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Shell Game Economics

Corporate medicine wins, you lose

BY DAVID FEINWACHS, MA, MHA, JD, PhD

Since 1984, most Minnesotans enrolled in Medicaid, a program funded by all taxpayers, have not really been able to choose their own doctor. For the past two years, Health Policy Advocates (HPA), a volunteer citizens' group, has championed bills in the Minnesota legislature that would give all Medicaid enrollees the right to opt out of managed care. These bills, SF404 and HF816, could give all Medicaid recipients the freedom to choose. There are many reasons this is good for patients including fewer care delays or denials and enhanced cultural compatibilities with caregivers.

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The Mental Health Collaboration Hub

Getting to Yes!

BY TODD ARCHBOLD, LSW, MBA

Once upon a time, there was a wise man who used to go to the ocean to do his writing. He had a habit of walking on the beach before he began his work.

One day, as he was walking along the shore, he looked down the beach and saw a human figure moving like a dancer. He smiled to himself at the thought of someone who would dance to the day, and so he walked faster to catch up.

As he got closer, he noticed that the figure was that of a young girl, and that what she was doing was not dancing at all. The young girl was reaching down to the shore, picking up small objects, and throwing them into the ocean.

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Minnesota Health Care Roundtable 57TH SESSION

Publishing November 2023

DIGITAL TRANSFORMATION IN HEALTH CARE

Passing the torch

BACKGROUND AND FOCUS:

Every part of health care delivery is being radically transformed by computer technology. From personal devices performing simple and accurate diagnostic procedures, to electronic medical records, credentialing, telehealth and more, every element of health care is in constant transformation. New methods of continuing medical education and the use of social media, as well as advances in medical science, are coming faster than any organization can keep up with. Just as many health care businesses now employ diversity, equity and inclusion officers, those same businesses are now hiring officers of digital transformation.

OBJECTIVES:

Our expert panel of diverse stakeholders will examine this phenomenon. We will discuss the pros and cons of how it has impacted health care delivery. We will compare how care delivery—from clinics to hospitals, to health systems, to public health to insurance companies—is becoming increasingly digital and how to utilize this emerging trend to its best end. What should the role of a digital transformation officer be and how should that office interact within an organization's leadership structure? We will provide guidance around adopting and building change management into digital transformation strategies.

JOIN THE DISCUSSION

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

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

PrairieCare Opens 30,000 Brooklyn Park Inpatient Hospital Expansion

More than a third of young adults struggle with mental illness and yet there are currently fewer than 200 psychiatric hospital beds for youth and only 590 total in Minnesota (not including state-run facilities), a state with 5.7 million residents. PrairieCare, one of the nation's most innovative, fastest-growing psychiatric health systems, has responded by adding 30 inpatient psychiatric beds, the largest expansion of mental health beds for adolescents and young adults in Minnesota in decades. The new facility will serve 1,000 teens and young adults annually who have mental health conditions like depression, anxiety, trauma and mood disorders. The 30,000 square-foot expansion is part of PrairieCare's Brooklyn Park inpatient hospital. "As mental health care leaders in this region, we have a responsibility to do everything we can to address this crisis and help more families find hope and healing," said Todd Archbold, PrairieCare CEO. "Too many young people are stuck boarding in emergency departments for days or even weeks, waiting for a mental health treatment option that isn't there. Our expansion will help alleviate this frustration for families and get them the immediate care they deserve." The expansion was built by Ryan Companies and took less than 12 months to complete. Down one hallway there are double-occupancy rooms with two beds for youth to share. A separate hallway offers single-occupancy rooms for young adults. Each room has its own restroom regardless of bed count. The doors to each restroom are padded and magnetic, allowing them to snap shut. They can also be easily removed for emergencies. The facility also includes classrooms, lobby areas and a "Zen den." All of the furniture is weighted, making it more difficult to lift or move. "It's not just about adding beds," NAMI Minnesota Executive Director Sue Abderholden said. "It's about adding a beautiful healing space." The new expansion is part of PrairieCare's comprehensive plan to address the mental health crisis, including other innovative efforts such as the AID Team that conducts free mental health screenings and assessments, the Psychiatric Assistance Line (PAL) for health care providers to get free consultations and referrals for their patients, and the Mental Health Collaboration Hub that helps connect youth boarding in hospitals and emergency departments to mental health treatment.

Indian Health Board Announces $24 Million New Wellness Center

On October 9, in observance of Indigenous People's Day, the first year it has been celebrated officially as a state holiday, the Indian Health Board of Minneapolis (IHB) announced it will break ground next year on a new health care campus. The future Menaandawiwe Wellness Campus will be located at 2027 E. Franklin Ave. in Minneapolis and combine traditional healing methods with state-of-the-art medical, dental and specialty services. "We're over 50 years in its making," said IHB CEO Dr. Patrick Rock, member of the Leech Lake Band of Ojibwe. "We're actually the first urban Indian health organization in the United States. That started a groundswell of people coming together and recognizing the lack of health care services to Indigenous people in the Twin Cities area." According to the Minnesota Department of Health, American Indian women, children and families experience the greatest health disparities in the state. Another report from MN Community Measurement found that Indigenous patients have significantly lower rates of optimal care

compared to the state-wide average. IHB was founded in 1971 to provide health care to urban American Indians. IHB provides primary medical care, dental services, mental and behavioral health, and recovery services, along with health and wellness education. "I've done research in Indian health for a couple decades and a common theme is Native patients don't feel welcome where they're at or there's different belief systems in place," said IHB Chairwoman Joni Buffalohead. "The Indian Health Board clinic here in Minneapolis is totally centered on culture." The new campus will break ground in the spring and will open in the spring of 2026. The architect is American Indian from Turtle Mountain, part of the DSGW firm. The construction company is Woodstone and its owner, Paul Meyer, is American Indian from White Earth. The $24 million project was made possible thanks to funding at the state and federal level. Attending the announcement ceremony, Lt. Gov. Flanagan described the funding effort as "Equity and grant making, equity and bonding, and saying that we are going to set aside dollars specifically for Indigenous communities and specifically for communities of color who have been left out of this process for far too long."

Fulcrum Health Joins MN RETAIN Study

Fulcrum Health, Inc. a physical medicine benefit management organization, recently announced its involvement in the Minnesota Retaining Employment and Talent After Injury and Illness Network (MN RETAIN), a state-wide research study designed to keep individuals in the workforce or to help them return to work as soon as medically possible after an injury or illness. MN RETAIN is a collaboration between the Minnesota Department of Employment and Economic Development, the Minnesota Department of Health, the Minnesota Department of Labor and Industry, the Governor's Workforce Development Board, Mayo Clinic, and Workforce Development, Inc. The study evaluates the benefit of early interventions to help workers stay at work and return to work. Fulcrum's participation allows more than 2,400 chiropractors in its ChiroCare network to refer patients to the MN RETAIN study. Once accepted, those patients receive services to support or sustain their employment, retain job skills, and help ease the transition back to work. Each worker in the intervention group is assigned a return-to-work case manager who serves as a liaison between the workers, their health care providers, employers, and other stakeholders to help them access services needed to return to work. "Time lost to injuries and long-term illness can cost employers and Minnesotans millions each year. This is whether employees are injured on the job or on their own time. Chiropractic care is an increasingly vital part of managing those injuries. They are also a part of a successful return to work and reducing future disabilities," said Deb Zurcher, DC, LAc, Assistant Chief Clinical Officer, for Fulcrum Health. "Fulcrum Health represents a standard of excellence among chiropractors, and participating in MN RETAIN gives providers an opportunity to deliver additional support for patients, while reinforcing the power of physical medicine to help people overcome injury and get back to work and life faster." Enrollment in MN RETAIN, which is funded by a grant from the U.S. Department of Labor and the Social Security Administration, will run through May 2024. For more information visit fulcrumhealthinc.org. For more information about MN RETAIN, visit MNRETAIN.com.

U of M and Global Experts Cite Male Infertility Crisis

In a recent edition of Nature Reviews Urology, a team of international

experts, including University of Minnesota Medical School faculty, is urging governments and health systems worldwide to recognize male infertility as a growing global health concern. "The most visible male reproductive health concern is reports of globally declining sperm counts. Possible causes for the decline include environmental and lifestyle factors and poorer quality sperm associated with advanced paternal age. These factors and others can contribute to or cause male infertility. All the more concerning is emerging data that suggests male reproductive ill-health as a 'canary in the coalmine' for overall health, such as metabolic and cardiovascular disease," said Christopher De Jonge, PhD, an adjunct professor in the Department of Urology at the U of M Medical School and co-founder of Male Reproductive Health Initiative (MRHI).

The report presents 10 recommendations and emphasizes the need for accessible diagnoses and targeted treatments, which are currently hindered by funding shortages, research gaps and inconsistent clinical practices. Recommendations include:

- Create a global "biobank" for data on genetic and environmental causes of infertility.
- Provide genomic sequencing and improved diagnostic tests for men facing fertility challenges.
- Conduct rigorous tests on the impacts of chemicals, especially endocrine-disrupting ones, on male reproductive health.
- Establish regulations and policies to protect men from harmful compounds and develop safe alternatives.
- Enhance training for health care workers to support male reproductive health throughout life.

