect the most sensitive data at some of the largest and most sophisticated businesses, national defense agencies and governments around the world.

Initial Results

We began the beta testing work almost two years ago, and it has progressed to the point that the company we worked with, Oracle, has recently released a commercial product. It would not be unfair to call it a game changer. Of the 13 beta test participants, it saved on average more than four and a half minutes per patient and 20-40% in documentation time daily. One of the primary care physicians in the study called it the most important EHR technology update he was going to see in his career. It works just as well for specialists as for primary care. Our surgeon is 60. After he started using it, he said he'd never work another day without it. We have a physician who had recently retired but worked part time in our urgent care, and we got him to use it. He said, "Hmm, that's the best note that I've written in my entire career!"

The documentation is better from a billing standpoint. The order entry, the AI search capabilities and the time savings from a chart review standpoint are huge. As excited as I've been for what this has done, I might be even more excited about what's next. From an efficiency and timesaving standpoint, and even more so from a patient care standpoint, we are seeing improvements. It has

Artificial Intelligence in Medical Practice to page 30 ▶

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◂ **Cancer Care in 2025** from cover

Systemic Therapies

The truth is not far from this real response. Our surgeries to remove cancers have become robotic surgeries with fewer complications despite being employed at more advanced stages of disease. In many cases radiation tactics are now digitized and targeted to be curative in and of themselves. Medical oncologists are now discussing "systemic therapy" options with patients rather than "chemotherapy" options. Systemic therapies are any treatment (oral, intramuscular, subcutaneous, IV, and only rarely infusional) that halts cancer in its tracks. Systemic therapies range from chemotherapy to immunotherapy (enabling the immune system to engage against malignancy) to targeted therapies often in the form of pills that inhibit specific proteins or genetic aberrations to inhibit tumor survival. All of these advances have prompted improved cure rates across nearly every malignancy, but every individual's cancer treatment is personalized and managed differently with a multidisciplinary team-based approach — that's where I begin to struggle in summarizing the cure for all patients. It's the incredible work and collaboration I see within my fellow medical oncology, radiation oncology, and surgical colleague physicians at Minnesota Oncology that gives me hope for a brighter future. Since the founding of our practice in 1995, Minnesota Oncology has remained the only independent, multispecialty group that specializes in treating patients with cancer or patients at high risk of cancer across the Twin Cities.

In many cases radiation tactics are now digitized and targeted to be curative in and of themselves.

Screening Advances

One of the greatest advances in the past 30 years has been the medical community's improved cancer screening strategies. As an example, the United States Preventive Services Taskforce's (USPST) guidelines to begin colonoscopy screenings at age 45 will undoubtedly cure more patients of colon cancer by catching it when the tumor can be curatively removed. There is a lot of ongoing research into why colorectal cancer is being diagnosed in more and more people under the age of 50. Just last week, I saw a 45-year-old whose stage II colon cancer had been curatively removed after being detected by the typical screening colonoscopy. Increased awareness of these public health initiatives is essential to providing cures. It is sobering to know that only 17% of patients ages 50 to 80 with a 20 pack-year smoking history have been receiving their annual low-dose CT scans according to USPSTF guidelines. To all physicians and health care providers reading this: ensure your patients are getting their guideline-recommended mammograms, colonoscopies, and CT scans! Do not forget to ask about patients and their family histories of malignancies! Please refer your patient to our high-risk breast clinic if your patient has a strong family history, BRCA gene mutation, or history of chest wall radiation, even if they aren't 40 years old yet!

A Look into the Future

Now that I'm off my soapbox of public service announcements, let's discuss the future. Will medical oncologists be obsolete 30 years from now? Will we have the cure for all cancers? While we all certainly hope this to be the case, I fear it will not be. We have not reached the point where we can prevent all cancers from ever occurring. At their essence, most cancers arise due to acquired genetic mutations in a cell that promote its survival to divide out of control. For every cancer this precise mechanism is different. In the example of pancreatic cancer, most are driven by mutations in the KRAS gene. Let's assume simplistically that pancreatic cancer was driven only by specific mutations in the KRAS gene: How would you re-engineer or treat the body to prevent it from making errors in its ability to perfectly replicate its own DNA 100% of the time, such that KRAS never gets mutated in the first place? It's not just a matter of diet and exercise. We see people who are carnivores, herbivores, omnivores, triathletes, farmers in rural Guatemala, urbanites in New York City and everyone else get this cancer.

Pancreatic cancer was first described in 1761, well before the advent of common-place pesticides. Just as any person is capable of making a typo on the computer and miss it during proofreading, so is our genome flawed in its ability to replicate itself perfectly. We hypothesize that more young people are getting colon cancer because of increased cellular division rates (mitosis) within the colon, increasing the probability for genetic mutations in known cancer genes. Increased rates of cellular division may be driven by a Western diet, antibiotics, energy drinks, intense exercise, and other factors. However, even the ideal, healthy colon of someone who lives off of biodynamically farmed land in the Andes has to replicate itself, which leads to risk for mutations over the course of one's life. In summary, we may not have a prevention for cancer itself in 30 years.

