Category:
SERVICE DELIVERY SYSTEMS

The strategies presented in this category can be used to help achieve the following public health improvement goals from Healthy Minnesotans: Public Health Improvement Goals 2004:

**GOAL 8:** Improve the outcomes of medical emergencies.

**GOAL 15:** Assure access to and improve the quality of health services.

**GOAL 16:** Ensure an effective state and local government public health system.

**GOAL 17:** Eliminate the disparities in health outcomes and the health profile of populations of color.
CATEGORY: SERVICE DELIVERY SYSTEMS

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Eliminate Barriers and Improve Access to Health Care

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Minnesota-specific studies show that one of every 11 Minnesotans lacks health care coverage. Approximately one-fifth of those uninsured individuals are children. The inability to pay for health care services is often the most substantial barrier to getting needed medical treatment for the uninsured.

When uninsured individuals seek medical care, it is often for costly intensive treatment necessitated by the absence of routine and preventive services. These more intensive health care services create a greater health risk to individuals and a greater financial burden to both individuals and the health care system. The high-cost services received by uninsured individuals often exceed their financial resources, and the costs get transferred to the health care system, which does not receive compensation for them. Shifting the costs of treating the uninsured to the health care system results in increased provider charges, higher insurance premiums, and higher taxes.

In recent years, the debate over access to health care has often focused on the availability of affordable health insurance, but many other factors inhibit access to quality health care. Lack of cultural competence on the part of providers, inability to understand the health care system, lack of transportation and childcare, ineffective outreach strategies, discrimination, and lack of comparative information about available health care services can all stand as obstacles to getting quality health care.

It is important to ensure that all individuals have adequate health insurance coverage and that inability to pay for services is no longer a barrier to good health. It is equally important to eliminate or minimize other barriers to receiving quality health care. For instance, often un- or under-employment or self-employment means that individuals and their families are unable to obtain affordable health insurance. Policies that address the link between insurance and employment can provide affordable alternatives for those not employed by large private or public organizations. Also, working with communities to improve their social conditions that affect their health, such as access to healthy affordable food, safe places to play and exercise, increasing social cohesion, and promoting educational opportunities, can help people live healthier lives with less illness and disease.

Strategies in this category contribute to achieving these ends by: developing mechanisms to ensure that individuals have a practical ability to maintain their own health but utilize the health care system as necessary; increasing the health care system’s capacity to appropriately address the needs of Minnesota’s increasingly racially and ethnically diverse population; ensuring an adequate rural health care infrastructure to meet the health care needs of rural Minnesota; and providing more comparative information on the health care system to support consumer choice and system accountability.
The strategies below can be used to work on this topic. Organizations that may play a role in implementing each strategy are indicated.

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Children and adolescents are Minnesota’s greatest resource. Assuring optimal health for all children, adolescents and their families is a major goal for those interested in maintaining and improving the public’s health. According to the 2000 census, almost 30 percent of Minnesota’s population is 19 years or younger, and many of them still have no coverage for their health care.

For those who do, the system is often fragmented, complicated to negotiate and focused on treating conditions. Increasing the coordination in communities of child-serving systems, developing a stronger focus on prevention, and increasing access to screening and early interventions for children will help to create a more family-friendly, seamless service delivery system.

Adolescents have unique health needs yet they are underserved in the health care system. They have fewer physician visits per year than almost any other age group. One reason is the lack of access to adolescent-focused health services. Increasing the number of adolescent-focused health services located in areas easily accessible and acceptable to adolescents can help to increase adolescent use of health services. Another reason is that traditional health services do not fit the needs of adolescents. Traditional health services are oriented primarily toward the treatment of physical disease and are designed to be reactive rather than preventive. Adolescent health needs are primarily social and behavioral in nature, issues that are more effectively addressed through preventive health services.

The strategies presented here focus on eliminating barriers and improving access to health care for both children and adolescents. See the sections on “Promote Access to Health Care” and “Health Care Coverage” in this category, and the section on “Parenting and Youth Development” in the category, *Child and Adolescent Growth and Development* for related strategies.

### Strategy: Establish mutual child health goals through community collaboration.

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**Background:**

Early identification and prevention require efforts that extend beyond one setting. As Wallace (1994) notes, “Looking at the community as a system helps provide insights into community organization for change. The political, economic, health, education, religious, communications, recreational, and social welfare sectors, and voluntary grass root and other community groups compose the forces that influence the community as a whole and the individuals in the community.” (*Maternal and Child Health Practices*, p. 91). Collaborative efforts between local and state health and human services providers, private health care providers and clinics, HMOs, schools, child care centers, and other important community groups can promote and increase early identification and prevention services as follows:
Form community and interagency collaboratives that focus on children. In community collaboratives such as the Children’s Mental Health and Family Services collaboratives, children’s issues can be discussed, and regular communication and planning by all important community members can influence the community as a whole. Information obtained can be shared with all agencies and community members.

Promote mutual goals. Children can benefit from consistent messages from a variety of health and community providers. These consistent messages help to create seamless systems that decrease barriers for children and their families. Other barriers to achieving these seamless systems need to be explored, addressed, and engaged. Collaboratives and coalitions can create a group mission including beliefs about the importance of early identification and preventive health services for children.

Promote and encourage interagency teams and projects. Interagency projects that are generated from collaboratives (e.g., community resource networks) link providers and establish a central clearinghouse of information that can facilitate provider and community linkages. These projects and networks help to connect families to appropriate services in an efficient and timely manner. Collaboratives also can encourage the interagency coordination of services, including WIC (Women, Infants, and Children), Child and Teen Checkups, Head Start, ECSE (Early Childhood Special Education), ECFE (Early Childhood Family Education), and others. This interagency coordination can facilitate seamless systems of services for children and families and prevent the duplication of services.

Additional resources:
Bibliographic resources:

Organizational resources:
- Cover All Kids Coalition 2002. Members of this public-private coalition work to promote health care coverage and preventive care for Minnesota children. Members work together to
increase awareness of health care coverage options for children, find new ways to reduce health disparities, and make it easier for parents to get preventive care for their children. (866) 489-4899, www.coverallkids.org

- Datanet is an online information system consisting of summarized statistical information serving Minnesota's governments, businesses, schools, nonprofit agencies and citizens. The system contains statistics about social, economic and demographic conditions in Minnesota. www.mnplan.state.mn.us/datanetweb

Evidence for strategy:
Research supports the concept that the communities’ social and physical environments can act as either a climate for growth or a set of barriers. Communities that work together to make change have been found to increase knowledge of resources and empower individuals to improve health choices.

Has this strategy been implemented in Minnesota?
Yes, many communities have begun the process of creating collaboratives and coalitions with support from the agencies that make up the Minnesota Children’s Cabinet: the Departments of Children, Families, and Learning; Health; Human Services; Economic Security; Corrections; Transportation; Finance; Public Safety; and Administration, as well as the Housing Finance Agency and Minnesota Planning.

Indicators for this strategy:
- Percentage of families knowledgeable about community resources and programs needed by their child and family members.
- Percentage of families using community resources and programs needed by their child and family members.
- Number and rate of incidents of substantiated child maltreatment.

For more information contact:
Nicole Brown, at (651) 215-8960, nicole.brown@health.state.mn.us, MDH Child Health Consultant, Maternal and Child Health Section.

Strategy: Use and promote standard guidelines, recommendations, or both for child and adolescent preventive services.

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Background:
The benefits of incorporating prevention and early intervention into health care practice have become increasingly apparent, as previously common and debilitating conditions have declined in incidence and severity. The American Association of Pediatrics advises that early identification of health problems in children leads to effective therapy of conditions for which definitive treatment is available. However, even in those instances in which the condition cannot be fully reversed, early intervention improves children’s outcomes and enables families to develop the
strategies and obtain the resources for successful family functioning. Early intervention can be accomplished by advocating and using a system of care, which follows child- and youth-specific standards and guidelines. These standards have been created with the expertise and informed opinions of a large number of health professionals and consumers, based on their review of the literature and extensive dialogue. This strategy can be achieved in the following ways:

- Provide education for health service providers on following standard care recommendations for preventive services. Education for all private and public health providers should include recommendations from established guidelines such as Bright Futures and/or the Guidelines for Adolescent Preventive Services (GAPS). These standards seek to identify problems early and to improve children’s health outcomes. They also go beyond treating disease to a comprehensive approach that actively promotes health and prevents disease before it occurs. Education should occur in formal educational settings (i.e., universities), as well as in workshops and continuing education presentations sponsored by professional organizations or community health agencies.