Commissioned by the MRHI, the report draws on insights from 26 experts across Australia, Argentina, Canada, China, Denmark, Germany, Italy, Spain, the U.K. and the U.S. It identifies crucial knowledge gaps and offers a roadmap for researchers, governments, healthcare systems and public education. "Much more research is required to develop improved diagnostic testing and therapeutic strategies, which requires funding. However, despite the World Health Organization and the American Medical Association recognizing infertility as a disease, research funding levels for female and male reproduction are vastly lower than for other diseases," Dr. De Jonge said. The next steps are to further disseminate the recommendations in the report to all stakeholders, including legislators, insurance companies, funding agencies and social networks.

Allina Providers Vote To Unionize

Doctors, physicians' assistants, and nurse practitioners who work at Allina Health recently voted 325 to 200 in favor of joining a labor union known as Doctors Council SEIU. This vote comes on the heels of another successful vote to unionize by 150 Allina physicians at the Mercy/Unity hospitals in March. "In between patients, your doctor is dealing with prescription refills, phone calls and messages from patients, lab results and more," said Dr. Cora Walsh, a family physician involved in the organizing campaign. "At an adequately staffed clinic, you have enough support to help take some of that workload," Dr. Walsh added. "When staff levels fall, that work doesn't go away." Dr. Walsh estimated that she and her colleagues often spend an hour or two each night handling "inbox load" and worried that the shortages were increasing backlogs and the risk of mistakes. "We feel like we're not able to advocate for our patients,"

said Dr. Matt Hoffman, another doctor involved in the organizing at Allina. Dr. Hoffman, referring to managers, added that "we're not able to tell them what we need day to day." Consolidation in the health care industry over the past two decades appears to underlie much of the frustration among doctors, many of whom now work for large health care systems. Doctors at Allina noted that staffing was a concern before the pandemic, that COVID-19 pushed them to the brink and that staffing has never fully recovered to its prepandemic levels. "We were promised that when we get through the acute phase of the pandemic, staffing would get better," Dr. Walsh said. "But staffing never improved." The 600 doctors organized a union because they felt an erosion of their ability to practice medicine, as critical thinkers, as scientists and as talented and compassionate dedicated professionals. This historic vote represents the largest private sector group of clinicians ever to have formed a union. Through this action they claim they can now advance their professions and guarantee they will be there for the patients and communities who need them.

State Issues Annual Drug Overdose Deaths Report

Overdose deaths held steady from 2021 to 2022, 1,356 to 1,343, marking a plateau after several years of sharp increases, according to the Minnesota Department of Health's (MDH) Statewide Trends in Drug Overdose: Preliminary 2022 Data Update (PDF). Fentanyl-related overdoses continued to take a tragic toll, keeping deaths at a historically high level, and is now involved in 92% of all opioid-involved deaths and 62% of all overdose deaths in Minnesota. Opioid-involved deaths increased 3% (977 to 1002 deaths) from 2021 to 2022. Deaths involving prescribed opioids, heroin and methadone decreased. Deaths involving heroin fell to a 10-year low, decreasing 56% (103 to 45 deaths) between 2021 and 2022. Psychostimulants (e.g., methamphetamine) and cocaine also contributed to the number of drug overdose deaths. Cocaine-involved deaths saw the largest increase of any drug category, increasing 27% (165 to 210 deaths).Drug overdoses have a larger impact on individuals, families and communities than deaths alone. For every one drug overdose death, there were nearly 13 nonfatal drug overdoses in 2022. The number of hospital-treated nonfatal overdoses remained relatively stable, decreasing 5% from 2021 to 2022 (17,792 to 16,934 overdoses), according to the data brief. Governor Tim Walz and Lieutenant Governor Peggy Flanagan's 2023 One Minnesota Budget included over $200 million to address substance use and overdoses—with $50 million of that coming to MDH over the next four years. The investment addresses prevention, harm reduction, treatment and recovery. Additionally, the governor and legislature passed a policy to reduce drug overdose deaths by requiring all schools, law enforcement officials, emergency responders and residential treatment programs to have naloxone on hand. MDH and the Minnesota Department of Education have posted a toolkit to help schools obtain cost-free naloxone and implement the new requirement. Additional state-led activities include expanding medication-assisted treatment, establishing new peer recovery support systems and launching the MN Naloxone Portal where mandated groups can access no-cost naloxone. Collaboration with other state agencies and federal funding partners help make this overdose and substance-use response work possible.

Linking Public Health to Health Care

Brooke Cunningham, MD, PhD, Commissioner, Minnesota Department of Health

What were your first thoughts when Governor Walz asked you to become the new Commissioner of Health?

I was excited and a little scared. The excitement was around all of the potential for positive impact, with all of the support for health equity from the Governor's Office, a budget surplus that could be used to improve the lives and thereby the health of Minnesotans, and increased public awareness of the value of public health. The fear was mostly around my transition into a political space and the daunting task of running a large, multifaceted agency that was still recovering from toll of the pandemic. I still took the job because of the opportunity of the current moment. As I've gotten older I have come to agree, if you aren't scared, at least some of the time, you probably aren't growing.

What have been some of the most surprising things you've encountered so far?

I have learned a lot about the political process. It's not quite as described in 8th grade civics class. I joined MDH as an assistant commissioner in March 2022. My first surprise was the attention and time that agency staff must give to the legislative session, to obtain the support and funding to continue their important work. At MDH, we begin our planning in the summer and that's late by some other agency's standards. This means that good ideas need to be "game-ready" early fall. As a member of the general public, I did not know "the calendar." I did not know that if you have an idea, start early. You certainly can't wait for the legislative session (or even mid-fall) to start to connect to state agencies.

The Minnesota Department of Health (MDH) has over 1,800 employees and an organizational chart that looks like the Rosetta Stone. What are some of the challenges managing the scope of the organization?

It is big, and I continue to find every day that it is filled with engaged, smart and passionate people who help make managing such a large organization a bit easier. To be successful I have to trust and rely on others, especially for subject

> "Physicians have great influence in society."

matter expertise. At the same time, in public health today, we talk a lot about system transformation, whether it's talking about reducing health inequities or about the ways in which agencies (federal, state, local, and/or Tribal) work together. System transformation requires a willingness to ask questions, to listen to perspectives that have not been traditionally valued and to challenge traditional ways of working.

MDH has an annual budget of over $1.5 billion, which sounds like a lot, but translates into you needing to improve the health of all Minnesotans for about $25 per month apiece. How do you make that work?

Historically public health has not been well funded. After years of under-investment, a recent analysis of Minnesota's governmental public health system suggested that further investments would be needed – to the tune of half a billion dollars annually – across both state and local public health to fully address our state's foundational public health needs. That said, we are so thankful for the investments made in state, local, and Tribal public health during the recent legislative session. Those investments will to allow us to better address big issues like suicide, drug overdoses, health inequities and the needs of families and children. The funding will help us to eliminate lead lines, tackle workforce shortages especially in rural Minnesota and develop strategies to reduce health care costs. Our experience operating on a limited budget means staff in public health agencies often work in multiple roles. We also recognize both the value of and frankly the need to collaborate with external partners to be successful.

What have been some of the most unexpected things you have encountered in opening the clinic?

The number of women who share with our physicians and medical staff that they feel seen and heard for the first time in their health care journey is shocking but motivating. The Herself Health whole person approach—our focus on female care services designed to address health and wellness issues that impact women and understanding what matters to our patients via customized care plans, regular dialogue, and active listening—has already had a major impact on our patients. We've also been surprised at the number of patients who want to get involved with their community via our clinics. Women wanting to volunteer, participate in community events or simply use our community-building events for socializing and relationship building has really taken off.

And of course, the demand. We knew we had built a primary care service that was fundamentally different from anything ever available, but we didn't know how long it would take us to attract patients. We've seen growing demand, so much so that we've opened three clinics in 2023, with more planned for 2024.

Addressing health care equity issues has been a major agenda item for MDH for decades and is an area of particular expertise for you. What are the biggest barriers to health care equity?

There are several barriers – which means there are so many ways to improve equity. Improving

access to high quality early childhood education, meaningful employment and affordable housing is key. So as Commissioner of Health, I am as excited about the legislative wins for the Departments of Housing Education and Economic Development as I am about investments in the Department of Health and the Department of Human Services. Eliminating inequities, however, is ultimately about sharing power, redirecting resources according to need and dismantling social inequality. This work requires political will and commitment not just from policymakers but from all of us.

What are examples of how physicians can interact with MDH?

Physicians are a tremendous resource in our communities, and we encourage you to seek out opportunities to serve on MDH special advisory boards, committees, and task forces. We have groups that address many areas of health, including chronic disease, newborn screening, maternal health, cannabis, sickle cell disease and now health equity. Providers can find more information on some options at Advisory Committees at MDH (https://www.health.state.mn.us/about/committees.html).

