

OFFICE OF

**RURAL HEALTH
& PRIMARY CARE**



MINNESOTA DEPARTMENT OF HEALTH

Minnesota's Rural Health Plan

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State Vision for Healthy Minnesotans

Minnesota's statewide public health goals were developed through a collaborative process involving state agencies, community organizations, local governments, health care providers, health plans, population advocates, businesses and schools. Together, these diverse partners produced *Healthy Minnesotans: Public Health Improvement Goals* ("Healthy Minnesotans"). These goals complement the national *Healthy People 2010* goals while assessing and addressing Minnesota's unique needs and strengths.

Healthy Minnesotans highlights current and important public health issues and draws attention to several broad public health goals for our state:

- Ensure a strong public health system
- Promote healthy communities and eliminate disparities throughout the lifespan
- Prevent the spread of infectious disease
- Make environments safe and healthy
- Prepare for disasters and emergencies
- Help all people get quality health services.

The *Healthy Minnesotans* goals of particular interest and applicability to the focus of the Office of Rural Health and Primary Care (ORHPC) are:

- **Promote healthy communities and eliminate disparities throughout the lifespan.** ORHPC provides support to clinics, hospitals, nursing homes, ambulance services, other providers, educational institutions and employers. This support strengthens the economic base of the community and region by focusing on local and regional collaboration, capturing efficiencies, eliminating duplication, and optimizing available federal, state and private sector financial resources.
- **Prepare for disasters and emergencies.** The 2005 Minnesota Legislature authorized the creation of the Minnesota Statewide Trauma System. It was established and placed within the Office of Rural Health and Primary Care, largely because of the Trauma Program's focus on incorporating rural hospitals and Critical Access Hospitals into the system.

Ambulance issues are magnified in rural areas, where demands are high but resources scarce. Minnesota emergency medical services leaders have identified top concerns in the industry as: regional program support, clinical quality improvement, rural workforce staffing, leadership development, community visibility, and medical direction.

- **Help all people get quality health services.** Rural residents are less likely to obtain certain preventive services and are further behind urban residents in meeting Healthy People 2010 objectives.¹ Ensuring access to and improving the quality of health services in rural Minnesota are top priorities in the ORHPC. Primary care and financial assistance programs administered through the ORHPC, such as the Rural Hospital Flexibility grant, promote continual rural access to health care services and promote opportunities to improve the quality of care for rural patients.

¹ Casey M., Call K., Klingner J. *Are Rural Residents Less Likely to Obtain Recommended Preventive Healthcare Services?* American Journal of Preventive Medicine, 2001; 21:182-188.

Summary

The rural Minnesota health care landscape is changing. The population and workforce are aging, new immigrant and minority populations are growing, and many areas are facing shortages in the health care workforce. The rural economy is diverse, creating significant disparities from region to region. Financing of health care is often dependent on government programs such as Medicaid, Medicare and MinnesotaCare. Ensuring quality health care involves both public and private sectors working together on local, regional, state and national levels. The goals of the 2008 Minnesota Rural Health Plan are broad based and meant to form a framework to ensure that rural communities have the structure, the tools and the resources to provide health care access and quality.

Goals:

- Ensure a Strong, Integrated Rural Health Care System
- Ensure a Sound Rural Professional Health Care Workforce
- Foster Improvements to Rural Health Care Access and Quality
- Support the Use of Health Information Technology and Telehealth Delivery in Rural Communities

Goal A: Ensure a Strong Integrated Rural Health Care System

- 1) Identify, assess and facilitate discussion of rural health care issues in order to develop policy and program improvement recommendations on prioritized issues.
- 2) Disseminate and encourage replication of promising practices and models for improvement in prioritized health areas.
- 3) Ensure continued successful implementation of Minnesota's Medicare Rural Hospital Flexibility Program.
- 4) Support infrastructure of health care system.

Goal B: Ensure a Sound Rural Professional Health Care Workforce

- 1) Foster and continue multi-sector, multiagency collaboration aimed toward creative approaches to Minnesota's health care workforce shortages.
- 2) Support health professional recruitment efforts.
- 3) Promote programs that encourage members of minority and immigrant communities to enter health care professions.
- 4) Promote health professional workforce retention.
- 5) Disseminate and encourage replication of promising education, recruitment and retention practices.

Goal C: Foster Improvements to Rural Health Care Access and Quality

- 1) Work with partner organizations to ensure rural representation in the development of local, state and national health care programs and policies and to maximize their effectiveness.
- 2) Seek and disseminate funding to address infrastructure needs of rural health care facilities.
- 3) Understand the rural health system's financial condition and support strengthening it.

- 4) Provide continuing and enhanced technical assistance to hospitals, clinics, nursing homes and other health care providers in order to strengthen the rural health infrastructure at the community level and improve its ability to meet community needs.
- 5) Conduct high quality research and policy analysis on rural health issues and encourage those doing general health care research to include rural breakouts and comparisons.

Goal D: Support the use of Health Information Technology and Telehealth Delivery in Rural Communities

- 1) Disseminate and encourage replication of promising practices and models for planning and implementing health information technology and telehealth programs.
- 2) Support expanded broadband access necessary for telehealth use.
- 3) Seek and disseminate funding to support the adoption and effective use of interoperable electronic health records in rural health care facilities.

1 Introduction

The Office of Rural Health and Primary Care promotes access to quality health care for rural and underserved urban Minnesotans. From our unique position within state government, we work as partners with communities, providers, policymakers and other organizations. Together, we develop innovative approaches and tailor our tools and resources to the diverse populations we serve.

Overview

The year 2008 marks Minnesota's 150th as the 32nd state in the United States of America. While the cultural roots of the state's founders are still evident in many parts of the state, much has changed. Rural Minnesota is in transition as the population ages and certain segments become more disparate, the economy becomes more diverse and increasingly fragile, and the challenges in accessing quality health care become more complex.

Minnesota ranked second in the nation in 2007 for relative healthiness, including personal behaviors, the quality of medical care, the community environment, and decisions made by public and elected officials. However, Minnesota also ranks high in health disparities, especially among minority populations. Blacks in Minnesota experience 63 percent more premature death than Whites. Residents in non-urban areas in Minnesota experience 31 percent more premature death than residents in the fringe counties of large metropolitan areas.²

The erosion of the working population contributes to the challenge to find qualified health care workers, especially physicians, nurses, pharmacists, dentists, mental health professionals and technicians in areas such as lab and radiology. Health care in rural areas is heavily subsidized through government funding including Medicare, Medicaid and MinnesotaCare and subject to ever changing regulation and funding. The elderly lack the traditional family caregiving networks and rely on a long term care system that is in financial jeopardy. Physical plants are decaying. The number of people uninsured or underinsured is rising and the population is growing increasingly diverse. Many rural areas lack the capacity to respond to emergencies and disasters.

Yet, with all these challenges, Minnesota continues to demonstrate a commitment to rural health care that reflects the willingness of communities to plan and work together.

² *America's Health RatingsTM: A Call to Action for People and Their Communities.* United Health Foundation, 2007.

This health plan looks at the trends, the challenges and the approaches needed to ensure that rural Minnesotans receive excellent health care across the lifespan, across the state.

The Minnesota Rural Health Plan is intended as a flexible document, responsive to the changing needs and landscape of Minnesota. It was developed using a number of resources including the 1998 and 2004 Minnesota Rural Health Plans, input and work plans from the Rural Health Advisory Committee and the Medicare Rural Hospital Flexibility Advisory Committee, rural health community forums conducted in 2008 and guidelines from Minnesota's Public Health Improvement Goals for 2010 (Appendix A).

Demographics

Minnesota's population has increased steadily in the last 20 years, although the rate of increase has slowed. Minnesota's population in 2000 was 4,919,479³; in 2007 that number increased to 5,263,610⁴. While the total number of Minnesota residents increased 12.4 percent between 1990 and 2000, growth rate dropped to 7 percent from 2000 to 2007.⁵

According to the State Demographer's office, Minnesota ranked among the states with the most rapid growth in the Hispanic/Latino population. This surge in the Hispanic/Latino population was most concentrated in Greater Minnesota, where the population grew from 17,168 to 47,480 or 176.6 percent between 2000 and 2004. In 2007, estimates of the Hispanic population in Greater Minnesota totaled 65,162, an increase of 37 percent.

Minnesota population continues to grow older. Census Bureau estimates show the median age rose from 35.4 years in 2000 to 36.6 in 2005. The fastest growing age group is people in their 50s, while the next most rapidly growing age group includes those over 85 years.

While all of Minnesota's population is aging, it is disproportionately affecting rural Minnesota. As of 2007, only 10 percent of the population was 65 and older in the seven-county metro area compared to counties beyond the Twin Cities region where 15 percent of the population was 65 years and older.⁶

The Minnesota Demographer's office reports that 30 percent of the state's total population and 41 percent of those 65 and older live in rural Minnesota.⁷ In Greater Minnesota, a majority of one-person households are elderly.⁸

³ U.S. Census Bureau

⁴ Minnesota Department of Administration. Office of Geographic and Demographic Analysis

⁵ Minnesota Demographers Office (1990) and 2000 U.S. Census

⁶ U.S. Census Bureau

⁷ *Implications of Rural Minnesota's Changing Demographics*, Minnesota Planning Critical Issues: Perspectives, July 2000.

⁸ Minnesota State Demographer, *Population Notes*, Jan. 2004.

Thirty-seven percent of Minnesota's rural population lives in a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA). Forty-six of the most rural counties have 13 percent of the state's population but only 5 percent of the state's practicing physicians. Parts of 30 Minnesota counties—mostly in the western and northern parts of the state—are designated as HPSAs. All or parts of 27 counties qualify as shortage areas based on low income⁹ (Appendix B).

Strengths

Minnesota brings significant strengths to rural health challenges, including:

- Numerous public and private collaborations to improve health care as well as community-level, regional and statewide initiatives
- Well-developed public health/community health planning systems
- Multiple rural health projects and grants managed through the Office of Rural Health and Primary Care
- Formal systems for community input through the Rural Health Advisory Committee, the Medicare Rural Hospital Flexibility Advisory Committee and other organizations
- Excellent data collection and research through the Minnesota Department of Health, the University of Minnesota and other agencies
- Multiple health education and training opportunities through state and community college systems
- Significant commitment of public resources to support the rural health system
- Strong public commitment to excellence and fairness in health care.

Challenges

The Rural Health Advisory Committee (RHAC), the Medicare Rural Hospital Flexibility Program Advisory Committee and participants in a variety of rural health care forums identified challenges in rural health care, including:

- Workforce shortages among primary care and specialty physicians, advanced practice registered nurses, pharmacists, dentists, mental health workers, ambulance personnel, radiology and laboratory technicians and others.
- Economic vulnerability of rural hospitals, clinics, long term care facilities, emergency medical systems and community-based care in an era of higher unemployment, a rise in the number of people who are uninsured or underinsured, and government spending cutbacks
- The growing elderly population, the increasing dependence on and confusion regarding Medicare and Medicare Advantage, and the insufficient infrastructure to care for the elderly in their homes and home towns

⁹ Minnesota Office of Rural Health and Primary Care, August 2008.

- Inadequate access to mental health and chemical dependency services
- Health disparities among rural populations of color, patients with limited English proficiency; lack of interpreter services and cultural awareness (Appendix C).

Goals

The goals of the Minnesota Rural Health Plan are broad based and meant to form a framework to ensure that rural communities have the structure, the tools and the resources to provide health care access and quality. The goals of the 2008 Minnesota Rural Health Plan are:

- Ensure a strong integrated rural health care system
- Ensure a sound rural professional health care workforce
- Foster improvements to rural health care access and quality, and
- Support the use of health information technology and telehealth delivery in rural communities.

Minnesota Rural Health Plan: Then and Now 1998-2008

The first Minnesota Rural Health Plan was developed in 1998 when the rural health picture was one of substantial decline in the utilization of services in rural hospitals, difficulty in maintenance of 24-hour coverage for emergency room services, significant financial losses and other issues such as aging plants and inadequate reimbursement. By 2004, when the rural health plan was updated and rewritten, 52 hospitals had converted to Critical Access Hospital status.

The 2004 Rural Health Plan set a framework to ensure that rural communities had the structure, the tools and the resources to provide health care access and quality across the lifespan and across the state. The goals included:

- Ensure a strong integrated rural health care system
- Ensure a sound rural professional health care workforce
- Promote effective health care networking and community collaboration
- Foster increased capacity and resources to ensure rural health care access and quality.

Since 2004, the Office of Rural Health and Primary Care has regularly assessed the Minnesota environment and initiated numerous projects, work groups and reports based on the goals of the State Rural Health Plan. Some examples include:

- Rural Mental Health and Primary Care Work Group with report and recommendations (Appendix D)

- Initiation of a state trauma system
- Creation of Healthy Communities for the Aging Population Work Group with report and recommendations
- Collaboration with rural telehealth providers and stakeholders
- Annual state Rural Health Conferences (Appendix E)
- A report to the 2007 Minnesota Legislature on swing beds and access to post-acute care in rural Minnesota
- Ongoing health care workforce analysis
- Grant programs focusing on increasing access, addressing health care infrastructure and fostering collaboration
- Health workforce loan repayment and health careers programs.

Development of the 2008 Rural Health Plan

The Minnesota Rural Health Plan has evolved from focusing on the stability of small hospitals to a broader look at accessing quality care throughout the community. Components of the 2008 plan build on the work done over the past several years and address the need to ensure a strong integrated rural health care system, a sound professional workforce, improvements to health care access and high quality health care, and support use of health information technology and telehealth delivery.

The 2008 Rural Health Plan is a culmination of the efforts of many work groups, standing committees, advisory groups and partnerships dedicated to improving the provision of and access to health care in rural Minnesota. The plan was developed in consultation with the Medicare Rural Hospital Flexibility Program Advisory Committee, the Rural Health Advisory Committee, Office of Rural Health and Primary Care (ORHPC) staff and others.

The Rural Health Advisory Committee (RHAC) is a 15-member governor-appointed committee that advises the commissioner of the Minnesota Department of Health and leaders of other state agencies on rural health issues. Members lead planning and priority setting and all policy analysis activities. It is staffed by the ORHPC, and its members lead planning and priority setting for ORHPC and all its policy analysis activities. In June 2007, the Rural Health Advisory Committee set its priorities for 2007-2009. Those priorities are:

- Rural health workforce issues
- Development of a new rural health care delivery model
- Population health issues (e.g., prevention and chronic disease, uninsurance and underinsurance, diversity, aging)
- Financial stability of the rural health system
- Quality improvement
- Information and communications technology.

These priorities were incorporated into the development of the 2008 Rural Health Plan (Appendix F).

Focused Work Group Projects – In late 2007 and 2008, the Rural Health Advisory Committee completed one work group project related to Rural Health Plan Development, and began a second work group. The Committee established a *Rural Health Reform Work Group* to offer a rural perspective on Minnesota health reform discussions. The work group studied the rural characteristics that affect health services, and proposed health reform options in response. Among their recommendations are:

- Redesign health care jobs and health care delivery for better coordinated prevention and health care services delivery.
- Increase support for primary care and for educating primary care practitioners.
- Support utilization of proven cost-effective technology, such as telehome care, telemental health services and teleradiology.
- Work toward universal coverage, while making incremental changes such as improving insurance options for small employers and workers with lower wages.
- Build on strengths of the rural system such as Critical Access Hospitals, which often serve as a hub around which to integrate and redesign community services (Appendix G).

Most recently, the Rural Health Advisory Committee formed a *Work Group on Developing a New Rural Health Care Delivery Model*. The work group has begun to review efforts underway to promote the medical home model and spell out any unique features that should be incorporated for the model to succeed in rural areas. The group will also look at the intersecting dynamics of primary care shortages, technology, rural demographics, and existing rural models of health service integration and care coordination to develop a viable rural model for the future.

The findings of both these work groups will feed into the ongoing and future editions of the Minnesota Rural Health Plan and the development of Flex Program strategies. The final work group reports are on the ORHPC Web site at <http://health.state.mn.us/divs/orhpc/pubs/index.cfm?pubtype=reports>.

Community Rural Health Forums

In January 2008, the Office of Rural Health and Primary Care convened a series of rural community health forums to solicit local insight into rural health challenges and opportunities. Feedback from those forums was one basis for guiding the Minnesota Rural Health Plan. Forums were held in four communities:

- Hibbing in northeast Minnesota
- Marshall in southwest Minnesota

- Mahnommen in northwest Minnesota
- Owatonna in southeast Minnesota.

Consumers and representatives from hospitals, clinics, health plans, nursing homes, area agencies on aging, local public health, emergency medical services, Area Health Education Centers, and legislative and congressional offices engaged in lively discussions at each of the sites.

Facilitators from the ORHPC guided the discussion as communities identified strengths and challenges in their region's health care environment, and potential solutions to problems (Appendix A).

The Top Issues

Although each group identified some regionally specific issues, broad priorities emerging throughout the state were, in no particular order:

- The importance of an integrated health care system
- The availability and efficient use of health information technology
- Access to health care, including transportation, specific services, continuum of care within the community, quality and
- Workforce issues.

2

The Rural Minnesota Landscape

The 2007 U.S. Census estimates 27 percent of Minnesota's population lives in nonmetropolitan, rural regions of Minnesota. That is a decline from the 2000 Census when 29 percent of the population was living in rural areas.

The Changing Demographics of Minnesota 1990-2007

Minnesota's population has shown steady increases in the last 20 years, although the rate of increase has slowed. Minnesota's population in 2000 was 4,919,479¹⁰. In 2007, that number increased to 5,263,610¹¹. While the total number of Minnesota residents increased 12.4 percent between 1990 and 2000, growth rate dropped to 7 percent from 2000 to 2007.¹²

Despite the U.S. Census estimates indicating overall population growth has slowed, certain regions of Minnesota continue to experience slight population growth. Estimates from 2007 show population growth largely concentrated in the metropolitan and central regions of the state.

Fast growing counties have younger age distributions with a large percentage under 45. A substantial decline in the 0-14-year-old age group occurred between 2000 and 2005 in many of Minnesota's rural counties.

The northeast experienced some population loss (-.52 percent) while the southwest region of Minnesota continues to undergo a population exodus (-3.18 percent) (Map 1).

Rural counties experiencing population growth likely have become recreational or retirement destinations of Minnesota. Counties undergoing population loss are likely experiencing economic downturns combined with an aging population.

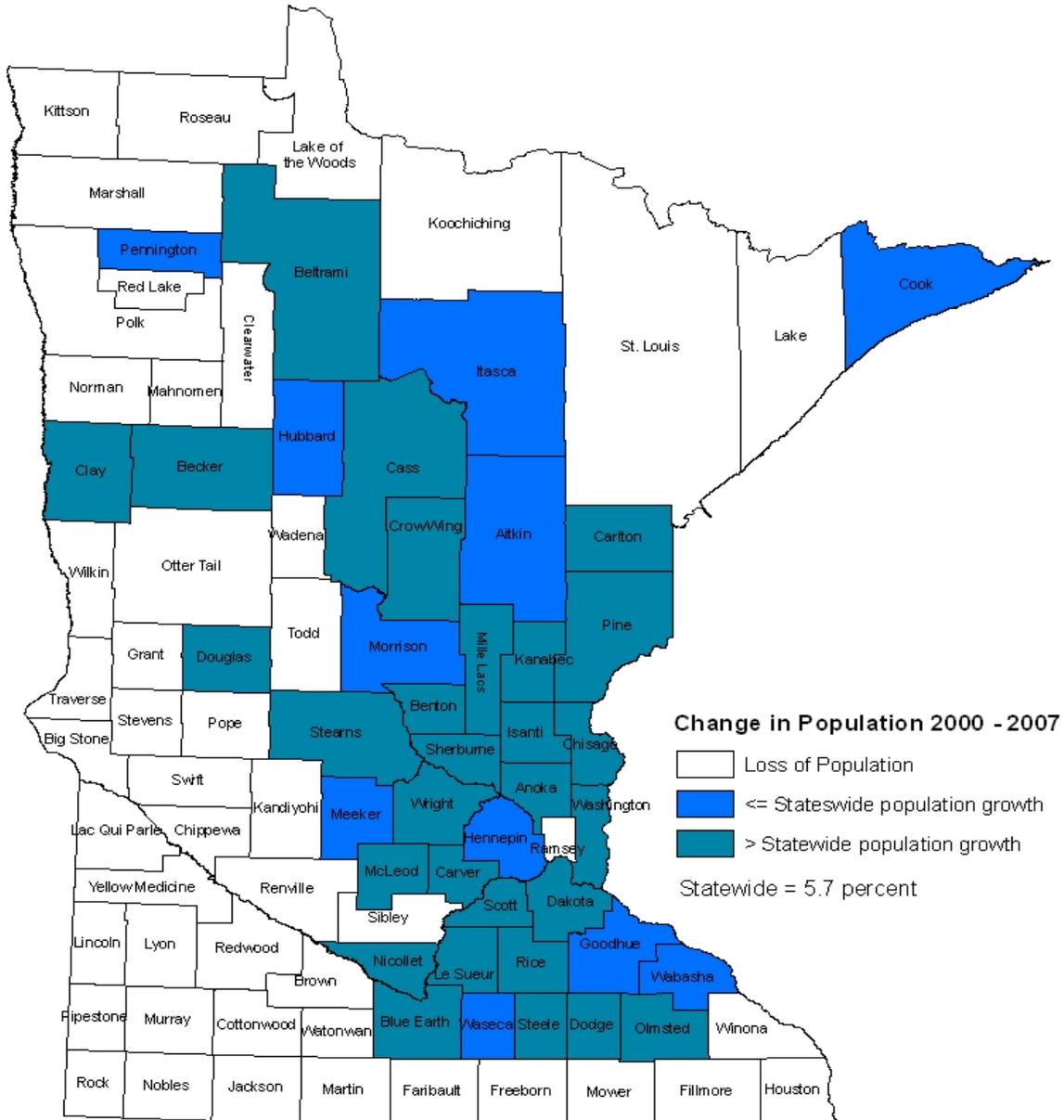
¹⁰ U.S. Census Bureau

¹¹ Minnesota Department of Administration. Office of Geographic and Demographic Analysis

¹² Minnesota Demographers Office (1990) and 2000 US Census

Map 1

Percent Change in Population 2000 - 2007 Minnesota



Source: U.S. Census Bureau

Diversity

Minnesota has been described as a “homegrown” state, meaning that most of its residents were born in Minnesota. In 2000, U.S. Census reports revealed that this characterization was changing. Minnesota was becoming a residence for people from other parts of the nation and world.

The 2000 Census revealed an increasingly racially and ethnically diverse Minnesota. Between 2000 and 2005, the non-White population (including Latinos), grew 21 percent—compared to the 2 percent increase for the White (non Latino) population. In 2007, the proportion of the total population reported as non-White remained around 11 percent.

Large segments of the non-White or Hispanic population traditionally have been concentrated in urban settings of Minnesota. This too has changed. The 2000 Census revealed rural counties such as Clearwater, Lyon, Mahnomen, Mower, Nobles and Watonwan represent some of the greatest areas of growth. Some of this growth is being attributed to the employment opportunities provided by large manufacturing and food processing plants located in these counties. As of 2007, non-White and Hispanic populations continue to increase in Minnesota’s rural areas, but at a much slower rate.

Hispanics/Latinos

While there were sharp increases among all populations of color in Minnesota, the greatest increase occurred among the Hispanic/Latino population, which grew from 53,884 to 143,382 (166 percent) during the 1990s.¹³ According to the State Demographer’s office, Minnesota ranked among the states with the most rapid growth in the Hispanic/Latino population. The Hispanic population is growing rapidly in both urban and rural areas¹⁴ (Map 2).

This surge in the Hispanic/Latino population was most concentrated in Greater Minnesota, where it grew from 17,168 to 47,480 or 176.6 percent. In 2007, estimates of the Hispanic population in Greater Minnesota totaled 65,162, an increase of 37 percent. The Hispanic population is projected to triple in the next 30 years.¹⁵

¹³ Ibid.

¹⁴ Migration Policy Institute, 2007

¹⁵ *Minnesota Population Projections by Race and Hispanic Origin 2000-2030*. Minnesota State Demographic Center, 2005.

Black/African Americans

Significant population growth also occurred in the Black/African American community living in Greater Minnesota. While only 9 percent of the Black/African American community lives outside the seven-county metro area, their numbers in Greater Minnesota grew from 5,296 in 1990 to 14,700 in 2000 (177.6 percent). In 2007, Census estimates indicated the African American population in Greater Minnesota continued to increase. Since 2000, African Americans total 26,366 in Greater Minnesota, a 79 percent increase. According to the Minnesota Demographer's office, in-migration from other states and from Africa are playing a role in this growth.

American Indians

According to the 2000 Census, 81,074 Minnesotans identified themselves as American Indian or Alaskan Native alone or in combination with other races. In 2007, an estimated 60,929 Minnesotans were American Indian. As 3 percent of the population, American Indians continue to make up a large portion of the non-White population living in rural Minnesota (Table 1).

Table 1

2007 Population by Selected Race and Ethnic Group	Metro	Micro	Rural	State
White alone	87%	96%	95%	89%
Black or African American alone	6%	1%	1%	4%
American Indian and Alaska Native alone	1%	1%	3%	1%
Asian Pacific Islander alone	4%	1%	1%	4%
Hispanic or Latino	4%	4%	2%	4%

Source: U.S. Census Bureau

Twenty-three percent (18,397) of American Indians in Minnesota live on one of the 14 reservations or associated trust lands in the state. The Red Lake Reservation had the highest concentration of people identifying themselves as American Indian or Alaskan Native (98.6 percent), while the Fond du Lac Reservation had the lowest (40 percent). The northwest counties of Beltrami, Cass and Mahnomen, where three of the largest Indian reservations are located, also had the greatest concentration of American Indians.

Asian/Pacific Islanders

In 2007, most of the Asian population continued to live in the Twin Cities area. The Census Bureau estimates that 84 percent of the Asian population in Minnesota is living in the seven-county metropolitan area, while 16 percent live in Greater Minnesota. Nobles, Olmsted and Swift are the only counties outside the seven-county metro area that have a concentration of Asians higher than the statewide average of 3.5 percent.

International Immigration

A significant contributor to Minnesota's growing population and increasing diversity is international immigration. The number of immigrants moving to Minnesota in 2002 was the highest it had been since 1982.¹⁶ From 1990 to March 2000, the foreign-born population entering Minnesota more than doubled totaling 54.5 percent. In 2005, 40 percent of all immigrants came from Africa and 28 percent came from Asia. Refugee arrivals in Minnesota in 2005 totaled 11.8 percent of all refugees coming to the United States.

As of 2004, 6.1 percent of Minnesota residents were foreign-born compared to 12 percent for the nation¹⁷. About 460,000 (10 percent) of Minnesota residents spoke a language other than English at home in 2006. This percentage is much lower than the national average (19.7 percent)¹⁸. Of these, 270,000 (58 percent) report being able to speak English "very well," slightly higher than the national average (56 percent). The common languages used at home in Minnesota other than English include:

- Spanish (36 percent)
- Asian/Pacific Island languages (27 percent)
- Indo-European languages (French, German, Russian, Scandinavian) (24 percent)
- African languages (9 percent)
- Other (Native American, Arabic) (4 percent)¹⁹.

Minnesota is home to the United States' largest population of Somali residents (approximately 29,000), and has the ninth largest population of African immigrants nationally. Other African countries with large populations in Minnesota include Ethiopia, Kenya, Liberia and Nigeria. One in five immigrants in Minnesota is African.²⁰

About 20,000 new African immigrants live in Minnesota's rural communities—many working in meat and poultry packing plants around the state. In 1990, fewer than 5,000 African immigrants were estimated to be living in Minnesota; in 2007, more than 80,000 African immigrants are estimated to be living in this state.²¹

Minnesota has the second largest Hmong immigrant population in the United States. Population estimates are difficult to determine because cultural and language barriers prevent many Hmong from completing census surveys. In addition, most census surveys do not include Hmong as an available ethnicity option. In 2006, The Hmong National Development Center in Washington, D.C. conducted a survey of Hmong in America and estimated 275,000 Hmong

¹⁶ Ibid.

¹⁷ U.S. Census, 2004

¹⁸ U.S. Census, 2006

¹⁹ U.S. Census, 2005

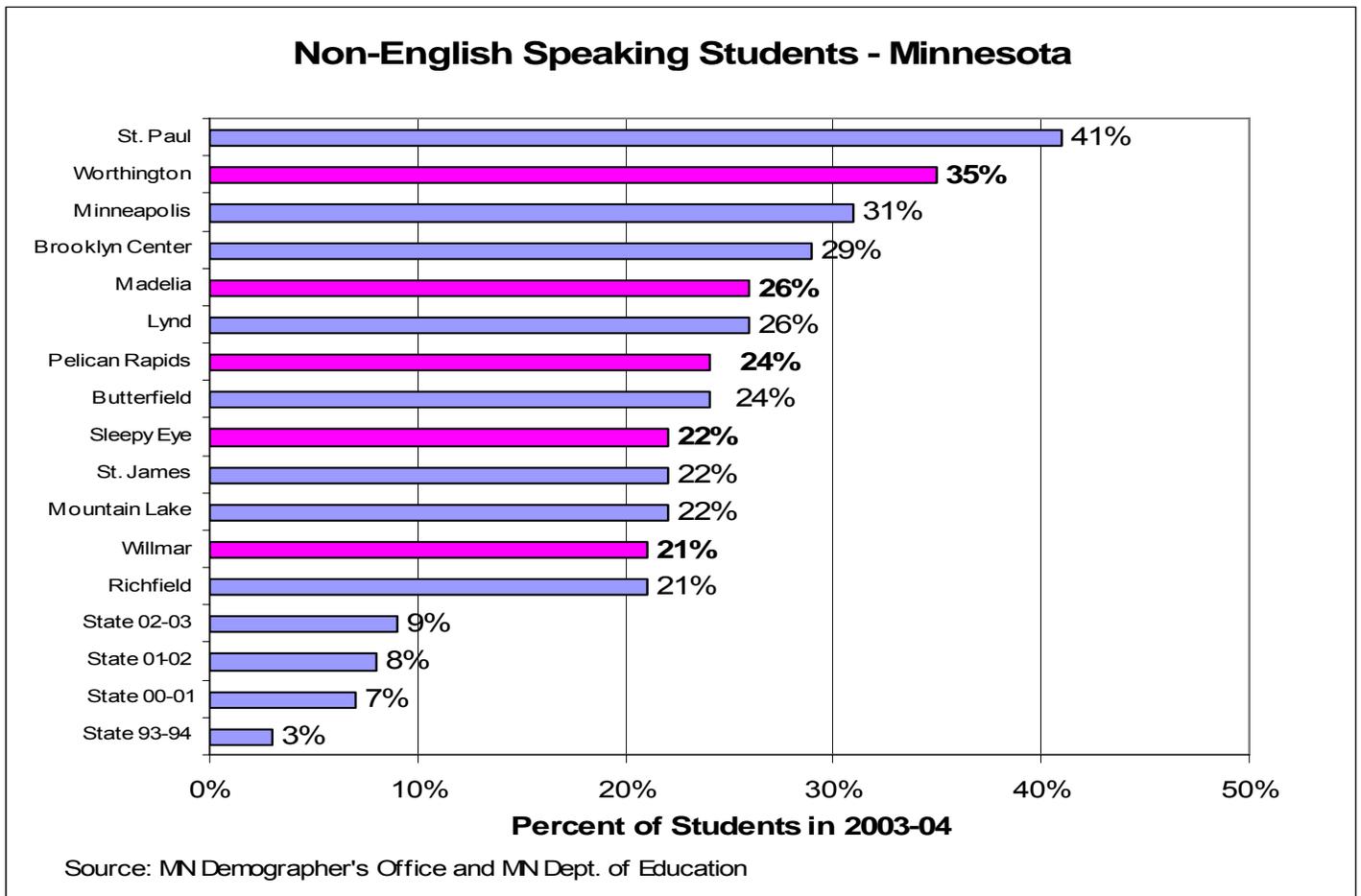
²⁰ *African Immigrants in Minnesota*, N. Remington, 2008.

²¹ *African Immigrants Finding a Home in Rural Minnesota*. The Twin Cities Community Newswire, November 2008

immigrants were living in the United States. Of those, approximately 49,000 were believed to be living in Minnesota. Local community estimates raise that number to 60,000-70,000 Hmong in Minnesota.²² Some Hmong clans have settled in rural Minnesota communities; the 2000 U.S. Census estimated 3,000 Hmong lived in rural Minnesota.

Currently, 90,870 Minnesota students do not speak English at home, with Spanish speakers being the largest and most widely distributed language group in Minnesota schools. Some of the smaller rural school districts with substantial populations of non-English speaking students are Worthington (35 percent), Madelia (26 percent), Pelican Rapids (24 percent), Sleepy Eye (22 percent), and Willmar (21 percent). In 2006, more than 120,000 residents of Greater Minnesota aged 5 years and older spoke a language other than English at home.²³ Roughly 43,000 of these individuals spoke English less than “very well.” As the number of rural Minnesotans with limited English speaking proficiency increases, so does the need for language access services in rural health care settings (Figure 1).

Figure 1



²² Hmong Cultural Center, 2007

²³ U.S. Census

Future Population Growth

Minnesota's population is expected to continue to grow in size and diversity over the next several decades, and accessible health care services are likely to be a quality of life consideration for new residents arriving in Minnesota. The State Demographer's office has projected that Minnesota's population will grow to almost 5.5 million by 2010 and over 6 million by 2035. Most of the growth is predicted to be due to the continued migration from other states and countries. Much of the growth will continue to occur in metropolitan areas, while Greater Minnesota is expected to see some growth, especially in regions where lakes and forests are becoming retirement destinations.

Minnesota's Aging Population

Minnesota population is growing older. Census Bureau estimates show the median age rose from 35.4 years in 2000 to 36.6 in 2005. According to the Minnesota State Demographer, the greatest influence affecting the median age is Minnesota's baby boom generation. The fastest growing age group is people in their 50s, while the next most rapidly growing age group includes those over 85 years.

