



Histotripsy

New Game-Changing Technology

BY ASHWIN S. KAMATH, MBBS

Hepatocentrism is the widely held belief among many ancient civilizations that the liver is the center of the human being and from it sprang life, the soul, emotions and intelligence. This belief persisted into the Middle Ages and was frequently referenced in art and literature.

Although modern science suggests this may not specifically be the case, the liver is vital to survival. It is the largest organ inside the body and has the unique ability to regenerate up to 70% of lost or damaged tissue in as quickly as six weeks. The first successful liver transplant occurred in 1967. In 2025, more than 12,300 liver transplants were performed in the United States. Today, liver cancer accounts for almost 5% of all cancer deaths. It is the sixth most common cancer worldwide, and its incidence is growing. Globally, more than 800,000 deaths annually are attributed to liver cancer. Against this backdrop, ultrasound scientists at the biomedical

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Female Urinary Incontinence

A difficult discussion

BY SHRAVYA KOVELA, PT, DPT, OCS

Stress urinary incontinence (SUI) is one of the most common conditions family physicians will never hear about, not because their patients don't have it, but because most won't bring it up unless asked directly. Research suggests that 62% of adult women experience urinary incontinence (UI), compared to 15% of men, yet only about a third ever discuss their symptoms with a physician. Most who stay silent don't do so out of ignorance about the condition. They simply decided, on their own, that it isn't bad enough to mention, or that nothing could be done about it.

This gap between how many women have UI and how many actually report it during a clinic visit is significant. Family medicine and primary care have a real opportunity to improve patient health by addressing this topic. Women who do eventually raise incontinence with a physician are most likely to bring it up in primary care, during an annual visit. No other specialty is positioned to regularly screen for UI. Women who do not bring up their UI, if screening doesn't happen in primary care, will go without diagnosis and without treatment.

Hiding in Plain Sight

Urinary incontinence is the involuntary loss of urine. The most common diagnostic categories are stress urinary incontinence (SUI), urge urinary incontinence (UUI), and mixed urinary incontinence (MUI).

SUI is the involuntary loss of urine that occurs with increased intra-abdominal pressure — coughing, sneezing, laughing, lifting, or exercise. A common cause is weakened or poorly coordinated

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COVER FEATURES

Histotripsy

New Game-Changing Technology

By Ashwin S. Kamath, MBBS

A new science, histopathy, utilizes ultrasound to vaporize liver tumors via bloodless surgery. Recently FDA approved, it has gained instant global acclaim.

Female Urinary Incontinence

A difficult discussion

By Shravya Kovel, PT, DPT, OCS

62% of women experience UI but most do not seek medical treatment. Flyte, a new FDA approved small at home medical device from Pelvital, delivers transvaginal mechanotherapy and marked improvements in 2 weeks.

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Financial Wellness for Health Care Professionals

Joel Swanson is the president and CEO of Associated Healthcare Credit Union

A look unique financial challenges faced by health care workers and specialized solutions. Considerations of financial health as part of health care.

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Minnesota's Medicaid Fraud Crackdown

Unintended negative consequences

By Alea Zemlicka

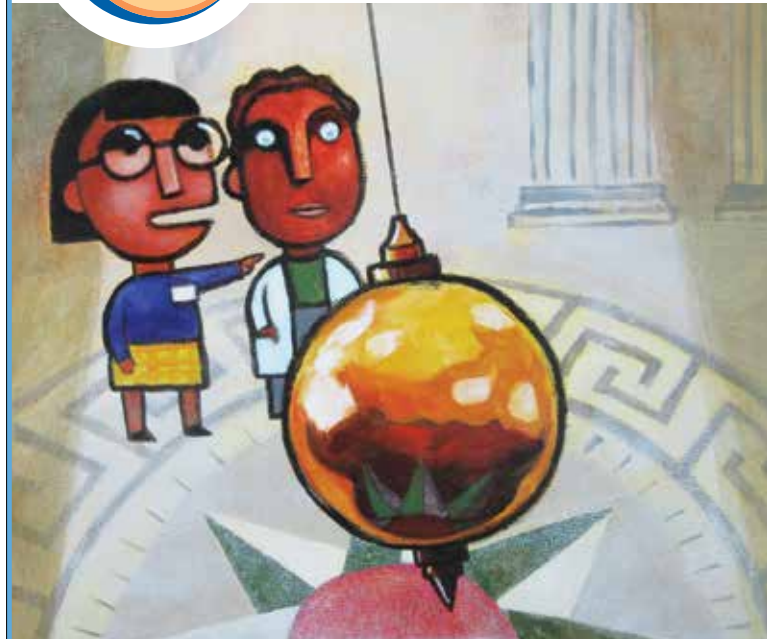
How recent efforts from the Minnesota Department of Human Services to comply with new fraud prevention, and thereby receive withheld federal funding, have resulted in hardships for clinics and patients.

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PUBLISHER Mike Starnes, mstarnes@mppub.com

ART DIRECTOR Scotty Town, stown@mppub.com

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BACKGROUND AND FOCUS:

At the heart of science is innovation. Global threats to public health, such as polio, AIDS and COVID, were successfully addressed through innovation. Advances in technology are improving outcomes across the entire spectrum of medical care with increasing speed. Unfortunately, misaligned financial drivers and shortsighted policies threaten innovation, creating health care affordability and workforce shortage crises. It is critical to make the problems these issues pose clear and work toward viable resolutions to them.

OBJECTIVES:

Our panel will cite examples of emerging innovations in medicine. They will discuss the need for improving policies that limit patient access and how this leads directly to higher costs and worse outcomes. We will define innovation in terms of how it applies to all elements of health care delivery and provide examples of how outside limitations can negatively affect the process. We will discuss what must be to ensure creating environments where innovation in medicine will thrive.

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.

Aspirus Announces Closure of Silver Bay Clinic

Aspirus Lake View's Silver Bay Clinic will close Dec. 31. The health care provider announced that future clinic visits, laboratory services and radiology will be relocated to the Lake View Two Harbors Clinic. In compliance with state law, a hearing was held at the end of July, providing a forum for community members to discuss the change in services. While state law required the hearing to take place, it does not give MDH authority to delay or prevent the proposed changes, closures or relocations. During the hearing Aspirus Lake View listed several reasons for the closure, including clinician shortages affecting rural health care and rapidly changing health care delivery across the state and nation.

"Health care delivery is changing rapidly, and within today's dynamic and challenging environment, we recognize that changes like these can

be difficult for the communities we serve," Aspirus Lake View said in a statement. "Health systems must be foresightful and responsible stewards of their resources. At Aspirus, we are committed to making decisions that ensure long-term sustainability while continuing to provide excellent, compassionate care for the communities we serve."

Silver Bay is unique town formed 70 years ago to support a mining company taconite processing plant. It has a population of 1,800 people, about 30% of whom are 65 and older. The Silver Bay clinic also served communities such as Finland and Isabella and the drive to Two Harbors is 30 minutes or more for all of them. The wider implications are troubling, if a town of 1,800 can't support a clinic what's the cutoff point, a town of 5,000 or 10,000?

Minnesota State Senator and Assistant Majority Leader, Grant

Hauschild representing district 03, which is most of the Arrowhead, issued a the following post on the closing, "The truth is, if we want rural health care to survive, we need our federal delegation to repeal the 'one, big beautiful bill' that has gutted rural health care funding. Without a change at the federal level, nothing can stop the eventual decline of rural health in our communities."

New Mayo Study Expands Clinical Trial Access

A recent study, published in JAMA Open Access and conducted by the Mayo Clinic's clinical impact initiative, detailed promising results from efforts to expand patient access to clinical trials through its decentralized clinical trials program. This program allows many research activities to take place outside a traditional research site through services such as remote informed consent, video visits, in-home blood draws, remote

monitoring and home delivery of oral study medications. Researchers found this approach expanded the geographic reach of clinical trials while increasing participation among patients who have historically faced barriers to enrollment.

"The most innovative clinical trials are often conducted at academic medical centers, while the majority of health care is delivered in community settings," said Tafia Haddad, MD, the study's first author. "We don't want a patient's zip code or geography to determine whether they can access these research opportunities."

Researchers also intentionally tracked participation among rural and historically underserved populations to evaluate whether decentralized clinical trials expanded access more equitably.

"We didn't want these decentralized capabilities to widen existing gaps in research participation, but rather

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our goal was to help close them," Haddad said. "From the program's inception, we intentionally focused on these metrics."

To help remove technology barriers, the program provides cellular-enabled tablets when needed, selects technologies with demonstrated ease of use, offers technical support and, when appropriate, gives participants options for how they engage with study teams.

