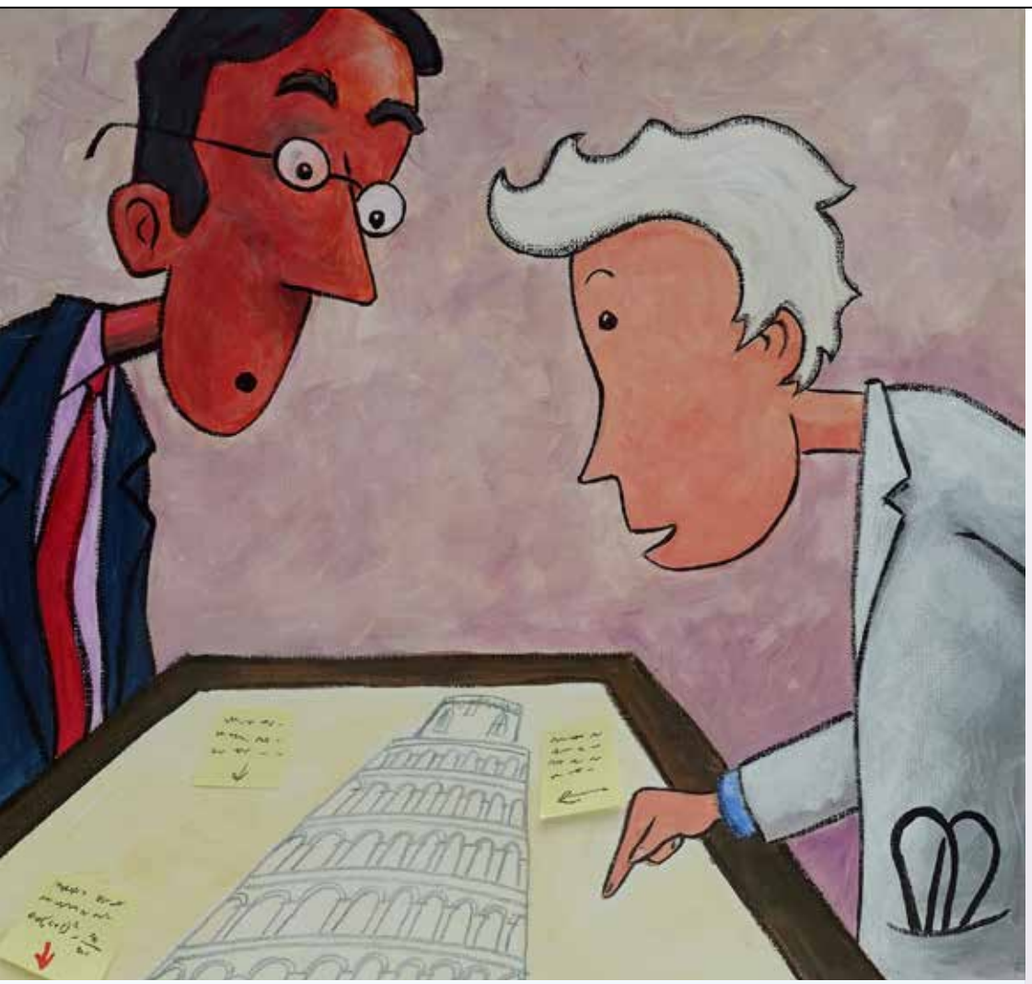
MINNESOTA
PHYSICIAN

FEBRUARY 2026

THE INDEPENDENT MEDICAL BUSINESS JOURNAL

Volume XXXIX, No. 11



Health Care Reform

A plan that could work

BY JOHN KRALEWSKI, PhD, MHA

The current turmoil in our health care delivery system is at a level requiring an immediate and carefully considered response. With so many different components, often in competition and/or conflict with each other, meaningful solutions are difficult to envision. As many critical elements involved with the provision of health care vary widely from state to state, it may well be that restructuring health care in Minnesota can happen only through actions taken in Minnesota and these may be best led by our state governor. Health insurance plans are exiting the field in Minnesota and those remaining are projecting double digit premium increases. The recent national failure to renew the Affordable Care

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Social Workers in Cancer Care

An important new member of the care team

BY NICOLE MARCOUILLER, DSW, LICSW, OSW-C

Comprehensive cancer care is based on the understanding that illness impacts the entire spectrum of the person's life. Like other chronic and life-limiting illnesses, cancer is not simply a medical issue. When we consider the goals not just of treatment, but of high quality of life, low symptom burden and long-term survivorship, the role of the interdisciplinary care team becomes vital. The range of health care professionals that compose the cancer care team is one of the largest and most varied that serves any medical condition and a vital member of that team is one trained in social work. As the largest providers of psychosocial support in cancer centers throughout the United States, oncology social workers (OSWs) are an integral part of that team. Understanding the full scope of work of OSWs and how to utilize those services is an opportunity to give patients the best outcomes.

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Minnesota Physician is published once a month by Minnesota Physician Publishing, Inc. Our address is 758 Riverview Ave, St.. Paul, MN 55107; email comments@mppub.com; phone 612.728.8600;. We welcome the submission of manuscripts and letters for possible publication.

Mayo Develops Smartwatch App to Predict Tantrums

In a recent study published in JAMA Network Open, researchers from the Mayo Clinic discussed findings from their development of an AI assisted, smartwatch-based system to alert parents in advance if their children are about to experience a tantrum. This is important for children with emotional and behavioral disorders as it provides an opportunity to intervene before the tantrum intensifies. The tool allowed parents to respond within four seconds of detection and shortened severe tantrums by an average of 11 minutes – about half average duration. The randomized clinical trial lasted 16 weeks and reported on 50 children between ages 3 and 7 who were receiving parent-child interaction therapy at the Mayo. Half the children used the smartwatch system, half did not. Data showed participants wore the smartwatch through 75% of the total trial time period. Previous related studies showed similar technology could predict a child's behavioral health state with an 81% rate of accuracy and provide 30-60 minute advance warning of an impending episode.

The smartwatch system detects physiological signals such as rising heart rate or movement and sleep changes and sends them to the parent's smartphone. Real time data analysis cues parents to react and assist their children. According to CDC data, mental, behavioral and emotional health issues affect nearly 1 in 5 children in the U.S.

"This study shows that even small, well-timed interventions can change the trajectory of a child's emotional dysregulation episode," says Magdalena Romanowicz, MD, a Mayo Clinic child psychiatrist who co-led the study. "These moments give parents a chance to step in with supportive actions — moving closer, offering reassurance, labeling emotions and redirecting attention before a tantrum intensifies."

Conclusions point to how smartwatch technology can give parents actionable steps to help their families in real time. Immediate alerts were able to measurably improve response times, providing positive changes in children's behavior. The technology demonstrated the feasibility of enhancing family engagement and helping to manage severe behavioral health symptoms at home. Considering that professional help is rarely immediately available, the smartwatch tool can help bridge a gap in pediatric mental health care.

UnitedHealthcare and Fairview Reach Contract Extension

UnitedHealthcare (UHC) recently announced a tentative agreement with M Health Fairview to keep more than 125,000 patients in network. The Minnesota-based health insurance provider says it reached a multi-year agreement "in principle" with Fairview and the two are working to finalize the terms of their new contract. As recently as mid-December the UHC website was instructing Fairview patients to find an alternative insurance carrier as they would no longer cover claims from Fairview. Part of the impasse centered on the UHC claim that Fairview demanded a more than 23% price increase for its commercial plans. The increase would have made it "significantly more expensive than any health system in the Twin Cities," according to a UHC spokesperson and would cost consumers and employers $121 million more. Fairview countered, saying that the increase would be stretched over three years and argued increases to rates over the past several years have been inadequate with costs driven by inflation, workforce shortages and the pandemic.

"Our goal in these talks was simple: make sure patients can keep getting care they need and to remove extra steps that can slow things down," read

a statement on the M Health Fairview website. "Reaching this agreement allows us to move ahead with confidence and focus on what matters most — supporting your health." If approved, here are the impacts on patients who use Fairview providers.

- UnitedHealthcare plans — commercial and Medicare Advantage — remain in network.
- Patients can continue seeing Fairview providers in 2026.
- Appointments already scheduled for 2026 will proceed as planned.
- No insurance plan changes are needed to stay in network.
- Emergency care remains available to all patients, regardless of insurance. The new contract will run through 2028 and will ensure full, uninterrupted in-network access to M Health Fairview for all UHC members, including UHC's Medicaid Plan in Wisconsin. Neither party released further contract details.

MDH Counters Trump Antivax Propaganda

The Minnesota Department of Health (MDH) recently announced it is aligning all of its immunization guidance with professional medical association recommendations rather than following those recently amended Centers for Disease Control and Prevention (CDC). The move comes after federal officials overhauled the childhood immunization schedule to reduce the number of routinely recommended vaccines.

"This change at the federal level does not reflect the best available science. Medical association immunization schedules are evidence-based, reflect current clinical practice and are developed through established professional review processes," said Minnesota Commissioner of Health Dr. Brooke Cunningham. "Aligning our recommendations with professional medical associations helps provide clarity and stability for families and providers by using a proven set of recommendations that doctors, and other clinicians, already know and trust."