A more likely medical reality 30 years from now is this: a world without chemotherapy with rapid development of immunotherapies and targeted

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therapies. Traditional chemotherapy will be replaced by other types of systemic therapies: biospecific antibodies that engage the immune system to target cancer cells; antibody-drug conjugates where an antibody binds to an antigen on cancer cells to deliver a chemotherapeutic payload; radioligand therapies that target specific antigens on tumor cells to deliver alpha-emitting radiation; and targeted therapies that exploit weaknesses in mutated proteins. These newer treatments are already in development. After 30 years of trying to figure out how to target KRAS, researchers have finally found a way. We will eventually be giving these new treatments before surgery to better shrink tumors and improve surgical outcomes to bring cures to patients who could have not been cured today.

> Medical oncologists are now discussing "systemic therapy" options with patients rather than "chemotherapy".

Google's DeepThink AI initiative that garnered the 2024 Nobel Prize in Chemistry was centered around computers' ability to rapidly model proteins. We will see researchers able to use this technology to model new drug chemical structures overnight — new treatments will be developed at rates we have never previously seen.

As the leader of our research program at Minnesota Oncology, I see firsthand how these innovations are not just theoretical—they're becoming reality in our clinics. We ensure that patients across the Twin Cities have access to the most promising clinical trials and cutting-edge treatments available, often before they are widely adopted. We have studies that offer new treatments after curative-intent surgeries to increase the likelihood of cure. Other studies are novel therapies that aim to prevent disease progression when other options are suboptimal or not available at all. In sum, we have over 50 studies available for our patients across disease states employing treatments such as novel immunotherapies, antibody-drug conjugates, targeted therapies and radiopharmaceuticals.

Thus, when friends and family ask me if we'll ever "cure" cancer, I tell them that the answer is already unfolding before our eyes — there will be no single magic bullet, but a cascade of innovations. We are moving away from dragging patients through long chemotherapy infusions to offering precise, immune-engaging and targeted treatments that speak a tumor's own language. We will catch cancers earlier through AI-assisted radiology cancer detection programs and primary care notifications to order their screening testing. AI-driven protein modeling will eventually accelerate drug development at a pace we once thought impossible. Ultimately, conquering cancer will remain a multidisciplinary team effort — physicians, public health champions, researchers and patients all advocating together — so that 30 years from now, "finding the cure" will feel less like a distant dream and more like a reality we've built, one patient at a time.

Eric Lander, MD, is the site research leader at Minnesota Oncology, where he coordinates clinical trials to bring the newest treatment options to patients.

He is a member of the American Society of Clinical Oncology and the American Society of Hematology.

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Forever Chemicals

What Physicians Need to Know

BY ALEXANDER BOGDAN, PhD, AND MOHAMED MOHAMED, MD

Forever chemicals are showing up in more than just the environment – they're showing up in your patients. Per — and polyfluoroalkyl substances (PFAS), used for decades in products from firefighting foam to nonstick cookware, are linked to a growing list of health concerns. As our understanding of PFAS grows, physicians are stepping into a vital role: helping patients make sense of emerging science, navigate uncertainties and take steps to reduce possible exposure.

Understanding PFAS

PFAS are a large family of man-made chemicals invented in the 1940s. Minnesota is one of 18 states that define PFAS as organic chemicals having at least one fully fluorinated carbon atom. There are only 19 states that have, or currently plan to have, a formal definition of PFAS.

The carbon-fluorine bond is one of the strongest known in chemistry, which gives PFAS useful properties, like resistance to water, oil, stains, heat and corrosion. Because of these properties, PFAS have been widely used in many products and industries. These include fabric and upholstery treatments, firefighting gear, nonstick cookware, medical devices, cosmetics and other everyday consumer products. It's also used in many industrial and manufacturing processes.

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The PFAS family includes thousands of different chemicals. Many of the most widely used PFAS are known for their persistence in the environment and building up in people's bodies. Unlike most chemicals that build up in the body, PFAS are water soluble because of their unique chemical structure. The combination of being water soluble and lasting for a long time in the environment can lead to wide-spread contamination.

Two well-known examples — perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS) — can stay in the human body for about three years. That's why reducing exposure to PFAS is so important. It's a balance of how quickly the body can get rid of these chemicals and how frequently new environmental exposures are introduced.

A Problem Revealed

In 2002, 3M notified the Minnesota Pollution Control Agency (MPCA) and the Minnesota Department of Health (MDH) that groundwater at their Cottage Grove campus was contaminated with this group of chemicals the company had been manufacturing for nearly half a century.

Further investigation showed the contamination wasn't limited to the 3M site. It had spread across most of the groundwater (aquifers) and much of the surface water (lakes and rivers) of the eastern Twin Cities metro area, including the Mississippi River. As a result, the drinking water of hundreds of thousands of Minnesotans, both through public water systems and through private wells, has been affected.

Historically, drinking water was the biggest concern for PFAS exposure. Today in Minnesota, municipal water systems generally have improved monitoring and treatment, so consumer products are now the larger concern. Well water can still pose a risk, but there is currently no broad recommendation to test all wells.

Since 2008, MDH has tracked PFAS levels in the blood of East Metro residents who were exposed through drinking water before filtration systems were installed. Testing in 2008, 2010, and 2014 shows that PFAS levels have gone down, demonstrating that efforts to reduce PFAS in drinking water are working.