The next phase of decentralized trials will focus on expanding collaborations with community health care providers so more study activities can be completed closer to patients' homes. Researchers expect continued advances in mobile diagnostics, remote imaging, digital health technologies and at-home drug treatments that could further reduce the need for travel while maintaining rigorous clinical research.

"We're already enrolling patients who have never stepped foot in a Mayo Clinic facility," Haddad said. "The long-term goal is to build an infrastructure that not only serves Mayo Clinic patients but can ultimately help other research organizations reach more patients, regardless of where they live."

Fulcrum Health Concludes Operations

After over 40 years of moving physical medicine forward, and improving access for both patients and providers, Fulcrum Health, Inc. will cease operations on August 31, 2026. What started as ChiroCare with a mission to improve insurance reimbursement and create a wider acceptance of physical medicine, grew into a much broader organization with more than 5000 unique providers and more than 3,000 practicing locations across 19 states. Beyond the ChiroCare network, Acunet was developed for acupuncture services, Trutouch was developed for massage therapy services and Theraflex was developed for physical, occupational and speech therapy services.

From the beginning Fulcrum was dedicated to transforming health care by unlocking the full potential of physical medicine. It developed innovative and inspiring ways to leverage specialized treatments and rehabilitative services that lowered costs, achieved better outcomes and increased patient satisfaction.

Fulcrum Health was accredited by the National Committee of Quality Assurance (NCQA) for following best practices in credentialing provider members in its networks. Credentialing was vital to improving insurance reimbursement for network members and thereby improving patient access. Fulcrum Health was also a multi-year recipient of the Press Ganey Human Experience of Excellence award for outstanding performance in patient satisfaction, achieving a 98% rating in a recent survey. Network members also benefited from an ever-expanding set of administrative tools designed to assist with various regulatory compliances and revenue flow. Another example of its broad scope activity was Fulcrum's Centers of Excellence (CoE) program. It was designed to recognize clinics that used standardized clinical protocols and an integrated, collaborative approach in achieving positive outcomes and improved quality of life for patients.

Fulcrum released a statement to provider members this March informing them of the coming closure and that it was actively coordinating transition pathways to ensure minimal disruption for the communities it served. It made clear that this was not an acquisition or sale, simply that Fulcrum was concluding operations. Reasons for this decision cited the evolving health care landscape, as well as ongoing market, regulatory and financial pressures.

The statement offered this concluding thought, "We are deeply grateful for the trust placed in Fulcrum Health and proud of the impact achieved alongside our partners over the years."

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U of M and Blue Cross Ink \$17M Naming Rights Deal

The University of Minnesota and Blue Cross and Blue Shield of Minnesota (Blue Cross) recently announced a ten-year collaboration to strengthen a shared dedication to advancing community health throughout Minnesota. Blue Cross will provide the university with \$1.7 million dollars per year for the next ten years to further a variety of health care-related activities. Included with this funding, the Minneapolis campus basketball arena will no longer be known as Williams Arena and will now be officially recognized as The Barn supported by Blue Cross and Blue Shield of Minnesota. The facility opened in 1928 as the Minnesota Field House and in 1950 was renamed Williams Arena, after Henry Williams, MD, who coached the university football team from 1900-1921.

As part of the agreement, Blue Cross and the University will create

opportunities for health innovation and collaborate on initiatives that promote well-being across the state. Programs will include on-campus health support for the Gopher community, in addition to professional development and industry exposure for students and alumni. The collaboration will focus on a variety of activations to improve health and well-being, including the establishment of new outdoor community basketball courts, the development of new youth sports clinics led by student-athletes and campaigns that promote mental health awareness and healthy lifestyle changes.

“For many years, Blue Cross and the University of Minnesota have played complementary roles in serving the people of this state — the University through its leadership in education, research and public service, and Blue Cross through its mission-driven commitment to improving health across every community,” said Dana

Erickson, President and CEO at Blue Cross. “As we look ahead, we’re proud to strengthen this enduring relationship and find new ways to come together to advance the health and well-being of all Minnesotans.”

“At the University of Minnesota, we are guided by our land-grant mission to serve all 87 counties across the state,” said University of Minnesota President Rebecca Cunningham. “We are proud of our new partnership with Blue Cross, which will help us deliver on our commitment to expand our health and health care workforce, advance lifesaving research and support the health of all Minnesotans.”

CDC Releases Troubling Vaccine Avoidance News

With schools returning to session nationwide, the CDC recently released a report, generated from state-provided data, showing that the number of unvaccinated children is growing. Surprisingly, Minnesota is

becoming one of the least-vaccinated states in the nation, with immunization rates among kids well below the levels needed to curb outbreaks of preventable diseases. The CDC data show immunization rates fell nationwide, with more than 24 states reporting exemption rates rising above 5% — the minimum associated with maintaining herd immunity.

Last year, Minnesota's kindergarten vaccination rate for diphtheria, tetanus and whooping cough (DTaP) was worse than every state except Idaho. Only Idaho and Wisconsin had fewer kids receiving their polio, chickenpox, or measles, mumps and rubella (MMR) vaccines. The share of Minnesota kids receiving medical or "personal belief" exemptions rose to 6.9%, almost twice the pre-pandemic rate.

These numbers were based on last year data, however to compound these problems, President Donald Trump



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recently signed an executive order calling for revamped childhood vaccine recommendations that promote his ongoing and discredited rhetoric. The order also directs the nation's health department to improve research on vaccines, which are already extensively studied. Trump called the announcement a "major victory for parents rights, religious and constitutional rights and for the gold standard science." He repeatedly suggested the number or timing of vaccines could play a role in rising rates of autism spectrum disorder, even as scientific consensus and decades of studies have firmly concluded there is no link.

Despite the biggest measles outbreak in recent memory, the CDC released a statement accompanying their report that failed to inform parents of the importance of routine vaccination in limiting the spread of illness. This raises serious concerns that the CDC is no longer the trusted health agency it once was.

The Trump administration's ongoing push for controversial vaccine policy changes corresponds to the vaccination rate in Minnesota for all diseases falling to roughly 86% and only around 92% of Minnesota kindergarteners who are immunized against hepatitis B. During the 2025-26 school year, an estimated 280,000 children nationwide started kindergarten without proof that they completed the measles, mumps, and rubella (MMR) vaccine series. In total, 92.4% of kindergarteners received it—below the proportion needed to prevent measles from spreading in the community.

Sanford Health Announces Innovative New Clinic

To address the growing need for primary care in the Fargo-Morehead community, and health care workforce shortage issues, Sanford Health recently announced the construction of a new clinic. The health system is investing \$1.4 million in building a clinic housed entirely inside Fargo South High School. The clinic will

include 7 exam rooms, a lab, waiting areas, intake space, staff break areas and will accommodate three providers. There is no access to the clinic from the school and it will have two separate entrances, one for staff and another for patients. It will include a dedicated parking lot for about thirty vehicles. Beyond expanding health care access, the new clinic will give students the opportunity to experience direct exposure to health careers.

Sanford's general capital fund is underwriting most of the expense, however the school district says it's expecting to spend about \$200,000 for a new sewer line and a new air handler as a result of the project. Existing classrooms at the school will be converted to accommodate the new clinic space. Both Sanford and Fargo public schools said the partnership creates a career development opportunity for students interested in health care.

"We are really excited about exposing students to health care jobs," said Susan Jarvis, Sanford chief operating officer.

Fargo public schools superintendent Dr. Cory Steiner said the district and Sanford have been working together to develop the program. He noted, "We're going to have a true clinic as an opportunity where our students can go and learn. It will help those that are interested in health fields get authentic opportunities. Working with Sanford this year and developing the program, we have the chance to develop something that's world class."

Construction is expected to begin early next year, with an opening targeted for 2028. 

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Financial Wellness for Health Care Professionals

Joel Swanson is the president and CEO of Associated Healthcare Credit Union

Please tell us how Associated Healthcare Credit Union (ACHU) got started and how it has changed over the years?

AHCU's story began in 1953 when five employees at Miller Hospital in St. Paul, where the Minnesota History Center sits today, decided to pool their resources and create a credit union to help health care workers support one another financially. For example, when a hospital employee needed a few hundred dollars for an unexpected expense, medical bill, household need or to buy a car to get to work. Smaller unsecured loans less than \$400 were typically not offered by big banks, where health care workers felt they were being treated as second-class citizens.

Seventy-three years later, the scale and complexity of financial needs have changed dramatically, but that basic idea remains relevant. Today, it might be helping a physician coming out of residency with significant student debt qualify for a home based on a signed employment contract. Or it might be preparing them with the financial literacy to manage the stress of their new high debt-high income financial status. Over the years, employee credit unions serving Blue Cross and Blue Shield of Minnesota, Children's Minnesota and Health-East joined AHCU, which now serves more than 12,000 members throughout the Twin Cities. It has evolved from a single-hospital employee credit union into an institution focused on the broader spectrum of Minnesota health care professionals, their careers and their families.