While all of Minnesota's population is aging, it is disproportionately affecting rural Minnesota. As of 2007, only 10 percent of the population was age 65 and older in the seven-county metro area compared to counties beyond the Twin Cities region where 15 percent of the population was 65 years and older²⁴ (Map 3).

Between 2000 and 2005, the elderly population dropped in many rural areas, particularly southwestern Minnesota. According to the Minnesota State Demographer, this is due to a long history of out-migration in these counties. Southwest Minnesota remains the region with the greatest concentration of residents 65 or older even though the population is declining in size. The older population is growing in north central Minnesota, an area popular with retirees and people seeking vacation homes.

Comparisons of median ages in 2007 across Greater Minnesota range from 30.5 years to 48.2 years. Border counties, such as Big Stone, Cook, Kittson, Lac Qui Parle, Lake of the Woods, Lincoln and Traverse, rank highest in median age, while Beltrami, Blue Earth and Clay rank lowest in median age.

Long term care issues are a primary concern for much of rural Minnesota. In Greater Minnesota, a majority of one-person households are elderly.²⁵ In Grant, Lac qui Parle and Traverse counties, 59 to 60 percent of solo households are people age 65 and over. This has much to do with the large

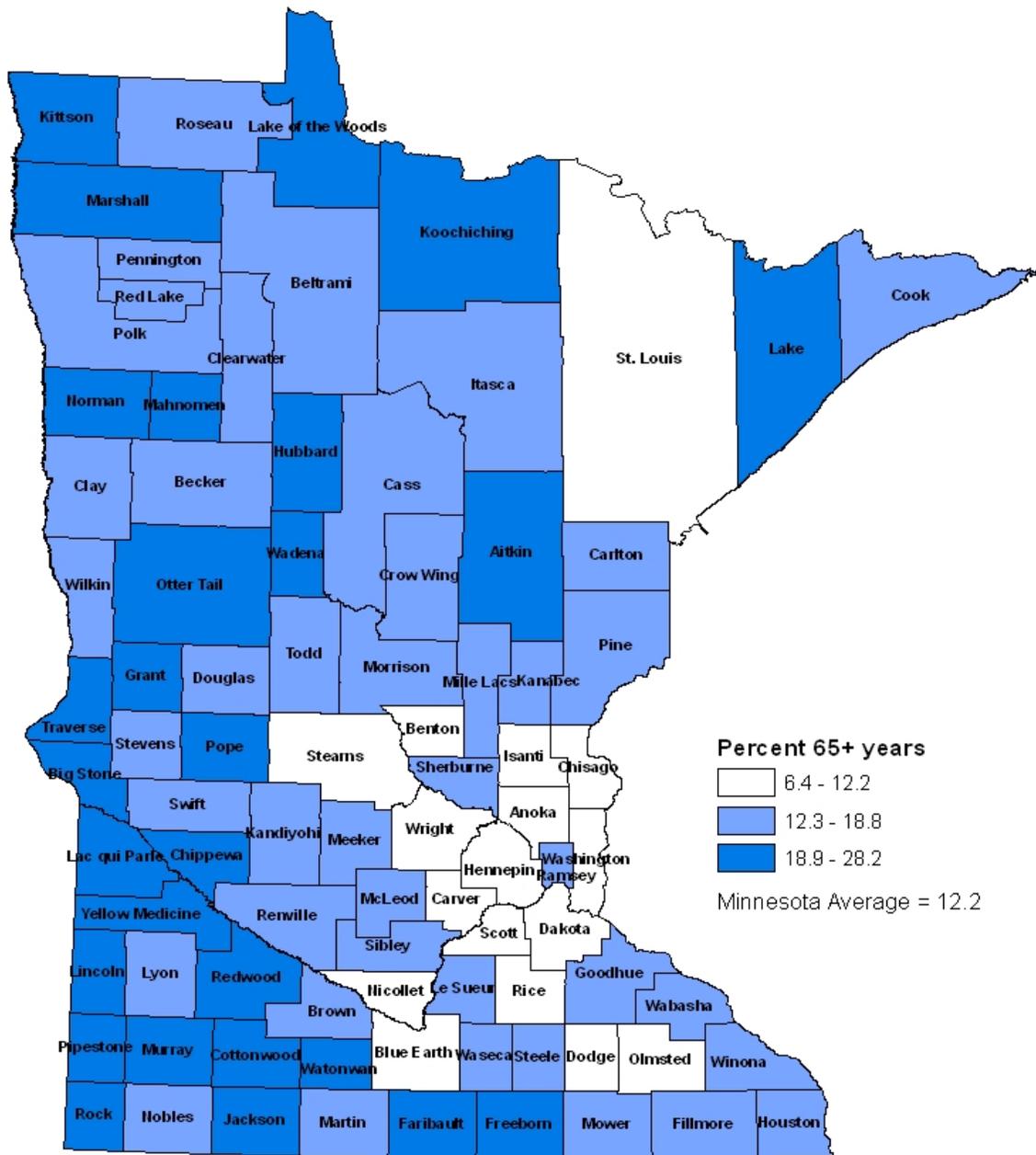
²⁴ U.S. Census Bureau, 2007.

²⁵ Minnesota State Demographer, *Population Notes*, January 2004.

majority of young people continuing to leave for better economic opportunities in urban areas.

Map 3

2007 Population 65+ years by County Minnesota



Source: U.S Census Bureau

Projections for Minnesota's Aging Population

Minnesota's population is expected to continue to grow and age rapidly. During the next decade, the fastest growing age group will be 50- to 64-year-olds. Projections show an explosion of the baby boom generation raising the median age from 35 to 41 by 2035. This aging of the population is being felt more strongly in rural Minnesota. The Minnesota Demographer's office reports that 30 percent of the state's total population and 41 percent of those 65 and older live in rural Minnesota²⁶ (see Map 4). The 65 and over age group is projected to grow by almost 700,000 between 2000 and 2030, a rate of 117 percent. That would bring the 65 and over population up to 1.3 million or 1 in 4 Minnesotans. The Minnesota Demographer predicts that most rural areas will see more than 20 percent of their population over age 65 by 2025.²⁷

Growing health care needs among the elderly are a top concern for policymakers in Minnesota. In 2006, the Rural Health Advisory Committee and the State Community Health Services Advisory Committee jointly published *Creating Healthy Communities for an Aging Population*. In their report the joint committees discussed a healthy aging community as one that: 1) addresses basic needs, 2) optimizes health and well-being, 3) promotes social and civil engagement, and 4) supports independence. Several recommendations were made in the report for supporting elder-friendly, healthy aging communities (Appendix H). The report is on the ORHPC Web site at: <http://health.state.mn.us/divs/orhpc/pubs/healthyaging/hareportnofs.pdf>

Transform 2010

Transform 2010 is a statewide initiative working to transform policies, infrastructures and services to prepare Minnesota for the coming age wave. By 2011, the large baby boom generation begins to turn 65 and, for the next 50 years, the aging of society will dominate the demographic landscape.

Transform 2010 seeks to heighten the sense of urgency to transform policies, infrastructures and services, so that Minnesota is prepared for these historic changes. In preparation, the Minnesota Department of Human Services (DHS) partnered with the Minnesota Board on Aging, the Minnesota Department of Health and representatives of 16 other state agencies and held a series of regional meetings throughout Minnesota collecting ideas for action. The primary themes to emerge from these meetings so far are:

- Redefine work and retirement
- Support caregivers of all ages
- Foster communities for a lifetime
- Improve health and long term care
- Maximize the use of technology.

²⁶ *Implications of Rural Minnesota's Changing Demographics*, Minnesota Planning Critical Issues: Perspectives, July 2000.

²⁷ *Changing Places: Shifting Livelihoods of People and Communities in Rural Minnesota*, Minnesota Planning Critical Issues: Perspectives, August 2001.

A report entitled, *Blueprint for 2010*, is available at the DHS Transform 2010 Web site:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_054450.

Minnesota's Rural Economy

Rural Minnesota has deep economic roots in agriculture and raw materials, and more recent standings in manufacturing and services. The economy is diverse, creating significant disparities from region to region.

Farming

Agriculture is still a major part of the rural economy, especially in the southern, western and northwestern regions. According to the Minnesota Department of Finance, only 2 percent of Minnesotans actually farm, but agriculture represents 20 percent of the state's economy. Minnesota is the nation's largest producer of sugar beets and sweet corn, green peas for pressing, and of farm-raised turkeys.

Minnesota's farmland is shifting from small, family-operated businesses to large agribusinesses. The percentage of land classified as farmland rose from 25.6 percent in 1992 to 27.6 percent in 2004. The average size of a Minnesota farm decreased by 3 percent between 1997 and 2002. The percentage of farms with 2,000 or more acres almost doubled from 1992 to 2002, and the percentage of farms with 100 to 999 acres decreased by an average of 25 percent between 1992 and 2002.²⁸

The United States Department of Agriculture (USDA) defines farm-dependent counties as those in which 20 percent or more of the personal income comes from farming. In 2004, Minnesota had 10 farm-dependent counties, compared with 29 farm-dependent counties in 1989.²⁹ Farm dependent counties are located in western Minnesota, along the South Dakota and North Dakota borders from Canada to Iowa. Although the number of farm-dependent counties has declined, farming continues to have a major economic impact in rural communities (Map 4).

Mining

In 2006, nearly 75 percent (2.9 million metric tons) of the country's iron ore was produced in Minnesota.³⁰ Most mining operations occur in the north and northeastern regions of the state (one county is classified as mining-dependent

²⁸ Economic Research Service of the U.S. Department of Agriculture.

²⁹ Ibid.

³⁰ Minnesota Department of Employment and Economic Development.

with more than 15 percent of the average annual labor income coming from mining).³¹

Manufacturing

Many of the counties previously classified as farm-dependent in southern Minnesota are now considered manufacturing dependent (meaning 25 percent or more of the average annual labor income comes from manufacturing). Twenty two of Minnesota's rural counties are manufacturing-dependent.³²

Tourism

Minnesota's 10,000-plus lakes attract scores of vacationers year-round. The USDA considers 14 counties, mainly in central, north central and northeastern Minnesota, to be non-metro recreation counties. This designation is derived by a number of factors, including the share of employment earnings in recreation-related industries in 1999, share of seasonal or occasional use housing units in 2000, and per capita receipts from motels and hotels in 1997. Many of the same counties are also retirement destination counties (counties in which the number of residents 60 and older grew by 15 percent or more between 1990 and 2000 due to in-migration)³³ (Map 4).

While agriculture, mining, forestry and manufacturing continue to be the significant sources of employment for rural Minnesota, some rural areas now rely more heavily on American Indian casinos and tourism adding to the growth and diversification of their economies. Between June 2005 and May 2006, travelers in Minnesota's rural counties spent more than \$5.9 billion (approximately half of all traveler expenditures statewide). Tourism supported approximately 145,300 full-time-equivalent jobs and created \$13.2 billion in resident income in rural Minnesota in the same period.³⁴

³¹ Economic Research Service of the U.S. Department of Agriculture.

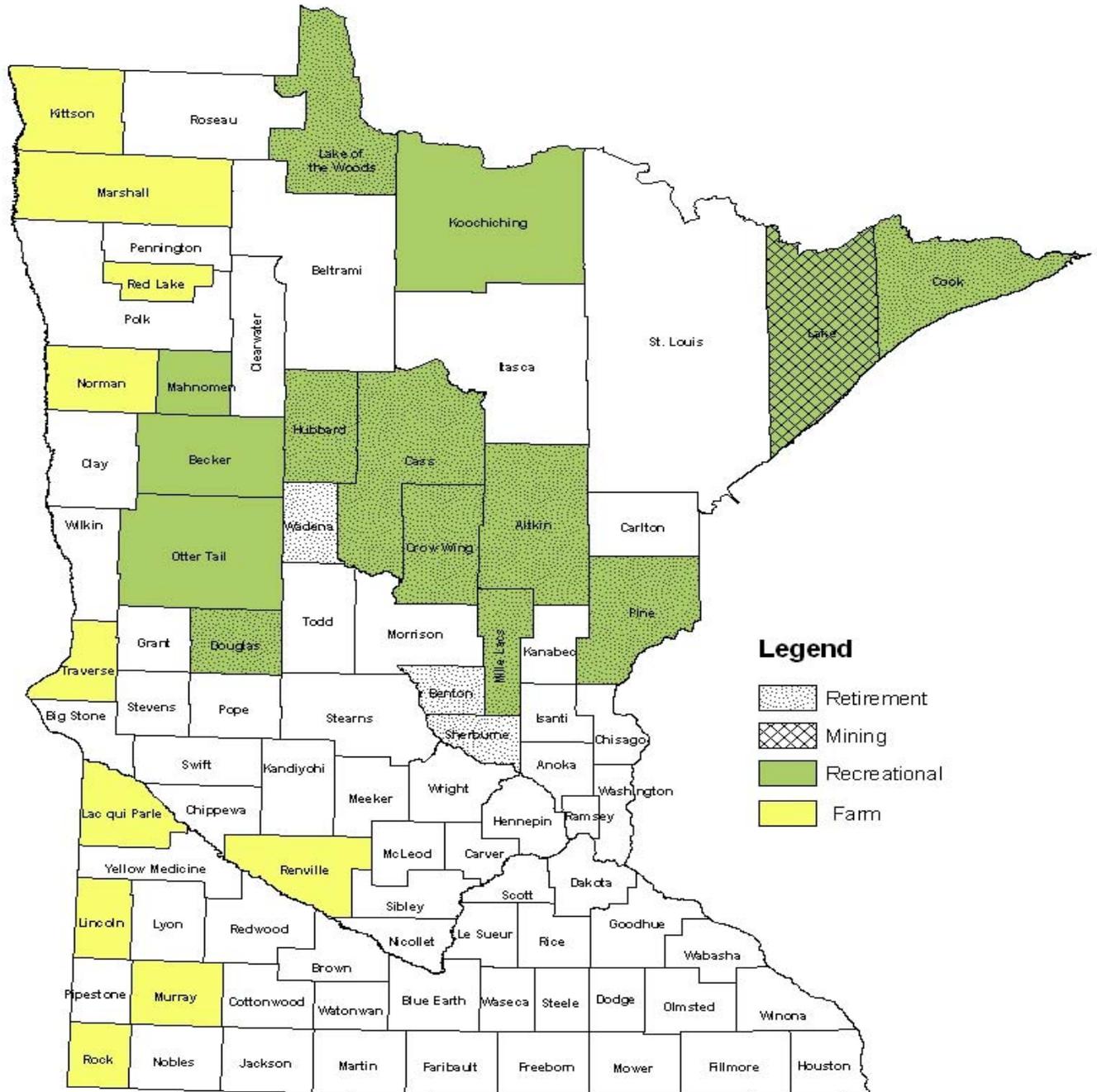
³² Ibid.

³³ Ibid.

³⁴ *The Economic Impact of Expenditures By Travelers (by Region) and The Profile of Travelers*, University of Minnesota Tourism Center, 2006.

Map 4

Farming & Mining Dependent Counties Recreation and Retirement Destination Counties Minnesota, 2008



Source: USDA, Economic Research Service

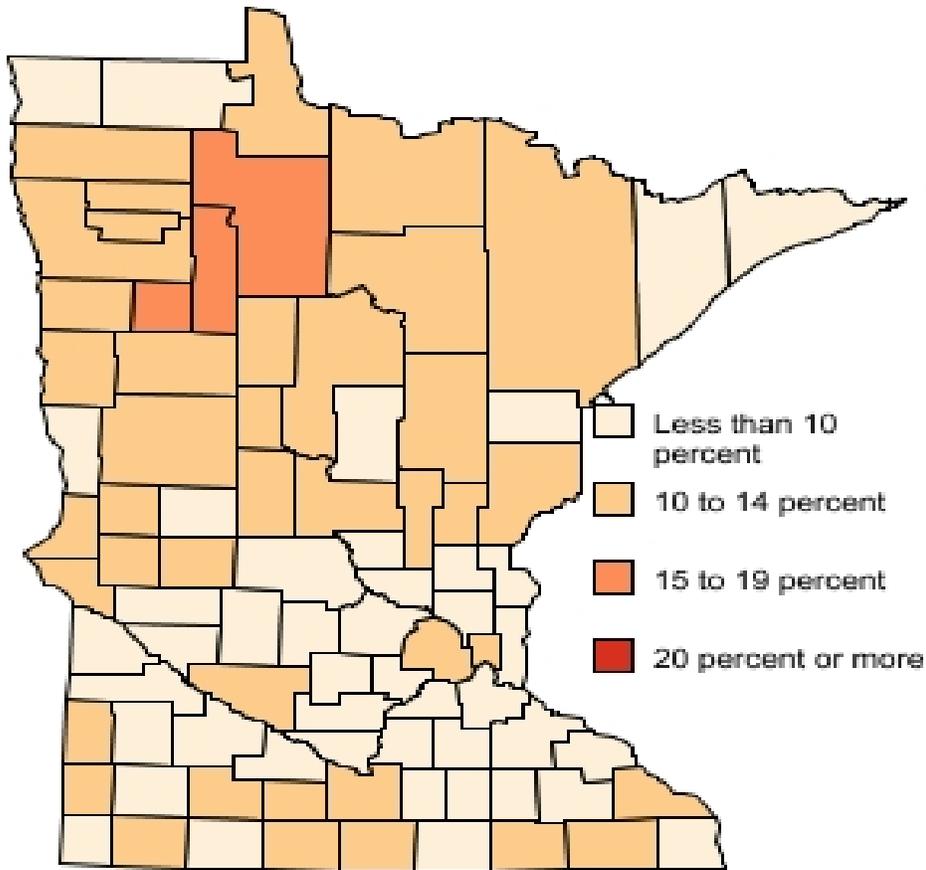
Poverty

According to the State Demographer's office, rural Minnesotans continue to earn less and have fewer opportunities for higher-wage careers than urban Minnesotans. Some of the more agricultural communities are also finding much of the original commercial trade leaving the area for larger cities.

The percentage of Minnesota's rural residents below the poverty line declined from 13.5 in 1989 to 9.7 in 1999; the estimated percentage for 2005 is up to 10.5.³⁵

Historically, Minnesota has had lower poverty levels than the nation as a whole. However, the state may be moving closer to the average. As of 2006, the national poverty rate was 13.3 percent. Minnesota ranked 44th in the nation with a poverty rate of 9.8 percent, almost 2 percent higher than in 2000. (In 2000, Minnesota ranked 49th, and had a poverty rate of 7.9 percent). However, the statewide median household income for all Minnesotans was \$48,451 in 2006, higher than the U.S. median of \$42,210.³⁶ (Map 5).

Map 5: Percent of Total Population in Poverty, 2005



³⁵ Economic Research Service, United States Department of Agriculture, July 2008.

³⁶ United States Census Bureau, 2006 American Community Survey.

While poverty among persons living in rural counties of Minnesota has historically been low, there is evidence of a gradual increase. In 2003, two rural counties had a poverty rate of 15 percent or higher; in 2005, one additional rural county's poverty rate rose above 15 percent. Similarly, the number of rural counties with a poverty rate of 10 to 14 percent rose from 14 in 2003 to 37 in 2005.³⁷ Households in these rural counties report median incomes that are well below the state and national median (See Map 5).

Per Capita Income

For several decades, per capita income trends in Minnesota have closely matched national trends, and Minnesota has long had the highest per capita income in the Midwest. However, since 2000, per capita income growth in Minnesota has been slightly lower than the U.S. average growth. In 2006, Minnesota's per capita income was \$38,859, with the exception of Olmstead County (which includes the community of Rochester, home of the Mayo Clinic). The income per capita in rural counties is \$29,306, well below the Minnesota average. Northwestern, western and central Minnesota had the lowest per capita incomes. From 2000 to 2006, southwestern Minnesota had the strongest growth (between 21 and 40 percent).³⁸

Unemployment

Minnesota's 2007 unemployment rate was 4.6 percent, matching the U.S. employment rate that year. In May 2007, the state's unemployment rate exceeded the national rate for the first time since 1976. Fifty-three counties (all rural) experienced unemployment rates greater than the state's average that year. The unemployment rate in 10 of those counties was higher than 7 percent, with Clearwater County climbing to 10.4 percent.³⁹

In May 2008, the state's unemployment rate jumped to 5.4 percent, its highest level since 1991, and a 12 percent increase over April 2008. The rate dropped to 5.3 percent, while the U.S. rate held steady at 5.5 percent in June 2008. Construction, manufacturing and trade, transportation and utilities have experienced significant losses over the last year. Six of the 10 non-metro Economic Development Regions had an unemployment rate that was higher than the state's average in May 2008, with the highest being in the Headwaters Region and east central region (both were at 6.9 percent).⁴⁰

Small Business

In 2006, 75 percent of businesses in Greater Minnesota had less than 10 employees.⁴¹ That same year, only 54.5 percent of business establishments located outside the Twin Cities offered health coverage. Only 34.9 percent of

³⁷ U.S. Census Bureau Small Area Income and Poverty Estimates.

³⁸ U.S. Census Bureau, Small Area Income and Poverty Estimates, 2005.

³⁹ Economic Research Service, USDA 2008.

⁴⁰ Minnesota Department of Employment and Economic Development.

⁴¹ Ibid.

employers with three to nine employees in Greater Minnesota offered coverage compared to 54.1 percent in the Twin Cities.⁴² Analysis of the employment characteristics of the uninsured in Minnesota show the largest percentage, 26.8 percent, are working for employers with less than 10 employees. Additionally, small employers are dropping coverage due to cost, or employees are declining coverage because it is no longer affordable.⁴³

Mortgage Foreclosures

From 2005 to 2007, one mortgage foreclosed for every 54 households in Minnesota. The highest rates of foreclosures (greater than 2 percent) in 2007 were in the rural counties surrounding the Twin Cities metro area. More than 20,400 mortgages foreclosed in Minnesota in 2007; approximately 6,900 (28 percent) were in rural Minnesota.⁴⁴

Homelessness

Every three years since 1991, Wilder Research has conducted a survey of persons experiencing homelessness in Minnesota. According to the 2006 survey, less than one-third (20 percent) of Minnesotans experiencing homelessness were living outside the Twin Cities. Homeless adults are similar across the state on many measures, including education levels, ages, how long they have been living in Minnesota and their main sources of income. On other measures, however, the picture in Greater Minnesota differs.

For example:

- 42 percent of children were in short-term, emergency arrangements (versus 26 percent in the metro area)
- 28 percent of men were veterans (versus 22 percent in the metro area)
- 61 percent had a chronic health condition (versus 54 percent in the metro area)
- 35 percent of women were escaping abuse (versus 30 percent in the metro area)⁴⁵.

Rural Hospitals

Although on average the financial performance of Minnesota's small rural hospitals has improved in recent years, many produce financial margins too low to provide or support the capital investment needed to update aging plants and keep pace with the changing technologies available to improve care.⁴⁶

⁴² Health Economics Program, Minnesota Department of Health

⁴³ *Health Insurance Coverage for Small Employers*, National Health Policy Forum – The George Washington University, 2005.

⁴⁴ *Foreclosures in Minnesota: A Report Based on County Sheriff's Sale Data*, HousingLink, April 2008.

⁴⁵ *Homelessness in rural Minnesota*, Wilder Research, 2006.

⁴⁶ *CAH Financial Indicators Report: Summary of Indicator Medians by State*. North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, 2006.

Half of rural Minnesota’s hospitals have attached nursing homes and significantly poorer financial performance than hospitals without nursing homes.

Thirteen rural hospitals closed between 1991 and 1999; four additional rural hospitals have closed since 2000 (Table 2).

Table 2

Closures of Rural Community Hospitals and Change in Licensed Beds, 1990-2007			
Hospital	Year Closed	County	Number of Beds
Fairview Milaca Hospital	1991	Mille Lacs	41
Greenbush Community Hospital	1991	Roseau	27
Heron Lake Municipal Hospital	1991	Jackson	16
Mountain Lake Community Hospital	1991	Cottonwood	24
Parkers Prairie District Hospital	1991	Otter Tail	21
Trimont Community Hospital	1991	Martin	24
Wells Hospital	1992	Faribault	28
Comfrey Hospital	1993	Brown	8
Pelican Valley Health Center	1993	Otter Tail	13
Lakefield Municipal Hospital	1994	Jackson	10
Karlstad Memorial Hospital	1995	Kittson	19
Community Memorial Hospital	1996	Fillmore	24
Harmony Community Hospital	1999	Fillmore	8
Arnold Memorial Health Care Cen	2002	Adrian	9
Zumbrota Health Care	2003	Goodhue	24
Minnewaska Regional Health Syst	2005	Pope	19
Divine Providence Health Center	2007	Lincoln	18
Total Rural Hospitals	16 hospitals		315 beds

Long Term Care

Nursing homes are in essence a rate-regulated industry in Minnesota, and Medicaid rates remain well below actual costs. This has been true historically and has been exacerbated in recent years by flat or falling rates due to state budget deficits and rising inflation, though assisted living or other alternatives

have proliferated. Many rural long term care facilities are at risk for closure, which threatens the safety net for an aging population.⁴⁷

The Economic Forecast for Rural Minnesota

In May 2007, the Minnesota Legislature approved the Next Generation Energy Act of 2007 directing the Minnesota Department of Commerce Office of Energy Security to manage a statewide transmission study of dispersed renewable generation potential. According to the first phase report on this study, there is great potential for wind farming in Greater Minnesota, especially in the northwest, west central and southwest areas.⁴⁸ According to the USDA-Economic Research Service, 65 percent of farm operator household incomes were from off-farm wages and salaries in 2007. If land-use for wind farming increases, the percentage of off-farm income will rise.

Minnesota's Department of Employment and Economic Development projects a mixed future for rural communities. In general, farming and mining industries are projected to do fairly well; the lumber and forest products industry is expected to fall. It is anticipated that Minnesota will closely follow the national trends and forecasts in rising energy prices, the over building of homes and rise in foreclosures, and the tightening of credit.

Overall, the number of employed Minnesotans is projected to increase through 2016. However, advances in technology will reduce or eliminate some positions, such as cashiering and manual warehouse inventory keeping—jobs that are proportionally more common in rural areas.

Long term, the average age of rural Minnesotans will continue to increase. By 2020, we will have more residents aged 65 or older than school-aged children. Also by 2020, migration will become the largest source of new workers in Minnesota.⁴⁹

Minnesota's Rural Health Care Workforce

A skilled rural health care workforce is necessary for both a healthy community and a strong local economy. An adequate supply of health care professionals is necessary to make care accessible. Clinics, hospitals and other health care employers, in turn, pump millions of dollars into local economies.

The Health Workforce Analysis Program

The Office of Rural Health and Primary Care (ORHPC) Health Workforce Analysis Program conducts surveys and analysis of a variety of health professions. The program has issued a number of reports on the status of the health professional workforce shortages including reports on physicians,

⁴⁷ Mapping The Future: Enhancing LTC for Older Minnesotans, 2005 to 2030. LarsonAllen.

⁴⁸ *Dispersed Renewable Generation Transmission Study, Volume I*. Minnesota Department of Commerce, June 2008.

⁴⁹ Minnesota Department of Employment and Economic Development, 2008.

nurses, dentists and pharmacists. Reports highlight the growing issues for rural Minnesota. Unless otherwise noted, information included in this section of the Rural Health Plan is derived from the data the Health Workforce Analysis Program staff gathered and analyzed. The most current report completed on each of the occupations surveyed is included in Appendix I.

One of every eight Minnesota private sector jobs is in health care.⁵⁰ The health care industry accounts for more than 20 percent of jobs in some rural counties. In all, more than 210,000 Minnesotans work in a wide variety of health care occupations. Physicians, nurses and dentists are the largest group, and perhaps most visible occupations, but health care centers employ a wide variety of occupations based in medicine, the biological sciences and health technology (Table 3).

Table 3

Selected Minnesota Health Occupations (2007)	
Number employed	Certification
490	Emergency Medical Technicians and Paramedics
580	Recreational Therapists
1,040	Diagnostic Medical Sonographers
1,920	Physical Therapists
3,680	Medical Records & Health Information Technicians
3,760	Dental Hygienists
4,400	Radiologic Technologists and Technicians
6,030	Pharmacy Technicians
6,450	Medical & Clinical Lab Technologists & Technicians

Number, Age and Gender

As the overall population ages, many professions face the challenge of replacing retiring workers. The workforce in some health care occupations is still relatively young, but a large share of the dentist, physician and nursing workforce is near retirement.

⁵⁰ U.S. Department of Commerce, *County Business Patterns, 2004*. Excludes railroad workers and self-employed.

Many health care occupations continue to be dominated by one gender. Most physicians and dentists are male, but female numbers are rapidly rising. Nursing and some allied health occupations continue to be mostly female. The rural health workforce is even more gender unbalanced than the rest of the state—there are fewer female physicians and dentists in rural areas, and very few male nurses in rural areas. (Table 4)

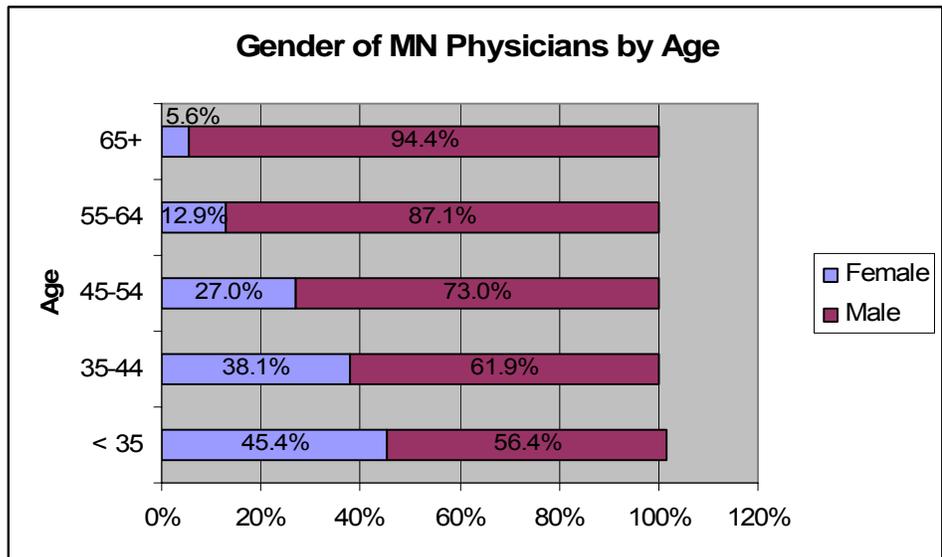
Table 4

Rural Minnesota Health Care Workforce*			
Profession (data year)	Number licensed	Median Age	% Female
Physicians (2007)	1,137	51	24
Physician Assistants (2007)	133	43	51
Registered Nurses (2006)	4,272	49	95
Licensed Practical Nurses (2006)	3,329	47	98
Dentists (2005)	230	53	12

*Numbers are estimates, based on ORHPC surveys

Physicians. Thirty-one percent of active physicians were 55 or older in 2007. The median age was 49. While the median age is similar across metropolitan and rural counties, rural physicians may be slightly older. (See Figure 2).

Figure 2

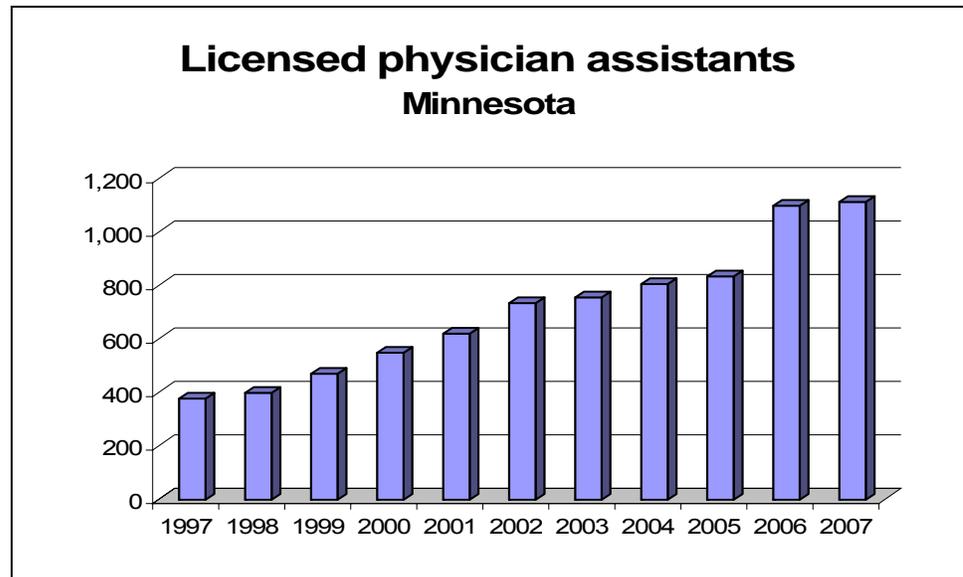


In 2007, 31 percent of Minnesota physicians were women, up from 21 percent a decade earlier. However, the overall gender percentages obscure a large difference between older and younger physicians. Only 18 percent of practicing physicians 55 or over are female, and 56 percent of physicians under 35 are female.

Women are a bit less likely than men to practice in rural areas. More than 76 percent of rural area physicians are male.

Physician Assistants. In July 2007, Minnesota had 1,111 licensed physician assistants, nearly three times the number of 10 years earlier, and a 34 percent increase in only two years. The number of licensed physicians increased only 27 percent from 1997 to 2007. As a result, the ratio of licensed physicians to physician assistants fell from 38 to 16.1 (Figure 3).

Figure 3



Some licensees are retired, not working as physician assistants, or living and practicing in other states. Based on survey responses and licensing data from the Minnesota Board of Medical Practice, the Office of Rural Health and Primary Care (ORHPC) estimates approximately 950 physician assistants were practicing at least part time at Minnesota practice sites in mid 2007. Using the July 1, 2007 population estimate for Minnesota, 950 physician assistants equate to 18 active physician assistants per 100,000 people. Based on data from about 2004, Minnesota ranked 33rd in the number of physician assistants per capita.