Also, physicians have great influence in society. As important as it is to interact with MDH, it is just as important to interact with colleagues, health system leaders and policymakers on behalf of public health. We need to do a better job of linking public health to health care, especially primary care. With health care costs increasing, we must develop new models of care and reimbursement that are simultaneously more inclusive (in all the ways, the "who" and the "how") and more sustainable. Of course, there are health conditions that can be modified through individual behavior and clinical treatment, but improving population health requires more intentional action and creativity on the part of health care partners than we've seen to date.

> "We encourage you to seek out opportunities to serve on MDH special advisory boards."

What are some of your short- and long-term goals for your tenure as Commissioner?

There are many, but a few I'll lift up here are:

Improving the data we collect and how we use it. We want data that all communities can see themselves in, that responds to communities' priorities and answers their questions. We want to improve the ways in which we share data, so that they are more usable, understandable and actionable.

Engage community partners early and often. We know some of the best solutions come from the communities most impacted. We must create workflows that reflect this as a core belief and then hold ourselves accountable to community input.

Promoting intra-agency wellbeing. All communities have experienced tremendous stress and uncertainty over the last few years. As we work to improve protect, maintain, and improve the health of all Minnesotans, we must also improve our own organizational health, wellbeing and functioning.

Linking Public Health to Health Care

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Shell Game Economics from cover

Current legislation directs the Minnesota Department of Human Services (DHS) to restrict most Medicaid enrollees to managed care plans. The proposed legislation would amend current statutes by adding this simple, straightforward clause: "but shall provide all eligible individuals the opportunity to opt out of enrollment in managed care."

To introduce the bill, HPA met with legislators, many of whom had no knowledge of these issues. It worked with bill authors and helped ensure these bills were heard in the appropriate committees. The goal was simply to improve the functional utility of the state's Medicaid program. Nothing in these proposals required anyone to opt out of managed care. It merely offered a choice to those who wished to do so.

This simple, logical, equitable and long-overdue measure would give Medicaid enrollees the basic right to choose their own health care provider. The concept had bipartisan support as well as the support of both conservatives and liberals. It passed various committee hearings in both bodies and was included in the Health and Human Services omnibus bill, where it appeared destined to become law. However, that did not happen. In the final hours of the most recent legislative session the bill was killed by interests that did not want to be identified and never publicly testified against it.

A Look at the Basics

Why were Medicaid enrollees not granted the freedom to choose their doctor and why is this now more important than ever before? Minnesota has a Medicaid program with more than a million enrollees. Most of these people are forced into a managed care organization (MCO) whether they want to be there or not. There is an exception to this. Some enrollees (about 200,000) who have Medicaid coverage are not required to be in a health plan. The Department of Human Services (DHS) will pay for their health care services on a fee-for-service basis, as opposed to prepaying for care of the other 800,000 enrollees, regardless of whether or not any services are provided. Who are these individuals who have the benefit of fee-for-service? They are the high-acuity, high-needs population. How do they get to fee-for-service? Essentially it is statutory language that allows persons with disabilities to opt out of managed care. Health plans are in full support and encouragement of this option as this population generates much higher per enrollee costs.

The federal Medicaid program allows states to offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both. Under the FFS model, the state pays providers directly for each covered service received by a Medicaid beneficiary. Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan. In turn, the plan pays providers for all of the Medicaid services a beneficiary uses that are included in the plan's contract with the state.

The majority of Medicaid enrollees, largely nondisabled children and adults under age 65, are in managed care plans. The enrollment of high-cost populations, such as people with disabilities, in managed care has been more limited than for lower-cost populations.

In general, states set provider payments under fee-for-service. It has been claimed that Medicaid fee-for-service payment rates for physician services are lower than those paid by other payers, raising concerns that low fees affect physician participation in Medicaid, and thus access to care. In the past there were concerns about this, but now most physicians are employees of large corporate entities. These entities want the Medicaid business as it allows them to control patient access to care and maximize their profits from government payments. It should be the patients' right to seek out the providers of their choice.

In Minnesota, we allocate $350 million per quarter to prepaid medical assistance programs alone. This money is given to health plans on a per enrollee basis with zero accountability or meaningful reporting on how it is spent. Being insulated from the highest-cost patients, denying or delaying care for the rest, all with no meaningful reporting, evokes shell game economics at its best.

In support of why Medicaid enrollees should continue to be denied freedom of choice, the Minnesota Council of Health Plans recently sent a letter to the state of Minnesota's House Ways and Means Committee. This committee could have been instrumental in providing freedom of choice. Further shell game economics were applied by addressing that this freedom would lead to increased medical costs. It bald facedly asserted that the current system required MCOs to achieve measurable and specific reductions in emergency room utilization, hospital admissions and hospital readmissions. Further incongruous statements touted MCOs' applying significant resources to achieving these results and to lowering health care costs for the state of Minnesota. Presumably this meant MCOs did not require more money to cover for Medicaid enrollees. Going so far as to posit that if this population were no longer enrolled in managed care, these efforts would cease and result in higher health care costs. The letter vaguely referred to supportive data showing the success or lack thereof of these efforts and that it could be used to estimate

cost increases due to elimination of the "containment efforts" that freedom of choice would yield. Of course, perhaps the state would save quite a lot with freedom to choose.

Naturally, increasing the number of FFS payments would increase the DHS workload. With 7,000 to 8,000 current employees and modern computer technology, however, how much of the near $1.5 billion we spend now might this save? The state actually estimated that freedom to choose would save tens of millions of dollars. The assertion that irresponsible physicians would drive up costs is, again, shell game economics. Rather than DHS taking a leadership role in helping the state save money there is hesitancy, reticence and obfuscation.

> Physicians must be the voice for Medicaid patients.

In 2019, 83% of all Medicaid beneficiaries were enrolled in some form of managed care. States allege that incorporating managed care into their Medicaid programs provides them with some control and predictability over future costs. There is no apparent data to support this assertion. Prepaid medical care has always been a controversial idea because it contains a built-in incentive to delay, deny and sequence needed care, to increase the profits of those organizations that have been prepaid to render such services. There has been debate for many years over the wisdom of managed care prepayment.

According to a recent report from the U.S. Department of Health and Human Services Office of Inspector General (OIG), "Three factors raise concerns that some people enrolled in Medicaid managed care may not be receiving all medically necessary health care services intended to be covered: (1) the high number and rates of denied prior authorization requests, (2) the limited oversight of prior authorization denials in most states, and (3) the limited access to external medical reviews."

If this isn't disturbing enough, who, according to the OIG, is most disadvantaged by these strategies? People of color. Thus it is imperative to understand what happened to the freedom-to-choose bill and to make sure patient choice is restored in the next legislative session.

Restricting Access

Who came in at the very last moment before the bill was signed and demanded that the right to opt out of managed care must be deleted? It was Hennepin County Medical Center and its health plan, Hennepin Health. They claimed that if given the ability to choose fee-for-service, many of their patients would do so and HCMC and Hennepin Health would suffer undue financial hardship. They cited potential lost revenue from a highly controversial federal drug discount program called 340B. This revenue accrues from serving Medicaid beneficiaries.

Though far from its original intention, the 340B program can generate substantial profits by providing participants the opportunity to buy deeply

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discounted drugs, which are then reimbursed by Medicare and private insurers at full cost. In some cases this can lead to 100% profit margins with no obligation to use 340B savings to directly help patients or lower the cost of care for them. Today, patients for whom 340B was intended to help are often paradoxically harmed by the program, cut off from timely and high-quality care by the lack of provider choice. This has been particularly acute for cancer patients who face quotas, wait lists and significantly higher costs. In another example of shell game economics and lack of payer reimbursement transparency, 340B prices are not publicly available. The program allows covered entities to acquire eligible drugs at a 20% to 50% discount. Participating hospitals are not required to use their 340B revenues in any particular way.

> The assertion that irresponsible physicians would drive up costs is, again, shell game economics

This in no way suggests any Minnesota entity is taking improper advantage of anything in the 340B program. The issue is simply that no matter which corporate entity profits from 340B, or exactly how, such profit isn't worth the sacrifice of one single patient's being deprived of the right to choose his or her own health care provider. If managed care organizations are doing a great job, which they claim that they are, then why are they worried their patients will immediately flee if given the chance. Also, if patients migrate to fee-for-service, any 340B discount isn't lost; it just goes to the Minnesota Department of Human Services. Is that worth depriving the Medicaid population of their most essential choice?

In efforts to pass the bill next year, Hennepin County Medical Center and Hennepin Health were presented the opportunity to withdraw their opposition and be exempted from its patients' having the freedom to chose. This offer was met with concerns of potential perceived inequities leading to potentially further and even worse, lost revenue. The bill was withdrawn with a key legislator telling proponents that the issue was too complex, required further study and perhaps some years down the road the problem might be addressed. Was Hennepin County, whose mission is serving the most needy and the least likely ever to be considered as an advocate for profits over patients, acting alone or was it an under-informed participant in shell game economics directed by other managed care organizations who oppose patient choice and their potential loss of revenue? It really doesn't matter.