You have an unusual window into the financial lives of Minnesota health care professionals. What are you seeing today that is surprising?

The original problem was access to fair financial services. Today the challenge is designing financial services around careers that don't always follow conventional financial assumptions. Minnesota has a world-class health care ecosystem. It is an enormous and growing part of Minnesota's economy. Health care and social assistance alone employed nearly 557,000 Minnesotans in 2025. Yet the people doing that work can still be financially stretched.



“ There's often a misconception that health care is one economic category. ”

And that isn't confined to lower-wage employees. The pressures differ by career stage and profession. For example, the median medical-school debt for the class of 2025 was \$215,000. The Association of American Medical Colleges (AAMC) puts the median four-year cost of medical school for the class of 2026 at about \$298,000 at public schools and \$408,000 at private schools.

Furthermore, this year the Federal Reserve reported that 59% of adults had experienced at least one major unexpected expense during the prior year, with vehicle repair or replacement the most common at 30%. A \$1,000 surprise means something different to a surgeon, a resident, a nurse, a medical assistant or a customer service representative. But financial friction can affect all of them. Student debt can delay home ownership, childcare can affect the shifts someone can accept, or a car repair can affect whether someone can reliably get to work. Financial resilience boils down to having realistic options to withstand unexpected expenses or income disruptions that meet the needs of someone in the health care industry.

Health care is widely regarded as a financially secure profession. How accurately does that reflect what you see?

There's often a misconception that health care is one economic category, experiencing higher incomes and financial status. A physician finishing fellowship, however, or an established specialist, an RN, a medical assistant or a nursing assistant can all work in the same building and have dramatically different financial lives. The latest Minnesota Department of Employment and Economic Development report shows Twin Cities vacancy data that puts the median wage being offered for open RN positions at about \$39.41 an hour, compared with \$19.93 for nursing assistants and \$21.29 for medical assistants.

Physicians, comparatively, have much higher earning potential but begin those earning years relatively late and with substantial education debt; the AAMC's median debt figure data mentioned earlier offers perspective. Most financial institutions and products ignore that unique income trajectory. In addition, in Minnesota, we have robust communities of insurers, med tech/med device, pharmaceutical, wellness — and a myriad of support and ancillary services, many of them innovators in their field. The roles in those organizations come in all shapes and sizes.

Personal approaches are necessary because income and financial wellness don't mean the same thing. What matters is the entire balance sheet; income, debt, savings, housing costs, family responsibilities and the predictability of that income. Financial security means much more than public perception and can vary widely within every industry sector.

What are some of the biggest challenges you see for those working in the health care industry today?

Health care leaders regularly cite burnout and workforce shortages as major challenges. Financial stress isn't necessarily the primary cause of health care burnout — staffing, workload, administrative burden, workplace culture and the emotional demands of caring for others are well-documented

factors. But financial pressure can make each of those pressures harder to manage.

If someone is already exhausted but can't afford to reduce hours, take unpaid time off, address a health issue, arrange childcare or absorb an unexpected expense, they have fewer options for finding relief.

For example, a stark finding from Mercer's 2026 health care industry survey was that 35% of workers say the cost of care limits their ability to seek care for themselves or their families, compared with 28% of workers overall. There's a real irony when people who spend their careers delivering health care are themselves struggling with the affordability of accessing it.

Are traditional financial products and underwriting models keeping pace with today's health care careers?

Not always. Financial underwriting tends to look backward because that's how risk models were designed. Health care careers can sometimes require looking forward. Consider a physician finishing residency who has a signed employment contract but doesn't yet have 12 months of attending-level

income. Or a clinician with substantial student debt whose income trajectory doesn't look like that of a conventional borrower.

AHCU changed its underwriting to address this problem. Our mortgage products allow consideration of employment contracts for clinicians beginning roles within 60-90 days. And it uses more flexible treatment of student debt. Because we hold those loans in portfolio, it provides the latitude to create terms that conventional, secondary-market underwriting typically do not. The insight wasn't that health care professionals needed another mortgage product with health care branding. It was that the underwriting itself needed to understand a health care career.

AHCU offers some unique financial services for the health care industry. What can you tell us about this?

Although we're not a therapist, a social-service agency or a health care provider, we do believe we have a responsibility to recognize when the problem in front of someone extends beyond a deposit account or loan and connect them with resources or organizations that are better equipped to help. We have certified financial coaching resources, as

well as trained financial service officers who can solve or optimize for most financial situations.

When more support is needed, FamilyMeans provides free budget and debt counseling through certified credit professionals, along with debt-management services and financial education. Its broader organization also provides counseling and mental-health services, grief and loss support, and aging and caregiver services.

TriUnity Foundation is another version of that principle. It's a very new grant-making nonprofit built by the credit-union movement that provides direct grants to people facing life-threatening or terminal illness. For its current 2026 cycle, its program offers \$2,500 and \$10,000 grant pathways, and AHCU members are among those eligible. AHCU has a pool of grant dollars reserved specifically for its members.

If financial well-being is becoming a workforce issue, how should Minnesota health care organizations respond?

The best organizations include financial well-being

Protecting the Financial Wellness of Health Care Professionals to page 30 ▶



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◀ Histotripsy from cover

engineering department of the University of Michigan began work that led to the development of a new field, histotripsy.

A Brief History

It began with a request from a pediatric cardiologist to develop a noninvasive, bloodless surgery technique that could remove tissue. Ultrasound had been known for more than 50 years by 2001 but had not been considered reliable, predictable or controllable enough for surgical applications. Eventually, researchers discovered a way to predictably and reliably create holes in a pig's heart suspended in liquid. Researchers continued working to solve the problems of directing ultrasound energy with enough precision that it could target places within the body only 1 millimeter wide. Their work ultimately led to histotripsy, which uses focused ultrasound energy to destroy targeted tissue without surgery.

The technology could be utilized in many ways; however, researchers initially focused on developing a product to remove tumors in the liver, and eventually clinical trials proved the concepts and mechanisms were successful. This led to the formation of a Minnesota-based company called HistoSonics, a product called the Edison Histotripsy System and, on Oct. 9, 2023, approval from the Food and Drug Administration (FDA) to bring

the technology to market. Today, histotripsy is a noninvasive treatment technique that uses ultrasound waves to destroy cancer cells while preserving healthy liver tissue.

Practical Applications

Understanding which patients may benefit from histotripsy begins with understanding the different types of liver cancer. There are two types of liver cancer: primary and secondary. The latter occurs when cancer spreads from another part of the body. Primary cancer typically begins in the liver or the liver's bile ducts. Unlike breast cancer, there is no early detection screening like a mammogram for liver cancer. Noticeable symptoms may not occur in the early stages of liver cancer. Physicians typically use blood tests, angiograms, CT scans or MRIs to make a liver cancer diagnosis. The five-year survival rate for liver cancer is 22%. Removing tumors while preserving as much liver as possible is paramount to increasing chances of survival. Histotripsy is one of the tools that can help achieve that goal.

Driven by its dedication to expert care and the use of technology that improves patient outcomes, Allina Health Cancer Institute became the first health system in the Twin Cities to use histotripsy as part of its multidisciplinary approach to liver cancer in September 2025. Histotripsy is expanding treatment options for patients with liver cancer who are not candidates for surgery. While the process may seem like something out of a sci-fi movie to patients, this

The process may seem
like something out of a
sci-fi movie to patients.

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technology is giving people with primary and metastatic liver cancers another option for life-saving care.

Each liver cancer case must be evaluated based on the number of tumors present in the liver, as well as the size and location of the tumors. Adding a liver surgeon to a cancer patient's care as early as possible gives the liver surgeon time to evaluate the disease and determine the best treatment approach. In some cases, histotripsy may be the only treatment needed. In others, it may be used in conjunction with surgery and other therapies to help render a patient cancer-free.

To treat a tumor with histotripsy, it must be visible. A tumor deeper than 12 cm could be difficult to see because of interference from the rib cage. The bubble cloud caused by cavitation is only about 3 cm wide. Larger tumors could require multiple overlapping treatments, which can increase complexity and certain risks, such as bleeding. In situations like those mentioned above, histotripsy may not be the best or only option for treatment.

Liver surgeons combine their years of expertise with training on the use of the histotripsy system. Training for clinical teams includes completing online modules and case observations as well as work with a physician proctor and clinical specialist to learn to use histotripsy. Training also includes practicing on animal liver pieces.