The statewide median age for physician assistants of 38 is younger than physicians, reflecting in part a shorter training period. The median age of rural physician assistants (PA) is 43. Thirty-five percent of metropolitan physicians were under 35 in 2005, compared to only 20 percent of rural PAs.

More than 60 percent of all physician assistants in Minnesota are women. Women especially predominate among younger ranks of physician assistants; 76 percent of physician assistants under age 35 are female. The gender of physician assistants does not differ much between urban and rural areas; 61 percent of rural physician assistants are women.

Nurses. As of June 2005, Minnesota had about 71,200 registered nurses (RNs) and more than 23,200 licensed practical nurses (LPNs). Although they take less time to train, the nursing workforce is older than the physician workforce. The statewide median age of registered nurses is 47. The median reaches 49 in rural counties. Twenty-nine percent of rural RNs were 55 or older in 2005. Only 14 percent were under 35.

The licensed practical nurse workforce is about the same age as the RN workforce. The median age in rural areas is 48, matching the statewide median. Twenty-eight percent of LPNs were 55 or older in 2005; 18 percent were under 35.

More than 93 percent of all registered nurses and 97 percent of all licensed practical nurses are female. Male nurses are even less common in rural areas than in more urban areas.

Respiratory care practitioners. In 2006, Minnesota had 1,596 registered respiratory care practitioners (RCP), an increase of 8 percent from 2005. The median age of respiratory care practitioners is 44. Micropolitan and rural RCPs are probably older than RCPs in metropolitan counties, but the small number of RCPs outside metropolitan counties makes the data less reliable. Statewide, 12 percent of RCPS were 55 or older in 2005.

More than six of 10 respiratory care practitioners are women. The gender mix differs only slightly between urban and rural areas. However, only several dozen RCPs practice in the state's most rural counties. Female domination of the field appears to be growing. Seventy-one percent of RCPs under age 35 are women.

Physical therapists. Based on survey responses, the Minnesota ORHPC estimates approximately 2,990 physical therapists were working at least part time in Minnesota in 2007.

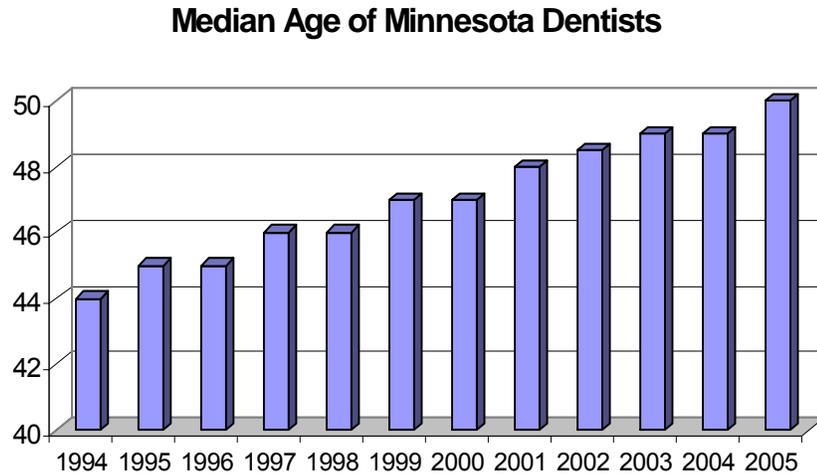
Physical therapists are relatively young, with a statewide median age of 42. Rural therapists are even younger, at a median age of 39. Only 9 percent of rural physical therapists were 55 or older in 2005, while 39 percent were under 35. This may reflect growth of the profession in rural areas after it became established in more urban areas.

More than three-quarters of practicing physical therapists are women. Male therapists are somewhat more common in rural counties, where only 68 percent are female. Women dominate the field at all age levels.

Dentists. In July 2005, more than 3,800 dentists were licensed to practice in Minnesota, but not all are practicing in Minnesota. Based on its annual survey of dentists, the ORHPC estimates that about 2,950 dentists were practicing at least part time in Minnesota in 2005.

There are fewer dentists in rural areas, and they are older and closer to retirement than their urban counterparts. The statewide median age was 49 in 2005. Rural dentists are even older, with a median age of 53. Thirty-eight percent of rural dentists were 55 or older, while less than one in four was under 45 (Figure 4).

Figure 4



The basic workforce concern is whether enough young dentists will enter the workforce to replace large numbers of retiring dentists, and whether enough of them will choose rural practices. From the point of view of dentists, it is also a question of whether dentists find rural practices economically viable. Many small communities are too small to support a full-time dentist.

Four of five dentists practicing in Minnesota are male. Eight out of nine rural dentists are male. Dentistry has lagged behind medicine in recruitment of women, but gender balance is improving. Forty-two percent of dentists under age 35 are female.

Dental assistants and hygienists. In January 2006, Minnesota had approximately 5,100 practicing dental assistants and 3,310 practicing dental hygienists. In rural Minnesota dental assistants had a median age of 35 and hygienists had a median age of 40.

Dental hygienists and assistants are the most female-dominated health care occupations in Minnesota. More than 99 percent of hygienists and assistants are women.

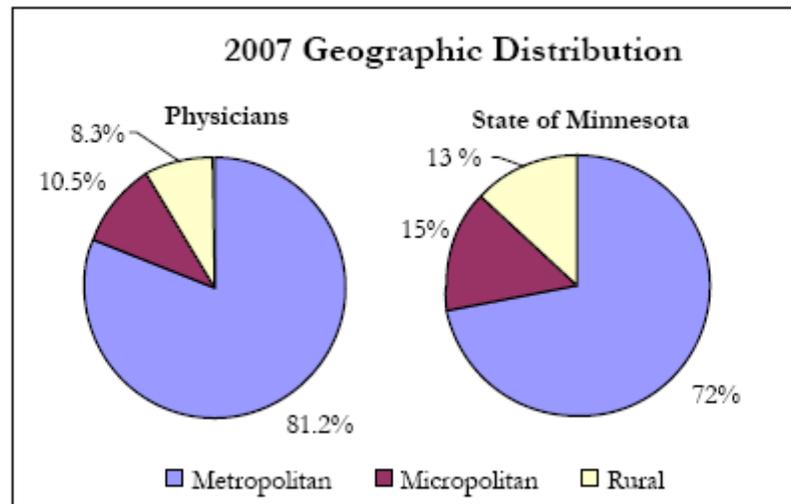
Geography

Physicians and other health care providers are disproportionately concentrated in urban centers with major hospitals and clinics. One measure of physician supply is the number of physicians per 100,000 population. ORHPC estimated

that about 13,700 physicians worked at least part time at a Minnesota practice site in 2007. This amounts to 262 physicians per 100,000 Minnesotans.

In 2007, only 8 percent of physicians in Minnesota practiced in a rural county. Eighty-two percent had primary practice sites in metropolitan counties, and 10 percent practiced in micropolitan counties (Figure 5).

Figure 5



Olmsted County has an unusually large number of physicians per 100,000 people, because it houses the Mayo Health System in Rochester, which serves many patients from beyond the immediate region. Olmsted County also has a high number of non-primary care specialists. Only 28 percent of Olmsted County physicians are in primary care specialties.

Hennepin and Ramsey counties are home to major medical facilities that serve patients from across the Twin Cities metropolitan region and the state. More than half of physicians in Hennepin and Ramsey counties are non-primary care specialists.

The largely rural northeast, north central, southwest and southeast regions actually have more primary care physicians per capita than the counties surrounding Minneapolis and St. Paul.

The northeast region is a special case. Physicians, especially specialists, in this region are heavily concentrated in Duluth. Duluth is a major medical center for the region. If St. Louis County is excluded, the number of primary care physicians in Carlton, Cook and Lake counties drops to 96 per 100,000 people, more in line with other rural regions of the state.

The most physician-poor region is the northwest, with only 67 primary care physicians per 100,000 people. This may partially reflect leakage of patients to clinics in Fargo and Grand Forks in North Dakota.

Primary Care and Specialists. The first concern in health care access is the availability of primary care physicians. Primary care physicians include family practitioners, internal medicine physicians, pediatricians, obstetricians and gynecologists. While primary care physicians are more specialized than the general practitioner, they remain the first point of physician contact for most people. Primary care physicians deal with the most common medical problems and are the first step before specialized care.

Forty-nine percent of physicians practicing at Minnesota sites claim a primary care discipline as their principle specialty. Eleven percent are surgical specialists and 40 percent practice in other specialties.

The good news for rural areas is that 78 percent of rural physicians practice in a primary care specialty. The bad news is rural areas have few specialists. An estimated 84 percent of surgical specialists practice in metropolitan counties. Only 4 percent practice in the state's 46 most rural counties. Ninety-one percent of non-surgical specialists practice in metropolitan counties. Only 2 percent practice in rural counties.

Primary care specialists account for only 44 percent of practitioners in metropolitan counties and 57 percent of practitioners in micropolitan counties.

The disparities are not surprising. Just as smaller communities are less likely to have specialized retail or other kinds of professional services, they are less likely to have large numbers of physicians, and may have few, if any, specialists.

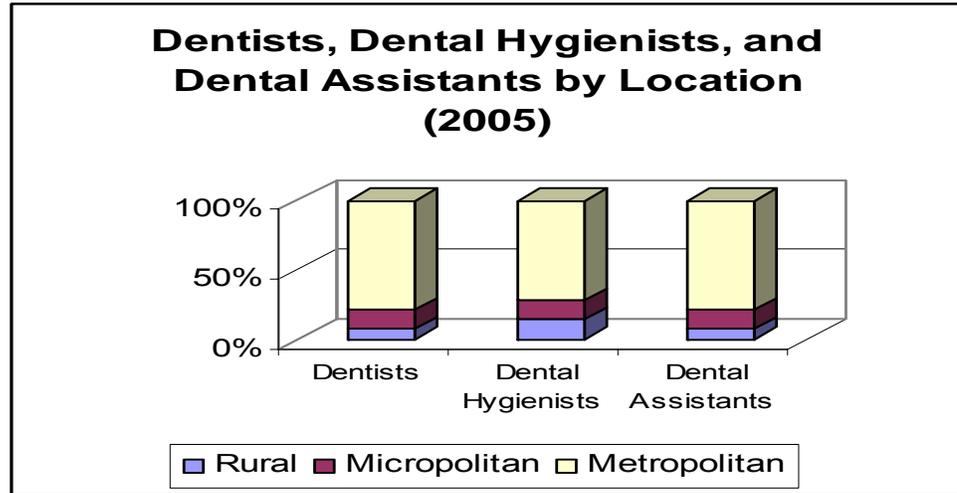
Physician assistants are distributed across the state in close proportion to population. Compared to physicians, physician assistants are more likely to practice in smaller cities and rural areas. The 46 most rural counties have 13 percent of the state's population and about 14 percent of the state's practicing physician assistants.

Small size does not alone put a community at risk, but distance from care does. The greatest distances between hospitals are in the northern half of the state. Lack of larger urban centers and remoteness combine most dramatically in large areas of northern Minnesota, but is also an issue in western Minnesota.

Dentists, Dental Hygienists and Dental Assistants. The geographical distribution of dentists is similar to that of physicians—more dentists per capita in urban areas and fewer in rural areas. In 2005, 78 percent of dentists had a primary practice site in one of the state's 20 metropolitan area counties. Only 8 percent practiced in the state's 46 rural counties.

Metropolitan area counties had nearly twice as many active dentists per capita as rural counties. Metropolitan areas had 64 dentists per 100,000 population and rural counties had 36. Micropolitan area counties, with 55 dentists per 100,000 population, were closer to the metropolitan standard (Figure 6).

Figure 6



Outside of Minneapolis-St. Paul, Rochester and Duluth, dentists are fairly evenly distributed across the state’s major regions. However, the metropolitan-micropolitan-rural analysis above suggests that in each of these regions, dental practices tend to be concentrated in more urban counties that are part of metropolitan and micropolitan areas.

The 46 most rural counties had only 9 percent of the state’s dentists. Approximately 30 percent of the state’s dental assistants and hygienists practice in rural locations.

The 2008 Minnesota Legislature passed legislation establishing a new oral health practitioner discipline, licensed by the Board of Dentistry and working under the supervision of a dentist. The legislation also created a work group to advise the Minnesota Department of Health commissioner on training and practice details for oral health practitioners. ORHPC convened and is hosting the work group and along with the Board of Dentistry will report the group’s recommendations to the Legislature in January 2009.

Aging Population

The state demographer projects that Minnesota will have nearly 78,000 more people over 85 in 2030 than in 2000. In part due to the aging population, the Association of American Medical Colleges recommends a 30 percent increase in medical school enrollments between 2006 and 2015 to alleviate an expected

physician shortage.⁵¹ Older adults suffer more chronic illnesses, use more prescription medicine, and have more difficulty with daily activities and mobility.⁵² Health workforce demands will vary by occupation, but may be especially strong for occupations such as licensed practical nurses, who often work in long term care settings.

The biggest demands for health care workers to meet the needs of an older population will be in suburban and lake-country Minnesota. This does not mean other rural areas don't have a supply problem. Rather, rural areas that already have trouble recruiting physicians and other health care professionals will be competing more than ever against suburban and other growth areas.

If an older population does, in fact, generate increased demand for health care, it can be assumed that wage levels will rise as health care provider organizations try to secure the labor they need. The question for rural areas is whether they will be able to compete in the market for labor.

Targeting resources to shortage areas

Medical technology has advanced significantly, but health care remains a labor-intensive industry. Physicians, dentists and other frontline health care professionals diagnose and treat people. Physicians or dentists can only see a limited number of patients a day. While provider numbers clearly matter, it is less clear how many are enough.

Several federal and state programs target funds to increase the number of practitioners in rural areas. Such programs require a standard for designating areas with shortages (Appendix A).

Health professional shortage areas. Thirty-seven percent of Minnesota's rural population live in a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA). Forty-six of the most rural counties have 13 percent of the state's population but only 5 percent of the state's practicing physicians. Parts of 30 Minnesota counties—mostly in the western and northern parts of the state—are designated as HPSAs. All or parts of 27 counties qualify as shortage areas based on low income.

Medically underserved areas. Parts of eight rural counties have populations designated as medically underserved. (Large areas of Minneapolis and St. Paul also have designated medically underserved populations).

⁵¹ Association of American Medical Colleges, *AAMC Statement on the Physician Workforce*, June 2006.

⁵² An overview of relationships between age and health care demand is found in *The Impact of the Aging Population on the Health Workforce in the United States*, pp. 10-13 (prepared by The Center for Health Workforce Studies, University of New York at Albany, for the Bureau of Health Professions, Health Resources and Services Administration, December 2005).

As with HPSA determinations, medically underserved areas are based on service areas comprising all or parts of one or more counties with population centers within 30 minutes travel time of each other. Service areas are scored based on percent of population below poverty, percent of population over 65, infant mortality rate and the per capita number of primary care physicians. Areas with qualifying composite scores are designated as medically underserved areas.

The lowest scoring (most underserved) service area in Minnesota is a lightly populated area in western Koochiching and northern Itasca counties.

Minnesota Strategies

Initiatives to meet rural health workforce challenges involve government, private industry and professional associations, and focus on two broad strategies: 1) attracting young people to health care careers and 2) encouraging health care professionals to work and stay in rural areas. A basic premise in these efforts is that young adults from rural areas, or students who have had positive rural experiences as part of their training, are most likely to take jobs in rural areas.

Recruitment of students to health care begins in high school or before. An alliance of health care employers, higher education institutions and government cosponsor a Minnesota Chapter of Health Occupations Students of America (HOSA). HOSA has more than 800 Minnesota student members. The Minnesota Department of Health, Minnesota Department of Education and the Minnesota Department of Employment and Economic Development promote health career education in secondary schools, and together with higher education and private industry sponsor an annual conference for secondary school health careers teachers. The Minnesota Department of Health also makes grants to local educational consortia to support health careers curricula. The grants are targeted to rural areas and long term care.

Minnesota's Area Health Education Centers (AHEC) support the University of Minnesota's Health Professions Schools by building on programs that place and support health profession students in rural clinical locations throughout the state. There are four regional AHECs in Minnesota.

The state also uses financial incentives to encourage health care professionals to begin their careers in rural or underserved areas. Loan repayment grant programs encourage primary care medical, mid-level practitioner and pharmacy students to practice in rural areas. State law defines rural to include all areas outside the seven-county Twin Cities area, with the exceptions of Duluth, Mankato, Moorhead, Rochester and St. Cloud.

A separate loan repayment program offers up to \$40,000 over two years to a wide range of medical, dental, mental health and social work professionals

who are practicing at sites in either a rural or urban health professional shortage area.

The state also offers loan repayment grants to nursing and dental students, but these programs are not restricted to rural areas. Grants are made to nursing students who commit to practice in nursing homes and Intermediate Care Facilities serving persons with Mental Retardation or a Related Condition (ICF/MRs). Dentists must agree to serve state public program enrollees or patients receiving sliding fee discounts.

The University of Minnesota Medical School and Dental School both promote rural practice. The University admits 55 students each year to its Duluth program. Students study two years in Duluth before transferring to the Twin Cities to complete their M.D. More than half of graduates who enter through the Duluth program enter family practice residencies.

The School of Dentistry rotates students through a two-week practicum at a clinic in Hibbing, which cares for mostly underserved families from northeastern Minnesota. The clinic is a joint venture of the University and Hibbing Community College. The University is considering opening a similar clinic in Willmar.

The University's College of Pharmacy opened a Duluth program in 2003, with a special emphasis on pharmacy practice in non-metropolitan areas. This year, first-year Duluth pharmacy students joined Duluth medical students in a 20-hour primary care medicine course in Grand Rapids and surrounding rural communities.

Many colleges in Minnesota train nurses, clinical laboratory professionals and other health care workers. Health care workforce issues are the focus of the Minnesota Healthcare Education-Industry Partnership (HEIP), a collaboration of Minnesota State Colleges and Universities, the health care industry and government. An HEIP taskforce worked on initiatives to increase the supply of clinical laboratory workers and established a Career and Technical Education Teacher Induction Program to support first-year secondary health careers teachers.

The Minnesota Dental Association (MDA) has made a strong push to promote rural dental practice over the past two years. MDA is concerned about the large number of rural dentists nearing retirement age, and the ability of small communities to find replacements. MDA encourages communities to create local task forces to promote themselves to prospective dentists and other health care professionals. The association emphasizes the economic contribution that a dental practice makes to a community. A solo-dentist practice typically employs two dental assistants, a dental hygienist and a receptionist. The chair of MDA's rural dentistry task forces estimates that a dentist needs 1,800 to 2,000 patients to be economically viable.

Other programs indirectly address rural health workforce needs by strengthening rural hospitals and clinics, possibly making them more attractive practice sites for physicians and other health professionals. These include grants to small hospitals and clinics for planning, quality improvement projects, and improved infrastructure and equipment.

Some communities have recruited foreign health care professionals to meet shortages. Nationally, only 41 percent of family medicine and 56 percent of internal medicine residency positions were filled by U.S.-educated physicians in 2006.⁵³ Non-citizens study under J-1 visas, but require a waiver to stay in the United States and work. Each state was originally allotted 20 waivers; allocations were raised to 30 in 2002. Physicians with waivers must work three years in a shortage or underserved area. Minnesota placed 22 waived physicians in federal fiscal year 2008. Of those, four are primary care physicians; the rest are specialists. More J-1 physicians have been placed in the northwest and southwest regions of Minnesota than in other parts of the state.

Workforce Planning Issues

Size and remoteness matter. Smaller markets mean fewer providers. Remoteness of providers creates access—and potentially—health outcome issues for rural citizens.

Rural-based physicians, dentists and other health care providers practice in locales that may be characterized by lower earning opportunities, financially vulnerable health care organizations, long distances to specialists or tertiary hospitals, limited access to advanced technologies and a lack of collegial support. For all these reasons, the smallest communities in the most remote locations have trouble attracting the health care providers they need.

The best health care is expensive. Health care delivery will change, in part to stay affordable. Health care organizations will use different occupational mixes and entirely new occupations to increase quality and control costs. Past examples of change include the emergence of physician assistants, nurse anesthetists and minute clinics. Health care workforce will continue to be a vital issue for rural residents, health care employers and their communities. Rural citizens need enough practitioners to receive timely, quality care. Hospitals and clinics need to be able to hire enough employees at salary levels they can afford. Rural communities will always compete in a larger market for workers. Industry, communities and government will have to work together to ensure access to health care across rural Minnesota.

⁵³ National Resident Matching Program, “Advanced Data Tables for 2006 Main Residency Match,” March 16, 2006, retrieved from www.nrmp.org.

Future Prospects

A Minnesota Department of Economic Security (now the Minnesota Department of Employment and Economic Development) report on the job outlook for 2000-2010 states, “demand for health care is anticipated to continue to grow as the population ages, and this will lead to increased demand for occupations such as registered nurses, pharmacy technicians, home health aides, and social and human service assistants.” How Minnesota will increase the supply of health care professionals to meet projected demand is likely to require additional, cooperative efforts that involve academia, ORHPC, health care advocates and local communities.

Examination of health care workforce shortage issues in rural Minnesota is provided in a series of ORHPC workforce profiles with examples included in Appendix D. The profiles focus on supply and demand issues as well as the distribution of the following health care occupations: physicians, nurses, pharmacy, dental and laboratory technicians. They provide current information about the professional activities, work hours, practice locations and specialties, educational background, job tenure, age, and gender of the various health care practitioners. Overall, the aging of the health care workforce and the decreasing number of graduates from Minnesota’s health professional programs creates a shortage of health care practitioners, which could become more acute and widespread in the future unless efforts to increase the supply of health practitioners are expanded. Proposals from the workforce profiles include the need to:

- Increase the capacity and funding of Minnesota’s medical, dental, pharmacy and other health professional programs to increase the supply of health professionals
- Create and enhance financial incentives, such as loan repayment and scholarships, to encourage students to pursue health professional degrees and practice in Minnesota working in regions with the greatest needs
- Support federal legislation to further subsidize medical, nursing, dental, pharmacy and other health professional schools.

Access to Health Care Services

The primary barriers to health care services in Minnesota can be categorized as geographic and socioeconomic. Driving distances, extreme weather and lack of transportation services create geographic barriers for rural Minnesotans in need of health care services. Health services along with health practitioners are disproportionately concentrated in urban areas of Minnesota. A shortage of health professionals and services increases the odds that rural residents will be forced to go greater distances in search of health care.

Reduced access to health care services has adverse effects on the health status of rural communities. We know nationally that rural populations are behind in

meeting Healthy People 2010 objectives. National studies also show that rural residents are somewhat more likely than urban residents to use hospital services including emergency room visits and overnight hospital stays.⁵⁴ Access to a source of care is a major factor keeping rural residents from enjoying preventative health care services.

Health Disparities Among Populations of Color

National research shows that persons of color are disproportionately affected by the lack of access to health care services and receive lower quality health care compared to Whites.

Age-adjusted death rates from 1996 through 2000 indicated considerable disparities in cancer, heart disease and HIV/AIDS for African Americans living in Minnesota.⁵⁵ As of 2007, the Minnesota Department of Health's Office of Minority and Multicultural Health reports that mortality rates for African Americans due to AIDS/HIV, diabetes, homicide, perinatal conditions and SIDS are more than twice the rates for Whites. For American Indians, age-adjusted mortality rates for cirrhosis, diabetes, homicide, nephritis, septicemia, suicide and unintentional injuries are more than twice the rate of Whites.⁵⁶

The cardiovascular disease death rate has improved for populations of color in Minnesota. Death rates from 1990 through 1998 were 33 percent higher than the state population and 44 percent higher than the total American Indian population.⁵⁷ The 2000-04 data indicate the disparity that existed between American Indians and Whites decreased from 57.6 to 34.0, and currently there is only a slight disparity in heart disease death rates between African Americans and Whites. While there were no disparities for heart disease deaths for Asians and Latinos in 1995-99, the death rates for 2000-04 have improved.

There have been improvements in diabetes death rates and decreases in disparities for African Americans and American Indians. Data from 1995-99 and 2000-04 show the death rate for Latinos remained virtually the same over the two time periods. The Asian diabetes death rate increased slightly but remains lower than the White rate of 22.3.⁵⁸

⁵⁴ *Urban and Rural Health - Health Care Services Use Differs*, Center for an Aging Society, Georgetown University, No. 7, Jan. 2003, p 5.

⁵⁵ Minnesota Department of Health Center for Health Statistics, *Populations of Color in Minnesota Health Status Report – Update Summary*, Fall 2002, p. 7.

⁵⁶ Minnesota Department of Health Center for Health Statistics, *Populations of Color in Minnesota Health Status Report – Update Summary 2007*.

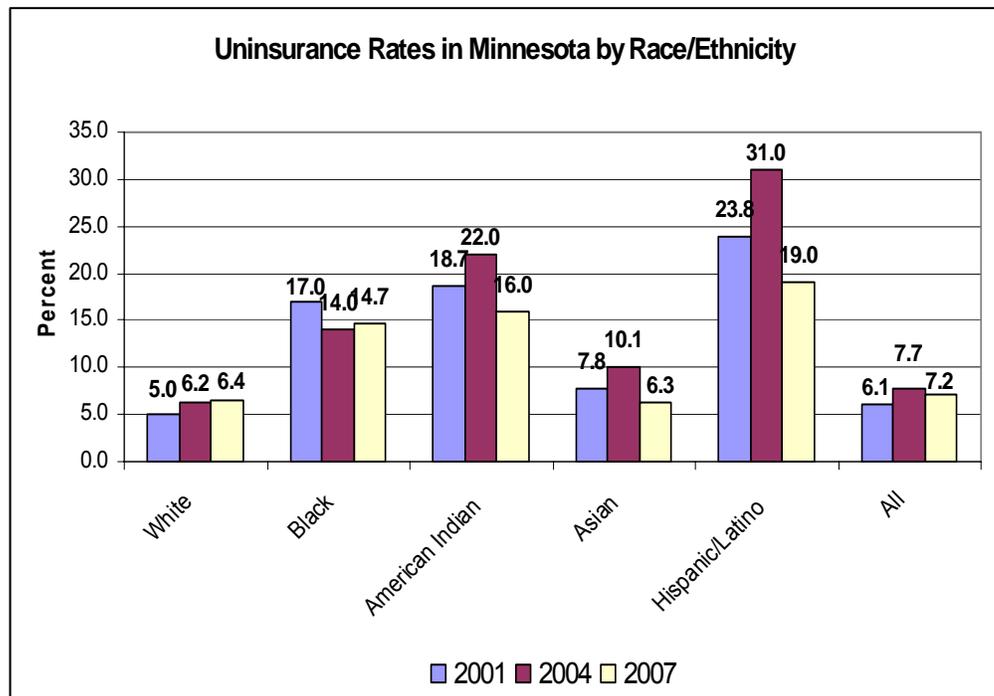
⁵⁷ Office of Minority and Multicultural Health (OMMH), *Eliminating Health Disparities: Cardiovascular Disease*, March 2001.

⁵⁸ Office of Minority and Multicultural Health, *Eliminating Health Disparities Initiative - 2007 Legislative Report*.

Analysis of uninsured rates indicates disparities also exist across racial and ethnic groups in Minnesota. The Health Economics Program of the Minnesota Department of Health conducted three health access surveys that reveal that all racial and ethnic groups except Asians experienced significantly higher rates of uninsurance compared to Whites in 2001, 2004 and 2007. In 2007, Hispanic/Latinos were up to three times as likely as White Minnesotans to be uninsured (19 percent compared to 6.4 percent). In addition, rates of uninsurance for Black Minnesotans (14.7 percent) and American Indians (16.0 percent) were also disproportionately high (See Figure 7).

The Health Economics Program also found that African Americans and American Indians were more likely to report having health insurance through public health insurance programs compared to Whites who more frequently reported having group insurance through their own family or family member’s employer.⁵⁹

Figure 7



Regional survey data indicate that Greater Minnesota’s racial and ethnic groups are experiencing similar obstacles to adequate health care services. For example, a 2002 regional health behavior survey of 10,500 residents in 27 counties in south central and southwestern Minnesota revealed that respondents of Hispanic/Latino origin are more likely to be without health insurance coverage (30.6 percent) compared to only 7 percent of all

⁵⁹ Minnesota Department of Health Center for Health Statistics, *Populations of Color in Minnesota Health Status Report – Update Summary*, Fall 2002, p. 14.

respondents reporting no health insurance coverage.⁶⁰ Another survey of adult residents in a nine-county region of northeastern Minnesota and northwestern Wisconsin asked respondents to list reasons for failure to receive needed medical care. Among residents of the nine counties in Minnesota who did not get necessary medical care, 38.3 percent of non-Caucasians said “insurance did not cover it,” compared to only 24.8 percent of all northeast Minnesotans who responded with the same reason.⁶¹ The second most frequent reason among non-Caucasian respondents was the medical care “cost too much” (22.8 percent), compared to 23.2 percent of all respondents who provided the same reason.⁶² Interestingly, 10.1 percent of non-Caucasian respondents cited “not being treated with respect” as a cause for failure to receive medical care, making it the third most frequent reason given. This is very different from all respondents, 10.4 percent of whom cited the medical need was “not serious enough” as the third most frequent reason for not seeking care.

Access to Mental Health and Behavioral Health Care

Physician workforce statistics show that 83 percent of psychiatrists in Minnesota practice primarily in urban areas (seven-county metro, Olmsted, Stearns and St. Louis counties).⁶³ Analysis of Minnesota’s rural hospitals reveals that only 20 (18 percent) have outpatient psychiatric services delivered onsite directly by hospital staff. In rural Minnesota, treatment for mental health problems is often unavailable and falls to an already strained primary health clinic system. The demand for inpatient psychiatric beds in rural Minnesota increased 37 percent versus 24 percent at urban sites from 1998 to 2002, driven partly by the unavailability of beds in the Twin Cities.⁶⁴

A persistent issue for rural primary care providers is the absence of emergency mental health services. An ORHPC survey of rural primary care clinics conducted in 2004 revealed more than half of the providers (56 percent) said emergency mental/behavioral health services are not available within the community.⁶⁵ Where emergency mental health services are unavailable, providers said most patients are transferred outside the community, most frequently to a hospital with inpatient treatment and available space.

In 2005, under the guidance of Minnesota’s Rural Health Advisory Committee, ORHPC formed a rural mental health work group to study the delivery of mental health care in rural primary care settings. The result was a

⁶⁰ *Regional Health Profile '02*.

⁶¹ *Bridge to Health Survey 2000*. Northeast Minnesota counties include Aikin, Carlton, Cook, Itasca, Kanabec, Koochiching, Lake, Pine and St. Louis.

⁶² *Ibid.*

⁶³ *Minnesota Mental Health and Chemical Dependency Treatment Utilization Trends 1998-2002*, Issue Brief 2004-07, MDH Health Economics Program.

⁶⁴ *Ibid.*

⁶⁵ *Rural Health Advisory Committee’s Report on Mental Health and Primary Care*, January 2005, Minnesota Office of Rural Health & Primary Care.

report entitled, *Mental Health and Primary Care in Rural Minnesota*, which identified the issues surrounding mental health care delivery and highlighted successful models of integrated primary care and mental health services in rural Minnesota (Appendix D). Some of the key findings from the report included:

- Shortages of rural mental health providers result in long waits for appointments and long travel to obtain specialty care.
- The cost of mental health care and the complexity of the payment system are barriers for patients seeking care.
- A stigma about mental/behavioral health is a barrier to care, especially in rural areas.
- Rural primary care practitioners would like more education on managing mental/behavioral health.

From these findings, efforts for improving mental health care delivery through the rural primary care system depend on a number of factors including:

- Availability of a trained professional workforce in primary and mental health care
- Adequate funding so health systems are able to provide needed mental health services
- Effective state and federal policies that support mental health care.

The report proposes a series of recommendations addressing three broad areas: 1) the need for a competent and qualified workforce; 2) up-to-date education for primary providers and policy; and 3) funding streams that support the complexity of care in rural communities. Some of the specific recommendations include:

- Enhance and promote mental/behavioral health education and training for all primary practice students.
- Promote and support demonstration projects and models of collaborative care between mental health providers and primary care providers.
- Support efforts to expand public program coverage of telehealth consultations by mental health professionals.
- Promote and develop rural site experiences for primary care and mental health practitioners that emphasize collaborative practice within the primary care setting.

The Mental Health and Primary Care in Rural Minnesota report continues to be a resource for improving mental health service delivery through the rural primary care system.

Mental health care as well as the continued difficulty finding beds for inpatient mental health needs remains a problem in rural areas. New concerns regarding local emergency medical services (EMS) and mental health

transports, and the mental health needs of veterans returning from the wars in Afghanistan and Iraq, are leading the discussions occurring in many rural Minnesota communities.

Rural Ambulance Services

Emergency ambulance personnel are an important segment of the rural health care workforce. In 2002, the ORHPC and Rural Health Advisory Committee issued *A Quiet Crisis: Minnesota's Rural Ambulance Services at Risk*. The report is based on a survey of ambulance services throughout Minnesota and provides information about Minnesota's ambulance personnel.

Minnesota's rural ambulance system relies heavily on volunteers. According to the report, "the proportion of ambulance volunteers is highest in areas where the resident population in the primary service area (PSA) is less than 15,000."⁶⁶ The southwest and south central regions of Minnesota have the highest percentage of volunteer ambulance personnel (91.0 and 91.9 percent respectively). Compared to urban staff, rural ambulance personnel are most likely to be older (45 percent are 40+ years compared to 34 percent of urban staff), unpaid (77 percent of rural staff are volunteer), and female (41 versus 20 percent of urban staff). These characteristics and a shrinking younger population have rural communities concerned about the retention and recruitment of EMS personnel.

