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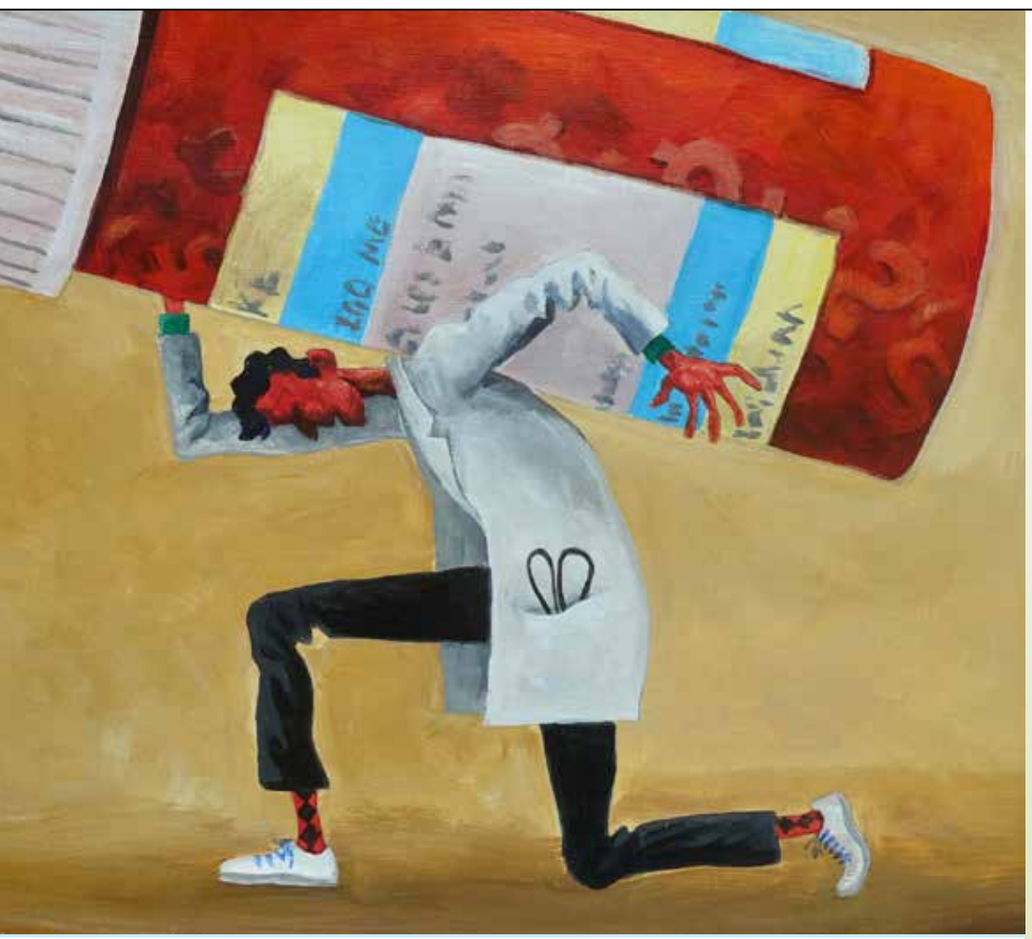

Health Care Affordability

A new statewide initiative

BY MATTHEW ANDERSON, JD, AND SHEILA KISCADEN

Health care affordability remains a defining quality of life challenge for many Minnesotans and a perennial policy challenge for our state as a whole. Patients struggle with higher and higher deductibles and prescription drug costs. Employers face year-over-year premium increases that far outpace inflation. Public programs consume an ever-growing share of state and federal budgets, squeezing out resources from other high-priority community needs.

At the same time, physicians, hospitals and clinics confront mounting pressures driving their costs of care delivery higher: workforce shortages and rising labor costs, increasing administrative complexity, growing prices for supplies and persistent payment pressures from insurers and public programs.

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It's Time to Heal, Minnesota

Dealing with societal trauma

BY MARCUS SCHMIT

Minnesota has been through a lot. That is not hyperbole — it is a straightforward description of what this state has experienced over the past six years, and what the people who live and work here have had to absorb, often without fully realizing the toll it was taking.

The term "societal trauma" describes what happens when events are large enough, disruptive enough, or frightening enough to affect not just individuals but entire communities. Unlike a personal crisis — a job loss, a health diagnosis, a family rupture — societal trauma lands on everyone at once. It disrupts the sense of safety that most people carry through daily life without thinking about it. And because it affects so many people simultaneously, the usual support systems — family, community and neighbors — are often stressed at the same moment they are most needed.

What makes societal trauma particularly challenging is that reactions vary widely and may not show up right away. Some people feel the impact immediately, in the form of anxiety, sleeplessness or difficulty concentrating. Others seem fine in the short term and only begin to struggle months later, when the immediate crisis has faded from public view but its weight has not lifted. Still others manage reasonably well on their own but are supporting partners, children, parents or patients who are not. There is no single right way to respond to collective hardship, which makes it easy for people to assume that because they are functioning, they are fine — and to miss the signs that something more complicated is happening beneath the surface.

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A new statewide initiative

By Matthew Anderson, JD, AND Sheila Kiscaden

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It's Time to Heal, Minnesota

Dealing with societal trauma

By Marcus Schmit

A new initiative from NAMI MN, Healing Minnesota, addresses statewide societal mental health trauma caused by events from COVID-19 the George Floyd protests, Operation Metro Surge and more.

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Minnesota Health Care Roundtable 62ND SESSION

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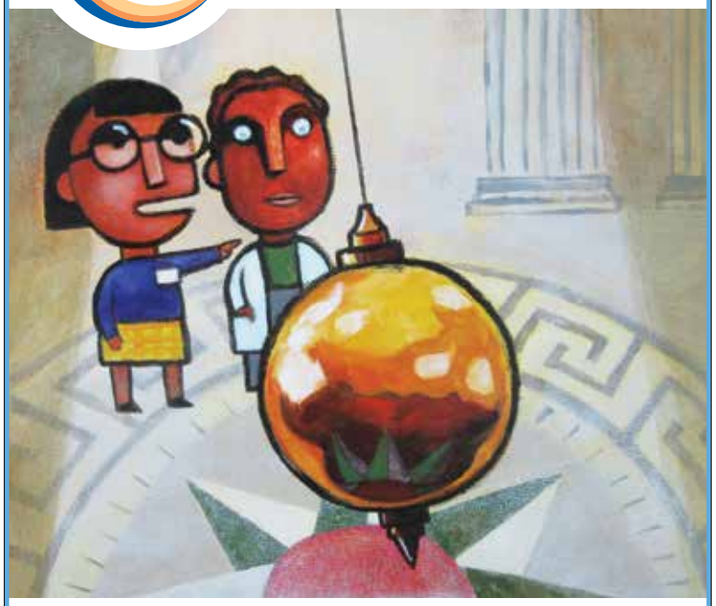

INNOVATION MANAGEMENT

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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.

DHS Announces New Initiative For People Exiting Incarceration

The Minnesota Department of Human Services (DHS) recently announced that it is pursuing a new initiative enabling people who are incarcerated to access behavioral health services through Medicaid in the months leading up to their release. The initiative, developed by the federal Centers for Medicare & Medicaid Services in 2023 under Section 1115 of the Social Security Act, is called the 1115 Reentry Services Demonstration. Primary goals are to reduce overdose deaths, improve public safety and help more people continue getting behavioral health services after release from incarceration. DHS is seeking federal approval to participate in this demonstration. Research shows that society benefits when people in correctional facilities receive the behavioral health services they need. The first phase of Minnesota's demonstration will involve three state prisons, four county jails and one Tribal detention center.

"Providing these services before release fills an important gap and can save lives," said Temporary Human Services Commissioner John Connolly. "Addressing a person's behavioral health needs before they leave incarceration can help them find stable housing, get a job and rebuild support networks upon reentering their communities — all of which strengthen public safety and lead to better long-term outcomes for communities." "This initiative recognizes a simple reality: People are more likely to succeed after release when they have access to the care and support they need before they leave incarceration," said Corrections Commissioner Paul Schnell. "Strengthening access to needed services during the community reintegration can reduce recidivism, improve public safety and help individuals return to their communities healthier, with more stability and better prepared for success."

Since December 2024, a reentry services working group has been focusing on the launch of this initiative and related policies for justice-involved individuals. Pending federal approval, people incarcerated at the selected sites could begin receiving pre-release services in early 2028. Eighteen states currently have Medicaid reentry demonstrations. On average, pre-release programs that address a person's mental health or substance abuse problems may reduce the cost of crime and long-run incarceration costs by $1.47 to $5.27 per taxpayer dollar, according to the White House's Council on Economic Affairs.

Mayo Creates New Collaborative

The Mayo Clinic recently announced a new internal alignment of its Berg Innovation Exchange and its Business Development initiative to unite commercialization and venture creation, thereby accelerating health care innovation worldwide. Since its launch, the Berg Innovation Exchange has connected innovators with expertise, mentorship and a global network of collaborators. The exchange has served as a catalyst for innovation within the Mayo Clinic and across the broader health care ecosystem, bringing together clinicians, researchers, entrepreneurs, industry leaders and investors to explore new approaches to health care challenges. The exchange helps innovators refine and validate new concepts by providing access to collaborators' collective expertise. Business Development complements those efforts through capabilities in intellectual property, licensing, venture creation, investment activities and commercialization.