Patients often ask what makes histotripsy different from radiation. Unlike heat-based ablation or radiation therapy, histotripsy does not injure

critical structures such as blood vessels and bile ducts. Histotripsy uses pulsed sound waves to create "bubble clouds" from gases naturally present in targeted tissue. These bubble clouds form and collapse within microseconds, generating mechanical forces strong enough to destroy tissue at the cellular and subcellular levels without heat or incisions. The treatment area can be controlled precisely, resulting in minimal collateral damage.

Depending on the size of the tumor, treatment can take as little as 10 minutes, although larger tumors may require more time. Because the procedure does not require an incision, patients typically do not need to stop taking important medications such as blood thinners or chemotherapy. Physicians have observed treatment zones shrink over time in histotripsy patients during follow-up visits, unlike ablation, where the treatment defect remains.

How it Works

If you break down the name of this technology, "histo" means soft tissue and "tripsy" means breaking apart. Using MRI and CT scans, the care team maps the patient's liver and identifies the location of cancerous cells. They later enter that information into Edison, the histotripsy system that delivers pulsed sound waves to the designated area. This system has three main components: the user interface control panel, automated treatment arm and treatment head. Edison

Removing tumors while preserving as much liver as possible is paramount to increasing chances of survival.

Histotripsy to page 12 ▶



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- Windom Area Health (Windom, MN)

needs a water source and electrical outlet to work, and the patient requires anesthesia to undergo the process. Once the patient is anesthetized, a flexible membrane filled with degassed water is placed over the area where treatment is needed. Sound waves pass through the skin and target cancerous cells without the use of a single scalpel.

Patients often experience several advantages following histotripsy. It is so painless that some patients have questioned whether it was performed because they did not feel anything. The most important benefit is preserving as much liver as possible. Other benefits include rapid recovery, same-day discharge and minimal disruption of treatment and daily activities.

Through innovation, the treatment of liver cancer has progressed from large open operations to the bubble clouds of histotripsy. As research advances and indications expand, histotripsy may transform the treatment of additional cancers, offering new hope for patients worldwide. To date this pioneering medical procedure has only been approved by the FDA for the treatment of liver cancer. Trials, however, are currently underway to investigate histotripsy's effectiveness when it comes to cancers of the kidney, pancreas and prostate.

Ashwin S. Kamath, MBBS, is a surgeon at the Allina Cancer Institute specializing in treating liver and pancreatic cancer.



The Edison Histotripsy System, developed by Histosonics, is displayed in the photo above. The screen on the left shows real time imaging of the tumors as they are being dissolved. The arm on the device to the right is positioned over the patient to direct the ultrasound.

As Dr. Kamath mentions at the end of his article, work is moving forward with trials to adapt this technology for use in treating other organs. The following information was recently released by Histosonics.

The Edison System has been adapted for successful treatments of the first patients in WOLVERINE, a prospective feasibility trial evaluating the Edison® Histotripsy System for the treatment of benign prostatic hyperplasia (BPH) at Prince of Wales Hospital in Hong Kong, a teaching hospital for The Chinese University of Hong Kong. The Edison System is a novel, non-invasive, image guided platform that uses the mechanical properties of focused ultrasound, called histotripsy, to destroy unwanted tissue without the need for invasive procedures, and with potentially fewer side effects than traditional, invasive therapies.

WOLVERINE is a prospective, multi-center, single-arm feasibility trial designed to evaluate the safety of the Edison® Histotripsy System for the treatment of symptomatic benign prostatic hyperplasia (BPH). The trial is expected to enroll and treat up to 20 patients. Following treatment, participants will undergo imaging within 72 hours of the procedure to assess the immediate treatment effect. Patients will then be followed longitudinally to further evaluate safety and procedural outcomes.

"BPH affects millions of men worldwide and most of the existing treatment options require invasive procedures or lengthy recovery times," said Mike Blue, Chairman and CEO, HistoSonics. "We believe histotripsy's ability to mechanically destroy targeted tissue, completely non-invasively, has the potential to transform how BPH is treated. In addition, this milestone represents significant progress in our pursuit to expand the unique benefits of histotripsy over a significant number of serious clinical conditions throughout the body."

"We are excited and extremely proud that Prince of Wales Hospital is the first center in the world to offer this novel treatment approach in a clinical trial and potentially benefit patients with BPH in the future," said Dr. Peter Chiu, study investigator and Associate Professor of The Chinese University of Hong Kong. "If shown to be safe and effective, the non-invasive nature of histotripsy has the potential to change how BPH is treated for many patients suffering from lower urinary tract symptoms around the world."

BPH is one of the most common urological conditions affecting aging men. Approximately 50 percent of men over the age of 50 and up to 80 percent of men over the age of 80 experience symptoms associated with BPH. Globally, more than 110 million men are affected by the condition, and its prevalence is expected to continue increasing as populations age.

The Edison Histotripsy System is currently cleared in the United States for the destruction of liver tumors. The use of the Edison System for the treatment of benign prostatic hyperplasia is currently limited to investigational use.



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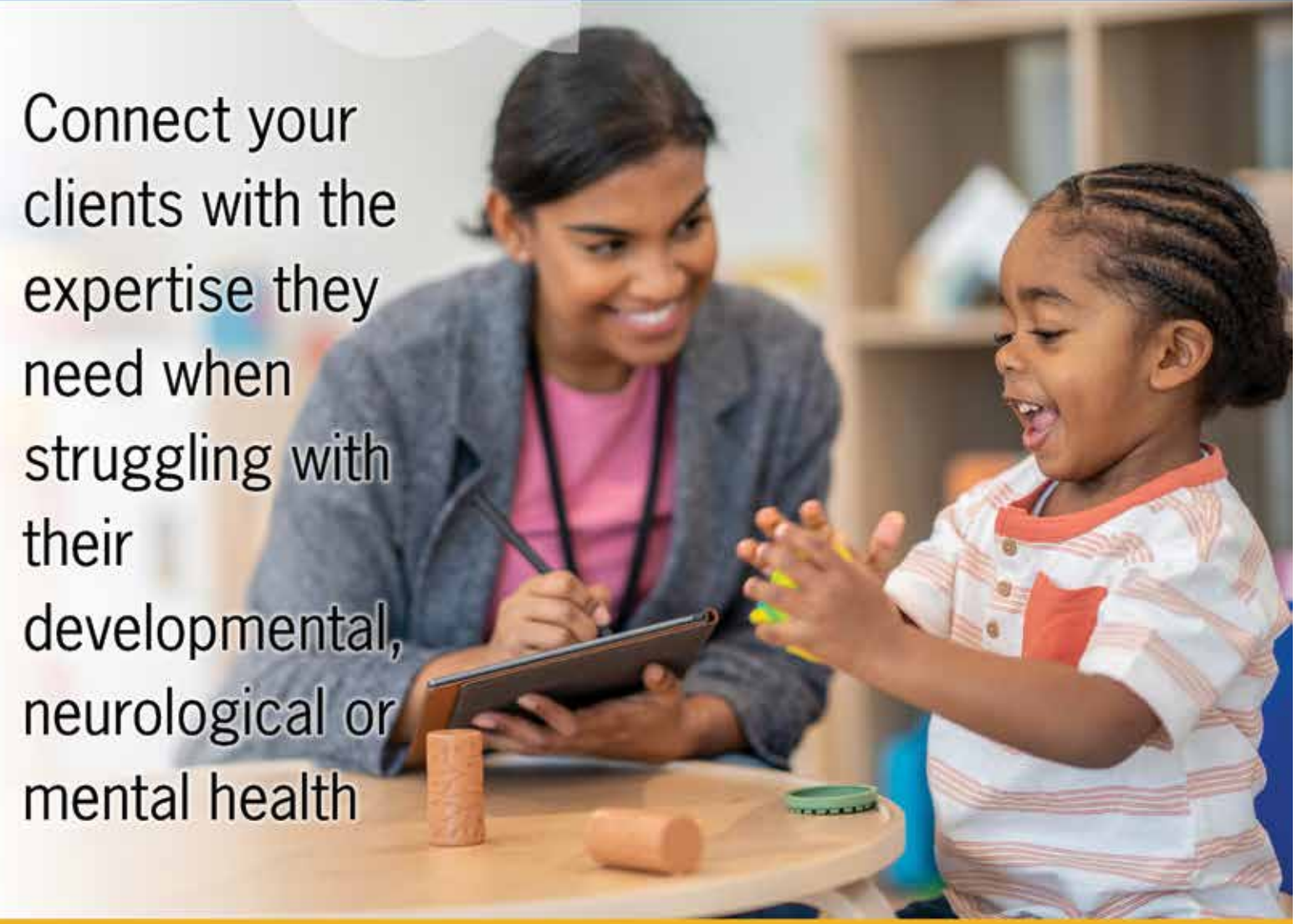
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A photograph of a woman with dark hair, wearing a grey blazer over a pink shirt and a stethoscope, sitting at a light-colored wooden table. She is holding a tablet and looking at a young girl. The girl, who has braided hair and is wearing a white and orange striped shirt, is clapping her hands and smiling. On the table are some wooden blocks and a small green container.