The unilateral move by the federal government to change the childhood immunization schedule did not follow previous processes that include intensive scientific review by an advisory committee. In order to provide Minnesotans with clear, science-based information about immunization, MDH is updating its website and other immunization guidance to follow the immunization schedules put out by professional medical associations.

Minnesota has previously shifted away from the federal CDC schedule for COVID-19 and hepatitis B vaccines. This action extends that approach across all vaccines. Aligning immunization recommendations with those of medical professional associations will help save lives, prevent infectious diseases, and ensure a simpler, more consistent approach for providers, parents and the public.

"The Minnesota Medical Association is very concerned about how the CDC's changes will add unnecessary confusion and uncertainty around vaccines," said Minnesota Medical Association president Lisa Mattson, MD. "We urge Minnesota parents and families to talk directly with their physicians about the critical role that childhood vaccines play in preventing serious disease and death. By vaccinating your child, you are not only protecting your child's health, but also the health of their classmates, friends and community."

At this time, vaccines recommended by professional medical associations continue to be covered by private insurance and available through the Minnesota Vaccines for Children (MnVFC) program.

Avera Opens New Digestive Health Center

Avera Health got the new year off to an exciting start by opening a new 127,000-square-foot medical office

building on its Louise Health Campus in Sioux Falls. The three-story facility, named Pavilion 2, is home to the Avera Digestive Health Center and the specialty of gastroenterology. Together with a six-story expansion for women's and children's services at Avera McKennan Hospital & University Health Center, the two facilities represent the largest building project in company history and encompass 350,000-square-feet of new patient care space.

In Pavilion 2, the ground floor is dedicated to gastrointestinal procedures. It includes eight general procedure rooms and two suites for specialized procedures, for example, endoscopic retrograde cholangiopancreatography (ERCP) and endoscopic ultrasound (EUS). The space allows for future growth. There are over 40 pre-/post-procedure rooms on ground floor, with capacity to expand. Patient registration for both procedures and clinic visits will take place on ground floor. This added space provides capacity to increase GI procedures by 100%.

The second floor will house the gastroenterology clinic with capacity for additional growth similar to the first floor. The lower level is attached to an underground tunnel between Avera Specialty Hospital and Pavilion 2. The lower level houses dedicated space for sterile processing.

"This is an exciting expansion on our Avera on Louise Health Campus. When we began developing this campus in 2017, our vision was to offer greater and easier access to convenient, high-end health services like orthopedics, gastroenterology and more. This campus has proven to be a destination for specialty health care services," said Ron Place, MD, regional president and CEO of Avera McKennan Hospital & University Health Center.

Factors driving growth in demand for GI services include a growing population, an aging population, and recommendations to begin colonoscopy screenings at age 45 instead of age 50.

"People today are more in tune with their own health. Rather than just live with troubling symptoms, they seek out specialty care, and we are pleased to have growing capacity to serve these needs," said Christopher Hurley, MD, a gastroenterologist in Sioux Falls.

Winona Health Earns Top Emergency Care Award

Winona Health was recently recognized as a national leader in emergency care and has received a 2026 America's Best Hospitals for Emergency Care Women's Choice Award. This recognition places its emergency care department in the top 7% of 4,655 hospitals nationwide and is a symbol of excellence based on customer experience. The honor reflects a commitment to what matters most, providing timely, effective and compassionate care to every patient. For over 130 years, the best possible care at Winona Health has happened as it always has — when it is there for emergencies that touch families.

"This award speaks to what our team focuses on every single day," said Andrew Teska, NRP, director of emergency services at Winona Health. "When patients come through our doors, they're often having one of the worst days of their lives. We don't get second chances in those moments. Being fully present, moving quickly, and caring deeply— that's what matters, and that's what our community deserves."

The Women's Choice Award is especially meaningful because it is based on patient satisfaction and publicly reported performance measures. Only hospitals that meet strict clinical criteria and earn high levels of patient recommendation are eligible, making this recognition a reflection of both quality care and community trust. The Winona Health emergency care department is staffed 24 hours a

day by dedicated physicians, associate providers, registered nurses and support staff, with specialty physicians on call to respond as needed. Patients of all ages are cared for and no one is denied treatment.

"What makes this recognition so special is that it honors the people behind the care," said Kara Bayer, associate vice president of hospital services. "Every caregiver, from our physicians and associate providers to our registered nurses and support staff, plays a role in ensuring our neighbors receive the care they need, when they need it most."

By earning the Women's Choice Award, Winona Health joins an elite group of health care organizations committed to empowering women and families to make informed health care choices while remaining deeply connected to the communities they serve.

Improper Medicaid Payments in Minnesota Far Below National Average

New federal data released by the U.S. Centers for Medicare & Medicaid Services (CMS) shows the overall rate of improper payment in Minnesota's Medicaid program is far below national averages. In the review released recently, CMS found an error rate of slightly over 2.1%, compared to a national average of 6.1%. The data for the review were compiled before the Minnesota Department of Human Services (DHS) began implementing new strategies to minimize the risk of fraud and harden its systems against bad actors. Reviewers at CMS checked billing statements and then compared them with medical records to ensure the billing was accurate.

"No amount of error or fraud is acceptable. Even one dollar is too much," said temporary DHS Commissioner Shireen Gandhi. "We're committed to making Minnesota a national model for preventing fraud and catching errors. This review shows we have strong internal controls that we continue to improve, and we are not stopping there as we accelerate our efforts to fight fraud."

The data came as federal authorities threaten to withhold $2 billion in annual funding related to program integrity. Since the fall of 2024, DHS has introduced new processes and reforms to detect and prevent fraud including:

- Identifying 14 high-risk services and establishing a Medicaid program integrity webpage for the public
- Auditing autism service providers, including on-site visits
- Discontinuing the Housing Stabilization Services program
- Establishing a moratorium on adding new service providers in 14 high-risk services
- Implementing licensure for autism centers
- Disenrolling inactive providers
- Beginning enhanced pre-payment review before fee-for-service payments are made to providers in the 14 high-risk services
- Developing plans to review and revalidate providers in the 14 high-risk services

The new federal report is the first hard data in the past year to identify the scope of improper payments in Minnesota's Medicaid program. CMS provides ongoing reviews to comply with a law passed by Congress in 2019. Minnesota officials say the review is just one more tool they will use to ensure the integrity of the programs the state uses to administer benefits.

"The CMS review confirms DHS is doing better than the national average in complying with Medicaid payment requirements. And in our ongoing effort to reduce errors and strengthen program integrity, the state is bringing on independent consultants to double-check payments, audit processes and recommend changes going forward," said Gandhi.

Excellence, Integrity and Collaboration

Kirsten Johansen, MD, president Hennepin Healthcare Research Institute

The Hennepin Healthcare Research Institute (HHRI) traces its roots back to 1952. Please share an overview of the journey from that point to today.

When HHRI was initially established in 1952, it was affiliated with Minneapolis General Hospital (the predecessor to Hennepin Healthcare, HHRI's current parent). Ground was broken on the first research building in 1958 to support the scientific work of dozens of hospital providers. In the decades that followed, many research projects were carried out with support from the community and the National Institutes of Health (NIH), which remains the primary source of HHRI's research funding today. Over the years, the organization has grown substantially and now supports the work of over 250 researchers who study a wide variety of topics. As the hospital's structure evolved, HHRI adapted, but the mission of conducting medical research in support of the community remains a primary focus.

In terms of research projects, what are some of the historical highlights?

One of our points of pride is our legacy of innovation in kidney care. Hennepin Healthcare performed the first kidney dialysis treatment and the first kidney transplant in the upper Midwest in 1963. These early innovations laid the foundation for our current research program in kidney disease that continues to transform how kidney disease is treated. I am honored to lead the United States Renal Data System (USRDS) contract at HHRI. USRDS is a large federal data system that leverages federal claims data for treating kidney disease to inform effective policy decisions and identify ways to better care for patients with kidney disease.

Also, in the early years, construction began at Hennepin Healthcare on the first hyperbaric chamber in the state of Minnesota in 1963. The chamber was originally designed to perform transplant surgery, but has also been used to treat wounds, carbon monoxide and nitrogen poisoning and a variety of other disorders. The chamber was replaced in 2012 and can now be used to create an oxygen environment up to three times the pressure and four times the oxygen concentration of normal conditions. Current HHRI research is exploring whether hyperbaric oxygen therapy can improve outcomes and reduce disability for people who experience a traumatic brain injury.

> "Medical research provides widespread benefits to society, and good health is important for us all, regardless of one's political orientation."

More recently, HHRI researchers worked with colleagues around the country to quickly develop and validate new laboratory tests to detect COVID-19, even before the World Health Organization declared COVID-19 a pandemic in March 2020. HHRI researchers also launched early clinical trials to study how to treat patients infected with the disease. COVID-19 studies conducted at HHRI included a variety of trials of potential treatments such as Remdesivir and convalescent plasma as the world tried to figure out how to deal with this new disease.

HHRI research affects not only the lives of local community members but also those from all across the globe. What can you share about some of your international work?

HHRI faculty in our Berman Center for Clinical Research recently completed a decades-long collaboration with colleagues at Monash University in Australia on the "ASPirin in Reducing Events in the Elderly (ASPREE)" study. ASPREE was the largest international trial ever funded by the U.S. National Institute on Aging and studied more than 19,000 participants 65 or older in the United States and Australia. Participants took either a daily low-dose aspirin or a placebo, and key study results found that daily low-dose aspirin had no benefit for healthy older people. The study also found a 38% higher risk of bleeding in those taking the daily aspirin. Because ASPREE was such a large and complex study, its data continue to be used for multiple sub-studies investigating other health issues affecting older adults.