"Innovation depends on strong connections between discovery, commercialization and collaboration," says Andy Danielsen, chief business development officer at Mayo Clinic. "This alignment expands opportunities

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to work with organizations around the world and provides the resources needed to translate ideas into products and services that benefit patients."

As health care continues to evolve, Mayo Clinic is committed to fostering relationships and collaborations that help advance innovation beyond institutional boundaries. Earlier access to expertise and strategic guidance can help innovators navigate key decisions and identify the most effective path forward. "The ultimate measure of innovation is whether it makes a difference in people's lives," says Peter Noseworthy, MD, medical director for Business Development. "Strengthening the connection between innovation and commercialization helps promising discoveries gain traction beyond Mayo Clinic and creates more opportunity for impact."

The exchange will continue to play an important role in identifying opportunities, encouraging collaboration and helping innovators transform promising ideas into meaningful advances. At its core, the effort reflects Mayo Clinic's belief that meaningful progress happens when people with diverse expertise come together to solve important challenges. "From the beginning, the vision of the exchange has been to help innovators find the expertise and opportunities needed to move ideas forward," says Jennie Kung, vice chair of Mayo Clinic Berg Innovation Exchange. "What started as a vision for accelerating innovation has grown into a community of innovators and problem-solvers and positions us to support even more meaningful work in the years ahead."

Sanford Bemidji Medical Center Announces Major Emergency Department Remodel

At a recent annual Bemidji area health care fundraiser, Pours for a Purpose raised nearly $415,000 and announced that the money would go to advancing a major expansion of the Sanford Bemidji Medical Center emergency department. As the region's largest nonprofit hospital and the only Level III Trauma Center within 70 miles of Bemidji, the medical center serves seven counties and 16 cities across Northern Minnesota with a collective population of more than 176,000 people. In 2025, the center provided emergency care to more than 26,500 local patients — an average of 73 patients per day. "When emergencies strike, every second counts. By updating and remodeling our emergency department, we can ensure local patients and families have access to the right care at the right time, close to home," said Jason Caron, MD, president and CEO for Sanford Bemidji. "With growing numbers of patients turning to us for emergency care, this is a priority for our region. We are beyond grateful to those who helped us bring this idea to life. Now, we need the support of our community to bring this project across the finish line." A $1 million gift from Dr. Richard and Nilla Stennes will facilitate the new emergency department, which will proudly carry their name.

The expanded emergency department will feature:

- New spaces, including new trauma rooms with state-of-the-art equipment, new treatment rooms, the addition of safety-enhanced behavioral health rooms and additional restrooms
- A remodeled "fast-track" space for enhanced care
- New care transition spaces for patients who are medically stable but not yet ready for the next step in care, such as those waiting for test results or discharge
- Renovations to all existing patient exam rooms and additional storage solutions
- The addition of a dedicated entrance and space for law enforcement, as well as additional safety enhancements for patients and staff

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"We are incredibly grateful to Dr. Richard and Nilla Stennes for stepping forward to launch this project. Their generosity and their love for this community is such an inspiration," Caron said. "We are also thankful to all those who gave in support of this effort at Pours for a Purpose." Construction timelines are yet to be released.

Judicial Ruling Mandates Arbitration in Fosston and Essentia Health Dispute

The City of Fosston, in northwestern Minnesota, and Essentia Health have an ongoing dispute regarding a 2009 affiliation agreement between the parties. The city of Fosston alleges that Essentia Health has failed to meet the community's needs, creating a violation of the agreement, and is seeking to terminate the local hospital's affiliation with Essentia. Fosston city leaders have maintained that services at Essentia Health have declined in the last several years, notably with the end of labor and delivery services at the hospital in 2022. While obstetric care is still offered in Fosston, residents face long drives for delivery care. Further concerns cite that Essentia Health has restricted the number of ambulances available to serve the community, removed a longstanding board member and understaffed facilities. Discussions around Fosston's regaining control of the hospital have been unproductive. Essentia Health has accused city leaders of misrepresenting basic facts of the agreement and misleading the people of Fosston. Furthermore, the health system broke ground this April on a $12 million, 5,500-square-foot expansion of the hospitals emergency department. Nonetheless, and despite previous arbitration rulings going in favor of Essentia Health, the city again filed to regain control. Polk County Judge Jeffrey Remick recently ruled that the court is required to order arbitration based on state law and a clear and unambiguous agreement between the entities. "The parties' agreement to arbitrate here is broad, and it applies to any dispute related to the terms of the 2009 affiliation agreement. Specifically, the arbitration provision clearly states that 'any dispute which is not resolved by mediation ... shall be submitted to binding arbitration."

In response, Fosston Mayor Jim Offerdahl said, "This ruling allows the City to take the next step in a process we have pursued on behalf of the Fosston community. Our goal has always been clear: to protect and strengthen access to high-quality health care in Fosston for the people who live, work and seek care here." City officials say they are hopeful that the hearing and a resolution to this matter will be reached in 2027. The results of the case could have large implications across many rural communities facing similar loss of service and consolidation concerns.

North Memorial Introduces New Virtual Reality Rehabilitation Therapy

North Memorial Hospital recently announced that it has become the first site in Minnesota to offer Bioness Integrated Therapy System (BITS) Functional Reality (FR) to patients. The innovative new system offers a software-based rehabilitation platform utilizing three modes of engagement: direct hand movements, simple head movements or handheld controllers. It uses virtual, mixed and functional reality environments to challenge patients' vision, motor skills and cognition in safe, real-life scenarios such as navigating a grocery store or driving. By bridging the gap between clinical rehab and daily life, BITS FR helps challenge executive function, balance, memory and hand-eye coordination. The immersive rehabilitation platform transforms how clinicians approach recovery for patients living with stroke, traumatic brain injury (TBI), concussion and

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spinal cord injury by integrating vision, motor and cognitive therapy into highly interactive environments designed to simulate real-world function.

The novel technology provides a 360-degree enhanced patient experience. Through wearing goggles patients can choose activities that are tailored to each individual and provide a unique therapy experience for each patient. BITS challenges and assess the visual, auditory, cognitive, motor and balance abilities of individuals, including those with deficits resulting from traumatic injuries and movement disorders as well as competitive athletes (e.g., abilities include visuomotor coordination, reaction time, visuospatial perception, visual and auditory processing, working memory, physical and cognitive endurance, balance control and postural stability).

The new technology was released less than a year ago and patients as well as clinicians nationwide have reported outstanding results. "With BITS Functional Reality, we are giving clinicians powerful new tools to deliver therapy that's more engaging, effective, and relevant to patients' daily lives," said Todd Cushman, chief executive officer, Bioness Medical. "This launch reflects our commitment to innovation that improves outcomes and empowers patients on their journey to independence." Unlike traditional rehabilitation exercises, BITS uses realistic lights, sounds and movement to create more immersive and functionally relevant therapy experiences. The technology is now being used across occupational, physical and speech therapy at North Memorial Health.

Blue Cross Expands Digital Access

Blue Cross and Blue Shield of Minnesota (Blue Cross) recently announced that it has expanded its plan members' access to Blue Care Advisor, an easy-to-use "digital front door." Since its launch in 2024, Blue Care Advisor has helped members in employer-based plans to get the care they need, when they need it, and to stay on track with personal health goals. Now, Blue Cross has expanded this AI-powered technology to make it available to seniors, improving how they navigate their health care and driving better outcomes at a lower cost. Blue Care Advisor is now available to all members enrolled in Blue Cross Medicare plans, including Medicare Advantage, Medicare Supplement (Medigap), Medicare Cost plans and Minnesota Senior Health Options (MSHO).

"Blue Cross is committed to continuously improving how our members experience and navigate their coverage," said chief strategy officer A.J. McDougall. "Blue Care Advisor is a proven tool for making our health insurance plans easier to understand and easier to use. I'm confident our Medicare members will enjoy how simple Blue Care Advisor makes it to manage all their health care benefits."

Using each member's unique benefits and claims data, Blue Care Advisor delivers personalized recommendations for available resources across multiple touchpoints. This individualized approach helps to close gaps in care and guide the next best action for each member's health and health care spending, while enabling Blue Cross customer service and care management teams to better serve each member's unique needs.

With the expansion to Medicare, Blue Cross is also introducing its new Blue Ribbon designation within the Blue Care Advisor Find Care tool. Leveraging a national dataset of cost and quality ratings for both in-person and virtual care, the Find Care tool will help members identify the highest quality, lowest cost options — helping to ensure they are receiving the best care possible at the right time and place, while effectively managing their health care costs. Members using Blue Care Advisor are more likely to receive preventive care across multiple key areas of health, including screenings for cancer and diabetes, as well as annual wellness exams.

The Intersection of Health Care and Public Safety

Dylan Ferguson, Director, Minnesota Office of Emergency Medical Services

What can you tell us about the mission of the Office of Emergency Medical Services?

The mission of the Minnesota Office of Emergency Medical Services (OEMS) is to protect and improve the health and safety of all Minnesotans by supporting a high quality, accessible and accountable EMS system. Regulation is a key part of that mission, but it represents only one element of broader responsibility. OEMS works to strengthen EMS as an essential part of Minnesota's health care system by setting statewide standards, licensing ambulance services and personnel and overseeing EMS data collection. The goal is to ensure patients receive safe and effective prehospital care.