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◀ Female Urinary Incontinence from the cover

pelvic floor muscles that normally keep the urethra closed under pressure. SUI disproportionately affects women. Pregnancy, childbirth, hormonal changes during lactation, perimenopause and the anatomical demands of the female pelvis all drive prevalence far higher than in men, for whom incontinence is more often tied to a specific surgical or neurologic event.

In women, SUI tends to develop gradually and cumulatively, which means it rarely announces itself as a discrete problem a patient thinks to schedule a visit around. Many women first notice symptoms earlier in life, for example after a first pregnancy, and describe the leakage as occasional and situational, something they can manage rather than something they should mention.

That framing has real costs, and they compound over time. Left undressed, SUI is strongly associated with reduced physical activity, social withdrawal, sleep disruption, sexual dysfunction and depressive symptoms. Urinary incontinence more broadly is a well-documented contributor to fall risk in older women, particularly from bathroom trips in the middle of the night.

One study found that a third of mid-life women scale back or stop exercise altogether specifically to avoid leakage during activity, a workaround that trades one long-term health risk for another. Women with incontinence report modifying their wardrobe, limiting fluid intake and avoiding social interactions to manage leakage. Annual out-of-pocket spending for routine care, such as covering pads and protection, can cost between \$900 to \$4000. This tends not

to reach a chart note because it is not presented by the patient as a medical concern. It's simply absorbed into how a patient goes about her week, her month, her years, often for years before it's ever named out loud in a clinical setting.

Starting the Conversation

Barriers to discussing UI exist on both the patient and the clinician sides. On the patient side, a Michigan poll found that women do not bring up their UI because they think it isn't a real health issue or one that can be addressed without surgery. This is related to a persistent belief that leakage is a normal and unavoidable consequence of childbirth or aging, and simply never bring it up because they were never asked. Notably, about half of women in that same poll said they find it easier to discuss urinary leakage with a female physician, a detail worth factoring into how and by whom the topic gets raised in practice.

On the clinician's side, incontinence competes for time in a visit against a long list of other concerns and necessary screenings. It's easy for a symptom the patient hasn't raised to simply not come up. Some clinicians default to the assumption that beyond suggesting at-home Kegels, which many patients struggle to do correctly on their own, effective treatment means referral to specialty care, such as surgical consult or pelvic floor physical therapy. But these resources aren't always available in a community, and even when they are, they're not accessible or palatable to every patient, leading to drop-off in care and poor adherence.

Female Urinary Incontinence to page 16 ▶



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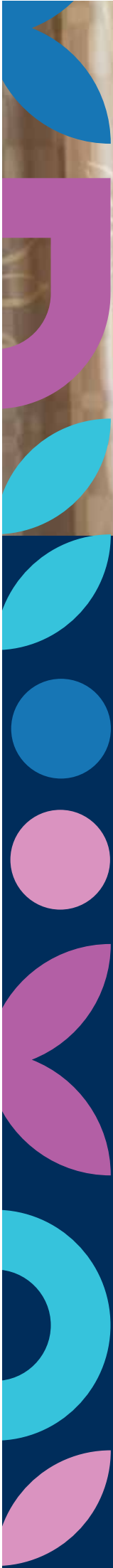
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◀ Female Urinary Incontinence from page 14

Without an easily accessible conservative option to offer during the visit, there's less incentive to open the conversation proactively when time is already limited.

The Michigan poll's authors put it plainly in their conclusions — incontinence is unique among conditions this prevalent in lacking routine screening, and primary care physicians are best positioned to close that gap simply by asking. A statement by Dr. Wanda Filer, MD, MBA, FAAFP and board director at Pelvital USA, summarizes this well, "Primary care clinicians know that we have to be screening for everything and there's just not enough hours in the day. Clearly, urinary incontinence is something that women, in particular, don't talk about. It's been normalized, which is sad, expensive and delays access to better care. If we don't ask, they may not willingly tell us because it's embarrassing or think it's something they have to age with. Asking one question opens the door to a conversation that may have immense impact on their lives."

Given how many women have already privately concluded their UI isn't worth raising on their own, if the clinician doesn't ask, for a large number of patients, there will be no treatment and no opportunity for improved quality of life.

Changing Outcomes

Successful treatment of female UI doesn't require a new intake form or a lengthy validated instrument at every visit. The first question of the brief, validated 3

Incontinence Questionnaire (3-IQ) screening tool, is enough to open the door. It asks, "Have you leaked urine in the past three months, even a little bit?"

When asked routinely at annual exams, postpartum visits, and perimenopausal check-ins, a single yes-or-no question can alert the clinician to symptoms that would otherwise stay unspoken, even though they are negatively impacting quality of life. A positive response can then be followed with more specific, validated screening as needed, but tasking that first simple question consistently is what changes outcomes.

Next Steps

Screening only closes the gap if there's somewhere useful for the conversation to go next. Unsupervised Kegel exercises are frequently recommended as a first-line conservative option, but an estimated 30 to 50% of women cannot correctly isolate and contract

these muscles from verbal instruction alone. A well-intentioned recommendation often produces little measurable benefit and, in time, poor adherence, increased frustration and feelings of failure.

From here, the options presented to a newly identified SUI patient have historically narrowed quickly to one of two options. First, a referral for pelvic floor physical therapy, which requires scheduling, transportation and repeat visits many women can't easily fit into their lives. The other option is a specialist consultation that may feel, to a patient who just barely

Women do not bring up their
UI because they think it
isn't a real health issue.

Female Urinary Incontinence to page 24 ▶

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Minnesota's Medicaid Fraud Crackdown

Unintended negative consequences

BY ALEA ZEMLICKA

A Minnesota clinic sought to add a new provider to its practice, submitting a Medicaid enrollment application on March 24, 2026. By early July, more than 100 days later, the application still had not been reviewed. When Integrity Health Network (IHN), which handles credentialing for the clinic, called the Minnesota Department of Human Services (DHS) to ask why, staff said the application would be handled “in the order it was received.” Two weeks later, an application submitted in July, months after the March application, was approved. When IHN’s credentialing team pointed out the contradiction, a DHS representative said, “They will get to it when they get to it.” The March application was finally approved Aug. 7, 2026, 136 days after it was submitted.

That case is not unusual. It is one of more than a dozen applications IHN, an independent practice association founded in 2010 that serves clinics in Minnesota, Wisconsin, North Dakota and Iowa, has tracked since May 2026. Approval times among those applications have ranged from seven days to more than 130, with no consistent relationship to when an application was submitted. The cause traces back to a much larger fight between Minnesota and the federal government over Medicaid fraud, a fight that has frozen routine enrollment processing for physicians, physician assistants, physical and occupational therapists

and speech-language pathologists who were never accused of anything, as well as for clinics themselves trying to open new locations or bring on new providers.

A Manufactured Deadline

The fraud concerns behind Minnesota’s enrollment backlog predate the federal funding fight that made headlines. On Oct. 29, 2025, Gov. Tim Walz ordered a third-party audit of billing for 14 Medicaid services identified as high-risk, pausing payments for those services for up to 90 days while claims were reviewed for irregularities. Optum, a division of UnitedHealth Group, was selected to conduct the audit. “We cannot effectively deliver programs and services if they don’t have the backing of the public’s trust,” Walz said when announcing the audit. “If you attempt to defraud our public programs and steal taxpayer dollars out from under the people who need them most, you will be stopped, and you will be held accountable.”

Three months later, the fight escalated. In January 2026, the Trump administration, through the Centers for Medicare and Medicaid Services (CMS), threatened to withhold roughly \$2 billion in annual Medicaid funding from Minnesota over concerns about fraud in the state’s program. To avoid the withhold, DHS agreed to a corrective action plan that paused new provider enrollment in the state’s high-risk service categories beginning Jan. 27, 2026, and required DHS to revalidate more than 5,500 providers already enrolled in those categories by May 31, 2026.

DHS did not act quickly after the January threat and did not begin implementing the revalidation effort, branded Minnesota Revalidate 2026, until May 1, 2026, one month before the May 31 deadline. This deadline was posted on the DHS website and described as urgent. During May, DHS told IHN by phone that no provider or clinic enrollment applications, of any kind, were being reviewed or worked on while the high-risk revalidations were underway. DHS did not proactively notify clinics, credentialing contacts or industry groups that enrollment processing would stop. IHN learned of the shutdown only after applications stalled, and then informed its own member clinics as well as contacts across the industry through the Healthcare Leaders Association of Minnesota (HLAMN), a professional association whose payor relations and government affairs committee, which includes IHN staff, said it had not been told about the change either.