Researchers in HHRI's Center for Infectious Disease Research participate in other international collaborations including the Strategies and Treatments for Respiratory Infections and Viral Emergencies (STRIVE) network. STRIVE is a global clinical research consortium established to respond quickly to infectious disease emergencies, so we are ready when novel illnesses like COVID-19 need to be studied through rapid implementation of clinical trials. The HHRI international coordinating center is one of nine centers within the STRIVE network and oversees the conduct of study protocols at over 20 clinical sites in the United States and four clinical sites in Mexico.

This past October, HHRI adopted a new mission and redefined its core values. Please tell us about why this happened and what it means.

We are excited about our new mission and core values. The new HHRI mission is "Transforming health and health care for all through ethical

research and meaningful community partnerships." The new core values for HHRI are "Excellence, Integrity, and Collaboration."

These principles are the result of an extensive strategic planning effort that solicited input from a broad range of internal and external stakeholders over an 18-month period that started in 2024. The work began during our routine planning cadence but evolved into a larger initiative in response to the major changes occurring in research in the United States during this time. This updated strategic framework represents a new chapter in HHRI's long history of pursuing research excellence by elevating the concepts of community and partnership in our vision of the future. It also better aligns with the commitment to transforming health and health care that we share with our parent organization, Hennepin Healthcare.

What are some examples of your current research projects?

Our researchers are experts in their fields tackling a variety of health care challenges related to chronic disease, emergencies, trauma, addiction and many others. We conduct basic, translational, clinical and epidemiological research. There's so much amazing work going on that it's difficult to choose highlights, but here are a few examples of work that is directly impacting patient care.

Frostbite

Hundreds of patients with frostbite seek care at Hennepin Healthcare's Emergency Department each winter. Severe frostbite can be devastating, so quickly evaluating and treating it can improve the chances of salvaging affected tissue. To help improve outcomes for frostbite victims, our researchers have developed a tool to evaluate frostbite called the Hennepin Frostbite Score, a standardized measure of how much tissue has been affected. The tool has already helped determine that each hour of delay in treatment can reduce the chances of limb salvage by 28%. Because of this work, more providers recognize that frostbite is an emergency, leading to faster treatment and better outcomes for patients. We recently initiated a new multi-center study to collect and harmonize data about frostbite incidence, treatment, and outcomes from 14 sites in North America to enable comparison of tissue salvage using the Hennepin Frostbite Score.

Spinal Cord Injury

Our Restorative Neurotrauma Lab is conducting the Epidural Stimulation After Neurologic Damage (E-STAND) study, a clinical trial to test and optimize the use of epidural spinal cord stimulation to restore movement in patients suffering from spinal cord injury and paraplegia. The trial's purpose is to examine how implanting an epidural stimulator can restore voluntary movement in people who haven't been able to move since they were injured. The implant is remotely controlled through a tablet application with monthly in-person adjustments. Using the data from the tablet and the in-person check-up, the study team adjusts the stimulation settings of the implant to optimize quality of life improvements based on the patient's unique preferences. Early results are promising, and patients in the study are also experiencing cardiovascular improvements, better core support, and reduced muscle spasticity.

New federal policies around funding medical research are creating disastrous results. What can you share about this?

The recent federal policies around funding

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Act will result in thousands of low-income Minnesotans unable to afford coverage. Both the public and private sectors should be concerned about this moral and economic dilemma. Uninsured families will still need basic health care and won't be able to pay the high costs. Consequently, hospitals and medical practices will experience millions in uncollectable billing, and some will be forced to close specific units to protect themselves from the financial burden. This is an immediate problem in rural areas where hospitals are already limiting services and closing service lines because they can't afford to keep them open given the low patient volume. This health insurance crisis is now at our front door and we need to respond. The far-reaching implications of these issues rise to the level where the state legislature needs to respond. The financial crisis supersedes the risks a new program might bring to restricted budgets. Consequently, an innovative new approach needs to be developed that will reduce health care costs and result in lower insurance premiums while protecting quality and access to care. A well-designed state program would not only lower health insurance premium costs but would also improve the efficiency of the provider system.

> Physicians are spending too much of their time treating patients with minor illnesses that can be treated by nurse practitioners.

What Research Can Tell Us

Many recent studies provide insight into these issues. First, the research is clear that provider costs can be reduced by at least 30% from limiting the use of services, and especially technologies, that make little or no contribution to patient health outcomes. There are several factors driving this waste. Hospitals and physicians make more money by these high utilization patterns, patients are unable to determine if they are needed and legal considerations favor overuse. For example, the overuse of imaging technologies including MRI procedures and CT scans when unrelated to a patient diagnosis. This overuse is often related to the ownership of these technologies. There is a significant increase in use if the technology is owned by a medical clinic or the medical practice is located next to a hospital. All of these data were adjusted to correct for case mix of patient illnesses. Scheduling fewer patients per hour also improves quality and reduces costs by having time to involve patients in their health care. Another factor increasing costs is that physicians are spending too much of their time treating patients with minor illnesses that can be treated by nurse practitioners or even registered nurses using care guides. Several studies have found that the employment of nurse practitioners by primary care medical group practices reduces costs and improves quality of care as well as patient satisfaction. Team care is gaining traction but most of the training programs still prepare nurse practitioners and physicians to practice independently. Consequently, when medical practices add nurse practitioners, they often fail to develop the team concept and costs increase rather than decrease. One recent research study found that one NP per physician lowers cost, however two per physician often increases costs because they tend to be used as assistants rather than independent providers.

The lack of adequate primary care clinician training to both provide and manage patient care is an important cost and quality factor because they control nearly 70% of total health care expenditures. In addition to their clinical decisions, they decide when to refer their patients to specialists and which specialists provide cost effective care. The savings achieved by well- managed primary care clinics is not trivial. One study found a 40% difference in the total cost of care provided and managed by primary care medical group practices after adjusting for differences in patient level illness and differences in reimbursement rates. An important additional finding was that quality is not found to be related to those cost differences. Differences in reimbursement is an especially troublesome challenge for patients with deductible provisions in their health insurance plans. Out-of-pocket payment for a routine clinic visit could vary as much as $50 depending on the patient's health insurance's negotiated contract with their clinic. And even more important, data related to these cost differences are not available to patients. Access to primary care is also an issue. Wait time for clinic appointments is often two weeks or more and phone calls are not returned until the end of the day. Consequently, patients often go to emergency departments for their primary care. This of course increases costs.

A Working Template

So, how could legislative leadership in Minnesota resolve these issues and create a better health care system? A good place to start would be to learn how the Fairview health care system developed its innovative model 10 years ago, designed to improve primary care. Their first analysis focused on the expected workload. This was accomplished by reviewing patient visits during the last six months from the electronic medical records, identifying the reason for the visit and the treatment provided. A review of these data, by a committee of nurses and doctors, found that about 30% of the visits could have been handled by

nurses using care guides. Another 25% could have been dealt with by nurse practitioners, leaving only 45% requiring physician level training. They also found that at least 40% of all visits could be resolved by phone rather than a clinic appointment.

The next step was to reconfigure the clinics organizational and physical structure to support this expanded team approach to providing care. Was this successful? Yes and no. Total cost of care for patients adjusted for illness level was 38% lower than the control practices and patient satisfaction was 30% higher. However, they were never able to get the health insurance plans to pay for services provided by nurses or even some phone visits and they had to return to a traditional care model. Can the Fairview experience and related research focused on medical group practices be used to develop a competing low-cost high-quality health care option with broad access to care?

> 40% of all visits could be resolved by phone rather than a clinic appointment.

We know that some primary care medical group practices provide high-quality care at lower costs. We also know that the high-cost practices can be expected to resist changing their practice styles as long as they attract patients and insurance plans or patients pay the higher cost. So how can enough patients be convinced to select lower cost primary care practices to cause the others to change as they lose patients. Passing the savings on to patients who choose low-cost practices would seem logical, but how can that be done? An innovative program developed by the health insurance plan for state employees has promise as a response to this issue. That plan was designed to protect enrollee choice of physicians and access to care while providing economic incentives to select low-cost practices. The health insurance plan accomplished this by creating three categories of primary care practices serving their enrollees based on cost and quality data available from their records. Enrollees are required to select a primary care practice and a physician in that practice to provide and manage their care. They could change physicians and even practices but needed to stay in the selected tier unless they wanted to change tiers. If enrollees selected a physician in the lowest cost tier that also met the plan's quality standards, all care is fully covered. Coverage for those choosing the second-tier practices includes co-pays, and enrollees selecting physicians in the highest cost tier includes both co-pays and deductibles. This not only reduced the overall cost of the health insurance plan, but it also caused the high-cost physicians to review their practice styles as they lost patients.

One of the attractive attributes of this approach is that it doesn't require major organizational change, and unlike some HMOs it retains free choice of physicians from a large set of providers. Health insurance plans can easily calculate physician practice cost and quality measures from their claims data and can work with high-cost practices to help them get into a lower cost tier. All of this should be welcomed by self-insured companies because it lowers costs

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while protecting employee access to high-quality health care provided by their choice of physicians. Changing established institutional patterns of health insurance in Minnesota, however, will be difficult as most of the current plans are doing well financially and have no incentive to offer a competing plan. Moreover, some physicians might claim that this program places limits on how they practice and results in lower quality of care so quality needs to be continually monitored.