As of 2008, Minnesota EMS delivery system is still a "patchwork quilt facing many challenges."⁶⁷ The challenges include:

- Statewide consistency on training availability
- Inadequate reimbursement from third-party insurers
- Communications dollars and
- Local government support.

The greatest challenge for rural ambulance services, according to the Minnesota Ambulance Association, continues to be the dependence on volunteer ambulance crews. The aging demographics of Minnesota's rural population mean fewer people are able to meet the demands of serving on ambulance crews, reducing the pool of potential volunteers. Combined with other existing challenges, this creates a situation where one to two rural ambulance services per year are going out of business.⁶⁸

Some recommendations for improving the financial and workforce status of rural ambulance services include:

⁶⁶ *A Quiet Crisis: Minnesota's Rural Ambulance Services at Risk*, Minnesota Department of Health-Office of Rural Health and Primary Care, December 2002.

⁶⁷ *Overview of Emergency Medical Services for Minnesota Elected Official*, Minnesota Ambulance Association, July 2008.

⁶⁸ *Ibid*

- **Strengthen and stabilize volunteer ambulance retention incentives** – this includes maintaining the current Emergency Medical Services Regulatory Board (EMSRB) longevity program along with increasing the amount to \$1,000 dollars per year of volunteer service, and dedicating a funding source for the program to reach the goal of \$1,000 per year of service.
- **Strengthen involvement of medical directors in ambulance service operations** – develop incentives for medical directors to participate in available national and state training opportunities and create additional training opportunities that better meet the needs of rural medical directors.
- **Support federal legislation** – to improve reimbursement and provide other supports to rural ambulance services.

More information about the state of Minnesota’s rural ambulance services and recommendations to improve their financial and workforce status is provided in *A Quiet Crisis* and can be accessed on the ORHPC Web site at <http://www.health.state.mn.us/divs/orhpc/pubs/ambulancerpt.pdf> (PDF:138pgs/1MB).

In 2007, the Minnesota Emergency Medical Services Regulatory Board formed a work group to assess the challenges and factors associated with transporting patients with behavioral or psychiatric disorders. Data the work group gathered and assessed indicated that 4 percent of all 911 emergency calls and 8.6 percent of all interfacility/medical transports in 2006 were behavioral/psychiatric disorder calls. The data also demonstrated that behavioral transports average 51 percent longer (in minutes) than other transports.⁶⁹

The work group issued several recommendations in their report. The report, including promising practices and background information on the availability of and access to psychiatric and behavioral health services, can be found online at:

http://www.emsrb.state.mn.us/docs/EMS_Behavioral_Health_Report.pdf (PDF:55pgs/17MB) (Appendix J).

Transportation

Lack of public or assistive transportation services in rural areas often compound the health need. In surveys, focus groups, and other forums, the lack of transportation is often cited as one of the primary barriers to accessing health care in rural areas. It was also cited as a major burden to health care access, especially in very rural areas and for the elderly population, during a

⁶⁹ *EMS Behavioral Health Report: An Examination of the Challenges of Transporting Behavioral health Patients in Minnesota and Recommendations for Improvement*, Minnesota Emergency Medical Services Regulatory Board, November 2007.

2007 Minnesota Rural Health Conference forum. Transportation has become one the Minnesota Rural Health Association's primary concerns.⁷⁰

Uninsured

The most common socioeconomic barriers to care are cost or lack of health insurance, high unemployment and persistent poverty. Historically, uninsurance rates in Minnesota have been lower than the national average. Rates of uninsured in Minnesota rose significantly between 2001 and 2004 from 6.1 percent to 7.7 percent. The recent rise in uninsurance rates in Minnesota is being attributed to a combination of factors, including insurance costs, economic downturn, erosion of employer-provided coverage and public program cutbacks. As of 2007, the uninsured rate remained stable at 7.2 percent in Minnesota.

The same cannot be said for residents of Greater Minnesota. Regional comparisons of uninsurance rates indicate that residents of non-metropolitan areas are more likely to be uninsured (Map 6). From 2004 to 2007, uninsurance rates continued to climb for residents of Greater Minnesota from 7.6 percent to 7.9 percent, while rates for residents of the metropolitan Twin Cities fell from 7.8 percent to 6.6 percent (Figure 8). Rural economic conditions and the prohibitive cost of purchasing coverage individually or as a small business add to high rates of uninsurance. Sometimes other factors, such as the presence of an American Indian reservation where residents receive health care services through the Indian Health Service, can create artificially high uninsurance rates (e.g., Mahnommen County). A county with a large minority or immigrant population also will influence uninsurance rates since these populations are more likely to be without any form of health insurance.⁷¹

⁷⁰ *Rural Minnesota Forum on Health Care Reform*, Center for Rural Policy and Development, September 2007.

⁷¹ *Populations of Color in Minnesota, Health Status Report*. Minnesota Center for Health Statistics, Spring 2007.

Map 6

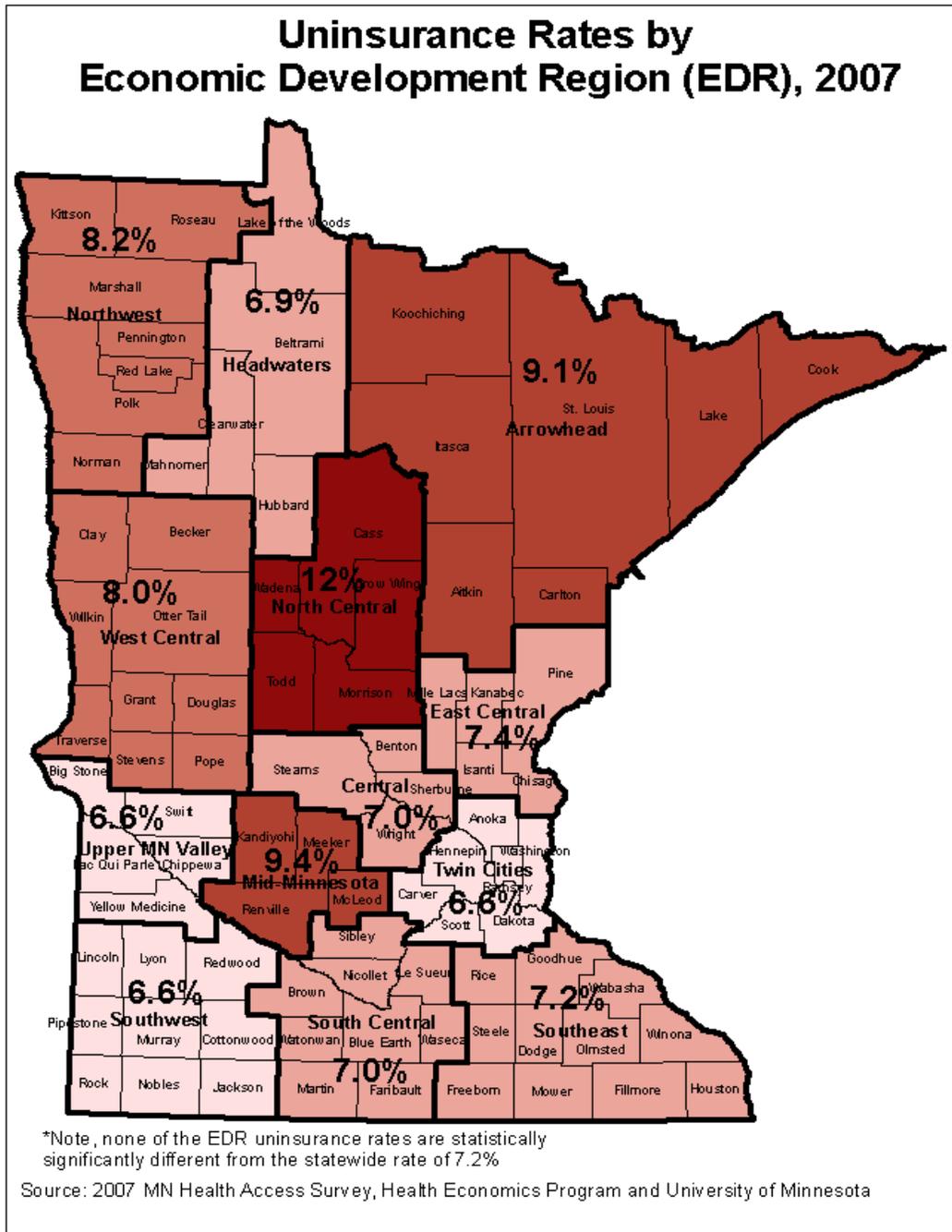
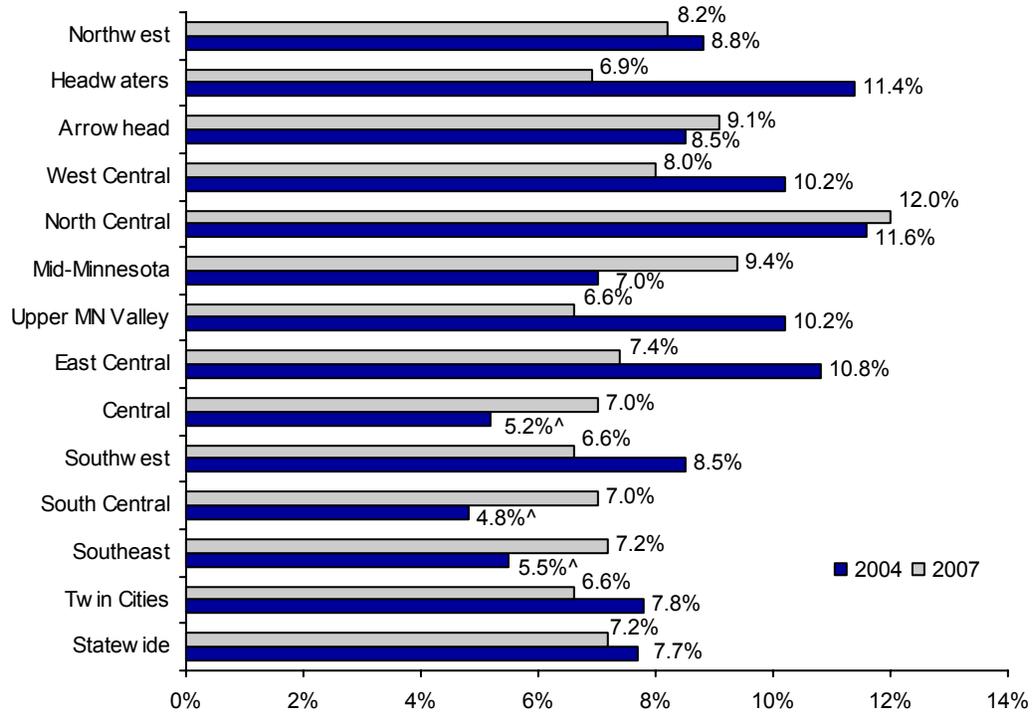


Figure 8

Uninsurance Rates by Economic Development Region, 2004 and 2007



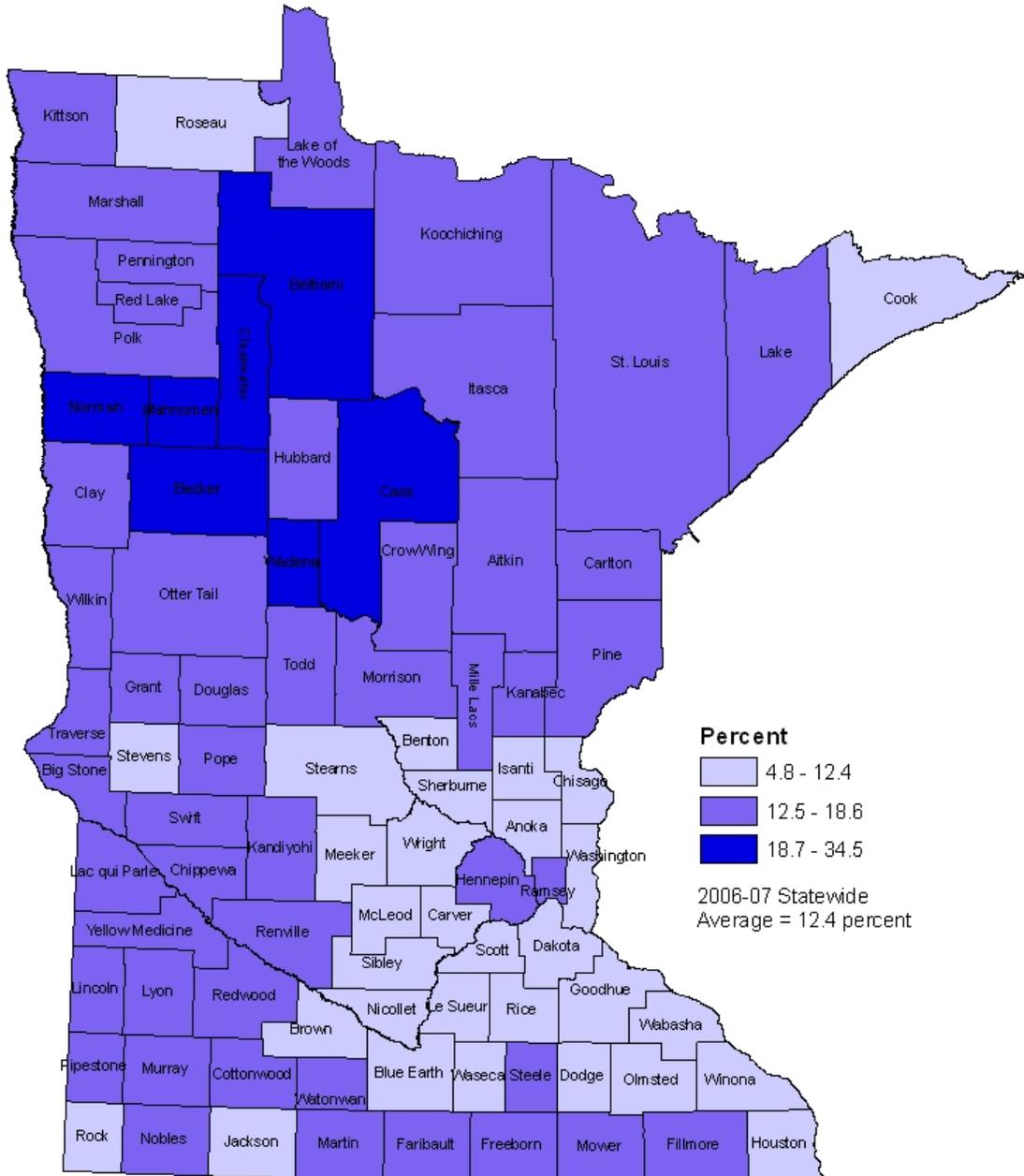
Source: Minnesota Health Access Surveys, 2004 and 2007

Uninsurance rates do not convey the entire picture about the lack of access to health care services. Many rural residents may have some health insurance, but face significant cost sharing or limits on benefits. An increasing number of working individuals with low incomes must either pay higher insurance premiums to maintain their employer-based insurance or purchase non-group health insurance, which come with very high deductibles and premiums. According to the Kaiser Family Foundation, 63 percent of the self-insured plans offered to applicants have benefit restrictions or additional cost sharing.⁷² In particular, coverage for maternity benefits, mental health care, and prescription medications tend to be limited, especially in comparison to what is typically offered under group health plans. Enrollment in income-based public programs, such as Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare, is another indicator that standard opportunities to obtain health care, such as employment, are unavailable. Counties like Becker, Beltrami, Cass, Clearwater, Mahnomon and Wadena have higher than average participation in Minnesota’s publicly funded health care programs (Map 7). This reaffirms that rural residents are less likely to have the usual access to private health insurance.

⁷² *Underinsured in America: Is Health Coverage Adequate?* Kaiser Commission on Medicaid and the Uninsured, July 2002.

Map 7

County Comparison of Monthly Average Enrollment in Public Health Insurance Programs* Minnesota - 2006-2007



*Public Health Insurance Programs include: Medical Assistance (MA), General Assistance Medical Care (GA), and MinnesotaCare.

Source: MDH Health Economics Program

Affordability and lack of health insurance were concerns frequently mentioned at all the ORHPC 2008 Community Rural Health Forums. This is not surprising since rural residents of Minnesota have lower average incomes and higher poverty rates compared to urban residents. Given the absence of universal coverage, the responsibility of providing essential health services to the most disadvantaged and vulnerable populations often falls to Minnesota's Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

According to the Minnesota Association of Community Health Centers (MNACHC), FQHCs provided care to over 68,000 (41 percent of their total patients) uninsured Minnesotans in 2005. Additionally, 81 percent had household incomes under 200 percent of the federal poverty level and 35 percent of patients were enrolled in a public health care program (MinnesotaCare, GAMC, Medicaid or Medicare). Reimbursements for care under these programs are more beneficial than no payment at all; however, they are still less than the cost of care provided. The rising percentage of uninsured and underinsured in Minnesota has increased uncompensated care costs that have been compounded by smaller percentages of insured patients. The MNACHC reports that the cost of serving the uninsured for member clinics has increased drastically. From 2002 to 2004, the costs increased 24 percent from \$14.8 million to \$18.4 million. In 2006, one urban and one rural FQHC satellite closed due to financial hardships related to uncompensated care costs and rising numbers of uninsured patients.

Underinsured

Though the majority of Minnesotans have medical and dental insurance, rising premiums and deductibles are contributing to the growing number of people with inadequate health coverage. Rural Minnesotans who are insured are more likely to have self-purchased insurance policies rather than employer-sponsored policies. Often individually-purchased policies include high premiums, deductibles and copayments.

In recent years, health insurance benefit sets that require higher enrollee cost sharing have become more common. In addition to the emergence of high-deductible "consumer-driven" health insurance products, enrollee cost sharing has risen in more traditional products as well. Enrollee out-of-pocket spending represented 14 percent of total spending per Minnesota enrollee in 2006, compared to 10 percent in 2000.⁷³ Minnesota farm families responding to a survey regarding health insurance have noted that their deductibles are so high they don't actually benefit from having insurance.⁷⁴

⁷³ *Health Insurance Premiums and Cost Drivers in Minnesota, 2006*. Minnesota Department of Health, Health Economics Program, October 2007.

⁷⁴ *How Farmers and Ranchers Get Health Insurance and What They Spend for Health Care*, The Access Project, December 2007.

Health Care Reform: Addressing the Needs of Rural Minnesotans

Health care reform emerged from the 2007 Minnesota Legislature as a priority issue (Appendix K). During the legislative interim, study, analysis and recommendations were developed in multiple forums for consideration during the 2008 legislative session. The Minnesota Rural Health Advisory Committee (RHAC) established a Rural Health Reform Work Group to offer a rural voice to the health reform discussions. This work group identified the unique features of rural Minnesota that should be taken into consideration in developing state-level health care reform proposals.

Results of the work group were compiled and a report entitled, *Health Care Reform: Addressing the Needs of Rural Minnesotans* (Appendix G) was published and shared with the Governor's Health Care Transformation Task Force and other stakeholders charged with making recommendations to the 2008 Legislature. Options and recommendations in the report are organized according to the themes for action undertaken by the Health Care Transformation Task Force established by the 2007 Legislature.

The premise of the work group and the report was that health care reform policies must be responsive to the unique characteristics of rural Minnesota and its health care system to achieve the results intended for citizens. Failure to account for the nuances of delivering care in rural areas may make access, care delivery and health outcomes worse instead of better. The need to substantially change the way health care is delivered has been well documented. In Minnesota, we are facing ever increasing costs for the provision of care. Few of these health care dollars are being used to manage chronic conditions or to prevent illness and promote good health. More people are going without insurance or are buying expensive policies with high deductibles and high out-of-pocket costs. The ratio of uncompensated care costs to operating expenses for rural hospitals has risen to levels only previously reported by urban hospitals in the late 1990s, indicating the uninsured or underinsured are turning more and more to emergency rooms for care in rural areas.⁷⁵

Studies show that despite the high cost of health care, quality outcomes are not assured. Care is not consistent across the continuum and medical practice varies from setting to setting. Patients are at risk for medical errors ranging from receiving the wrong medications to undergoing the wrong surgery. Along with rising cost and poor quality, the health care system is challenged by a growing population of people with chronic illnesses and conditions. The health care system in the United States responds well to acute episodes, but does not have a consistent way of caring for people with long-term chronic conditions. At a time when more people have multiple conditions requiring the kind of coordination of

⁷⁵ *Minnesota Hospitals: Uncompensated Care, Community Benefits, and the Value of Tax Exemptions*. Minnesota Health Economics Program, 2007.

care that primary care practitioners provide, the primary care workforce is eroding. More and more medical students are opting for specialty professions.

These shortcomings are compounded in rural areas where access to primary and specialty care can be problematic, the population is older, poorer and less insured, employers are less likely to offer health insurance and the health system infrastructure is financially fragile.

Statewide Trauma System

Trauma is the third leading cause of death in Minnesota. On average, trauma claims the lives of 2,400 Minnesotans annually. States that have implemented comprehensive statewide trauma systems have increased survival rates by 15 to 20 percent.

As of August 2005, Minnesota has its own comprehensive statewide trauma system. The goal of the trauma system is to decrease injured patients' time to definitive care by ensuring that their medical needs are appropriately matched with hospital resources (Appendix L).

Participation in the statewide trauma system remains voluntary. But wide-scale participation will ensure that a statewide, cooperative effort is in place to care for seriously injured patients.

A State Trauma Advisory Council (STAC) was appointed in late 2005. Nearly 50 percent of its members are rural hospital and EMS providers. The STAC established criteria for participation in Minnesota's Statewide Trauma System, working within the established Critical Access Hospital process to avoid duplication of requirements or undue compliance burdens. The criteria are such that nearly every hospital in Minnesota is able to participate in this voluntary system if they choose.

Designations

As of September 2008, Minnesota's Statewide Trauma System has 36 designated trauma hospitals: four Level I, three Level II, 10 Level III and 19 Level IV. Twenty-three of these are Critical Access Hospitals. Over 15 additional hospitals are currently in various stages of the designation process.

System Review and Improvement

In 2007, the American College of Surgeons (ACS) conducted a comprehensive review and assessment of the statewide trauma system. The multidisciplinary team consisted of eight nationally recognized trauma and EMS experts. Their objective was to "help promote a sustainable effort in the graduated development of an inclusive trauma system for Minnesota." Over 60 trauma stakeholders from across Minnesota attended during the four days.

An 80-page final report contained 79 recommendations covering 17 specific component areas of the system. Many of the recommendations naturally overlap with the state's EMS system, thus there is a need to coordinate analysis and planning with the state EMS Regulatory Board (EMSRB). To do so, a Joint Policy Committee (JPC) was formed. This committee is examining and prioritizing each item, and will be making future agency work plan recommendations to the EMSRB and STAC.

Improving Access to Provider Training

There has been a marked increase in the demand for Comprehensive Advance Life Support (CALs) Benchmark Labs for physicians and mid-level practitioners since the advent of the state trauma system. CALs is the preferred path for rural providers to meet the educational standards for participation in the trauma system. Timely and affordable access to this training has become a problem for two reasons. The Benchmark Lab portion of the training requires overnight travel to Minneapolis, making it nearly impossible for many rural providers to attend. For those who are able to make the trip, the waiting list is over a year long.

Along with this demand for training is the realization that simulated mannequin labs are becoming more lifelike, and are relatively inexpensive and portable. In addition, Advanced Trauma Life Support (ATLS)—another pathway for meeting the trauma system training standards—has been utilizing mannequin labs for years to teach procedures. In recognition, the STAC approved waiving the CALs Benchmark Lab requirement for physicians and mid-levels if the ATLS skills are incorporated into the CALs Provider Course and taught in a similar fashion to ATLS (e.g., mannequin simulator).

The state ATLS coordinating body is planning to provide the course in rural areas throughout the state. This is a first for Minnesota, and perhaps nationally. This course is traditionally taught only in Level I or II trauma facilities located in the larger population areas.

The MDH trauma program purchased five TraumaMan simulated trauma mannequins and is providing these to all ATLS and CALs training institutions to significantly reduce the costs of the courses incurred with renting the mannequins. Reducing costs will improve affordability for students, and encourage additional courses to be offered.

Data collection and submission are required for all participating trauma hospitals. The trauma system utilizes a secure web-based registry, which is free for all hospitals. Training on how to use this system is regularly scheduled via webinar technology. Rural hospital participation has been very good.

Consultations

Staff from the MDH trauma program regularly travels to rural hospitals to provide individualized consultations in preparation for applying to become designated. Staff also maintain and provide a vast resource of documents, template policies, etc. for use by all hospitals. These best practice offerings allow a rural facility to incorporate what works best for them, and not have the immense burden of recreating them.

Future Focus for 2009

Plans are underway for continued development of the statewide trauma system, including: conducting regional training seminars; hiring a trauma registry epidemiologist; implementing a statewide trauma performance improvement plan. In addition the program will conduct a statewide trauma benchmark, indicators and scoring assessment. This comprehensive report to the Legislature regarding the implementation of the voluntary trauma system, including recommendations for including the trauma system criteria in rule, will be completed in the fall of 2009.

Health Information Technology

Minnesota, like many states, is at a crossroads in the use of health information technology. There has been a long-standing statewide commitment to ensure affordable, accessible, quality health care. In recent years, many have recognized that health information technology adoption and effective use will transform the health care system. Increased availability of technology and high-speed communications have further supported Minnesota's rural health care providers in adopting health information technology, but until recently these efforts were sporadic and at times, isolated.

Minnesota e-Health Initiative

Minnesota's formal recognition of the need to integrate health information technology into the health care system began in 2004 with legislative authorization to form a Minnesota e-Health Initiative, a broad public-private collaborative to accelerate the adoption and use of health information technology in order to improve health care quality, increase patient safety, reduce health care costs and improve public health. The Minnesota e-Health Initiative⁷⁶ developed a common vision around four broad goals:

- **Empower consumers** with information to make informed health and medical decisions.

⁷⁶ <http://www.health.state.mn.us/ehealth/>

- **Inform and connect health care providers** by promoting the adoption and use of interoperable electronic health records and electronic health information exchange.
- **Protect communities and improve public health** by advancing efforts to make public health systems interoperable and modernized.
- **Enhance the infrastructure** through:
 - Standards for health information exchange
 - Policies for strong privacy and security protection of health information
 - Funding and other resources for implementation
 - The assessment and monitoring of progress on adoption, use and interoperability.

Several significant statutory changes and mandates have been enacted in support of health information technology use and adoption:

- A 2007 requirement that all hospitals and health care providers have interoperable electronic health records by 2015, requiring CCHIT (Certification Commission for Healthcare Information Technology) certification if available for the setting
- A requirement to develop a statewide plan to achieve the 2015 EHR Mandate (adopted June 2008)
<http://www.health.state.mn.us/ehealth/ehrplan.html>
- A requirement that all health care providers and payers establish and use an e-prescribing system by January 1, 2011.

Funding for Rural Health Information Technology

Recognizing the unique needs of rural and community health care providers in adopting health information technology, the 2006 Minnesota Legislature appropriated \$1.3 million in matching grants for the adoption of interoperable electronic health record (EHR) systems, health information technology (HIT) or health information exchange.

In recognition of the urgency for rural health care providers to meet the statutory requirements for HIT adoption, the 2007 Legislature added additional funding to support providers in rural and underserved areas, increasing the biennial grant appropriation to \$7 million dollars, and adding \$6.3 million in no-interest loans.

Not all health care providers are eligible for this funding, however. Emergency Medical Services providers are notably excluded from most funding programs.

HIT Adoption in Rural Minnesota

Data on adoption of EHRs in Minnesota hospitals has not been analyzed on a rural-urban basis, but available data suggests that Minnesota hospitals, including rural hospitals, are moving toward EHR adoption (Tables 5 and 6).

Table 5: EHR Adoption Rate in Rural and Urban Primary Care Clinics – September 2007

	All		Rural		Urban	
	2005	2007	2005	2007	2005	2007
Fully Implemented	17%	42%	13%	20%	20%	58%
Implementation in process	29%	20%	23%	28%	34%	13%
Implementation in next 12 months	11%	11%	13%	15%	10%	9%
Implementation in next 13-24 months	16%	13%	22%	21%	11%	8%
Implementation beyond 25 months		9%		11%		7%
No plans for Implementation		5%		5%		4%

*Source:

Stratis Health surveys, 2005 and 2007

Table 6 EHR Adoption in Minnesota Hospitals - 2007

Electronic Health Record Implementation	No	Yes, partially implemented	Yes, fully implemented	N
Has EHR	34	49	15	98
EHR includes:				
• patient level data	8	39	26	73
• results management (from lab, radiology, etc)	4	17	53	74
• order entry management	8	26	40	74
• decision support	21	37	16	74

*Source: Minnesota Hospital Association extraction of AHA Survey 2007 data

A 2006 Rural Health Resource Technical Assistance Center survey of Minnesota’s Critical Access Hospitals to assess their use of health information technology suggests a mixed picture for Minnesota’s CAHs:

- 77 percent of respondents do not use electronic health records
- 48 percent have a formal HIT plan and 88 percent have funding included in their budget for purchase of HIT
- 50 percent do not share clinical data among departments within the hospital
- 12 percent share clinical data electronically with other hospitals
- 14 of 62 hospitals use telemedicine to consult with clinicians at other sites.

CAH Health Information Technology Toolkit

To assist Minnesota’s Critical Access Hospitals in implementing health information technology in their facilities, Stratis Health, Minnesota’s Quality Improvement Organization, created an e-Health Grant Health Information Technology Toolkit for Rural and Small Providers, which was distributed in June 2007 through the Minnesota Flex Program.

Lessons Learned

Feedback from e-Health grant projects have identified a number of common themes for rural and smaller providers echoed nationally:

- Implementing health information technology is very complex and almost always takes longer than anticipated; thorough and systematic planning is critical.
- Collaboration is essential among providers who share health information within a community and should be initiated early in the planning process.
- Funding health information technology in addition to other capital expenditures is a major financial strain for rural and small health organizations.
- Adequately preparing and engaging the workforce is a critical success factor.
- Budgeting time and staff for EHR implementation is challenging as staff usually have both management and direct patient care responsibilities.
- Some EHR products do not fit rural health care where the hospital, physicians and long term care are often a single entity.
- Some EHR products may not be interchangeable among provider types, especially when independent entities. Required features can be substantially different by provider type.

Telehealth

Minnesota's current landscape for telehealth mirrors somewhat the development of health information technology. Telehealth services have grown in Minnesota with early efforts beginning in the early 1990s, and expanding gradually since. Considerable progress in providing telehealth services has been made in rural Minnesota. Telemedicine consultative specialty care, mental health services, and in-home monitoring have grown along with the ability of providers to safely exchange electronic patient data to support practitioners in delivery of telemedicine services.

Current community and regional successes have benefited from the creativity and initiative of a few individuals determined to respond to needs for health care services that might not otherwise be available. Those individuals gathered support, networked, found resources, and focused on finding ways to connect their patients to the services they needed. Efforts to interconnect those providers, add services, and create a telehealth system in Minnesota have begun to formalize and strengthen.

Minnesota Telehealth Forum 2006

In September 2006, the Minnesota Office of Rural Health and Primary Care hosted the first statewide forum to gain a common understanding of existing services and needs, identify barriers and challenges to development of an interoperable telehealth network of services in Minnesota, and make

recommendations that would support further development. Some common themes emerged:

- Minnesota's telehealth services are strong, but lack coordination and leadership.
- Telehealth services exist, but no directory of services or list of providers is available.
- Reimbursements for telehealth services are sporadic and often do not provide sustainability. The "business case" is not solid for investing in telehealth services.
- Providers and consumers lack an understanding of the benefits of telehealth in providing access to high quality, accessible care.

Minnesota Telehealth Registry

In response to the 2006 Forum recommendations, the Minnesota Office of Rural Health and Primary Care partnered with the University of Minnesota to survey Minnesota's health care providers to 1) develop an online searchable directory of telehealth services and providers, and 2) develop a deeper understanding of telehealth service delivery in Minnesota, including financing, staffing, facilities and equipment, etc., and 3) promote the use of telehealth services among Minnesota health care providers. The results of the 2007 Minnesota Telehealth Survey⁷⁷ and the Minnesota Telehealth Registry can be found at:

<http://www.mti.umn.edu/>

Rural Broadband Access in Minnesota

According to the Center for Rural Policy and Development, as of 2006, 49 percent of all Minnesota households used broadband to connect to the Internet, with 57 percent adoption in metro-area homes and 39.4 percent in rural homes.

Some rural communities and health care providers have in place the infrastructure to handle the telecommunications requirements for both Health Information Exchange (HIE) and telehealth. However, many providers struggle to obtain the level of broadband required to reliably, safely and securely transmit data or provide telehealth services while ensuring privacy and security for the patient. In the 2007 Minnesota Telehealth Survey, cost was listed as the top reason by respondents for not implementing telehealth services. Minnesota's telecommunications industry is moving forward in establishing broadband options for rural parts of the state. However, costs for delivering service to rural communities can be significantly higher than to their urban counterparts.

Universal Service Administrative Company (USAC) reimbursement is intended to even the costs of obtaining high-speed connections for rural health care providers. In reality, due to significant administrative barriers, the reimbursement

⁷⁷ Minnesota Telehealth Inventory 2007

mechanism is difficult for small Minnesota providers to access and therefore underutilized. It does not apply to equipment and infrastructure costs, further adding to the affordability issue for small rural health care providers.

Greater Minnesota Telehealth Broadband Initiative

In fall 2006, the Federal Communications Commission (FCC) announced a pilot program to expand reimbursements for telecommunications services to support statewide and regional telehealth networks in network planning, infrastructure build out and network operation. In fall 2007, the FCC authorized the Greater Minnesota Telehealth Broadband Initiative to apply for up to \$5.4 million in reimbursements over three years.