Collaboration is central to this work. OEMS partners with ambulance services, hospitals, physicians, regional programs, tribal governments and local communities to identify challenges and develop practical solutions. This collaboration may involve grants, workforce initiatives, improved data quality and support for innovative care models.

Physicians play a particularly important role. Minnesota has long emphasized strong medical direction in shaping prehospital care. The EMS Physician Advisory Council brings physician leaders together to advise on clinical issues and emerging opportunities to improve patient care across the state.

Ultimately, our goal is to ensure that every Minnesotan has access to an evidence-based EMS system that delivers consistent high quality care and functions as an integrated part of the broader health care system.

What are some of the biggest challenges your office faces?

A central challenge facing EMS is one of identity. EMS operates at the intersection of health care and public safety, serving critical roles in both areas. This dual position is a strength but can also create difficulties because EMS does not fit neatly into either category. Decisions about workforce, funding and system planning are often made through a health care lens or a public safety lens, even though EMS depends on both.

> "Improving outcomes is ultimately what defines Minnesota's EMS system."

The demands on EMS continue to grow. Clinicians now provide complex care in homes, workplaces, nursing facilities, schools and on roadways. They contribute to trauma care, stroke care, cardiac care, behavioral health care and public health preparedness. Many policies and reimbursement structures, however, have not kept pace with this evolution.

OEMS works to bridge these worlds by partnering with health care organizations, physicians, public safety agencies, legislators and local communities. The goal is to build a system that recognizes EMS as essential health care infrastructure. Whether addressing workforce shortages or evaluating new care models, the focus remains on ensuring timely access to high quality emergency medical care for Minnesotans in every community.

There are several different national organizations that address emergency medical services, what are ways you coordinate with some of them?

Although EMS systems vary by state, many face similar challenges. Workforce sustainability, rural access, clinical outcomes and emerging technology all benefit from national collaboration. OEMS actively participates with several organizations that support this shared work.

Through the National Association of State EMS Officials (NASEMSO), OEMS collaborates with counterparts across the country on workforce development, funding strategies, regulatory modernization and national data standards. These discussions help Minnesota learn from other states while contributing its own experiences.

OEMS also partners with the National Highway Traffic Safety Administration (NHTSA), which provides leadership in EMS system development. This partnership supports evidence-based practices, trauma systems, traffic safety and emerging programs such as prehospital blood administration.

In addition, OEMS works with the Health Resources and Services Administration (HRSA) through the Emergency Medical Services for Children program. Because pediatric emergencies are relatively infrequent, national collaboration ensures Minnesota clinicians remain ready to care for critically ill or injured children.

These partnerships help Minnesota remain engaged in national EMS efforts and ensure patients benefit from current evidence and innovation.

How are workforce shortages affecting the work you do?

Minnesota's EMS system experienced significant workforce challenges during and after the COVID-19 pandemic. Retirements increased, burnout intensified and education pipelines were disrupted. For a period, Minnesota lost credentialed providers at a faster rate than new ones were entering the profession, raising concerns about long term sustainability.

Legislative investments and OEMS initiatives have helped reverse that trend. Expanded education opportunities, recruitment efforts and workforce development programs have increased the number of newly certified EMS professionals. This progress is positive, but recruitment alone is not enough, retaining experiences clinicians is equally important.

Retention remains a significant challenge. Approximately half of Minnesota's EMTs and three quarters of its paramedics are actively providing patient care on an ambulance. Rising call volumes and growing clinical complexity make the retention of experienced clinicians just as important as recruiting new ones.

These realities shape OEMS priorities. Reducing barriers to entering the profession, supporting career longevity and improving workplace sustainability remain central to ensuring a resilient EMS workforce capable of meeting the needs of Minnesota communities.

Please tell us a little about the Sprint Paramedic program.

The Sprint Paramedic Program, created by the Legislature in 2024, is one of Minnesota's most innovative EMS initiatives. The goal is to improve timely access to Advanced Life Support (ALS) in rural communities where geography, workforce limitations and call volume make traditional staffing models difficult to sustain.

Two regions, Otter Tail and Grant Counties and St. Louis County, are currently participating in the pilot. Rather than requiring each rural ambulance service to independently provide ALS coverage, multiple Basic Life Support services share a strategically deployed paramedic who can rapidly respond to high acuity emergencies. This approach brings advanced care closer to patients while allowing local ambulance services to continue serving their communities.

Early results are encouraging. In the St. Louis County pilot, the Sprint Paramedic arrives before the transporting ambulance in about half of responses, allowing advanced assessment and treatment to begin sooner. The program has also helped volunteer services maintain two person crews during staffing shortages.

The pilot runs through June 2027. OEMS intends to provide a comprehensive evaluation to the Legislature, including analysis of patient care, rural system strength and long-term sustainability.

What are some of the advances in technology that have improved patient outcomes the most in emergency medical services?

EMS is now capable of delivering increasingly sophisticated medical care before patients reach a hospital. Advances in evidence-based treatment, communications technology and decision support allow EMS clinicians to begin definitive care earlier, when every minute matters.

One important development is the expansion of prehospital blood administration. Air ambulances have carried blood products for years, and more ground services are beginning to do the same. Early administration of whole blood or components for severe hemorrhage or shock can improve stability before hospital arrival.

EMS innovation is also improving treatment for opioid use disorder. Several Minnesota services now administer buprenorphine in the field following overdose. This early intervention reduces withdrawal symptoms and helps patients engage in long-term treatment and recovery.

Telemedicine presents additional promise. Pilot projects are studying how real time consultation between EMS clinicians and physicians can support complex care in the field, particularly in rural areas. These efforts represent a broader shift toward delivering the right care as early as possible rather than simply transporting patients faster.

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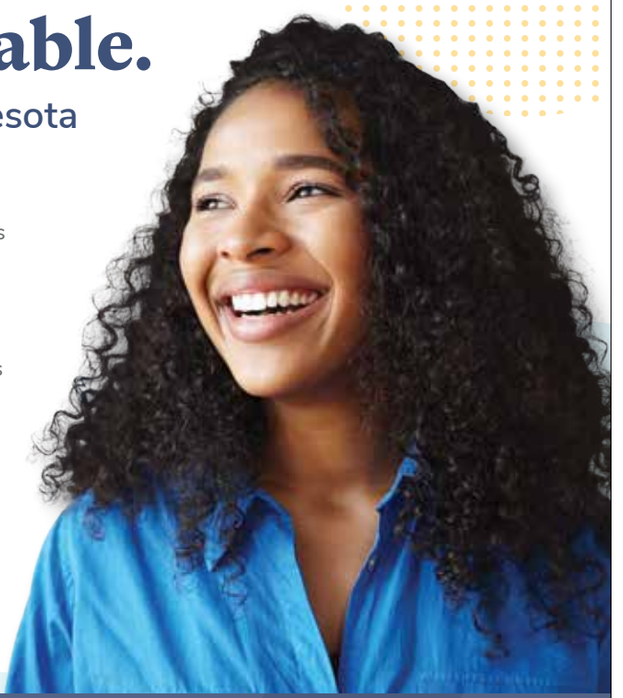

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◂ **Health Care Affordability** from cover

These realities often produce an unfortunate dynamic. Discussions about affordability too often devolve into calls for reducing reimbursement for services. At the same time, discussions about sustaining physician practices and access to care often sound like capitulating to ever-rising health care costs. Neither perspective adequately captures the complexity and intertwined mechanics driving affordability concerns in today's health care system.

A Legislative Response

Seeking more thoughtful, data-informed, ongoing policy analysis and development, the Minnesota Legislature recently established the new Center for Health Care Affordability within the Minnesota Department of Health (MDH). The Legislature saw the benefits of a center with a long-term commitment to thorough consideration of policy options and solutions.

> Physician participation will be essential.

The center's mission is to serve as the state's primary resource for understanding why health care spending continues to grow, how affordability (and unaffordability) of care affects Minnesotans and which policy approaches and reforms are most likely to improve affordability — both for individual Minnesotans and the health system as a whole — while preserving or improving access and quality. The center's mission is not to regulate physician practice or dictate payment policy.

In launching the center, MDH convened two task forces to advise it in directing the initial work. First, the Health Care Affordability Advisory Task Force (HCAATF), consisting of Minnesotans representing those who pay for care — patients and their families, employers and other purchasers and stakeholders — as well as health policy experts. This task force's objective is to review state and national data on health care cost and consider utilization trends, reliable research and studies, cost containment efforts in other states and the experiences of Minnesotans impacted by high and rising health care costs. With this context and background, the task force offers recommendations to the center and MDH for developing actionable policy changes designed to help reduce the financial strain of health care costs on individual Minnesotans and our state's health care system as a whole.

Recognizing that the task force's recommendations would benefit from greater subject matter expertise of leaders from organizations directly responsible for financing, delivering and coordinating care for our population, MDH also convened a Provider and Payer Advisory Task Force (PPATF). This group's members, including several physicians, have experience in health care delivery systems, independent clinical practices, rural health care, pharmaceutical financing and delivery, health insurance and other related fields. They offer a different level of perspectives and analysis of the topics the HCAATF discusses and provide valuable advice to shape the HCAATF's eventual recommendations.