This new concept needs some high-profile agency to champion adoption. Highly respected hospital-based systems such as Fairview might find it attractive as their self-insured program for their employees but that wouldn't open the plan to others. The health insurance plan provided for state employees would be a natural sponsor because their plan already has many of these features. The state government could offer this program as an extension of its existing health insurance plan and contract with a private sector entity to market and manage it. Perhaps UCare could be reconstituted and assigned this role. With the current projected large increases in health insurance costs there is an urgent need for a competing plan, and the state legislature should take the lead in responding to this opportunity. Moreover, they can do so without breaking the state budget by establishing a supporting premium that still would be 30% less than the commercial plans and protecting the plan from adverse selection by reviving the state program for enrollees with high-cost health care needs funded by a small tax on all health insurance plans.

> Political leadership in Minnesota should welcome this opportunity to further the state's historically innovative culture.

Political leadership in Minnesota should welcome this opportunity to further the state's historically innovative culture. This should be an especially important motivator for our legislature. Minnesota is widely recognized nationally and even internationally for being innovative. This includes technologies in industry and manufacturing, the development of HMOs and the medical group practice concept in the health care field and the clinical breakthroughs developed by the university physicians and the Mayo Clinic.

An important dimension of this state model is that it provides a mechanism and leverage to influence some other changes in health care financing and delivery. For example, we know that prescription drug companies will negotiate lower prices if they can count on a guaranteed volume and that agreeing on one brand of an expensive drug often provides that needed volume. Since prescription drugs account for nearly 15% of health care costs this proposed health insurance plan could reduce these costs and further reduce their premium. The leverage of this health insurance plan would also enable it to strengthen rural health care in Minnesota. A good place to start would be to invite rural community leaders to meet with the health insurance plan to start discussions about the changing rural environment and realistic expectations for health care in their community given the rapidly changing rural economy and the need to maintain access to medical and surgical specialty service that are shifting to larger communities. Trade centers are shifting and the locations of many health care providers are following those trends. Small farming communities do not have a large enough population to support a physician but could become linked to a clinic 20 miles away with a nurse practitioner and perhaps a nurse doula located on site and linked electronically to the parent clinic. These discussions backed by lower health insurance costs and flexible payment plans would likely generate several rural health care models. What we know is that one model does not fit all and that local planning along with flexible payment plans are key factors. Our legislature should recognize this exceptional opportunity to create meaningful health care reform for the citizens of Minnesota.

Conclusion

Development of the model discussed in this article involves major changes and will require an extensive effort to generate bipartisan political support. The health insurance crisis, however, requires urgent action. An attractive immediate response would be to open the current state employees' health insurance plan to all Minnesotans with incomes at or below twice the poverty levels. That would go a long way in resolving the problem and would signal to Washington that we still know how to be creative.

John Kralewski, PhD, MHA, is a professor emeritus at the University of Minnesota, where he was the founder and director of the Center for Health Services Research in the School of Public Health for more than 30 years.

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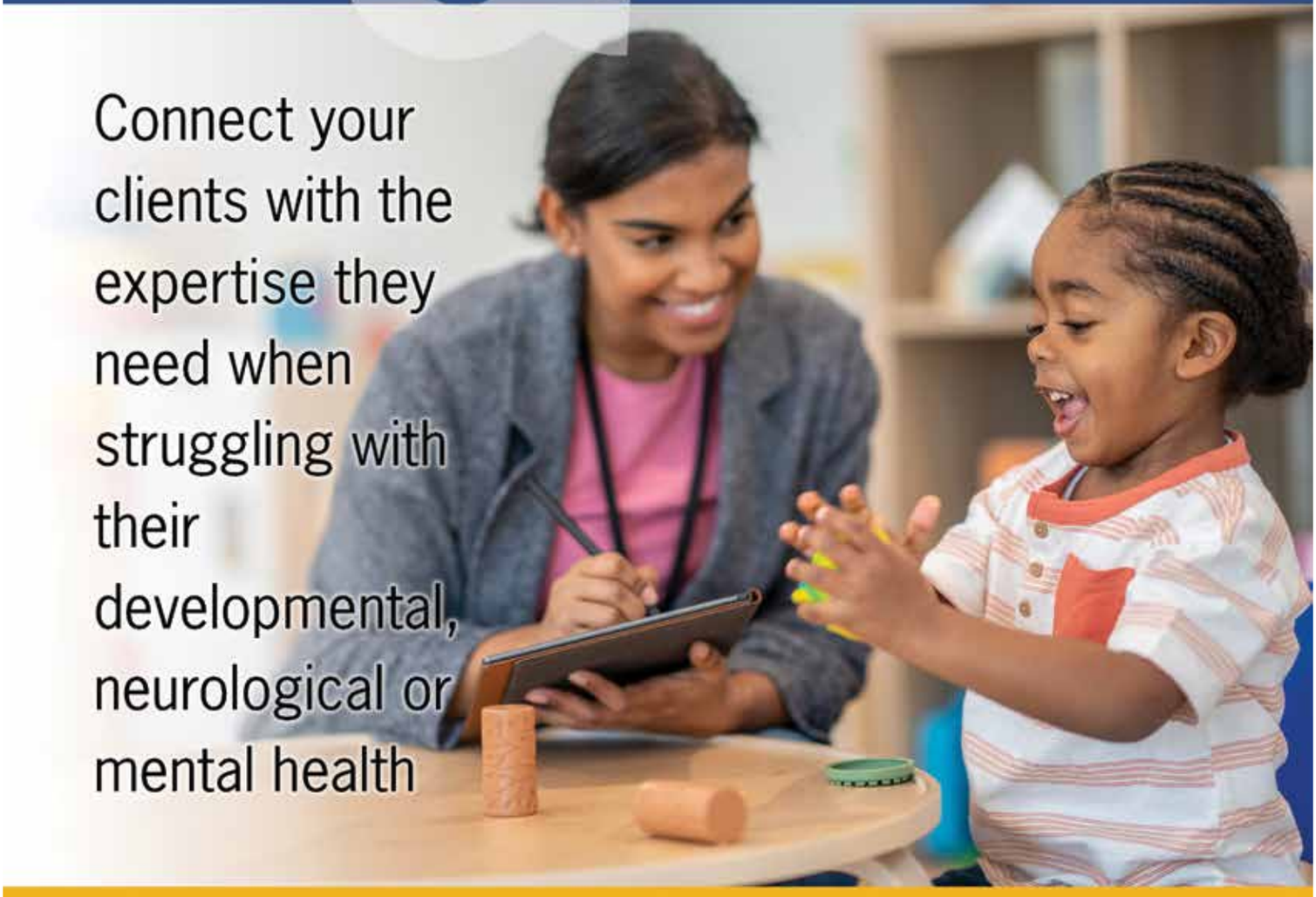

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◂ **Social Workers in Cancer Care** from cover

The Need for Multidisciplinary Care Teams

A multidisciplinary approach to cancer care is a patient-centered model. This approach to care recognizes that health care professionals with different specialties and skill sets are necessary to meet the full spectrum of patient needs. In their role in a multidisciplinary care team, OSWs approach care from a systems approach. Central to social work training, systems theory provides a framework for viewing human behavior as interconnected through family, community, and social systems. People are affected by systems, and further, people affect the systems in which they live. OSWs recognize and work to advocate and mitigate the impact of inequitable systems and historical trauma while engaging the individual and community strengths that support patients through medical challenges. This comes with the awareness that a patient's cancer also affects family and community. This understanding has become increasingly relevant in health care settings as discussions of social drivers of health (SDOH) become more engrained in how one approaches care and is particularly applicable in oncology.

SDOH are the non-medical factors linked to health care outcomes. These include where people live, work, and learn and incorporate factors such as income, education and social support. SDOH are estimated to influence up to 50% of health care outcomes.

An example of this, when considering comprehensive cancer care, is the understanding of financial toxicity (FT). This involves the adverse financial impacts that can come with cancer care, including growing debt and decreasing assets. It can linger for years following a cancer diagnosis and has not only financial implications, but also psychological and medical impacts. Patients with financial toxicity are almost three times as likely to report psychological distress and more than 30% of patients in lowest income groups report delays in care or skipping prescription refills. Almost 20 percent of low-income cancer patients report cutting pills in half to reduce medication expenses. This includes both medications to treat their cancer as well as those to address side effects. With this in mind it is easy to understand how financial toxicity is linked with lower reported quality of life and higher mortality rates.

History of Oncology Social Work

Early medical social work started in 1905 when Massachusetts General Hospital hired Ida Cannon and Garnet Pelton to assist with addressing the social factors affecting service delivery and patient outcomes. Cannon is credited with creating the field of medical social work based on her recognition of the intimate link between illness and social conditions. Later, Dr. Jimmie Holland promoted the idea of psychosocial distress as the sixth vital sign in medicine and was a key contributor to the development of the National Comprehensive Cancer Network's (NCCN) distress thermometer. Her work at Memorial Sloan Kettering was the foundation of the field of psycho-oncology and helped pave the path for OSWs today.