Moving Forward

Supporters of the proposal have no intention of allowing this obfuscation to go unchallenged. They will be back in 2024. Assisted by investigative journalism, physician advocacy and perhaps other organizations, it is hoped that legislators and members of the public will be made aware of 340B and other "red herring" issues.

Minnesota physicians must be involved in this and related issues. Physicians are being blamed for the ever-increasing cost of health care. Physicians, of course, are not to blame. It's misguided legislation and shell game policy, designed to over-bill, under serve and manipulate revenue at the expense of patients and the reputations of physicians who care for them that are to blame. The costs projected for the freedom-to-choose bill estimated the state could easily save tens of millions of dollars, if not more. Managed care organization claims of the benefits of their "care coordination" are unquantifiable.

These claims seem to imply that incompetent and unskillful physicians will continue their over utilization of health care services and continue to escalate the cost of care. Compare that notion to the findings of the OIG. Which do you think is more probable? Something is very wrong here. Our health care programs seem to have as their primary focus maximization of institutional, corporate and agency profit. There is a complete lack of transparency and accountability, which lends itself to scapegoating physicians and others who must defend their patients as well as their professional integrity. It is apparently easy for those who focus on maximizing profit over positive health care outcomes to convince policy makers to restrict patient choice. This past legislative session has demonstrated that yet again.

To restore the right for patients to choose their own physician, physicians will need to take a leadership role. They must inform themselves about issues such as 340B, contact legislators, demand action and advocate for patient rights. At the core of this issue is addressing racial disparities, providing meaningful choice for patients and exposing the myth that physicians care more about reimbursement than patient access to quality care. Physicians must be the voice for Medicaid patients. Payers want the public to accept that the corporate practice of medicine is the basis for our health care system, and that physicians cannot and will not interfere. They are wrong, and physicians must lead in making this point. If not, then the corporate practice of medicine will further subsume the physician practice of medicine. It is time to demand fair treatment for patients and demonstrate that it is physicians and not corporate or governmental interests that practice medicine. Equally important, physicians must demonstrate that it is the "corporate" practice of medicine that is the real cost driver.

> The corporate practice of medicine will further subsume the physician practice of medicine.

Dave Feinwachs, MA, MHA, JD, PhD, joined the Minnesota Hospital Association (MHA) in 1981 and served as its general counsel and director of advocacy until 2010.

The Mental Health Collaboration Hub from cover

He came closer still and called out "Good morning! May I ask what it is that you are doing?"

The young girl paused, looked up, and replied "Throwing starfish into the ocean."

"I must ask, then, why are you throwing starfish into the ocean?" asked the somewhat startled wise man.

To this, the young girl replied, "The sun is up, and the tide is going out. If I don't throw them in, they'll die."

Upon hearing this, the wise man commented, "But, do you not realize that there are miles and miles of beach and there are starfish all along every mile? You can't possibly make a difference!"

At this, the young girl bent down, picked up yet another starfish, and threw it into the ocean. As it met the water, she said, "It made a difference for that one."

The "Star Thrower" tale above is adapted from a writing by Loren Eiseley in 1969. The contrast between futility and determination serves as the inspiration for those who work tirelessly every day, despite constant challenges, to help youth in psychiatric crisis.

Every day in Minnesota dozens of youth present to hospitals and emergency departments in a psychiatric or behavioral health crisis. The number of youth in emergency departments in crisis has doubled in the last decade, overwhelming hospital staff and infrastructure that is designed for medical emergencies. Stories of youth boarded (stuck) on medical units, hallways and even parking garages have become more common as they have no place to go. The situations are intense, and services are scarce. The average boarding time is increasing as well, in some cases up to weeks or even months. This is a result of an underfunded and understaffed system of mental health care providers and human service systems.

> The average boarding period is increasing, in some cases up to weeks or even months.

Studies have consistently sounded alarms about inadequate funding for mental health and addictions care. When compared to reimbursement rates for general medical procedures, mental health ranks among the lowest, resulting in hospitals' prioritizing access to more profitable services. The state's Medicaid rate covers approximately 60% of the actual cost of providing mental health care. It took state law to require insurance plans to pay at least the Medicaid rate for mental health services (some paid less) and to include coverage for psychiatric residential treatment facilities, one of the most needed services that insurance companies had refused to cover (and at its core a blatant violation of parity). It is unconscionable that our government and insurance plans acknowledge this crisis yet do nothing to fund better access and sustainable services.

In response to this crisis, and in an effort to save more starfish, community stakeholders began to meet in August 2022 to address this problem. Months later the Mental Health Collaboration Hub (MHCH) launched statewide, in 2023, to help connect youth stuck in boarding situations get connected to safe living and mental health treatment environments. More than 150 organizations and over 350 individual users, including nurses, case managers, administrators and more, collaborate daily in the MHCH. Hospital staff enter de-identified case information into the MHCH, which then matches the cases with available treatment and support services. Without the MHCH, hospital staff are forced to randomly call numerous treatment centers, group homes, foster care systems and more, all around the state to find availability of the most appropriate placement or intervention. In order to find the right intervention, they must consider the patient's age, psychiatric condition, special medical needs, guardianship, insurance coverage and more. These youth who are boarding actually represent a very small percentage of cases who present to hospital and emergency departments, but they require the most resources—including specialized interventions and robust ancillary services. The MHCH does all of this for the case worker, functioning as a care pathways marketplace. It matches cases to providers based upon the specific case criteria, and it even notifies the providers when there is a match. Case workers also participate in a weekly video call to share more detailed information on cases and provide consultation to one another.

Shared Goals

In the summer of 2022, providers across the state began to meet to talk about the boarding crisis. They represented the state's largest hospitals, counties, mental health treatment centers, group homes and advocacy groups. They began identifying specific cases of youth who were boarding in inappropriate settings and tried to connect them to care. Most cases were boarding in hospitals and emergency departments, but some were boarding in county

administration buildings and even hotels. The cases being discussed were among the most difficult to place. Many youths were in foster care or county custody, often lacking clear contacts for health care decision-making or coverage for services.

The provider group began meeting weekly and tracking their efforts in a secure SharePoint site. It became clear that there were paths forward, but it would require aligned goals, creativity and tenacity to break through barriers. They dubbed their efforts, "Getting to yes!" As each week passed, one or two kids were often able to get the necessary intervention and safe placement they needed. The efforts involved were extraordinary in terms of both the number of providers it took and the constant brainstorming. The process lacked efficiency.

The Minnesota Department of Health awarded the state's largest psychiatric health system, PrairieCare, a Pediatric Mental Health Access Program grant through the Health Resources and Services Administration (HRSA). This funding allowed the provider group to build a secure online platform for centralized communication and automation. Thus, the Mental Health Collaboration Hub was born. The grant also helps to support administrative and technical support for the platform, as well as education and outreach. Any health provider or human services agency in the state can register its organization and build a profile to interact within the Hub.

Case Trends

The MHCH aggregates data from each case submission along with user interactions with the cases to provide insights in a custom dashboard, available to all users. This includes a breakdown of ages, genders, diagnoses, risk factors and more. It also helps us understand which cases are boarding the longest and which providers interact the most with cases.

While most youth who are boarding are struggling with a severe mental illness, it is most often the behaviors corresponding to those illnesses that are impacting their situation. Nearly 75% of all cases had two or more psychiatric diagnoses. The most common psychiatric diagnosis was PTSD or trauma related disorders (36%), followed by ADHD (31%), and then anxiety (27%) and depression (27%). Autism spectrum, a developmental disorder that may present through dysregulated behaviors, was diagnosed in 17% of the youth.

While tracking both psychiatric and medical diagnoses is important, almost all boarding cases present with additional risk factors, often related to a mental health condition, which may include aggression, self-harm, suicidality, elopement risk or substance use. It is often these behaviors that present risks to an intervention or safe placement. The complexity of these cases requires very specific care. Aggression was the most common risk factor present in 70% of all cases. In order to find placement, however, it was critical for providers to better understand the kind of aggression, whether it was toward specific individuals or toward property, or verbal aggression, for example.

The most sought-after treatment recommendation or placement was a group home (40%) followed by a residential treatment program (31%). Some youth have been able to benefit from a shorter-term intensive intervention such

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as psychiatric hospitalization, but most need longer-term ongoing stabilization in a safe setting, which may even include therapeutic foster care (20%). It is important for providers to understand the differences in care settings and how each of them can be accessed. Barriers to access often include lack of capacity in that setting (often exacerbated by staffing shortages), or a lack of insurance coverage or county payment. Both barriers have made access to Minnesota's crucial Psychiatric Residential Treatment Facilities (PRTFs) especially difficult.