DHS’s own public postings confirm the shape of the effort, if not the notice failures. DHS has extended the high-risk enrollment moratorium twice: a July 10, 2026 posting on its provider news page states that CMS approved extending the enrollment moratorium on 12 of Minnesota’s 14 designated high-risk services through Jan. 27, 2027, and a separate moratorium specific to nonemergency medical transportation providers in the seven-county metro area was extended to the same date in a July 23, 2026 posting. Both postings state explicitly that DHS will not process new enrollment applications, including those already pending, for the named high-risk categories during the moratorium.

Those categories do not include the disciplines IHN’s member clinics work in. That distinction matters: DHS’s own published moratoriums have applied to a defined list of high-risk services. The delays IHN’s clinics experienced in initial enrollment and affiliation processing, for providers entirely outside



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those categories, were not part of any published freeze. When DHS redirected its staff to meet the high-risk revalidation deadline, ordinary enrollment and affiliation processing for everyone else slowed regardless. Clinics that had done nothing wrong, operating entirely outside any high-risk category, were pushed to the back of the line and have borne the consequences ever since.

Inviting Confusion

The distinction between enrollment, affiliation and revalidation matters because DHS, providers and the public often describe these three different processes as though they were one. Revalidation applies to a provider or clinic with an existing, active enrollment; it requires submitting a recredentialing application attesting that the information on file is still accurate. Enrollment applies to a provider who is new to Medicaid and needs an initial application, or to an existing provider being added to a new place of employment. A clinic can also enroll a secondary location under an existing enrollment.

When DHS narrowed its focus to high-risk revalidations, clinics whose providers needed initial enrollment or affiliation approval before they could see patients were delayed. Some of the affected applications were already pending before the revalidation effort began. Providers tied to those applications could not see Medicaid patients until their enrollment was approved and effective. DHS has honored the effective date originally requested on an approved application in the past, allowing retroactive billing, but DHS has not made that an explicit guarantee directly and many clinics have been reluctant to rely on it. If DHS

did not honor a requested effective date after a provider saw patients while still pending, the clinic could be left with unpaid claims and significant financial loss. Some commercial health plans previously required Medicaid credentialing before their own credentialing could proceed; several plans have since built workarounds allowing providers to be credentialed and see patients without waiting on Med-

icaid approval, though not universally. That information is not widely published. IHN has learned which plans have workarounds through its own relationships with those plans, not through public guidance.

By the Numbers

IHN does not have statewide figures for how many providers have been affected, only its own member clinics' experience. Since May 2026, IHN has tracked 13 provider enrollment and affiliation applications. As of mid-August, seven remained pending,

including one submitted April 1 that had not been approved after more than four months, and two applications submitted Aug. 5 and 6 that were too new to have been reviewed. Of the six that were approved, turnaround time ranged from seven days to 136 days. Two applications submitted within four days of each other, using the same enrollment record and the same submission process, were treated differently, one approved and one left pending. Raising this inconsistency with DHS, representatives sometimes offered no explanation at all. At other times they suggested enrollment type or submission method might explain the gap, which was clearly not the case.

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◀ Minnesota's Medicaid Fraud Crackdown from page 19

The financial effect on clinics has been difficult to quantify precisely because losses are largely indirect. Clinics have hired providers who could not begin seeing Medicaid patients until their enrollment cleared, creating scheduling and staffing burdens and, in some cases, salary costs for providers who could only see a portion of their expected patient load. During May, before commercial health plans had built workarounds, several plans would not credential a provider until Medicaid enrollment was confirmed, compounding the delay across both Medicaid and commercial patient populations, until plans adjusted their own processes in late May and early June.

Limbo, With No Way to Escalate

Before 2026, DHS allowed a provider or credentialing contact to open a case on a pending enrollment application once it had been open for 30 days, triggering review within three to five business days. This was DHS's standard practice prior to the revalidation effort. That option no longer exists. Near weekly calls to DHS's provider enrollment line, with hold times reaching an hour, have consistently confirmed that no process exists to open a case or escalate a stalled application, and that DHS could not provide a timeline for when applications would be reviewed or when case escalation would resume.

The problem was compounded by a second, unrelated rollout. DHS's new authentication platform, LoginMN, launched June 13, 2026, in the middle of the revalidation crunch. Since then, IHN has been unable to access the enrollment records of providers whose applications were submitted before the new platform went live, and some providers and clinics have lost access to their own enrollment applications entirely. DHS's email support for LoginMN issues

told IHN to call for help, however in so doing DHS redirected staff back to email. This support loop has not resolved the underlying access problems. The support launch timing compounded problems in an already difficult period. DHS was simultaneously expected to be reviewing enrollment applications that clinics and providers often could not check the status of because of the same platform problems, leaving DHS resources that could otherwise be processing enrollment applications tied up instead in resolving portal access issues.

A Structural Weakness

What happened in Minnesota is not an isolated state failure; it is what happens when a routine, multiyear federal requirement is compressed into months with no added staff, no added technology and no transition plan. Federal regulation, 42 CFR 455.414, already requires state Medicaid agencies to revalidate every enrolled provider at least once every five years. CMS's decision to demand a functional equivalent of that cycle in a matter of months, for thousands of providers at once, produced the backlog that spilled into routine enrollment and affiliation processing.

Minnesota is unlikely to be the last state to face this. In April 2026, CMS sent identical letters to all 50 governors and state Medicaid directors, asking each state to confirm within 10 days whether it would immediately begin revalidating high-risk providers and to submit a two-year revalidation strategy within 30 days. Ohio's governor signed an executive order accelerating revalidation for certain provider types. Missouri began an expedited review of roughly 2,500 providers. CMS separately sent detailed program-integrity inquiries to California, Florida, Maine and New York, and began reviewing every state's Medicaid Fraud Control Unit ahead of its annual federal recertification, a level of scrutiny that has already cost Hawaii's fraud unit its federal funding. The nonpartisan Medicaid and CHIP Payment and Access Commission has recommended that CMS reduce duplicative federal requirements, improve transparency around how "high-risk" designations are made, and examine program-integrity gaps created by managed care structures, changes that speak directly to what went wrong in Minnesota's rollout.

Minnesota's own corrective action plan, submitted to avoid the threatened \$2 billion annual funding withhold, included 17 specific commitments, according to the health policy research organization KFF. Included was a pause on new enrollment in high-risk service categories beginning Jan. 27, 2026, revalidation of more than 5,500 providers in those categories by May 31, 2026 and increased use of data analytics to screen claims before payment. CMS accepted the plan, resolving the threatened annual withhold, but a separate dispute over already-paid claims has continued. CMS deferred more than \$350 million in Minnesota Medicaid payments by June, according to KFF, and an additional \$199 million in July, citing insufficient documentation, according to the news organization Stateline.

It is difficult to separate the policy substance from the politics surrounding it. Walz, in a July 2026 post responding to the additional \$199 million payment freeze, wrote that the funding fight was an effort "to cut your health care so that Trump can afford the tax cuts he gave to billionaires," as reported by Stateline. HHS Secretary Robert F. Kennedy Jr., in a news release accompanying that same freeze, framed the administration's position as straightforward accountability, "States that receive federal Medicaid funding must demonstrate that every dollar meets federal requirements. When they cannot, we will not release federal funds until they do." Every state that has faced this level of

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◀ **Minnesota's Medicaid Fraud Crackdown** from page 20

federal scrutiny so far, Minnesota, California, Colorado, Illinois, Maine and New York, is led by a Democratic governor, a pattern state officials and health policy researchers have both noted publicly.

Finding a Way Through

Considering what DHS could have done differently, one decision stands above all others: running the high-risk revalidation effort and the LoginMN platform rollout at the same time, without adding staff to keep standard enrollment processing running. That decision produced a backlog that could take months to resolve, has kept providers from seeing patients, and has kept new clinics from starting practice or securing contracts with health plans that require Medicaid enrollment first. Some health plans have built workarounds; others have not.

There is also uncertainty about how long the current slowdown will last, and conflicting signals about its scope. DHS's own provider news postings describe moratoriums tied to specific high-risk categories, extended through Jan. 27, 2027, not a freeze on all enrollment. But a commercial health plan that meets regularly with IHN said that DHS told them that new enrollments generally, not just those in the high-risk categories, may not be reviewed again until 2027. DHS has not made that statement publicly, and IHN has not seen it in writing. The gap between what DHS has published and what at least one health plan says it was told in a meeting is a sign of how little clarity clinics currently have to plan around.

For clinics navigating the current process, there are several practical steps that can be taken. Screenshot every enrollment submission, since LoginMN's

access problems have made it difficult to retrieve that information later. Set up LoginMN account access well before it is needed, not after a problem arises. Track every submission date and every call to DHS. Submit applications as early as possible, and build the current processing delays into practice and hiring timelines rather than assuming standard turnaround.