Oncology social work began to gain traction in the 1970s. With Dr. Holland's work, there was a growing recognition among cancer settings of the need to have a member of the team that understood, and could address, the psychosocial impact of a cancer diagnosis and its treatment. Moreover, as cancer became increasingly treatable, the long-term impacts of survivorship reemphasized the need for dedicated professionals that support patients with these long-term needs. The Association of Oncology Social Work (AOSW) started in 1984 as a way to bring together OSWs active in the work and wanting to expand the profession. Today, AOSW has over 1200 members working to promote best practices for patient care.

As the advancement of the profession has continued in the decades since AOSW started, recognition of the needs for psychosocial screening and support for cancer patients has also grown among cancer organizations. In 2008, the Institute of Medicine (now the National Academy of Medicine) published its report, Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs. This report highlighted the needs to prioritize psychosocial cancer care. By 2015, the American College of Surgeons Commission on Cancer (CoC) required accredited programs to screen and address psychosocial distress. The National Comprehensive Cancer Network (NCCN) and the American Society of Clinical Oncology (ASCO) have also provided guidelines that support the need for psychosocial cancer care.

Oncology Social Work Today

Today, oncology social workers are the largest providers of psychosocial care in oncology settings in the United States. OSW scope of practice ranges from direct practice to advocacy and advancing the needs of cancer patients through systemic change. In direct practice social work, intervention crosses a broad spectrum of patient needs. OSWs meet patients where they are and aim to support the patient in exploring their goals and addressing any barriers to those goals of care. This can include very practical resource concerns including transportation, food insecurity and financial challenges. OSWs are active in supporting patients as they navigate community, state and federal systems. This role can include guidance through the process of applying for services, understanding potential eligibility for different benefit programs and direct connection to services.

Like all jobs in health care, the role of the OSW can be complex. While OSWs must maintain awareness of those resources and policy changes that may be affecting access, the work goes well beyond resource navigation. Access to appropriate psychological support from cancer through survivorship or end of life is vital to maintaining quality of life. Anxiety and depression, increased risk of suicide ideation, specific death anxiety and existential distress are not simply side effects of cancer care, but elements of living with a potentially life limiting illness. The majority of OSWs are clinical social workers-masters, trained and independently licensed after years of supervised practice. Licensed Independent Clinical Social Workers (LICSW) are trained to diagnose and treat mental health conditions. OSWs are commonly providing supportive counseling, support groups, and when settings allow for it, they provide billed psychotherapy services to cancer patients.

The Association of Oncology Social Work (AOSW) started in 1984.

Vulnerable Populations

Just as cancer does not discriminate and anybody may find themselves in need of care, all patients may at times find themselves in need of social work support. When thinking of cancer patients and social work, practical and financial resource needs easily come to mind; however, addressing the mental health effects of cancer treatment, survivorship and caregiving are also significant. Though many such effects go undiagnosed, it is estimated that almost a third of cancer patients struggle with depression or anxiety. Despite this, a recent study indicated that 73% of patients with depression in cancer care go untreated, with only 5% being connected to a mental health professional. Anxiety and depression during cancer care have been linked with poor treatment adherence, lower quality of life, higher self-reported pain and higher mortality.

Certain populations are more vulnerable to certain impacts of cancer care and should receive special consideration in assessment and outreach. Older adults living on a fixed income may struggle with a sudden increase in medical expenses. Access to Medicare for this population can provide a resource other age groups do not have, though it is important they are connected to a plan that meets their needs. On the other hand, young patients are often particularly vulnerable to the long-term financial toxicity that comes with cancer care. They may not have had the years in a career to save money and have a cushion for coverage, they are also often faced with missing formative career building years, and the impact of treatment may lead to challenges as they reintegrate into employment. This population may also face unique challenges in relationship development and family building.

Patients living in rural communities face their own challenges in accessing cancer care. They often face travel and housing costs to access treatment. As rural cancer clinics face budget constraints and clinics close, these problems will only increase. Twenty-five percent of the U.S. population lives in rural communities, and access to treatment is increasingly difficult for these patients. On average they travel twice as far as urban patients for treatment, and for cancer patients, this is a heavy burden. While telehealth has mitigated some of these

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challenges, cancer patients need regular labs and to be on site for infusions and radiation, so it cannot replace all care. Further, rural communities have more internet access issues, creating additional concerns. Social workers are often tasked with identifying transportation resources or connecting patients with local lodging as they travel to more urban settings for care.

Beyond Patient Care: Benefits of having a Social Worker on your Team

While clinical social workers in a health care setting, including oncology, can bill for psychotherapy visits as well as for advanced care planning visits, infrastructure in many settings is not set up for that billing. Principal Illness Navigation (PIN) codes are also available for reimbursement though the payments can be quite minimal.

Beyond psychotherapy codes, primary financial benefit to having strong oncology social work teams in place comes from saved costs. Though often overlooked, social workers regularly save health care systems money. Studies indicate that having social workers active on teams leads to improved standard quality metrics.

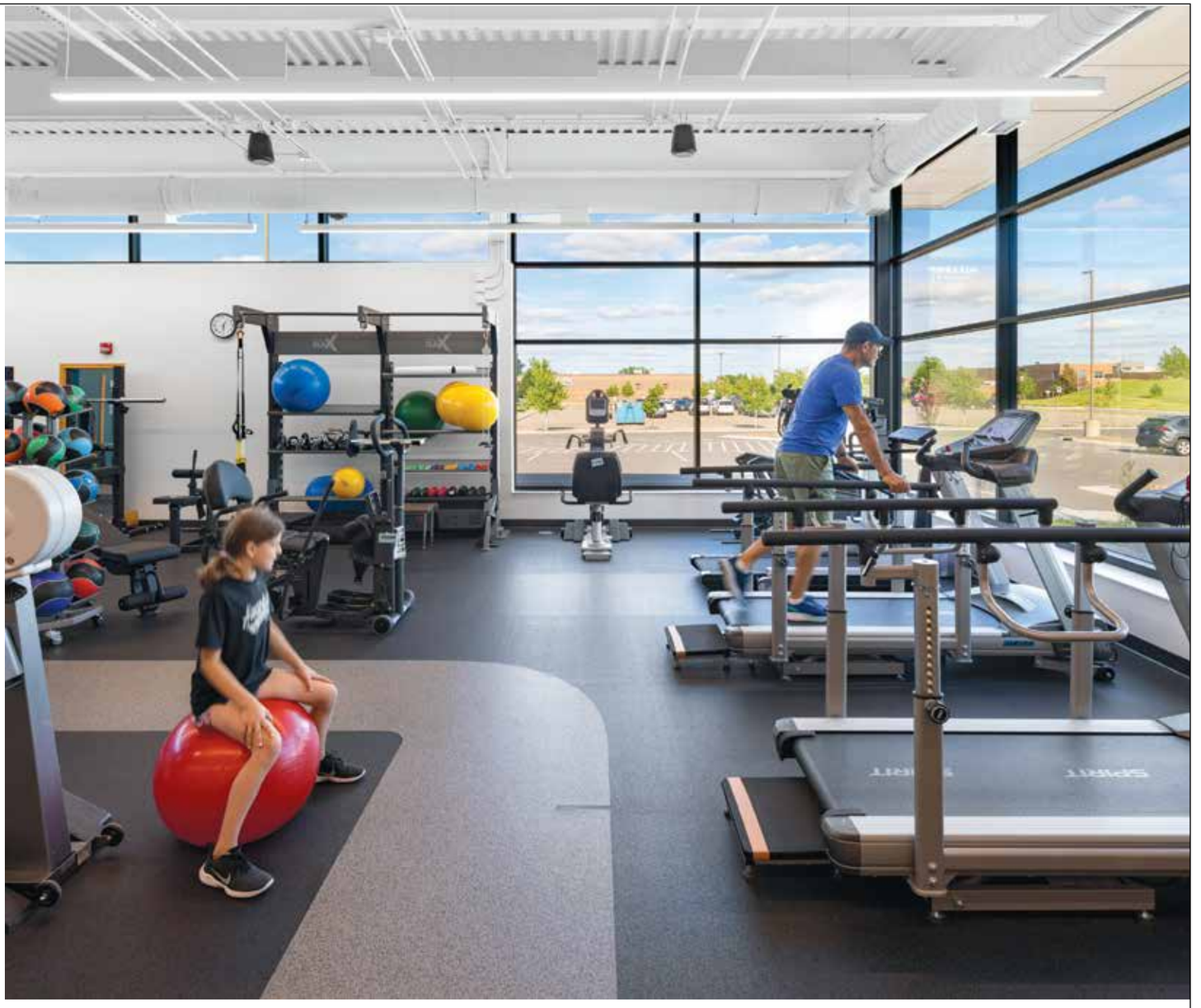
Moreover, social workers are consistently shown to have a positive affect on health care and service utilization as well as cost savings. Social workers are important to efficient discharge plans in inpatient settings and known to prevent patient rehospitalizations. There is extensive research to show that social work improves health outcomes and reduces patient costs. A systems approach provides them with the perspective to consider factors in the community that can support or hurt patient outcomes and mitigate those needs efficiently and effectively.