- Increase the number of Medicaid-enrolled children and adolescents who receive the benefit of Child and Teen Checkups. Child and Teen Checkups provide a means of prevention, timely detection, and treatment of health problems of a higher-risk population. Further education on the components and benefits of Child and Teen Checkups should be furnished for providers, clinics, health plans, and all agencies and staff who work with children. Current preventive health care recommendations, as well as identification of, and suggestions for, overcoming barriers to care should be discussed. Also, objective feedback to providers from health plans and the Minnesota Department of Human Services about how they’re doing may increase the appropriate use of this program.

- Increase educational opportunities for families, agencies, and staff who work with children. Outreach to families and explanation of the benefits of routine preventive pediatric health care and services must be increased. Use of such program materials as Putting Prevention into Practice - Child Health Guide is a way for parents to track and prompt preventive care. Patient education through pamphlets and workshops sponsored by community health agencies and health plans in clinics and other community settings will increase understanding. Community-based educational initiatives to expand current popular knowledge about the importance of preventive health care services, current recommendations on prevention, and the different types of providers and ways to access them in each community should be enhanced.

Additional resources:

Bibliographic resources:

  http://www.aap.org/policy/re9939.html


Minnesota Health Improvement Partnership. 2001. *Adolescent Preventive Health Services: Opportunities for Improvement*. Minnesota Department of Health. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Adolescent Health Report”.


**Organizational resources:**

Adolescent Health Website with quick and easy access to current information and resources about teen health. Includes information and resources for providers, parents and youth. Screening tools, guidelines, educational materials and links to other great websites. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Adolescent Health Services”.

Cover All Kids Coalition 2002. Members of this public-private coalition work to promote health care coverage and preventive care for Minnesota children. Members work together to increase awareness of health care coverage options for children, find new ways to reduce health disparities, and make it easier for parents to get preventive care for their children. The Clinical Guidelines Committee of the Cover All Kids Coalition (which is comprised of physicians, nurses, and staff from health plans, MDH and DHS) are working to identify, clarify and communicate clinical guidelines information on the preventive care of
This information is current as of Fall 2002
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Evidence for strategy:
Research shows that comprehensive preventive health care is beneficial and relatively inexpensive. Studies of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) programs in Michigan, North Dakota, Virginia, and Pennsylvania have documented effectiveness of preventive care in improving children’s health status and lowering their medical costs. [Keller, 1983]

Has this strategy been implemented in Minnesota?
Yes, a variety of programs and organizations (e.g., Child and Teen Checkups, Cover all Kids Coalition) are working to encourage the use of standard guidelines and/or recommendations to promote preventive services.

Currently, the MDH, the Minnesota Department of Human Services, and health plans have representatives training providers to screen children using the Child and Teen Checkup guidelines throughout the state. In some counties, Child and Teen Checkup coordinators and health plans sponsor provider training in the private and public health settings.

Health Plans, working through the Metro Action Group (MAG), work with clinics to improve processes such as charting, billing and improving access of adolescents and disparate groups to preventive health services.

Indicators for this strategy:
- Percentage of children on Medical Assistance who receive Child and Teen Checkups according to the recommended schedule.
- Percentage of children who receive regular, comprehensive preventive health visits.

For more information contact:
Nicole Brown, at (651) 215-8960, nicole.brown@health.state.mn.us, MDH Child Health Consultant, Maternal and Child Health Section.

Strategy: Decrease provider barriers to providing health screening for children.

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Background:
The usefulness of preventive and early identification screening and services ultimately depends on health care provider participation. Ways to decrease barriers for providers include:
- Utilize educational seminars, technical assistance, and other dissemination techniques to improve health care provider information and participation. Educational workshops on reimbursement and billing issues, referral and community resources,
components of screening, state rules, and forms provided by state and community health agencies and health plans will decrease provider barriers.

- Increase the caliber and number of staff and decrease turnover of staff that work with children. Staff of programs and agencies that work with children are often among the lowest-paid and least-recognized professionals in the U.S. Staff (e.g., child care providers, early childhood and school teachers, school nurses, and child welfare staff) are often responsible for first identifying children’s needs and making referrals. Increasing the caliber of staff and decreasing turnover in these agencies and programs through improved training and working conditions will strengthen early identification and prevention efforts. Training, provided by community health agencies and others, through continuing education workshops on the identification of children who need screening is one way to raise the caliber of staff. Also, increasing support for school nursing and advocacy for following recommended staffing levels will expand children’s services greatly. Promoting the importance of staff who work with children is a necessary first step toward increasing their pay and working conditions.

Additional resources:

Bibliographic resources:

- Minnesota Health Improvement Partnership. 2001. *Adolescent Preventive Health Services: Opportunities for Improvement*. Minnesota Department of Health. For more information see the website for strategies resources at: [www.health.state.mn.us/strategies/](http://www.health.state.mn.us/strategies/). Click on “Adolescent Health Report”.

Organizational resources:

- Adolescent Health Website with quick and easy access to current information and resources about teen health. Includes information and resources for providers, parents and youth. Screening tools,
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- Cover All Kids Coalition 2002. Members of this public-private coalition work to promote health care coverage and preventive care for Minnesota children. Members work together to increase awareness of health care coverage options for children, find new ways to reduce health disparities, and make it easier for parents to get preventive care for their children. (866) 489-4899, www.coverallkids.org


Evidence for strategy:
Research indicates that decreasing barriers for providers through continuing education and providing structured preventive health documentation forms increase provider knowledge and participation [Duggan, et al., 1990]. Additional research supports the benefits of early identification and prevention services for children.

Has this strategy been implemented in Minnesota?
Yes, currently the MDH, the Minnesota Department of Human Services, and county Child and Teen Checkup coordinators provide training for health care providers on billing issues and components of screening, as well as information on decreasing barriers. The Minnesota Departments of Health and Human Services have also created provider documentation forms available for preventive well-child visits.

Health Plans, working through the Metro Action Group (MAG), work with clinics to improve processes such as charting, billing and improving access of adolescents and disparate groups to preventive health services.

In addition, a variety of programs and organizations (e.g., Child and Teen Checkups, Cover all Kids Coalition) are working to decrease provider barriers to providing preventive health screening to children.

Indicators for this strategy:
- Percentage of children who are immunized on an appropriate schedule.
- Percentage of children who receive regular, comprehensive preventive health visits.
- Percentage of children participating in early childhood care and education who do not require special education services in kindergarten or the first grade.
- Percentage of children with vision and hearing problems at the time of entry into kindergarten.

For more information contact:
Nicole Brown, at (651) 215-8960, nicole.brown@health.state.mn.us, MDH Child Health Consultant, Maternal and Child Health Section.
Strategy: Increase access to health screening for children.

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Background:
Several key activities can be implemented to help increase access to health screening for children. For related strategies, see the sections on Promote Access to Health Care, and Health Care Coverage in this category. Activities to increase access to health screening for children are described here:

- Provide outreach to eligible families to receive Medicaid. Currently, many children have limited access to care because they are uninsured. Outreach to increase services to children eligible for Medicaid is possible through joint efforts. Medicaid and public health agencies can use their public health infrastructures (i.e., access to schools, Head Start programs, and WIC) to coordinate Medicaid eligibility and enrollment with other services for children. They can also increase outreach to families by placing eligibility workers at different sites (out-stationing) such as clinics, hospitals, or WIC, or by providing transportation to welfare offices.

- Increase insurance for children through employer-based plans. Family insurance through employer-based plans remains a primary vehicle through which many children receive health coverage. Barriers to employers providing benefits for dependants need to be explored, and expansion of employer-sponsored health coverage for children must be strongly advocated by the state, community, and each individual employer. Increasing awareness through community campaigns and dialog is a first step for community and state health agencies in understanding the barriers.

- Decrease barriers to health care. Children who do have insurance through private or Medicaid services continue to face other barriers to receiving preventive health care and early identification of health problems. Transportation, childcare issues, and the inability of a parent to take off work are health care barriers, which families confront. Promoting school-based health centers will decrease some of these concerns for school-aged children.

- Increase the use of recall systems to notify parents and children of upcoming screenings. Once children are incorporated into a primary health care system, a recall system to notify parents and children of their recommended upcoming health screening will increase numbers of children screened.

Additional resources:
Bibliographic resources:


Solloway, MR., and Budetti, PP. 1995. 