Protective Legislation

The Minnesota Legislature took steps to address the risks of PFAS exposure, enacting Amara's Law in 2023, named for Amara Strande of Cottage Grove. Amara, who died at age 20 while battling a rare form of cancer, testified at the state capitol about living amid PFAS contamination. Although it is extremely difficult to tie any single health condition to a specific exposure, Amara and her family's advocacy galvanized bipartisan support for one of the nation's most stringent bans on PFAS. The first phase of the law took effect on Jan. 1, 2025, eliminating PFAS in nearly all products in 11 different categories. By 2032, Amara's Law will end all nonessential use of PFAS in Minnesota.

Domestic production of some types of PFAS ended over 20 years ago, and some companies have pledged to stop manufacturing PFAS by the end of 2025. Because of PFAS that already exist in the supply chain and the persistence of PFAS in the environment, however, human exposure will likely continue for the foreseeable future.

What Physicians Need to Know About PFAS to page 20 ▸

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Closing the Gap

Strengthening HPV Vaccine Confidence

BY LAUREN DYBSAND, MPH; KYLIE HALL, MPH; MAEVE WILLIAMS; AND TRACIE NEWMAN, MD, MPH

Vaccines remain one of the greatest public health achievements of our time. Although most Americans support routine immunizations, the rise of falsehoods, politicization and distrust has made vaccine conversations increasingly difficult. Today's health care providers are navigating more questions, more skepticism and more uncertainty than ever before.

In the wake of the COVID-19 pandemic, progress toward increasing adolescents vaccinated against HPV in the U.S. has slowed. Despite nearly two decades of robust data demonstrating that HPV vaccines are both safe and highly effective, HPV vaccination rates remain suboptimal, highlighting an ongoing challenge to reach national vaccination goals.

In Minnesota, only 55% of 13-year-olds have initiated the HPV vaccine series, and just 29% have completed it. According to the Minnesota Department of Health (MDH), these low rates stand in stark contrast to higher uptake of school-required adolescent vaccines in the same cohort, such as Tdap (71.3%) and MenACWY (69.5%). The persistent gap in HPV vaccination points to missed opportunities for providers to recommend the HPV vaccine with the same consistency, confidence and urgency as they do for other adolescent immunizations.

Even when parents are open to vaccination, they often do not receive a clear and confident recommendation. A 2016 study found that many parents never received any recommendation for HPV vaccination, and when they did, it was often hesitant, unclear or delivered too late. Parents who received a high-quality recommendation were 10 times more likely to vaccinate their child. This underscores the pivotal role providers play in HPV vaccination efforts and the barriers they may face in fulfilling it.

Challenges for Providers

Clinicians are busy, stretched and often asked to do more with less. Despite these challenges, health care providers are consistently shown to be the most trusted source of vaccine information for most Americans. This has held true before, during and after the COVID-19 pandemic. Yet many providers remain hesitant to initiate vaccine conversations — often due to fear of parental resistance, time constraints or underestimating how supportive parents actually are. Public polling, however, tells a different story: the vast majority of U.S. adults (91%) believe childhood vaccines are safe, and four in five support school vaccine requirements.

So, what's really getting in the way? Often it comes down to confidence. Even experienced clinicians can feel uncertain about how to begin the conversation, what words to use or how to respond when a parent expresses hesitation.

One strategy that shows promise in addressing vaccine hesitancy is motivational interviewing (MI). MI is a patient-centered communication approach that has been increasingly explored in vaccine conversations, particularly around the HPV vaccine. Studies suggest that MI can help increase vaccine uptake by addressing hesitancy in a nonconfrontational, empathetic way. Rather than telling patients what to do, MI invites them to explore their own motivations and concerns, helping them arrive at informed, values-driven decisions. It's a skill set that can be especially powerful for busy clinicians looking for brief, effective ways to engage.

A Peer-to-Peer Approach

In partnership with MDH, the North Dakota State University Center for Immunization Research and Education (CIRE) launched a new initiative in Minnesota from January through June 2025. The goal was to deliver short, practical and peer-led education sessions to providers, focused specifically on HPV vaccine conversations.

These sessions were presented in 25 clinics across the state, primarily those with lower HPV vaccination rates. More than 397 health care professionals participated, with sessions typically held over the lunch hour to reduce disruption to clinical flow.

A key component of the project was the use of local physician champions, also referred to as "VaxChamps," to deliver educational sessions at local clinics. These trusted Minnesota clinicians, selected for their peer credibility, geographic reach, communication skills and passion for vaccination, received training in both content and delivery. The standardized presentation included information on HPV vaccine safety and efficacy, Minnesota-specific

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coverage rates and cancer burden, and communication strategies such as presumptive language, sandwiching and motivational interviewing. Case studies were also used to demonstrate real-world application of these tools. See the graphic for an overview of the key educational components related to communication that were included in each presentation.

The structure for visits was simple and included a 50-minute presentation followed by time for questions and answers and peer discussion. To improve attendance, the project offered a free meal, free continuing education credits, a Maintenance of Certification (MOC) point for the American Board of Pediatrics and a $25 stipend per participant.

> Providers need support to engage in meaningful, effective vaccine conversations.