The Greater Minnesota Telehealth Broadband Initiative (GMTBI)—Minnesota’s FCC Rural Healthcare Pilot Project—represents five health care networks. Each network contains multiple health care sites in towns/cities throughout the state:

- Minnesota Telehealth Network: 38 Minnesota sites and nine North Dakota sites
- Medi-Sota, Inc.: 31 hospital consortium in southwestern Minnesota and South Dakota
- North Region Health Alliance: 21 hospital consortium in northwest Minnesota and northeast North Dakota
- SISU Medical Systems: 16 hospital IT consortium primarily in northeast Minnesota
- Minnesota Association of Community Mental Health Programs: 78 facilities statewide.

The GMTBI vision is to enable a set of standard telehealth connection services throughout Minnesota that will allow any health care location in the state to share one or more telehealth services with any other health care location regionally, and ultimately nationally.

The three- to five-year goal for the pilot is to interconnect the sites identified by the GMTBI and to lay the foundation for future development and expansion of the network to sites beyond the pilot program.

Summary

The rural Minnesota landscape is a dynamic portrait of changing demographics, changing economy and changing health care needs. The rural population is both older and more culturally diverse than it was. Rural economic viability is tied more to tourism, government and entrepreneurship than traditional agriculture. Health professional workforce shortages are linked to the aging of the workforce and the drain of the population to urban and suburban areas. Access to health care services is an issue not only because of the loss of health care professionals but also because of the increase in the number of people who are uninsured or

underinsured. Yet, with all the changes, rural Minnesota continues to be a viable and vibrant landscape, ready to adapt and readjust.

3

Goals and Objectives

The goals of the Minnesota Rural Health plan are broad based and meant as a framework for ensuring that rural communities have the structure, tools and resources to provide access to quality health care across the lifespan and across the state.

Goals:

- Ensure a Strong, Integrated Rural Health Care System
- Ensure a Sound Rural Professional Health Care Workforce
- Foster Improvements to Rural Health Care Access and Quality
- Support the Use of Health Information Technology and Telehealth Delivery in Rural Communities.

Overview

Healthy rural communities depend on strong integrated systems that provide health care services through family practice clinics, local hospitals, ambulance services, skilled nursing facilities, hospice and home care services, and local public health services. Health care systems contribute to a rural community not only through direct care services but also by providing a significant economic base. Health care services in some communities are one of the largest employers, providing jobs and health insurance.

State and federal funding have helped support rural health care through programs such as the Medicare Rural Hospital Flexibility Program, which establishes Critical Access Hospitals (CAHs), Rural Health Clinics and Federally Qualified Health Center designation as well as a variety of other grant programs. Hospital closures have slowed but many rural communities still struggle to maintain basic services due to financial constraints, workforce shortages, an aging population and population shifts.

Goal A: Ensure a Strong, Integrated Rural Health Care System

Objectives:

- 1) Identify, assess and facilitate multi-stakeholder discussion of rural health care issues in order to develop policy and program improvement recommendations on prioritized issues.
- 2) Disseminate and encourage replication of promising practices and models for improvement in prioritized health areas.
- 3) Ensure continued successful funding and implementation of Minnesota's Medicare Rural Hospital Flexibility Program.
- 4) Support the rural health system infrastructure.

Objectives for Goal A

1) Identify, assess and facilitate multi-stakeholder discussions of rural health care issues in order to develop policy and program improvement recommendations on prioritized issues.

The Office of Rural Health and Primary Care (ORHPC) staffs, participates and facilitates in a number of forums for identifying, assessing and discussing rural health issues. The Rural Health Advisory Committee identifies significant areas of concern and develops work plans to assess the issues and make recommendations to the commissioner of the Minnesota Department of Health. The Medicare Rural Hospital Flexibility Program Advisory Committee meets regularly to discuss issues of importance to rural hospitals and systems of care and to make recommendations regarding the direction of that program in the state. The State Trauma Advisory Council was established by legislation to advise, consult with and make recommendations to the commissioner of the Minnesota Department of Health regarding the development, maintenance and improvement of the statewide trauma system.

The ORHPC provides additional research and policy analysis on a broad range of rural health issues.

A number of other forums in both the public and private sectors exist to study, prioritize and make recommendations on rural health issues, including the Minnesota Rural Health Association, the Rural Health Resource Center and the University of Minnesota Rural Health Research Center.

Fruitful partnerships already exist among these entities. It is in the best interest of rural Minnesota for these partnerships to continue and flourish. Issues are identified through community forums, advisory committee meeting discussions, and discussions with a variety of other organizations addressing rural health

issues. (Refer to Appendix A for information regarding the 2008 Community Forums and Appendix F for the RHAC 2007-2009 Priorities) Once issues are identified and prioritized, recommendations are targeted toward a number of audiences including local, state and federal lawmakers, private sector policymakers, and public-private collaborators.

2) Disseminate and encourage replication of promising practices and models for improvement in prioritized health areas.

The survival of quality health care in rural Minnesota depends in part on the ability of health care systems to adapt and innovate. Sharing successful projects, programs and ideas strengthens health care for everyone. Promising practices and models can include:

- Clinical practices that improve quality and patient satisfaction
- Local and regional coalitions to improve access to care
- Community efforts to address health problems (such as one small Minnesota community's highly successful, affordable and replicable weight-loss program)
- Innovative and successful projects supported by Minnesota Flex Grants and other state rural health grant programs
- Successful models for planning and implementing health information technology and telehealth programs.

Promising practices and the lessons learned by those involved in their development, implementation and sustainability often detail the advantages and struggles of providing quality health care in a rural area.

3) Ensure continued successful funding and implementation of Minnesota's Medicare Rural Hospital Flexibility Program.

The Medicare Rural Hospital Flexibility (Flex) Program has had a significant impact on the viability and sustainability of Minnesota's small rural hospitals and the development and integration of Minnesota's rural health system. The ongoing funding of this program is crucial in ensuring that essential health care services are maintained, and the development and integration of Minnesota's rural health system by rural hospitals continues. In addition, the Flex program is the source of funding for innovative efforts to improve access to services in rural communities. (See Appendix A for the 2008 Flex Program Objectives and related information.) Continued successful implementation in Minnesota will include meeting the following critical program objectives:

- Support quality improvement and performance improvement efforts for Critical Access Hospitals and throughout the rural health care delivery system.

- Support and strengthen Minnesota’s 79 Critical Access Hospitals, which act as the hubs of their communities and regions in developing rural health systems that address the growing chronic care, disease prevention and health promotion needs of rural communities.
- Support emergency medical services performance improvement, integration and state trauma system development.
- Support the development, implementation and enhancement of formal and informal rural health networks across the continuum of care.

4) Support the rural health system infrastructure

- Grants, technical assistance, leadership training, etc.

Goal B: Ensure a Sound Rural Professional Health Care Workforce

Objectives:

- 1) Foster and continue multi-sector, multi-agency collaboration aimed toward creative approaches to Minnesota’s health care workforce shortages.
- 2) Support health professional recruitment efforts.
- 3) Promote programs that encourage members of minority and immigrant communities to enter health care professions.
- 4) Promote health professional workforce retention.
- 5) Disseminate and encourage replication of promising education, recruitment and retention practices.

Overview

The shortage of qualified health care professionals continues to be problematic for rural Minnesota. As the population of currently practicing doctors, nurses, dentists, pharmacists and other professionals ages, the challenge to maintain a sound workforce will grow. Efforts to attract a younger workforce to rural areas have met with limited success. Urban areas can offer higher wages, better working hours, and more educational and cultural opportunities. Plans for ensuring the strength of the rural professional workforce need to encompass a broad base of programs and innovations focused on education, pay and opportunities for professional growth within the community, as well as building the capacity of the higher education system and increasing numbers of faculty.

Objectives for Goal B

1) Foster and continue multi-sector, multi-agency collaboration aimed toward creative approaches to Minnesota’s workforce shortages.

Minnesota’s health workforce issues cannot be resolved by any one agency or organization. Addressing the health care workforce shortage involves a number of sectors including the education system, providers, public agencies and the community. The regulatory and licensing sector also needs to be involved to

explore issues such as scope of practice. Minnesota has a number of successful partnerships already in place addressing the needs and barriers to providing a quality rural workforce, including:

- Health Education-Industry Partnership (HEIP). Led by Minnesota State Colleges and Universities (MnSCU), HEIP seeks to bring health employers, educators and government partners together to develop relevant, forward-thinking health care education programs. Recent innovative programs include a multi-sector partnership to develop training for community health workers focusing on minority communities and a program to increase nursing faculty to expand the educational system capacity.
- Area Health Education Center (AHEC). This federally-supported program, directed by the University of Minnesota's Academic Health Center, develops activities that nurture youth as they explore health careers, provides community-based inter-professional training for health professions students, and supports continuing education for health care professionals and community members. There are four regional AHEC program offices across the state.
- Minnesota Department of Health-Office of Rural Health and Primary Care (ORHPC) Health Workforce Analysis Program. In collaboration with Minnesota's professional licensing boards and others, ORHPC collects, analyzes and reports on supply and demand of 12 different professions (with plans for adding more), and is an integral partner in Minnesota's health care workforce planning efforts. (See Appendix I for more information).
- Minnesota Departments of Labor and of Employment and Economic Development. Projects include nurse training in partnership with rural hospitals and providers.

2) Support health professional recruitment efforts.

Ensuring a sufficient workforce involves successfully recruiting qualified students into health care programs and recruiting practicing professionals into rural communities. The following examples illustrate how this is currently being done; these efforts will continue to be supported:

- Expansion of programs and services into workforce shortage areas not currently addressed, such as mental health professions and radiology technicians
- Direct services offered by the nonprofit Rural Health Resource Center including assisting Minnesota's rural communities in health professional recruitment, and coordination of Minnesota's participation in the national online Rural Recruitment and Retention Network (3RNet)

- Development of centralized information sources on education programs, scholarships and financial aid and rural health workforce projects within the Minnesota higher education system
- Development of additional, and expansion of existing, programs that expose elementary and secondary students to health professions
- Execution of programs and projects such as loan forgiveness programs, the J-1 Visa waiver program, the Summer Health Care Internship program, H-1B nursing education projects and Department of Labor workforce retraining programs.

3) Promote programs that encourage members of minority and immigrant communities to enter health care professions.

Special efforts need to be made to recruit minorities and immigrants living in rural Minnesota into health care professions. Minority and immigrant communities represent a strong and willing workforce committed to the rural setting. Increases in the number of minority health professionals will help address health disparities as well as contribute to the economic health of rural areas. Examples of existing programs and projects that could be strengthened and expanded include:

- Partnerships between secondary and post-secondary schools and community health care providers
- Mentorship programs, scholarships and loan repayment
- Exploration of expedited licensing and credentialing of health professionals trained in foreign countries
- Continued strong partnerships with the Minnesota Department of Health Office of Minority and Multicultural Health and the communities and programs it supports.

4) Promote health professional workforce retention.

In addressing the health professional workforce shortage, attention also needs to focus on retaining those qualified professionals already in the rural health workforce. The 2003 ORHPC Registered Nurses Survey, for example, indicated that almost 15 percent planned to leave nursing for other types of jobs. Current and ongoing efforts to keep the current workforce address a number of areas. Examples include:

- Support for a rural communications infrastructure that encourages local and regional continuing education and opportunities for educational advancement for health professionals

- Work group discussions and recommendations regarding support for key licensed primary care professionals’ ability to practice at their “top of license”
- Support for professional education programming, including programs such as Comprehensive Advanced Life Support (CALs)
- Effective dissemination to rural health care professionals of educational opportunities
- Support of workplace improvement innovations such as nursing magnet hospitals
- Continued research and data collection on the status of the workforce
- Support for efforts to ensure appropriate and adequate compensation for rural health professionals.

5) Disseminate and encourage replication of promising education, recruitment and retention practices.

Sharing successful innovations provides opportunities for providers, educators and communities to tailor initiatives to their own needs. Promising practices are highlighted in ORHPC’s and other organizations’ publications and Web sites, and shared through workshops, community forums and statewide conferences.

Goal C: Foster Improvements to Rural Health Care Access and Quality

Objectives:

- 1) Work with partner organizations to ensure rural representation in the development of local, state and national health care programs and policies and to maximize their effectiveness.
- 2) Seek and disseminate funding to address infrastructure needs of rural health care facilities.
- 3) Understand the rural health system’s financial condition and support strengthening it.
- 4) Provide continuing and enhanced technical assistance to hospitals, clinics, nursing homes and other health care providers in order to strengthen the rural health infrastructure at the community level and improve its ability to meet community needs.
- 5) Conduct high quality research and policy analysis on rural health issues and encourage those doing general health care research to include rural breakouts and comparisons.

Overview

Without funding and other resources, many rural areas in Minnesota will be hard pressed to provide even a basic level of services. Increases in health care costs and in the numbers of people who are uninsured or under-insured are an ever-increasing challenge to rural communities. Many hospitals and nursing homes are challenged by aging, outdated facilities and have few resources to update them.

Infrastructure to provide high speed Internet access and cell phone access is lacking in some parts of the state.

Objectives for Goal C

1) Work with partner organizations to ensure rural representation in the development of local, state and national health care programs and policies and to maximize their effectiveness.

Rural health issues affect all sectors of the community. For rural health programs and policies to make sense, it is important to involve a range of partners in their development. It is also critical that the rural voice be represented in health care program and policy discussions at all levels. Partners involved in strengthening rural health programs and policies in Minnesota include:

- Office of Rural Health and Primary Care and the Rural Health Advisory Committee
- Minnesota Rural Health Association
- Minnesota Department of Health Office of Minority and Multicultural Health
- Area Health Education Centers
- Minnesota Center for Rural Health/Rural Health Resource Center
- University of Minnesota and Minnesota State Colleges and Universities
- Stratis Health
- Emergency Medical Services Regulatory Board
- Center for Rural Policy and Development
- Minnesota Rural Partners
- Minnesota Department of Human Services
- Minnesota Department of Education
- Minnesota Hospital Association
- Minnesota's long term care associations, Minnesota Health and Housing Alliance and Care Providers of Minnesota
- Health professional associations such as the Minnesota Medical Association, Minnesota Academy of Family Physicians, Minnesota Nurses Association, Minnesota Association of Physician Assistants, Minnesota Pharmacists Association
- Minnesota Ambulance Association
- Minnesota Council of Health Plans
- Rural representatives on public and private committees, commissions and task forces addressing health care issues.

Productive partnerships already exist among many of these entities, and of course, it is in the best interest of rural Minnesota for these partnerships to continue and flourish.

2) Seek and disseminate funding to address infrastructure needs of rural health care facilities.

It is estimated that rural Minnesota hospitals alone need more than \$99 million to shore up aging facilities and plants. Countless skilled nursing facilities and clinics are also in need of repairs and renovations. Additionally, many of our rural health care facilities do not have access to modern communication technology such as high speed Internet, telemedicine and cell phones. Funding from a variety of sources (including state, federal and private foundations) is needed to strengthen the rural health provider infrastructure. Current funding examples include:

- Small Hospital Improvement Program (SHIP)
- State funding for hospital capital improvements and planning
- State funding for the planning or implementation of interoperable electronic health records, related applications or health information exchange
- Federal funding through the U.S. Department of Agriculture for rural communications infrastructure
- Local bonding and fund raising initiatives.

3) Understand the rural health system's financial condition and support strengthening it.

Funding from public and private sources help ensure access to care, innovations in care and the general strength of the rural health system.

- Conduct periodic assessments of the financial condition of Minnesota's rural health system, including operations, capital improvement, and growth/diversification needs
- Educate policymakers and funders on the resource needs of Minnesota's rural health system
- Collaborate with other state, federal and private rural health funders to maximize the input of current funding programs
- Seek opportunities as appropriate to advance initiatives for new funding.

4) Provide continuing and enhanced technical assistance to hospitals, clinics, nursing homes and other health care providers in order to strengthen the rural health infrastructure at the community level and improve its ability to meet community needs.

Rural communities have long demonstrated resourcefulness and resiliency in ensuring health care services. Often, with some technical assistance, hospitals, clinics and other providers can develop solutions to health care issues. ORHPC

provides technical assistance directly in its areas of expertise—as do some of its partner organizations—and supports or arranges technical assistance on a wide array of topics, including:

- Clinical quality improvement and patient safety
- Performance improvement approaches, such as Balanced Scorecard
- Discharge planning
- Reimbursement and practice management issues
- EMS and ambulance service planning and management
- Needs assessment, diversification and marketing
- Community economic impacts of the rural health sector, through projects such as Rural Health Works
- Financial advice and feasibility information for Critical Access Hospitals, Rural Health Clinics and Federally Qualified Health Centers
- Grant writing workshops, information on available funding.

5) Conduct high quality research and policy analysis on rural health issues and encourage those doing general health care research to include rural breakouts and comparisons.

High quality research is needed to identify and prioritize needs, validate issues and point the way toward successful solutions. In May 2008, Governor Pawlenty signed significant health care reform legislation into law. At minimum, the reform package includes:

- The Statewide Health Improvement Program
- Health care homes
- Payment reform, quality measurement and cost/quality transparency
- E-Health and
- Insurance coverage and affordability.

Implementation of this comprehensive health care reform package will make significant progress toward achieving quality, affordable, accessible health care for all Minnesotans. In May 2007, the RHAC formed a work group and developed *Health Care Reform: Addressing the Needs of Rural Minnesotans*, a report regarding the unique characteristics of rural Minnesota and their implications for policymakers. The ORHPC and many of its partner organizations will continue to have a key role in providing the rural voice and considerations in this important health delivery movement.

Research can take place in a number of sectors including institutions of higher education, public programs and privately funded programs. Examples of current research organizations supporting rural health in Minnesota include but are not limited to:

- The Office of Rural Health and Primary Care and the Rural Health Advisory Committee
- The Center for Rural Policy and Development
- The University of Minnesota Rural Health Research Center
- University of Minnesota Duluth Center for Rural Mental Health
- Minnesota Center for Rural Health/Rural Health Resource Center.

Partnerships exist among these organizations already exist and strengthening them will only lead to better rural health policies and programs for rural Minnesotans.

Goal D: Support the use of health information technology and telehealth delivery in rural communities (New 2008 Goal).

Objectives:

- 1) Support expanded broadband access necessary for telehealth use.
- 2) Seek and disseminate funding to support the adoption and effective use of interoperable electronic health records in rural health care facilities.

Overview

The adoption and effective use of electronic health information systems can play a significant role in transforming the health care system and in supporting healthier communities. New tools are bringing the power of information systems to the practice of medicine and public health, improving both quality and safety.

Minnesota policymakers recognize that more effective use of information—including the timely exchange of information—will be needed to improve the quality and safety of care. Several significant mandates were enacted in the 2007 and 2008 legislative sessions that impact all health care providers in Minnesota:

- All health care providers and hospitals have an interoperable electronic health record (EHR) system by 2015
- A statewide implementation plan to meet the 2015 interoperable EHR mandate
- All health care providers and payers establish and use an e-prescribing system by January 2011.

Objectives for Goal D

1) **Support expanded broadband access necessary for telehealth use.**

Investment in health information technology is beyond the reach of many rural health care providers. The lack of reimbursement for telemedicine services also hampers broad rural acceptance and utilization of this technology. Additionally, the lack of coordination and communication across systems is the biggest challenge for small providers. Broadband networks have not yet reached some of the more remote locations in rural Minnesota preventing some residents of small towns from being directly engaged in their own health care, an important feature of the health care home.

2) **Seek and disseminate funding to support the adoption and effective use of interoperable electronic health records in rural health care facilities.**

Electronic health records (EHRs) and telehealth services are being used more frequently, bridging the geographical distances that can interfere with access to health care. However, the rural health care infrastructure is under-resourced and not all rural health providers have the financial capacity to fully implement EHRs or exchange information electronically.

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Appendix A: Flex Advisory Committee, Flex Program Objectives, 2008 Flex Work Plan

Medicare Rural Hospital Flexibility Program

Overview and New Objectives

Overview

Minnesota continues to demonstrate its commitment to the health of our rural population through multiple strategies. Through the Medicare Rural Hospital Flexibility (Flex) Program Minnesota has seen the financial stabilization of many rural hospitals, the growth of networks and partnerships to increase quality and access to care, greater support for emergency services and a greater emphasis on the role of the critical access hospital in the health of the community. The Office of Rural Health and Primary Care (ORHPC) and Minnesota's Flex Program stakeholders continuously scan the rural health environment, assess needs and respond to changing conditions.

Although there have been improvements, particularly with the conversion of 79 hospitals to Critical Access status, rural Minnesota still faces significant health related challenges. The Minnesota Flex Program, through the Minnesota Rural Health Plan and related assessments, brings a systems approach to these challenges. The Minnesota Flex Program incorporates the federal goals of the Flex program into its planning and programming to address the following issues:

1. Growing aging population with increased chronic care needs

Rural Minnesota is undergoing major shifts in demographics, especially with the aging population. Although only 30 percent of the state's total population lives in rural Minnesota, 41 percent of those 65 and older currently live there. All counties with more than 20 percent of the population 65 and older are in rural Minnesota. With the aging of the population comes an increased incidence of chronic disease and disability.

2. Stressed rural health care delivery system

All 79 hospitals that qualify for critical access status in Minnesota have been designated as CAHs. Minnesota's Flex Program has therefore progressed to placing greater emphasis on support of existing CAHs, network development and support, integration of EMS services, and support of quality improvement initiatives. Although on average Minnesota CAH's financial performance has improved in recent years, the need for support remains among Minnesota CAHs for several reasons. Among those CAHs now in the black, many produce financial margins too low to provide or support the capital investment needed to update aging plants and keep pace with changing technologies. In addition, half of Minnesota CAHs own and operate nursing homes. Minnesota is one of only two states with a rate equalization law that requires private pay rates to be no higher than Medicaid rates paid by the state. In essence, nursing homes are a rate-regulated industry in Minnesota, and Medicaid rates remain well below actual costs.

3. EMS and Trauma system challenges

Most of Minnesota's ambulance services are located in low population rural areas (231 vs. 41 in urban areas). Of 4,533 rural ambulance personnel in Minnesota in 2002, 3,481 were volunteers. Daytime hours, weekends and holidays are the most problematic shifts to fill, and about 900 ambulance personnel (half from rural areas) leave an ambulance service each year. At any time, 74% of Minnesota's ambulance services are recruiting.

Ambulance issues are magnified in rural areas, where demands are high but resources scarce. Minnesota EMS leaders have identified top concerns in the industry as:

- Regional program support
- Rural workforce staffing
- Clinical Quality Improvement

- Leadership development
- Community visibility
- Medical direction

Minnesota Statewide Trauma System: The 2005 Minnesota Legislature authorized the creation of the Minnesota Statewide Trauma System. A State Trauma Program was established and placed within the Office of Rural Health and Primary Care, largely because of the program's focus to incorporate rural hospitals and CAHs into the system. Further, the Trauma Program has dedicated staff in ORHPC who provide technical assistance and consultations for hospitals seeking a trauma level designation, and these staff members will contribute to Minnesota's Year 10 Trauma objectives.

4. Lack of access to technology such as broadband, health information technology and tele-health as well as lack of technology support workforce

Minnesota's Flex program grants and state rural health grants have long supported projects in planning and implementing health information technology and telemedicine. Four years ago efforts directed toward statewide development also began, with the creation of the Minnesota Department of Health's e-Health Advisory Committee. This public-private advisory committee developed recommendations intended to address health information exchange, including coordination with telehealth development. ORHPC efforts during these discussions ensured that rural interests were being represented. The 2007 Minnesota Legislature, in response to the recommendations of the e-Health Advisory Committee, authorized significant funding to support e-Health development, appropriating \$14 million for support of providers in rural and underserved areas. Despite state funding for HIT and \$5.3 million from the FCC Rural Health Care Pilot Program, the need for additional support remains unmet.

5. Economic disparities; uninsured and underinsurance

Rural Minnesota residents are poorer than urban residents and more likely to receive public assistance including TANF, food stamps and Supplemental Social Security (SSI). In addition, the rate of uninsured rose in Minnesota from 5.7% to 7.4% between 2001 and 2004. (MDH, 2006) Rural Minnesotans who are insured are more likely to have self-purchased insurance policies rather than employer-based policies that often include high deductibles and high co-payments. A respondent from a recent study on Minnesota farm family insurance said, "We just make the deductible then the year is over so we never really feel the benefit from having insurance." (The Access Project, 2007)

6. Lack of access to mental health services

A workgroup sponsored by the Minnesota Rural Health Advisory Committee on rural mental health and primary care found that rural primary care providers are seeing an increase in mental and behavioral health issues in their clinics. The shortage of mental health providers results in long waits for appointments and long trips to obtain specialty services. The workgroup surveyed Critical Access Hospital emergency rooms regarding mental health emergencies and found that lack of psychiatric beds, lack of adequately trained staff, lack of resources in the community and lack of transportation are significant barriers to appropriate care (Mental Health and Primary Care, 2005).

7. Rural health status disparities

A recent analysis of Minnesota's health status comparing rural populations to urban populations found that rural residents are more likely to smoke and less likely to wear seat belts. Motor vehicle death rates are higher and so are unintentional injuries. Older rural residents suffer more tooth loss than their urban counterparts. Rural Minnesotans have higher cancer fatality rates and higher mortality rates due to heart disease.

8. Increasing minority and immigrant population

Rural Minnesota has experienced significant growth in minority and immigrant populations. Much of the growth has been attributed to the employment opportunities provided by manufacturing and food processing plants located in rural counties. For example, between 1990 and 2000 the rural Hispanic population increased by 176 percent and the Black African American population by 177.6 percent (U.S. Census, Minnesota Demographer). Rural hospitals and health care systems are being challenged to provide culturally appropriate care and care for those whose first language is not English.

9. Health care workforce shortages and an aging health care workforce

Thirty-seven percent of Minnesota's rural population lives in a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA). Forty-six of the most rural counties have thirteen percent of the state's population but only five percent of the state's practicing physicians. Along with physician shortages are significant shortages of nurses, dentists, pharmacists and ancillary medical personnel. Moreover, the rural workforce currently in place is aging. For example, the median age of a rural physician is 48 years. Forty-five percent of the rural ambulance workforce is over the age of 40, with 67 percent of the rural ambulance services indicating they have difficulty finding coverage for all the shifts particularly during the daytime when volunteer personnel are at their regular jobs (A Quiet Crisis: Minnesota's Rural Ambulance Services at Risk, 2002).

The Minnesota Rural Health Plan

The preceding environmental assessment is informing the update of Minnesota's Rural Health Plan, now underway. The new plan will be submitted by the required ORHP deadline, three months following receipt of the Year 10 Notice of Grant Award.

Background: The first Minnesota Rural Health Plan was developed in 1998 when the rural health picture was one of substantial decline in the utilization of services in rural hospitals, difficulty in maintenance of 24-hour coverage for emergency room services, significant financial losses and other issues such as aging plants and inadequate reimbursement. By 2004, when the rural health plan was updated and rewritten, 52 hospitals had converted to Critical Access Hospital status.

The 2004 Rural Health Plan set a framework to ensure that rural communities had the structure, the tools and the resources to provide health care access and quality across the lifespan and across the state. The goals included:

- Assure a strong integrated rural health care system
- Ensure a sound rural professional health care workforce
- Promote effective health care networking and community collaboration
- Foster increased capacity and resources to assure rural health care access and quality

Since 2004, The Office of Rural Health and Primary Care, through Flex and its other programs, has regularly assessed the Minnesota environment and initiated numerous projects, workgroups and reports based on the goals of the State Rural Health Plan. Some examples include:

- Rural Mental Health and Primary Care Workgroup with report and recommendations
- Initiation of a state trauma system
- Creating Healthy Communities for the Aging Population Workgroup with report and recommendations
- Collaboration with rural telehealth providers and stakeholders
- Annual State Rural Health Conferences
- Report to the 2007 Minnesota Legislature on swing beds and access to post-acute care in rural Minnesota
- Ongoing healthcare workforce analysis
- Grant programs focusing on increasing access, addressing health care infrastructure and fostering collaboration
- Health workforce loan repayment and health careers programs.

Within the structure of the State Rural Health Plan, the Flex program has addressed federal Flex Program goals in a variety of ways. Examples include:

- Designation of Critical Access Hospitals in Minnesota. With assistance from the Minnesota Flex Program, all eligible small Minnesota hospitals have attained designation, for a total of 79 Critical Access Hospitals.
- Development and Implementation of Rural Health Networks. The Flex program has expanded beyond the original hospital network agreements to support other types of networks such as telepharmacy, telehealth, joint CAH ventures such as home care and joint training and group purchasing.
- Support of existing Critical Access Hospitals. Through grants and technical assistance, the Flex program has supported Critical Access Hospitals in a variety of projects intended to strengthen the CAH and its role in the health of the community. Examples include funding for equipment, mock surveys, performance improvement efforts such as benchmarking balanced scorecard and funding for hospital-initiated community chronic disease management programs.
- Improvement and Integration of Emergency Medical Systems Services. The Flex program has made substantial contributions to the development of Minnesota's State trauma System. In addition, the Flex program has provided financial and technical assistance to rural ambulance services for training, equipment and financial planning.

- Improving Quality of Care. The Flex program has worked collaboratively with Stratis Health, Minnesota's Quality Improvement Organization, on projects such as community continuity of care collaboratives and an annual rural quality conference.

The outcomes of Minnesota's Flex program activities have also received ongoing evaluation at the state and national level. In addition to documenting results, these evaluations have also guided the course of program planning and operation.

Year 9 Rural Health Plan Activities: Revision of the Rural Health Plan has moved forward on several fronts:

Priority setting and planning by the Rural Health Advisory Committee - The 2004 Rural Health Plan was guided and approved by the Minnesota Flex Program Committee and the Rural Health Advisory Committee (a 15 member governor appointed committee that advises the Commissioner of Health and other state agencies on rural health issues.) The Rural Health Advisory Committee leads planning and priority setting for the ORHPC and all its policy analysis activities. During Year 9, the Rural Health Advisory Committee set its priorities for 2007 – 2009. Those priorities are

- Rural Health Care Workforce Issues
- Developing a New Rural Health Care Delivery Model
- Population Health Issues
- Financial Stability of the Rural Health System
- Quality Improvement Information and Communications Technology

These priorities will also inform the development of the Rural Health Plan, which will be reviewed by the Rural Health Advisory Committee as part of its adoption.

Focused Work Group Projects - During Year 9, the Rural Health Advisory Committee completed one workgroup project related to Rural Health Plan Development, and began a second workgroup. The committee established a Rural Health Reform Work Group to offer a rural perspective on Minnesota health reform discussions. The work group studied the rural characteristics that affect health services, and proposed health reform options in response. Among their recommendations are:

- Redesign health care jobs and health care delivery for better coordinated prevention and health care services delivery.
- Increase support for primary care and for educating primary care practitioners.
- Support utilization of proven cost-effective technology, such as telehome care, telemental health services and teleradiology.
- Work toward universal coverage, making incremental changes along the way such as improving insurance options for small employers and lower wage workers.
- Build on strengths of the rural system such as its Critical Access Hospitals, which often serve as a hub around which to integrate and redesign community services.

Most recently, the Rural Health Advisory Committee formed a Work Group on Developing a New Rural Health Care Delivery Model. The work group has begun to review efforts underway to promote the medical home model and spell out any unique features that should be incorporated for the model to succeed in rural

areas. The group will also look at the intersecting dynamics of primary care shortages, technology, rural demographics, and existing rural models of health service integration and care coordination to develop a viable rural model for the future.

The findings of both these work groups will also inform the Minnesota Rural Health Plan and the development of Flex Program strategies.

Statewide Community Forums - The Minnesota Flex Program sponsored four community forums throughout rural Minnesota. The nearly 100 attendees included representatives from Critical Access Hospitals (CAH) and other rural health care providers, Emergency Medical Service (EMS) volunteers and personnel, community leaders, congressional delegation staff, and consumers from all four corners of the state. The forums were structured to solicit impressions from participants on assets of and challenges of CAHs, other providers, and EMS in their communities, and then to solicit recommendations for innovative change to address the identified challenges. Participants provided a wealth of information, diverse perspectives, and thoughtful suggestions.

Program Evaluation Results – The most recent Minnesota Flex program evaluation project focused on Quality Improvement Activities, Outcomes, and Needs of Minnesota’s Critical Access Hospitals. This evaluation reviewed Flex-supported quality improvement activities and made recommendations for future programming. These findings will also be reflected in the Rural Health Plan.

Flex Goals and the State Rural Health Plan

The Minnesota Flex Program will address each Flex grant goal with a methodology that includes input from our stakeholders, updated data on rural health needs and a plan approval process that involves both the Minnesota Flex Program Committee and the Minnesota Rural Health Advisory Committee.

The Minnesota Flex Program Committee meets periodically to provide input on the goals of the Flex program. The committee is made up of twelve CAH administrators, representatives from Stratis Health (the state Quality Improvement Organization), the Minnesota Hospital Association, the Emergency Medical Services Regulatory Board, the Minnesota Rural Health Association and other stakeholders. The Flex Committee has been engaged in Rural Health Plan and Flex Program development to assure the plan address all goals of the Flex program.

The Rural Health Advisory Committee is comprised of legislative, hospital, health profession, long term care and consumer representatives appointed by the governor. They will be asked to review and provide input into the Minnesota Rural Health Plan and to assure that the health plan addresses Minnesota’s broader rural health needs.

Involvement of both committees will assure that a broad rural health constituency is engaged in the planning process. Additionally, the State Trauma Systems Advisory Council will review the plan as it relates to trauma response and emergency services.

For membership of each committee, see Attachment 6, Appendix, pages 11-13.

APPROACH

Minnesota's Flex Program methods during Year 10 build on and continue the approach developed last year for the five – year period that began with 2007 – 2008. The approach includes ongoing assessment and planning based on stakeholder involvement, community, state and federal data, and field research in rural Minnesota communities and hospitals, culminating in the updated Rural Health Plan. Work plan strategies include grants and other financial assistance supported by Flex funds and significant state dollars, technical assistance, partnerships through which the QIO, hospital association, state survey division and other partners deliver expert services to CAHs and rural communities, technical assistance by ORHPC, coordination with the Rural Health Resource Center's Minnesota Rural Performance Improvement (MRPI) Program, and policy development by ORHPC and the Flex Program Committee.