Financial toxicity often presents as medication nonadherence or delayed treatment decisions and missed appointments and scans. When we consider the noncompliant patient within the context of SDOH and FT, as social workers do, we begin to see that without adequate health care coverage or without the income to pay for their medications, for example, patients are facing choices about how to pursue care. Additionally, cancer patients with a mental health diagnosis are shown to incur higher health care costs than those without. Oncology social workers have the capacity to address these needs, supporting providers' treatment plans and patients' ability to access care safely and with fewer service interruptions.

Looking Ahead

Unfortunately, the challenges facing cancer patients are growing. As the treatments improve in their effectiveness the number of patients living as survivors grows with it. This very positive development comes with the reality that those patients must live with long-term follow-up, as well as the physical, emotional and financial aspects of care. As oncology care providers understand, cancer care does not end with the final treatment cycle. Simultaneously, policy changes are affecting insurance access and funding for community programs, exacerbating the challenges patients are already navigating. Social workers in the oncology space will continue to be an important part of the solution. There is a tight link between direct practice and advocacy for improved access and best patient outcomes. Social workers can thread that needle, working to meet those patient needs while supporting the work of the multidisciplinary care team. This ultimately will lead to the best outcomes for patients.

Nicole Marcouiller, DSW, LICSW, OSW-C leads the social worker care team at Minnesota Oncology.



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Legislative Session Preview

Heavy on Technology and AI Considerations

BY DAVID HOLT, JD

Every legislative session brings an increasing number of health care issues to the table, and this year is no exception. As the intersection of technology, insurance and patient care becomes more complex, understanding these proposed changes is more critical than ever for the physician community. Minnesota finds itself at a crossroads: does it double down on the managed care models of the last thirty years, or does it pivot toward a decentralized, tech-regulated future?

The sheer volume of health care-related filings in 2026 suggests that the era of incrementalism may be ending. Legislators are no longer tinkering at the margins of policy; they are questioning the fundamental architecture of how care is delivered, paid for and audited. For the practicing physician, these bills represent more than just administrative changes, they represent a potential reclaiming of clinical autonomy.

Medicaid Reform and the Retail OP Market (SF1261)

The authors of SF1261 propose a revolutionary shift by creating a retail outpatient medical market for public program enrollees. This bill aims to empower patients with direct funding for onsite payments, effectively removing Managed Care Organizations (MCOs) from the administration of MinnesotaCare and Medical Assistance. Proponents believe this will streamline access and reduce the administrative overhead that often bogs down public programs, creating a frictionless environment for both patients and providers.

By shifting to a retail model, the state would essentially bypass the middleman. Currently, the state pays MCOs a capitated rate, a fixed amount per member per month, to manage the health of enrollees. Under SF1261, the funding would follow the patient more directly to the point of care. This could theoretically allow physicians to be paid at the time of service, mirroring the efficiency of the private cash-pay or direct primary care (DPC) markets, but scaled for the public safety net. For many independent practices, this could be the difference between remaining solvent or being forced into a large hospital system acquisition.

Opponents, such as the Council of Health Plans, warn that the state may be unable to manage the complexities of direct billing and claims administration. They argue that MCOs provide more than just payment processing; they provide population health management, data analytics and narrow-network coordination that keeps costs predictable. Critics of the bill cite concerns regarding increased fraud and the logistical nightmare of replacing a system that has been the standard for decades, despite its known friction points.

Furthermore, there is a technical concern regarding claims leakage and how the state would handle catastrophic costs that exceed a retail budget. The debate ultimately hinges on a fundamental question: is the friction of MCOs a bug or a feature designed to control costs? If it is a feature, removing it might lead to a surge in utilization that the state budget cannot sustain. If it is a bug, removing it could spark a renaissance for independent medical practice in Minnesota.

Prohibiting AI in Prior Authorization (HF2500)

This controversial bill pits business interests against patient care in the rapidly evolving AI world. The authors propose an explicit prohibition on the use of algorithms or artificial intelligence in the review of health insurance prior authorization (PA) requests. Introduced as a direct response to rising frustration among both patients and physicians, this bill addresses high denial rates and treatment delays that have become synonymous with modern utilization management.

There is significant concern that AI systems, if left unregulated, could exacerbate these issues by prioritizing averted expenditure over actual patient health needs. Proponents of the ban argue that current AI systems, often referred to as black boxes because their decision-making logic is opaque, are designed primarily to increase denial rates. In some documented cases nationally, algorithms have been used to deny claims in batches, with reviewing physicians spending less than an average of 1.2 seconds per case. This financial incentive creates a profound conflict of interest that can lead to systematic denials with little to no human oversight.

Algorithmic Malpractice Regulators and medical boards remain wary that allowing an algorithm to make final coverage denials could be legally interpreted as practicing medicine without a license. Because these decisions directly

dictate whether a patient receives a specific treatment, they are viewed by many as medical determinations. If a computer makes that call, who is held liable when a denial leads to a catastrophic patient outcome? The legal framework for algorithmic malpractice is nonexistent, leaving physicians in the lurch when they are forced to fight a machine for their patient's life.

Opponents of the bill point to the potential for AI to streamline what is currently a slow and paper-heavy process. They argue that digitizing prior authorization and using machine learning could make the process significantly faster, potentially reducing the time patients wait for care by days or even weeks. Some insurers suggest that AI can be used for gold-carding or auto-approvals in clear-cut cases, which would actually reduce the administrative burden on physician offices.

> Legislators are no longer tinkering at the margins of policy.

Banning AI in Utilization Review (SF1856)

While HF2500 targets the gatekeeping phase of the initial request, SF1856 goes deeper into the ongoing management of care. The authors propose a ban on AI specifically within utilization review (UR) for health insurance. By defining artificial intelligence clearly within the statute, referencing existing federal definitions, the bill aims to ensure that critical coverage decisions remain in the hands of human professionals who are accountable for their medical judgment.

The central theme here is the protection of the nuanced, personalized approach to medicine that automated systems struggle to replicate. Physicians report that unregulated AI frequently overrides clinical evidence and good medical judgment in favor of rigid data points. In a recent survey, over 90% of doctors noted that these automated guidelines had a negative impact on clinical outcomes for their patients. The nuance of a patient's co-morbidities or social determinants of health is often lost on an algorithm that is programmed to look for the average case.

The Bias in the Machine The bill also seeks to prevent the use of predictive technologies that may introduce systemic bias. For example, if an algorithm is trained on historical data that show lower utilization or poorer outcomes in certain zip codes, it might inadvertently learn to deny care more frequently to patients from those areas, codifying existing health care disparities into a digital standard of care. By mandating human-centric review, SF1856 attempts to keep the art of medicine alive in a world increasingly dominated by data science.

Opponents caution that a total ban might be a blunt instrument that stifles innovation. They suggest that instead of a ban, the state should focus on human-in-the-loop requirements —guardrails that require human sign-off for any denial while still allowing AI to assist in gathering data or flagging administrative errors. They argue that AI is excellent at spotting a missing lab result or an incorrectly coded procedure, which could save human reviewers hours of manual labor.

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The Patient-Centered Care Bill (SF 1059)

The authors of the Patient-Centered Care Bill propose a complete overhaul of how MinnesotaCare and Medical Assistance are administered. Building on the themes of SF1261, this legislation seeks to return the focus to the patient-physician relationship by removing the intermediary MCO layer entirely.

Under the current system, the carve-out of various services to different managers has led to a fragmented experience for patients. A patient might have one entity managing their physical health, another for their mental health, and a third for their pharmacy benefits. This siloed approach often results in dropped balls, where a mental health provider is unaware of a physical health change because they are operating under different administrative umbrellas. This bill proposes a unified, state-administered system that prioritizes continuity of care over the management style of private insurers.

Opponents argue that these organizations provide necessary coordination of care and cost-containment measures that the state is not equipped to handle internally. They point to the 1990s as a time of runaway costs and uncoordinated services. Proponents, however, argue that the 2026 version of the state government has significantly better data tools and digital infrastructure than it did 30 years ago, making a state-run fee-for-service or value-based model more viable than ever.

General Prior Authorization Reform (Chapter 127)

While new bills are being debated, it is important to note that Minnesota already passed broader legislation effective this year to reform prior authorization. Chapter 127 was designed to limit the use of PA for certain high-stakes services, such as:

- Outpatient mental health services.
- Initial cancer treatments and oncology medications.
- Post-stabilization emergency care.
- Medication-assisted treatment (MAT) for substance use disorders.

> The legal framework for algorithmic malpractice is nonexistent.

The current session will likely debate how these existing laws interact with the new proposals to ban AI. There is a risk of legislative clutter, where overlapping laws create confusion for providers and insurers alike. Opponents of further reform argue that the 2026 changes should be allowed to mature — essentially giving the ink time to dry — before adding more layers of regulation.

Advocates for children with complex medical conditions argue, however, that even with Chapter 127 in place, insurers are finding workarounds to delay expensive therapies. For these families, the move to ban AI isn't just a policy preference; it's a desperate attempt to force a human being to look at their child's chart and see more than a line item on a spreadsheet.

Conclusions and Considerations

Beyond the clinical implications, these bills represent what could be a massive shift in the Minnesota health care economy. If MCOs are removed from the public sector, billions of dollars in state contracts will be reshuffled. This could lead to a more competitive market for providers but might also lead to initial volatility in reimbursement rates as the state builds out its own payment infrastructure.