Confidence Makes a Difference

One of the most compelling findings from the pre- and post-training surveys was the dramatic improvement in provider confidence after just a single session. Before the training, only 25% of participants (54 out of 212) felt moderately or very confident recommending the HPV vaccine to 9- and 10-year-olds. Afterward, that number tripled to 75% (210 out of 280). Confidence in talking to vaccine-hesitant parents saw an even greater shift, from just 11% (22 out of 212) to 80% (223 out of 280).

These are not small changes. For a busy provider, increased confidence means being more likely to start the conversation, deliver a strong, clear recommendation and stay engaged when questions or hesitations arise. It means fewer missed opportunities, more meaningful interactions and ultimately more patients protected against HPV-related cancers. When patients hear the same confident message from multiple staff members across their care team, that consistency builds trust — one of the most powerful drivers of vaccine acceptance.

This aligns with previous research showing that strong, consistent messaging from confident providers is one of the most effective strategies for increasing vaccination rates. In past projects, some clinicians expressed dread at seeing vaccine-hesitant families on their schedules, anticipating conversations that were not only time-consuming but also emotionally taxing. In some cases, these encounters were avoided altogether. Equipping providers with clear, practical tools can shift this dynamic — helping them feel more prepared, more confident and more willing to engage. Building provider confidence enhances communication, fosters trust with families and ultimately can lead to higher vaccine uptake.

Participant feedback reinforced these findings. Nine out of 10 respondents in the post-training survey (244 out of 277) believed their strong vaccine recommendations would influence a patient's decision to vaccinate. Most also reported they intended to use what they learned in their daily practice (255 out of 280) and would recommend the training to others (260 out of 279).

Many participants shared how the training helped them reframe their approach to HPV vaccine conversations, shifting from hesitant to proactive, from unsure to confident. Several said they planned to immediately apply the

Closing the Gap to page 18 ▶

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◂ **Closing the Gap** from page 17

communication strategies they learned. As one provider put it, "This was a really great training session and very relevant to the work we do. Hoping we see an increase in our HPV vaccine numbers."

The Power of the Whole Team

One key takeaway from the project was recognizing that vaccine conversations shouldn't fall solely on providers. Although the original goal was to educate providers, over half of the attendees turned out to be nurses. Opening the sessions to all clinic staff led to stronger engagement and a more unified approach to vaccine communication. Everyone in the clinic, from providers, nurses, medical assistants, front desk staff to schedulers, plays a role in shaping vaccine acceptance. When all team members deliver the same message, such as, "Your child is due for three vaccines today, including protection from whooping cough, HPV cancers and meningitis," families hear it as routine care — not a topic up for debate. This team-based approach ensures patients receive consistent, confident messaging about HPV vaccination throughout their entire visit.

Each staff member gained not only foundational knowledge about HPV and the vaccine, but also practical communication strategies to use in their specific roles. The inclusive format also gave staff at each clinic the opportunity to ask questions, raise concerns and learn directly from trusted local physicians, the VaxChamps, who brought both credibility and real-world experience to the conversation. This dynamic helped address providers' questions, allowed for open dialogue and built team-wide confidence. As a result, clinics left the training better equipped to coordinate care, reinforce strong vaccine messaging at every touchpoint and foster a culture that supports vaccine acceptance.

The impact extended beyond the clinic staff who received the training. The physician VaxChamps were also deeply engaged and energized by the experience. All reported feeling confident in delivering the content, and many expressed interest in continuing vaccine-related education and outreach in partnership with CIRE. Their credibility, relatability and passion were critical to the project's success, serving not only as educators but as champions of a team-based approach to vaccine confidence.

Real-World Limitations

Like any project, this initiative encountered several challenges. Recruiting clinics was occasionally difficult, with some clinics being hard to reach and scheduling visits proving complex due to the need to coordinate clinic availability, VaxChamp schedules and project travel. One of the greatest limitations was measuring the long-term impact of educational efforts. Although a four-week follow-up survey was developed, response rates have been low, largely because many clinic visits occurred during the final weeks of the project.

Still, the short-term impact was clear — higher confidence, positive feedback and strong interest in applying the tools. Even a single, well-structured session, when delivered by a trusted peer, can have a meaningful effect on provider behavior. Among those who completed the four-week follow-up survey, 82% (9 out of 11 respondents) said they often or sometimes use the communication techniques taught during the training in their clinical practice. Additionally, 73% (8 out of 11) reported feeling more confident when discussing vaccination with hesitant patients.

Final Thoughts

Improving vaccination rates isn't about a single message or one-time training — it's about building provider confidence, reinforcing consistent practices and supporting follow-through over time. Minnesota's health care providers are among the most trusted voices in their communities. With the right tools and training, they can reduce missed opportunities, strengthen vaccine conversations and ultimately help prevent HPV-related cancers in future generations.

Every patient encounter is a chance to make a difference. Now more than ever, providers need support to engage in meaningful, effective vaccine conversations — grounded in empathy, clarity and compassion. Provider confidence is key. Projects like this not only deliver practical tools and peer-tested strategies but also help build the confidence clinicians need to navigate these often complex conversations. And the demand is clear: many participants asked for additional training on a range of vaccine topics, reinforcing the ongoing need for education and support.

By continuing to invest in evidence-based, provider-focused education, we can turn trusted relationships into action — protecting the health of Minnesotans for years to come.

Lauren Dybsand, MPH, is the assistant director.

Kylie Hall, MPH is the operations director.