A Bed is Not a Bed

Most children in boarding situations require complex mental health treatment provided by very specific levels of care that include group homes, children's residential facilities (CRF), or psychiatric residential treatment facilities (PRTF). For individuals with a mental or behavioral disorder, it is critical to have a clear diagnosis and only then can one understand the best treatment or intervention. The Diagnostic and Statistical manual of Mental Diseases (DSM) details more than 300 distinct mental illnesses in five general categories. The most common category of disorder that appears in the most complex boarding cases are neurodevelopmental disorders and externalizing disorders. For those with severe illnesses or behavioral conditions who require a long-term placement (i.e., residential treatment, group home or hospitalization), every bed type is different, serving a different population.

> Insurance reimbursements are steadily 20% less for a psychiatric evaluation than a medical evaluation.

As of today, Minnesota has 93 licensed children's residential facilities with a total of 1,586 beds, each serving a unique population. Facility sizes range from a handful of beds to larger campuses with upward of 100 beds. Each licensed facility serves a distinct age range, specializes in treating certain conditions, and may even have criteria regarding gender, IQ and county of residence. Additionally, certain certifications are required to treat conditions such as substance use disorders. Some specialties by facility include eating disorders, autism spectrum disorder, sexual misconduct and obsessive-compulsive disorder (OCD). Furthermore, it is not uncommon for criteria to change as organizations evolve, particularly the age range they are capable of treating. While these various specialties can be a beautiful thing for some individuals, the imbalance of capacity within each of them and the constantly changing landscape creates frustration for providers looking to make referrals.

More than 80% of counties in Minnesota are designated to have a shortage of mental health professionals. We have seen a 30% reduction in children's residential treatment beds since 2020, and only 220 inpatient psychiatric beds for youth exist in the state today. This is a startling lack of options, and it is further exacerbated by staffing shortages that limit these capacities even further.

Nearly 80% of youth psychiatric hospitalizations are to care for internalizing disorders such as anxiety or depression (which are often co-occurring). Individuals with neurodevelopmental conditions may benefit less from a short-term hospital placement and more from a longer-term residential or group home placement. Therefore, in complex boarding cases, acute psychiatric hospitalization is not always the solution.

Maladaptive Coping Skills

We now have a better understanding of the complexity of factors that lead to boarding situations based on the insights captured within the Mental Health Collaboration Hub. We know that the social determinants of health play a consistent role, as do social supports and biological factors. The predominantly present risk factor is aggression. It is crucial, however, that we understand that in almost all boarding cases aggression is a manifest of maladaptive coping skills. Most youth feel little control over their situation. They lack the introspection and vocabulary at their phase of development so they struggle to talk effectively about their feelings and emotions. This may manifest in variations of aggression (which is a broad and generic term) that simply describe their way of trying to have power or control. With the exception of individuals who may be experiencing delusions (which is incredibly rare, especially in youth), aggressive behaviors are a maladaptive coping skill developed by youth yearning for control.

It is also important that we not conflate violence with mental illness, which is a harsh stigma that may deter individuals from seeking treatment. While not mutually exclusive, they are entirely different. Too often the general media obtusely connects these issues with little context or correlation. The reality is that individuals with severe mental illness are more likely to be victims of violence or abuse. Additionally, most incarcerated individuals with a mental illness were charged with nonviolent crimes.

Kids do well when they can, and we all develop skills or behaviors that serve us when we need them. They may not always be healthy, but they may feel effective.

Fragmented Systems of Care

The Mental Health Collaboration Hub has brought together a community of providers with shared goals and now a better understanding of what our communities need to prevent boarding situations. However, we still lack the resources and services that our youth and families need. We also need to develop shared nomenclature and systems that result in better assessment and triage of youth with mental illness and behavioral conditions.

Nobody struggles to find a dentist or a physical therapist. Nobody is ashamed to get an annual physical or to get a flu shot. We are quick to talk about courage and determination when battling cancer. In contrast, individuals struggle to find a psychiatrist, fear discrimination if they talk to a therapist and feel uncomfortable when talking about a mental illness. We need to work relentlessly to increase awareness and normalize conversations about illnesses ranging from anxiety and depression (internalizing) to ADHD, ASD, and schizophrenia. We can do much more upstream to prevent worsening of illnesses and create better access to care.

Our mental health systems are embarrassingly underfunded. You get what you pay for, and we do not pay for mental health care. Insurance reimbursements are steadily 20% less for a psychiatric evaluation than a medical evaluation (using equivalent CPT codes). General hospitals and medical systems are vocal about needing to close mental health units that cannot cover their own costs. Our systems will pay for costs of mental health care one way or another. It behooves us all to build a strong system of mental health care that is easy to access and provides high quality services. We have the vision and motivation to make this happen.

Our mental health systems are embarrassingly underfunded.

With the help of the Hub, mental health providers can now carefully yet quickly review cases to determine if they can effectively treat a specific child. Together Minnesota's provider community has already identified over 140 children and adolescents in boarding situations. Of this group, more than 75% have been discharged from inappropriate settings, and most of them are now receiving mental health treatment.

The Mental Health Collaboration Hub is a transformational asset that has opened doors, both figuratively and literally. However, it is merely a conduit to existing services — it has not created additional capacity or improved funding for the services themselves. The result is a better connected, yet fraught system of mental health care providers. We have discovered vulnerabilities and opportunities, and providers are constantly pivoting to remain viable. When youth can't get the right mental health care when they need it, it taxes other parts of our system exponentially. When our systems don't pay, our communities pay through trauma and tears.

Todd Archbold, LSW, MBA, is the chief executive officer at PrairieCare.

The Vanquish Water Ablation System

A novel prostate cancer treatment

BY CHRISTOPHER DIXON, MD

Prostate cancer ranks as the second most prevalent cancer among American men, trailing only skin cancer. The American Cancer Society estimates 288,300 new cases and 34,700 deaths from prostate cancer in the United States in 2023. Although, one in eight men will confront a prostate cancer diagnosis during his lifetime, most of those diagnosed will not die from it. Today, over 3.1 million men in the U.S. are living with prostate cancer. The risk of prostate cancer increases with age, with six in 10 cases found in men over 65 and it is more prevalent in African American men and Caribbean men of African ancestry.

For decades, the primary approaches for treating prostate cancer have been radical prostatectomy or radiation therapy. Recent years, however, have seen a mounting consensus that these aggressive treatments may amount to overtreatment for many men because of the significant risk of life-altering side effects such as urinary incontinence (UI) and erectile dysfunction (ED).

Approximately 90% of prostate cancer diagnoses involve cancer localized to the prostate gland (clinically localized disease). Patients are categorized into one of six risk groups based on prognosis: very low, low, favorable-intermediate, unfavorable-intermediate, high, and very high risk. Radical therapy is typically unnecessary for individuals with "very low" and "low" risk diseases, leaving active surveillance the most commonly recommended management strategy for this demographic. For higher-risk groups, radical therapy remains the preferred treatment.

Men in the middle of the risk spectrum, those with clinically localized "intermediate" risk disease, face the challenging decision of balancing the risk from prostate cancer with the risk to their quality of life. Their cancer is deemed clinically significant but not immediately life threatening. According to 2023 National Comprehensive Cancer Network (NCCN) guidelines, both active surveillance and radical treatment are appropriate options for intermediate-risk disease, leaving these patients grappling with the tough choice between the two extremes of active surveillance and radical treatment.

A pressing need exists for a therapeutic approach that bridges the gap between these two options by actively managing the disease while minimizing adverse quality-of-life side effects.

A Novel Approach

Minnesota-based Francis Medical has introduced an innovative approach to prostate cancer treatment that capitalizes on the energy released when sterile water vapor (steam) returns to its liquid state. Its water vapor ablation system, Vanquish™, deploys vapor to target cancerous regions within the prostate while safeguarding nerves and other surrounding structures, thereby reducing the likelihood of undesirable treatment side effects.

The process begins when water is heated, with energy added at a rate of 1 calorie per gram for every 1°C increase in temperature. This process continues until the temperature reaches 100°C (when water transitions from liquid to vapor), generating the latent heat of vaporization, which contains more than five times the energy (540 calories) per gram compared to its liquid state. Vanquish uses this energy to kill the cancerous prostate tissue.

During the ablation procedure, sterile water is converted to vapor and delivered through a needle-shaped catheter with a porous distal tip placed within the targeted tissue. Prostate cells are surrounded by interstitial fluid-filled spaces. In 10-second treatments, vapor exits the catheter at a higher pressure than the extracellular environment, moving convectively through prostatic tissue, displacing interstitial fluid, and reaching cell membranes. Rapid phase transformation of water vapor back to its liquid state (condensation) releases the stored latent heat of vaporization directly onto the affected cell membranes, denaturing them and causing cell death.