There is currently no formal process to expedite a stalled application. DHS updates its provider news page as changes occur, but does not proactively notify providers or credentialing contacts before those changes take effect, making regular review of DHS's own website necessary. DHS in the past has honored originally requested effective dates once an application is approved, and it has done so in IHN's experience so far, but it has not made that a formal guarantee, and the volume of changes during 2026 makes it too risky to advise a provider to see Medicaid patients before enrollment is officially effective.

A broader recommendation is collective rather than individual: join an advocacy or industry group. Few clinics have the staff time to track DHS policy changes, monitor enrollment records daily, or call the department every week. A group of clinics working together, such as IHN's member network or associations like HLAMN, is better positioned to identify a problem like this early, share information across the industry, and prepare for its effects, than any single clinic working alone.

Alea Zemlicka is the marketing and credentialing supervisor at Integrity Health Network, an independent practice association serving clinics across Minnesota, Wisconsin, North Dakota and Iowa. 

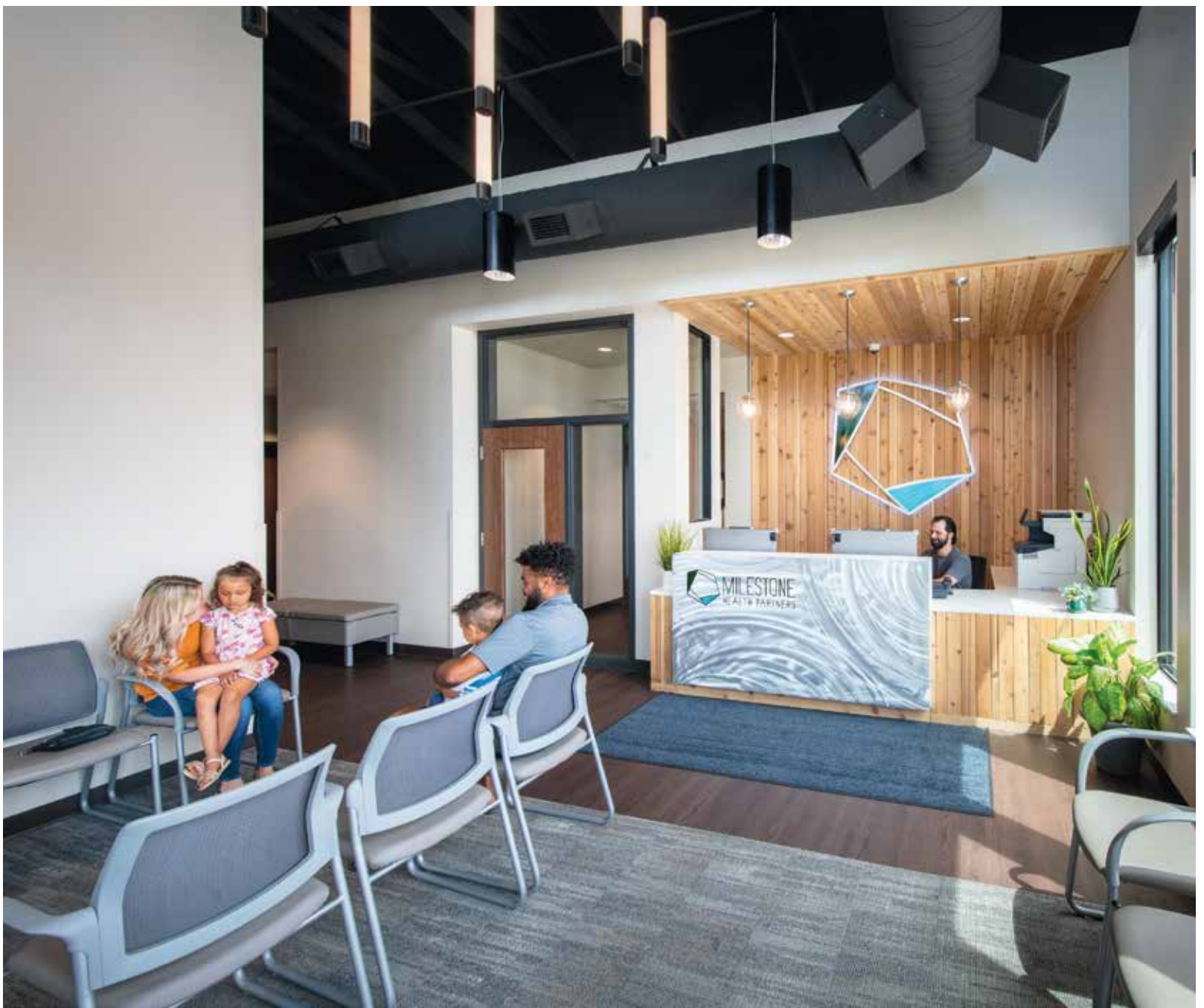
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◀ Female Urinary Incontinence from page 16

worked up the nerve to mention leakage at all, like an alarming escalation to surgery.

A Promising New Solution

That gap between screening and accessible, effective first-line treatment is precisely what Flyte, developed by Pelvital, was designed to address. FDA-cleared since 2020, this at-home device delivers transvaginal mechanotherapy directly to the pelvic floor musculature to treat stress urinary incontinence and weakened pelvic floor muscles.

Mechanotherapy is the clinical triggering of mechanotransduction – the process by which cells respond to mechanical stimuli – for tissue repair and rehabilitation. It has both a cellular and a neuromuscular impact. At the cellular level, mechanical stimulation deforms the cell's cytoskeleton, triggering a reflexive repair response that recruits additional filaments and stem cells. At the neuromuscular level, mechanotherapy stimulates mechanoreceptors in muscles that activate the tonic vibration reflex (TVR). This in turn engages the proprioceptive nervous system, improving neuromuscular facilitation, motor learning and muscle memory.

Typically prescribed in family medicine or gynecology, Flyte requires minimal clinic visits, no specialist referral and no equipment apart from the device itself. It can be effective with just five minutes of use a day, for six weeks, in the

privacy of the patient's home. Women with incontinence wait an average of six or more years from symptom onset before seeking treatment, according to the National Association for Continence. Removing scheduling, travel and adherence barriers to that first step matters just as much as the treatment's efficacy.

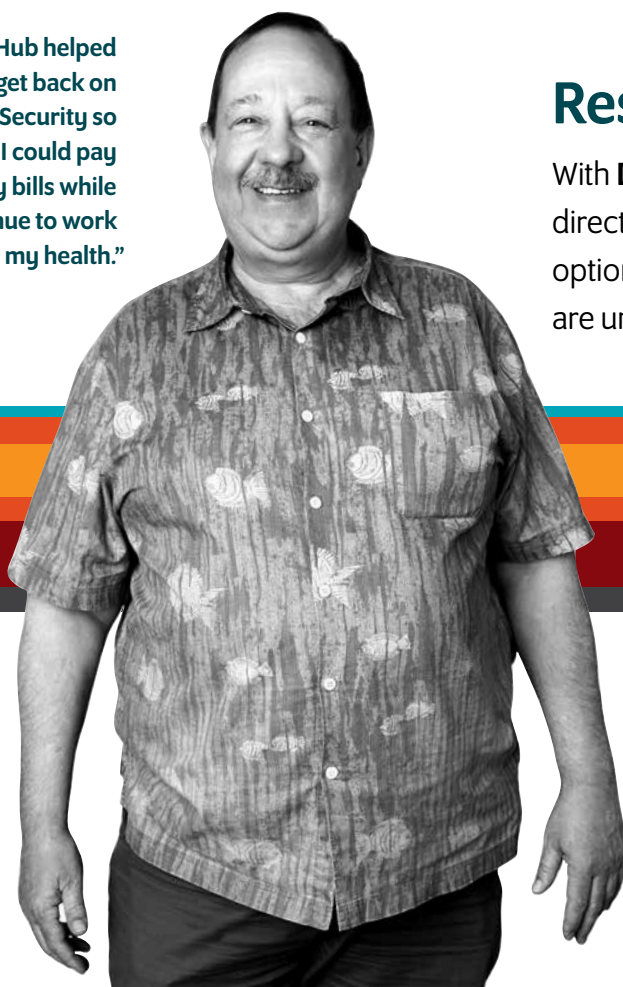
Its efficacy is backed by clinical evidence. A prospective cohort study of 60 women with SUI, who had already failed pelvic floor muscle training (PFMT) and were referred to surgery, found that Flyte's mechanotherapy — mechanical oscillation superimposed on device-guided Kegels — achieved continence in 82% of participants. Improvement was measured with the 1-hour pad weight stress test, with 77% remaining continent at two-year follow-up – and none going on to pursue surgery.