Tracie Newman, MD, MPH, is the medical director.

Maeve Williams is the vaccine education project manager.

All hold these positions with the North Dakota State University Center for Immunization Research and Education.

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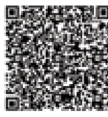

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◀ **What Physicians Need to Know About PFAS** from page 14

PFAS Can Affect Human Health

In the past 20 years, we've learned a lot about the health risks of PFAS exposure. More important, this is not just a Minnesota or an East Metro problem. Studies show that almost everyone on the planet has come into contact with PFAS — from food and consumer products to household dust and drinking water. For most Minnesotans, the majority of PFAS exposure comes from non-drinking water sources.

We also know that PFAS can reach babies throughout pregnancy and from breastfeeding, because many of these chemicals can easily cross the placenta and enter breastmilk.

PFAS can enter the body through swallowing (eating or drinking) and breathing. Once in the body, PFAS mostly attach to proteins in the blood, especially to albumin, and to a lesser extent tissue proteins.

Most PFAS are not broken down by the body. In fact, when some PFAS are metabolized they simply turn into another type of PFAS. The body gets rid of PFAS mainly through urine, but the kidneys can also reabsorb some PFAS, which makes them stay in the body longer. Depending on the type, PFAS can stay in the body for anywhere from about a week to more than eight years. For some people, especially those who menstruate, are pregnant or are breastfeeding, PFAS may leave the body more quickly. There is also some evidence that dialysis can help reduce PFAS levels in the body.

Growing Concerns

Concerns about PFAS began in the 1970s when the chemicals were first found in the blood of workers who handled them. In the 1990s, researchers began studying the health effects of PFAS in lab animals like rats and mice. By 1998, 3M provided evidence to the Environmental Protection Agency that PFAS were also found in the blood of people who were not exposed at work, likely because of widespread use in consumer products and industries.

Research from both lab and human studies shows that PFAS may cause health problems even when there are very low levels in the blood — lower than many other harmful chemicals. Recently, the National Academies of Sciences, Engineering and Medicine, or NASEM, (Guidance on PFAS Exposure, Testing, and Clinical Follow-Up; 2022) and the Agency for Toxic Substances and Disease Registry, or ATSDR, (PFAS Information for Clinicians; 2024) released information for clinicians on PFAS summarizing the health effect associations seen in the epidemiological data.

Both organizations found evidence of an association with:

- Increases in cholesterol levels
- Small decrease in birth weight
- Lower antibody response to some vaccines in children
- Renal cell carcinoma

ATSDR found evidence of an association with, and NASEM found limited/suggestive evidence for:

- Testicular cancer
- Pregnancy-induced hypertension or preeclampsia
- Changes in liver enzymes

ATSDR found no consistent evidence of an association, and NASEM found limited/suggestive evidence for:

- Thyroid disease and dysfunction
- Breast cancer
- Ulcerative colitis

Some of these associations were found only with specific PFAS. For example, kidney and testicular cancer were associated only with PFOA.

Talking to Your Patients

It's pivotal to convey what is and is not possible with the knowledge we have today. It's also important to approach a patient's concerns with compassion and empathy. When talking with a patient when there's uncertainty here are some thoughts to keep in mind:

- Focus on their emotional needs and actively listen.
- Use clear, simple language; validate their feelings; and offer reassurance where you can.
- Emphasize your commitment to their care and support.
- Let them know that Minnesota is actively working to reduce PFAS exposures.

There are no FDA-approved treatments to remove PFAS from the body. While we cannot erase past exposure, patients can take meaningful steps to reduce future exposure and improve their overall health.

Reassure your patients that PFAS likely contribute only a small amount to overall health risks, except in cases where people have a high level of exposure over a long period of time. This additive effect can be similar to other uncertain environmental exposures such as air pollution, microplastics or other industrial chemicals.

What Physicians Need to Know About PFAS to page 22 ▶

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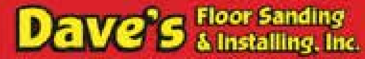

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◀ **What Physicians Need to Know About PFAS** from page 20

Clinicians Have a Critical Role

As a trusted source of health information, you play a key role in helping patients understand their risk and take steps toward safer living. Some thoughts to keep on mind include:

- PFAS are everywhere, but exposures vary.
- Exposure reduction is the best available intervention.
- You don't need to have all the answers — point patients to credible resources and support their broader health goals.

While PFAS are a health concern, people can usually do more for their health by focusing on known risks and keeping up with regular checkups and preventive screenings with their doctor.

Most PFAS are not broken down by the body.

Blood Testing for PFAS

There are blood tests that can tell us about the amount of PFAS in a patient's blood. The results, however, have some important limitations. PFAS testing is not a routine clinical test, meaning insurance may not cover the cost.

Blood testing shows the amount of PFAS in your patient's blood at the time of the test. It does not show how levels have changed over time, how your patient was exposed or what their current exposure is. Most labs test only for a small number of the thousands of different types of these chemicals.

At this time, PFAS blood testing cannot diagnose or predict illness or disease. Many health issues associated with PFAS, such as increased cholesterol and decreased thyroid hormone levels, are common. These health issues can be caused by many factors, and there is currently no way to know or predict if PFAS exposure has or will cause a health problem.

