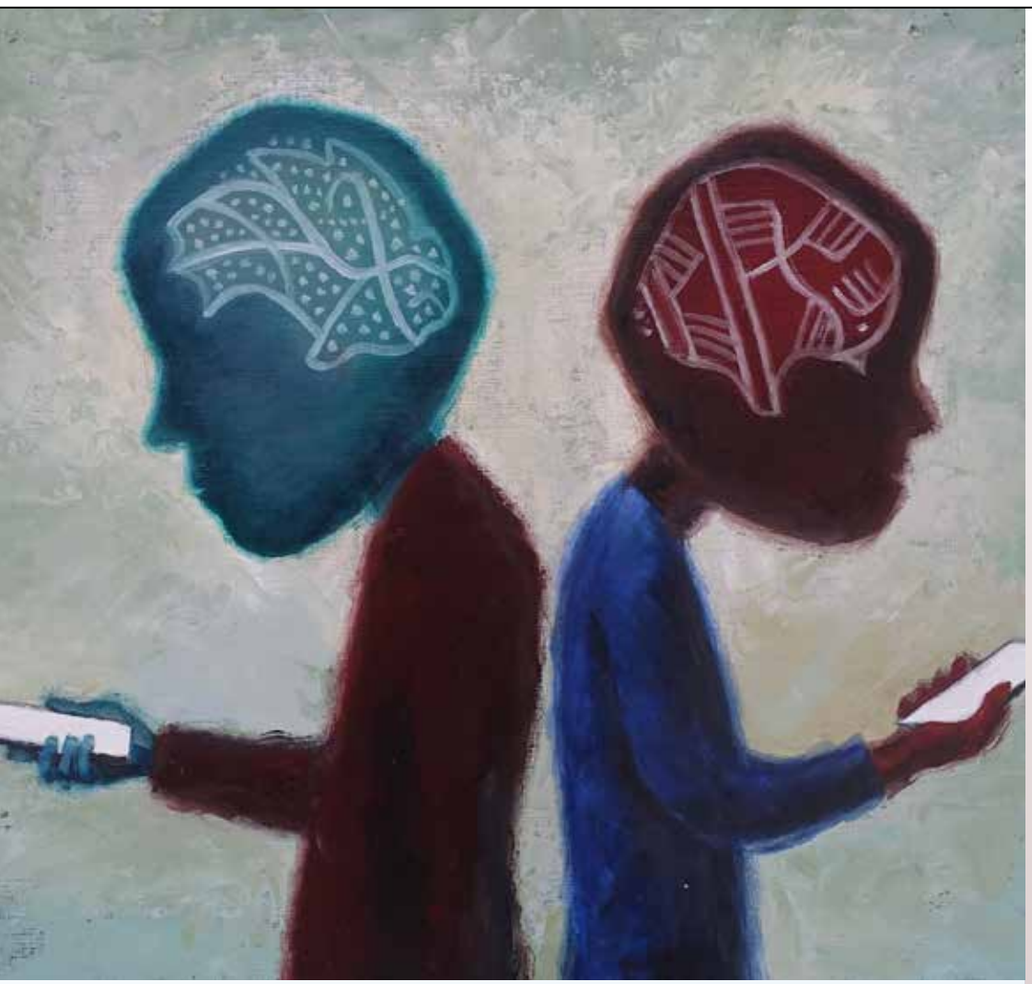
MINNESOTA
PHYSICIAN

DECEMBER 2025

THE INDEPENDENT MEDICAL BUSINESS JOURNAL

Volume XXXIX, No.09



Prioritizing Mental Health Well-being

Fostering a better informed society

BY TODD ARCHBOLD, LSW, MBA

The increasing prevalence of mental health issues, particularly among children and adolescents, is alarming. The National Institute of Mental Health reports that nearly one in five youth from 13 to 18 experiences a severe mental disorder at some point in their lives, and in nearly 70% of cases, the onset of symptoms occurs before 14. This significant number of cases can be attributed to many factors, including heightened societal pressures, increased awareness of mental health issues, social media-related issues and the lingering impact of the COVID-19 pandemic.

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Barriers and Bridges

Mental Health Care for Rural Communities of Color

BY MITRA MILANI ENGAN AND MARNIE WERNER

Rural Minnesota is changing. Across its small towns and open landscapes, people of color are becoming a larger part of the community — some newly arrived from other countries, others whose families have called this region home for generations. Finding mental health care can be a struggle for anyone living in rural areas, but it can be even harder for BIPOC residents (Black, Indigenous and People of Color).

Nationwide, there is an acute shortage of mental health providers and services in rural areas, and in Greater Minnesota this shortage is very real. Setting up further potential shortages and complicating access to care, more than half of rural providers are over the age of 55. There is a reluctance among new providers to practice outstate related to lower income potential. Additionally, bottlenecks in the training

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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.

Medica to Acquire Parts of UCare

Medica and UCare recently announced an agreement through which significant contracts and assets of UCare will be taken over by Medica. Individuals enrolled in UCare's 2026 Medicaid and Individual and Family plans will continue to receive services without interruption. The transaction is anticipated to close in the first quarter of 2026. Individuals enrolled in a UCare plan for calendar year 2025 will continue to receive coverage without interruption. For the 2026 plan year, eligible individuals may continue to enroll in health coverage offered by either Medica or UCare. UCare is making some very difficult changes so it can continue serving Minnesotans. While ending its Medicare Advantage plans and reducing service areas for some Medical Assistance and MinnesotaCare plans, UCare will continue to offer a broad range of health plans.

"Combined, UCare and Medica have nearly a century of industry expertise and a shared commitment to community-driven coverage for those who need it most," said Hilary Marden-Resnik, president and CEO of UCare. "This is a significant agreement that will enable us to preserve access to coverage for Minnesota's most vulnerable members."

"As a nonprofit, community-focused health plan, Medica has a long history of serving members in Minnesota, guided by our mission and trusted relationships with providers, customers and members," said Lisa Erickson, CEO of Medica. "Now we have the opportunity to build upon both Medica's strengths and UCare's legacy, allowing Minnesotans to continue to have a health care experience that ensures they feel cared for."

UCare has clearly stated that it will remain in business and is deeply committed to its mission of serving Minnesotans with compassion, care and respect. While some plans are changing, its focus on community health and access to care remains strong.

UCare is evolving to meet today's challenges while staying true to its values. These changes are intended to stabilize the organization and to continue serving its communities and delivering on its mission. Providers or members with questions are encouraged to visit Medica.com or UCare.org for more information.

State Freezes Payments to 14 Medicaid Services

Gov. Tim Walz recently announced that in response to significant widespread fraud, his administration is pausing all payments for 14 Medicaid services for up to 90 days pending a third-party audit. Minnesota public programs have been victims of blatant fraud resulting in the loss of hundreds of millions of dollars in recent years.

The Department of Human Services (DHS) identified 14 Medicaid service types as "high-risk" because of "vulnerabilities, evidence of fraudulent activity, or data analytics that revealed potentially suspicious patterns, claim anomalies or outliers," DHS Temporary Commissioner Shireen Gandhi wrote to the federal government.

Affected programs include:

- Integrated Community Supports
- Nonemergency Medical Transportation
- Peer Recovery Services
- Adult Rehabilitative Mental Health Services
- Adult Day Services
- Personal Care Assistance/ Community First Services and Supports
- Recuperative Care
- Individualized Home Supports

- Adult Companion Services
- Night Supervision
- Assertive Community Treatment
- Intensive Residential Treatment Services

In pausing the funding, Walz said, "We cannot effectively deliver programs and services if they don't have the backing of the public's trust. In order to restore that trust we are pumping the brakes on 14 programs that were created to help the most disadvantaged among us, yet have become the target of criminal activity." Minnesota's Medicaid autism treatment program is among those with frozen funding.

Walz says that the review of payments could result in longer wait times before the providers are paid, but the state will still meet federal rules, which require payment within 90 days. Gandhi says the department intends to pay most claims within 30 days. The governor's office said the state has outsourced the audit to Optum, which will analyze Medicaid billing and flag issues for DHS to review. Of note and question, Optum is a part of UnitedHealth Group, a Minnesota-based health care giant currently under U.S. Department of Justice investigation for various seemingly fraudulent practices.

UofM Accuses Fairview of Hostile Attempt to Takeover Medical School

Recent contract negotiations between Fairview Health and physicians practicing at the University of Minnesota Medical School have taken a bad turn. Whereas there have been various, ongoing and evolving partnerships between Fairview and the university, creating and rebranding components and entities for nearly 30 years, fundamental challenges continue. To a significant extent, the mission of a land grant educational facility may simply be incompatible with that of a corporate entity. Regardless, M Physicians, a clinical practice of the University of Minnesota Medical School faculty, rebranded by an existing Fairview agreement, recently announced a new 10-year working arrangement extension. The framework for this arrangement has been called into question for several reasons by the Regents of the University of Minnesota, and the state attorney general has been brought into what is now a contentious debate of legal authority. A separate agreement between Fairview and the UofM is set to expire at the end of next year, and the regents claim that agreement prohibits the proposed new contract with M Physicians without their involvement. They claim the new agreement would make M Physicians "a captive entity to Fairview" instead of an independent and key part of the university's academic health center, which could also give Fairview significant leverage in any ongoing partnerships with the university. They claim the recent actions strongly overstep Fairview and the University of Minnesota Physician's authority — and represent a hostile takeover of the University of Minnesota Medical School. They also claim that it puts the interests of a single regional provider and a physician group above Minnesotans, and handcuffs the university's ability to provide medical education and conduct life-saving research. Details of the Fairview-M Physicians partnership are expected to be worked out by the end of 2025; the regents, however, in their letter to the attorney general have urged forestalling the action. Citing four specific remedies, the regents have requested mediation and will present a standstill plan by 12/31/2025. Fairview claims to be open to discussions with the UofM; several events over the course of the partnership, however, create cause for concern. Failed potential business relationships with Sanford Health and Essentia Health, as well as debates over the sustainability of Fairview financial investments in university infrastructure are recent examples. The complex relationship, having gone through

leadership changes at every level on both sides, continues to face significant internal communication challenges.