U.S. Preventive Services Task Force. 
*Guide to Clinical Preventive Services* (2nd ed.). Baltimore, MD: Williams & Wilkins. 
http://www.ahcpr.gov/clinic/cpsix.htm


Organizational resources:

- Cover All Kids Coalition. Members of this public-private coalition work to promote health care coverage and preventive care for Minnesota children. Members work together to increase awareness of health care coverage options for children, find new ways to reduce health disparities, and make it easier for parents to get preventive care for their children. (866) 489-4899, www.coverallkids.org

http://www.dhs.state.mn.us/HlthCare/ctc/default.htm

Evidence for strategy:

Increasing access to care for children and families will increase health status. Research shows that children who receive Medicaid insurance are more likely than children with no insurance to have a regular source of medical care, visit physicians and dentists more frequently, and receive routine preventive care.

Has this strategy been implemented in Minnesota?

Yes, currently some counties provide out-stationing to increase the numbers of eligible families participating in Medical Assistance programs. Also, there are many school-based health care centers in middle and high schools, which decrease barriers for families. The Child and Teen Checkup program uses a reminder database to generate letters about upcoming screening to all eligible children on Medical Assistance.

Indicators for this strategy:

- Percentage of children and families covered by health insurance.
- Percentage of children who are immunized on the appropriate schedule.
- Percentage of school districts, which have a school-based clinic.
- Percentage of children who receive regular, comprehensive preventive health visits.
- Percentage of families whose transportation needs are met.
- Percentage of workplaces with family-friendly policies.

For more information contact: 
Nicole Brown, at (651) 215-8960, nicole.brown@health.state.mn.us, MDH Child Health Consultant, Maternal and Child Health Section.
**Strategy: Increase access to adolescent-specific health services.**

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**Background:**
Adolescents are underserved in the health care system. They have fewer physician visits per year than almost any other age group. One reason for this is the lack of access to adolescent-focused health services. Increasing the number of adolescent-specific health services that are located in areas easily accessible and acceptable to adolescents can help to increase adolescent use of health services. For related strategies, see the section on “Parenting and Youth” in the Child and Adolescent Growth and Development category. Increasing access to adolescent-specific health services can be accomplished by working in one or more of the following four areas:

- Increase the awareness of adolescents and their parents of adolescent-specific health services. This is important because it can help to increase community support for, and utilization of, adolescent-specific health services. This can be achieved by working with health plans, CHS agencies, schools, etc., to get the word out about available adolescent-specific health services and their benefits for teens.
- Develop support for increased utilization of school nurses within local community schools. School nurses provide a valuable set of services to adolescents within the school setting. These services play an important role in connecting teens to needed health care. Healthy People 2010, a set of health objectives for the Nation, include an objective to increase the proportion of the Nation’s elementary, middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750. In 1994, the ratio of school nurses to students was 1:1650 [University of Colorado Health Services Center, September 1994]. Increasing the number of nurses available to provide health services to students will improve access to health services for teens.
- Develop support for school-based or linked clinics. School-based health centers operate in or near schools to bring primary health care services to students who have difficulty accessing the established health care system in the community. These primary health care services include health assessment and screening, treatment of minor acute illness, counseling and health promotion, and management of stable chronic conditions. Locating clinics in or near schools reduces barriers to health services for youth. Developing support for school-based/school-located clinics requires work at the state level (to increase the demand and support for school-based/school-located clinics and to increase funding) and at the community level (to build community support for locating clinics in or near local schools).
- Develop support for adolescent health services in places frequented by high-risk youth (e.g., juvenile correction settings, drop-in centers for homeless youth, etc.). High-risk youth often have
the most significant barriers to needed health services. Locating adolescent-specific services in locations that already serve high-risk youth increases access to health care.

Additional resources:

Bibliographic resources:

- Minnesota Health Improvement Partnership: Adolescent Health Services Action Team. 2001 *Adolescent Preventive Health Services: Opportunities for Improvement*. Minnesota Department of Health. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Adolescent Health Report”.

Organizational resource:

- Minnesota Adolescent Health Care Coalition, an informal collaboration of more than 40 members representing health care providers, health plans, health associations, government, public health, hospitals, foundations, non-profit agencies, and educational organizations. The mission of the Coalition is to improve the health status of adolescents by influencing the health care system in order to better meet the unique needs of adolescents and their families. For more information, contact the Maternal/Child Health Section of the Minnesota Department of Health at 651-215-8960.
- Minnesota Department of Health. Adolescent Health Web Page. The site provides quick and easy access to current information and resources about teen health. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Adolescent Health Services”.

Evidence for strategy:

Studies show that access to school-based primary health care for teens is associated with increased use of services, decreased use of emergency rooms, and decreased hospitalizations.
Has this strategy been implemented in Minnesota?
Yes, there are a number of school-based/school-linked adolescent health clinics in Minnesota; in the Minneapolis and St. Paul public school systems, for example, there are clinics in the elementary, middle, and senior high schools.

Indicators for this strategy:
- Number of school-based/school-located clinics in the community.
- Utilization rates and demographics of the clinics.
- Ratio of school nurses to students in a school.
- Number of clinics in places frequented by high-risk youth.
- Level of awareness of, and support for, school-based/school-located clinics among adolescents and parents.

For more information contact:
Sarah Nafstad, at 651-281-9956, sarah.nafstad@health.state.mn.us, MDH Adolescent Health Coordinator.

Strategy: Improve effectiveness of adolescent-specific health services.

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Background:
Adolescents are underserved in the health care system. They have fewer physician visits per year than almost any other age group. This is due in part to traditional health services not fitting the needs of adolescents. Traditional health services are oriented primarily toward the treatment of physical disease and are designed to be reactive rather than preventive. Adolescent health needs are primarily social and behavioral in nature, issues that are more effectively addressed through preventive health services. The focus and content of adolescent health services need to be adapted to better meet the unique health needs of adolescents. Steps in implementing this strategy include:

- Develop an increased focus on healthy youth development in all health programs and policies (see the strategies on Parenting and Youth Development in the category, Child and Adolescent Growth and Development). Our current health care system is traditionally focused on health problems (primarily diagnoses and treatment of health problems and to a certain extent, prevention of health problems). The piece that is missing in youth health is a focus on promotion of healthy development, in addition to prevention of risk behaviors and health problems. This change in focus requires a culture change in our health care system. This involves education of those who work in these areas regarding healthy youth development and the discussion of ways in which this perspective can be infused into the current system.

- Promote the use of recognized adolescent health standards as the norm when providing health services to adolescents. Examples of these standards are the Guidelines for Adolescent Preventive Services [GAPS], Bright Futures, and Child and Teen Checkup.
**Guidelines.** These sets of guidelines have been developed by a broad range of adolescent health experts and are widely accepted by the health care system. Yet they have not been routinely implemented in current health systems and services. It is important to increase the acceptance and implementation of these standards as the norm for providing adolescent health services.

- Work with health professional training systems to improve adolescent health training curricula. Many health providers lack the knowledge, skills, and comfort to provide effective adolescent health services. This strategy focuses on increasing and improving training for health providers through front-end academic training (at universities, colleges, VoTechs, etc.) and through continuing educational training (through professional organizations, public health, etc.).

- Forge links between adolescent health, mental health, social services, and educational systems to improve integration of services for teens. Due to the psychosocial and behavioral nature of adolescent health problems, mental health and social services are an essential component of effective adolescent health services. Yet there is a wide gap between coordination and integration of physical health, mental health, and social services for teens. It is important to increase the coordination and integration of these systems.

- Involve adolescents in the design of health services. Youth input is essential in designing effective health services for teens.

**Additional resources:**

Bibliographic resources:

- American Medical Association, Department of Adolescent Health. (1992). *Guidelines for Adolescent Preventive Services (GAPS).* Chicago, IL: Author. [Contact AMA, Department of Adolescent Health, 515 North State Street, Chicago, IL 60610, Phone: (312) 464-5842. To order, call (800) 621-8335, or contact http://www.ama-assn.org/ama/pub/category/1947.html]


- Minnesota Health Improvement Partnership: Adolescent Health Services Action Team. 2001 *Adolescent Preventive Health Services: Opportunities for Improvement.* Minnesota Department of Health. For more information see the website for strategies resources at: [www.health.state.mn.us/strategies/](http://www.health.state.mn.us/strategies/). Click on “Adolescent Health Report”.


- Resnick, MD, et al University of Minnesota. 1997. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *JAMA* 278(10): 823-832. This is a national study that used a cohort of
MN adolescents. It provides an excellent overview of the "connections" between family, child, school and community that protect youth from risk behaviors.

Organizational resources:

- Adolescent Health Website with quick and easy access to current information and resources about teen health. Includes information and resources for providers, parents and youth. Screening tools, guidelines, educational materials and links to other great websites. For more information see the website for strategies resources at:
  www.health.state.mn.us/strategies/
  Click on “Adolescent Health Services”.

