

Quarterly

FALL 2009

OFFICE OF
**RURAL HEALTH
& PRIMARY CARE**
MINNESOTA DEPARTMENT OF HEALTH



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DIRECTOR'S COLUMN



Mark Schoenbaum

WHERE IN THE WORLD?

"Only 10 percent of medical graduates go into general practice and their distribution is alarmingly uneven...Without incentives of various kinds, the supply of new GPs to replace those retiring will continue to dwindle, and they will continue to be thin on the ground in the less heavily populated areas—in turn both reacting to and accelerating the long-term trend of population drift from the north and east to the west and south."

You've seen these headlines before, but you may be surprised that this quote is from the October 2009 issue of *Connexion*, France's English-language newspaper, and refers to that country's health workforce challenges. I was surprised, too, so I took a look at physician workforce issues internationally.

A few years ago the World Health Organization (WHO) examined the world supply of physicians, together with each region's share of world health expenditures and global disease burden. In 2004, the Americas had 10 percent of the global burden of disease, 50 percent of the world's health expenditures, and about 20 percent of the world's supply of physicians. Europe had over 35 percent of the world's physicians, also with 10 percent of the disease burden and 32 percent of the world's health expenditures. In contrast, Southeast Asia and Africa each had 1 percent of the world's health expenditures, over 24 percent of the global burden of disease and from 2 percent (Africa) to 11 percent (Southeast Asia) of the world's physicians.

It seems that, whether you look locally or internationally, there's a mismatch between physician availability, health needs and the economic power to compete for skilled health workers. I'm not sure whether to feel depressed, motivated, or both simultaneously, that the variations in health workforce we see in Minnesota's rural and underserved areas are mirrored around the world.

I also found it informative to look at the strategies considered worldwide to reduce these geographic differences. The French editorial proposed incentives for new graduates to start their own primary care practices. The World Health Organization article discussed increasing training programs in countries with needs-based shortages and focusing on retention in countries where the issue is external competition. Where needs are high and health care purchasing power low, the WHO suggests a mixture of training and recruitment policies. WHO urges government and other organizations to consider increasing financial support of health care workers to improve recruitment and retention. It also recommends that policies take into account practice styles, work hours and workforce demographic trends like aging and gender. WHO discusses telemedicine as a “cost-effective workforce strategy” and states “nurses and other health workers can help to make the clinical work more productive, particularly in certain patient-care services where there are skill overlaps.” It all sounds familiar, doesn’t it?

How can we respond to local concerns that turn out to be worldwide issues? At a national level in the United States, major workforce investments were included in the 2009 Recovery Act, and more are proposed in the health reform bills. Many of the strategies proposed internationally are at work here in Minnesota, though of course additional effort and investment is needed to meet our state’s workforce challenges. Minnesota’s Area Health Education Centers (AHECs) are making a growing contribution in most regions of the state; and, at the community level, many of you are working creatively to recruit and retain health care workers, using these external resources and tools of your own. Taking a lesson from environmentalists, perhaps we can “think globally and act locally,” changing the world one community at a time.

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COMMUNITY FOCUS



IMPLEMENTING MINNESOTA’S STATEWIDE TRAUMA SYSTEM

by Tim Held, Minnesota Department of Health, Trauma System Coordinator

In northern Minnesota, Thanksgiving night was cold when two vehicles carrying eight passengers collided head-on at highway speed. One person died at the scene. Six were transported to the local rural hospital—five in critical condition.

All of the severely injured patients suffered multi-system trauma. Several required chest tubes; others suffered head, abdominal and severe orthopedic injuries. Additional staff responded by protocol to the emergency room from the ICU and med-surgical units to assist. All of the patients were examined quickly and cared for efficiently.

Five patients were emergently stabilized and transferred by three area ambulance services to a regional level II trauma center capable of providing definitive care. Helicopters were grounded due to weather so helicopter crews assisted with the ground transfers. One of the helicopter crew members commented that the emergency department appeared to be functioning as smoothly as a level I trauma center.