An essential characteristic of water vapor is its ability to respect the natural boundaries of the prostate. During treatment, vapor pressure is sufficient to expose cell membranes but insufficient to penetrate denser tissues like the prostatic capsule and pseudo-capsule, effectively preserving them as physical barriers. Unlike conductive energy methods, vapor conforms to the

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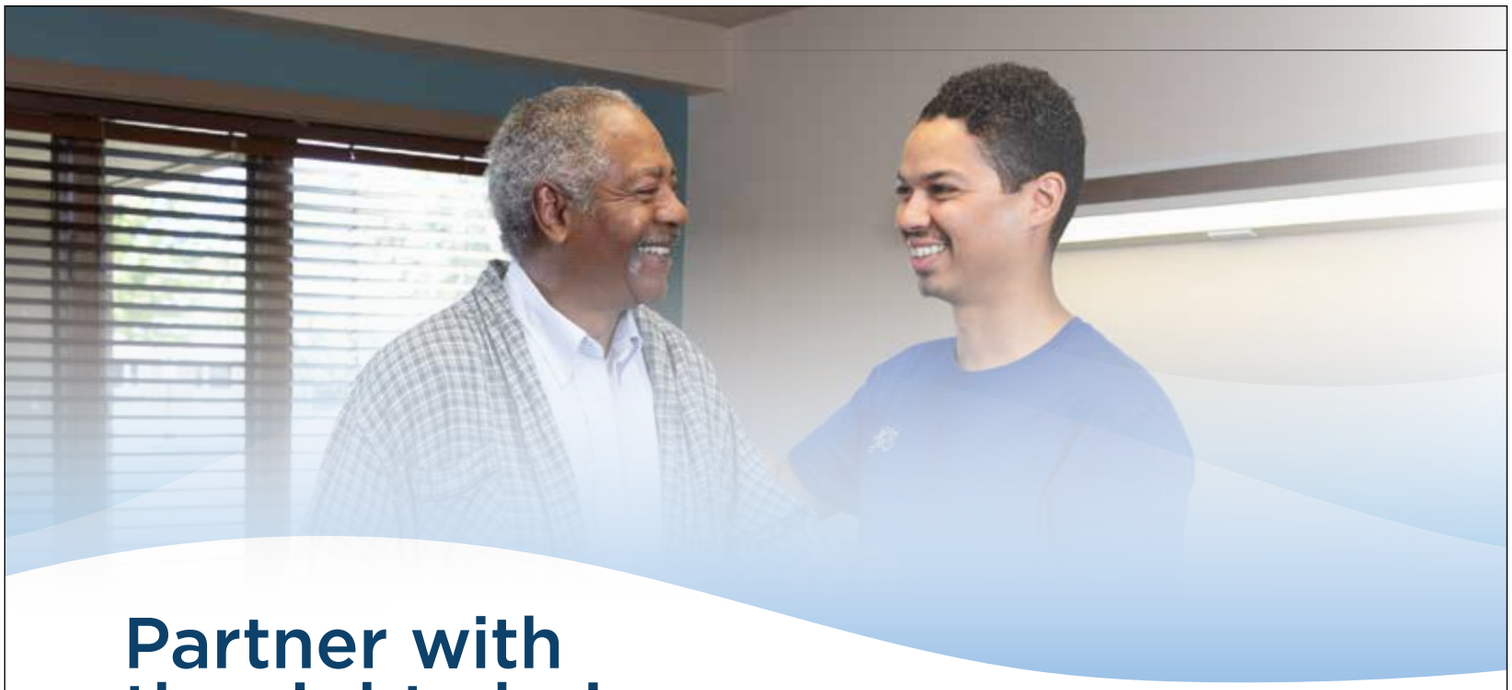

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prostate's anatomy, optimizing thermal dose delivery to the targeted tissue and minimizing damage to nerve bundles and surrounding structures. Convective heat transfer uniformly delivers thermal energy throughout the treatment region, unlike conductive ablation modalities that create thermal gradients.

Day of the Procedure

The Vanquish product is in the pre-market approval phase and not yet available commercially. For patients currently being treated in clinical studies, the procedure is conducted on an outpatient basis at a hospital or ambulatory surgery center under general anesthesia. Pretreatment multiparametric MRI (mpMRI) and a prostate biopsy pinpoint the desired ablation location. The primary treatment plane, intersecting the target lesion, is determined using measurements from mpMRI sequences. A comprehensive treatment plan is then devised, allowing for overlapping treatments within the target, distal and proximal planes to encompass the entire lesion plus the desired margin.

The Vanquish water vapor ablation system includes a custom cart housing a generator, a monitor and an extendable arm for positioning the monitor directly over the patient. The monitor displays live ultrasound and cystoscopy images, pertinent treatment data and electromagnetic tracking tools aiding in navigation of the prostate. A proprietary stabilization system supports the ultrasound probe and treatment device, offering full freedom of motion when disengaged and enabling hands-free operation when locked in place.

> One in eight men will confront a prostate cancer diagnosis during his lifetime.

The procedure involves transurethral delivery of the treatment device into the prostatic urethra, conducted under cystoscopy visualization. The device is subsequently rotated to the desired treatment angle, and a needle-shaped catheter is advanced through the prostatic urethra to the chosen treatment area within the prostate. Advancement of the vapor needle is visualized under transrectal ultrasound (TRUS), aided by an electromagnetic tracking system that overlays visual targeting tools onto live ultrasound images. Additionally, bio-capacitance sensors on the needle tip inform the user as the needle approaches the prostate capsule.

Once the treatment needle is delivered to the target tissue, individual 10-second vapor treatments are administered, generating a clear hyperechoic effect under TRUS. A single treatment creates a 1 ½ to 2 cm diameter ablation volume in unobstructed tissue. However, due to vapor's constrained movement dictated by the prostate's natural anatomy, the treatment volume is evenly distributed within the confines of the zone it is delivered to. Individual treatments are spaced approximately 1 cm apart, creating an overlapping effect until the complete ablation of the target lesion plus the desired margin is achieved.

Postprocedure, patients typically go home the same day, report minimal pain and can often resume normal activities as early as the following day. Vanquish clinical study protocols recommend retaining a catheter for at least three days, but earlier removal is possible. Water vapor therapy also allows for retreatment or additional treatments if new cancer is detected later. It also keeps the option open for more radical therapy if needed.

An Accelerated Path to Commercialization

Water vapor has already been proven safe and effective for treating benign prostatic hyperplasia (BPH) and is commercially available as Rezūm, owned by Boston Scientific. Following Boston Scientific's acquisition of Rezūm technology from NxThera, the founding company, a spinoff company, Francis Medical, was established to explore water vapor's potential in urological cancer treatments. Initially, the company's focus lies in addressing prostate cancer followed by bladder and kidney cancer.

Founded in 2018, Francis Medical is privately held and headquartered in Maple Grove, Minnesota, with 35 full-time employees. It is a tribute to and legacy of the inventor's father, Francis Hoey, who endured prostate cancer treatments that had harsh implications on his everyday living before the disease took his life in 1991. The company embodies a strong, purpose-driven culture centered around a shared mission encapsulated in its tagline, "Tough on cancer. Gentle on patients."

The procedure is conducted on an outpatient basis.

To date, the company has secured $80 million in funding for the ongoing development and execution of clinical studies to obtain U.S. regulatory approval by late 2025, closely followed by international approvals. The company recently announced receiving Breakthrough Device Designation from the FDA. This designation expedites the review of innovative technologies that promise more effective treatment or diagnosis of life-threatening or irreversibly debilitating diseases or conditions. To qualify for Breakthrough Device Designation, a device must demonstrate the potential for superior treatment compared to existing standards of care.

"Our goal is to become the first-line therapy of choice for patients with prostate cancer," said Michael Kujak, president and CEO. "We are excited that the FDA has recognized the potential of our technology to be a breakthrough for patients who today face the difficult choice between addressing their cancer and avoiding the debilitating morbidities often associated with current standards of care."

Francis Medical is currently conducting its VAPOR 2 pivotal U.S. clinical study. VAPOR 2 is a prospective, multicenter, single-arm study designed to treat 235 patients with intermediate-risk, localized prostate cancer in up to 30 U.S. clinical sites. Three Minnesota sites have been chosen

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Self Evident Truths

Welcoming foreign born medical professionals

BY BRAD FERN

Last year, almost 27% of U.S. physicians were foreign born according to the Bureau of Labor Statistics. (That compares with 18% foreign born of all employed people in the nation.) Approximately 26% of registered nurses and 40% of home health aides are immigrant workers. Immigrants play an essential role in the U.S. health care system and will be an important part of its future.

Unfortunately, many foreign-born physicians and nurses have to deal with prejudice and ignorance both outside and inside the workplace. Whether from corporate policies, well-meaning but uninformed colleagues, and most often from patients themselves, difficult and sometimes hurtful challenges set them apart. A better understanding of the process foreign-born health care providers encounter will lead to a healthier and more robust health care delivery system. A good start to this understanding is asking the question, how can native-born physicians and other health care professionals best support their foreign-born colleagues?

First, consider the impact of cultural bias, especially the insidious impact of microaggression. Then weigh the issues of cultural marginality, appraise the dynamics of culture shock and reflect on how they impact the lives of physicians and other health care providers. Finally, it is important to examine the professional barriers faced by foreign born-physicians.