Physicians must also consider the AI arms race. If Minnesota bans insurance AI, but the rest of the country adopts it to lower administrative costs, does Minnesota become an island of high-touch, high-cost care? Or does it become a sanctuary for physicians who are burnt out by algorithmic medicine? There is a potential for Minnesota to attract top-tier medical talent looking for an environment where clinical autonomy is legally protected. Conversely, there is the risk that national insurers might raise premiums in the state to offset the higher costs of manual human labor.

Furthermore, we must consider the impact on medical education. If the next generation of physicians is trained in a state where AI is banned from the insurance process, will they be prepared to work in other states where AI is the primary interface? These are the long-term, existential questions that the 2026 session aims to answer.

David Holt, JD, is a health care attorney at Holt Law, a firm specializing in health care law.

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Therapeutic Use of Psilocybin

Legislation to create a new state program

BY JESSICA L. NIELSON, PhD

A 44-year-old Minnesota patient presents for follow-up of treatment-resistant major depressive disorder. Over the past decade, multiple antidepressants have been trialed across several medication classes. Augmentation strategies produced partial response but intolerable side effects. The patient completed structured psychotherapy, maintains employment and continues to experience persistent anhedonia, emotional blunting and intermittent passive suicidal ideation. Near the end of the visit, the patient asks a question that is becoming increasingly common in clinical settings across the state:

"Is psilocybin therapy going to be available in Minnesota? And if it is, is it something that could actually help someone like me?" (clinical vignette)

A conversation many physicians are starting to have

For Minnesota physicians, this question is no longer hypothetical. The state is considering legislation that would establish a regulated therapeutic access program for psilocybin-containing mushrooms, based on recommendations from the Minnesota Psychedelic Medicine Task Force (PMTF). The proposal reflects a broader shift occurring across medicine, public health and policy, one that forces clinicians to balance scientific uncertainty, patient demand and evolving regulatory frameworks. Understanding what is being proposed, what the evidence currently shows and where legitimate concerns remain is increasingly relevant to routine clinical practice.

Why this policy conversation is happening now

The PMTF was charged with reviewing the scientific literature, various legal frameworks and regulatory considerations related to psychedelic therapies. The task force ultimately recommended the creation of a state-regulated clinical program allowing supervised therapeutic use of psilocybin, alongside separate recommendations to fund and expand research and to decriminalize the use and possession of psilocybin mushrooms.

Several forces are converging to drive this discussion. First, treatment-resistant psychiatric and substance-use disorders remain major drivers of morbidity. Many patients cycle through multiple therapies with incomplete or short-lived benefit. Second, psychedelic-assisted therapy research has expanded significantly over the past decade. While still limited compared to traditional psychiatric drug trials and currently available treatments, randomized controlled studies have shown promising signals for certain patient populations, particularly when combined with psychological support.

Third, patients are increasingly aware of psychedelic therapies through media coverage, clinical trial publicity and peer experiences. Some are already pursuing treatment in unregulated settings or outside the United States, raising safety and continuity-of-care concerns. Finally, several states have begun exploring regulated access with models in Oregon, Colorado, and most recently in New Mexico, opening the doors for other states to evaluate whether controlled therapeutic pathways may reduce harm compared to unregulated access. For clinicians, the practical reality is simple: regardless of personal position on psychedelic therapy, patients will continue asking about it, so it would be wise to know more about the risks and benefits, and how to navigate these conversations with patients and whether this is a treatment option physicians may want to explore further.

What the proposed Minnesota therapeutic access program would do

Patients would require certification from a licensed physician confirming a qualifying medical condition. Screening would evaluate potential contraindications, including psychotic disorders, cardiovascular risk factors and medication interactions. If contraindications are identified, further evaluation could be required before enrollment. From a physician's perspective, this resembles screening processes used for other higher-risk interventions, including interventional psychiatry treatments or certain specialty pharmacologic therapies. Physicians would then determine if patients are eligible for the program and provide recommendations, similar to how patients are recommended for the medical cannabis program that has been up and running in Minnesota since 2015 with great success.

Structured therapy model

The proposed program emphasizes a multi-phase care model. Following

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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.**

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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.

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sufficient screening to determine eligibility for patients, treatments are suggested to be conducted in three phases:

Preparation sessions: Patients receive education, risk counseling, and expectation setting. These sessions allow for the patient and facilitator to establish a therapeutic relationship and build rapport and trust through discussing boundaries, preferred methods for support and other important issues that may come up during and after the session.

Supervised administration sessions: Therapy occurs under supervision from a licensed mental health professional with additional certification in psilocybin facilitation. Facilitators will procure the dose for the patient and administer and facilitate the psilocybin session in a clinic or in the patient's home, with medical monitoring for safety.

Integration sessions: Follow-up sessions help translate experiences into therapeutic behavioral change. Much of the work of psychedelic therapy occurs in the sessions after the experience. Integration sessions allow the material that was uncovered during the psilocybin session to be discussed and processed, and to map out next steps for the treatment plan and journey toward healing, including whether doing another psilocybin session is warranted.

This structure mirrors most clinical trial protocols with psychedelics, as well as the structure being used currently at ketamine clinics branding their services as psychedelic-assisted therapy. The structure of these sessions in addition to the rapport between the patient and the therapist are crucial for good outcomes. Clinical research with psychedelics like psilocybin has shown repeatedly that to maximize the therapeutic benefits, aspects of set (a patient's mindset and expectations) and setting (the location and competency of the therapist/facilitator) are some of the most important components of the therapeutic process.

Regulated supply chain and quality control

The program would license cultivation and testing facilities to ensure standardized dosing, potency consistency and contaminant screening. While most of the clinical trials with psilocybin use a pharmaceutical/synthetic version cleared by the Food and Drug Administration for use in clinical trials, this program, like those already available in Oregon and Colorado, will use naturally grown psilocybin mushrooms. There are over 200 different species of psilocybin-containing mushrooms with different potencies that require adjustments in source material used for treatment sessions. Other states have developed the infrastructure for testing and dosing psilocybin mushrooms so they can be administered accurately. The therapeutic dose from clinical trials ranges from 25-50 mg of psilocybin. This sounds like a small dose relative to how "magic mushrooms" are discussed in the lexicon of people who use them, often referring to a "heroic dose" as 5-7 grams of dried whole mushroom that may help someone achieve a peak or breakthrough experience. Yet depending on the species of the mushroom, dosing by weight (e.g., just eating a handful of mushrooms) may yield drastically different experiences in terms of subjective intensity and the actual concentration of psilocybin that a patient will experience.

Infrastructure and protocols from other state programs exists for testing, dosing and administering to patients, allowing the regulation and supply to help reduce risks. Additionally, there would be a strict chain of custody over who has access to mushrooms being used for therapy to prevent diversion and

abuse of the supply, with similar protocols for dispensing controlled substances that are being used for clinical trials.

The evolving role of physicians

Physicians would likely engage in several roles, even if not directly administering psilocybin therapy. These include:

- Diagnostic certification for qualifying conditions
- Medical risk screening and contraindication assessment
- Consultation within multidisciplinary care teams to increase safety oversight and reduce liability risk
- Participation in outcomes monitoring and public health data reporting
- Potential participation as psilocybin facilitators (with additional training and consideration of DEA/prescribing risks)

> Much of the work of psychedelic therapy occurs in the sessions after the experience.

Some physicians may pursue facilitator training, though participation is expected to vary widely by specialty and practice environment. It should be noted that psilocybin is currently a schedule 1 drug under the Controlled Substances Act, so involvement in the program where administration or handling of psilocybin occurs may put DEA prescribing licenses at risk. Like medical cannabis programs, these interventions are not being made available as prescriptions or to be dispensed at pharmacies that store and dispense other controlled substances. Physicians and prescribers may recommend eligible patients for the program; however, risk around current licenses should be evaluated depending on level of involvement that physicians choose to have with the program.

Current evidence: encouraging but incomplete

Current research suggests psilocybin-assisted therapy may show benefit for certain conditions, particularly treatment-resistant depression, some anxiety disorders and substance-use disorders when delivered in structured therapeutic settings. A thorough review of clinical trials with psilocybin are covered in the PMTF final legislative report (2025).

Physicians, however, should recognize important limitations about the evidence from psilocybin clinical trials. This includes:

- Smaller study populations compared to traditional psychiatric trials
- Methodological challenges, including placebo blinding
- Limited long-term durability data

Most data come from underground use and submission as experience reports to databases such as Erowid and Shroomery.

Potential advantages of a regulated therapeutic access program

For patients who have failed multiple standard treatments, even moderate

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improvement can significantly affect function and quality of life, and psilocybin therapy may expand the options for treatment-resistant patients. Patients are already accessing psychedelic substances outside formal medical systems, and regulated programs could provide medical screening, standardized dosing and emergency response capability, as well as move patients from unregulated to regulated environments.

Structured outcome monitoring could help clarify long-term safety and effectiveness and inform future clinical standards, thus accelerating evidence development for accepted medical uses of psilocybin. In addition, the structured therapy model aligns with emerging evidence that context and therapeutic alliance influence outcomes for patients, allowing for the integration of pharmacologic and psychotherapeutic care.

> Nearly 40 other states have introduced legislation to expand access to psychedelic medicines like psilocybin.