As co-chairs of the Health Care Affordability Advisory Task Force, we are fortunate to work with thoughtful and committed members of both task forces. Recently, the HCAATF submitted a letter to Minnesota's Commissioner of Health, Brooke Cunningham, MD, based on our first synthesis of information and data from health policy research, perspectives of our members, feedback from community conversations with patient and consumer advocates and input from our partners on the PPATF. While our work continues, the letter outlined our initial recommendations to date.

More specifically, we suggested five policy priorities or topic areas to guide the center's initial research and policy development efforts. These five priorities offer an early glimpse into how Minnesota may seek to improve health care affordability over the coming years and why we hope physicians across the state will be part of the conversation.

Asking the Right Questions

One of the first observations the HCAATF reached was that Minnesota lacks a shared definition and common understanding of what "health care affordability" means.

Most people recognize that health care is expensive and, too often, unaffordable. Yet we lack commonly accepted benchmarks for determining what constitutes affordable health care for individual households or for the state's health care system as a whole.

The center uses two "north stars" to guide its work: slowing the rate of growth of total health care spending in Minnesota while maintaining or improving our residents' health outcomes, and reducing the number of Minnesotans who delay or forgo needed care because of cost. Those objectives are intentionally broad and reflect an important thread that runs throughout our task force's work: efforts to improve affordability must account for our community's values with respect to quality and access.

The task force recommends that the center develop affordability benchmarks or standards, such as defining what constitutes an "affordable" rate of

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growth in statewide health care spending and what proportion of household income should reasonably be devoted to health care.

Of course, we expect that benchmarks or standards may not apply uniformly or may need to vary based on household characteristics. For example, what might constitute an affordable portion of income going to health care for a household at the higher end of the socio-economic scale might be wholly unaffordable for a household on the lower end of the scale. Similarly, what is affordable at the household level might vary based on disease burden, social or geographical context or any number of factors that might call for relying on a measure of affordability that is more variable.

At this stage in our work we are not presupposing which affordability standards or guides the center should adopt, but rather encouraging it to consider similar standards used in other states, available research and input from subject matter experts and the diverse experiences of Minnesotans trying to balance their financial resources with their health care needs.

The task force believes evidence and research informed affordability benchmarks, at both the overall system level and the individual household level, will provide a common framework for the center, Minnesota' s policymakers and the public to use when evaluating progress over time and assessing various policy proposals.

Why These Five Priorities?

Every meeting of the task force reinforced the truism that there is no single cause of rising health care costs, and there will be no single solution.

Health care spending reflects demographic changes, technological innovation, pharmaceutical pricing and distribution chains, workforce shortages, insurance design, administrative complexity and waste, misaligned payment systems and incentives, market consolidation and fragmentation, profit-taking by intermediaries without corresponding improvements in outcomes or patient experience and many, many other factors. Any serious affordability strategy must acknowledge that complexity without conceding to it.

After several months of discussion and review of state and national data, trends and research, the task force identified five areas where the center's additional research and policy development appear most likely to improve affordability. They are:

High and Variable Prices and Price Growth Commercial health care prices vary substantially across Minnesota and even within a single clinic or hospital, and often without corresponding differences in quality or patient outcomes. Understanding why those differences exist and, more important, when they reflect legitimate differences in cost or performance versus market dynamics or negotiating leverage is one of the center's highest priorities. Minnesota's All-Payer Claims Database and existing analytic resources provide an unusually strong foundation for answering those questions and developing evidence-informed policy recommendations.

Examining Market Consolidation Minnesota's health care marketplace has experienced substantial horizontal and vertical consolidation over the past two decades. Hospitals have merged, physician practices have joined larger systems, insurers have consolidated and increasingly complex organizations now combine provider, insurance and administrative functions.

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Consolidation is not inherently good or bad. In some circumstances, for example, integration may preserve access to care that otherwise could not survive independently. At the same time, national evidence demonstrates that health care consolidation is correlated with increased market leverage and higher prices for services, and rarely produces improvements in quality or outcomes for patients.

The center will examine where consolidation benefits patients and communities, where it may reduce competition and whether Minnesota's existing oversight processes could be modified to produce better results for residents and communities.

Better Understanding Impacts of Private Equity and Investor-Driven Incentives Private equity investment in health care has generated considerable national attention, yet relatively little is known about its overall role in Minnesota's health care system.

Investor-backed organizations now participate in physician practices, ambulatory surgery centers, behavioral health, dental care, dialysis services, hospice care, skilled nursing facilities and many other sectors of health care. Some investments bring needed capital, management expertise, innovation and operational improvements. Others have raised questions regarding incentives, price increases, higher total spending and long-term affects on patient care.

Rather than beginning with predetermined conclusions, the task force believes Minnesota needs a clearer understanding of the extent of investor involvement in our health care system, the incentives these ownership structures create and the benefits and risks they bring before considering if policy changes are warranted.

Looking Beyond Premium Increases For patients, affordability is more often experienced through monthly premiums, deductibles and other out-of-pocket expenses rather than directly from provider reimbursement rates.

Recent premium increases in Minnesota's individual and small-group insurance markets have intensified these concerns, and are emblematic of similar premium price pressures faced by employers. While insurers already undergo actuarial review, the task force believes Minnesota should also explore whether insurance market oversight can better address affordability by improving transparency into the factors driving premium growth and evaluating whether existing regulatory approaches adequately support long-term affordability of health insurance.

Following the Money in Prescription Drugs Prescription drugs are one of the fastest-growing components of health care spending, yet many aspects of pharmaceutical pricing and distribution are remarkably opaque.

Manufacturers, wholesalers, pharmacy benefit managers, pharmacies, insurers, employers and regulators all influence what patients ultimately pay for their medications. Financial relationships throughout the pharmacy chain are difficult for physicians, employers and even health plans themselves to fully understand, let alone influence.

The task force believes additional transparency and understanding should precede further regulation. Before recommending new policies, Minnesota

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should better understand where pharmaceutical spending growth occurs and why, how existing state and federal reforms are impacting drug pricing and spending and where greater accountability and regulatory limits may be needed.

What Isn't on the List

It is of interest that several topics commonly associated with affordability did not emerge among the task force's initial priorities.

The group did not begin with physician quality reporting, utilization management, value-based payment, prior authorization, scope of practice changes or physician performance incentives. Nor did it propose simple, across-the-board cuts to reimbursement rates.

That does not mean those topics lack importance or are not worth considering. Some might become areas of focus of future work for the center. But the task force concluded that Minnesota should first better understand broader market and regulatory forces that influence affordability before pursuing more targeted delivery-system reforms that might unintentionally threaten quality of or access to care, or financially benefit the bottom line for certain health care stakeholders without necessarily improving affordability for Minnesotans or lowering health care spending overall.

Why Physician Engagement Matters

The Center for Health Care Affordability is in its formative years. Its research and recommendations developed over the next 12 to 24 months may influence legislative discussions, regulatory proposals and broader policy conversations for years to come.

Physician participation will be essential. Physicians understand how high-quality care requires skilled professionals, modern facilities, advanced technology and sufficient resources to meet patients' changing needs. At the same time, physicians also witness the consequences of unaffordable care every day — patients delaying treatment, declining diagnostic testing or rationing medications because of cost.