New Mayo Study Finds Few Women Seek Menopause Care

A recent study published by the Mayo Clinic of 5,000 women ages 45 to 60 found that most did not seek care for the symptoms of menopause. More than 3 out of 4 respondents experienced menopause symptoms, with many reporting substantial effects on daily life, work productivity and overall well-being. More than one-third (34%) of women who were surveyed reported moderate to very severe symptoms. Sleep disturbances and weight gain were among the most common issues reported by more than half of participants. Perhaps the most significant finding was that more than 80% of the survey respondents did not seek medical care for their menopause symptoms. Despite the ready availability of effective treatment options, the study found that menopause symptoms remain underrecognized, undertreated and inadequately addressed by the health care system. It is likely that most women are navigating this stage of life without medical care to help manage menopause. Many survey responses indicated a preference for symptom self-management with others citing either being too busy to seek care or being unaware that effective treatments exist. The survey indicated only about 1 in 4 women were receiving any treatment for menopause symptoms. "Menopause is universal for women at midlife, the symptoms are common and disruptive, and yet, few women are receiving care that could help them," says lead author Ekta Kapoor, MBBS, an endocrinologist and menopause specialist at Mayo Clinic in Rochester. "This gap has real consequences for women's health and quality of life, and it's time we address it more proactively." Without proper treatment, menopause symptoms can negatively affect sleep, mood, cognition, and productivity at work and at home. The findings underscore the importance of health care professionals proactively identifying and managing menopause symptoms in patients who may be struggling with them. The study noted that women often do not voluntarily mention concerns about menopause symptoms to their health care professional.

Efforts are underway to destigmatize menopause care, making it more visible and accessible. "Our goal is to educate women and health care professionals about menopause," Dr. Kapoor says. "We can close the gap between need and care — and help midlife women live healthier, more fulfilling lives."

Herself Health and Midi Health Form New Alliance

Herself Health and Midi Health, recently announced a new collaboration. Herself Health, now operating five clinic locations across the Twin Cities all focused on serving women over age 65, and Midi Health, a virtual care provider offering support to over 200,000 women nationwide, are offering a hybrid model that combines virtual services with in-person primary care clinics across the Twin Cities. Midi Health focuses on perimenopause and menopause support, hormone therapy, lifestyle coaching and mental health services. The new model will expand the age range of Herself Health patients and offers a continuum of care that addresses the needs of midlife and older women. Women in midlife can now benefit from a more connected experience across care settings. Herself Health will offer primary care virtually and in-person at its five clinics across the Minneapolis–St. Paul area, including annual wellness visits, gynecological care, behavioral health support and, when needed, more complex or chronic condition management. Patients may

engage with providers, accessing hormonal care through Midi Health and primary care through Herself Health, depending on their individual needs.

As part of its continued investment in women's care, Herself Health — which has historically focused on women over age 65 — is also now expanding its model to serve younger women seeking women-focused primary care. Beginning in January 2026, Herself Health will launch a paid membership program designed for women ages 50–64, offering enhanced access to care and personalized health support. The program will include on-site mammography and a dual x-ray absorptiometry (DEXA) scan to measure bone density at select Twin Cities clinics, available to both Herself Health and Midi Health patients.

CIDRAP Relaunches Coronavirus Vaccine Roadmap

The University of Minnesota's Center for Infectious Disease Research and Policy (CIDRAP) recently announced the launch of a new, improved Coronavirus Vaccines R&D Roadmap (CVR), a global, open-access platform designed to track scientific progress toward the development of broadly protective coronavirus vaccines. Created in partnership with the Coalition for Epidemic Preparedness Innovations (CEPI), the new website transforms CIDRAP's Coronavirus Vaccines Research and Development (R&D) Roadmap into a dynamic, continuously updated resource for researchers, policymakers and funders. The roadmap — originally launched in 2023 with support from the Rockefeller Foundation and the Gates Foundation — outlines key goals and milestones to guide global coronavirus vaccine R&D. With CEPI's investment, and in collaboration with 50 scientific experts from around the world, the new initiative serves to monitor progress in these priority research areas and further catalyze coronavirus vaccine development critical for future preparedness and response.

The new site hosts three integrated components:

- **Coronavirus Vaccine Technology Landscape:** a curated, continually updated database of coronavirus vaccines in preclinical and clinical development, including broadly protective, SARS-CoV-2 and MERS vaccine candidates.
- **R&D Progress Tracker:** an interactive tool that monitors scientific advances and reports progress toward achieving the roadmap's defined goals and milestones according to five major topic areas: virology, immunology, vaccinology, animal and human infection models, and policy and financing.
- **CVR Scholar Hub:** an online resource center featuring literature reviews, data syntheses and other materials supporting researchers in coronavirus vaccine development.

"The launch of this new digital home marks an important next step for the roadmap and for the broader vaccine research community," said Dr. Michael Osterholm, Regents Professor and Director of CIDRAP. "We now have a centralized, open-access resource that allows scientists, funders, and policymakers to see in real time where progress is being made and where critical gaps remain. Our goal is to turn information into action — accelerating discovery, collaboration and preparedness for the next coronavirus threat."

Coronaviruses remain among the top pandemic threats identified by the World Health Organization. The Coronavirus Vaccines R&D Roadmap Initiative website and associated resources are freely available at cvr.cidrap.umn.edu.

Creating a More Just Society for All

Jamie Verbrugge, president and CEO, Catholic Charities Twin Cities

Please tell us about the mission of Catholic Charities Twin Cities (CCTC).

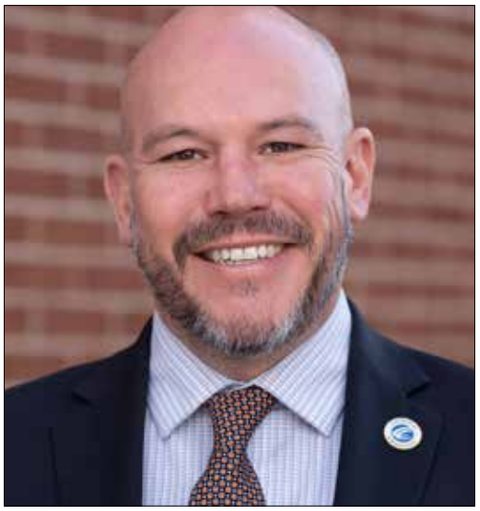
For more than 150 years, Catholic Charities has been an integral part of the Twin Cities community, directly serving our most vulnerable neighbors. For us, caring goes beyond belief.

We deliver essential services including affordable housing, emergency shelter, nutritious meals, mental health care, addiction resources and more. CCTC offers a lifeline to those facing hardship, providing support and developing solutions to build stronger communities. Regardless of faith, identity, background or circumstances, we treat everyone with dignity and respect. This transformative work wouldn't be possible without our dedicated staff and the generous support of our donors, volunteers and advocates.

Our services are organized to serve in four service categories: aging and disability services, adult emergency services, children and family services and single adult housing. With facilities across the Twin Cities, we work tirelessly to respond to immediate crises and offer pathways to greater stability. We strive to create a more just society for all by fostering strong partnerships with community organizations and individuals.

You have invaluable perspective on the relationship between homelessness and health. What can you share about this subject?

Housing is widely recognized by health professionals as a fundamental component of health care. Without safe and stable housing, maintaining physical and mental health becomes nearly impossible. This is especially true for individuals experiencing homelessness, who face disproportionately high rates of comorbid conditions such as asthma, diabetes, chronic pulmonary disease and substance use disorders. Homelessness often exacerbates these conditions, creating dangerous circumstances—particularly for those who are unsheltered and exposed daily to the elements, community violence and infectious diseases in settings like encampments.



> "We have always served people regardless of faith, identity, background or circumstance."

Individuals who access shelters also face health challenges. The high density of most shelters facilitates the spread of respiratory illnesses, influenza and other communicable diseases. Limited privacy, the absence of strong support systems and the chronic stress of homelessness further intensify physical and mental health challenges.

Equity within health care systems also plays a critical role. Black, Indigenous, and People of Color (BIPOC) communities are disproportionately represented among those experiencing homelessness, making them more likely to suffer poorer health outcomes due to systemic inequities in health care access and delivery.

Please tell us some of the ways you are working with the health care delivery system to assist the population you serve.

We recognize that many of the individuals we serve have not had access to, nor prioritized, the most basic elements of health care. With this in mind, we work to remove barriers that prevent our clients from receiving quality care. We actively engage in preventive health initiatives by partnering with organizations to provide immunizations, screenings and testing at our sites. Several of our facilities host medical providers who deliver primary and urgent care directly on-site. Two of our locations are co-located with Federally Qualified Health Centers, while others collaborate with medical professionals to ensure accessible care. In addition, highly skilled volunteers contribute essential services such as foot care.

CCTC has also partnered with health care systems to establish recuperative care programs in both Minneapolis and St. Paul. These medical respite programs offer a safe place for adults experiencing homelessness to heal after hospital discharge, when they are not yet ready to return to a shelter or the streets. Our staff support individuals by helping them follow discharge instructions, attend follow-up appointments and connect with housing services, ensuring care that promotes recovery and stability. Key partners in this work are Hennepin County Healthcare for the Homeless (at our Minneapolis respite location) and Regions Hospital and United Hospital (at our St. Paul respite location).

We also collaborate with broader community initiatives that improve the health and well-being of the people we serve. A good example of this is the Fairview Community Health and Wellness Hub in St Paul. Located next to our Catholic Charities Dorothy Day Place campus, the Hub addresses health disparities while providing a range of services.

We believe that working in partnership will enhance our impact and improve the health and well-being of our neighbors and the broader community for generations to come.

What are ways this work could be expanded?