Reducing Exposure

The best advice a physician can provide is simple, clear guidance on what their patients can do to minimize their exposure to PFAS. There are many labels and certifications for products made without PFAS, such as "PFAS-free," "PFOA-free," "PFOS-free," or "fluorine-free." These labels, however, may still allow small amounts of PFAS, and not all products are labeled. Products of this type include:

- Food packaging (microwave popcorn bags, fast food wrappers, pizza boxes)
- Nonstick cookware (use stainless steel or cast iron instead)
- Stain- and water-resistant clothing, carpets and upholstery
- Some personal care products (shampoo, dental floss, cosmetics)
- Some cleaning products, paints and sealants.

Also, PFAS can accumulate in fish. Direct patients to the Minnesota Department of Health's Fish Consumption Guidance, especially for local waterbodies.

What Physicians Need to Know About PFAS to page 24 ▶

Visit www.roundtablerx.org to learn more.

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Great design brings us together, great healthcare keeps us together — advancing individualized therapy programs that reach out to rural communities.

What Physicians Need to Know About PFAS from page 22

Know Your Water

The Minnesota Department of Health and the Minnesota Pollution Control Agency have online resources that monitor public water systems and track known sources of PFAS contamination. Patients on private wells may want to test if they live near a known contamination site. These resources include:

- MPCA Minnesota Groundwater Contamination Atlas
- MPCA What's in My Neighborhood
- MDH Interactive Dashboard for PFAS Testing in Drinking Water
- MDH PFAS and Private Wells

Ongoing Work

In the East Metro, public health action is still underway. Many cities have constructed large water treatment facilities to remove PFAS from drinking water, and biomonitoring studies show that PFAS levels in people's blood have gone down. Many private well owners in areas affected by the PFAS plume have received in-home granular activated carbon filter systems to reduce their exposure. This work continues as we learn more about how far the PFAS contamination has spread and how these chemicals affect health.

One thing is now clear. PFAS exposure is a potential health risk for everyone, not just for those who live near manufacturing and waste sites. For most people outside highly contaminated areas, drinking water isn't the main source of exposure. PFAS are found in many everyday products, which means nearly everyone has been exposed in some way. Fortunately for Minnesotans, Amara's Law is a great step toward reducing everyone's exposure.

This article's purpose is to give clinicians a foundation for understanding PFAS and tools to help guide patient conversations. While reducing exposure is important, the most helpful message clinicians can share is to encourage healthy habits. Many of the health issues linked with PFAS, such as high cholesterol, liver enzyme changes, pregnancy complications such as preeclampsia, and various types of cancer, are also associated with lifestyle factors, genetics and other environmental exposures. For example, obesity is a major risk factor for several of these same conditions.

Whether answering patient questions, interpreting uncertain risks or guiding people through potential exposure concerns, physicians play a central role in helping reduce risk from these persistent environmental concerns.

Learn more online about PFAS at the Minnesota Department of Health Per- and Polyfluoroalkyl Substances (PFAS) website.

Alexander Bogdan, PhD, is an epidemiologist and principal toxicologist in the Environmental Surveillance and Assessment section of the Minnesota Department of Health.

Mohamed Mohamed, MD studies occupational and environmental health. He is collaborating with the Minnesota Department of Health on PFAS exposure and communication strategies for physicians.

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Creating Positive Change from page 9

the child or other members of the family safe. In these situations, the parent understandably states that they cannot bring the child home.

Prior to this session, these parents would be referred to child protection for neglect. But the reality is that the system was neglecting the child, not the parent. Being referred to child protection can affect a parent's employment and the other children in the home. A child protection worker doesn't have a magic wand, they can't magically make the necessary services appear.

Two very brave parents came forward and testified at the capitol. It had a huge impact, and the bill passed.

What are some of the most dramatic recent advances in services and treatment for people with mental health conditions?

I think the biggest one for me is the development of the First Episode of Psychosis programs. In the past, maybe a young person was hospitalized and received some medications. But it wasn't intensive, despite the fact that schizophrenia can be one of the most disabling conditions in the world. But FEP programs work to identify someone early (typically young people wait over a year to seek help) and then to provide intensive and coordinated care. I've met so many young people leaving these programs who are doing well. The hardest part of all of this is that despite its success, it's not fully funded, and so there are waiting lists and there is only a handful of programs, largely in the metro area. A percentage

Mental health parity is still a dream and not areality.

of the federal mental health block grant funds FEP programs, and we have been able to successfully advocate for state grant funding as well. Some of the funding from legalizing cannabis can also go to these programs. The Department of Human Services is supposed to be looking at how Medicaid can fund FEP, and last session we asked that it be mandated under private insurance.

How can the role of community help advance mental health care?

Many people with serious mental illnesses experience loneliness. Former U.S. Surgeon General Dr. Vivek Murthy declared loneliness a public health crisis. Loneliness affects people's health (diabetes, heart attacks, stroke) and can make it more difficult to follow a treatment plan. Health and mental health professionals rarely ask people about their social connections. Families are often the safety net for people with more serious mental illnesses and yet HIPAA is used as a shield against their involvement. Many professionals think about the social determinants of health (housing, employment, etc.) but few think about how we address a person's loneliness.