Two months earlier this rural hospital was designated as a level III trauma center. In preparation for designation, the staff dedicated time and effort to improve their trauma care. They refined policies and protocols to more effectively manage major trauma patients. Physician and nursing staff attended trauma training. The State Trauma System was there to assist throughout the entire process.

That night, staff understood their responsibilities as a level III trauma hospital in their community. Staff from all over the hospital functioned competently and comfortably together to save the lives of these severely injured patients.

The Minnesota Statewide Trauma System is a voluntary, inclusive network of currently trained and equipped trauma care providers throughout the state ensuring that optimal trauma care is available and accessible everywhere.

The System

For a severely injured person, the time between sustaining an injury and receiving definitive care is the most important predictor of survival—the “golden hour.” The chance of survival rapidly diminishes with time, despite the availability of resources and modern technology. However, research is clear that a geographical (statewide) system approach to trauma care is the best means to protect the public from premature death and prolonged disability from severe injury. It extends the golden hour.

Trauma systems reduce death and disability by identifying the causes of injury and promoting activities to prevent injury from occurring, and by ensuring that the resources required for optimal trauma care are available.

A trauma care system ensures that the infrastructure is in place to deliver the “right” patient to the “right” hospital, and emergency medical and hospital resources are effectively coordinated to optimize the delivery of care and outcomes.

Hospitals are at the center of providing definitive life-saving care. Entry is through Emergency Medical Services, which provides initial stabilization of

patients and safe and rapid transportation to appropriate hospitals. Often, survivors require rehabilitation services before and after returning to home. This piece of the puzzle is crucial for patients to realize their fullest post-injury potential.



Ongoing training and education of care providers is a pillar of the system. Data/quality improvement/research provide the scientific and evidence-based knowledge necessary to appropriately modify the system and hold it accountable to the citizens of Minnesota. It also informs how the system employs injury prevention strategies to maximize limited resources to achieve best outcomes.

Phased Implementation

Minnesota passed legislation in 2005 to form a voluntary statewide trauma system. Participation remains voluntary but wide-scale participation will ensure that a statewide, cooperative effort is in place to care for seriously injured patients.

Three phases of development are envisioned before the system is fully implemented and can be expected to produce the public health outcomes of saving lives and reducing disabilities on a statewide scale. Minnesota is beginning Phase 2, while continuing Phase 1.

Phase 1: Saving lives through hospital participation and development of system infrastructure

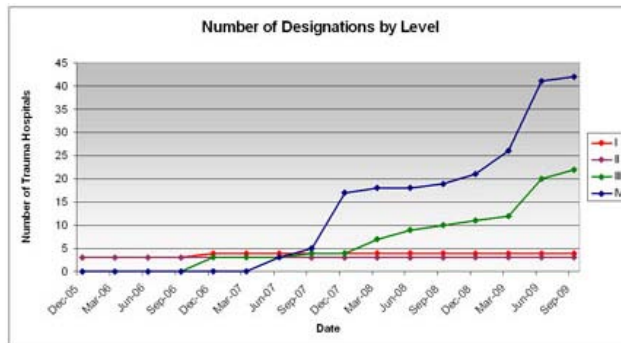
Hospital participation

From the outset, the vision was to build a statewide trauma system that would be inclusive of all hospitals, particularly rural. This partnership with rural health care providers is critical to achieving the best possible statewide trauma care.

Of the 129 hospitals in Minnesota eligible for participation in the state trauma system, 71 are designated: four Level Is, three Level IIs, 22 Level IIIs and 42 Level IVs. Of these, 41 are Critical Access Hospitals.

An additional 20 hospitals are in the process of designation. An executive level survey of all non-designated rural hospitals revealed that all intend to join the system.

This is remarkable, given that participation is voluntary and requires significant administrative and medical staff commitment and networking of resources.