Minnesota employs a multi-part strategy for investing federal Flex funds. In Year 10, Minnesota proposes to leverage Flex funds with \$9.5 million in related state rural health funding. Flex funds will be used for direct assistance and coordination, program planning, targeted focused grants to partners with specialized expertise to achieve Flex objectives, such as the QIO and the state hospital association and the Comprehensive Advanced Life Support (CALs) program, and targeted Flex grant funds for hospital, quality, EMS and network projects that address the priorities established in the program guidance. Each aspect of the Minnesota program will incorporate measurement, reporting, accountability and evaluation.

In response to the requirements of the Federal Flex program guidance, the needs and stakeholder input described above, and in anticipation of a completed Rural Health Plan by fall of 2008, Minnesota proposes a 2008-09 state Flex Program with the following goals and objectives:

- A. Continue updating and revision of the Minnesota Rural Health Plan to reflect the current rural health needs and the current goals of the Federal Flex Program and the needs of Critical Access Hospitals and the communities they serve.
- B. Support quality improvement and performance improvement efforts for Critical Access Hospitals and throughout the rural health care delivery system.
- C. Support and strengthen Minnesota's 79 Critical Access Hospitals as the hubs for their communities, regions and for the state in developing rural health systems that address the growing chronic care, disease prevention and health promotion needs of rural communities.
- D. Support emergency medical services performance improvement, integration and state trauma system development.
- E. Support the development, implementation, and enhancement of formal and informal rural health networks across the continuum of care.
- F. Evaluate the processes, outputs and outcomes of Minnesota's Flex program on an ongoing basis.

EVALUATION PLAN

Minnesota's evaluation plan operates with a regular ongoing structure to gather program information and analyze it for performance improvement. The process focuses on the program's state and local impact on Minnesota's rural health system, using retrospective reviews and data collection tools for on-going measurement and reporting. Evaluation is integrated and institutionalized into all ongoing and evolving program processes. It includes evaluative input from state stakeholders on past and current Flex program activities; reviews of all potential data sources for information, analysis and program planning; review of a select number of Flex grants, invoices and program reports. It studies both state level organizational performance of ORHPC and the program's state partners as well as local organizational performance of CAHs and other rural health system entities. The Minnesota evaluation process yields regular reviews and reports, which are used to advance state-level program performance and improve the effectiveness of program strategies at the local and regional level.

In addition to ongoing evaluation activities (see Report on Prior Year and Work plan Objective F for details), during Year 10 the Office of Rural Health and Primary Care will undertake an in depth evaluation of the impact of flex funding that supports CAHs designated by the State of Minnesota as either Level III or Level IV Trauma Hospitals. This evaluation will establish baseline reports and analysis of required performance improvement standards and trend them over time. It will provide feedback to participating hospitals for integration into their internal trauma care QI/PI programs. All trauma hospitals will report specific injury data as required in the Minnesota trauma registry and its accompanying data inclusion/exclusion criteria. These reports and analyses will assist in identifying gaps in care and serve as objective measures for improvement. Continual improvement toward full compliance will reduce death and disability for injured Minnesotans in rural areas.

New Objectives – Year 10

Objective A: Update and revise the Minnesota Rural Health Plan to reflect the current rural health needs and the current goals of the Federal Flex Program and the needs of Critical Access Hospitals and the communities they serve.

Development of the new Rural Health Plan will reflect the perspective of a mature Flex program focused on system development and on quality and performance improvement. The vision for the plan includes using the infrastructure and financial stability of the Critical Access Hospital as the hub for developing rural health systems that address the growing chronic care, disease prevention and health promotion needs of rural communities. This means supporting networks and collaborations that address the continuum of care from prenatal to quality end-of-life care in each rural community.

Objective B: To support quality improvement and performance improvement efforts for Critical Access Hospitals and throughout the rural health care delivery system.

Minnesota's Year 10 strategy for quality and performance improvement continues successful activities begun in prior years and initiates new projects. Efforts will include increased resources and focus in the areas of quality and performance improvement and capacity building. ORHPC, Stratis Health QIO and the Minnesota Hospital Association (MHA) will work with CAHs to improve quality and performance by expanding performance improvement benchmarking and public reporting of quality data through Hospital

Compare and other state and national reporting programs. Quality improvement will be an ongoing focus of technical assistance and funding and will be at the center of new activities for CAHs by the QIO and the Hospital Association.

Objective C: To provide ongoing support to CAHs and CAH-eligible hospitals.

The Year 10 approach for supporting hospitals arises from the needs assessment, guidance from CAHs and the state hospital association, and findings from research and field experience of Flex and ORHPC staff during recent years. ORHPC will provide financial and technical support to CAHs with Flex and state funds and personnel. Activities include a summit for all CAHs; topics will include information technology/telemedicine, electronic health records, quality and performance improvement, leadership culture and patient safety, access to capital, CAH/FQHC integration; best practices in revenue management and other business systems, and patient services improvements. ORHPC will continue to assist CAHs with their re-surveys through on site training. Work will continue on an analysis of financial implications of CAHs with attached long term care facilities. Support will continue on implementation of a MN Hospital Association multi-CAH performance improvement benchmarking effort. ORHPC will continue to provide consultation on reimbursement issues. In addition to discrete projects in each area, ORHPC will offer Minnesota CAH and Network Quality and Performance Improvement Sub-Contracts on a competitive basis.

Objective D: To support Emergency Medical Services performance improvement, integration and State Trauma System Development.

In Year 10 Minnesota's Flex Program EMS methodology will continue to build upon the known challenges facing Minnesota's rural EMS system and upon the assessment and strategies expected from the Rural Health Plan. The EMS approach includes a central focus on State Trauma System development and related efforts to establish formalized trauma programs within CAHs, encouraging CAHs to become trauma centers, integrate EMS into trauma operations and improve overall trauma care in their communities. Strategies include Trauma System development, designation and training, support for improved EMS medical direction, and focused support and funding for improving performance of recruitment and retention, reimbursement and restructuring.

In addition to discrete projects in each area, ORHPC will offer Minnesota Flex EMS and Trauma Performance Improvement sub-contracts on a competitive basis. These sub-contracts will provide focused funding for rural EMS projects authorized by the Flex Program guidance, specifically supporting EMS agencies in efforts of recruitment/retention, reimbursement and restructuring. Sub-contract support will assist rural EMS providers to respond with proven interventions to the major changes affecting the rural health system and rural communities. With such support, local and regional EMS partners working together will be better able to assess their environments and community needs through approaches such as the local-level Benchmarks, Indicators, and Scoring (BIS) process, and plan and implement strategic responses to improve rural EMS delivery.

Objective E: To support the development, implementation, and enhancement of formal and informal rural health networks across the continuum of care.

Minnesota's Flex networking goal in year 10 will continue efforts to develop rural health networks, CAH networks, and other forms of networks, all with the goal of providing integrated, high quality care to patients. In response to needs for expansion of integrated interoperable electronic health records and health information exchange, along with expansion and coordination of telehealth services, ORHPC is directing resources toward ensuring that statewide efforts support rural providers.

The Flex program will support CAHs' formal and informal networks that improve regional collaboration and leadership. The program will continue to offer Rural Health Works community economic analysis and planning assistance. Formal vertical networks will be supported and expanded through the Flex Program's coordination with the Minnesota eHealth Initiative and its emphasis on health information technology networks. ORHPC will support CAHs, clinics, health information exchange initiatives that advance the HIT, telemedicine and communications infrastructure objectives of the Institute of Medicine Rural Quality Report strategy on information and communications technology (ICT). ORHPC will continue to convene telemedicine stakeholders, and provide continuing support to telepharmacy, tele-mental health and other technology based partnerships, including the Greater Minnesota Telehealth Broadband Initiative, Minnesota's FCC Rural Health Care Pilot Program project. Minnesota will provide state grants and loans for collaborative electronic health records (EHR) and HIT projects, and support the continued development and use of an online dynamic directory of telehealth services in Minnesota.

Objective F: Conduct a thorough annual evaluation of the Flex Program and use the results to refine the current program and to enhance the future program.

Findings in the evaluation of Minnesota's Flex program are used on an ongoing basis to refine the program and further the objectives through data-driven decision making. The ORHPC will continue its established ongoing evaluation of technical assistance and other services to CAHs and other rural health providers. We will continue evaluating subcontractor processes and outcomes, as well as stakeholder involvement in and support of the Flex program. New evaluation activities have been added to the MN Flex evaluation plan for Year 10 in order to gather more data to guide planning for support of CAHs and other rural providers, for enhancing quality of care in rural Minnesota, and for other objectives as needed. Program efforts will continue to synchronize with the national effort and state and federal data will be used to evaluate program strengths, weaknesses and outcomes, improve program systems and guide the future of Minnesota's Flex program.

Office of Rural Health & Primary Care

Minnesota's Rural Hospital Flexibility Program

Supporting rural systems of care: *Economic and demographic changes have jeopardized the availability of health care resources for many rural Americans and put their health status at risk. Congress created the Medicare Rural Hospital Flexibility (FLEX) Program to improve access and quality and relieve some of the financial pressures on rural hospitals and emergency medical services (EMS).*

Medicare Rural Hospital Flexibility Program

The Balanced Budget Act of 1997 established the Flex Program to help rural communities preserve access to primary and emergency health care services by:

- Establishing and supporting Critical Access Hospitals
- Enhancing emergency medical services
- Improving health care quality
- Promoting rural health networks and community development.

Federal funding is available on a competitive basis to support state Flex Programs. The Minnesota Department of Health Office of Rural Health and Primary Care (ORHPC) has applied for and received federal funds since the start of the program.

Critical Access Hospitals

Beginning in 1998, small rural hospitals meeting state and federal criteria were eligible to convert from traditional hospital licensure status to Critical Access Hospital (CAH) licensure status. CAHs receive higher, cost-based reimbursement for Medicare services and are allowed greater flexibility in staffing. In return, CAHs must have:

- Emergency services available 24 hours per day
- No more than 25 beds
- An average length of stay of 96 hours or less and
- A network agreement with another hospital.

By the federal deadline of January 1, 2006, all qualifying hospitals in the state had become CAHs. Minnesota now has 79 Critical Access Hospitals.

The Minnesota Flex Program

The focus of Minnesota's Flex Program is supporting rural systems of care with the Critical Access Hospital as the hub. The Flex Program assists rural communities through grant programs, technical assistance, and special initiatives that ensure access to health care services across the continuum of care and over the lifespan. A Flex Program Advisory Committee provides input for Flex Program planning and ensures program accountability.

Other program elements

Emergency Medical Services: EMS services are vital to rural communities and an essential element of emergency preparedness. Flex-funded EMS projects help rural EMS providers with challenges like staff recruitment, retention and training, and operations issues such as reimbursement and hazard management.

Quality and Performance Improvement: Small rural hospitals often lack the capacity and resources to pursue organized quality and performance improvement initiatives. Flex funding promotes projects that improve patient health and safety, and promote and preserve local access to care.

Promoting Networks and Community Development: Many rural hospitals cannot support a full range of specialty and high tech services. Flex funding supports networks that promote system efficiency, and improve access to a wide range of services. The Flex Program also supports local leadership development, planning, and hospital collaborations with other community providers.

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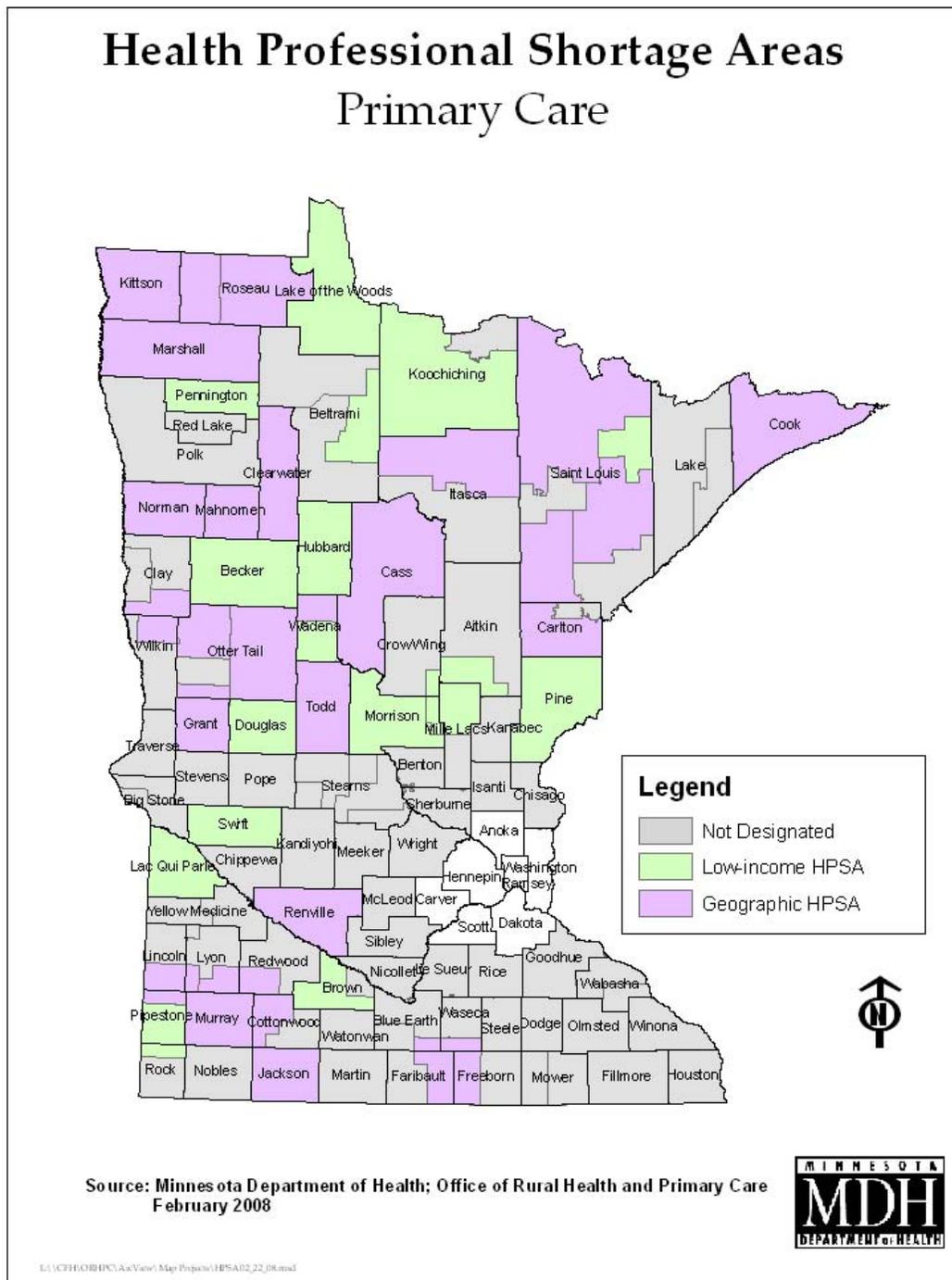
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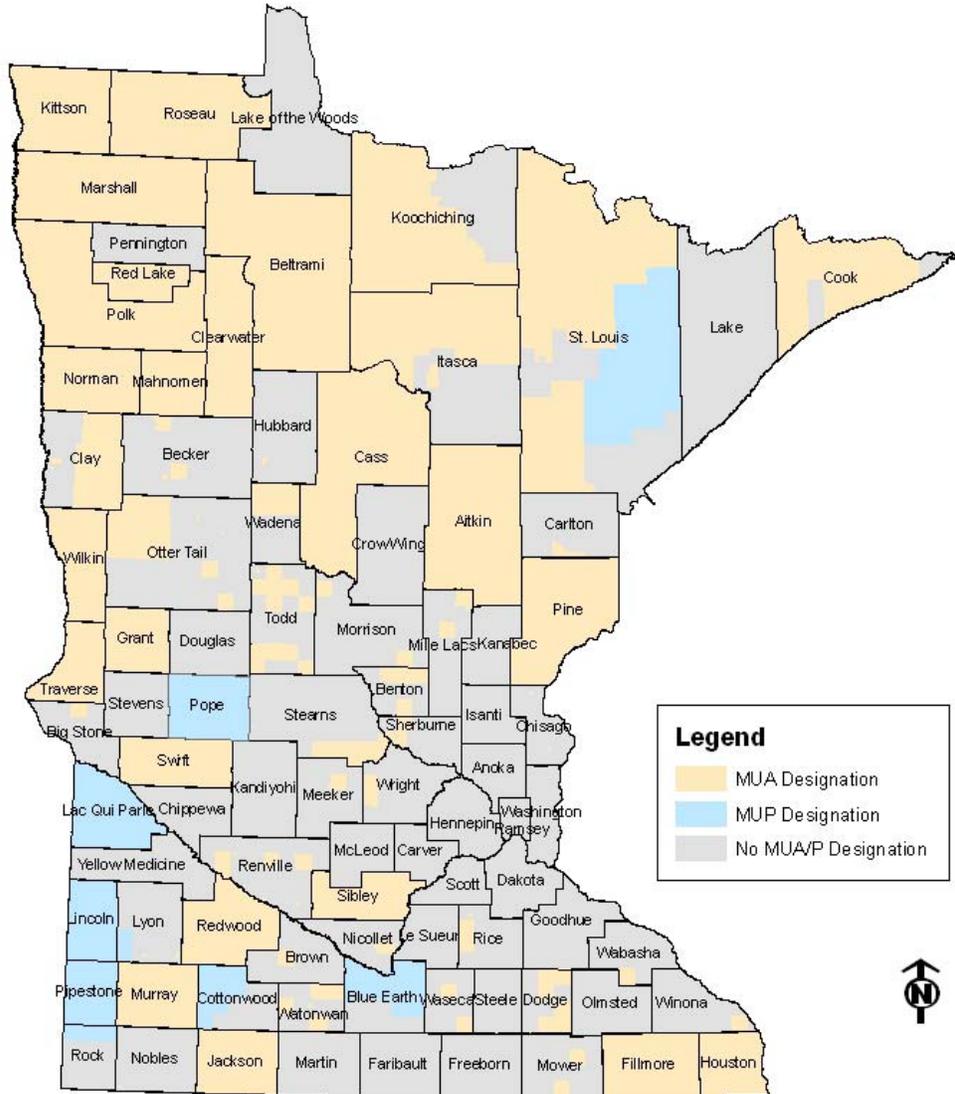
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Appendix B: Health Professional Shortage Areas and Medically Underserved Areas



Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs)



Legend

- MUA Designation
- MUP Designation
- No MUA/P Designation

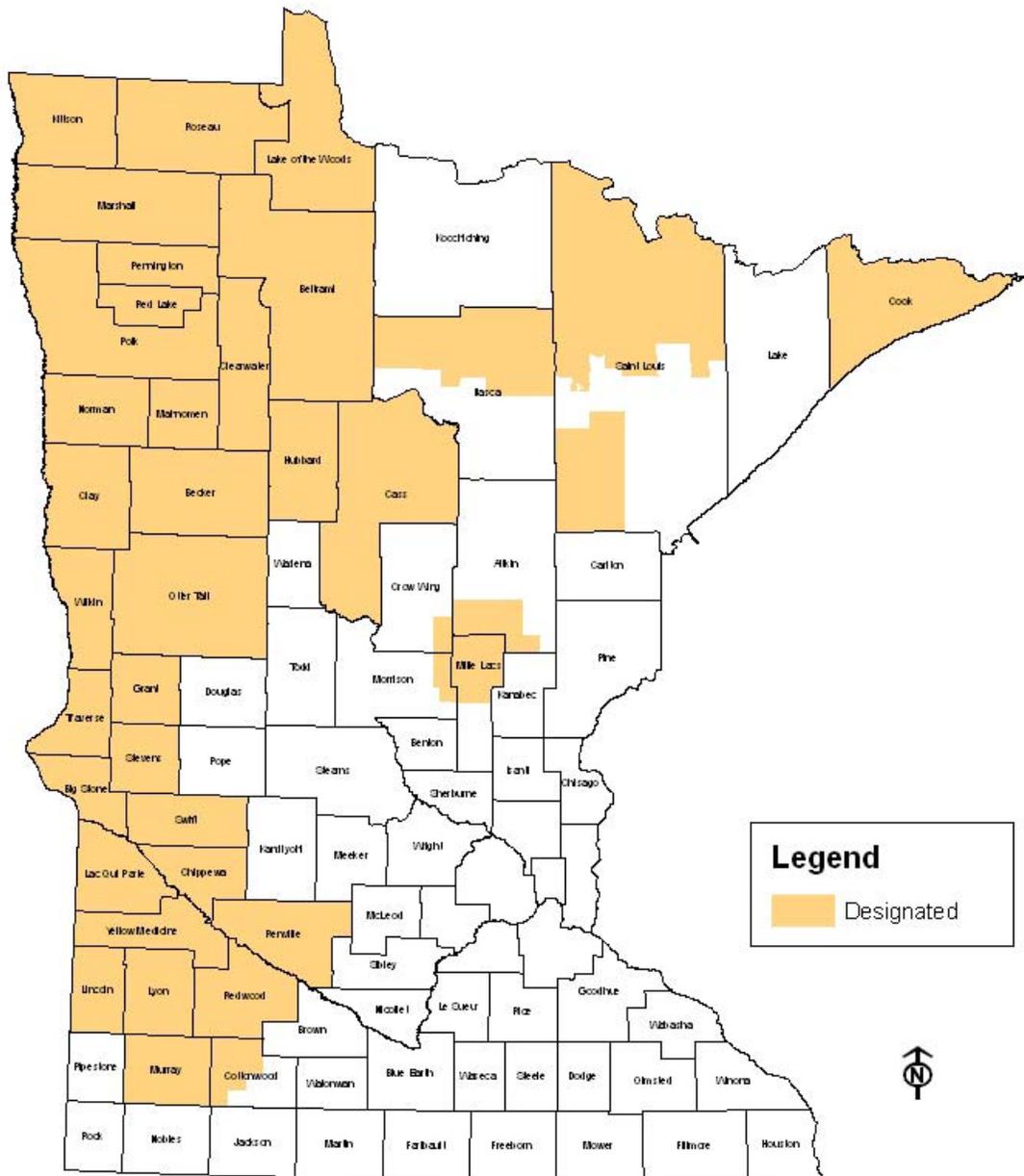


Source: Minnesota Department of Health
Office of Rural Health and Primary Care
February 2008
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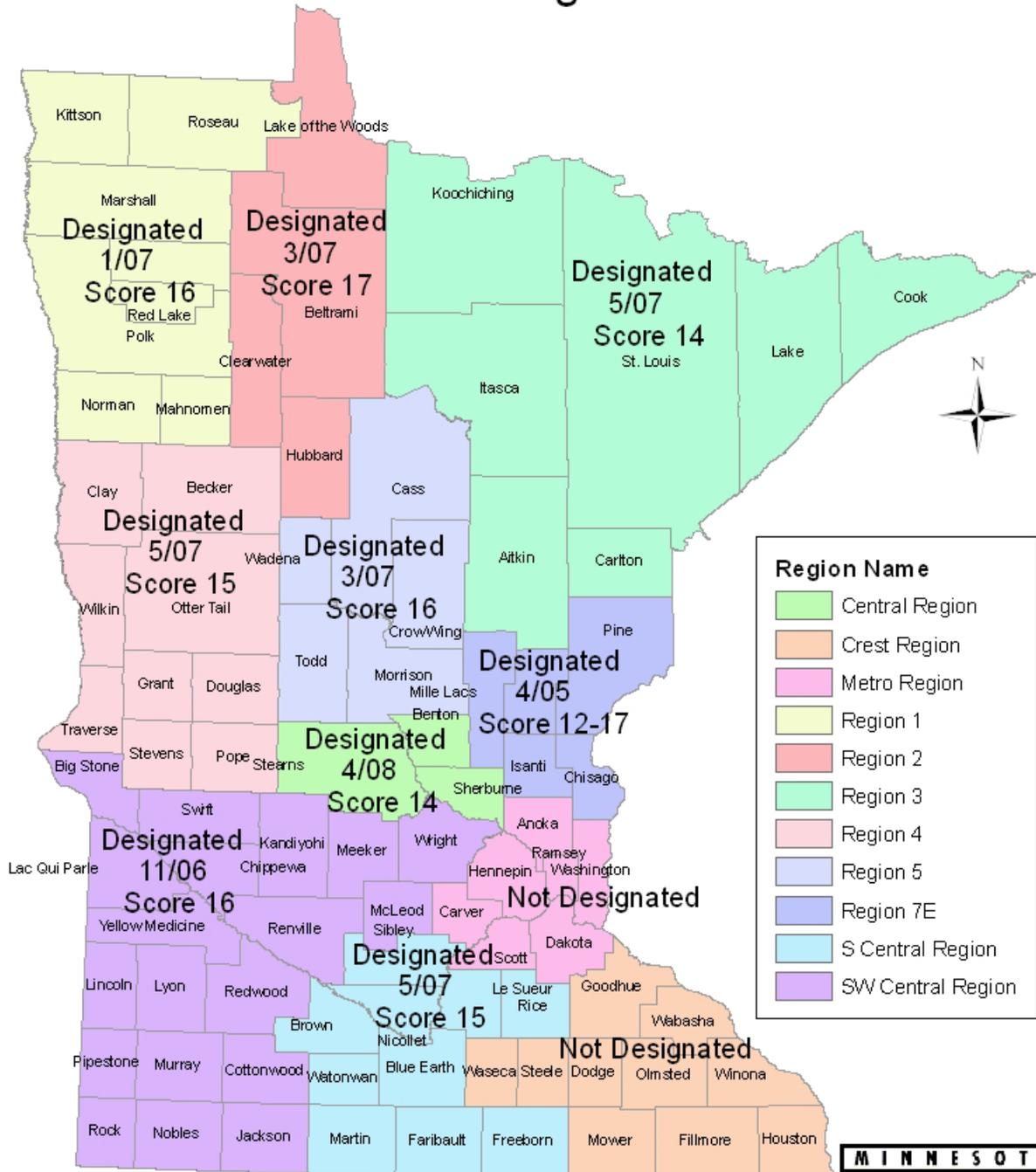
Health Professional Shortage Areas

Dental Designations



State DD HPSA February 2008

MN Rational Service Areas - Mental Health HPSA Designations



Source: Minnesota Department of Health
Office of Rural Health, May 2007
HPSA designations 7_08.mxd



Appendix C: Language Access Services in Critical Access Hospitals for People With Limited English Proficiency

ABSTRACT

Objectives. This study examined how well Critical Access Hospitals (CAHs) were meeting the needs of patients with limited English proficiency in rural Minnesota. The specific objectives were to: 1) describe the level of resources and policies devoted to the provision of language access services; 2) assess the demand for language access services; 3) assess the availability, quality and costs of providing language access services; and 4) compare the costs of providing language access services in rural areas in Minnesota by region and proximity to metropolitan areas.

Methods. Respondents were staff from CAHs in rural areas in the state of Minnesota (n=60). Data on language access services were obtained using a mail questionnaire. Results were analyzed using counts, frequencies, and cross-tabulation analysis.

Results. Key findings were: 1) less than half (41%) of CAHs had designated staff for managing language access services for patients with limited English proficiency; 2) a majority of CAHs provided oral and written translation services as well as signage posted in languages other than English; 3) nearly one quarter (23%) of CAHs assessed the skills and competencies of interpreters; 4) the average reported cost to provide language access services for each limited English proficient patient encounter was \$68, but reimbursement for providing these services was limited; and 5) the costs of providing language access services varied by region and proximity to metropolitan areas.

Conclusions. CAHs used a variety of methods to provide language access services for patients with limited English proficiency. Practice and policy implications of study findings are discussed.

The complete report is online at <http://www.health.state.mn.us/divs/orhpc/rhac/pubs.html>.

Appendix D: Mental Health and Primary Care in Rural Minnesota

Executive Summary

Mental health is an integral part of a person's general health and well-being. In rural areas, where specialized mental health services are scarce, accessing mental health professional services can involve long drives and long waits. Primary care is often the only system for delivering mental health services.

Recognizing the important role of primary care in rural mental health care, the Rural Health Advisory Committee (RHAC), a governor appointed committee charged with advising the Commissioner of Health and others on rural health issues, formed a statewide work group to study access to mental health services through the primary care system. Over the past year and a half, the work group examined state and national information on rural mental health and primary care, surveyed rural providers, looked at examples of promising practices for education and care delivery. This report presents these results, along with recommendations for public and private policymakers that will improve care through the rural primary care system.

Key Findings

Work group study, discussion and surveys done over the past year and a half show:

- Rural primary care providers are seeing an increase in mental/behavioral health issues in their clinics.
- The shortage of rural mental health providers results in long waits for appointments and long travel to obtain specialty care.
- The cost of mental health care and the complexity of the payment system are barriers for patients seeking care.
- A stigma about mental/behavioral health problems is a barrier to care, especially in rural areas.
- Rural primary care practitioners would like more education on managing mental and behavioral health.

Integration of mental health into primary care is a key to ensuring the best quality services. Innovations already exist in some rural Minnesota communities, including integration of mental health professionals within the primary clinic system and use of telecommunication services.

Recommendations

Improving mental health care in the primary care system is dependent on a number of factors including:

- Availability of a trained professional workforce in primary and mental health care
- Adequate funding so health systems are able to provide needed mental health services
- Effective state and federal policies that support mental health care.

Health Professional Education

These first recommendations are targeted at academic health programs that train health professionals who care for patients with mental/behavioral health concerns. These recommendations also apply to health professional organizations and associations responsible for continuing education.

- Enhance and promote mental/behavioral health education and training for all health profession students training in primary practice.
- Enhance mental/behavioral health training for those in family medicine residencies.
- Promote and develop rural site experiences for primary care and mental health practitioners that emphasize collaborative practice within the primary care setting.
- Develop and support rural site experiences for those in psychiatric residency programs.
- Develop and support accessible mental health related continuing education for rural primary care providers.
- Include mental/behavioral health content in conferences and other continuing education opportunities for primary care providers, as well as nontraditional audiences such as pharmacists, dentists, school nurses, counselors and law enforcement personnel.

Health Systems

The second set of recommendations include a variety of entities including health care provider systems and networks, hospitals, clinics and payer systems.

- Promote and support demonstration projects and models of collaborative care between mental health providers and primary care providers.

- Develop a common set of mental health benefits. Support the work being done through the Minnesota Mental Health Action Group to develop a basic set of mental health benefits common to all health plans.
- Advocate for funding streams that promote collaborative and integrated mental health and primary care models.
- Promote and expand telehealth collaborations to strengthen delivery of mental health services in remote and underserved areas.
- Develop quality improvement projects that address mental health bed capacity, appropriate patient transfer and continuing education for emergency room personnel.
- Create an understandable guide to the current payment system for mental health care for rural primary care providers and rural mental health providers.

State and Federal Policies and Programs

The third set of recommendations are meant for policymakers including the legislature, state agencies and the federal government.

- Expand state-funded health professional loan forgiveness programs to include psychologists, social workers and other mental health professionals who agree to work in rural areas
- Support efforts to expand public program coverage of telehealth consultations by mental health professionals.
- Eliminate the funding rule for the Medical Education and Research Costs program that requires small sites to have at least a 0.5 FTE health professional student in any given discipline in order to receive training reimbursement.
- Eliminate the copayments on psychopharmaceuticals for Medicaid and MinnesotaCare.
- Support the Minnesota Mental Health Action Group's efforts to develop best practice and benefit models.
- Provide Medical Assistance reimbursement for care management and coordination of care for patients with complex mental health needs.
- Establish an access-to-care standard that recognizes both distance to services and waiting time.
- Promote development and utilization of electronic records in mental/chemical/behavioral health. Ensure that the rural mental health community is represented in state level discussions on developing and implementing electronic health records.
- Support the development of crisis response teams through collaboration with the Minnesota Department of Human Services, counties and health plans.
- Promote mental health emergency quality improvement projects in critical access hospitals through funding from the Medicare Rural Hospital Flexibility grants.

- Improve Medicare coverage for mental illness and bring it to parity with physical illness coverage. The current Medicare Part B coinsurance rate for mental health services is 50 percent as opposed to 20 percent for physical health services.
- Create a coordinated state data collection and analysis system for mental health incidence, prevalence and treatment data in Minnesota.

Improving mental health service delivery through the rural primary care system involves approaches that recognize the need for a competent and qualified workforce; up-to-date education for primary providers and policy; and funding streams that support the complexity of care.

Appendix E: The 2008 Minnesota Rural Health Conference

JUNE 23-24, 2008 • DULUTH, MINNESOTA



ENGAGING COMMUNITIES & TRANSFORMING HEALTH CARE
MINNESOTA CRITICAL ACCESS HOSPITAL & RURAL HEALTH CONFERENCE

Dear Rural Health Colleagues,

The Critical Access Hospital and Minnesota Rural Health Conference is an opportunity to exchange ideas and share experiences on rural health care innovations and collaborations. In keeping with this year's theme, **Engaging Communities and Transforming Health Care**, speakers, presenters and exhibitors will showcase forward-thinking ideas in response to emerging challenges.

Everyone is encouraged to attend this two-day conference! Monday morning and early afternoon focuses on Critical Access Hospitals and their communities. Monday afternoon features the Rural Health Policy Forum with state legislators, followed by an early evening reception overlooking the Duluth Harbor. Tuesday takes an in-depth look at quality, and the workforce, financial viability and population of rural health communities. In the middle of this full day of keynotes and breakout sessions, we will stop to recognize the Minnesota Rural Health Hero and Team nominees.

Please join us in Duluth—your participation ensures that this event is an effective forum for learning and collaborating about critical rural health issues. We look forward to seeing you there.