- Minnesota Adolescent Health Care Coalition, an informal collaboration of more than 40 members representing health care providers, health plans, health associations, government, public health, hospitals, foundations, non-profit agencies, and educational organizations. The mission of the Coalition is to improve the health status of adolescents by influencing the health care system in order to better meet the unique needs of adolescents and their families. For more information, contact Sarah Nafstad, at 651-281-9956, MDH Adolescent Health Coordinator.

  http://www.dhs.state.mn.us/HlthCare/ctc/default.htm

- National Adolescent Health Information Center. 1994, July. Investing in Preventive Health Services for Adolescents [Fact Sheet]. San Francisco:

University of California School of Medicine, Division of Adolescent Medicine. [For more information, contact Department of Pediatrics and Institute for Health Policy Studies, 1388 Sutter Street, Suite 605a, San Francisco, CA 94109, (415) 502-4856, Fax: (415) 502-4858; http://youth.ucsf.edu/nahic/.

- University of Minnesota, Division of General Pediatrics and Adolescent Health, Adolescent Health Training and Fellowship Program. Information can be obtained by contacting Dr. Robert Blum, Director, Box 721, 420 Delaware Street, SE, Minneapolis, Minnesota 55455, (612) 626-2820.

Evidence for strategy:
Research has shown that traditional preventive services provided by physicians can have a significant impact on behavioral change, including behavioral change among adolescents. In addition, there is extensive research to show that adolescents who are supported by an array of protective factors (such as connection to caring adults, positive connection to school, opportunities and recognition for meaningful activities in the community, etc.) are less likely to engage in risky behavior and experience poor health outcomes. It is presumed that use of a healthy youth development framework in developing and implementing policies, professional training and funding will make a difference in the health outcomes of adolescents.

Has this strategy been implemented in Minnesota?
Yes, the Adolescent Health Care Coalition is focusing on strategies aimed at changing the health care system to focus on preventive
health services (using adolescent-specific standards, looking at funding, etc.). The Coalition is actively involved in reaching out to health care providers, funders and consumers with a health promotion/healthy youth development model of health care. They are also promoting the adoption of an Adolescent Health Position Statement among a wide variety of organizations involved in the health care system.

**Indicators for this strategy:**

- Number of adolescent health programs based on a healthy youth development model.
- Number of adolescent health policies based on a healthy youth development model.
- Number of adolescent health training programs for health professionals that use a healthy youth development model within their curriculum.
- Number of adolescent health funders who incorporate a healthy youth development/health promotion model into funding decisions.
- Number of health care providers who utilize adolescent health standards in their routine care of adolescent patients.
- Number of health care providers who are trained in adolescent health care and are comfortable providing services to adolescents and their families.
- Number of collaborative efforts focused on improving adolescent health that includes health, mental health, social services, and education providers.

**Strategy:** Increase funding for adolescent-specific health services and improve reimbursement for adolescent sensitive services.

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**Background:**

Effective adolescent-specific health services are often not supported by the traditional health care system, nor are they adequately funded. These activities propose to stabilize funding to support and strengthen existing services:

- Increase funding for adolescent health services. This strategy focuses on funding of services from a broad perspective, including resources available from health plans, government agencies, social service agencies, and foundations. Special attention should be given to increased funding for school health services (i.e., school clinics and nurses).
- Improve reimbursement for adolescent sensitive services. Adolescents in need of sensitive health services (such as STD testing and treatment, mental health services, family planning, etc.) are often unwilling to seek services unless they can receive these services in a confidential manner. When services are provided confidentially, they are frequently not reimbursed by insurance companies due to problems with maintaining confidentiality through billing. Billing processes, such as sending an explanation of benefits notice

**For more information contact:**
Sarah Nafstad, at 651-281-9956, sarah.nafstad@health.state.mn.us, MDH Adolescent Health Coordinator.
to the policy holder (often a parent or caregiver), threaten the ability of health providers to maintain confidentiality. This activity focuses on adapting reimbursement policies and procedures in ways that protect confidentiality for adolescents.

Additional resources:
Bibliographic resource:
- Minnesota Health Improvement Partnership. 2001. Adolescent Preventive Health Services: Opportunities for Improvement. Minnesota Department of Health. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Adolescent Health Report”.

Organizational resource:
- Minnesota Adolescent Health Care Coalition, an informal collaboration of more than 40 members representing health care providers, health plans, health associations, government, public health, hospitals, foundations, non-profit agencies, and educational organizations. The mission of the Coalition is to improve the health status of adolescents by influencing the health care system in order to better meet the unique needs of adolescents and their families. For more information, contact Sarah Nafstad, at (651) 281-9956, the MDH Adolescent Health Coordinator.

Evidence for strategy:
The Minnesota Adolescent Health Care Coalition has been actively working on improving the reimbursement for adolescent sensitive health services by bringing together health plan representatives and health providers to initiate changes in billing procedures that will support confidentiality of services to adolescent patients. These efforts are currently in process, and, over time, their impact will become more evident.

Has this strategy been implemented in Minnesota?
Yes, many communities in Minnesota are looking for ways to increase funding for adolescent-specific health services. In addition, the Minnesota Adolescent Health Care Coalition is focusing on strategies aimed at changing the health care system to focus on preventive health services by using adolescent-specific standards, looking at funding, etc. See the evidence section above for more information.

Indicators for this strategy:
- Amount of funding available specifically for adolescent health services.
- Percentage of adolescent sensitive services for which reimbursement is received.

For more information contact:
Sarah Nafstad, at 651-281-9956, sarah.nafstad@health.state.mn.us MDH Adolescent Health Coordinator.
**CATEGORY: Service Delivery Systems**

**TOPIC: ELIMINATE BARRIERS AND IMPROVE ACCESS TO HEALTH CARE – CHILDREN AND ADOLESCENTS WITH SPECIAL HEALTH CARE NEEDS**

The strategies below can be used to work on this topic. Organizations that may play a role in implementing each strategy are indicated.

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<th>Strategy</th>
<th>Governmental Public Health Agencies</th>
<th>Health Plans</th>
<th>Hospitals &amp; Clinics</th>
<th>Educational Systems</th>
<th>Community-based Organizations</th>
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<td>Develop a medical home for children and adolescents with special health needs.</td>
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<td>Include health care issues and appropriate health care professionals in transitional planning for adolescents with special health needs.</td>
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<td>Implement a standard for service coordination for children (aged 21 years and younger) with special health needs.</td>
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<td>Promote family-centered, community-based, culturally competent, and coordinated care and services for children with special health needs and their families.</td>
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Much of the focus on access to health care has been centered on the financial barriers and on addressing the issues of the uninsured. Though it is beginning to change, many other access issues, including cultural competence among providers, transportation and childcare, have received less attention. Similarly, those for whom access is problematic have traditionally been defined as low-income, minority and/or rural. While it is true that these are very real issues for these people, another population requires similar attention with regard to access to health care.

Children, adolescents, and their families with special health needs experience barriers to proper health care that are unique to them. Families of children with special health care needs face challenges in obtaining services that are comprehensive. Their needs must be addressed by health, education, and social services. Care may be fragmented, duplicated, confusing, and costly. In addition, children with special needs and their families are uniquely challenged by the health care system. The special health conditions with which they live often put greater demands on caregivers and on the health care system; they require increased dependency on others; often children and adolescents with special health needs are unable to ask for help, or to communicate clearly with providers and/or family members; they experience social isolation, the misinterpretation of behaviors characteristic of their disability and societal attitudes that devalue people with disabilities.

It is crucial that service delivery systems adapt to accommodate those with special health needs to assure and promote optimal health, access to services, maximal habilitation and rehabilitation, well-being, prevention of secondary disabilities, unnecessary out-of-home placements, and premature death. In addition, communities and systems can also become more aware, responsive, and supportive to children with special needs and their families by including them in all aspects of community life as well as in program and policy-making decisions.

For related strategies, see the sections on Children and Adolescents, Promote Access to Health Care, and Eliminate the Disparities in this category; and the strategies in the Child and Adolescent Growth and Development, Mental Health and Pregnancy and Birth categories.

**Strategy: Develop a medical home for children and adolescents with special needs.**

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**Background:**
Children with special health needs frequently see a variety of medical and program specialists, each of whom makes recommendations, gives prescriptions, and offers treatment services. As a result, families may receive conflicting recommendations or they may have unrealistic expectations placed upon them by...
disparate medical care providers. Frequently families feel that, because their child is seen by specialists, they do not need an ongoing relationship with a local medical care provider, and they utilize the local physician for episodic care instead of their child’s primary care.