Infrastructure

The State Trauma Advisory Council (STAC) is a 15-member advisory council to the commissioner of the Minnesota Department of Health (MDH). It includes clinical and administrative expertise from all aspects of trauma care, both rural and urban. The Council's flexibility to incorporate criteria change has produced statewide support for the system and its ability to substantially impact clinical outcomes.

MDH manages and provides a secured, web-base registry free of charge for all designated trauma hospitals to use. Certain data are required for submission, and individualized reports are available for each hospital. The state trauma registry can be linked to the state EMS registry to provide a more complete record of care. Several upgrades have been made based on user feedback.

Education is another core component. The Comprehensive Advanced Life Support (CALs) course has anchored rural hospital participation in the system. The CALs program recently began offering a traveling trauma skills module to specifically address the access and affordability needs of rural providers.

Minnesota will soon be the first state to offer rural-based Advanced Trauma Life Support (ATLS) courses. The course complements CALs, which is focused on rural emergency department teams often led by family physicians. State ATLS leaders are breaking from national tradition and taking the course, at reduced rates, to the most rural areas of the state. This is evidence of patient-focused, wide-scale stakeholder collaboration in the system.

Integration of all state agencies and programs with ties to trauma care cultivates government efficiency and collaboration. The trauma system regularly collaborates with the Minnesota Emergency Medical Services Regulatory Board. It is also a partner with the Minnesota Departments of Public Safety and Transportation's Toward Zero Death program.

Phase 2: Saving lives though data-driven quality measurement, assessment, analysis and improvement

A mature trauma system is able to measure, evaluate and improve the processes and outcomes of care rendered by all levels of the trauma care continuum—from 9-1-1 dispatch through rehabilitation.

After four years of infrastructure development and implementation, stakeholders are evaluating whether the current data requirements are adequate to conduct the desired level of system analysis. Answering this question and making any necessary changes are priorities for the STAC. State and regional level quality improvement and peer review initiatives will then begin the tasks of quality measurement, assessment, and analysis and improvement of the system.

Regional Trauma Advisory Committees (RTAC) will have a key role in this effort. RTACs advise, consult with and make recommendations to the STAC. In this manner, the commissioner is better able to modify the system criteria based on a region's unique geography and the state's hospital and health professional distribution.

RTACs will form when regional 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.

Phase 3: Saving lives through full system integration, outcome-based clinical guidelines, public policy, and contribution to evidence-based body of literature

A mature trauma system produces clinical guidelines based on reliable data. This is the natural result of a system that is using outcome data to drive its decision making. It is at this point that measurable differences in morbidity and mortality will be experienced at a statewide level.

Further, it will take new networking into the rehabilitation communities to establish data ties with the trauma system. Rehabilitation of severely injured patients is a core component of the trauma system's continuum of care. Building the system from the front end (i.e., EMS and the acute care phase of hospital evaluation, transfer and admission) has been the early focus of system development. But it is understood that integrating rehabilitation into the system is critical to ensuring that all Minnesotans are receiving optimal care for their life- and limb-threatening injuries. This is a challenging but key goal of Phase 3 system development.

While we are several years away from Phase 3, Minnesota can be proud of the rapid and well coordinated growth of the statewide trauma system. A trauma medical doctor explained the path to successful implementation this way, "Being a trauma center is a journey, not a destination. But it's a journey our patients will be grateful we made."

More information is online at <http://www.health.state.mn.us/traumasystem/>, or contact Tim Held at (651) 201-3868 or tim.held@state.mn.us at the Office of Rural Health and Primary Care.