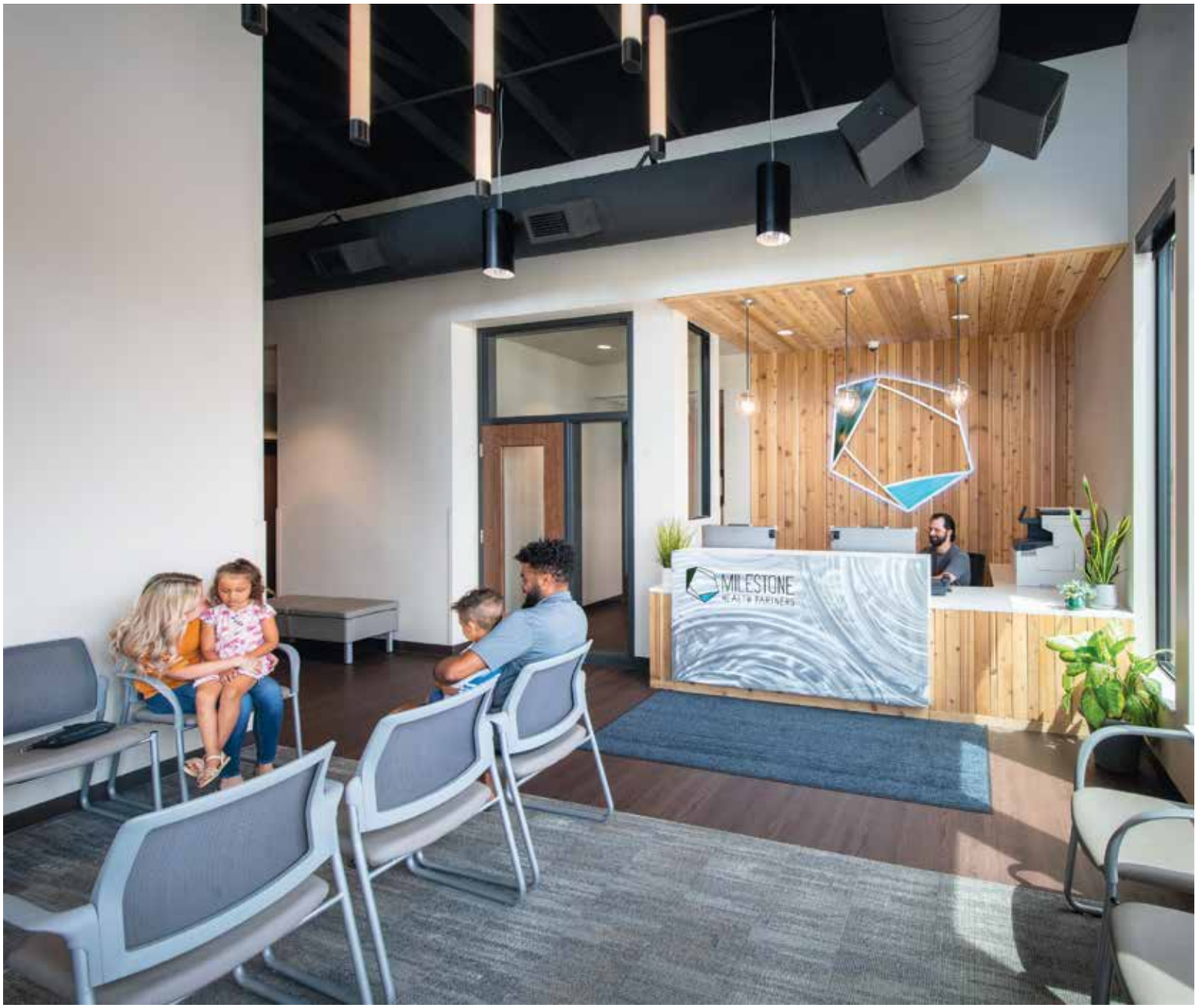
Our recent statement of priorities is not a set of predetermined policy conclusions; it is an invitation to engage further in thoughtful, evidence-informed discussions about how Minnesota can deliver high-quality, accessible care while ensuring that our residents can afford to benefit from it.

Reasonable people will disagree about specific health policy solutions. That is both inevitable and healthy. But if Minnesota is to make meaningful progress on improving health care affordability, those conversations must include physicians.

The center's work is only beginning. We invite physicians to join in its efforts.

Matthew Anderson, JD, is a senior lecturer in the Health Policy and Management Division of the University of Minnesota's School of Public Health. He is the Health Care Affordability Task Force Co-Chair.

Sheila Kiscaden, is a former Minnesota State Senator and has served on numerous health care-related legislative initiatives. She is the Health Care Affordability Task Force Co-Chair.



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Bridging the Gap

Multidisciplinary Pain Management

BY LARRY STUDT, MD

Consider a typical chronic pain patient. Now in her late 60s, years of lower back pain have narrowed her once vibrant lifestyle full of family events, volunteering, hobbies and outdoor activities into a constant struggle for relief. Her sleep suffers, so on top of hurting, she's tired all the time. Stretching exercises, physical therapy, a litany of medications and even surgery may have helped for a while, but the pain is still nagging.

Cases like this are unfortunately all too common; more than 50 million adults in the U.S. live with chronic pain, yet it remains one of the most difficult conditions in medicine to treat. Far too many suffer for years while searching for answers, frustrated, discouraged and uncertain whether meaningful improvement is possible at all. Today's chronic pain patients are increasingly complex from a medical standpoint; many are managing multiple chronic conditions simultaneously. Arthritis, diabetes, obesity, cardiovascular disease, sleep disorders, depression, anxiety or the long-term effects of previous injuries and surgeries are all common among chronic pain patients, and these conditions often interact with one another, making it difficult to address a single source of pain. They may have already seen multiple physicians, undergone surgery, completed physical therapy, tried numerous medications or pursued alternative medicine.

In the hypothetical case above, her lower back pain compounded into reduced mobility, loss of physical conditioning, disrupted sleep, social isolation, depression and diminished quality of life. The pain affects not only the body but also the patient's confidence, independence and ability to engage in meaningful activities. These realities make it increasingly difficult to separate the physical, psychological and social dimensions of pain, and they are a primary reason multidisciplinary pain management is so important. During my years with Nura Precision Pain Management, a pain clinic that specializes in multidisciplinary care, I have witnessed significant changes in both the patients we treat and the therapies available to help them.

As health care has grown more specialized, chronic pain patients have become more challenging to treat. Specialization has driven real advances, but it also leaves gaps for patients whose pain doesn't fit neatly into one specialty: a surgeon may fix a structural issue but can't resolve anxiety or sleep disturbances; a physical therapist may restore mobility but can't manage medications; a psychologist may address coping but can't perform a procedure.

Chronic pain sits at the intersection of physical, psychological, behavioral and social factors. Therefore, a coordinated team approach is so much more effective than a series of disconnected referrals. Multidisciplinary pain management breaks the siloed structure of specialized medicine and closes that gap in coordinated care for patients — anesthesiologists, neurologists, physiatrists, physical therapists, psychologists, occupational therapists and nutritionists — each specialty supports the others. Interventional procedures can create enough relief for rehabilitation to work, physical therapy rebuilds strength and function, behavioral health addresses the sleep, stress and coping challenges that accompany chronic pain and medication becomes one part of the plan rather than the whole plan. The goal of a multidisciplinary, holistic approach isn't simply less pain, but more function, independence and better quality of life.

Decades of research have consistently demonstrated that chronic pain patients show the best improvement when treatment includes a variety of modalities. A landmark review published in American Psychologist found that interdisciplinary pain programs measurably improve physical functioning, reduce disability, enhance quality of life and lower health care utilization. In the same review, the authors also highlighted a concerning trend: although evidence supporting the efficacy of interdisciplinary pain care is widely accepted, access to these programs has declined.

Data from the Commission on Accreditation of Rehabilitation Facilities (CARF) outline this shift, tracking a historical contraction from over 200 accredited interdisciplinary chronic pain programs down to fewer than 90 (a seven-year study ended in 2005). Further compounding the decrease in access, many multi-modal clinics simply restructured, downsized or transitioned into single-discipline practices, further limiting access to effective pain treatment.

This is a frustrating paradox from a clinical perspective. Comprehensive, interdisciplinary care is the best path forward for restoring quality of life AND managing systemic longer-term health care costs for chronic pain patients. Yet, reimbursement pressures, rising operating costs, staffing challenges and

the resource-intensive nature of multidisciplinary care are driving health care networks to stop offering these unified services.

Along with changes in the complexity of treating chronic pain patients, reimbursement models have also transformed considerably in the past few decades. This is the reason most often cited for the closure of multidisciplinary pain clinics. The underlying economics are straightforward: standard insurance reimbursement models heavily favor high-volume, interventional procedures while chronically underfunding the time-intensive cognitive, physical and behavioral therapies that form the bedrock of complex pain management. The result is a system in which comprehensive pain management may be clinically advantageous but operationally difficult to sustain. This structural shift has created a significant gap between clinical ideals and real-world patient access. According to national data from the U.S. Pain Foundation, a striking 76.5% of chronic pain patients who managed to secure care at a dedicated pain center reported that the facility offered access only to a physician, completely lacking integrated behavioral or rehabilitative specialists.

More than 50 million adults in the U.S. live with chronic pain.

When clinic networks face these financial strains, the consolidation can be highly disruptive. Financial restructuring and sudden closures of larger regional pain groups have occasionally left tens of thousands of complex patients looking for new providers all at once. As the medical community adapts to these economic realities, the challenge moving forward will be advocating for reimbursement models that value collaborative, holistic healing over isolated interventions, ensuring patients receive the comprehensive care they actually need.

The change for a patient can be a big shock. In the Twin Cities, as clinics have closed or restructured, many patients have found themselves unexpectedly searching for new providers and new care teams after years — sometimes decades — of receiving care from the same practice.

Care Coordination

Coordination is easier described than delivered. Without a multidisciplinary model, patients seeking holistic treatment on their own are at an extreme disadvantage; most have little understanding about what therapies are available, how to engage multiple providers, or even how to manage referrals, scheduling and insurance. Of course, chronic pain patients must still manage their pain day-to-day, as best they can. Insurance alone can be its own maze for individuals: coverage rules, prior authorizations and network requirements often differ by discipline, so a patient may need separate approvals for physical therapy, behavioral health and interventional procedures — each with its own visit limits, copays and paperwork. Trying to manage their care alone, even a motivated patient can lose momentum just trying to keep the paperwork straight, and the multi-modal approach quickly narrows down to whatever is easiest to schedule and find coverage for. Providers face the same problem in reverse: without a shared structure, each specialist may see only their piece of the puzzle and may find their reimbursement denied or reduced. A multidisciplinary model such as the one Nura has used since 1995 creates one point

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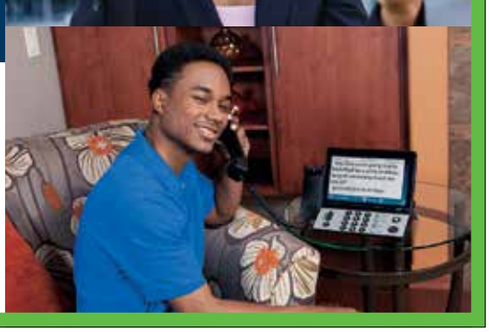

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The Telephone Equipment Distribution Program is funded through the Department of Commerce – Telecommunications Access Minnesota (TAM) and administered by the Minnesota Department of Human Services.