Families and professionals have identified the need for the provision of comprehensive services through a pediatric medical home for children with special needs. Simply put, a medical home means a source of ongoing, comprehensive, family-centered care in the child’s community. Services for children with special needs are difficult for families and professionals to access and coordinate. Primary care providers are not always comfortable in providing care to children with special needs. In addition, some may not have the time and some may lack the resources and the knowledge of those resources necessary to coordinate them to meet the children’s and families’ needs. Lack of knowledge of a family’s comprehensive needs and available community resources as well as non-family-centered care, poor reciprocal coordination, and cross-cultural interactions are barriers for families and professionals.

The development of a medical home for children with special needs requires new partnerships and changes in physician offices, management, coordination of care, staffing, and staff training. The medical home should include the following elements:

- Provision of preventive care, including but not restricted to: immunizations, growth and development assessments, appropriate screening, health care supervision, and patient and parental counseling about health and psychosocial issues.
- Assurance of ambulatory and inpatient care for acute illnesses, 24 hours a day, seven days a week (during the working day, after hours, and on weekends), 52 weeks of the year.
- Provision of care over an extended period of time to enhance continuity.
- Identification of the need for subspecialty consultation and referrals and knowledge of where and from whom they can be obtained. It is important to provide the consultant with medical information about the patient. It is equally important that there is some evaluation of the consultant’s recommendations to ensure that they are indicated and appropriate, well implemented, and interpreted clearly by the family.
- Interaction with school and community agencies to assure that individual children’s special health needs are addressed.
- Maintenance of a central record and database containing all pertinent medical information about the child, including information about hospitalizations. This record should be accessible, but confidentiality must be assured.

These elements should assure quality comprehensive services, including primary, well-child preventive, specialty, illness, and emergency care. However, all medical homes need to have:

- A family-centered approach to service delivery that is culturally competent.
- Geographic and financial accessibility so that a child may remain in his/her
medical home even if insurance status changes.

- Assurance that families have access to all relevant information regarding public and private sector insurance.
- Coordination (through community linkages and partnerships) of services needed by the child and family.
- A process for planning, providing, and evaluating services based upon partnerships with families, which incorporates the principles of family and professional collaboration.

As a special consideration, the onset of adolescence brings the youth and primary care provider unique challenges and opportunities in the provision of a medical home. The transfer of decisions about care, as well as the actual care, from the parent to the adolescent requires special training of the adolescent, parents, and primary care physician on process and techniques. Should that adolescent receive medical care coverage through a managed care entity, this entity becomes a partner in the planning and provision of the youth’s care. All partners need training on the provision of a medical home to an adolescent with special health needs, including the issues surrounding transition of health care. The goal of this process is a successful transition of the child to the adolescent, and eventually the adult, health care system.

Additional resources:
- ‘SPECIAL CONNECTIONS’ Newsletter – The SAFE at Home Project. MDH. Contact: Sarah Thorson, (651) 281-9992, e-mail: sarah.thorson@health.state.mn.us.
- Reiss, J. The Purchaser’s Tool. (This checklist can be used to evaluate health plan features for children with special health needs. This tool is not copyright protected.) The authors and sponsors encourage readers to print and distribute this document. Acknowledgement of the source of the material is appreciated. Contact: John Reiss, Ph.D., Institute for Child Health Policy, 5700 SW 34th Street, Suite 323, Gainesville, FL 32606. www.ichp.edu/mchb/purchaser.

Organizational Resource:
- The Washington State Medical Home Training and Resource Project. A statewide train-the-trainers project: A regional training network of 17 volunteer teams of physicians, public health or office nurses, and early intervention family resource coordinators provide training and consultation to local primary care providers, office staff, and others. Contact: Kate Orville, (206) 685-1279.
Evidence for strategy:
This strategy uses several different models and has been field tested in several states, including Arizona, Hawaii, Tennessee, and Washington State. A model (SAFE at Home) is currently being developed and field tested by Minnesota Children with Special Health Needs (MCSHN) at the Minnesota Department of Health.

Has this strategy been implemented in Minnesota?
Yes, this strategy will be implemented as a demonstration project by MCHSN in cooperation with HealthPartners and UCare and with support from the federal Maternal and Child Health Bureau.

Indicators for this strategy:
- Number of children with special health needs who have a “medical home.”

For more information contact:
Minnesota Children With Special Health Needs, at (800) 728-5420 or (651) 215-8956 (metro).

Strategy: Include health care issues and appropriate health care professionals in transitional planning for adolescents with special health needs.

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Background:
Often, the identification of children with special health needs stops with those individuals who have visible disabilities, require special education services, or both. In every school system in Minnesota, there are students with chronic health conditions who do not receive the benefits of transition-planning services because they do not qualify for special education services. Their conditions may not be readily apparent to the casual observer; however, their health status may have a significant impact upon their future post-secondary-training choices, as well as their employment opportunities.

In Minnesota, at the present time, only those students with an Individualized Education Plan (IEP) receive formal transition-planning services. State and local education agencies are mandated to initiate and carry out the transition-planning process for students with IEP’s. Community Interagency Committees (CTICs) are responsible for the identification of current services, programs, and funding sources within the community for secondary- and post-secondary-aged youth with disabilities and their families. They are also charged with facilitating the development of multi-agency teams to address present and future transitional needs of individual students on their IEPs.

CTICs are required to assure that the transitional needs of individuals are met by developing a community plan addressing these expectations and to participate in systems-change activities by bringing to the table issues and identified gaps in services that relate to transitional planning for youth with disabilities. There are five areas of transitional planning that are reviewed in
each IEP: post-secondary education and training, employment, community participation, recreation and leisure activities, and home living.

Health care planning is not included as a separate entity and typically does not get attention for each student. Health care professionals (in the form of therapists and occasionally a school nurse) may be a part of the transition-planning team, but there is no consistent participation of these professionals for each Minnesota student with an IEP. The identification of those students with special health needs, long-term disability, or both, who do not have eligibility for special education services, is problematic. School health programs vary from school to school, and not all students with health concerns have contact with their school’s health department.

In identifying those students who could benefit from health care planning assistance, it is important to do so based on the consequences of a health condition rather than on limitations of function or listings of diagnostic problems. Using a definition that emphasizes the consequences of a condition increases the number of students benefiting from transition services in their middle school and senior high school years. With this definition, 18 percent of the child population can be identified as having a health condition that is certain to last for at least one year and to cause limitation in function, activity, or social role; a dependency on medication, special diet, medical technology, assistive device, or personal assistance to compensate for, or minimize, limitation of function; or the need for medical care or related services over and above the usual for the child’s age. School health programs can extrapolate potential numbers of students with health conditions in their system using this definition and begin the process of identifying those students so that transition-planning services can be implemented for them.

The changing face of medical care coverage in Minnesota makes addressing health care issues in transitional planning essential. Ensuring that a student leaves a secondary school program prepared for the next phase of living includes updating equipment, identifying and establishing appropriate adult medical care, and reviewing care coverage resources, as well as addressing the often unspoken questions surrounding human sexuality. Students need to be provided with opportunities to take responsibility for their own health care in a developmentally appropriate manner by giving them skills and knowledge for self-advocacy.

Steps that can be taken to implement this strategy include:

- School health staff can participate in the IEP staffings for those students aged 14-22 to identify their future health care needs.
- Notices can be inserted into the local school district’s newsletter inviting parents of students with health concerns to contact the school health department to review health care needs and planning.
- A basic list of items to be reviewed on a periodic basis includes, but is not limited to:
  - Is there a primary care physician established for the student?
¬ Does the student have a “medical home”?
¬ If the student is being followed by a pediatric specialist, what, if any, arrangements need to be made to transfer that care to adult specialty medical care?
¬ Does the student have medical care insurance?
¬ Will that health care coverage continue past age 18?
¬ Are there any potential restrictions on what will be paid for by that coverage, such as, therapies, equipment, medical visits, specialty examinations, etc.?
¬ Does the student have a good understanding of his or her medical situation and know what care is optimal in the future in a developmentally appropriate manner?
¬ Is there an understanding of preventive medical and dental care needs?
¬ Does the student have any questions or concerns regarding human sexuality?
¬ Does the student use durable medical equipment that may need upgrading?
¬ Does the student have any assistive technology needs?
¬ Does the student’s medical or physical condition have an impact upon future post-secondary training or employment choice?

Additional resources:
Bibliographic resources:

¬ Minnesota Department of Health, *Minnesota Health Status Reports.* Each county health department has a copy for their county. In addition, requests can be made by phone: (651) 676-5062 or at [http://www.mnplan.state.mn.us/datanetweb/health.html](http://www.mnplan.state.mn.us/datanetweb/health.html).
¬ Morningstar, ME. 1996. *University of Kansas Department of Special Education: Transition Quality Indicators.* Beach Center on Families and Disability.