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SPECIAL FEATURE

PLANNING PAYS: **UPFRONT INVESTMENT LEADS TO EHR SUCCESS**

by Anne Schloegel, Project Planner for the Office of Rural Health and Primary Care

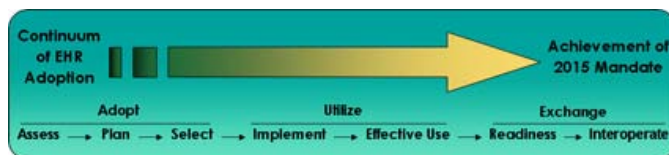
The adoption and use of health information technology in Minnesota has been the driving vision of the Minnesota e-Health Initiative, a public-private collaboration started in 2004. Health information technology (HIT) and electronic health records (EHR) are recognized as critical tools to improve quality, increase patient safety, reduce costs, and help consumers make the best possible decisions about their health.

In recognition of the importance of HIT, the Minnesota Legislature passed a law requiring all health care providers to have an interoperable EHR by 2015. They also understood that purchasing and installing an EHR system is a costly endeavor for many small hospitals and safety net providers. To address this, the Legislature appropriated \$14.6 million in grants and loans to support the adoption of interoperable EHRs between 2006 and 2008.

Statewide Plan for Successful Implementation

As further help to providers, in 2008 the Minnesota e-Health Initiative released a statewide plan for all hospitals and providers in Minnesota to meet the 2015 mandate. The plan identified a "Minnesota model" with three major steps – Adopt, Utilize, Exchange – to achieve interoperable health information exchange.

Minnesota Model for HIT Adoption and Exchange



The model recognizes that implementing an electronic health record (EHR) is not simply computerizing the existing paper record. EHR adoption is a change across the entire organization. An EHR is only a tool. It challenges providers and organizations to identify inefficient processes, assess impact of the adoption on staff and workflow,

- Assess both network hardware and broadband infrastructure needs and consider upgrading both. Determine site readiness through an external IT infrastructure evaluation. Comprehensive needs assessments are crucial for successful product selections.
- Address long-term funding and sustainability plans at the start.
- Allow ample time for EHR selection. Compare EHR products. Other users and vendor demonstrations are knowledge sources. Evaluate vendor implementation and training plans, as well as the EHR system.
- Involve key stakeholders in the entire process and ensure that everyone thoroughly understands the project goals. Leadership and staff must participate and “own” the EHR project. Broad staff participation is critical, even though it may reduce direct patient care time.
- Address organizational decision-making differences when working with a collaborative—consensus building is time consuming but crucial to success.
- Partner with another facility to take advantage of lessons learned and help avoid pitfalls. Networks for purchasing and support are recommended for smaller organizations.

Success stories: planning pays off

Over the course of the grant program, some of the grantees were able to apply for and receive planning and assessment grants, and come back later for implementation funding. Grantees completed solid planning and readiness assessments that informed and guided the EHR selection process. As a result, time management and workflow changes in their organizations are progressing smoothly and are predicted to result in more effective use of the EHRs beyond “go live.”

The People’s Center Medical Clinic at Cedar Riverside is a community clinic serving 12 neighborhoods in southeast Minneapolis. It is a gateway for immigrants, refugees and migrants with low incomes. An interoperable EHR system will help support this frequently shifting population. The People’s Center received a planning grant in 2007, an implementation grant in 2008 and an EHR loan in 2009.

After assessing the organization’s needs, the People’s Center together with other clinics, hospitals and staff conducted an extensive planning and selection process. During this 18-month evaluation period, the People’s Center 1) established an internal EHR team, 2) retained the services of an experienced EHR consultant, 3) reviewed and ranked the organization’s EHR expectations 4) thoroughly evaluated many products and vendors.

The People’s Center completed the assessment and planning process in September 2008. They selected their referral hospital’s EHR product, which would allow the clinic to interoperate more easily with the hospital. The People’s Center began implementation in January 2009. Effectively using the EHR system is their next goal. An overall project task timeline was created and customized to their needs; this timeline has kept the project on track for the “go-live” date.

The main lesson learned was ***broad staff participation was critical to the product selection process***. It was important for all staff to understand the differences among EHRs, including ways of handling clinical information. There was more work, along with reductions in provider/patient time, while staff contributed to the planning and selection process, put together proposals, worked with consultants, and organized meetings.