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of contact for the patient, one shared plan for the clinicians and knowledgeable administrative support to ensure alignment with insurance providers.

To make patient access even more challenging, the workforce pipeline for professionals in pain management is showing signs of strain. A 2025 study from the UC Davis School of Medicine found that applications from anesthesiology residents to pain medicine fellowship programs, the largest traditional source of future pain specialists, declined 45% between 2019 and 2023. The trend is concerning because pain management requires more than technical expertise. Clinicians in the field routinely care for patients whose pain has affected every aspect of their lives, often after years of unsuccessful treatment. The work can be extraordinarily rewarding, but it also demands patience, empathy, resilience and a willingness to navigate complex medical, psychological and social challenges. As health care systems across the country report difficulties recruiting and retaining pain specialists, maintaining access to multidisciplinary care becomes increasingly dependent on attracting the next generation of providers to a specialty that remains both critically important and uniquely demanding.

> Chronic pain sits at the intersection of physical, psychological, behavioral and social factors.

It's worth noting that not every behavioral health provider is equipped to provide pain-specific care. Training in approaches developed specifically for pain, such as cognitive behavioral therapy for chronic pain or acceptance and commitment therapy, is paramount, as is experience working as part of a coordinated pain management team rather than in isolation. Patients and referring physicians alike should feel comfortable asking a prospective behavioral health provider directly about their experience treating chronic pain, rather than assuming any licensed therapist can fill this role.

The Patient Perspective

One lesson learned over the years is that patients rarely arrive seeking multidisciplinary care. They come looking for relief. They often believe the answer lies in a medication adjustment or a procedure. Sometimes that is part of the solution. More often, however, meaningful improvement occurs when multiple factors are addressed together. One of the responsibilities of pain specialists is helping patients understand how medicine, movement, behavioral health and lifestyle changes can work together to improve both pain and function.

Of course, one size never fits all. I have seen patients achieve meaningful improvement only after combining medication optimization with physical therapy and behavioral health support. Others have benefited from advanced interventional procedures like an intrathecal pain pump, but their long-term success depended on maintaining physical activity and function afterward. Still others arrived convinced their pain couldn't be touched, only to discover relief in an individualized, coordinated treatment plan. These observations reinforce a simple lesson: chronic pain is rarely solved by a single intervention and the most successful outcomes occur when patients become active participants in their comprehensive and personalized treatment plan.

This is the model Nura has built its practice around: physicians, psychologists, physical therapists and advanced practice providers working together under one roof, rather than referring patients out and hoping the pieces come together on their own. Time and again, we've seen that patients do best when treatment is coordinated across disciplines instead of delivered in isolation, and that conviction is why we've stayed committed to comprehensive, team-based care even as reimbursement pressures have pushed other clinics to scale it back. It is why we continue to be at the vanguard of multidisciplinary pain management.

The future of pain medicine will undoubtedly bring new technologies, new procedures and new treatment options. But it will be just as important to preserve access to coordinated, patient-centered models that let new therapies and tried-and-true treatments reach the people who need them. The evidence supporting multidisciplinary care is substantial: for many patients living with chronic pain, coordinated treatment is the difference between simply managing symptoms and regaining meaningful function, independence and quality of life. As physicians, health care leaders and policymakers weigh the future of pain management, ensuring access should remain a priority. For millions of Americans living with chronic pain, this is not simply a health care issue — it is a quality-of-life issue. For the patient described at the start of this piece, and for the tens of thousands like her, that access can mean the difference between merely managing pain and reclaiming a life.

Larry Studt, MD is a family medicine and occupational health physician who serves as the medical director of Nura Pain Clinics in Minnesota. With over 30 years of medical experience, he specializes in collaborating across multidisciplinary teams to develop comprehensive, compassionate care plans for patients living with complex chronic pain.

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It's Time to Heal, Minnesota from the cover

One category of impact deserves special attention: what happens to children. Research on Adverse Childhood Experiences (ACEs) has established over decades that traumatic events in early life can affect health and well-being long into adulthood, raising the risk of depression, anxiety, substance use and physical health problems. Children who lived through the isolation of the COVID-19 pandemic, or who watched news coverage of violence and civil unrest, or whose families were torn apart by immigration enforcement are carrying experiences that may not surface clinically for years. Supporting children's mental health now is an investment in outcomes that extend across a lifetime — and it requires understanding the context in which those children have been growing up.

> Healing from trauma rarely happens on its own or all at once.

Minnesota Needs a Break

To understand why healing is needed, it helps to simply name the sequence of events Minnesotans have navigated.

The COVID-19 pandemic arrived in 2020 and brought with it, illness and death but prolonged isolation, grief, economic disruption and the psychological burden of sustained uncertainty. Long after the acute phase of the pandemic ended, its effects continued. Communities were still navigating disruptions in relationships, routines and trust — in institutions, in each other and in the future — when the next wave arrived.

The murder of George Floyd in May 2020 sent ripples across the country, but the epicenter was here. Minnesota experienced some of the largest increases in anger, sadness and anxiety documented anywhere in the nation in the weeks following Floyd's death. The unrest that followed raised hard questions about public safety, race and justice that communities are still working through. For many Minnesotans — particularly Black Minnesotans — this was not a single event but a reckoning with the experience of accumulated harm that long preceded 2020.

In the years that followed came a sustained surge in violent crime in the Twin Cities metro, economic uncertainty, a tragic school shooting and a political assassination that left many Minnesotans feeling that the ground beneath them was less stable than it had been. Then, beginning in December 2025, Operation Metro Surge brought more than 3,000 federal immigration officers into the Twin Cities, with arrests exceeding 100 people per day at the peak of the operation. Three people died in connection with the operation. Families were separated. Children lost parents. Entire communities — immigrant and non-immigrant alike — lived in a state of fear and grief that no community can absorb without consequence. For many Minnesotans, proposed Medicaid cuts have added financial anxiety to an already heavy emotional load — threatening access to the very services that support recovery.

At NAMI Minnesota we saw the consequences in real time. During the peak of Operation Metro Surge, calls to our helpline increased by 120% and our social media engagement skyrocketed. The number of people reaching out in the grip of suicidal thoughts rose sharply. We knew of teenagers who attempted to take their own lives after their parents were detained. I described then what we were witnessing as "collective trauma and collective grief" — and that is exactly what it was. The surge in calls and clicks was not just a data point. It was a signal: communities were hurting in ways that demanded an organized, sustained and compassionate response.

That signal was not surprising to anyone who works in mental health. What was striking was the scale and the speed. It confirmed what the research has long shown — that large-scale traumatic events create population-level mental health needs — and it made clear that whatever response we mounted could not be a short-term fix. Recovery from this kind of accumulated disruption takes time. It takes resources. And it takes a commitment to staying present long after the news cycle has moved on.

An Appropriate Response

This summer, NAMI Minnesota launched *Healing Minnesota: Recovery Now, Mental Health Always*. The initiative is our organized answer to everything described above — and a commitment to the long road of recovery that lies ahead.

The initiative brings together community organizations, mental health providers, educators, faith leaders, philanthropic partners and public institutions around a shared purpose: making sure Minnesotans have what they need to heal and that mental health stays at the center of the public conversation long after the headlines fade. The Medica Foundation is among the primary sources of funding for the effort. We are grateful for their partnership and for their recognition that the work of recovery requires sustained investment, not one-time attention.

The core activities of Healing Minnesota span several areas. Community conversations and healing events are being organized across the state, designed to give people a space to share what they have experienced and to feel less alone. Multilingual educational materials are in development to reach communities in the languages they speak and through the cultural frameworks that shape how they understand mental health and help-seeking. Funds are available to help fill gaps for organizations providing mental health support in their communities. And a statewide report is being prepared, informed by interviews with community leaders, service providers, advocates and people directly affected that will document the mental health impact of recent events and generate recommendations for policymakers, health systems and community organizations.

How success will be measured is a question we take seriously. We are tracking reach: how many people participate in community events, how many download or engage with educational materials and how many connect with services they did not know about before. We are asking whether awareness and help-seeking behavior changes over time. And we are paying close attention to whether this initiative shifts the longer-term policy and funding landscape for mental health in Minnesota — because lasting recovery requires systems that are built to support it, not just programs that address immediate need.

Engaging People Where They Are

One of the things we have learned over years of doing this work is that mental health support lands differently depending on who is offering it, through what relationships and in what language — literal and cultural. A program designed without input from the communities it is meant to serve will reach some people and miss many others.

Abe Gebeyeheu, EdD, a culturally specific school-based mental health therapist and NAMI Minnesota partner in the initiative, puts it plainly: "Mental health services are most effective when grounded in culture, faith, language, family values and the community's lived experiences. Care must be built on trust and shaped by community voice, recognizing that healing is not only an individual process but also a collective one."

That means our coalition-building strategy is not just about convening organizations — it is about recruiting trusted voices within specific communities: faith leaders, cultural liaisons, community elders and others whose credibility is relational, not institutional. When someone who is already trusted in a community says, "This is real, and here is where you can get support," the message carries weight that an institutional campaign cannot replicate on its own.