Organizational resources:
¬ The Minnesota Department of Children, Families and Learning. Contact: Jayne Spain, at (651) 582-8200.
¬ PACER, Phone: (612) 827-2966 or (800) 53-PACER, 4826 Chicago Avenue South, Minneapolis, MN 55417.

Evidence for strategy:
The inclusion of health care planning in transitional planning for adolescents with chronic illness, disability, or both improves adult outcomes, increases access to medical care and improves the likelihood of achieving the greatest possible independence, as well as assures the continuity of ongoing health care.
Has this strategy been implemented in Minnesota?
Yes, Cloquet Senior High School recently received an award of excellence, which is granted by the Minnesota Transition Leadership Committee, a state-level planning group, to those programs that demonstrate superior transition planning in Minnesota. One of the criteria is inclusion of health care planning.

Indicators for this strategy:
- Number of transitional plans that include health care planning components.
- Number of students without individual education plans who have chronic illness or disability and receive health care planning assistance prior to leaving high school.
- Number of schools using definitions of health conditions based on the consequences of the conditions.
- Number of schools using individual education plans.

For more information contact:
Minnesota Children With Special Health Needs, at (800) 728-5420 or (651) 215-8956 (metro).

Special notes:
In 1984, amendments to the Education Act for all Handicapped Children represented the first major attempt in federal policy to improve planning and preparation for transition from school to adult life for students with special needs. In 1990, the passage of the Individuals With Disabilities Education Act (IDEA) required state and local education agencies to initiate and carry out the transitional planning process for students with IEPs.

It was at this time that Minnesota formed the State Transition Interagency Committee (SIC) to address transition issues, which have a statewide impact. The SIC formulated legislation that created community-level interagency committees known as Community Interagency Committees.

Strategy: Implement a standard for service coordination for children (aged 21 years and younger) with special health needs.

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Background:
Families of children with special health care needs face challenges in obtaining services that are comprehensive. Their needs must be addressed by health, education, and social services. Care may be fragmented, duplicated, confusing, and costly. Service coordination is a method of overcoming some of these obstacles. The term service coordination reflects current concepts of family and person-centered philosophies, and emphasizes the central role the individual/family plays in identifying needed services. Service coordination will assist individuals and families in working with complex systems across agency lines and will enhance their ability to live full lives in the community. Families are the ultimate decision-makers for their children.
Service Coordinators must be knowledgeable about other services, including special education, social services, family support, respite, community programs, public health, and parent-to-parent support, as well as local, state, and federal laws governing these services. It is recognized that the responsibility for meeting the needs of children with special health care needs is a responsibility shared by families, public agencies, and private providers. As the child grows, his or her needs change. The agency providing service coordination must assure that these needs are met and addressed as the child moves through the system and that the transition is smooth. Implementation of this strategy requires that:

- Children (aged 21 years or younger) with known or suspected special health problems are identified.
- An individualized assessment is conducted to identify psychosocial, mental health, medical, educational, and financial needs. Family resources should be assessed with attention to the family's values, choices, and culture.
- Service coordination to develop a comprehensive plan based on family needs, choices, and priorities assists the family in removing financial barriers and other barriers to obtaining service; identifies and clarifies resources; provides information and assistance in obtaining appropriate resources; helps in the coordination of services; offers periodic review and updating of the plan; and develops a single-family plan with involvement from agencies and organizations working with the family.
- Facilitation by the service coordinator of access to the appropriate medical, financial, educational, support, and social resources for children with special health needs and their families is done in a timely manner. The access includes advocacy in the education, health, social services systems, etc.

- Training provided to service coordinators on the roles and responsibilities of service coordination.
- Education is provided to the family regarding the diagnosis, methods of care, treatment protocol, and self-advocacy skills, so the family can make informed decisions and effectively use the care system.
- An information system for data collection is maintained.

Service coordination includes the identification of needs, assessment, and re-assessment; information and referral for families and professionals, including referrals for appropriate evaluation, treatment, and follow-up, as well as the connection of families to systems of care; development and monitoring of individual family-service plans; patient and family education; advocacy; crisis intervention; and ongoing family support. The skills of a service coordinator include, but are not limited to, assessment; advocacy; joint problem solving; identification of alternatives and linkage of resources; fact finding; information sharing; education or teaching; process interpretation and counseling; and observation and reflection. Standards need to be in place to ensure that children receive the best possible care, there is good communication among everyone involved, and costs are controlled without compromising the quality of care.
Additional Resources:

- Interagency Early Childhood Intervention. 1995. *Many Hats of Service Coordination* (Chapter 3).
- The Coordinated Interagency Act (Minnesota Statute 125A.023 and 125A.027).

Evidence for strategy:

In 1998, Minnesota passed two statutes, 125A.023 and 125A.027, known as the Interagency Services for Children with Disabilities Act. This system is now formally referred to as the Minnesota System of Interagency Coordination (MnSIC) by state and local partners. The purpose of this act is to: “develop and implement a coordinated, multidisciplinary, interagency intervention service system for children ages three to 21 with disabilities.” The legislation states that Minnesota must identify and develop a plan for every child and youth with a disability.

Has this strategy been implemented in Minnesota?

Yes, currently coordinated services are available for children up to age 9 with plans to provide them to children up to age 21 by 2003.

Indicators for this strategy:

- Number of children receiving service coordination.
- Changes in the child's health or illness status.
- Cost of care.
- Parent and family satisfaction.
- Number of school days missed.
- Number of referrals generated by the service coordinator.

For more information contact:

Minnesota Children with Special Health Care Needs, at (651) 215-8956 (metro) or (800) 728-5420. For more information see [http://www.mnsic.org](http://www.mnsic.org).
the website for strategies resources at: www.health.state.mn.us/strategies/
Click on “Services for Children with Special Health Needs”.

**Strategy: Promote family-centered, community-based, culturally competent, and coordinated care and services for children with special health needs and their families.**

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**Background:**
In 1987, the U.S. Surgeon General set as a national goal the promotion of family-centered, community-based, culturally competent, and coordinated care and services for children with special health needs and their families. In the intervening years, most public health and other programs working with this population have stated that their services are family-centered, community-based, culturally competent, and coordinated, but there has been no clear way for programs to assess their outcomes in regards to this standard.

Nationally accepted philosophies have been established and (briefly) include:
- Family-centered services. The family is central to a child’s life, and, therefore, the family should be central to decisions that need to be made concerning the child’s care. The family’s needs and desires determine all aspects of service delivery and resource provision. Professionals are seen as the agents and the instruments of the family and intervene in ways that maximally promote family decision-making capabilities and competencies.
- Community-based services. This philosophy involves designing services to be delivered in the “least restrictive” manner to the child and family. This may mean in the home, close to home, in a child-care setting, at a relative’s home, or wherever the family feels most comfortable and which fits with the service the provider can realistically offer.
- Culturally competent services. One of the most common barriers to family-centered services can be the difference in beliefs and customs held by families and their service providers. In addition to ethnicity or race, culture can be influenced by any combination of factors, including spiritual beliefs and social and educational experiences, as well as economic and geographic living conditions. Cultural differences have an impact on the definition and interaction of families, parenting behavior patterns, traditions, and language, as well as how illness, disability, or both are viewed. It is culture that defines the structure of all families, provides families with a variety of ways of coping with the world, and determines the way they respond to their fundamental role in providing food, shelter, nurturing, spiritual, intellectual, and emotional sustenance for their children.
- Coordinated services. Children with special health needs and their families typically require multiple services from
different providers associated with different agencies. As a result, services may become extremely fragmented. The many public and private programs that serve this population have differing mandates, eligibility requirements, and inconsistent policies. Coordinating these services is of utmost importance to the quality of life for the child and family. See the strategy in this section, “Implement a standard for case management for children (ages 21 years and younger) with special health needs,” for additional information.