Family Medical Center and St. Gabriel’s Hospital, Little Falls and Albany Area Hospital and Medical Center expanded existing collaborative relationships to implement an EHR system and health information exchange. Eventually the exchange will include a larger referral network. This collaborative received a planning grant in 2007. Completing a comprehensive planning process provided the necessary tools to move forward with this community-based project and they received an implementation grant in 2008.

The goal for this collaborative was to develop a common electronic health record that could be conveniently and securely accessed throughout central Minnesota. A comprehensive electronic health record assessment and plan was completed for seven medical entities including Family Medical Center, St. Gabriel’s Hospital, Albany Area Hospital and Medical Center, Avon Medical Clinic, Holdingford Medical Clinic, Little Falls Orthopedics and Randall Lake Area Clinic. Using the assessment results, a detailed EHR implementation work plan was developed for the health care systems.

The significant lessons learned included selecting an experienced consultant to assist with planning, and ensuring that leadership and staff were engaged and focused on the shared goal of improved patient care. Collaboration was expensive and time consuming but needed to determine appropriate allocations. ***Thinking about what is best for the patients in the community rather than what is best for individual entities involved was key.***

Lac qui Parle Health Network (LqPHN) is a network of three integrated health systems in southwest Minnesota. Appleton Area Health Services, Appleton; Johnson Memorial Health Services, Dawson; and Madison Lutheran Home, Madison came together several years ago to coordinate HIT investments and share HIT technology resources. In 2006, they received their first grant for planning. The work accomplished with this state funding set Lac qui Parle up to receive one of 16 \$1.5 million federal Critical Access Hospitals (CAH) HIT grants in 2007. The following year, the network secured another state e-Health grant to help complete its EHR

implementation.

The planning grant funded development of a strategic information technology (IT) plan for each of the independent members of LqPHN. An IT consultant with Critical Access Hospital experience helped significantly with the assessment and planning stages. The plans included cost of ownership projections and technical assessments and recommendations along with estimated benefits for the collaborative ownership of an EHR system through LqPHN. The federal funding to follow allowed LqPHN to begin to implement the IT strategic plan. IT staff was hired and a virtual IT department established through LqPHN. Their cooperative organizational model provided the governance for decision-making to move the project forward. Contracted training prior to implementation helped prepare staff to work with the vendor.

Prior to this project there was only part-time IT support. Now each organization employs full-time IT directors who support each other as well as their individual organizations. Implementation went extremely well, thanks in part to regular communication among the IT staff and fixing minor glitches at one site before they affected the others. This also resulted in savings and developing network configuration best practices.

Continuous and refresher training over the next two years will focus on effective use. Staff will be attending Stratis Health's technical assistance seminars on effective use, funded through the Office of Rural Health and Primary Care.

Lac qui Parle's biggest lesson learned: **getting to "effective use" is a process—it takes time and patience to fully utilize an EHR system.**

Looking ahead

In 2009, the federal government included \$31 billion to accelerate adoption and use of electronic health records in the American Recovery and Reinvestment Act through Medicare and Medicaid incentives, from 2011 through 2015, with penalties looming thereafter. To be eligible for the incentives, providers must demonstrate that they have implemented and are "meaningful users" of certified electronic health records, which will include the use of health information exchange for prescribing, lab results, quality reporting, and the use of computerized physician/provider order entry (CPOE), among other things.

The Minnesota e-Health Grant and EHR Loan Programs helped address the two largest barriers for Minnesota providers implementing electronic health records: access to capital to purchase and adopt EHRs and technical assistance in using EHRs effectively. The programs helped some Minnesota providers improve the quality of health care and put them in a better position to potentially access federal HIT incentives that begin in 2011.