Building on these findings, the Pelvital SUI Training (P-SUIT) trial, a randomized, double-blinded study of 119 women, was conducted at the University of Minnesota with Nissrine Nakib, MD, director of pelvic floor medicine and professor of urology, as principal investigator. The study found that mechanotherapy delivered through the Flyte device significantly reduced 24-hour pad weight ($p<0.001$) and improved quality of life scores ($p<0.001$) in women with mild, moderate and severe SUI. Improvements appeared in as little as two weeks, adherence held above 80% at six weeks and roughly 7 in 10 became dry or near-dry within 2-12 weeks. Durable improvement was noted at 2-year long-term follow-up.

Barriers to discussing UI
exist on both the patient
and the clinician side.

Female Urinary Incontinence to page 26 ▶

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New Online CME Course

Healthcare providers play a key role in supporting their patient's return-to-work. MN RETAIN has collaborated with Mayo Clinic to develop a CME accredited course entitled *Preventing Needless Work Disability: The Healthcare Provider Role*. **Take the course to learn how you can best support your patient's return-to-work.**



Providers with one or more patients enrolled in the RETAIN intervention group will receive \$100 after completion of the online course.

This course has been updated and is now comprised of one module and takes approximately 45 minutes to complete.

Providers who have completed the CME are also eligible for additional reimbursement to support future patients participating in the program (patients also receive \$100 at enrollment).



For further information about how to obtain CME credit, visit ce.mayo.edu/retain

☎ 507-284-4537
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MN RETAIN is a collaborative program led by the Minnesota Department of Employment and Economic Development (DEED), Minnesota Department of Health (MDH), Department of Labor. MN RETAIN is funded by the U.S. Department of Labor and the Social Security Administration under a grant award of \$19,518,509 to the Minnesota Department of Employment and Economic Development that will be incrementally provided. 100% of grant funding is from U.S. Federal funds.

◀ Female Urinary Incontinence from page 24

A subsequent review of the published literature on transvaginal mechanotherapy for SUI concluded that its outcomes on pad weight and quality of life are superior to traditional PFMT. It provided continence and durability outcomes comparable to surgery, without the risks and cost.

To better understand how Flyte performs in everyday practice, Pelvital surveyed 411 women who had been prescribed Flyte. Demographics of note were an average age of 54 (range 24-80) and an average parity of nearly two births. Improvement was significant and quick; in just six weeks, mean baseline pads/day reduced from 2.36 to 1.08, and improved further to 0.74 at 12 weeks and 0.59 at six months. Quality of life followed the same trajectory: scores on the ICIQ-UI-SF questionnaire improved from a mean of 12.43 out of 21 at baseline to 7.06 at six weeks ($n=411$, $p<0.001$), continuing to 5.55 at 12 weeks ($n=266$, $p<0.001$) and 5.07 at six months ($n=74$, $p<0.001$).

These improvements line up with a measurable drop in how many patients were considering surgery (from 31% at baseline to 9% at six weeks), an outcome that matters because it means fewer women need to escalate to invasive treatment. Patients also reported high satisfaction (99%) and found the device easy to use (97%), both practical considerations for an accessible, conservative treatment for at-home use.

The idea for Flyte originated with a team of researchers at the Arctic University of Norway who were using a different application of mechanotherapy to treat muscle injury and deterioration. When they noted an impact on urinary incontinence, they conceptualized a method for transvaginal delivery of mechanotherapy directly to the pelvic floor. The intellectual property was later transferred to Pelvital, a Minnesota company. Pelvital is headquartered in

Eagan, Minnesota, meaning this conservative first-line option was studied, in significant part, in Minnesota's own academic medical community.

Increasing Awareness and Access

Strong data alone doesn't guarantee a treatment reaches the patients who need it, and Flyte's continued adoption focuses on the bigger picture of solving an access problem. In practice, a physician who identifies SUI on screening can prescribe Flyte much like any other prescribed treatment. The order is routed through trusted durable medical equipment partners who verify the patient's specific insurance benefits and communicate any patient cost responsibility before fulfilling, so the patient knows what she owes before committing rather than after. Insurance coverage itself has been expanding steadily, with many insurance plans in Minnesota covering it when prescribed with medical necessity.

UI affects over half of adult women and is chronically underreported in clinic visits. It has measurable long-term costs to physical health, mental health and independence the longer it goes unaddressed. There is, however, an accessible, evidence-based, first-line option that a physician can prescribe when appropriate, with the patient able to start using it at home the same week. Family physicians don't need a new screening infrastructure to address this problem. They need to ask one question, routinely, of every woman in the room — normalizing urinary incontinence and offering a treatment path that is right for the patient, opening the door to a better quality of life sooner than most patients realize is possible.

Shravya Kovela, PT, DPT, OCS, is director of clinical education and marketing at Pelvital, the Minnesota-based women's health tech company that developed Flyte. 📍



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◀ Protecting the Financial Wellness of Health Care Professionals from page 9

as part of their workforce design, instead of an optional benefit topic. Compensation is obviously part of the equation, but so are things such as predictable scheduling, childcare considerations, emergency savings, student debt, career-development financing, access to trustworthy and relevant financial coaching as well as financial products that work with health care career paths.

A financial partnership can fill some of that gap. AHCUC was created for Minnesota's health care community, therefore, it has health care specific financial literacy and education content to present and share — including presentations earning CME credits. It develops products that meet the unique needs of health care professionals — including options for co-creating value with employers. We have locations in and near health care hubs, such as Children's and United in St. Paul, with plans to be convenient throughout the Twin Cities' health care corridors.

What can you tell us about the inroads bitcoin and blockchain technology are making into health care?

It's important to separate Bitcoin from blockchain technology. Health care organizations need

predictable values, strong privacy controls, regulatory compliance and a reliable settlement of funds. A highly volatile asset, such as Bitcoin, isn't a strong fit.

Blockchain is more interesting because it can be used without asking a patient or hospital to speculate on cryptocurrencies. Examples such as health records, clinician credentialing and pharmaceutical supply chains are being studied and developed.

On the payment and settlement side, stablecoins are potentially a powerful financial tool. They can move and settle digitally around the clock and, in some applications, bypass traditional payment intermediaries and some of the fees associated with card or cross-border payment rails. And they remain tied to currencies, that don't fluctuate as much as Bitcoin, such as the U.S. Dollar. It's an emerging area. Congress created the federal regulatory framework for stablecoins in 2025 through the Genius Act, for which both bank and credit-union regulators are creating and implementing rules in 2026.

Innovations in banking are starting to include AI. How do you see this now and where it could be going?

Banks and credit unions have used forms of artificial intelligence for years — particularly in fraud

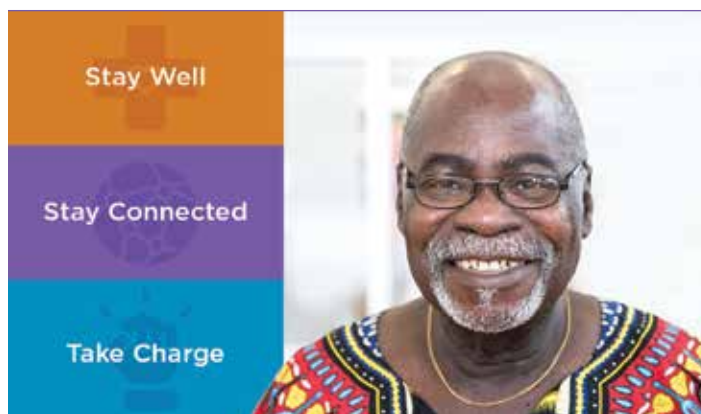
detection, risk scoring and transaction monitoring. The newer innovations include Generative AI, which allows systems to work with language, documents, conversations — and Agentic AI, which can potentially complete multiple steps of a task rather than simply answering a question. In the near-term, AI will work beside employees, not replace them — for example, to summarize a complicated application, surface missing documentation, analyze cash flow, draft correspondence and more. AI will probably become one of our best tools for fighting fraud — and one of fraudsters' best tools for committing it.

For consumers, AI can help them understand their money, make recommendations and assist them to take authorized actions. It's even being tested to infuse emotional health support that drives financial decisions. Physicians are likely to be familiar with the use of AI, as a June 2026 study by JCI, a global leader in accrediting hospitals and health systems outside the U.S., noted that more than 80 percent are already using AI professionally.

Joel Swanson is the president and CEO of Associated Healthcare Credit Union. ■

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A photograph of three women walking on a paved path in a park. The woman in the foreground is wearing a grey hooded jacket with white fur trim and glasses. The woman behind her is wearing a black jacket. The woman to the left is wearing a white shirt and a pink jacket. They are all smiling and walking towards the camera. The background is a lush green park with trees.

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