Utilizing a brief checklist to evaluate a program’s progress towards the provision of family-centered, community-based, culturally competent, and coordinated services may be helpful. The following is a sample checklist to help assess if services meet these criteria:

___Is there consumer input during the planning process?
___Is there consumer participation in program evaluation?
___Is there a process in place to identify and document gaps in services?
___Is there an up-to-date awareness of other resources for families?
___Is there collaboration with other programs and systems to fill identified gaps in services?
___Is there a focus on family strengths and expertise?
___Is there an avoidance of deficit-based language and actions in describing or working with children with special health needs and their families?
___Is there a focus on all family members, not just those in the household?
___Is there a mechanism in place to solicit informal feedback from family members?
___Is there recognition and understanding of a family’s aspirations and goals?
___Are there ways in place to appropriately involve “absent” family members?
___Is there permission for families to modify program plans as needs change?
___Is there support for family participation in established community activities?
___Is there recognition and understanding that a family defines itself?
___Is there allowance in the program for periods of transition in a family’s life?
___Is there recognition when a family’s needs have either been met or not been met?
___Is there help for families to “move on”?  
___Is the staff culturally competent?
___Is there ongoing staff development on diversity issues?
___Is there acknowledgment of the possible differences in values between staff and the families served?
___Is there recognition of the impact that a family’s own experiences, perhaps for generations, with the “system” may have on their comfort levels with program services?
___Are there ways to identify and provide feedback on institutionalized forms of discrimination?

Additional resources:
Evidence for strategy:
Nationally, the Interagency Early Intervention programs, as well as the Head Start programs, have utilized family-centered service provision for many years as the cornerstone of their services for children and their families.

Has this strategy been implemented in Minnesota?
Yes, all infants and toddlers involved with the Interagency Early Intervention programs have an Interagency Family Service Plan (IFSP) based upon the principles of family-centered care. The IFSP serves as a model of how family-centered services can be developed in a variety of settings. All Head Start programs in Minnesota also practice family-centered service provision.

Indicators for this strategy:
- Number of families conducting periodic evaluations of their programs and services.
- Level of family satisfaction with programs and services.
- Level of family comfort with programs and services.
- Degree to which family needs have or have not yet been met.

For more information contact:
Minnesota Children With Special Health Needs, at (800) 728-5420 or (651) 215-8956 (metro). For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Services for Children with Special Health Needs”.

Special notes:
The provision of family-centered services is highly individualized. There is no “one size fits all.” Family satisfaction with services varies from family to family, depending upon the family’s needs at any particular moment.
The strategies below can be used to work on this topic. Organizations that may play a role in implementing each strategy are indicated.

<table>
<thead>
<tr>
<th>Encourage development and strengthening of Minnesota’s health care work force through community, regional and state initiatives.</th>
<th>Governmental Public Health Agencies</th>
<th>Health Plans</th>
<th>Hospitals &amp; Clinics</th>
<th>Educational Systems</th>
<th>Community-based Organizations</th>
<th>Businesses/Work Sites</th>
<th>Other</th>
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<tr>
<td>Encourage development of regional and community health insurance options for small employers and self-employed individuals.</td>
<td>Governmental Public Health Agencies</td>
<td>Health Plans</td>
<td>Hospitals &amp; Clinics</td>
<td>Educational Systems</td>
<td>Community-based Organizations</td>
<td>Other</td>
<td>Individuals</td>
</tr>
<tr>
<td>Develop methods to ensure access to health and long term care for Minnesota’s increasing senior and elderly population.</td>
<td>Governmental Public Health Agencies</td>
<td>Health Plans</td>
<td>Hospitals &amp; Clinics</td>
<td>Educational Systems</td>
<td>Community-based Organizations</td>
<td>Other</td>
<td>Area Agency on Aging</td>
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<tr>
<td>Encourage sharing of health care resources among facilities within communities and within regions through informal and formal networking arrangements.</td>
<td>Governmental Public Health Agencies</td>
<td>Health Plans</td>
<td>Hospitals &amp; Clinics</td>
<td>Educational Systems</td>
<td>Community-based Organizations</td>
<td>Other</td>
<td>Business/Work Sites</td>
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<tr>
<td>Provide culturally competent health care services to new and diverse people.</td>
<td>Governmental Public Health Agencies</td>
<td>Health Plans</td>
<td>Hospitals &amp; Clinics</td>
<td>Educational Systems</td>
<td>Community-based Organizations</td>
<td>Other</td>
<td>Business/Work Sites</td>
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</table>
Access to quality health care in Minnesota is unevenly distributed among the population, both demographically and geographically. A number of factors contribute to lack of access to health care, including:

- Availability of providers due to workforce shortages.
- Lack of access to affordable health care coverage.
- Aging population.
- Cultural barriers for new people attempting to negotiate a complex health care system.
- Distance, especially a problem in rural areas.
- Inability for consumers to understand complicated health care systems.
- Number and proportion of scheduled women who complete screening.

Workforce shortages are being experienced in all employment sectors, but are felt acutely in the health care sector, especially in rural communities, as young people migrate to larger population centers, and the remaining population is increasingly elderly. This issue is emerging not just as a concern, but has reached crisis proportions and must be addressed collaboratively by education, business, and government working together.

Lack of access to affordable health insurance coverage is becoming an increasing reality for many Minnesotans as health care costs rise at double-digit rates. This is particularly true for small business employees or self-employed individuals. Rural areas, where small businesses and self-employment is common and choices are limited, are especially affected. Underinsurance shows up in higher deductibles and co-pays, and limitations on health care options.

Minnesota’s population is aging. Over the next two decades, the number of Minnesotans over age 65 is expected to increase by two-thirds, and those over 85 by almost three-quarters. Again, this demographic shift is felt more keenly in rural parts of the state. Older Minnesotans means more problems associated with aging: cancer and other chronic diseases, social isolation and mental health issues, and various forms of disability and dependency. This places stress on primary and acute care systems, emergency medical services, specialty and long-term care, and community-base services.

As Minnesota’s populations of color and new populations continue to rise, our communities are challenged to expand their resources, including their health care systems. Language barriers, lack of cultural competence on the part of providers, absence of a diverse health care workforce, discrimination, lack of transportation, insurance difficulties and immigration issues all contribute as barriers to health for diverse populations (see the section on “Eliminate the Disparities” in this category for further information).

Distance has already been identified as an issue especially affecting rural areas. Combined with shortages in health care providers, lack of transportation and changing demographics (more elderly and more new people), distance between facilities, providers, and health care consumers affects both cost and access to care.

The strategies presented here attempt to address some of the barriers to access that have been identified. For related strategies...
see “Health Care Coverage” within this category.

**Strategy:** Encourage development and strengthening of Minnesota’s health care work force through community, regional and state initiatives.

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**Background:**
Workforce shortages are being experienced in all employment sectors, but are felt acutely in the health care sector, especially in rural communities, as young people migrate to larger population centers, and the remaining population is increasingly elderly. This issue is emerging not just as a concern, but has reached crisis proportions and must be addressed collaboratively by education, business, and government working together. Some ways to do this include:

- Encourage young people to enter health and long term care careers by convening partnerships between health and long term care employers, school districts, and post-secondary institutions to develop health careers curricula aimed at middle- and high-school age students that meet state graduation standards and articulate with post-secondary programs.
- Encourage community hospitals and clinics to provide internship and positive employment experiences for young people in their communities.
- Encourage community and health care leaders to consider ways to pool resources through networking or shared health care provider positions by convening partnership discussions.
- Educate consumers and employers on the use of non-physician alternatives to primary care, including nurse midwives, nurse practitioners, and physician assistants.

**Additional resources:**
Organizational resources:

- Health Education-Industry Partnership, Minnesota State College and University System, (507) 389-6224 or [www.tip.mnscu.edu/heip/](http://www.tip.mnscu.edu/heip/)
- Minnesota Department of Children, Families & Learning, Division of Life Work Development, (651) 582-8513 or [http://children.state.mn.us/](http://children.state.mn.us/)
- Minnesota Department of Health, Office of Rural Health & Primary Care, at (651) 282-3838. For more information see the website for strategies resources at: [www.health.state.mn.us/strategies/](http://www.health.state.mn.us/strategies/). Click on “Office of Rural Health & Primary Care”.

**Evidence for strategy:**
Statistical and anecdotal evidence exists of increasing health care worker shortages at all levels, including information about physicians, nurses, allied health, nurses aides, aging demographics, and migration to large urban centers from rural areas.

**Has this strategy been implemented in Minnesota?**
Yes, various strategies have been and are being implemented on a community, regional and statewide basis, including health professional loan repayment programs, health professional shortage area
designations, and health care-education partnerships.

**Indicators for this strategy:**
- Adequate supply of health professionals and non-professionals in both urban and rural health care settings.
- Health and long term care facilities continuing to operate in rural areas and underserved urban communities due to adequate worker supply.

For more information contact:
Office of Rural Health & Primary Care, at (651) 282-3838. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Office of Rural Health & Primary Care”.