However, many other hospitals and providers will continue to seek resources to meet Minnesota's 2015 mandate and take advantage of the federal incentive payments. The Office of Rural Health and Primary Care is committed to assisting Minnesota's safety net providers identify available opportunities as they arise.

For more information about future availability of Minnesota's EHR loan funds or other HIT funding opportunities, contact Anne Schloegel at anne.schloegel@state.mn.us or (651) 201-3850.

The complete statewide plan and companion guide, *Addressing Common Barriers to the Adoption of EHRs: A Practical Guide for Health Care Providers*, are [online](#).

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RHAC MEMBER PROFILE

ORHPC TALKS WITH RURAL HEALTH ADVISORY COMMITTEE (RHAC) MEMBER JODE FREHOLTZ

Please explain your professional work to us . . .

I began working in the field of mental health as a coordinator for a chemical detoxification unit in Bertha. I went on to work in a residential facility—then in supported employment—and then in housing support.

I currently work with Consumer Survivor Network (CSN) of Minnesota. It is required that all of the employees at CSN must have had personal experience with a mental health diagnosis. The really awesome part of my job is teaching our communities and persons who have received mental health services that recovery is possible and probable. A mental illness is not who I am. I take care of myself and I'm responsible for my wellness. I am not dangerous, lazy or stupid. I have many jobs, own my home and am a productive, active member of society.

This is the message I bring to the RHAC committee, the State Mental Health Advisory subcommittee, to our legislators, providers, family members and my community as a whole. It is the best job I have ever had. I feel very supported by my colleagues and my supervisor, Maureen Marrin.

In addition to my work with CSN, I'm a supervisor part time for the Region 5+ Mobile Crisis Outreach team covering



Jode Freholtz

Aitkin, Cass, Crow Wing, Morrison, Todd and Wadena counties. And I work part time at McDonalds where my 21-year-old son is my boss.

And your life away from work?

Several years ago I wrote my personal mission statement, "To use my God given talents of passion, knowledge and intensity to teach, support and assist those who allow me to enter their lives." Among my many professions, the most important is being a mother, grandmother and support to people in my life. I have four grown children—two daughters and two sons—all successful adults who live within an hour of me. I also have seven grandchildren ages 3 months to 18 years old.

Rural Minnesota has been my lifelong home and it suits me. I don't watch TV. My cell phone doesn't work at home. My Sandy Creek Ranch south of Nimrod is surrounded by acres of pine trees. There is a river a half mile down the road. Black bears and wild turkeys hike past as I go to work. I cut my firewood, do a pretty good job of making horse fence, love to cook and feed people and have company.

What do you think are the most important issues facing rural health?

Transportation to medical appointments will always be an issue in rural Minnesota. No one has come up with a good answer to this problem. Many in my region are far from a provider, may not be able to drive, may not be able to afford a vehicle or may not have family or friends to take them to appointments.

Lack of transportation, as well as the high level of poverty in the area, impacts the mental health of rural Minnesotans. The suicide rate is climbing, services are declining and even where there are services they may not be accessible.

Rural Minnesota also has difficulty recruiting and keeping psychiatric professionals due to the climate, the pay, etc.

What do you think would make the most difference for rural health?

As chair of the telemental health RHAC work group, I'm encouraged. I can foresee a future in which telemental health could be extremely valuable to outstate Minnesota.

As our population continues to age, we will have to deal with a declining workforce and the health issues that come with age. We need to keep our legislative representatives aware of what our needs are and give them constant feedback on the job they are doing for us.

We need to keep supporting each other through our faith communities, our friendships, our families as well as paid providers. It will take all of these partners to keep Minnesota healthy.

The Rural Health Advisory Committee advises the commissioner of the Minnesota Department of Health and other state agencies on rural issues; provides a systematic and cohesive approach toward rural health issues; and encourages cooperation among rural communities and providers. Meeting information is [online](#) or contact Tamie Rogers at tamie.rogers@state.mn.us or (651) 201-3856.

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