Mark Schoenbaum, Director
Office of Rural Health and
Primary Care – Minnesota
Department of Health

Barbara Muesing, President
Minnesota Rural
Health Association

Sally Buck, Associate Director
Rural Health Resource Center –
Minnesota Center for Rural Health

Office of
Rural Health Primary Care
MINNESOTA DEPARTMENT OF HEALTH



Rural Health
Resource Center

KEYNOTE SPEAKERS



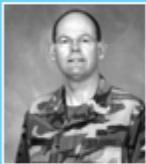
Gary Boelhower, Ph.D.
*Chair of Theology and Religious Studies,
College of St. Scholastica*

Making the Best Possible Decisions

We make decisions all day, every day.

Leaders make wise decisions. Fortunately

wise management decision making is a skill that can be honed using a process that encompasses options and alternatives. Dr. Boelhower will identify a set of operating principles for effective decision making. Using this criteria to make sound judgments reduces stress, gives you time to think, and provides a model that you can rely on.



Chaplain (Maj.) John Morris
*Army Chaplain, Minnesota Army
National Guard*

The Challenges of Reintegration for Combat Veterans and Their Families

The wars in Afghanistan and Iraq have

produced over 1.5 million new combat veterans. The return of these veterans to our communities is a significant public health issue. In compelling detail, Chaplain Morris will describe Minnesota's Beyond the Yellow Ribbon program, which has become a national model to address the key issues of reintegration facing combat veterans, their families and communities, and how health care providers can help.



John Becknell
Best Practices in Emergency Services

The Troubled State of Rural EMS and the Good News Ahead

The Institute of Medicine report on the
Future of Emergency Care calls the state

of EMS "troubled" and describes a unique set of problems. Fragmented delivery models, uneven care, scarce resources, dwindling volunteers, recruitment and retention problems, an aging population, an inadequate reimbursement model, increasing transport distances and growing expectations for disaster preparedness have all created an uncertain future for rural EMS. But all is not dark. In some areas the sun is breaking through as communities, government and health care leaders understand the important role and value of EMS in rural health. Starting with the current challenges to rural EMS this fascinating and fast moving presentation explores where we are, how we got here and then envisions the exciting possibilities of rural EMS systems becoming fully integrated into health care and public health.

MONDAY JUNE 23

CRITICAL ACCESS HOSPITAL DAY

7:30 a.m. – 5:00 p.m.

Registration

7:30 a.m. – 8:30 a.m.

Continental Breakfast (Lake Superior Ballroom Foyer)

8:30 a.m. – 8:45 a.m.

Welcome and Introductions (Lake Superior Ballroom)

8:45 a.m. – 10:00 a.m.

Opening Keynote – Making the Best Possible Decisions

Gary Boelhower, Ph.D., College of St. Scholastica

10:00 a.m. – 10:30 a.m.

Break (Exhibit Hall)

10:30 a.m. – 11:30 a.m.

Breakout Session 1

1A – Lakewood Health System: A Case in LEAN Principles

Tim Rice, M.B.A., Lakewood Health System

Cindy Swenson, R.N., Lakewood Health System

Presenters will explain how to improve quality, increase safety and reduce costs by defining a performance management approach, developing strategies for performance improvement, fostering a culture of continuous daily improvement, and considering people, processes and technology.

1B – Making Long Term Care Feasible

Gregg Redfield, Minnesota Hospital Association

Al Vogt, Cook Hospital

John Fossum, Ely-Bloomenson Community Hospital

Hospitals with attached nursing homes in Minnesota have struggled with the direct and indirect costs of nursing homes compared to reimbursement received. This session will provide attendees with financial strategies on how to assess their nursing home and learn from two other rural hospitals who are dealing with these financial issues.

1C – On the Rural Roads with Pediatric Simulation Training

Karen Mathias, M.S., A.P.R.N.-B.C., Children's Hospitals and Clinics of Minnesota, Simulation Center

Barbara Peterson, R.N., Children's Hospitals and Clinics of Minnesota, Simulation Center

This introduction to simulation in health care and its use in rural areas to support pediatric and neonatal emergency training will

demonstrate simulation via a video clip, and take simulation from a concept to a customized program for rural hospitals.

11:30 a.m. – 12:30 p.m.

Networking Lunch (Exhibit Hall)

12:30 p.m. – 1:30 p.m.

Breakout Session 2

2A – The Strategic Foundation Beneath our Health Care Transformation – Physician Integration, Electronic Health Records (EHR) and Community Collaboration

Toby Frier, M.B.A., New Ulm Medical Center

Participants will learn how New Ulm Medical Center implemented physician integration; a fully operable EHR; and wellness and prevention partnerships to stabilize health care costs and address community health challenges.

2B – Health Care Construction: Moving Your Project From Concept to Reality

Colleen Spike, R.N., St. Peter Community Hospital

About two-thirds of Minnesota's rural hospitals were built in the 1960s or earlier, yet are accommodating a much different health care delivery system with immense changes in technology. The prospect of rebuilding can be daunting but very doable with the right preparation, planning and support.

2C – Implementing a Culture of Safety in Small Rural Hospitals

Marilyn Grafstrom, LifeCare Medical Center

Annette Krizler, R.H.I.T., Stratis Health

Rick Nordahl, Sanford Tracy Medical Center

Rural hospitals participating in culture work have provided a better understanding of their safety culture and helped identify current strengths and challenges, along with opportunities to improve the safety of patients in their hospitals.

1:40 p.m. – 2:40 p.m.

Breakout Session 3

3A – CAH Medicare Survey and Program Evaluation

Jill Myers, Wipfli

Be confident and prepared for your next CAH Medicare survey. This session will review the Medicare Interpretive Guidelines for CAHs, focus on areas commonly cited and provide tips and tools for ensuring a smooth survey.

3B – Culture of People

Rick Nordahl, M.B.A., H.C.A., Sanford Tracy and Westbrook Medical Center

A shift in culture is how health care will be transformed. Focusing on people — our consumers and our employees — will make the difference in how we deliver care and how it is received. This session will provide an overview of the strategic initiative to enhance employee engagement that in the end focuses all strategy on the patient/customer.

3C – CALS – Emergency Team Training for Rural Health Care Providers

Darrell Carter, M.D., Comprehensive Advanced Life Support

Kari Lappe, R.N., Comprehensive Advanced Life Support

Comprehensive Advanced Life Support (CALS) presents a single curriculum that covers the majority of emergency/critical care situations so that rural health care providers are proficient in treating undifferentiated emergencies, including disasters.

2:40 p.m. – 3:00 p.m.

Break (Exhibit Hall)

3:00 p.m. – 5:00 p.m.

Minnesota Rural Health Association (MRHA) Rural Policy Forum (Harbor Side Ballroom)

5:00 p.m. – 6:30 p.m.

Evening Social Reception (Harbor Side Ballroom Foyer)

TUESDAY JUNE 24

6:45 a.m. – 8:00 a.m.

MRHA's Annual Meeting (Boardroom)

The election of officers for 2008-2009 will be conducted in conjunction with the regular board meeting agenda. Guests/observers are welcome.

7:30 a.m. – 3:00 p.m.

Registration

7:30 a.m. – 8:15 a.m.

Continental Breakfast (Exhibit Hall)

8:15 a.m. – 8:30 a.m.

Welcome and Introductions (Lake Superior Ballroom)

8:30 a.m. – 9:30 a.m.

Opening Keynote – The Challenges of Reintegration for Combat Veterans and Their Families

Chaplain (Maj.) John Morris, Minnesota Army National Guard

9:30 a.m. – 10:00 a.m.

Break (Exhibit Hall)

10:00 a.m. – 10:50 a.m.

Breakout Session 4

4A – Navigating the Grant Process

Judith Bergh, Minnesota Department of Health-Office of Rural Health and Primary Care

Tami Lichtenberg, Rural Health Resource Center

As both grant writers and grant reviewers, these presenters are uniquely qualified to explain the basic elements of successful grant proposal writing and explore funding sources.

4B – Quality Improvement for a Healthy Minnesota

Kim McCoy, M.P.H., M.S., Minnesota Department of Health

Bill Riley, Ph.D., University of Minnesota

Sandy Tubbs, B.S.N., Douglas County Public Health

As members of the Minnesota Public Health Collaborative for Quality Improvement, 38 local health departments in Minnesota used the Model for Improvement to implement eight quality improvement projects. This session describes the process and demonstrates how it improved the delivery of mental health services.

4C – Culture Matters: Improving Cultural Competency in Minnesota's Rural Physicians Offices

Mary Beth Dahl, R.N., C.P.C., C.P.H.Q., Stratis Health

Jeff Walkup, Stratis Health

Stratis Health (Minnesota's Quality Improvement Organization) worked with approximately 30 physician offices on providing culturally-competent care for their patients, using assessments, demographic information, a series of DVDs and other tools and resources.

4D – Addressing Dental Access Through Community-based Education

Barbara F. Brandt, Ph.D., University of Minnesota

Patrick Lloyd, D.D.S., M.S., University of Minnesota

Lawrence J. Massa, Rice Memorial Hospital

Paul Shulz, D.D.S., M.P.H., University of Minnesota

This session will describe the successful partnership of the University of Minnesota School of Dentistry, the Minnesota

Area Health Education Center and community organizations and members to develop and operate community-based dental clinics in Hibbing and Willmar, Minnesota.

4E – Office of Rural Health, Department of Veterans Affairs

Kara Hawthorne, Office of Rural Health, Department of Veterans Affairs

Rural health remains a challenge for our broader health care system, and the unique issues faced by veterans pose even greater difficulties. The Office of Rural Health was established to address the unique needs of veterans residing in rural areas. Presentation will look at current Veterans Affairs programs, and considerations for new initiatives.

11:00 a.m. – 11:50 a.m.

Breakout Session 5

5A – A Report on the Design, Implementation and Progress of Post-Doctoral Residency in Rural Psychology

Kimberly Haala, Ph.D., Minnesota Consortium for Advanced Rural Psychology Training

Jeffery Leichter, Ph.D., MeritCare Health System

Sue Sailer, L.S.W., Perham Memorial Hospital and Home

The founders of the Minnesota Consortium for Advanced Rural Psychology Training will explain how they went from addressing a need for customized training of post-doctoral psychologists to full implementation and how their success can be replicated.

5B – Increasing Supply of Primary Care Physicians in Rural Minnesota

Frank B. Cerra, M.D., University of Minnesota-Twin Cities

Raymond G. Christensen, M.D., University of Minnesota-Duluth

Ira Moscovice, Ph.D., University of Minnesota Rural Health Research Center

This session will discuss options for stimulating the supply of primary care physicians, with specific emphasis on strategies that can be used by the Academic Health Center at the University of Minnesota, federal and state governments, and the private sector.

5C – Improving Continuity of Care After Treatment Through the use of Survivor Care Plans

Elizabeth Moe, M.P.H., Minnesota Department of Health

Anna Ourada, Minnesota Cancer Alliance and the American Cancer Society

Cancer Survivor Care plans are proving to be a useful tool in improving communication among oncologists, primary care physicians and their patients about treatment, possible side effects and necessary follow-up care.

5D – Financial Leadership for Nonprofit Organizations

Kate Barr, M.A., Nonprofits Assistance Fund

This session will discuss how to provide leadership by setting the tone for accountability, ensuring competence in financial management staff, incorporating financial decisions in all planning activities, and communicating useful and honest financial information both within and outside the organization.

5E – Bridging Youth, Family, Community: Working Together to Build a Healthy Community

Michele Andringa, Unity Family HealthCare

The Bridges program improves the lives of children and strengthens their families by offering school-based, early intervention mental health services and an intensive, evidence-based family support program.

12:00 p.m. – 12:45 p.m.

Awards Luncheon (Harborside Ballroom)

12:45 p.m. – 1:10 p.m.

Coffee and Dessert (Exhibit Hall)

1:10 p.m. – 2:00 p.m.

Breakout Session 6

6A – Educating Rural Health Care Students Using an Academic EHR System: A Collaborative Effort in Minnesota

Valerie DeFor, M.H.S.A., Healthcare Industry

Education Partnership

Kathleen Thiede, M.A., College of St. Scholastica

Learn about the academic EHR technology, which the College of St. Scholastica developed and MnSCU campuses and private colleges are using throughout the state.

6B – Engaging Communities and Transforming Health Care Through Administrative Simplification

Shelagh Kalland, Administrative Uniformity Committee

Minnesota will require all health care providers and group purchasers to exchange three common health care administrative transactions electronically, using a standard data format and content. Learn about Minnesota's nation-leading efforts to reduce health care administrative burdens and cost, how the law is being implemented, and what it means for providers.

6C – Take Heart America: Sudden Cardiac Arrest Survival Initiative, an Imperative and Life Saving Collaboration of our Communities

Robert Kempenich, Take Heart St. Cloud

Charles Lick, M.D., Allina Medical Transportation

Janet Steinkamp, M.A., Take Heart St. Cloud

Take Heart America is a demonstration project designed to deploy state-of-the-art resuscitation science strategies to improve survival from sudden cardiac arrest (SCA) in Anoka County and St. Cloud, Minnesota; Columbus, Ohio and Austin, Texas. The goal in the St. Cloud area is to improve the overall survival rate of out-of-hospital SCA from 5 percent to more than 20 percent.

6D – Minnesota Rural Palliative Care Project

Janelle Shearer, M.S.N., Stratis Health

Sandra Stover, Cook County North Shore Hospital

Palliative Care is a system and philosophy of delivering health care to provide comfort and relieve pain and other symptoms of chronically ill and dying patients. Stratis Health and Fairview Health System are collaborating on the Minnesota Rural Palliative Care Project to increase awareness and build skills.

6E – New Models of Care: Interprofessional Practice and Education Teams

Brendan Ashby, M.B.A, M.P.H., C.H.E.S., Northeast Minnesota Area Health Education Center

Raymond Christensen, M.D., University of Minnesota - Duluth

Julie Shelton, St. Mary's Duluth Clinic

Chris Thiessen, Gateway Clinic

This session will describe Interprofessional Practice and Education (IPE) projects operating throughout the state with support from Minnesota Area Health Education Center to address health disparities and ultimately improving community health outcomes.

2:15 p.m. – 2:45 p.m.

Closing Keynote – The Troubled State of Rural EMS and the Good News Ahead

John Becknell, Best Practices in Emergency Services

2:45 p.m. – 3:00 p.m.

Closing Comments and Prize Drawing

LOCATION & LODGING

Duluth Entertainment and Convention Center (DECC)
350 Harbor Drive, Duluth, MN 55802
(218) 722-5573 • www.decc.org

Lodging

Rural Health Conference rates will be held until May 24, 2008.

Canal Park Lodge
www.canalparklodge.com
250 Canal Park Drive
Duluth, MN 55802
(218) 279-6000 • (800) 777-8560

Group Name: Minnesota Rural Health Conference
\$94.00/night plus tax.

Inn on Lake Superior
www.theinnonlakesuperior.com
350 Canal Park Drive
Duluth, MN 55802
(218) 726-1111 • (888) 668-4352

Group Name: Minnesota Rural Health Conference
\$94.00/night plus tax.

Weather

In June, temperatures in Duluth range from 56 to 78 degrees. We recommend that you dress in layers!

Duluth, MN



Registration Fees

Pre-payment required

- \$150 full conference registration
- \$75 one-day registration
- \$100 full conference registration for speakers (\$50 discount)
- Travel Discount: \$100 full conference registration for those who travel more than 250 miles one-way to Duluth
- \$30 full conference registration for students

Continuing Education Credits (CEUs and CMEs)

Application has been made for continuing education for health care executives, nurses, nursing home administrators, pharmacists and physicians.

Cancellations/Substitutions

Registration fees, minus a \$40 processing charge, will be refunded if written cancellation is received before June 13, 2008. If a registered person cannot attend, a substitute is welcome. Please fax or email the name of the substitute to (218) 727-9392 or nclement@ruralcenter.org, so the attendee list can be updated.

Reasonable accommodations are available (e.g., dietary needs or sign language). Contact Summer Fosdick, Rural Health Resource Center, (218) 727-9390 ext. 233 or sfosdick@ruralcenter.org.

HIGHLIGHTS

Exhibitor Fair

The Exhibit Fair will be the center of activity for the networking lunch, breakfast, dessert and breaks. Informational exhibits with program and resource information will be on display throughout the conference.

Last year's conference attracted 50 exhibitors and we anticipate an equally large number of exhibitors again this year, including Minnesota Children's Hospitals and Clinics Simulation Bus.

If your organization would like to sponsor the Minnesota Rural Health Conference, contact Summer Fosdick at (218) 727-9390 ext. 233 or complete the forms online at www.health.state.mn.us/divs/orhpc/conf/2008/index.html.

Monday Evening Reception

Monday June 23, 5-6:30 p.m.

Join us for an evening reception including live entertainment, appetizers and a cash bar overlooking the Duluth Harbor.

Minnesota Rural Health Association Policy Forum

Dr. Jack Geller, president of the Minnesota Rural Health Association, will convene the popular Rural Health Policy Forum. Don't miss this opportunity to engage in a lively discussion with health care leaders from the Minnesota Legislature.

Minnesota Rural Health Awards Presentation

Tuesday, June 24, 12-12:45 p.m.

The Minnesota Rural Health Hero and Team Awards will be presented following the luncheon on Tuesday, June 24.

Gift Giveaway

Participants who visit the Exhibit Fair and stay until the end of the conference are eligible for prizes.

**2008 Minnesota Critical
Access Hospital and
Rural Health Conference
Planning Committee**

- Benedictine Health System
- Minnesota Ambulance Association
- Minnesota Area Health Education Center
- Minnesota Dental Association
- Minnesota Department of Health-Data Resources and Management, Health Economics Program
- Minnesota Department of Health, e-Health Initiative
- Minnesota Department of Health-Office of Public Health Practice
- Minnesota Department of Human Services
- Minnesota Hospital Association
- Minnesota Medical Association
- St. Peter Community Hospital
- Stratis Health
- University of Minnesota Rural Health Research Center

The Minnesota Department of Health - Office of Rural Health and Primary Care, Minnesota Rural Health Association and Rural Health Resource Center - Minnesota Center for Rural Health would like to thank members of the Planning Committee who contributed time and resources to develop the program, provide networking opportunities and promote the conference.

REGISTRATION FORM

Please return the completed form with payment by **June 9, 2008** to:
2008 Minnesota CAH & Rural Health Conference
Rural Health Resource Center, Minnesota Center for Rural Health
600 East Superior St. Suite 404, Duluth, MN 55802 • Fax: (218) 727-9392
Registration and the registration brochure are available online at:
<http://www.health.state.mn.us/divs/orhpc/conf2008/index.html>

First Name	MI	
Last Name		
Organization	Title	
Street Address		
City	State	Zip
Telephone	Email	

Please include an email so we can email your registration confirmation

Breakout Sessions (Please choose one from each session)

Monday	Tuesday
Session 1: 1A 1B 1C	Session 4: 4A 4B 4C 4D 4E
Session 2: 2A 2B 2C	Session 5: 5A 5B 5C 5D 5E
Session 3: 3A 3B 3C	Session 6: 6A 6B 6C 6D 6E

Special Events (these events are included in your registration fee, please check if you plan to attend)

- Networking Lunch, Monday, June 23
 - Evening Reception, Monday, June 23
 - Continental Breakfast, Tuesday, June 24
 - Awards Luncheon, Tuesday, June 24
- choose one: Chicken Walleye

CEU/CME Credit (check one):

- American Academy of Family Physicians
- Minnesota Board of Examiners for Nursing Home Administrators
- Minnesota Board of Nursing
- Minnesota Board of Pharmacy
- Non-ACHE Category II Healthcare Executive

Registration Fee

- \$150 Full Conference
- \$100 Speaker/Travel Discount
- \$75 Monday only
- \$75 Tuesday only
- \$30 Student

Total Amount Enclosed:

- Check (payable to RHRC) Check #: Visa MasterCard

Card Number Expiration Date

Card Holder name Email

Company name (if company credit card)

Credit Card Billing Address (if different from address above)

Card Holder Signature Date

Questions contact: Summer Fosdick, (218) 727-9390 ext. 233 or sfosdick@ruralcenter.org

Note: By providing your contact information, you authorize the Rural Health Resource Center to communicate with you regarding event information and to process your registration, including credit card charges, if you choose that format.

Appendix F: Rural Health Advisory Committee, Priorities



Rural Health Advisory Committee

October 2008

The Rural Health Advisory Committee is a statewide forum for rural health interests with a diverse membership. The Committee's duties are defined in statute to:

- Advise the commissioner of the Minnesota Department of Health and other state agencies on rural health issues
- Provide a systematic and cohesive approach toward rural health issues and planning, at both a local and statewide level
- Develop and evaluate mechanisms to encourage greater cooperation among rural communities and among providers
- Recommend and evaluate approaches to rural health issues that are sensitive to the needs of local communities and
- Develop methods for identifying individuals who are underserved by the rural health care system (Minnesota Statutes section 144.1481).

2007-2009 Work Plan

Areas of Concern

- Rural Health Care Workforce Issues
- Development of a New Rural Health Care Delivery Model
- Population Health Issues – Prevention and Chronic Disease, Diversity, Aging Uninsurance/Underinsurance
- Financial Stability of the Rural Health System
- Quality Improvement – Mental Health, Veterans' Issues, Emergency Care, Pay for Performance
- Information and Communications Technology

Projects

- Workgroup: Developing a New Rural Health Care Delivery Model
- Minnesota Rural Health Plan Update

Reports and Briefs

- Health Care Reform: Addressing the Needs of Rural Minnesotans (2007)
- Retaining Rural Nurses (2007)
- Creating Healthy Communities for an Aging Population (2006)
- Rural Mental Health and Primary Care (2005)
- Health and Well-being of Rural Minnesotans (2005)
- Rural Health Profiles (2003-2005) on Ambulance Services, Clinics, Hospitals, Hospice, Nursing Homes, Pharmacy
- A Quiet Crisis: Minnesota's Rural Ambulance Services at Risk (2002)
- Senior Health: A Report on Geographic Access to Health Services for Rural Seniors (2001)

Members 2008

John Baerg (Butterfield) Consumer
Thomas Boe, D.D.S. (Moorhead) Licensed Health Care Professional
Debra Carpenter (Erhard) Consumer
Ray Christensen, M.D. (Duluth) Higher Education
Thomas Crowley, Chair (Wabasha) Hospitals
Jode Freyholtz (Verndale) Consumer
Steve Gottwalt (St. Cloud) House of Representatives
Jeffrey Hardwig (International Falls) Physician
Margaret Kalina (Alexandria) Registered Nurse Representative
Diane Muckenhirn (Hutchinson) Mid-Level Practitioner
Tom Nixon (Deerwood) Volunteer Ambulance
Mary Ellen Otremba (Long Prairie) House of Representatives
Yvonne Prettnier-Solon (Duluth) Senate
Julie Rosen (Fairmont) Senate Member
Nancy Stratman (Willmar) Long Term Care

A Comparison of ORHPC-Related Rural Health Goals and Priorities

2007-2009 RHAC Priorities	2006 ORHPC Strategic Plan Goals	2008 Rural Health Plan Goals
Workforce	Support development of the health care workforce required to meet the needs of rural and underserved Minnesotans	Ensure a sound rural professional health care workforce
Rural Health Care Delivery Model	Ensure a strong, integrated rural health care system	Ensure a strong, integrated rural health care system
Personal & Population Health	Ensure a strong, integrated rural health care system	Foster improvements in rural health care access & quality
Financial Stability	Strengthen financial stability and capacity of Minnesota's rural & underserved urban health care system	Ensure a strong, integrated rural health care system
Quality Improvement	Ensure a strong, integrated rural health care system	Foster improvements in rural health care access & quality
Information & Communications Technology	Promote information and communications technology that meets rural Minnesota's health care needs	Support the use of health information technology and telehealth delivery in rural communities

Appendix G: Health Care Reform: Addressing the Needs of Rural Minnesotans

Executive Summary

Health care reform emerged from the 2007 Minnesota Legislature as a priority issue. During the legislative interim, study, analysis and recommendations were developed in multiple forums for consideration during the 2008 legislative session.

The Rural Health Advisory Committee (RHAC) established a Rural Health Reform Work Group to offer a rural voice to the health reform discussions. RHAC is a 15-member statutory body established to advise the Commissioner of Health and other state agencies on rural health issues. RHAC recommends and evaluates approaches to rural health concerns that are sensitive to the needs of local communities.

This work group identified the unique features of rural Minnesota that should be taken into consideration in developing state-level health care reform proposals. Rural Minnesota has 80 percent of the state's land area, 30 percent of the total population and 41 percent of those 65 and older. This older population has more chronic disease and disability, and there are other health status differences between rural and metro areas. Rural Minnesota has also experienced significant growth in minority and immigrant populations. Rural employment is disproportionately characterized by low-wage, part-time and seasonal jobs, making uninsurance more common. Rural Minnesotans who are insured are less likely to have employer-sponsored policies and more commonly have individually-purchased policies, often with high premiums, deductibles and copays.

Members of the work group included policy experts, health care providers, and academicians. Results of the work group will be shared with the Governor's Health Care Transformation Task Force and other stakeholders charged with making recommendations to the 2008 Legislature.

Options and recommendations in this report are organized according to the themes for action undertaken by the Health Care Transformation Task Force established by the 2007 Legislature.

Options and Recommendations

Reduce health care expenditures and limit the rate of growth.

- 1) Increase support for primary care and for educating primary care practitioners.
- 2) Reduce duplication by supporting integration and coordination of services.
- 3) Redesign health care jobs and health care delivery for better coordinated prevention and basic health care services delivery.
- 4) Support utilization of proven cost-effective technology, such as telehome care, telemental health services and teleradiology.

Increase affordable coverage options and ensure all Minnesotans have coverage.

- 1) Work toward universal coverage. The combined effects of higher uninsurance rates, lower availability and lower participation in employer coverage, lower rural incomes, and fewer satisfactory individual or small group market insurance options, leads this report to conclude that a comprehensive coverage solution will be required to meet the insurance needs of rural Minnesota.
- 2) Until a comprehensive coverage solution is available, this report recommends continued efforts such as those below, with a narrower focus on rural Minnesota, to improve coverage options.
- 3) Consider improving the affordability of commercial insurance by providing income-related premium subsidies on a sliding scale on policies purchased in the private market to any rural Minnesotan who has been without employer based coverage for more than 12 months.
- 4) Consider revisiting approaches for state participation in reinsurance strategies for the individual or small group markets, with attention to those issues determinant of past failures such as adverse selection, rising premiums and dwindling subscribers. Reinsurance, if available at a reasonable cost, may have the potential to improve the chances for pool approaches for these groups to succeed.
- 5) Revise the asset-related eligibility of MinnesotaCare in acknowledgement of the illiquid farmland assets held by lower income farm families.

Improve quality and safety of health care.

- 1) Financially support rural health promotion and chronic disease management pilots that integrate care provided by Critical Access Hospitals and community providers across the continuum.
- 2) Develop and incorporate rural relevant measures for quality into pay for performance strategies.
- 3) Design and support a rural health delivery model (i.e., medical home) where chronic and acute care is seamless.

Improve the health status of Minnesotans.

- 1) Develop a community-based health care mission covering the continuum of care from health promotion and disease prevention to chronic disease management and end-of-life care.
- 2) Support the role of local public health in data gathering, health promotion and disease prevention.

Change state health care purchasing to promote higher quality with lower cost.

- 1) Support and document the comprehensive approaches to case management, primary care, mental health and dental care being taken by state public programs' county based purchasing projects.
- 2) Study further options for expanding MinnesotaCare (or another state-sponsored but not necessarily state-subsidized program) to those with lower incomes and higher assets as well

- as small businesses (less than 10 employees). Support county and regionally based purchasing cooperatives.
- 3) Ensure that access standards for managed care networks reflect and support the rural health infrastructure.
 - 4) Allow pilot project initiatives that offer flexibility with how health care coverage is purchased by state employees or subsidized enrollees, with the goal of encouraging the development of rural-focused collaborative health networks.

Promote appropriate and cost-effective investment in new facilities, drugs and technologies.

- 1) Provide support for affordable and accessible electronic communication technologies (i.e., broadband) to ensure availability and sustainability of telehealth capacity in rural areas.
- 2) Develop rural centers of excellence through the University of Minnesota and Minnesota State Colleges and Universities to train the rural technology workforce needed to staff health information technology applications.
- 3) Develop centralized technical support models.
- 4) Expand support for telehealth in Minnesota.

Support options for serving small employers and employees and self-employed.

- 1) Increase affordable health care coverage for small employers.
- 2) Support county and regionally based purchasing cooperatives and alliances.
- 3) Encourage demonstration projects with new health benefit structures designed for rural residents who may have low incomes with high assets.
- 4) Continue to monitor innovative efforts in other states and be open to implementing those ideas on a demonstration or pilot basis.
- 5) Regularly assess the viable health coverage options available in rural Minnesota, through both formal and informal means.

Reduce administrative costs.

- 1) Provide rural and small facilities support for converting to standardized billing and eligibility systems.
- 2) Reduce duplication and centralize the repositories where quality data reported to government and private groups is collected.
- 3) Continue support for the adoption of interoperable electronic health records by maintaining the funding of state sponsored grants, loans and other financing options.

Appendix H: Healthy Aging Communities

Minnesota Department of Health

Fall 2005

Healthy Aging Community Models

Communities are finding new and creative ways of addressing the needs of older adults. The following models showcase a variety of ways that communities have responded by:

- Addressing basic needs
- Optimizing health and well-being
- Promoting social and civic engagement
- Maximizing independence for the frail and disabled.

Programs of All-inclusive Care for the Elderly (PACE) – A Rural Possibility

Since 1983, PACE has been serving frail senior citizens in urban programs throughout the United States. The program enables at risk seniors to live as independently as possible, in their homes and communities. PACE programs offer a comprehensive set of services including:

- Medical care
- Physical and occupational therapy
- Transportation
- Nutrition and meals-on-wheels
- Day care and respite services
- Home care and chore services.

The PACE model of care is supported through federal, state and private funds.

PACE in Winona, Minnesota: A rural PACE program is being developed by Winona Health Services, the Sauer Memorial Home, St. Anne Extended Healthcare and the Winona State University Nursing program. It will offer programs and services, including home and day care and nutrition, at the lowest cost possible. The Winona PACE program coordinates with the Department of Human Services - Minnesota Senior Health Options Program.

A Design for the Future

Osceola Medical Center, in Osceola, Wisconsin, has a service area that includes Polk, St. Croix, Washington and Chisago counties, the fastest growing counties in Wisconsin and Minnesota. In response to enormous population growth and the challenge

to expand services, the medical center is envisioning the development of a 21st Century health care campus, which will provide medical care from birth to end of life, emphasize disease prevention and promote active healthy lifestyles.

In partnership with Ecumen Senior Care Services, the expansion of an existing nursing home will include:

- Independent Senior Living
- Respite Care Center
- Adult Day Care Services
- Senior Activities Center
- Assisted Living Complex.

Working with Wild River YMCA, the campus complex also plans to have soccer and baseball fields, recreational activities and programming for all ages, a fitness center, a day care center and swimming pool. The design incorporates walking and biking paths connecting the Campus to Osceola, housing developments and environmentally friendly facilities and green space.

A Social Housing and Care Model

The philosophy of Green House is to provide excellent health care without making health care the central focus. The Green House concept seeks to reform traditional nursing home structures to actively engage residents and ward off loneliness, boredom and helplessness.

Green Houses transform physical space from the traditional nursing home design. For example, the ranch style Green House in Tupelo, Mississippi includes a communal dining table and open kitchen shared by nine residents. Resident care is conducted by Certified Nursing Assistants who perform and participate in all tasks related to the residents' care from cooking, cleaning and laundry to assistance with medications and daily tasks. Nurses visit the residents in their home to provide additional medical needs.

Healthy Aging Community Models – page 2

A recent study by Rosalie A. Kane, a professor at the University of Minnesota's School of Public Health, compares the quality of life for residents and staff members in Green Houses with two traditional nursing homes. Early results show differences that significantly favor Green Houses over other locations.

Beyond the Traditional Senior Center

Food is the chief lure of Mather Café Plus in northwest Chicago. Mather Lifeways has created attractive storefront venues that have become "hang-outs" for older people who are not interested in attending a traditional senior center. The cafés offer reasonably priced, varied menus and opportunities to take advantage of programs and services that older adults find interesting and/or vital to their independence, including:

- Exercise programs
- Computer classes and other education opportunities
- Nurse and social worker services.

The café menus, services and daily programs are based on feedback provided by older community members.

To identify safe and accessible café locations, Mather staff examined where older people in these neighborhoods go and how they get there. Mather has since opened an additional "Café Without Walls" in a church in another community, offering lunch and a lecture or another activity once a month.

Future objectives include:

- Integrating a health care and community outreach component into the cafés
- Engaging older people in teaching classes and staffing the cafés
- Using the cafés as a base to serve homebound community members.

Safety and Independence at Home

Initiated in St. Paul, Minnesota in 1981, the Living At Home/Block Nurse Program (LAH/BNP) offers support and services to any person over 65 living in the community regardless of ability to pay. It uses and coordinates existing agencies/services within the community that support an elders' desires to live in their own home. Volunteers provide many of the social and support services free of charge including:

- socialization and respite support
- simple home repairs, lawn and garden services
- assistance with paperwork
- transportation.

Professional nurses and trained staff work collaboratively with home care and public health agencies to provide health screenings, blood pressure/glucose monitoring, medication management, and health maintenance referrals/reminders. Skilled health care services are coordinated with a partner nursing agency or community provider.

An LAH/BNP is started by a community organization of interested residents who receive technical and sometimes financial start-up assistance from the Elderberry Institute. Local fundraising, in-kind contributions, and volunteers sustain the program. There are 17 programs in Minneapolis-St. Paul and 24 Greater Minnesota programs serving 928 elders.

Healthy Aging and Chronic Disease

Chronic Disease in Minnesota

Over the last century, Americans experienced dramatic gains in life expectancy due largely to improved sanitation, better medical care and increased use of preventive health services. With this has come a major shift in the leading causes of death from infectious diseases and acute illnesses to chronic diseases and degenerative illnesses.