Last year, at CCTC, our programs for children, families and adults assisted more than 33,000 people, regardless of faith, background or circumstance. We know that the work we do makes a real difference in the lives of the people we serve. We also know there is more to do.

Several factors could improve the impact and reach of this work. Addressing upstream challenges would help prevent housing instability before it occurs, reduce more costly long-term costs and improve outcomes for vulnerable populations.

We also know that there needs to be sustained funding to maintain this work. We face challenges in planning ahead as the funding is uncertain. This makes it difficult to retain staff and invest in programs.

Working to build stronger cross-sector partnerships which foster collaboration between government, nonprofits, health care providers, and employers would expand our reach and sustainability.

Despite the challenges across our agency, we're continuing our 150-year history of serving our neighbors in need: we're innovating programs, building new service models and finding fresh ways to connect people with the resources and opportunities they need to be successful.

CCTC provides a wide range of services that address mental health issues, including substance use concerns. What can you tell us about this work?

While we are not a direct provider of behavioral health treatment services, we recognize that the individuals who come to us often have a wide range of needs that must be addressed and supported for long-term success. Central to this work is having empathetic, well-trained staff who are welcoming and committed to building healthy relationships with those seeking our services. All staff receive training in trauma-informed care, crisis de-escalation and strategies that promote healthy living for people experiencing homelessness. Additionally, we employ specialists with advanced behavioral health training to support direct care staff in developing care plans, implementing effective interventions and arranging outside care when needed.

We are also reimagining the way we engage people who are struggling with mental illness. This work includes:

- Developing a housing-focused behavioral health support team (HBST), which is a specialized group of case managers and behavioral health professionals who provide intensive support to meet the unique needs of individuals with complex health conditions. Embedded within the emergency shelters, the HBST connects people in crisis with resources that help them make progress towards stability.
- Utilizing a team of behavioral health professionals dedicated to serving residents in our permanent supportive housing programs. This team travels between housing programs to help manage the mental and behavioral challenges that our residents face, working alongside housing case managers to identify and support people who are struggling. This innovative approach helps ensure that our residents have the necessary resources to be successful and remain stably housed.

We understand that this work cannot be done alone. Our staff actively partner with behavioral health professionals and organizations to provide additional on-site services that improve accessibility whenever possible. We know that the easier services are to access, the more likely individuals are to engage in follow-up care and ongoing support. We also maintain extensive networks and relationships with acute care providers and public partners, ensuring that individuals can be connected to higher levels of care when necessary.

How does Minnesota work with other states in supporting this mission and how does your chapter work with others in the state?

We are a member of Catholic Charities USA (CCUSA), one of the largest private networks of social service providers in the country. CCUSA provides professional support through best-practice sharing, continuing education and advocacy at the national level.

Our staff engage with CCUSA in many ways, and one with the most affect is participation in its communities of practice. These groups connect staff with peers nationwide on topics such as leadership, mental health and housing. Through these communities, team members can ask questions, exchange ideas and learn directly from colleagues doing similar work across the United States.

While the Catholic Charities network is central to our foundation, we also collaborate with a broad range of partners to ensure we fully advance our mission. We actively participate in the communities of care in both Hennepin and Ramsey counties, working with local stakeholders to support coordinated efforts to address homelessness in our community. In addition, we engage with organizations that help older adults age safely in place and those that promote healthy development and early learning for children facing some of the greatest opportunity gaps in our country.

Our staff are often sought out for participation in committees, task forces and legislative input because of our long history in the community, experience in policy development and direct practice in the community.

Children's health issues are an important part of your work. What are some ways you are helping to improve children's health?

Our work with children and families has always been rooted in a deep commitment to opportunity and well-being. Research shows that individuals with higher educational attainment live healthier, longer lives. Yet, we also know that Minnesota's Black and Brown children face some of the greatest opportunity gaps and educational disparities in our nation.

Since the 1980s, Catholic Charities has invested in quality early childhood education in North Minneapolis through the Northside Child Development Center (NCDC). NCDC goes beyond providing early education and childcare—it takes a holistic approach to supporting the entire family. From verifying immunizations and scheduling well-child checkups to ensuring dental care, staff help make sure critical health needs are met. Families also receive education on child development and parenting strategies to strengthen their role as caregivers. Through partnerships, NCDC offers healthy food options, parent education and other essential supports. As a result, NCDC graduates leave prepared for a strong academic future.

We also operates a children's day treatment program for youth whose mental health challenges interfere with school success or community engagement. This year-round program serves up to 40 children in kindergarten through eighth grade across the Twin Cities metro area. It combines intensive mental health treatment with academic instruction tailored to each child's needs, complemented by family therapy through a partnership with Minneapolis public schools special education. Day treatment provides skills development, individual and group therapy and family psychoeducation and support. The program serves children who have experienced trauma or have a mental health diagnosis and benefit from a smaller, structured and less stimulating environment that fosters healing and learning.

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Prioritizing Mental Health Well-being from cover

In recent months, public discourse surrounding mental health has been increasingly influenced by misinformation and sensationalism. As mental health professionals, we must navigate this complex environment, where misinformation can exacerbate existing challenges and hinder access to care. Claims that misrepresent the science behind mental health treatment in particular can pose a significant threat to individuals struggling with mental health issues.

Mental illness is real, common and treatable. These three tenets are essential in fostering a better understanding of mental health issues and the importance of seeking help. First, mental illness is real; it affects millions of individuals across diverse demographics and can be identified through comprehensive evaluations and even biological or neurochemical markers. For example, research has shown that conditions like depression and anxiety can be associated with alterations in neurotransmitter levels, such as serotonin and dopamine. Neuroimaging studies have also identified structural and functional brain changes in individuals with mental disorders, providing further evidence of their biological basis. Recognizing mental illness as a legitimate health concern is crucial for reducing stigma and encouraging individuals to seek the support they need.

Second, mental illness is common; according to the National Institute of Mental Health, nearly one in five adults in the U.S. experiences mental illness in a given year. This prevalence underscores the need for widespread awareness and accessible resources to support those affected. Finally, mental illness is treatable; evidence-based therapies, including cognitive behavioral therapy (CBT) and medication, have been shown to be effective in managing symptoms and improving quality of life. Studies indicate that CBT can lead to significant reductions in symptoms for various mental health conditions, with research suggesting that up to 70% of individuals with anxiety and depression benefit from this form of therapy.

> Misinformation can worsen health disparities and hinder effective disease prevention.

The rise of misinformation in health care, particularly regarding mental health, has reached alarming levels, exacerbated by the rapid dissemination of information through digital platforms and social media. This environment not only fosters confusion but also undermines public trust in legitimate health information, leading to harmful consequences for individuals seeking help. Vulnerable populations are disproportionately affected, as misinformation can worsen health disparities and hinder effective disease prevention efforts. Addressing these challenges requires a coordinated approach that emphasizes health literacy, promotes evidence-based communication and establishes clear standards for verifying credible sources. Health literacy, particularly in mental health, involves understanding the nature of mental illnesses, recognizing the signs and symptoms and knowing how to access appropriate care.

The concept of health care literacy is relatively new and its definition is evolving. For instance, we now identify personal health literacy as differentiated from organizational health literacy. Focusing on personal health care literacy, the term reflects the ability to use health information to make well-informed decisions. This concept builds on the capacity to obtain, process and understand basic information pertaining to making specific health care decisions. This involves reading and comprehension skills, as well as understanding charts, graphs and related data that can inform making choices around risks, benefits and taking action. From a public health or organizational health literacy perspective it is critical that such information is accurately and reliably presented.

Looking at this idea more specifically, we can address mental health literacy, which requires an understanding of the role of antidepressants, those that are scientifically proven treatments for many individuals suffering from depression, anxiety and other mood disorders. Antidepressants work by altering the brain's chemistry to help improve mood and emotional regulation. While some individuals may experience withdrawal symptoms when discontinuing antidepressants, this is not synonymous with addiction.

The process of discontinuing antidepressants is typically guided by health care providers, who monitor patients and establish benchmarks for when it is appropriate to taper off medication. Addiction is characterized by compulsive drug-seeking behavior and a loss of control over use, which is not the case for most individuals taking antidepressants as prescribed. In fact, these medications are greatly improving their lives and often the lives of those around them.

The American Psychiatric Association (APA) emphasizes the importance of understanding the nature of antidepressants and the misconceptions surrounding them. It highlights that the symptoms some people experience when changing dosage or discontinuing use merely reflect the brain's adjustment, and are not indicative of an addiction. The APA also notes that the benefits of antidepressants in treating severe mental health conditions far outweigh the risks when used appropriately under a healthcare provider's guidance.

Moreover, the effectiveness of mental health treatments extends beyond medication. Research has consistently shown that psychotherapy, particularly evidence-based approaches like CBT, can lead to significant improvements in mental health outcomes. A meta-analysis published in Psychological Bulletin found that CBT is effective for a wide range of disorders, including depression, anxiety, and PTSD, with many individuals experiencing lasting benefits even after treatment has concluded. Additionally, integrating lifestyle modifications, such as exercise and mindfulness practices, has been shown to enhance treatment efficacy and overall well-being. These findings reinforce the notion that mental health treatment is not only effective but also essential for fostering resilience and recovery.

> The troubling trend of mental health misinformation threatens public health.

Dr. Mark Olfson, M.D., M.P.H., a psychiatrist and professor of epidemiology at Columbia University Mailman School of Public Health, stated, "For an adult with depression, a one-year delay in treatment is significant. For a young adolescent with depression, however, that same time period presents far greater developmental risks." This statement underscores the urgency of timely intervention, especially for younger populations who are particularly vulnerable to the consequences of untreated mental health conditions.