Programs such as community support programs, clubhouses and drop-in centers provide opportunities for people with mental illnesses to connect and engage. Studies on clubhouses have shown that they promote employment, reduce hospitalization(s), and improve people's quality of life. All counties should have one, but they don't. Until very recently even Ramsey County did not have one.

NAMI Minnesota also runs free peer-led support groups so people know they are not alone on

Creating Positive Change to page 28

from the very beginning

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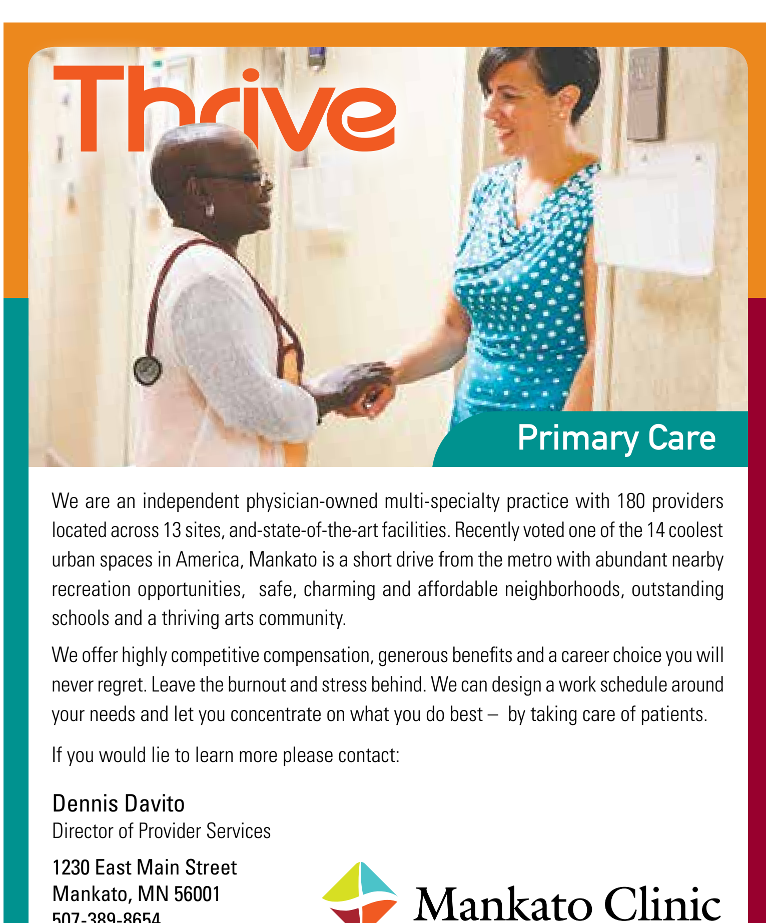

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Creating Positive Change from page 26

this journey. These are in person and virtual, and there are specific groups for LGBTQ2S+ and for people from BIPOC communities.

Many people may not realize the extent of the unconscionable funding cuts the Trump administration is making to mental health care or the outcomes these cuts are sure to create. What can you share about this?

The changes to Medicaid – such as work/volunteer requirements and six-month renewal checks – will largely hurt those young adults experiencing their first serious symptoms of a mental illness. They are not certified as disabled and yet they cannot work for the time being. People don't "live off" Medicaid – they are insured under Medicaid. The way money is saved under the changes to Medicaid is through increasing the number of uninsured people. The red tape for the work requirements and six-month renewals will result in people losing their health insurance. We are very concerned that it will lead to an increase in uninsured people, which will lead to greater use of the ED for care, which will lead to greater uncompensated care, which could lead to hospital closures.

We've seen the cuts to important agencies such as NIMH, SAMHSA, the Departmetn of Education, CDC – all which have helped support children and adults with mental illnesses. The push against DEI has hurt efforts to better understand how different populations respond to medicines, treatments and more.

> "People don't "live off" Medicaid – they are insured under Medicaid."

For example, there is high suicide rate among LGBTQ2S+ teens. And yet the option under the emergency number 988 for a line just for that community was eliminated.

What can be done to spread awareness of the issues around mental health care and assure that everyone who needs this kind of care is able to receive it?

Mental health parity is still a dream and not a reality. Since COVID we have seen a real increase in the number of employers concerned about their employees' mental health. They are instituting training, quiet rooms, accommodations and more. When employers start really looking at their health plan's mental health benefits and start demanding parity is when we will see real movement.

Employers need to care about their employees' mental health. According to the APA Center for Workplace Mental Health, 42% of surveyed working adults reported experiencing burnout ("a state of emotional, mental, and often physical exhaustion brought on by prolonged or repeated stress"), and 48% said that they "always" or "sometimes" struggle to get away from their work at the end of the day. Another survey found that 58% have considered quitting their jobs as a result of their mental health.

NAMI Minnesota has been providing presentations and classes to employers to help them understand the benefits of talking about mental health in the workplace and reducing negative attitudes.

Sue Abderholden, MPH, is the executive director of the National Alliance on Mental Illness (NAMI) Minnesota. After leading the organization for 25 years she has recently announced her retirement.