It also means being honest about the differences in what communities need. The experience of Operation Metro Surge in immigrant communities — the fear, the family separation, the uncertainty about what might happen next — is distinct from, though connected to, the experience of a rural Minnesotan who watched the same events unfold on a screen and felt unsettled in ways they may not have words for. Both are real. Both matter. And both require approaches tailored to their specific context.

Healing from trauma rarely happens on its own or all at once. What helps most: staying connected to others rather than withdrawing, maintaining routines that provide a sense of stability and limiting news and social media when it feeds anxiety more than it informs. For those experiencing more persistent

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symptoms — sleeplessness, intrusive thoughts, emotional numbness or constant unease — professional support makes a real difference and seeking it is a sign of self-awareness, not weakness. Children benefit from honest, age-appropriate conversations, reassurance and consistency in daily routines. None of this requires a diagnosis or a referral. It is where recovery begins.

Healing Is About All of Us

The most stubborn obstacle in any mental health initiative is not lack of resources or lack of programs. It is the deeply human tendency to believe that mental health struggles are something that happen to other people and to believe that seeking help is a sign of weakness rather than courage.

Large-scale traumatic events create population-level mental health needs.

Minnesota's humility, resilience and self-sufficiency serve us well in many circumstances. But it can work against recognition of genuine need. Those who have functioned through COVID, through the George Floyd protests, through years of community upheaval, through the fear of Operation Metro Surge — people who kept showing up to work, kept caring for their families, kept doing what was required — may not think of themselves as someone who needs support. The data suggest otherwise.

Our rollout strategy begins with individuals and organizations already engaged with mental health, already willing to be champions. We are building outward from there, using the networks those trusted partners bring with them to reach people who have not previously seen NAMI Minnesota as an organization that speaks to their experience or their community's experience.

That expansion of our reach is itself part of what Healing Minnesota is about. NAMI Minnesota has historically been most visible to individuals and families navigating serious mental illness — and we will always be there for them. This initiative is a signal that our mission extends to every Minnesotan navigating the mental health effects of living through difficult times. The invitation is open to everyone.

What Physicians Can Do

Minnesota's physicians are in a unique position in relation to this initiative — and in relation to the broader challenge it addresses. You see the effects of societal trauma in your exam rooms, often without patients naming it. Fatigue that does not have a clear physiological explanation, or anxiety that has intensified over the past several years. Sleep disruption, irritability, difficulty concentrating. The patient whose physical complaint is real, but whose underlying distress is something harder to diagnose.

Physicians are also part of the community that has been through what their patients have been through. The past several years have been hard on everyone in health care — and the professional norm of projecting competence and steadiness can make it difficult to acknowledge that personally. The people who care for everyone else need care too.

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It's Time to Heal, Minnesota from page 22

Healing Minnesota invites physicians to engage at three levels.

The first is personal. Consider your own mental health as something worth attending to — not as a professional risk, but as a human need. The same conversation you would have with a patient who described years of accumulated stress is a conversation worth having with yourself, or with a trusted colleague or with a professional who can help.

The second is in your practice. The staff who work alongside you — medical assistants, nurses, front desk personnel, administrators — all are members of the same community, carrying the same weight. Creating space to acknowledge that, connecting people to resources and modeling the willingness to seek help when needed can shift the culture of a workplace in ways that matter.

> Supporting children's mental health now is an investment in outcomes that extend across a lifetime.

The third is with your patients. A single question probing the affects these traumatic events have made them feel can open a door that patients are waiting for someone to open. NAMI Minnesota's helpline, support groups and educational materials are free, accessible and designed to be a welcoming first step for people who are not sure where else to turn.

Recovery Is Possible

Minnesota has been through a lot. But that is not where the story ends. Across this state, every day, people are reaching out for help and finding it. Communities are coming back together. Families are rebuilding. Organizations that were stretched beyond capacity are finding partners and resources they did not have before. The dramatic increase in calls to our helpline and engagement with our social media during Operation Metro Surge was alarming — and it was also a sign that people knew where to turn, that they reached out rather than suffering alone and that we were there to answer.

Healing Minnesota is built on the conviction that recovery is not just possible — it is already happening, and it will go further and reach more people with coordinated effort, sustained commitment and the involvement of trusted voices across every sector of Minnesota life.

The medical community is one of those voices. When physicians say to their patients, staff and colleagues that what they are carrying is real and help is available — it matters. It reduces stigma. It opens doors. It changes outcomes.

We have seen what Minnesotans can do when we face something hard together. We showed the world how to respond to a series of traumatic events. Now, with your help, let's show the world how we recover.

Marcus Schmit is the Executive Director of NAMI Minnesota, where he has led the organization since November 2025.

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Use our resources to help you expand your knowledge of the latest rehabilitation guidelines and to properly address the needs of your stroke patients.

Learn more about how your facility can benefit:

www.Heart.org/PostAcuteStroke

Congratulations to these participating MN sites:

- Appleton Area Health (Appleton)
- CentraCare-St. Cloud Hospital (St. Cloud)
- Courage Kenny Rehabilitation Institute (St. Paul)
- Courage Kenny Rehabilitation Associates (Minneapolis)
- Courage Kenny Rehabilitation Institute TRP (Golden Valley)
- Gunderson St. Elizabeth's Hospitals & Clinics (Wabasha)
- Hennepin County Medical Center (Minneapolis)
- MHealth Fairview Acute Rehabilitation Center (Minneapolis)
- North Memorial Health Care (Robbinsdale)
- Pipestone County Medical Center (Pipestone)
- Regions Hospital (St. Paul)
- Glencoe Regional Health Services (Glencoe)
- Glenfields Living with Care (Glencoe)
- Sanford Medical Center (Thief River Falls)
- St. Luke's Hospital of Duluth (Duluth)
- Madelia Health Hospital (Madelia)
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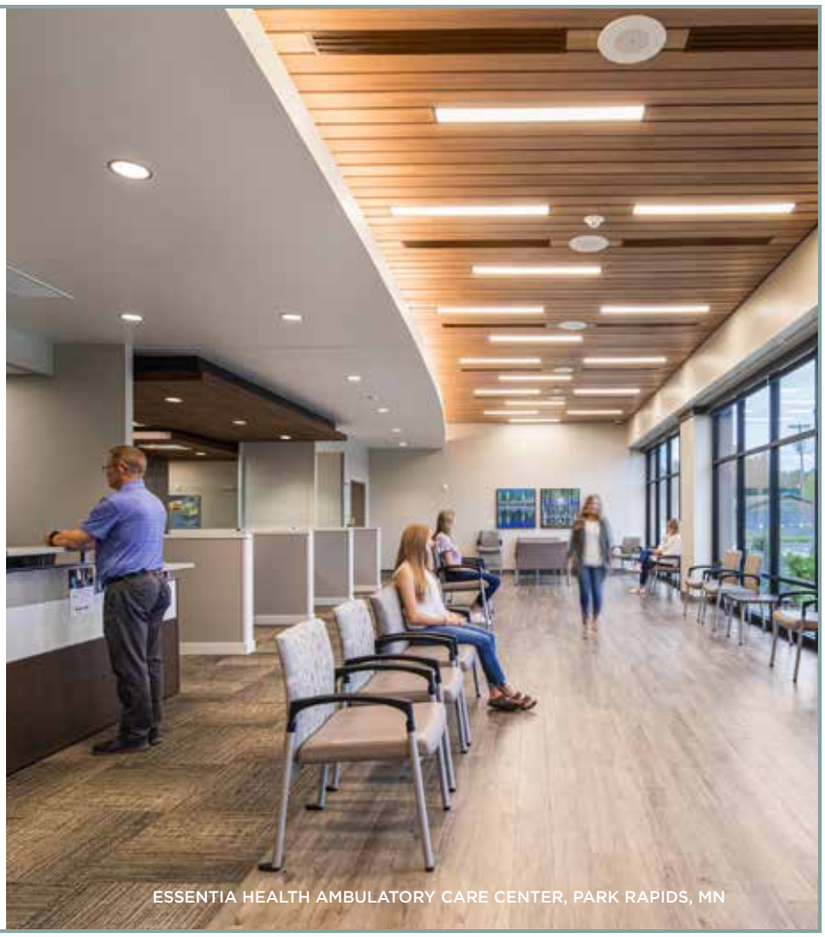

ESSENTIA HEALTH AMBULATORY CARE CENTER, PARK RAPIDS, MN

Moving online creating a healthier Minnesota

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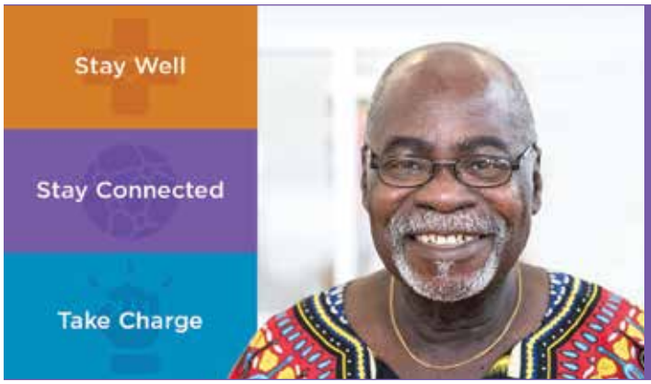

In March all of our community-based courses were canceled due to COVID-19. With a network of 160 statewide partner programs, and over 850 certified program leaders we can help your patients overcome the challenges of self-isolation and take charge of their health.