Barriers in Accessing Care & the Impact of Misinformation

Accessing mental health treatment is often hindered by three primary barriers that can significantly impact individuals seeking help. The first category, which we can refer to as "structural barriers," encompasses tangible obstacles such as lack of insurance, insufficient transportation options and limited access to reliable internet services. These barriers are closely linked to the social determinants of health, which highlight how socioeconomic factors, including income, education and community resources, can influence an individual's ability to obtain necessary care. The second barrier is the pervasive stigma surrounding mental health issues, which can instill a fear of discrimination and judgment. Many individuals may worry about being labeled as "weak" or "unstable," leading them to avoid seeking help even when they are in desperate need of support. The third barrier is perhaps the most insidious: a lack of awareness that one is suffering from a diagnosable mental illness. For instance, someone experiencing chronic depression may find that their feelings and ambitions are muted, leading them to believe that their struggles are simply a part of life rather than a treatable condition. Similarly, individuals with high anxiety may unconsciously avoid social situations, not realizing that their behavior is a symptom of their mental health challenges. In both cases, these individuals are suffering but may not recognize the need for help, which prevents them from seeking the treatment that could significantly improve their quality of life.

Misinformation regarding mental health creates an additional barrier and can have dire consequences, including increased stigma, fear and

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reluctance to seek help, leading to increased suffering and potentially tragic outcomes. In addition, barriers to mental health care are particularly pronounced for children and adolescents. Dr. Olfson pointed out that there are already numerous obstacles limiting access to child and adolescent mental health care, including stigma, cost and regional mental health workforce shortages. Increasing public fear and uncertainty with misinformation creates yet another obstacle between children and the care they need.

The Role of Evidence-Based Care

APA's Council on Children, Adolescents, and Their Families stated, "A public health strategy grounded in prevention, early intervention, structural equity, and evidence-based care offers the best path forward." This holistic approach is essential for addressing the multifaceted nature of mental health challenges faced by young people today.

In the face of misinformation, it is essential to advocate for evidence-based mental health care and balanced studies that further advance the field. This approach relies on scientific research and clinical expertise to guide treatment decisions. Evidence-based care encompasses a range of interventions, including psychotherapy, medication and lifestyle changes, tailored to meet the individual needs of patients.

> Addiction is characterized by compulsive drug-seeking behavior and a loss of control over use, which is not the case for most individuals taking antidepressants as prescribed.

The APA states, "evidence-based practice is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."

Addressing Structural Forces

Structural forces play a significant role in mental health outcomes, particularly for marginalized populations. Issues such as poverty, housing instability, racism and immigration stressors contribute to the mental health crisis among young people. Research has shown that marginalized youth are facing a particularly severe mental health crisis, with rates of suicide among Black youth rising faster than for any other group over the past two decades. The spread of mental health misinformation within these populations must therefore be swiftly addressed to prevent further harm.

Dr. Lisa Fortuna, M.D., M.P.H., chair of APA's Council on Children, Adolescents, and Their Families, addressed misinformation about the overprescribing of psychiatric medications, acknowledging that this could be an issue among some patient populations; however, a lack of appropriate prescribing is also a concern for populations whose access to care is often limited, such as youth living in rural areas or minority groups. This is why organizations such as the APA and the American Academy of Child and Adolescent Psychiatry (AACAP) promote comprehensive models to address health among youth.

To help with this, PrairieCare supports a statewide Psychiatric Assistance Line (PAL) that allows any medical provider direct access to a board-certified

psychiatrist to assist in evidence-based medication management. In addition to direct consultation, PAL also provides ongoing education to the primary care community to ensure best practices in psychiatric care. This initiative is a crucial step toward ensuring that all children have access to the care they need.

Collaboration and Improved Communication

Addressing misinformation in mental health requires a collaborative effort among various stakeholders, including health care providers, policymakers, educators and the media. By working together, we can create a comprehensive approach to mental health that prioritizes evidence-based care and promotes accurate information.

Policymakers have a crucial role to play in supporting mental health initiatives and funding research that advances our understanding of mental health conditions and treatments. Additionally, educators can incorporate mental health education into school curricula, helping to foster a culture of understanding and support from an early age.

The media also bear responsibility for reporting accurately on mental health issues. Sensationalized headlines and misleading statements can perpetuate stigma and misinformation. Through the explosion of social media, there are many sources for every kind of information that willfully thrive on propagating misinformation, and there are no regulations to prevent this. The media should be accountable for providing balanced coverage that highlights the importance of evidence-based care and accurately details the experiences of individuals living with mental health conditions.

Part of the problem lies in the scientific community's struggle to communicate clearly. We've built a strong, globally respected scientific infrastructure that is not easily translatable into usable information that the general public can understand. This disconnect can lead to confusion and mistrust among the public regarding mental health treatments.

A goal with scientific research is publication in high-impact-factor journals, which can create an insular environment where scientists are talking to themselves in circles. This elitist perception can alienate the very individuals who need to understand the benefits and risks of mental health treatments.

Ultimately, the troubling trend of mental health misinformation threatens public health, and it is therefore imperative that we challenge these misconceptions and advocate for balanced assessment and evidence-based approaches to mental health care. Learning to provide health care in an era of misinformation will require new partnerships and greater collaboration with a wider net of stakeholders. Specific to behavioral health, this includes community-based resources and better-informed solutions.

As we face these current challenges, it is essential to recognize that everyone, regardless of political orientation, has been touched in a very personal way by the difficult issues that behavioral health poses. By keeping in sight that proper medical care can and does present a wide range of viable solutions to these issues, we can foster a more informed and compassionate society that prioritizes mental well-being.

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◂ **Barriers and Bridges** from cover

and licensing systems combined with other factors are barriers for young people choosing to become mental health care providers and thereby easing the serious issues posed by the coming wave of retirements. Lack of access to care is part of the reason rates of mental illness and suicide are higher in rural areas. "We can provide suicide hotlines to farmers all day long, but that doesn't address the root cause," said a member of the Upper Sioux Community in southwestern Minnesota who has worked with Minnesota farmers.

The greater distance between communities and the sparse population of smaller towns create adverse economies of scale that increase the cost of providing services, which in turn has led to clinic closures and health care consolidation, further squeezing the supply of services, and resulting in even longer drives to receive services.

Cost of care is, of course, a major issue. Whether people have health insurance through their employer, buy it themselves or receive it through a public option, costs continue to rise. "I can recognize when a kid is really struggling," said a school administrator and social worker in Willmar, but on more than one occasion, when she recommended to a parent that their child be seen by a doctor for depression, the parent replied, "Okay, but we don't have health insurance."

A lack of transportation also limits mental health care access in rural areas, where people are more likely not to have their own vehicles or are unable to drive because of age or disability. Public transportation is usually not available. According to a 2024 Minnesota Department of Health report on the state of rural health care, patients seeking inpatient mental health and chemical dependency treatment must travel three times farther than their urban counterparts. These barriers are significant for all rural families and are even greater for people of color.

Contributing Factors

Other factors affecting people of color in rural areas can be lower incomes, an inability to speak English or speak it well, or they simply don't believe there is such a thing as mental illness and/or that anything can be done about it. These circumstances all make the standard rural barriers to access even higher. Additionally, there are significant issues around trust brought on by past social and medical experiments imposed especially on African Americans and Native Americans that would today be unethical. As a result they see the health care system as a continuation of these past experiences, while fear of encounters with the law make people reluctant to call for help when a family member is in crisis.

The aspect of the issue that is easiest to measure is the lack of licensed mental health care providers who are also people of color. Erik Sievers is the executive director of Hiawatha Valley Mental Health Center, which serves a population of about 160,000 in five rural counties in southeastern Minnesota. "We're an agency of about a hundred or so. We have one provider who's not a white person. One," he said.

A common understanding of a community's experiences and culture is important, especially when it comes to mental health. Steve, whose heritage is both African American and white, hears similar things from the students he works with at a local college. "Representation, I think, is what's stopping a lot of students [from seeking help]. It's hard to be able to connect with people that you don't think will understand what you've experienced."

An example of the differences among cultures can be seen in attitudes toward individualism and collectivism among America's various ethnic and racial groups. Mental health professionals from Latin American, Asian, African and Middle Eastern backgrounds understand from their own experiences that multigenerational households are quite normal in those cultures.

On the other hand, a mental health professional of northern European descent, a culture that emphasizes individualism, might see extended family and multiple generations living together in one home as not normal or even healthy.

According to Gabriel, a long-time school social worker in rural West Central Minnesota, it's important that school social workers build trust with students, but the trust part often comes only when students see social workers who share their racial or cultural background.

"As a person of color, you're looking for someone you can relate to, someone that maybe can understand your culture, because a lot of times, you know, in smaller towns, you feel isolated," he said. "The problem of putting [BIPOC people] all together is that you don't recognize that the Somali community has specific traumas, Latinos have different traumas, Karen have different traumas in history," says Juan, a community leader in Willmar, originally from Peru. "Our journeys have been different."

This is the case for Native Americans. "Native people from Upper Sioux aren't going to seek out mental health resources that are not provided by Upper Sioux," says Brooke, a Dakota tribal member, health care provider, artist and activist. "So if I'm going to go see a person of color as a therapist, there's a tendency [for that therapist] to categorize the indigenous experience as racial rather than as socio-political, which then is a whole other level of like, 'Okay, now I get to educate you on this during therapy hours that I'm paying for? Great.'"

Additional Barriers

There are many barriers for people who want to become licensed mental health providers. Student loans and the prospect of limited income are significant deterrents that keep people from entering the field. This may contribute to why only half of people who graduate with a degree that leads to becoming a licensed mental health care provider role actually attain a license.

For people of color, becoming licensed is even harder. Jessica Estrada is a mental health therapist practicing in Spicer, Minnesota, (population 1,081), while also pursuing her doctorate in social work. "It's hard for anyone to go to college with so much debt...," she said, "but it's even harder for those like Hispanics and Somalis, who are already struggling financially, to even try to think of going to school to get more BIPOC providers out there."

For people of color, becoming licensed is even harder.