Potential risks and concerns physicians may reasonably have

Compared with standard psychiatric treatments, evidence remains limited in duration and scale for psilocybin-assisted therapy according to FDA approval standards. The dearth of appropriate clinical data is largely due to psilocybin's being a schedule 1 drug, making the research and potential access challenging. Schedule 1 status poses risks for prescribers and ongoing uncertainty regarding institutional participation, as well as malpractice considerations.

When it comes to risks for patients, considerations include acute psychological distress, cardiovascular complications in vulnerable patients, symptom destabilization in bipolar or psychotic spectrum disorders, muscle spasms in patients with spinal cord injury and medication interaction risks. These risks reinforce the importance of medical screening and collaborative care.

Additional considerations

Questions remain regarding long-term credentialing, training standards and division of clinical responsibility between facilitators and physicians. Other state programs have demonstrated potential challenges including high cost, workforce limitations and uneven geographic access.

Several cultural and ethical factors should be considered with psilocybin therapy, such as engagement and reciprocity with Indigenous communities. Also, accessibility for medically complex or mobility-limited patients, special considerations around access and care for veteran mental health needs and broad public education rooted in science and public health.

Second clinical vignette: PTSD and patient access realities

A 36-year-old veteran establishes care after relocating to Minnesota. PTSD symptoms persist despite pharmacologic and psychotherapeutic treatment. The patient reports peers traveling internationally for psychedelic therapies and asks whether Minnesota will offer supervised options.

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Regardless of policy outcome, physicians will increasingly encounter patients navigating these decisions.

Three key takeaways for Minnesota physicians

1. The proposal is designed as a therapeutic public health framework. The program emphasizes screening, supervision, regulated supply and monitoring rather than commercial access.
2. Evidence supports careful exploration, not uncritical adoption. Psilocybin therapy may represent a meaningful option for some patients, but long-term data remain limited and data are evolving out of other state-regulated programs.
3. Physician engagement will shape safety and clinical credibility. Participation in screening, monitoring and care coordination will likely determine how safely the program evolves.

Final perspective

Psilocybin therapeutic access represents an intersection of psychiatry, neuroscience, addiction medicine and public health policy. For physicians, the most important question may not be whether psychedelic therapies will enter clinical practice, but how they can be integrated safely, ethically and scientifically into modern health care systems. The push to develop a psilocybin therapy program in Minnesota signals a broader shift toward exploring new therapeutic modalities for chronic and treatment-resistant conditions. Physician engagement, whether it be supportive, cautious or skeptical, will likely influence how these therapies develop within Minnesota's health care system. We hope that influence can be leveraged to help expand access to more options for healing for providers and patients in Minnesota.

Nearly 40 other states have introduced legislation to expand access to psychedelic medicines like psilocybin. Sometimes those efforts are impeded due to pushback from physicians who are not well informed on the clinical trials and therapeutic potential of psychedelic medicines and oppose such access simply because they haven't received FDA approval yet and want to express an overabundance of caution. Those who are knowledgeable about the science, research and safety profile of psilocybin therapy, however, can be powerful advocates for helping to convince skeptical physicians and legislators about the promise of this type of therapy so we can implement sensible legislation and access programs that expand the toolkit providers can use to help support the complex care needs of their patients.

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Note this article was written with assistance from ChatGPT

Related Links:

nielsonlab.umn.edu/
www.health.state.mn.us/people/psychmed/index.html
www.oregon.gov/oha/ph/preventionwellness/pages/oregon-psilocybin-services.aspx
dpo.colorado.gov/NaturalMedicine
www.nmhealth.org/about/mcpp/mpp/
www.lrl.mn.gov/docs/2024/mandated/241756.pdf

Excellence, Integrity and Collaboration
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medical research have been very disruptive. Medical research provides widespread benefits to society, and good health is important for us all, regardless of one's political orientation. It's mystifying to see our current leadership pulling back on these investments. One of the things these events might be indicating is a gap in our communication strategies as researchers. Perhaps we need to do a better job of communicating about our work in a more accessible way, so that when decision-makers prioritize where our collective resources are invested, there's an established common understanding about the shared benefits of medical research.

Other elements of these policies, such as deleting access to scientific research, spreading blatant misinformation and conflating research with political agenda have also been debilitating. What are the best ways to deal with these issues?

The best way to deal with these issues is to keep the facts and data front and center in the conversation. Reasonable people can disagree about what the facts mean, and debate is healthy and necessary in a democracy and in science. However, we will continue to struggle to find solutions to our biggest problems if we don't have a common understanding of the facts. It's easier said than done, and this is definitely the long game, but facts are durable. Keeping the focus on hard data also requires clear, accessible communication.

Recently, some clinical trials have been abruptly canceled, in some cases with cancer patients denied access to potentially life-saving treatment over conflict with new federal research funding policies. What do you have to say about this?

I think it's a tragedy, and worse, it was unnecessary.

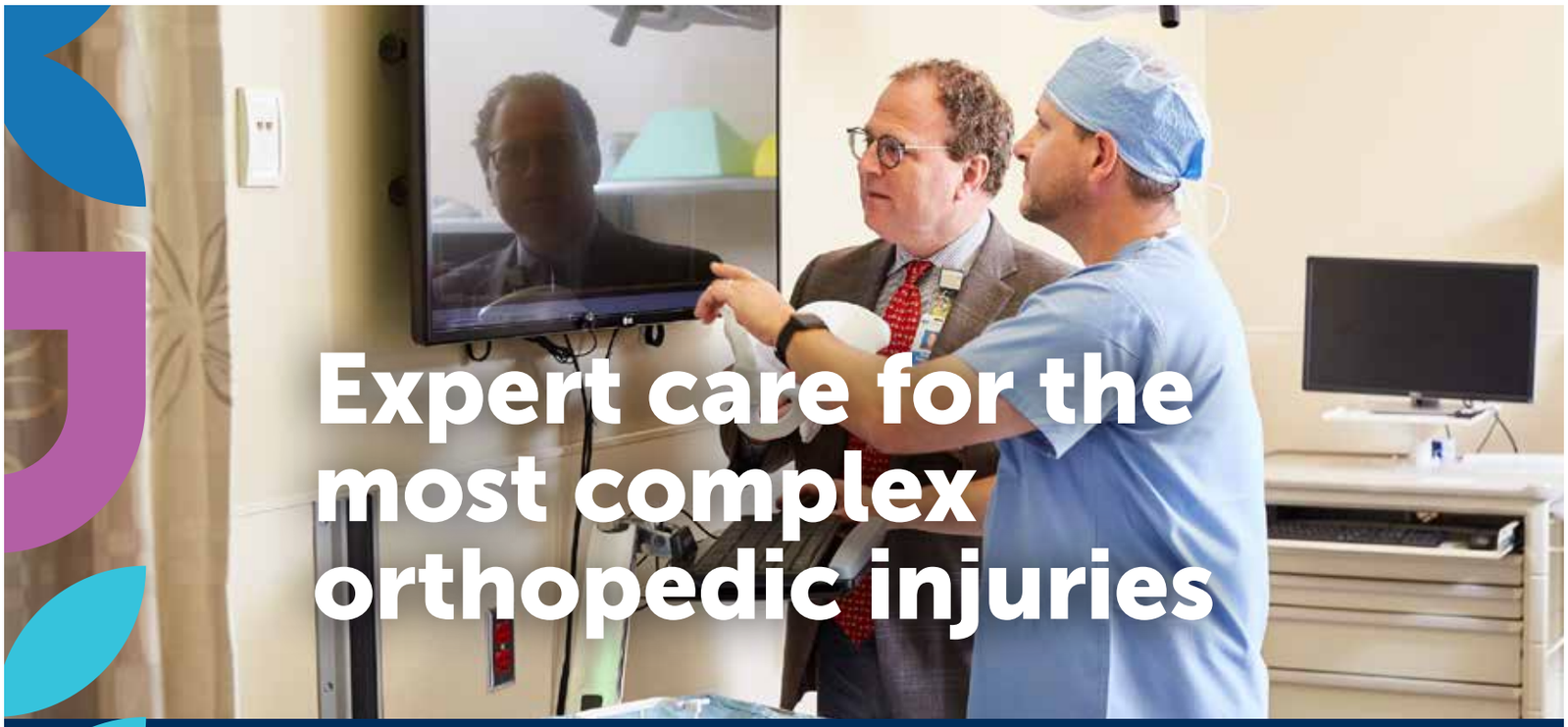
AI is changing medical research. What are some examples in terms of HHRI projects?

I'm working on a project where we're training AI to "read" clinical notes to pull out mentions of specific concepts as well as positive and negative sentiments to see if these are related to access to kidney transplant. There are important considerations around patient privacy and data security that are unique to working with AI, and we are doing our due diligence to address those issues so we can harness the power of this potentially game-changing technology. There's no doubt that AI is going to be a powerful tool that we need to learn how to use safely to enhance the effectiveness and efficiency of the research we do.

Is there anything else about HHRI that you would like to share with our readers?

HHRI has been at the forefront of many medical advances — leading the way with innovative research and treatments and showing that it can pivot and respond quickly to changing circumstances. As a small institution embedded within a safety net hospital, our work is particularly focused on improving care for people with fewer resources. Yet, our work in areas like trauma, frostbite, kidney disease, geriatrics, infectious disease, addiction and others has transformed care for people nationally and internationally. These are wild times, but we've weathered difficulty in the past, and we remain committed to our mission.

Kirsten Johansen, MD is the president Hennepin Healthcare Research Institute.



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