We are pleased to offer these programs in an online setting that can now be accessed in the safety of your patients homes. The live, online courses are facilitated by trained and certified leaders in HIPAA-secure, easy to use video conferencing settings.

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www.yourjuniper.org or call 1-888-215-2174

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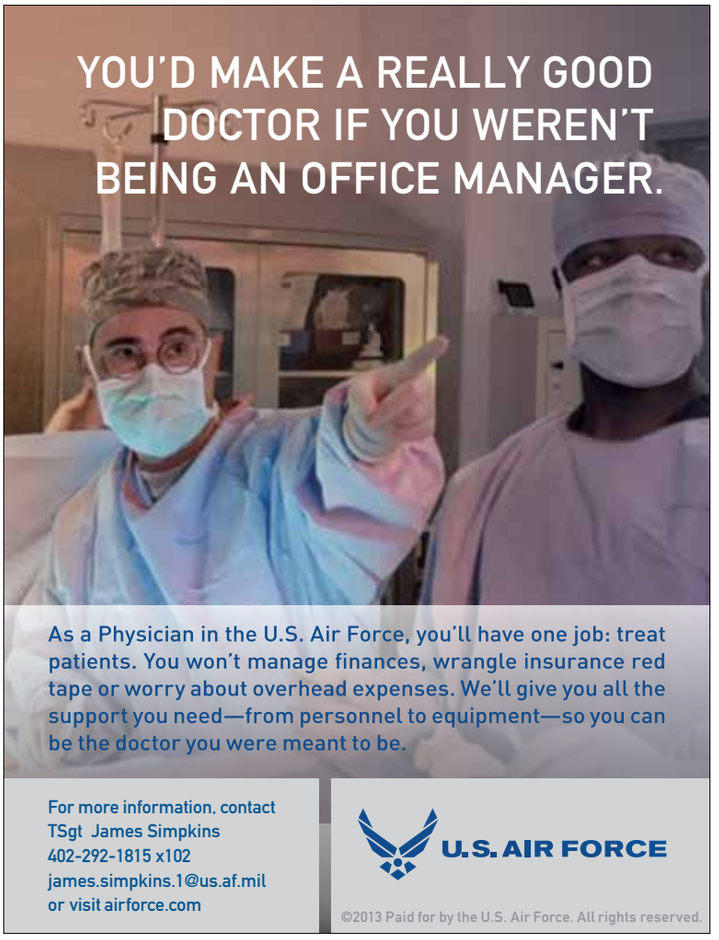

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Minneapolis VA Health Care System

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Ely VA Clinic

Current opportunities include:

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The Intersection of Health Care and Public Safety from page 9

What further advances do you see on the horizon?

Some of the most significant advances in EMS may come from changes in how and where care is delivered. The traditional model of evaluating each patient and transporting them to an emergency department is evolving toward providing the right care in the right place at the right time.

Telemedicine will likely continue expanding. Improved communication technology will allow EMS clinicians to consult physicians in real time, supporting better treatment decisions and creating more opportunities for safe non transport care. Minnesota's pilot projects already explore these possibilities.

Unmanned aerial systems, or drones, may also play an important role in rapid delivery of lifesaving resources. Equipment such as AEDs, blood products, naloxone, and tourniquets could reach patients more quickly, especially in rural or hard-to-reach areas.

Another major advancement involves deeper integration of EMS into the health care system. Community paramedicine, mobile integrated health care, treatment in place models and new payment approaches recognize that EMS is more than transportation. As these models mature, EMS will serve as a flexible health care resource that improves care coordination and patient outcomes.

Please discuss some of the financial pressures your office faces.

Financial sustainability is one of the most significant challenges for Minnesota's EMS system. OEMS works closely with ambulance services that are operating under increasing financial strain. Recent statewide reporting found that nearly two thirds of ambulance services operated at a loss during their most recent fiscal year, with combined deficits exceeding $57 million.

EMS is a readiness-based system. Ambulances must maintain trained personnel, specialized equipment and vehicles ready around the clock, regardless of call volume. Fixed costs are constant, even on days with few or no transports. At the same time, reimbursement has historically been tied to transport rather than the readiness, assessment and treatment provided on every response.

As EMS becomes more integrated into health care, funding structures must be evaluated. Minnesota has made important investments through grants and targeted legislative initiatives, but long-term stability will require collaboration among policymakers, insurers, health care providers and EMS leaders. OEMS supports this work by providing objective data and evaluating new options for sustainable funding.

What are some of the key elements of care coordination that you encounter in your work?

Care coordination begins before a patient arrives at the hospital. EMS is often the first point of medical contact, and effective transfer of information between EMS clinicians and hospital teams is essential for strong outcomes. OEMS plays an important role in strengthening these connections across the health care system.

Minnesota's model places significant responsibility on physician medical directors, who guide local protocols, oversee quality improvement and ensure care remains evidence based. OEMS supports these partnerships by establishing statewide standards and facilitating communication among EMS agencies, hospitals and physicians.

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Family Medicine opportunity in Breezy Point/Pequot Lakes Minnesota

Located in the central Minnesota community of Breezy Point, home to beautiful Pelican Lake, many fine golf courses and pristine wooded landscapes, Cuyuna Regional Medical Center is seeking an experienced Family Medicine physician for its growing multi-specialty clinic.

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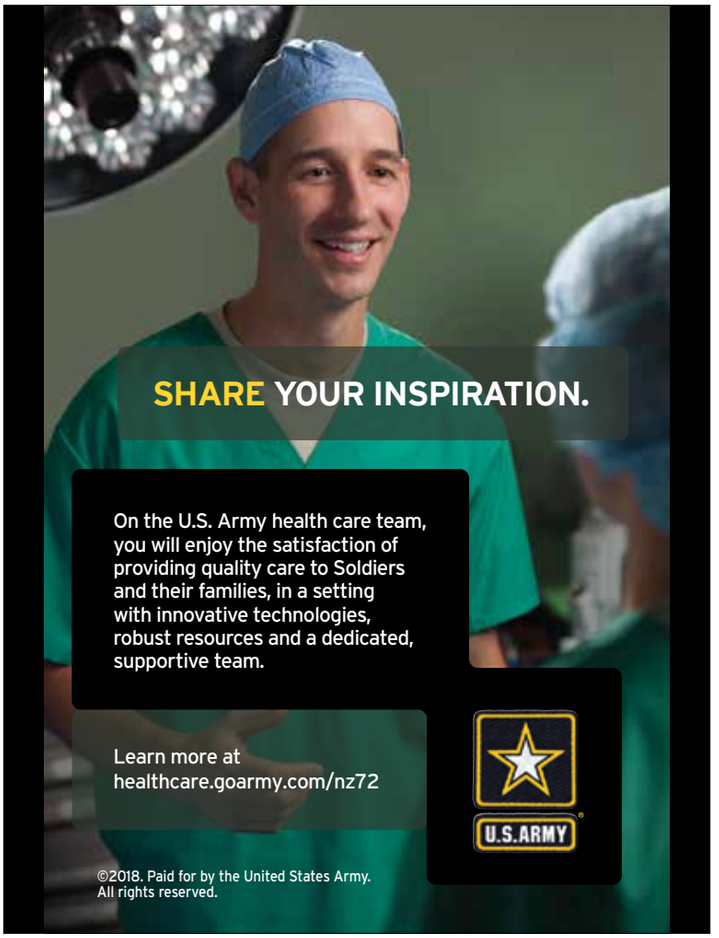

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www.olmstedmedicalcenter.org

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Technology also enhances coordination. Minnesota's Hospital Hub system rapidly shares electronic patient care reports with receiving hospitals, giving emergency department clinicians timely access to prehospital information. OEMS also supports the state's Medical Resource Communication Centers, which coordinate complex or high acuity incidents in real time.

Strong relationships between clinicians, physicians and system partners ultimately make coordination successful and improve continuity of care for patients.

What can physicians do to help improve emergency medical services?

Physicians are central to the success of EMS, and that involvement extends far beyond emergency medicine. Every physician who interacts with EMS can help strengthen the system by sharing expertise, supporting education and collaborating to enhance patient care.

Minnesota benefits from strong physician participation through local medical direction. Physician medical directors help shape protocols, guide quality improvement and ensure EMS clinicians practice evidence-based medicine. This relationship is one of the state's defining strengths.

Specialists across disciplines can contribute valuable education and clinical experiences to EMS students and practicing clinicians. Physicians can also participate in research, quality initiatives and system planning efforts that help EMS evolve alongside broader health care.

Most importantly, physicians can view EMS as an extension of their care team. Early prehospital care often shapes everything that follows in the hospital. When physicians, hospitals and EMS agencies work together as true partners, patients receive more coordinated, higher quality care. That shared commitment to improving outcomes is ultimately what defines Minnesota's EMS system.

Dylan Ferguson was appointed by Governor Tim Walz to serve as the inaugural director of the Office of Emergency Services. He started this new role on January 1,2025 and brings decades of work in public service, administration and EMS experience to the position.

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

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

DEPARTMENT OF HEALTH

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