The licensing process has its issues, too. In 2022, the Association of Social Work Boards (ASWB) reported that a test taker's demographics are the strongest predictor of whether that social worker will pass the exam required to become a licensed mental health care professional: 80% of white female examinees passed the ASWB clinical exam, while pass rates for other groups were lower, sometimes much lower.

Stigma and fear

A major and common barrier to seeking care for symptoms of mental illness, regardless of race, is stigma. Mental health and mental illness can be difficult to talk about, especially in communities where these concepts may not be seen as relevant, or that a path to care is clear.

"In working with families of color, I think that's one of the biggest things," says Gabriel, the middle-school social worker. They feel isolated in a community where most people don't look like them. "It's kind of like, 'I'm not gonna put myself out there to get hurt.'"

Many of the people of color interviewed said there is a perception in their communities that mental illness does not exist in their culture. Language barriers are another major isolating factor. With mental health care, patients need to be able to accurately relate their thoughts, feelings, perceptions, and physical symptoms, but the many dialects of a language can become a problem. Miranda, a Spanish-language interpreter, found with one patient, "They were speaking Caribbean Spanish. That is not my Spanish."

Medication is another common barrier. "The whole piece about medication that you hear is, 'Well, I'm not putting my kids on meds,'" says a school social worker. The parents may have experience with a family member who was a drug user, and they fear their own child could become addicted. "It's kind of unrealistically based sometimes, but it's real to them," she said.

Expanding Access

When it comes to developing mental wellness programs for people of color, it is

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important to incorporate a group's heritage and culture into those programs. The initiatives need to be designed and delivered by the cultural communities they are intended to serve. Research from the National Institutes of Health on suicide prevention programs for Indigenous people, for example, found that initiatives that were developed with and by the community, drawing on local culture, knowledge, need and priorities, had "substantial [positive] impact on suicide-related outcomes...."

The Role of Mentorship

Being mentored by a professional with a similar background is vital for career development in the mental health care field. Estrada, the mental health therapist and doctoral candidate from Spicer, was mentored by a BIPOC supervisor through the National Association of Social Workers, but the funding for that program is limited, "so it's not everyone that gets it," she said. "I'm just lucky I got it.... Finding a mentor who understands the unique challenges of being a person of color in the mental health field can be difficult. Aspiring clinicians of color may feel they need to navigate the professional world alone, which can be discouraging and contribute to burn out."

> As a person of color, you're looking for someone you can relate to.

Licensure reform

The unbalanced passing rates for standardized licensing tests have not gone unnoticed, and those who write the tests are encouraging social work licensure reform. Some of their recommendations include:

- More input from mental health providers of color in the development of standardized tests.
- Replacing standardized multiple-choice exams with alternatives such as competency-based evaluations, portfolios or supervised practice assessments.
- Reducing cost and structural barriers. For example, remove retake waiting periods; provide free and low-cost test preparation resources; lower or remove exam fees; and offer language accommodations, including ESL support.

In 2024, Minnesota passed legislation giving people in groups that have traditionally had difficulty with the licensure test a pathway around the test.

Based on a successful pilot program with Hmong immigrants and others for whom English is a second language, licensing candidates now have the option to either take the traditional exam or complete additional supervision hours to receive their license.

Direct-Entry Mental Health Practitioners

Allowing mental health care providers to get more on-the-job training as a supplement to, or even replacement for, academic education would create faster expansion of the mental health care workforce.

With plumbers and electricians, there's a training process where a person is paid while learning on the job. A system of education could help in which new mental health care providers could come into the field directly in some capacity and be paid.

Supervised hours are also an issue for clinics. Currently, to become licensed, a graduate must amass a certain number of hours where they see clients while supervised by a licensed provider. Those hours cost the clinic money. Licensed providers are paid for their time spent seeing clients, but not always when they are supervising interns. As a result, many rural clinics can't afford to supervise students, despite the fact that hosting a student is one of the most effective ways to attract — and keep — a student at a rural clinic.

More and Better Mental Health Support in Schools

Pete, a recent high-school graduate, is acutely aware of the need for both better mental health support and mental health education in high schools. He lost a close friend, a 17-year-old Somali, to suicide in 2024. Now he advocates for mental wellness education in Minnesota's high schools.

He feels optimistic despite the challenges many rural communities face when it comes to a lack of mental health services. He says he definitely sees "an uptick in people organizing things [at school], and that's really cool. I feel that we are waking up to these problems and addressing them and having more conversations.... I want to have my career be rooted in helping people wake up."

Reinventing How People Use Spaces

There are many opportunities for "informal therapy" in rural places, but to create these spaces, we may need to change the way we think about how people use spaces.

Nearly every person interviewed mentioned the need for gathering spaces where people feel safe and welcome, but as rural populations shrink, towns

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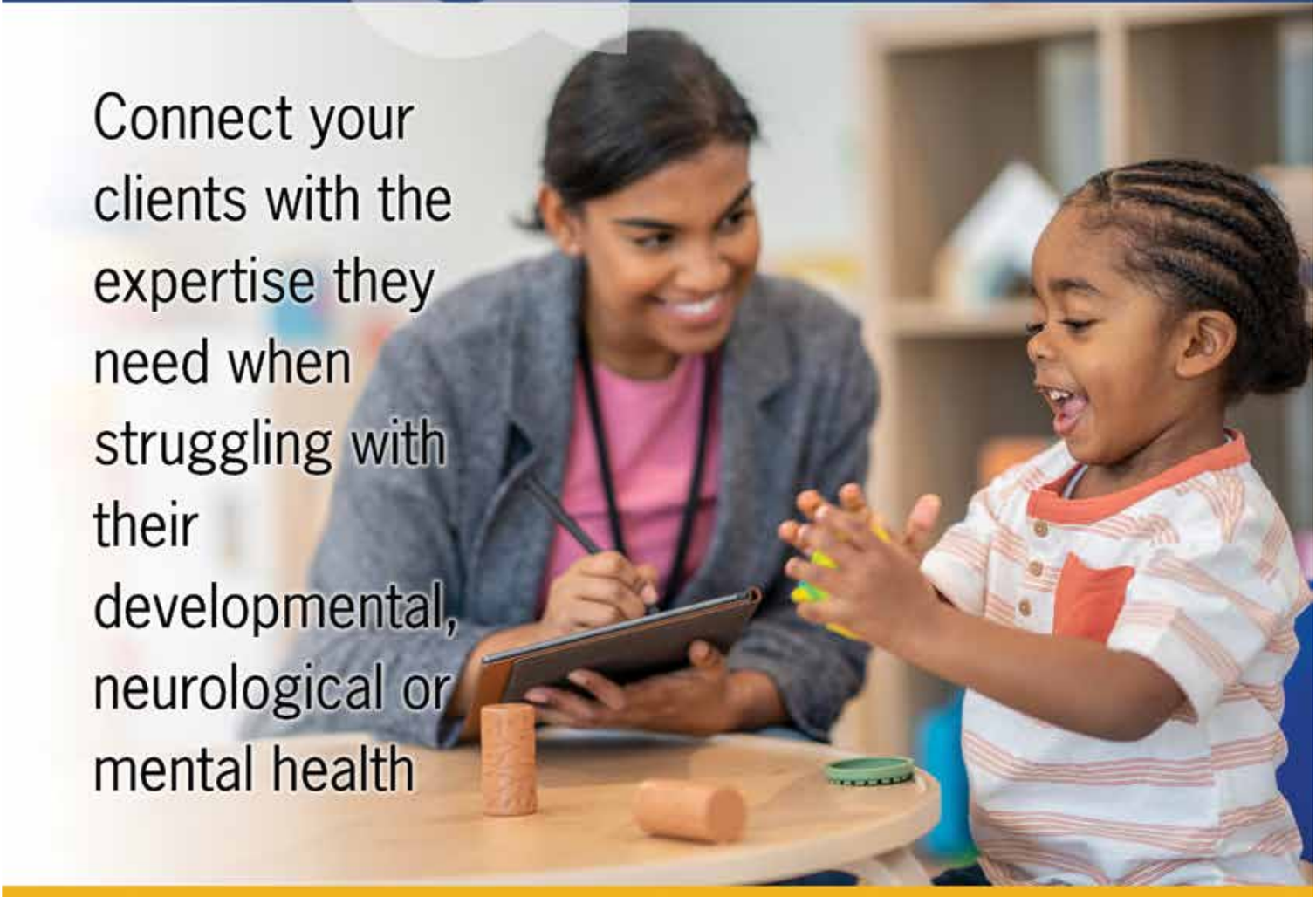

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have lost many of the traditional places where non-structured, informal gatherings were easy — local diners, coffee shops churches and bars.

Even in towns where these places do still exist, people of color may not feel welcome, so they create their own spaces. New immigrants often gather regularly at local parks and on small-town street corners where they can speak in their native languages, share stories, eat together and play sports, all important to their well-being.

For people of color, becoming licensed is even harder.

In Conclusion

The lack of service providers, the distance people must travel, stigma and fear around talking about mental health, plus related negative social determinants such as chronic poverty and substance abuse, are significant issues for people of color in rural Minnesota. The characteristics of rural BIPOC communities can vary widely, but when it comes to accessing mental health care and health care in general, they all share a similar combination of barriers. There are several ways that people of color and their communities are tackling these issues themselves.

- ***Make it okay to talk about mental health***
  Stigma and the fear it creates is endemic to both white and BIPOC communities, keeping people from seeking help. Getting the message out that it's okay to talk about mental health will help.
- ***Get information out there***
  Information transfers more slowly in rural areas, and BIPOC communities can be disconnected from regular channels. We must encourage better communication on what's working in different communities and among different ethnic groups.
- ***Informal help***
  Isolation is the enemy of good mental health. Figuring out ways to get people together to talk about what's bothering them or even to just have a good time may be the most important solution of all.

Passing legislation that will change policy, approve funding and move students from start to licensed in today's system will take time. Meanwhile, there is a clear need for further research on the mental health care needs of communities of color in rural areas of Minnesota and the U.S.