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- **Nephrologist**

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Current opportunities include:

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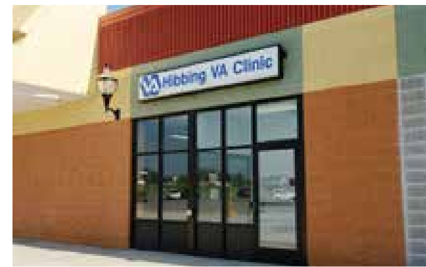

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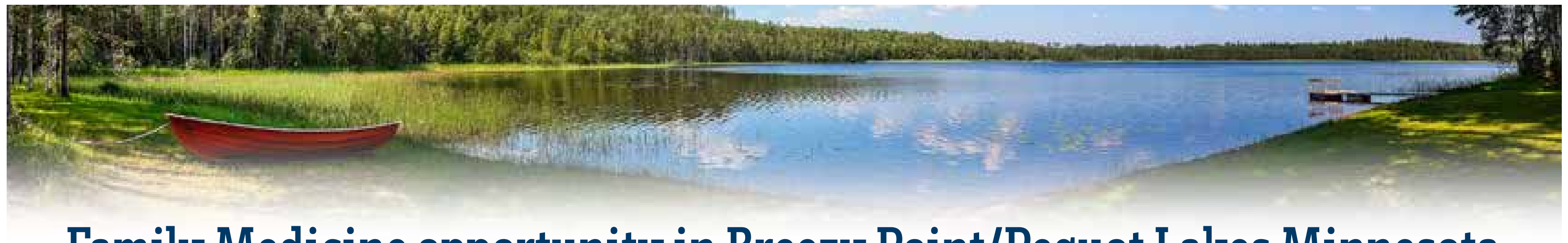

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◂ **Artificial Intelligence in Medical Practice** from page 11

immediately reduced a lot of physician burnout and will, it is hoped, bring the joy back to the practice of medicine and health care.

Looking Ahead

Of all the many things I have seen first-hand in my career that claimed they would save time and money, and related benefits, this is the first thing that really works. Although it is promising, it is in the early stages. Now is when it is most important to learn from mistakes made in other areas of significant advancement in health care delivery. Many advances have promised to make health care delivery more efficient and expand capacity, but they didn't really turn out that way. For example, everyone could agree the concept of EHR was very positive. The AMA has noted that a fundamental mistake in EHR development was a lack of physician-directed presence during the design-development-deployment cycle. Perhaps a physician worked with businesses, racing to bring a product to market, but the emphasis was more on sales and profits than on the development of a meaningful solution. More time went into building proprietary systems that could not communicate with other systems and required ongoing purchase of enhanced technology rather than into actually improving patient care. This created huge problems and is why we are working directly with other practices nationwide to assure it does not happen again.

Managed care was another example of something seemingly well intended that turned into a long and enduring cascade of disaster. A relatively small number of individuals have seen excessive financial benefit from what essentially put middlemen with no medical training between physicians and patients and created such questionable things, among many others, as prior authorizations and pharmacy benefit management. When the Health Maintenance Act of 1973 began to reshape health care, the concept of cost transparency was not a driving force. It was clear some kind of regulations and governance would be required, but physicians did not guide the industry as it evolved. This must not happen as AI in health care evolves.

Regulation

Creating regulation around something as innovative and unprecedented as AI presents many challenges. There are already regulations and guidelines from several sources. The industry is so new and moving forward so quickly, however, that these are basically works in progress, and like everything else in legislative regulations, are de facto battlegrounds for partisan politics. In the Biden era, the U.S. Department of Health and Human Services Office of Civil Rights issued a rule concerning a nondiscrimination section of the Affordable Care Act that could impose penalties on physicians if they rely on algorithm-enabled tools that result in discriminatory harms. The Federation of State Medical Boards issued a set of principles declaring physicians to be liable for harm caused by algorithm-enabled tools, though they do not have power to create law. The AMA believes that such accountability should rest with those in the best position to know the potential risks of the AI system and to mitigate potential harm, such as developers or those mandating physician use of the AI tool. They hold that physicians should not be held liable when information about the quality or safety of the AI system is unknown or withheld.

The Biden administration issued several policies around AI in health care. On July 23, 2025, however, the Trump administration issued Winning the Race: America's AI Action Plan. This plan includes 90 policy recommendations that will shape future AI guidance and policies affecting a range of entities and industry sectors, including health care and entities involved in clinical research.

Beyond useful guidance such as that the U.S. must achieve global dominance in AI, it builds on Trump's executive order on Unleashing Prosperity through Deregulation. This includes work with federal agencies to identify, revise or repeal regulations and guidance that it deems may unnecessarily hinder AI development or deployment. It recommends AI-related discretionary funding but to "limit funding if the state's AI regulatory regimes may hinder the effectiveness of that funding," essentially reducing federal support for states that have AI regulations that contravene the Trump administration's position. On the same day that the White House issued the plan, Trump signed another executive order titled Preventing Woke AI in the Federal Government to prevent AI models that incorporate "ideological biases or social agendas," including DEI.

Underscoring the difficulty of creating meaningful AI regulations is the lack of guidance or definitions of the terminology used in the executive orders. This will make health care-related AI use and compliance difficult. At a time when guidelines and regulations are being developed that will further reshape health care delivery it is important for physicians to be involved with that process.

Ryan McFarland, MD, is a family medicine physician who practices obstetrics at Hudson Physicians. He is part of a nationwide team of physicians who have worked extensively with Oracle to help develop their AI health care solutions.

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