Under the best of circumstances, immigrant physicians face considerable hurdles to practice in the U.S. — from state licensing requirements to rigid visa rules, Conrad 30 J-1 Waivers to education augmentation, and so on. In addition to being an already mind-numbingly arduous process, the COVID pandemic made becoming a physician in the U.S. even harder with office closures and suspension of visa services overseas. It's just plain difficult for immigrant physicians. In addition to the bureaucratic obstacles, the subtle cultural dynamics can make it even more challenging.

Cultural Bias and Microaggression

Patrick Robinson is a psychotherapist who lectures on issues of cultural understanding. He immigrated to the U.S. from Korea when he was 14, and he now works as a mental health crisis intervention specialist for a hospital system in the Midwest. He stresses that it's important we understand how physicians experience prejudice and bias like anyone else.

"When you come from a different culture, especially if you look different than the dominant culture, there are cues that constantly remind you that you are different. Whether you're walking down the street, at work, or walking into a store, foreign-born people are constantly reminded."

India is the country from which most foreign-born physicians immigrate to the US, with China second, and many more physicians coming from Pakistan and the Philippines. Nigeria and Jamaica are the most common countries of origin for immigrant registered nurses, and about 40% of home health aides are foreign born. That means a significant number of health care providers look different from those of the dominant culture, and they are more likely to feel set apart.

In his lectures, Robinson emphasizes the impact of "microaggressions." Complimenting a person on how articulate they are, for instance, commenting on how well they speak English, or making their race or ethnicity the topic of conversation. Robinson says that a lot of microaggressions come from patients, the seemingly innocuous comments and cues that don't let immigrants forget they are different.

But you don't have to look different from the dominant culture to be reminded you're different. Svetlana, a nurse who emigrated from Russia, describes how language can be a problem. "They know the minute you open your mouth, and it's harder for us to know the common words for many medical conditions. That can put the patients off and make it harder to build rapport. For example, a physician might be advising a patient about the side effects of neuroleptic medications and talk about tardive dyskinesia. The doctor might not know how to talk about this colloquially. If I'm the patient," Svetlana says, "I see this physician who comes in and talks to me highly with all these complicated words, and it turns me off."

Age, gender and religion are cultural factors, too. Dr. Fatima is from Libya. Her son was transitioning from grade school to middle school, and she was

growing more and more uncomfortable with the way American girls dressed and the way they were allowed to interact with the boys. Dr. Marek from Poland says, "America is the most youth-centered culture on the planet. The relationships between young people and adults, how you address, it's coded in language, it's coded in culture. In most countries in the world, age is still treated with respect." And when you look at reactions to young African male immigrants as opposed to the reactions to young African female immigrants, or mothers with small children, the males will be less welcome or even seen as threatening.

The bottom line is that it's difficult to acclimate and assimilate, and if a health care provider looks different from the mainstream providers, he or she will be challenged all the more.

Consider the impact of cultural bias.

Beyond helping ease the nation's physician shortage, employers see the value immigrant providers provide: elevated levels of understanding, better serving diverse patient populations and a more expansive corporate culture, for instance. Health care systems and providers can support this important segment of the health care workforce by understanding — as best they can—how it feels to be caught between multiple cultures.

Understanding Marginality

Foreign-born health care providers often find themselves suspended between the cultural norms they've known since childhood and the strains, influences and cultural resistances of their new home. They are what social scientists call "cultural marginals," individuals who straddle two (or more) cultures but are not fully part of either.

Encapsulated Marginals Some cultural marginals experience persistent emotional and psychological strain because they fail to reconcile the differences between their new surroundings, their former home and their own sense of self. Cultural competency pioneer Janet Bennett calls marginals who struggle to integrate "encapsulated marginals."

Basha emigrated from Poland. When asked about feeling encapsulated, she says, "What's funny for you is not funny for me, and vice versa. What's appropriate for you is not appropriate for me, and I have had to learn by making mistake, after mistake, after mistake. At some point my brain would shut down. I couldn't speak any more English. I was done. It gets exhausting."

Encapsulated marginality is a state of mind that looks outside of the self for orientation, seeking clarity for expectations and relying on external sources for acceptance and belonging. It is a normal human reaction to culture change, and it can be very painful for whoever experiences it, consuming enormous amounts of cognitive and emotional energy. Left unaddressed, it can lead to withdrawal, feelings of isolation, feelings of alienation, depression, anxiety and burnout.

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Predictably, there is a direct correlation between the likelihood of becoming encapsulated and the degree of differences between the cultures being straddled.

Hypervigilance Michael was a health care executive who had emigrated from Ghana and was working for a Chicago-based health care organization. Because he had emigrated when he was quite young, only the hint of an accent set him apart from anyone born and raised in Chicago.

Michael's culture shock issue was unique. He was certain that his colleagues were not racist, and he was convinced that no one in the company was discriminating against him. He was suffering hypervigilance. He was unable to forget about his race and was unable to relax and focus on his work, even around colleagues who emigrated from other parts of the world.

The CEO of Michael's company, who was proactive about supporting his employees, had established an employee assistance program. With the help of several of Michael's close colleagues and the support of the program, Micheal realized that he had been traumatized by the racism he experienced as a child when he first arrived in the U.S. With this new insight, he was empowered to shift his mindset, to relax and to focus.

Constructive Marginals Conversely, there is subset of cultural marginals Bennett calls "constructive marginals," described as immigrants who create their own identity (often based on their marginality) and shift between cultures fluidly. Constructive marginals construct their new identities, and they are more likely to develop their own internal sense of authority, their own standards for success, and develop a well-established sense of agency.

Constructive marginals tend to adapt by embracing the assumption that one has a place, that one belongs, but not necessarily that one fits in. They develop constructive assumptions while embracing complexity, contemplating nuance and making abstract connections. Very easy to say. Extremely difficult to do.

Understanding Culture Shock

In addition to the concept of marginality, an essential part of understanding the immigrant experience is understanding culture shock, loosely defined as: "The normal stage of adapting to a new culture when a person becomes troubled by the differences in values, norms and customs between their home culture and the new culture they are in. Typical feelings may be anxiety, confusion, homesickness, depression and anger."

The term "culture shock" was first coined by Canadian anthropologist Kalervo Oberg in the 1950s and then refined by others. Experts agree that there are generally five stages to culture shock. They are the honeymoon, culture shock, gradual adjustment, adaptation of biculturalism, and, for some, re-entry.

Honeymoon At first, immigrants tend to be very positive and curious about their host countries, and just as an individual may experience a vacation to a foreign country, he or she may be fascinated by the differences. The doorknobs are different, the toilets, the architecture, the food, the way people relate, the priorities are different; so many things are unique. The tendency is to emphasize the positives when first immersed in another culture, to idealize the differences. It can be exhilarating. An immigrant experiencing the honeymoon stage will tend to be positive, curious and open to new and exciting experiences.

Elaina is an executive who emigrated from Ukraine. She cautions about the culture shock honeymoon stage, "Never confuse vacationing with immigration. Your experience staying somewhere for a couple of weeks or months is nothing compared with moving somewhere permanently."

Culture Shock The culture shock stage begins when an individual starts to be troubled by the very differences they may have been fascinated by when they first immigrated. They may have been missing the subtle cues all along (the subtle communications, the niceties and the avoidances), but culture shock begins to make them aware of how missing those cues sets them apart.

Frustration with assimilation may transform into expressing contempt or disapproval for the host culture. The cultural differences become bothersome or seen as inferior. Fascination may transform into confusion, frustration, extreme homesickness, feelings of hopelessness or dependency, disorientation and isolation.

In extreme cases, culture shock can develop into depression, anxiety issues, insomnia and eating disturbances.

Gradual Adjustment The adjustment stage is a turning point, of sorts. The cloud of culture shock begins to dissipate. The individuals begin to develop a more balanced, objective view of their experiences. They begin to develop routines and patterns that begin to make them feel at home.

They begin to feel a new sense of belonging and sensitivity to the host culture. They may begin to turn their marginalized circumstance into a unique identity constructed upon their own priorities and belief in self. The internal operating system reemerges and the differences begin not to matter. The emphasis becomes about ownership and belonging but not necessarily fitting in.

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Mental Health Collaboration Hub

The MHCH is a secure online portal that helps connect youth and families in psychiatric or behavioral health "boarding situations" to safe and healing mental health treatment. Users can connect with appropriate living and mental health treatment settings based on the unique needs of the patient.