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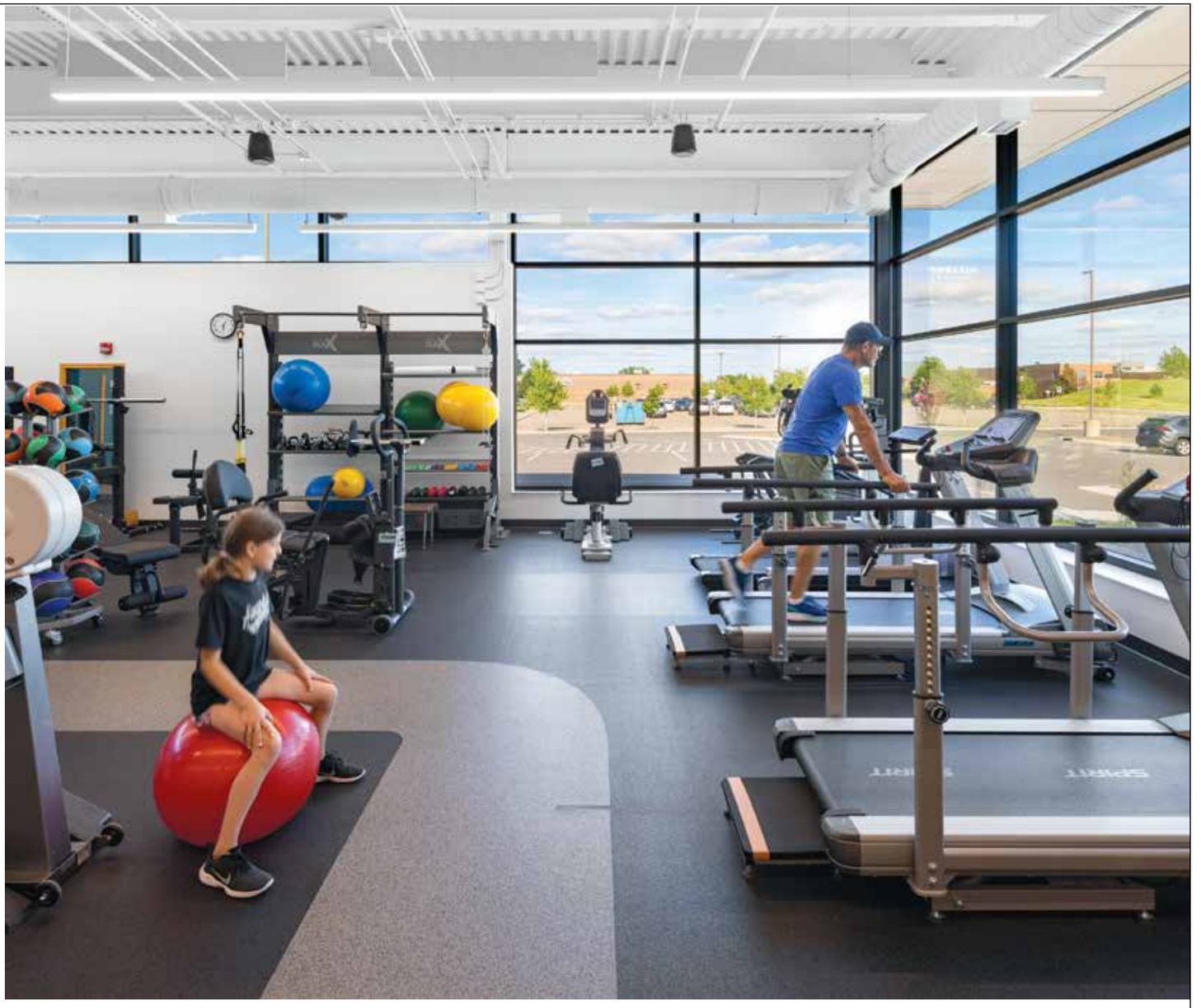
This article is excerpted from an extensive research project that was recently posted on their website. To view the entire report please visit: www.ruralmn.org/barriers-bridges/



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Pediatric Migraines

Diagnosis and Treatment

BY KATHERINE L. FERGUSON, MD

Headache is one of the most common conditions seen by neurologists. Physicians in most fields of medicine encounter patients with headache and migraine frequently and there is a significant overlap with other medical conditions. It is estimated that migraine affects one in eleven children and is more prevalent in girls than in boys. Migraine can have a significant effect on the lives of children and their families causing school absences and inability to participate in normal activities during childhood. It is important to recognize and treat early to avoid disability, impact on mental health, medication overuse and progression to chronic migraine.

A Look at Causes

The cause of migraine is multifactorial. There is a strong genetic predisposition with the risk of migraine being 40% in a child with one parent with a history of migraine and 75% when both parents have a migraine history. Combined with environmental factors and lifestyle habits, this results in migraines in children. Hormones, infection, inflammation, other disease processes, medications and head trauma can influence the age at presentation as well as frequency and severity of migraines. Habits around sleep, hydration, diet, stress and mental health also contribute significantly. The pathophysiology of migraine is not fully understood. It is generally accepted that there is a massive wave of neuronal depolarization across the cortex called the cortical spreading depression, which can result in aura. There is then activation of the trigeminal sensory nerve fibers, resulting in release of proinflammatory and pain molecules including cGRP, substance P and neurokinin A. There is increasing evidence that repeated migraines result in sensitization where neurons become more responsive to these molecules, and this is at least in part responsible for the progression of acute to chronic migraine.

Defining Terms

Migraine is the most common primary headache disorder in children and adolescents. Migraine can start in children as young as toddlers and in children this young may be characterized by periods of irritability and sometimes vomiting before a child is even able to express pain. The International Classification of Headache Disorders 3rd edition defines migraine in children as a recurrent headache disorder manifesting in attacks lasting two to 72 hours. The diagnostic criteria include at least five attacks to be given the diagnosis. They must have at least two of four characteristics including unilateral location, pulsating quality, moderate to severe pain intensity and aggravation by or causing avoidance of routine physical activity. They must also have nausea and/or vomiting or photophobia and phonophobia. This is a lengthy definition, but in practice many headaches that providers may consider tension type actually meet this migraine definition. For example, a headache of moderate severity that causes a child to want to rest and is accompanied by any degree of nausea meets the definition of migraine. Chronic migraine is defined by at least 15 headache days per month with at least eight of those being migrainous.

Symptoms

Migraine symptoms can be visual, sensory, speech or language, motor, brainstem or retinal. They can be accompanied by an aura. Auras are fully reversible symptoms that can happen before, during or after the headache. The most common aura in children is visual, this can be flashes of lights, colors or shapes. To be consistent with an aura the symptom must fulfill at least three of the following:

- At least one aura symptom spreads gradually over more than five minutes
- Two or more symptoms occur in succession, each individual aura symptom lasts five to 60 minutes
- At least one aura symptom is unilateral
- At least one aura symptom is an addition to one's senses, commonly visual perceptions such as flashing lights, zig-zag lines, etc.
- The aura is accompanied or followed within 60 minutes by headache.
- Young children can have difficulty describing an aura so it can be helpful to ask them to draw a picture of it. It is important to determine the presence of an aura so that families can recognize this as the onset of the migraine and treat with medication as early as possible.

Migraines are more commonly bilateral in children than in adults. They often become unilateral after puberty in late adolescence. Young children may not be able to describe the pain quality or location and are unlikely to describe photophobia or phonophobia. We more often have to infer this from

their behavior. For example, we can infer photophobia by children asking for sunglasses, burying their head under a pillow or refusing to open their eyes. Phonophobia can manifest as children asking to turn off the television or complaining of their siblings being too loud. Normally active children will want to lie down or will avoid normally desired activities.

Diagnostic Procedure

A thorough history is the first step to diagnosing migraine. Asking about the above diagnostic criteria as well as triggers, relieving factors, medications attempted, habits around sleep, hydration, nutrition and mental health screening are all necessary. A detailed neurologic exam including fundoscopy is important to rule out alternative causes.

Red flag symptoms in children with headaches include waking from sleep due to a headache or vomiting, headache caused by valsalva, associated neurologic symptoms that do not meet criteria for aura or abnormalities on neurologic exam. Many children will endorse waking from sleep with headache when asked, but to be a red flag this needs to be a headache that started during the night and is the cause of their waking. It is less concerning if the headache was present before sleep or they woke up for another reason and realized they had a headache. Headaches that are daily at onset, rapidly worsening, or headaches unresponsive to medication are also more concerning for an alternative etiology.

Workup for migraine can include laboratory testing and imaging, most likely an MRI. Labs to consider include CBC, CMP, vitamin D, vitamin B12, ferritin, hemoglobin A1C, TSH and celiac antibodies. A child with headaches that meet diagnostic criteria for migraine and who has a normal neurologic exam with no red flags on history or exam likely does not need imaging studies. If the pattern of headache has been stable for more than six months this is also reassuring as is a strong family history of migraine. Other diagnostic testing can include EEG, for example if atypical aura are present, or vessel imaging or sleep studies.

> Patient and family education is a critical part of migraine treatment.

Treatment Options

The first step for treatment of migraine in children and adolescents should be optimizing lifestyle factors and healthy habits. This includes maintaining a consistent bedtime and wake time with sufficient sleep for the child's age. Many teenagers with migraine need to be counseled to avoid screen time of all varieties for at least 30 to 60 minutes before bed. This often requires buy-in from parents to enforce. Additionally, children should eat a healthy and varied diet and avoid skipping meals, especially breakfast. Obesity can be a risk factor for worsening migraines. We should promote regular activity and exercise as well as sufficient and consistent hydration. Finally, children should avoid caffeine, especially the high caffeine energy drinks that are popular with teenagers. Stress, mental health and the demanding schedules of activities common in children today can also contribute to migraines.

When considering further treatment of migraine there are options for both acute and preventive treatment. Acute migraine treatment is used to

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end a migraine attack in an attempt to stop the pain and other associated symptoms. The goal is to find a regimen that allows children to continue with their normal activities, but often this is a challenge given the side effects associated with medication treatment of migraine. In general, the earlier we treat a migraine the better it will respond to medication treatment.