- Two thirds of all Minnesotans, who die each year, die from a chronic disease.
- Chronic diseases represent the leading causes of death in adults ages 50 to 64 as well as those over 65.
- About 80 percent of older Americans are living with at least one chronic condition and 50 percent have at least two chronic conditions.ⁱ

In addition, more than one third of adults age 65 years and older fall each year. Of those who fall, 20 to 30 percent suffer moderate to severe injuries that reduce mobility and independence, and increase the risk of premature death.ⁱⁱ Of Minnesotans, 25.4 percent of 45- to 54-year-olds, 29.4 percent of 55- to 64-year-olds, and 32.5 percent of those 65 and older reported being limited in activities because of physical, mental or emotional problems.ⁱⁱⁱ

Risk Factors for Chronic Disease

Although the risk of disease and disability increases with advancing age, poor health and declining quality of life are not inevitable consequences of aging. Family history is an important factor in all chronic diseases, but three key modifiable risk behaviors contribute significantly to the major causes of premature death and disability:

- Tobacco use
- Physical inactivity
- Poor diet.

Preventive efforts directed at the three key risk behaviors can be highly effective among the elderly in decreasing or delaying disease and disease complications, reducing pain and disability, and maintaining mobility and independence.

Modifiable Behaviors	All Minnesota Adults	Prevalence 65+ years
Tobacco Use ^{iv} -- Adults who are current smokers	21.1% (2003)	8.1 % (2003)
Physical Activity ^v -- No physical activity in the past month	15.8% (2004)	23.0 % (2004)
-- 30+ minutes of moderate physical activity five or more days or 20+ minutes of vigorous physical activity three or more days	49.0 % (2003)	42.1 % (2003)
Fruit & Vegetable -- Intake equals 5+ per day ^{vi}	24.5% (2003)	33.5 % (2003)

Heart disease, cancer, stroke, diabetes, osteoporosis, arthritis, hypertension, obesity and possibly Alzheimer's disease may be prevented, delayed or diminished in impact by addressing these behaviors at all ages.

Chronic diseases and conditions and poverty are interconnected. It is the poorest people who are most at risk of developing chronic diseases and conditions, developing complications and dying prematurely. Chronic diseases and conditions may also contribute to poverty as they affect the family's ability to maintain employment, insurance and income.^{vii}

While overall rates for Minnesota adults for many chronic diseases and conditions are lower than the national average, significant disparities in death rate and rates of complications exist between racial and ethnic groups in the state. This is particularly true for diabetes, heart disease, stroke and cancer.^{viii}

Healthy Aging & Chronic Disease – page 2

Strategies for Intervention

As with younger populations, effective intervention requires addressing not only individual behavior, but also addressing the community support systems and environmental conditions that will support healthy choices for adults. There is an important role for public health, health care providers, agencies on aging and community partners in creating and supporting environmental conditions and services that allow people to maximize their potential for healthy aging.^{ix}

Some evidence-based strategies that can be implemented by communities include:

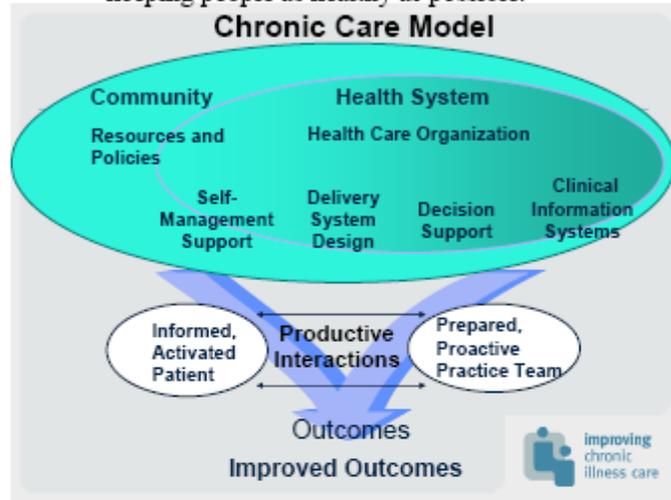
- Increasing the availability and accessibility of pedestrian-friendly environments and recreational facilities and activities for seniors
- Increasing the availability and accessibility of healthy foods, especially fruits and vegetables
- Creating smoke-free environments
- Improving systems to provide attention to medication management
- Increasing the availability of effective community-based chronic disease self-management education and smoking cessation programs
- Providing home safety assessment and assistance
- Improving systems to provide appropriate screening for chronic disease, falls and their risk factors.

It is a mistake to regard age as a downhill grade toward dissolution. The reverse is true. As one grows older, one climbs with surprising strides.

~George Sand

Chronic Care Model

The Chronic Care Model can be used to identify essential components of a system that encourages high-quality chronic disease management working across the continuum of sectors in health, public health and the community. Using this model we can move from a system that is reactive to one that is proactive and focused on keeping people as healthy as possible.



The Chronic Care Model was developed by Ed Wagner, MD, MPH, Director of the W.A. MacColl Institute for Healthcare Innovation at the Center for Health Studies, Group Health Cooperative of Puget Sound, with support from The Robert Wood Johnson Foundation: www.ihl.org/IHL_Topics/ChronicConditions/AllConditions/Changes/

ⁱ Centers for Disease Control and Prevention. Public health and aging: trends in aging—United States and worldwide. MMWR 2003;52(06):101-106.

ⁱⁱ Falls Free: Promoting a National Falls Prevention Action Plan, The National Council on the Aging, Home Safety Council, Archstone Foundation, 2005

ⁱⁱⁱ Behavioral Risk Factor Surveillance System, Prevalence data, Minnesota 2003, www.cdc.gov,

^{iv} Behavioral Risk Factor Surveillance System, Prevalence data, Minnesota 2003, www.cdc.gov

^v Behavioral Risk Factor Surveillance System, Prevalence data, Minnesota 2004, www.cdc.gov

^{vi} Behavioral Risk Factor Surveillance System, Prevalence data, Minnesota 2003, www.cdc.gov

^{vii} Preventing Chronic Diseases: A Vital Investment, WHO Global Report, WHO, 2005

^{viii} Minority and Multicultural Health, Minnesota Department of Health, www.health.state.mn.us

^{ix} Public health and aging: Trends in aging—United States and worldwide. MMWR, February 14, 2003/52(06); 101-106

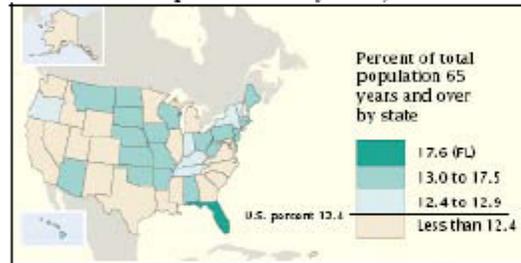
Demographics of an Aging Population

Aging in the United States

In 2000, 35 million people over the age of 65 lived in the United States, accounting for about 12 percent of the total population. The 65 and older population makes up more than 15 percent of most European Union countries and nearly 19 percent in both Italy and Japan.

Within the age 65 and over population in 2000, 18.5 million (52.9 percent) were aged 65-74, 12.3 million (35.2 percent) were aged 75-84, and 4.2 million (11.9 percent) were aged 85 and over. State percentages of people 65 years and over vary widely across the U.S. (see map below).

Percent Total Population 65+ by State, 2000



In 2000, women made up 58 percent of people aged 65 years and over and 69 percent of those 85 years and over. Older women are less likely than older men to be married and twice as likely to live alone. A majority of older men (65 percent) are veterans.

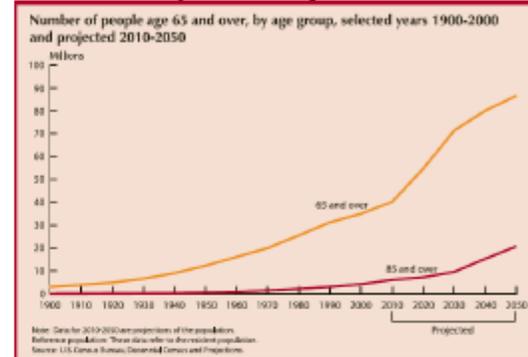
(Adapted from "We the People: Aging in the United States", US Census Bureau: www.census.gov/prod/2004pubs/cenr-19.pdf)

Life expectancy has increased over time in the United States, although it varies by gender and race. In 1900, life expectancy at age 65 was 12 years and at age 85 was 4 years. In 2000, average life expectancy at age 65 was 19 years for women and 16 years for men. Average life expectancy at age 85 was 7 years for women and 6 years for men.

As the baby boomers (those born between 1946 and 1964) start turning age 65 in 2011, the number of older people will begin to

increase dramatically. The older population is projected to double by 2030 (to 71.5 million) and represent 20 percent of the total U.S. population.

Current and Projected 65+ Population in the U.S.



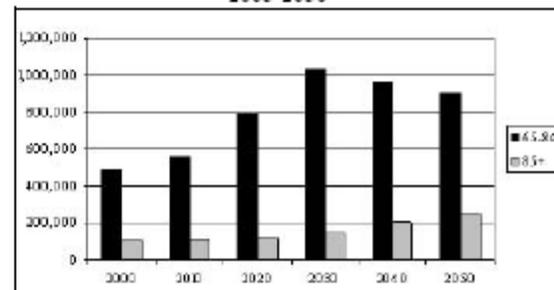
(Adapted from "Older Americans 2004: Key Indicators of Well-Being," Federal Interagency Forum on Aging-Related Statistics: www.agingstats.gov/chartbook2004/OA_2004.pdf)

Aging in Minnesota

From now to the year 2030, Minnesota will be aging like never before. The baby boomers—1.5 million strong in Minnesota—will lead the way. The 65 and over population is currently the fastest growing age group.

Between 2000 and 2030, the 65 and over population will increase from 12.1 percent to 24 percent of the total state population (or about one in every four Minnesotans). That equals a doubling of the older population from 600,000 to 1.2 million. From 2000 and 2050, the 85 and older population will nearly triple from 90,000 to 250,000 (see graph below).

Minnesota's Older Population by Age Group 2005-2050

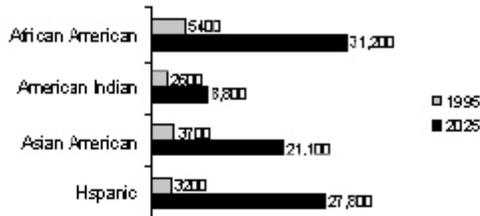


Demographics of an Aging Population – page 2

Minnesota's Diverse Aging Population

Racial and ethnic diversity within Minnesota's elderly population will increase over the next 30 years. Between 1995 and 2025, the proportion of Minnesota's elderly who are nonwhite will increase from 3.7% to 9.8% (from 11,700 to 61,100 persons).

Population 65+ for Four Race/Ethnic Groups

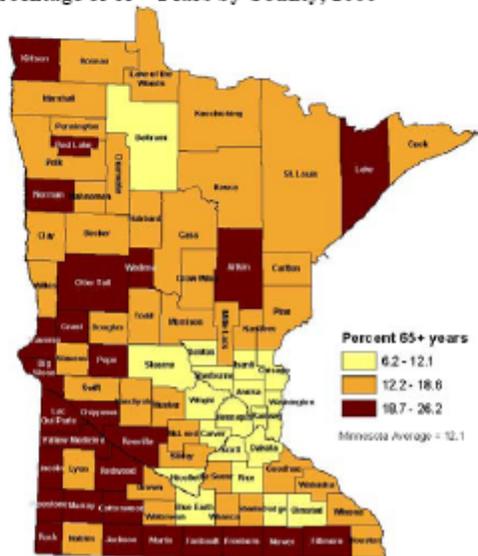


(Adapted from the Minnesota DHS Project 2030: www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_005435_hcsp)

Minnesota's Population Shifts

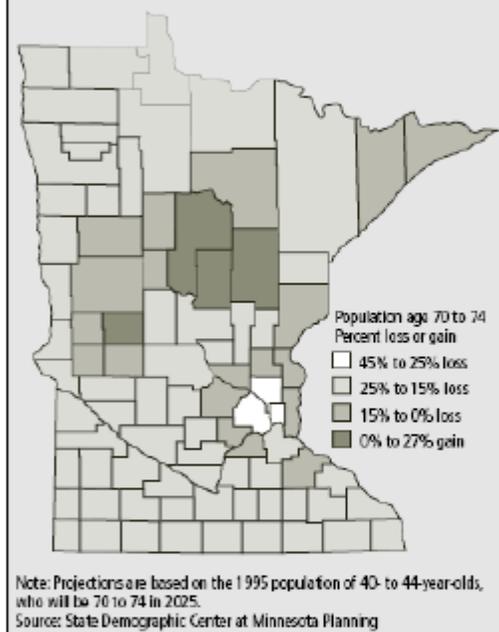
Rural Minnesota is undergoing major shifts in demographics, especially in the aging population. While 30 percent of the state's total population lives in rural Minnesota, 41 percent of those 65 and older currently live there. All counties where more than 20 percent of people are 65 or older are in rural Minnesota.

Percentage of 65+ Years by County, 2000



From 1995 to 2025, 45 counties can expect an increase in the older population, while 42 can anticipate a decline. Many counties in the southwest and the north are expected to lose more than 10 percent of their elder population. Most growth is projected to occur in the corridor of counties from Olmsted County in the southeast, northward through the Twin Cities suburban counties up to Lake of the Woods counties.

FUTURE RETIREES LIKELY TO MOVE TO RECREATIONALLY RICH AREAS BY 2025



Over the next 30 years, counties in Minnesota's north central lakes region—including Aitkin, Crow Wing, Cass and Douglas—are expected to gain the greatest percentage share of retirees. This continues a trend in which retirees have been moving out of high population density areas, such as Ramsey and Hennepin counties, to amenity-rich areas such as the lakes region and other states such as Arizona, Nevada, Florida and Western Wisconsin.

(Adapted from "Implications of Rural Minnesota's Changing Demographics", Minnesota Planning; http://server.admin.state.mn.us/pdf/2000/rural_01.pdf)

Healthy Aging Communities

Definition of Healthy Aging

Healthy aging is the development and maintenance of optimal physical, mental and social well-being and function in older adults. This will most likely be achieved when communities are safe, promote health and well-being and use health services and community programs to prevent or minimize disease.

(Adapted from WV Rural Healthy Aging Network, West Virginia University Center on Aging: www.hsc.wvu.edu/coa/rhan/)

Dimensions of Aging Communities

Healthy aging communities promote health across the life span and recognize the multi-dimensional complexities of supporting older adults. These communities recognize that two older adult populations exist—the healthy, functioning majority and the frail minority—and plan accordingly.

The probability of some type of disease or chronic condition increases with age. After age 85, only one person in 20 is fully mobile and roughly half of people over 85 will suffer some type of cognitive impairment or dementia.

(Adapted from "Taking Care: Ethical Caregiving in Our Aging Society" President's Council on Bioethics, 2005: www.bioethics.gov)



A community that promotes healthy aging must look at an array of interrelated issues including:

- Health and wellness
- Housing
- Transportation
- Financial security
- Work and retirement
- Recreation, arts and education
- Civic engagement
- Technology.

(Adapted from "Aging Friendly Communities" Nebraska Cooperative Extension HE Form 536.)

"The defining characteristic of our time seems to be that we are both younger longer and older longer. . ."

~The President's Council on Bioethics "Taking Care: Ethical Caregiving in Our Aging Society"

Individuals, communities and systems can assess their abilities to address these interrelated issues by asking:

- Do we address basic needs?
- Do we optimize physical and mental health and well-being?
- Do we promote and support social and civic engagement?
- Do we have systems and programs that maximize the independence of frail and disabled seniors?

(Adapted from The AdvantAge Initiative, <http://www.vmsny.org/advantage/>)

Addressing Basic Needs

The basic needs of the aging population are the same as the basic needs of any population—food, shelter, safety and transportation. For the aging population it means a community that can offer:

- Appropriate and affordable housing
- A safe home and community
- Access to necessities such as nearby shopping
- Transportation, including public and volunteer options and
- Accessible health care and medical facilities and services.

"The virtues required to age well are the universal virtues needed by human beings of every age; the old are not a separate species, but human beings living human lives who should be held to human standards."

~The President's Council on Bioethics "Taking Care: Ethical Caregiving in Our Aging Society"

Healthy Aging Communities – page 2

Optimizing Health and Well-being

Research shows that access to appropriate and affordable health care is one of the highest priorities of older Americans. Healthy aging communities ensure that:

- People are encouraged to live healthy and active lives
- A health care infrastructure is supported including hospitals, clinics, long term care, home care and hospice
- Health services are well coordinated
- Health professionals are in adequate supply and skilled to meet the needs of older adults
- Community and provider systems are in place to manage chronic conditions and
- Caregivers—both family and volunteer—are valued and supported.

(Adapted from "Aging Friendly Communities" Nebraska Cooperative Extension HE Form 536.)

"If I'd have known I was going to live this long, I would have taken better care of myself."

~Eubie Blake

Promoting Social/Civic Engagement

Connectedness to family, friends and community is one of the social determinants of health. Healthy aging communities provide opportunities to be involved through:

- Arts and recreation
- Age-friendly employment
- Educational opportunities
- Caregiver support
- Volunteer opportunities and
- Church and spiritual support activities.



Supporting Independence for Elderly

Most elders prefer to live in their own homes. According to the 2000 census data, 76.4 percent of Minnesotans 65 and older live in owner occupied housing.

Healthy senior communities support the concept of "aging in place"—the idea that older people have the option to remain in their own homes and environments as long as possible to avoid—or at least reduce—the need for institutional arrangements. Healthy aging communities support systems that include home care, chore services and accessible transportation.

(Adapted from "A Report to the Nation on Livable Communities: Creating Environments for Successful Aging" AARP: http://assets.aarp.org/center/ibeyond_50_communities.pdf)

A Healthy Community for all Ages

Supporting the development of healthy aging communities does not *only* benefit older adults. Increasing affordable housing benefits young families as well as older people. Providing services to support independent living reduces the stress on younger caregivers while helping people with disabilities of all ages.



Initiatives that bridge the generations integrate the old with the young, transmit knowledge to future generations and reinforce the value of people of all ages.

These community-wide benefits reflect the reality that older adults are important members of families and neighborhoods. Older adults need services and support that help them live their lives with dignity and respect so they can continue to contribute to their communities.

(Adapted from The AdvantAge Initiative, <http://www.vmsny.org/advantage/>)

Creating Communities for Healthy Aging: The Local Public Health Role

Protecting and Promoting Health

Minnesota's city and county public health departments are responsible for protecting and promoting the health of *all* residents. The issues of aging are not new for public health. With rapidly increasing numbers of seniors, many local public health departments are facing more challenges in meeting their needs.



The local public health approach to supporting healthy communities for seniors has three key elements:

- Preventing problems before they occur, and preventing existing conditions from getting worse;
- Connecting seniors to a wide array of services that are available in their communities; and
- Partnering with the community to address service gaps, leverage additional resources and create an environment that supports healthy aging.

Focus on Prevention

Local health departments help prevent health problems. Prevention occurs at several levels:

- Health education and wellness clinics provide people with the information they need to make healthy choices and keep chronic diseases, like diabetes, at bay.

- Screenings, such as for elevated blood pressure or blood sugar levels, help to identify problems early and prevent complications or more serious illness.
- Services - such as providing injections, monitoring medications, and changing dressings for those with chronic illnesses - help keep seniors independent.

Linking Seniors to Available Services

A healthy life is not just about individuals making healthy choices. Social, economic and physical environments play significant roles in supporting good health.

Local public health departments address individual needs in a community context. They work to ensure that services are available in the community; they link seniors to services they need.



Community services that can have a positive influence on health include:

- Transportation to medical appointments, grocery shopping and community events;
- Chore services to help seniors stay in their homes;

Creating Communities for Health Aging: The Local Public Health Role, *Continued*

- Affordable housing in safe neighborhoods;
- Exercise classes and indoor walking clubs; and
- Respite care and support groups.

Building Community Partnerships

Bringing people together to increase understanding, generate ideas and leverage community resources is fundamental to public health. Collaboration is critical in extending limited resources, encouraging community ownership of a health problem and its solutions, and building a broad base of support.

Local public health departments find many ways to help the community understand how everyone can have a positive influence on health: for seniors, for themselves, for their families and for their futures.



One of the tools supporting partnerships is the creation of local public health goals. The goals guide the selection of strategies and help to highlight the roles that everyone can play in health.

Local public health departments also draw attention to the issues of health for seniors by convening and participating on a wide variety of committees, task forces and advisory groups. Many community issues have a public health component and have the potential to affect seniors: for example, community development that includes decisions about where grocery stores are to be located.

Local public health departments are essential to improving and protecting the health of seniors across Minnesota. They offer health services to seniors through wellness clinics, link seniors to area home care and other services, and work with community partners, like the local Area Agencies on Aging, and other community partners.

They are on the frontlines of change as the state adjusts to increasing numbers of seniors who will require community-based services.

Community-based Examples

Many Minnesota cities and counties are finding innovative ways to support seniors in their communities. For example:

- Sherburne County offers frequent clinics at senior housing units. In addition to conducting screenings, they refer people to medical or other services as needed.
- The Chisago County public health nurse service created “Planning and Preparing to Stay Home,” a menu of options that introduce home and community-based services to people before their needs become critical.
- The “Quality of Life for Seniors” group in Winona is made up of providers and citizens working to close service gaps in areas like affordable housing, respite care, transportation, public education and more.
- Carlton County formed an “Elder Collaborative” with other community members and the Fond du Lac Reservation to address seniors’ needs and services.

Appendix I: Health Care Workforce Program and Publications

In 1993, the Minnesota Legislature mandated regular surveys of the state's health care providers on a variety of issues. Working with Minnesota's licensing boards, the Office of Rural Health and Primary Care collects practice data for health professionals in conjunction with regular licensing renewals.

Survey participation is optional so the data does not represent all licensed professionals. Response rates vary between 60 percent and 90 percent, depending on the profession surveyed. Data includes major professional activities; hours per week in each major professional activity; practice location and setting; specialties; race and ethnicity (added in 2005).

Profession-specific data and reports:

- **Physicians**
- **Registered Nurses**
- **Licensed Practical Nurses**
- **Dentists**
- **Dental Hygienists**
- **Dental Assistants**
- **Physical Therapists**
- **Physician Assistants**
- **Respiratory Care Specialists**
- **Pharmacists, Pharmacy Technicians and Pharmacies**
- **Clinical Laboratory Professionals**
- **Occupational Therapists**

Other health workforce analysis and reports

- **2007 Demand Assessment Survey** *December 2007*
- **2006 Demand Assessment Survey** *March 2007*
- **2005 Demand Assessment Survey** *May 2006*
- **Aging Trends:**
Physicians, Registered Nurses, Licensed Practical Nurses and Dentists *May 2006*
- **Overview of Minnesota Health Care Employment** *April 2006*
- **Demographics of Physicians, Nurses and Dentists: Urban-Rural Comparisons of Minnesota's Health Care Workforce** *November 2005*
- **Comparing Minnesota's Health Professionals 2004** *October 2005*
- **2003 Minnesota Health Workforce Demand Assessment**

Appendix J: EMS Behavioral Health Report



EMS BEHAVIORAL HEALTH REPORT

An Examination of the Challenges of Transporting
Behavioral Health Patients in Minnesota
and Recommendations for Improvement

November 2007

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EXECUTIVE SUMMARY

Faced with a growing demand for transporting patients with behavioral or psychiatric disorders, Minnesota's ambulance providers are searching for ways to meet the need. A major concern expressed by the ambulance industry has not only been the growing number of these transports, but the distances patients must be transported to an available psychiatric treatment facility. In response to these concerns, the Emergency Medical Services Regulatory Board (EMSRB or Board) created the EMS Behavioral Health Work Group to examine the issues and recommend solutions. This report summarizes the efforts of the work group, its findings and recommendations.

In creating the work group, the Board made efforts to draw from all parties affected by the problem to assure that any recommendations served the patients as well as the providers. During the course of the monthly meetings from April through September of 2007, all parties were encouraged to share concerns from their respective points of view. While much anecdotal information was shared, objective data was also examined.

Through the Minnesota State Ambulance Reporting (MNSTAR) system, the Board has collected data on all ambulance runs since mid 2003. MNSTAR data substantiated the increasing demand, both in number of interfacility transports of patients with behavioral/psychiatric disorders and in the growing length of time involved in these transports. The total number of behavioral disorder transports increased by 23% from 2005 to 2006. Compared with other non-psychiatric interfacility transports in 2006, behavioral health transports, on average, took over one and one-half times (51%) longer. Work group members agreed that the distance which many patients had to travel for admission to a psychiatric facility is a concern that needs a solution.

The Minnesota Department of Human Services has developed and expanded an array of mental health services in recent years, which in the long term should help address the problems. It appears that one of the more promising options, the nine (soon to be ten) 16-bed Community Behavioral Health Hospitals (CBHHs) that have opened since 2006 across the state, are still too new or not yet functioning at a level to have entirely relieved the pressure on the system. Hospital emergency departments are far too frequently housing psychiatric patients until suitable placements can be found, and patients are far too often traveling great distances from their community support networks in search of admission. Whether it is the ambulance or law enforcement transporting the patient, the transporting agency is feeling the strain on their budget and the toll it is taking on their other responsibilities.

After examining the problem, the work group agreed upon some recommendations that may offer some solutions. Several of the recommendations are focused on system-wide changes, which are beyond the sphere of the group's influence or ability to change, such as increasing the number of beds for behavioral health patients and supporting changes in Medicare reimbursement for ambulance service, especially for long distance transports. Other recommendations, however, focus on solutions closer to home, including pilot testing a new bed tracking system for locating psychiatric beds and promoting the use of crisis response teams in emergency departments for assessment, de-escalation, determining mode of transport and locating suitable placements. There are additional findings and recommendations contained in this report which should be of interest to

lawmakers, mental health advocates and healthcare providers alike. Hopefully, this report will stimulate further dialog and opportunities for creative solutions.



Mark Schoenbaum, Director
MDH, Office of Rural Health & Primary Care
Board Member of EMSRB and Work Group Chair



Mary Hedges, Executive Director
Emergency Medical Services Regulatory Board

Appendix K: Minnesota Health Reform

June 2008

2008 Health Care Reform Summary

In 2008, Governor Pawlenty signed significant health care reform legislation into law. These reforms, which include recommendations of the Governor's Transformation Task Force and the Legislature's Health Care Access Commission, create a comprehensive health care package making significant advances for Minnesotans in the following areas:

Public health

- Establishes and funds a statewide health improvement program (SHIP) to reduce the percentage of Minnesotans who are obese or overweight and reduce the use of tobacco.
- Appropriates a total of \$47 million for this activity in fiscal years 2010 and 2011.

Health care coverage/affordability

- Provides MinnesotaCare coverage for an estimated 8,700 additional people by 2011.
- Expands MinnesotaCare eligibility for adults without children to 250 percent of federal poverty and parents with incomes up to \$57,000 annually.
- Reduces the MinnesotaCare sliding-fee premiums to increase affordability.
- Increases outreach for state health care programs.
- Streamlines access to applications for state public health care programs and requires further study to improve coordination between state health care programs and other assistance programs.
- Requires the study and development of a proposal to promote affordable access to employer-sponsored health insurance through the use of direct subsidies and/or tax credits and deductions.
- Requires employers that have 11 or more full-time equivalent employees and do not offer group health insurance to establish

and maintain a Section 125 Plan, which allows employees to purchase health insurance with pre-tax dollars. Employers have the opportunity to opt out of this requirement.

- Provides grants and tax credits to cover certain employers' cost of establishing Section 125 Plans.¹
- Agreement to establish a tax credit for the uninsured to purchase coverage through a Section 125 Plan.
- Creates a workgroup to make recommendations on the design of an "essential benefit set" that provides coverage for a broad range of services and technologies, is based on scientific evidence of clinical and cost effectiveness, and requires lower enrollee cost-sharing for certain services.

Chronic care management

- Promotes the use of "health care homes" to coordinate care for people with complex or chronic conditions.
- Requires DHS and MDH to develop and implement standards of certification for health care homes by July 1, 2009.
- Establishes standards for state certification of health care homes and evaluating outcomes. Health care homes will receive care coordination payments from public and private health care purchasers.

Payment reform and price/quality transparency

- Encourages quality improvement, by increasing transparency of quality and establishing a single statewide system of quality-based incentive payments to be used by public and private health care purchasers.



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2008 Health Care Reform Summary - page 2

- Creates a powerful set of tools to allow consumers and health care purchasers to compare providers on overall cost and quality of care. This information will be used to create incentives for health care providers to innovate on ways to deliver health care with higher quality and lower cost and it will also be used to create consumer incentives to use high-quality, low-cost providers.
- Promotes transparency and accountability by establishing “baskets” of health care services to allow consumers to more easily compare cost and quality of care across providers, and to promote provider innovation on cost and quality.
- Convenes a workgroup to develop strategies for engaging consumers in understanding the importance of health care cost and quality, specifically as it relates to health care outcomes, consumer out-of-pocket costs, and variations in cost and quality across providers.
- Provides for legislative oversight and establishes a Health Care Reform Review Council for stakeholder review and input on implementation of the payment reform provisions of the bill.

Administrative efficiency

- Enhances health care quality, patient safety and Minnesota’s ability to achieve interoperable electronic health records by ensuring that providers use nationally-certified electronic health record systems when available.
- Advances the use of health information technology by requiring that all prescriptions be ordered electronically by 2011.
- Requires a study and report on reducing claims adjudication costs for health care providers and health plans by adopting more uniform methods of processing claims.

Health care cost containment

- Requires health care cost savings to be measured against projected costs without reform.²
- Results in significant potential overall health care cost savings. Compared to baseline projections, the health care reforms in this bill are estimated to have the potential for cost savings of about 12 percent by 2015. This represents a potential savings of about \$6.9 billion compared to baseline projections.

Other

- Requires a study and report on health care workforce shortages.
- Requires a study and report on community benefit standards for nonprofit health plans.
- Requires a study and report on health care coverage for long-term care workers.
- Requires a workgroup to develop recommendations for the education and regulation of oral health practitioners.³

Endnotes

The health reform measures passed this session are included in the health care reform bill, Chapter 358, Senate File 3780, unless otherwise noted.

1. Omnibus tax bill
Chapter 366, House File 3149
2. Supplemental budget bill
Chapter 363, House File 1812
3. Omnibus higher education bill
Chapter 298, Senate File 2942

Appendix L: Minnesota Statewide Trauma System

MINNESOTA STATEWIDE TRAUMA SYSTEM



August 2006

Regional Trauma Advisory Committees

System Background

Minnesota's statewide trauma system was established in July 2005 when Gov. Pawlenty signed legislation into law charging the Commissioner of Health to adopt criteria ensuring that severely injured people are promptly transported and treated at trauma hospitals appropriate to the severity of their injuries.

System Governance

The commissioner is charged to both seek the advice of the State Trauma Advisory Council (STAC) in implementing and updating the criteria and to adapt and modify the criteria as appropriate to accommodate Minnesota's unique geography and the state's hospital and health professional distribution. The latter requirement may be aided by the establishment of Regional Trauma Advisory Committees (RTACs).

Regional Structure

Minnesota law allows for the formation of up to eight RTACs, as needed. The statutory functions of the regional organizations are to:

- advise
- consult with
- make recommendations to

the STAC on suggested regional modifications to the statewide trauma criteria that will improve patient care and accommodate specific regional needs.

Each regional advisory committee may have up to 15 members. The membership is appointed

by the commissioner in consultation with the Emergency Medical Services Regulatory Board (EMSRB).

Potential Goals

Beyond the functions defined in statute, some suggested RTAC roles are:

- Collaboratively develop comprehensive institutional trauma care plans and share best practices.
- Develop strategies to identify and maximize resources within the region.
- Promote the sharing of scarce resources.
- Collaborate to develop and revise EMS triage and transport guidelines.
- Encourage the participation of all hospitals and EMS providers in the regional catchment area.
- Provide a forum for the resolution of conflicts.
- Enhance communication among members.
- Coordinate with other regional entities to identify and curtail duplication of efforts (e.g., surge capacity, bypass/divert guidelines).
- Encourage collaborative training.
- Support the development of regional injury prevention activities.
- Benchmark regional quality assurance/improvement data against state aggregate data.
- Investigate and pursue grants and other funding opportunities.
- Maintain an awareness of local, regional, state and national standards for trauma care.



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Regional Trauma Advisory Committees – page 2

RTAC Formation

Regions form when neighboring stakeholders self-organize and apply to the commissioner through the STAC for selection. Stakeholders may be anyone who has a vested interest in the provision of trauma care in the region such as health care providers, hospital administrators, EMS personnel and elected officials.

The borders of RTACs should be constructed so as to acknowledge existing health care provider relationships and referral patterns. They should be large enough to include all regional stakeholders, yet small enough to consider the resources and unique geography of the region.

Related programs in Minnesota use regional structures to administer their programs, such as the EMSRB and MDH Bioterrorism Hospital Preparedness Program (BHPP). The EMSRB regional programs are organized as either joint powers (government) or 501(c)(3)s (privately organized for a qualified purpose). The BHPP regional programs are organized through hospital compacts with one hospital in the region designated as the fiscal agent. There is neither a prohibition against nor requirement for these regional entities to assume the role of RTAC.

Funding

Currently, there is no funding allocated for the establishment or ongoing support of RTACs in Minnesota.

The trauma system legislation does permit regional committee members to receive compensation for expenses incurred in the performance of their duties, i.e., meals, lodging and mileage. But, at this time, there is no such provision in the statewide trauma system budget.

Additional information

Interest and inquiries regarding RTACs should be directed to:

Tim Held

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**MINNESOTA STATEWIDE
TRAUMA SYSTEM**



August 2006

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Regional Trauma Advisory Committees – page 2

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