This resource is accessible to any health system or human service organization in Minnesota, such as:

- Hospitals
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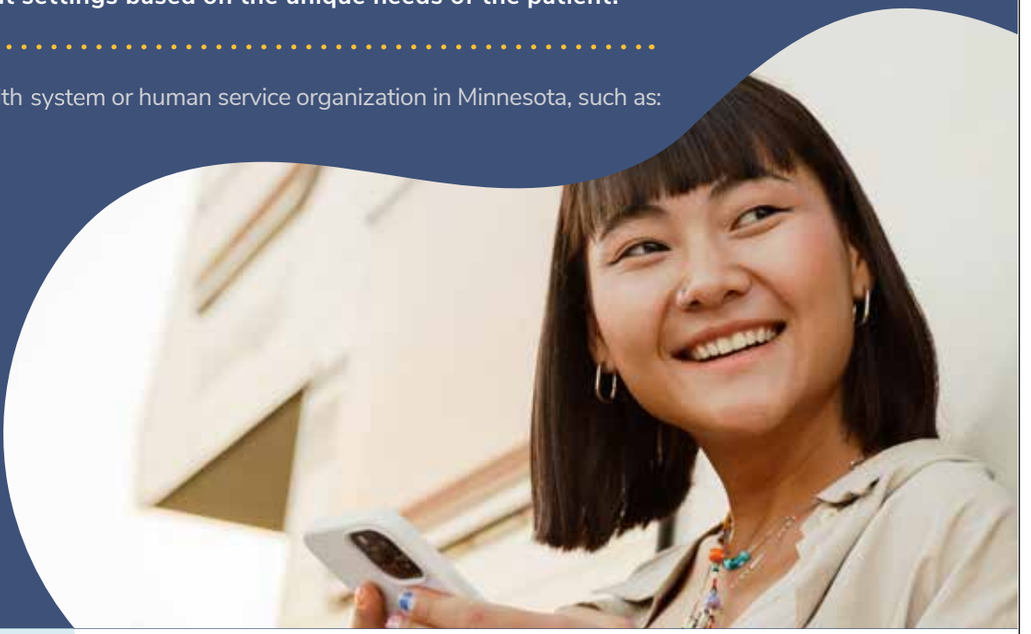

How MHCH Works

The Hospital submits de-identified case information that is accessible to providers across Minnesota.

The MHCH automatically connects the case to providers based on the criteria of the care setting (age, gender, diagnosis, etc.) and capacity.

Users of the MHCH can view cases and collaborate to help with the best setting for the patient's needs.

Users can also participate in weekly video calls to network and interact in real-time.

Contact Us
admin@mnpsychconsulthub.com
855-431-6468

The MHCH is accessible online 24/7/365 to help youth in need.

The Mental Health Collaborat ion Hub is managed by the statewide Psychiatric Assistance Line (PAL) through a grant from the Minnesota Department of Healt h, and with administrative support from the Metro Health Coalition and AspireMN .

◀ **Self Evident Truths** from page 24

Adaptation of Biculturalism The adaptation of biculturalism stage can be summarized as the great forgetting. One becomes released from the frustrations of culture shock in that they just don't matter anymore. One begins to feel at home and doesn't look back.

Dr. Marek says about cultural adaptation, "It's partly a skill, but it is also partly a choice to navigate your marginality and play it to your advantage rather than being constrained by it. I can easily imagine that many people in many contexts feel limited by their immersion. But, in most cases, I play it to my advantage."

Re-entry Shock The re-entry shock stage happens when individuals returns to their culture of origin and realizes that they've changed in relation to it. They may feel that they wouldn't necessarily fit in "back home" anymore.

Mikhail, a medical student from Eastern Europe, says, "You go home and it isn't what you expected it to be anymore. I didn't fit in anymore. There were even words I forgot from my native language. It was weird, but it's clear now that the U.S. is where I consider home."

Conclusion

Harvard University professors Robert Kegan and Lisa Lahey regard the cognitive and emotional energies of people to be an organization's most valuable resource. This is especially true of health care organizations. It behooves health care leaders to attend to the issues faced by their foreign-born physicians, nurses, PAs, technicians and others.

Hospital systems can educate their leadership and staff about the issues of marginality and culture shock. They can circumvent this staggering loss of their most valuable resource by anticipating the first two stages of culture shock and then being proactive when their negative manifestations arise.

Know that new immigrants tend to be fascinated with cultural differences and that fascination may fade and turn to angst. Have the support systems in place and the organizational cultural awareness in place so your foreign-born physicians, nurses and others have the support to progress toward adaptation.

Supporting foreign-born colleagues often requires paradoxical thinking. One must strive to understand as much as possible, while understanding that you will never completely understand. Know that you don't know. Strive to listen, observe and empathize the best you can.

Generally, the best advice about supporting our foreign-born colleagues comes from Jean, a health care provider who emigrated from Asia. She says, "I just want to forget about it. You're not reminded several times a day about your ethnicity or background. No one comes up to you and starts speaking German, Italian, or Norwegian. No one gives you a hard time when you're eating potato salad or goulash. So, don't do it to me. Just let me relax and forget about it. That's what I want."

Brad Fern is president of Fern EPC, a coaching organization that specializes in adaptive coaching for physicians and health care executives. He is a licensed psychotherapist.

The Vanquish Water Ablation System from page 21

for participation: The University of Minnesota (Christopher Warlick, MD), Mayo Clinic (Lance Mynderse, MD), and Minnesota Urology (Aaron Milbank, MD). Researchers anticipate using the one-year follow-up data from the VAPOR 2 study to support an FDA submission for U.S. market clearance. Patients in VAPOR 2 will continue to be monitored for five years to gather long-term cancer outcomes. This pivotal study follows a 15-patient U.S. early feasibility study that demonstrated an excellent safety and efficacy profile, with 14 out of 15 patients being free of clinically significant cancer at the study's conclusion.

Dr. Naveen Kella, of The Urology Place in San Antonio, Texas, treated the first patient in the VAPOR 2 study. "I am excited to participate in the VAPOR 2 study, and it is a great privilege to treat the first patient," said Dr. Kella. "Currently, prostate cancer patients find themselves in the difficult position of balancing the oncological risks of the disease with the life-altering side effects that can often accompany traditional treatments. Water vapor therapy shows great promise to provide patients with another option to proactively manage their cancer risk while preserving quality of life."

Francis Medical is working to establish Vanquish as the primary therapy of choice for treating prostate cancer for patients and their physicians. They are developing this simple water vapor procedure to offer a safe, effective and convenient method for ablating cancerous tissue within the prostate, all while safeguarding nearby nerves and other critical structures. This approach promises to deliver lifesaving cancer control while maintaining a high quality of life.

> The FDA has recognized the potential of our technology to be a breakthrough for patients.

Although prostate cancer is currently the company's primary focus, preliminary research shows excellent promise for applying water vapor therapy to bladder and kidney cancer. Francis Medical plans to shift resources to accelerate the development of these additional applications as the Vanquish system for prostate cancer transitions into commercial use.

"The vision that started this company and continues to drive us is to create a better experience for the patient," said Michael Hoey, founder and chief technology officer. "Everyone in the company shares this vision, and we strive each day toward getting this life-altering therapy into the hands of urologists and their patients."

Christopher Dixon, MD, is a urologist and chief medical officer at Francis Medical. He has contributed to the VA Cooperative Studies Program and received National Institutes of Health research grants.

Linking Public Health to Health Care
from page 9

Over the last several years, we've seen a decrease in the public's trust in science, medicine, public health and government. How is MDH working to rebuild trust? How should physicians be involved?

This is something we dealt with before COVID-19, but it was certainly elevated and accelerated during this unprecedented time. For MDH, I think it starts with staying true to our values of integrity, collaboration, respect, science and accountability. We have to show up consistently and with humility, literally and figuratively meet people where they are, strengthen current relationships (for example, we can't let the partnerships that we developed during the pandemic wither) and cultivate new ones. Physicians can help build trust in science, medicine and public health by serving on our advisory boards, committees and taskforces. Also by proactively affirming their support for public health decisions in their practice settings, both with patients and colleagues, and when asked for their perspectives in everyday conversations with friends, family and neighbors.

You led an effort to teach doctors, especially white doctors, how to talk to their black and brown patients and about racism in health care. What can you share about those teachings?

I believe, done well, talking about racism may benefit patients, and done poorly that such conversations can be harmful. For physicians (and public health professionals), it is critically important to understand the multiple ways in which exposure to racism, over the life course, contributes to adverse health outcomes (e.g., individual and/or caregiver exposure to racism as adverse childhood events; racism as a chronic toxic stressor and the pathophysiology of the stress response; and the interlocking systems that contribute to social marginalization and disadvantage). Although this knowledge is key, as with most things, successful doctor-patient communication is influenced by other factors, such as the duration and quality of the relationship, the degree of trust, attending to what is said and not said and to nonverbal cues, naming fear, using plain language and honoring patient preferences. When talking about racism, it is particularly important for physicians to reflect on their own race-related beliefs, reactions, anxieties and intentions, or else there is a real risk of harm.

> "Improving population health requires more intentional action and creativity."

Brooke Cunningham, MD, PhD, was appointed in January 2023 as commissioner for the Minnesota Department of Health. She is responsible for directing the work of the Minnesota Department of Health. MDH is the state's lead public health agency, responsible for protecting, maintaining and improving the health of all Minnesotans.

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