Most patients will start with over-the-counter analgesics including acetaminophen, ibuprofen and naproxen. NSAIDs are generally more effective in migraine treatment, but acetaminophen can help especially in younger children. The next most common class of acute treatment medications is the triptans, which cause serotonin receptor activation. Only four of the seven triptans are FDA approved for patients under the age of 18, which include rizatriptan, almatriptan, zolmitriptan and sumatriptan with naproxen. Rizatriptan is the only one approved for patients under the age of 12. Nasal sprays, oral dissolving tablets and subcutaneous injections are available for patients with significant vomiting or young children unable to swallow tablets. Triptans can be more efficacious when used in conjunction with an NSAID. Patients will also frequently use medications to target associated symptoms, for example, using ondansetron for treatment of nausea.

If first-line acute treatment is ineffective, some patients with migraine should be given a second-line plan. This most often is one or more medications that the child will take scheduled for 24 to 48 hours to attempt to stop the attack. This is especially important in children with a pattern of prolonged migraines or those who have previously needed treatment with IV medications to terminate a migraine. Medications most commonly include over-the-counter NSAIDs or prescription NSAIDs including ketorolac or diclofenac, anti-emetics including ondansetron or prochlorperazine and diphenhydramine.

The pathophysiology of migraine is not fully understood.

Migraine Prevention

Excessive use of these acute treament medications can result in medication overuse headaches. Using over-the-counter medications more than 15 days per month or triptans more than 10 days per month are the most common situations in which patients can develop overuse headaches. When patients are using their acute treatments excessively or do not have an effective acute treatment option, then preventive medications are the next step in treatment. Preventive treatment is used routinely even in the absence of an acute migraine to attempt to improve the frequency or severity of migraine over time. This should be considered in patients with more than two migraines per week or in whom migraines are significantly impacting their life, for example, children missing school routinely because of migraine.

First line prevention for migraine are the neutraceuticals. These are low risk and have few side effects. They include riboflavin (B2), magnesium and coenzyme Q10. Riboflavin is used at a dose of 100mg twice daily for children weighing

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less than 40kg or 200mg twice daily for those weighing over 40kg. Side effects include yellow urine. Magnesium dosing is approximately 9mg/kg/day to a max of 500mg dosed at night due to side effects of sedation. Additionally magnesium can cause GI upset, which appears to be less significant with magnesium glycinate. Finally, coenzyme Q10 can be given 50mg twice daily for children weighing less than 40kg and 100mg twice daily for those weighing over 40kg. There is not evidence to suggest that combining these is more effective than choosing one. Neutraceuticals can take at least three months of regular use to see benefit.

If migraine persists after neutraceuticals, first-generation medication options for prevention are topiramate and amitriptyline. The CHAMP trial in 2017 was a randomized controlled trial studying amitriptyline versus topiramate versus placebo for migraine prevention. This study showed equal efficacy among all three arms and decreased headache days in 70% of patients. Choosing between amitriptyline and topiramate is largely based on side effects for the specific child. Amitriptyline can commonly cause sedation, increased appetite, dry mouth, GI upset, dizziness and rarely arrhythmias. Topiramate side effects include decreased appetite, paresthesias, sedation, cognitive fogging and kidney stones. Other options with less evidence include gabapentin and beta blockers, most commonly propranolol. Cyproheptadine can be helpful especially for younger children up to approximately age 10.

It is an exciting time for children with migraine, largely due to the development of the cGRP inhibitors. This is a class of migraine medications used for both acute and preventive treatment. They are the first medications for migraine that specifically target a molecule involved in the pathophysiology of migraine. They include the small molecule inhibitors, or Gepants and cGRP monoclonal antibodies. Calcitonin gene-related peptide (cGRP) is expressed in pain fibers that innervate the meningeal and cerebral arteries. cGRP causes vasodilation and inflammation and ultimately cortical spreading depression resulting in migraine symptoms. The cGRP inhibitors are so effective, safe and well-tolerated that the American Headache Society published a position paper in March 2025 to say that cGRP inhibitors should be considered first-line therapy in patients over age 18. The only side effects are injection site reaction and constipation. Many of the cGRP inhibitors are currently in studies in children, and the first, fremanezumab, was recently approved by the FDA for children ages 6 older, weighing at least 45 kg. This is an injection done at home every four weeks with an auto-injector. Many others are currently in trials and we hope they will be available for children in the future.

Non-medication Options

More and more children and their families are looking for non-medication options for treatment of migraine. These can also be useful in children with significant side effects or concerns for polypharmacy. There are other injection options for children with difficult to treat migraines, but these can be limited by insurance coverage. They include botox for chronic migraine and peripheral nerve blocks or trigger point injections most often for acute treatment. Additionally there are three FDA approved neuromodulation devices for use in children. The Nerivio or Remote Electrical Neuromodulation (REN), gammaCore non-invasive vagus nerve stimulator (nVNS) and SAVI Dual or single pulse trancranial magnesic stimulation (sTMS). These can both be used for acute and preventative treatment of migraine. They are less likely to have side effects, but unfortunately can be costly and are often not covered by insurance.

Other Considerations

Many children will outgrow migraine as they get older. Predicting which patients will outgrow them is challenging, but often they can improve after puberty as hormones begin to regulate. A strong family history of migraine can mean that a child is more likely to have migraines into adulthood, as is a young age at migraine presentation.

Patient and family education is a critical part of migraine treatment. Families need to understand the difference between their acute and preventive treatments. Children need to learn what the beginning of their migraine feels like so it can be treated early. They have to be comfortable telling a teacher or an adult when a migraine starts and be able to access their acute treatment quickly. This may mean working with the school nurse and classroom teacher to ensure the child can keep the medication at school. Giving specific and concrete suggestions for lifestyle interventions results in the most success.

Finally, our language around migraine can affect our patients greatly and how they are perceived by others including health care providers. Referring to migraine in the singular state rather than plural "migraines" indicates that this is a chronic neurological disease. There is disease burden even between acute attacks. Using the word attack instead of headache to refer to a migraine occurrence helps account for the many symptoms other than headache that can accompany a migraine. Lastly, avoid using the phrase migraine cocktail as this is vague and can refer to a number of different medications. It also minimizes the severity of the migraine and can stigmatize the child as medication or pleasure-seeking.

Katherine L. Ferguson, MD, is a pediatric neurologist at Noran Neurology.

The Regulatory Outlook

Fraud Risks, Legislative Wins and a Path Forward

BY DAVID HOLT, JD

As the holiday season begins, the collective mood in the Minnesota health care community is often a sophisticated mix of exhaustion and anticipation. Providers look forward to year-end breaks, family time and perhaps a moment of silence after another chaotic year. Yet, there is also the bracing for the annual "administrative hangover." This includes the scramble to finalize the books, renew contracts and prepare for the next year that inevitably hits before the champagne corks pop on New Year's Eve.

Attorneys and compliance officers often find themselves in a precarious position during this festive season. They are tasked with reminding clients of the risks of fraud, waste, and abuse (FWA), audit trails and regulatory pitfalls just when organizations want to focus on growth, bonuses and patient care. It is a necessary friction.

Looking toward 2026, however, the regulatory landscape is not merely a list of new threats. While the environment remains perilous for the unprepared, there are genuine legislative developments that Minnesota practitioners should view as victories. The legislature has responded to the collective concerns of the provider community regarding administrative burden and professional well-being.

The following analysis breaks down the current landscape into three distinct categories: the current enforcement trends practitioners must watch, the new Minnesota laws that offer relief and the proactive compliance steps necessary to navigate the coming year.

The Enforcement Landscape: FWA Trends

Federal and state regulators do not take holiday breaks. The Department of Justice (DOJ) and the Office of Inspector General (OIG) have signaled aggressive enforcement priorities for 2025 and 2026.

For Minnesota practitioners, the risks are local, specific and higher than ever. The era of "pay and chase" is evolving into "predict and prevent," utilizing data analytics that rival those of major tech firms. Several key trends are currently driving enforcement activity.

Third-Party Risk and Oversight While the "Feeding Our Future" scandal primarily involved child nutrition funds, its shockwaves are felt across all government-funded sectors in Minnesota, including health care. This case serves as a massive red flag regarding the systemic failure of oversight.

The crux of this fraud was a failure to validate whether services were actually provided. Money flowed to entities that claimed to be serving thousands of units with little to no physical verification. For health care providers, this translates to renewed, aggressive scrutiny on third-party billing and partnerships.

Regulators are operating under the assumption that if oversight failed in one state sector, it is likely failing elsewhere. The Minnesota Department of Human Services (DHS) and other state agencies are under immense pressure to prove they are monitoring the flow of funds.

If a practice works with Management Services Organizations (MSOs), external billing companies or aggressive marketing firms, it is effectively "sponsoring" their conduct. The legal doctrine of vicarious liability means a practice cannot outsource its compliance risk.

Regulators in Minnesota are hypersensitive to entities that bill for high volumes of services with little direct oversight. If a physician serves as the medical director of a clinic where they rarely see patients, or signs off on charts prepared by a third-party vendor without reviewing them, they are in the danger zone. If a provider's name is on the claim, the provider owns the risk, even if a vendor prepared it. The defense of "the biller did it" is treated with decreasing leniency in the current climate.

Medical Directors and Facility Oversight A specific and growing area of risk involves physicians who serve as medical directors or consulting providers for facilities such as nursing homes, hospices or inpatient treatment centers.

There is a tendency for physicians in these roles to be "painted with a broad brush" by regulators. Even well-intentioned doctors who have little to do with the day-to-day operations of an assisted living or hospice facility can suffer significant legal and reputational damage if illegal activities occur under their watch.

A common scenario involves the "rubber stamping" of orders or reviews. For example, psychiatrists visiting inpatient treatment facilities for medication management reviews often face enormous pressure to sign off on dozens

of client charts in a single afternoon. If a physician signs off on these reviews without genuinely assessing the patients, perhaps assuming the facility's staff has managed the details correctly, they risk allegations of billing for services not rendered or services that lack medical necessity.

This aligns with the government's aggressive use of the "Worthless Services" theory of liability. Under this theory, the government argues that if the care provided, or the oversight exercised, was so substandard or deficient that it effectively amounted to no care at all, billing Medicare or Medicaid for it constitutes fraud.

This is being applied aggressively in hospice care, for example, if providers are admitting patients who are not terminally ill, or failing to provide the palliative care required by the hospice benefit. Another area of potential concern involves inpatient treatment where physicians may be billing for medication management or supervision when they were not physically present or did not perform a substantive review.

> A practice cannot outsource its compliance risk.

If a provider operates in these spaces, clinical documentation must prove not only that the service happened, but that the quality and necessity of that service were verified by the billing physician.

Telehealth and High-Cost Anomalies Nationally, the "honeymoon phase" of telehealth enforcement is over. During the public health emergency, regulators offered flexibility to ensure access to care. That grace period has expired.

The OIG's 2025/2026 Work Plan explicitly targets telehealth schemes, using sophisticated data mining to find statistical anomalies. Regulators are looking for the "impossible day," where providers bill for more than 24 hours of time-based services in a single day.

However, they are also looking for subtler patterns, particularly regarding Evaluation and Management (E/M) upcoding.

The Minnesota Department of Human Services has admitted to flagging unusually high billing trends. In response to broader oversight concerns, the state has implemented a new third-party audit system. This system is designed to catch outliers faster than ever before. If a provider is billing high-complexity codes, like 99215s, at a rate significantly higher than their peers, or billing for prolonged services without metadata to support the duration of the call, an audit is inevitable.

Additionally, kickbacks remain a priority. There is a crackdown on arrangements where telemedicine companies pay providers specifically to order durable medical equipment (DME) or genetic testing, such as high-cost PCR panels, without a valid patient relationship. Receiving a per-chart fee to review records and order equipment for patients never examined is a priority enforcement area.

Legislative Relief: Wins for Minnesota Providers

Despite the heightened scrutiny, the 2024 Minnesota legislative session produced some of the most provider-friendly changes seen in years. These

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structural changes are designed to reduce administrative burden and improve the quality of professional life.

Prior Authorization Reform After years of advocacy, Minnesota passed a sweeping Prior Authorization (PA) reform law. Although the full weight of the law takes effect in 2026, the transition begins now, and the changes are significant.

Among them, health plans will be prohibited from requiring PA for sensitive areas of care, including outpatient mental health services, substance use disorder treatment and cancer treatments consistent with national guidelines. This removes the barrier between a patient in crisis and the help needed.

The law also mandates tighter timelines for PA decisions. The timeline for urgent medication requests drops to 48 hours. Furthermore, once a PA is approved for a chronic condition, it generally cannot be revoked or require frequent re-approval. This aims to spare patients and staff from the "monthly approval dance" that wastes thousands of administrative hours.

This law directly attacks a major source of administrative burnout and signals a legislative shift in power back to the provider's clinical judgment.

Physician Well-Being and Credentialing Another significant victory is the new law regarding credentialing and mental health. For decades, physicians and other providers have avoided seeking mental health treatment due to the fear that answering "yes" to intrusive credentialing questions would trigger investigations and jeopardize their licenses or hospital privileges. These questions are often asked broadly if a provider had ever been treated for a mental health condition.

The new Minnesota law prohibits health systems and licensing boards from asking about past or current health conditions unless they currently impair the provider's ability to practice.

This distinction shifts the focus from "illness" to "impairment." A provider can have a diagnosis and be in treatment, and as long as they can perform their job safely, it is not a matter for the credentialing committee. This step reduces stigma and encourages a healthier workforce, which ultimately protects patients better than the punitive systems of the past.

> Practices must know who is touching their money and their data.

Reimbursement Adjustments The legislature also authorized reimbursement increases for specific sectors under Medical Assistance (MA), including mental health and dental services. While higher rates across the board are always desired to match inflation, these targeted increases acknowledge the critical shortage of access in these areas. By boosting these rates, the legislature is attempting to shore up the safety net for the state's most vulnerable populations.

Moving Forward: Proactive Compliance as a Strategy

The bridge between the risks of enforcement and the rewards of legislative reform is compliance.

While often viewed as a burden, or the "vegetables" of the health care dinner table, compliance is no longer just a shield. It is a strategic advantage. In light of the "Feeding Our Future" scrutiny and the new PA laws, proactive compliance is the only safe bet in a volatile environment.

Building a robust compliance program does not just avoid fines. It builds the infrastructure necessary to utilize the new laws. For example, providers cannot benefit from faster PA turnaround times or PA bans if internal documentation is so poor that the insurer denies the claim for "lack of medical necessity" instead of "lack of PA."

Furthermore, with the governor's new third-party audit system coming online, the ability to self-audit and correct errors before the state finds them is the difference between a simple refund and a fraud investigation.

Actionable Steps for 2026

To make this practical, Minnesota health care practices should consider taking four specific steps before the first quarter of 2026.

The "Vendor Scrub" Practices must know who is touching their money and their data. It is important to review contracts. Pull every contract with a third party that touches billing, coding or the revenue cycle. Check to ensure a valid, up-to-date Business Associate Agreement (BAA) is in place.

It can be very helpful to conduct your own audit action. Select 10 random claims processed by an external biller and trace them back to the medical record. Did the service happen? Is the documentation there? Is the code correct? If a discrepancy is found in a sample of 10, statistically, a systemic problem likely exists. Documenting this audit serves as a "Good Faith" defense if regulators ever investigate.

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Update Credentialing Forms Peer review committees, practice owners and HR managers must revise questionnaires immediately.

It is vital to review initial application and renewal forms. Look for questions asking about "any past mental health treatment" or broad questions about "conditions." If you find these terms, remove them. Replace them with legally compliant language that focuses strictly on current impairment and the ability to perform the essential functions of the job. Failure to do this could expose the organization to discrimination claims under the new state law.

Prepare for PA Data Collection The new PA reform law includes reporting requirements for payers, but providers should not rely on payers to police themselves. It is advisable to start tracking PA denial rates and turnaround times now. Create a simple dashboard: date requested, date responded, outcome and reason. When the law fully kicks in, these longitudinal data will be necessary to prove if a payer is noncompliant with the new 48-hour mandates.

Risk Assessment Conducting a formal risk assessment is a requirement for HIPAA and a best practice for general compliance, yet it is frequently overlooked in private practice. To do this, gather practice leaders, such as the administrator, medical director and IT Lead, for a brief strategy session. Identify what keeps the leadership up at night. Common answers include employee theft, data breaches, audit risk or unhappy staff. Document these risks, rank them by likelihood and impact and create a plan to address the top three. Documenting this meeting counts as a "compliance activity" and demonstrates a culture of compliance.

> If a provider's name is on the claim, they own the risk.

Conclusion

As the industry heads into 2026, the message for Minnesota health care practitioners is one of cautious optimism.

The government is watching where the money goes more closely than ever, fueled by the fallout of past scandals. The risks of audits and allegations of "worthless services" are real, particularly for physicians supervising facilities.

Yet, the regulatory environment is also shifting. The new prior authorization reforms and well-being laws are victories for the sanctity of the doctor-patient relationship and the mental health of the workforce. They are recognition that the system requires repair.

The smartest move this season is to tighten internal controls immediately. Auditing partners, cleaning up documentation and refreshing compliance plans may not be festive activities. Ensuring a practice is audit-proof, however, provides the peace of mind necessary to truly enjoy the holidays.

David Holt, JD, is the CEO of Holt Law, a firm focusing on health care law with offices in California and Minnesota.

Creating a More Just Society for All
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What are some of the most surprising or least known things that are part of your work?

Many in our community believe we only serve individuals who identify as Catholic. In reality, we have always served people regardless of faith, identity, background or circumstance.

While our work is often associated with supporting those experiencing housing instability, we serve individuals and families across the lifespan in a variety of ways. Our approach begins by understanding each client's unique situation and partnering with them to create a plan that moves them toward stability and success.

Other statistics of note: Each year, CCTC serves over one million meals at locations throughout the Twin Cities. More than 98% of older adults in our case management program remain safely in their homes and communities. We provide over 500,000 nights of safe housing and shelter annually to individuals and families in need. And in 2024, one in three families connected with our homelessness diversion program avoided spending even a single night in a shelter when they reached out for help.

What can the health care delivery system in general, and physicians in specific, do to assist with the vital services you provide?

Addressing housing instability and homelessness requires the collective efforts of our entire community. These are public health issues and should be treated as such. Health care providers can play a critical role in prevention by incorporating housing stability screenings into routine medical care. Doing so would require health systems to educate staff on available resources and how to respond when patients identify housing needs. Partnerships between health care systems and nonprofit organizations like ours can provide essential support. Taking these steps early can help prevent the negative health outcomes associated with homelessness—ultimately saving health care resources over time.

It is equally important for health care providers to create safe, welcoming spaces where individuals experiencing homelessness feel comfortable sharing their needs. Many people struggling with housing insecurity experience shame and self-doubt. Environments free of judgment and focused on support are key. Integrating behavioral health services into primary care significantly increases the likelihood that individuals will engage in treatment—especially when recommended by a trusted health care partner who demonstrates genuine investment in their success.

Comprehensive discharge planning is essential for long-term stability. While health care cannot solve every challenge a person faces, it can ensure that patients leave acute care or other medical settings with clear resources and connections to assistance. This proactive approach helps bridge the gap between health care and housing support, fostering better outcomes for individuals and communities alike. We encourage health care professionals to volunteer, advocate, and share resources as they are able.

Jamie Verbrugge is the president and CEO, Catholic Charities Twin Cities.

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