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**Strategy: Encourage development of regional and community health insurance options for small employers and self-employed individuals.**

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**Background:**
Lack of access to affordable health insurance coverage is becoming an increasing reality for many Minnesotans as health care costs rise at double-digit rates. This is particularly true for small business employees or self-employed individuals. Rural areas, where small businesses and self-employment is common and choices are limited, are especially affected. Under-insurance shows up in higher deductibles and co-pays, and limitations on health care options. Ways that local organizations can do this include:

- Explore ways that members of communities and regions can pool resources to help small employers and self-employed individuals purchase affordable, quality health insurance products.
- Engage members of the community, including policy makers, community leaders, employers, health care providers, and consumers in developing strategies that balance affordable health insurance coverage with quality of care.
- Assist community members in accessing available resources for planning and execution of strategies.

**Additional resources:**
Organizational resources:
- Minnesota Department of Commerce, at (651) 296-6789 or (800) 657-3602 or www.commerce.state.mn.us/ [Regulates insurance companies or indemnity products.]
- Minnesota Department of Health, Health Economics Program, at (651) 215-5800. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Health Economics Program”.
- Minnesota Department of Human Services, at (651) 296-1256 or (800) 657-3729, ext. 61256 or www.dhs.state.mn.us
- Minnesota Insurance Healthline (612) 222-3800 or (800) 642-6121.

**Evidence for strategy:**
The data indicate that increasing numbers of Minnesotans are either uninsured or underinsured.
Has this strategy been implemented in Minnesota?
Yes, health care purchasing alliances are being developed in five regions of the state: northwest, southwest, north central, and northeast regions of the state.

Indicators for this strategy:
- Development of community and regional health care purchasing alliances that are available to small employers and individuals.
- Measurements of uninsurance and underinsurance exhibit downward trend.

For more information contact:
Minnesota Department of Health, Office of Rural Health & Primary Care, at (651) 282-3838. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Office of Rural Health & Primary Care”.

Strategy: Develop methods to ensure access to health and long-term care for Minnesota’s increasing senior and elderly population.

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Background:
Minnesota’s population is aging. Over the next two decades, the number of Minnesotans over age 65 is expected to increase by two-thirds, and those over 85 by almost three-quarters. Again, this demographic shift is felt more keenly in rural parts of the state. Older Minnesotans means more problems associated with aging: cancer and other chronic diseases, social isolation and mental health issues, and various forms of disability and dependency. This places stress on primary and acute care systems, emergency medical services, specialty and long-term care, and community-base services. For related strategies see “Promote healthful aging and support the well-being of the elderly” in the category, Disability/Decreased Independence. Things that you can do to ensure access to health and long-term care for Minnesota’s elderly population include:
- Convene community and regional partnerships between health and long term care providers, the faith community, policy makers, and consumers to develop appropriate and affordable health and long term care options for older members of the community.
- Educate senior citizens and their families about health and long term care options in their communities through existing senior citizen programs.
- Assist the community in considering ways to engage the healthy senior population in providing health and senior services to others in need through employment or volunteer opportunities.

Additional resources:
Organizational resources:
- Elderberry Institute/ Living at Home Block Nurse Program, (800) 320-1707 or www.elderberry.org/
- Minnesota Association of Area Agencies on Aging, (507) 288-6944 or www.minnesota-aaa.org/
- Minnesota Department of Health, Facility and Provider Compliance Division at (651) 215-5800. For more information see the website for strategies
resources at: www.health.state.mn.us/strategies/. Click on “Facility and Provider Compliance Division”.

- Minnesota Department of Human Services, Minnesota Board on Aging, at (800) 882-6262 or www.dhs.state.mn.us/

Evidence for strategy:
Demographic statistics in Minnesota clearly indicate a growing elderly population, with its increasing demands on the health care system.

Has this strategy been implemented in Minnesota?
Yes, various strategies have been and continue to be employed to respond to the upward trends in aging population. Further expansion of programs will be required as the “baby boomer” population ages and there are more demands on the system.

Indicator for this strategy:
- Number and make up of community and regional partnerships looking at long term care options.
- Increased understanding among senior citizens and their families about health and long term care options in their communities.
- Numbers of senior citizens engaged in providing health and senior services.
- Numbers and kinds of senior services available in urban and rural Minnesota.

For more information contact:
Minnesota Department of Health, Office of Rural Health & Primary Care, at (651) 282-3838. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Office of Rural Health & Primary Care”.

Strategy: Encourage sharing of health care resources among facilities within communities and within regions through informal and formal networking arrangements.

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Background:
Distance has already been identified as an issue especially affecting rural areas. Combined with shortages in health care providers, lack of transportation and changing demographics (more elderly and more new people), distance between facilities, providers, and health care consumers affects both cost and access to care. Some ways to address this include:

- Convene discussions within communities between health care facilities, such as hospitals, clinics, long term care facilities, home care, public health, emergency medical services, pharmacy, and others to explore ways to share resources through the use of informal or formal networking arrangements.

- Convene discussions between community, county and regional leaders, health care facilities and providers, including hospitals, clinics, long term care facilities, home care, public health and others to explore ways to share resources and provide access to primary, specialty and emergency health care through the use of informal or formal networking arrangements.

- Assist community members in accessing available resources to assist them in
Additional resources:
Organizational resources:
- Minnesota Center for Rural Health, (218) 727-9390 or www.ruralcenter.org
- Minnesota Department of Health, Office of Rural Health & Primary Care, at (651) 215-3838. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Office of Rural Health & Primary Care”.
- Rural Health Policy Research Institute (RUPRI), (573) 882-0316 or www.rupri.org/
- Rural Health Research Center, University of Minnesota, (612) 624-6151.
- Rural Information Center Health Service (RICHS), 1-800-633-7701 or www.nal.usda.gov/ric/richs/

Evidence for strategy:
The large distances to facilities and providers, especially in rural areas, supports the need for collaboration and consolidation of services. This need becomes even more critical when other issues are factored in such as the documented health care workforce shortages in primary and specialty health care, home care, long term care, allied health, pharmacy and emergency medical services in rural and underserved urban areas.

Has this strategy been implemented in Minnesota?
Yes, community and regional health care services networking efforts have been growing over the last ten years. Initiation of the Minnesota Rural Hospital Flexibility Program in 1999 has encouraged communities and regions to develop networking relationships. Evidence indicates that further collaboration and regionalization of services will continue.

Indicators for this strategy:
- Number of and participants in discussions occurring in communities to explore ways of sharing resources.
- Numbers of community members that are accessing available resources and making networking arrangements strong and viable.
- Number of health care provider networks in Minnesota.

For more information contact:
Minnesota Department of Health, Office of Rural Health & Primary Care, at (651) 282-3838. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Office of Rural Health & Primary Care”.

Strategy: Provide culturally competent health care services to new and diverse people.

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Background:
As Minnesota’s populations of color and new populations continue to increase in numbers, our communities are challenged to expand their resources, including their health care systems. Language barriers, lack of cultural competence on the part of providers, absence of a diverse health care
workforce, discrimination, lack of transportation, insurance difficulties and immigration issues all contribute as barriers to health for diverse populations (see the section on “Eliminate the Disparities” in this category for further information). Some ways that communities can address these issues include:

- Assess needs of new members of community through focus groups, surveys, and other assessment methods. Design training around perceived needs.
- Assess cultural competence of organizations and individuals through surveys, interviews, and group discussion.
- Develop training in partnership with people who are part of the population being addressed.
- Make use of alternative learning strategies, such as distance learning, workshops, and dialogues, as well as traditional classroom training.

Additional resources:
Organizational resources:
- Minnesota Cultural Diversity Center, (952) 881-6090 or www.mcdc.org/
- Minnesota Department of Health, Office of Minority and Multi-Cultural Health, at (612) 296-9799. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Minority Health”.

Evidence for strategy:
Demographic statistics in Minnesota clearly indicate a growing influx of new people, not only in urban but in rural settings. In addition, disparities in health outcomes for populations of color in Minnesota are strong indicators that further development is required. As rural communities experience significant influx of new people, provision of culturally competent care will be crucial to healthy outcomes for all members of the community.

Has this strategy been implemented in Minnesota?
Yes, the Center for Cross-Cultural Health, begun in 1997, has been assisting health care providers and facilities meet the health needs of ethnically, linguistically, spiritually, and culturally diverse patients. In addition, health plans, systems and facilities in urban and rural communities have conducted their own training in cultural competence and diversity.

Indicators for this strategy:
- Changes in perception among staff in organizations that have received training in responding to diverse people.
- Changes over time in cultural learning needs.
- Perception by minority or ethnic populations that they are receiving appropriate health care delivered in a culturally sensitive manner, as measured by a survey or focus group tool.

For more information contact:
Minnesota Department of Health, Office of Rural Health & Primary Care, at (651) 282-3838. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Office of Rural Health & Primary Care”.

This information is current as of Fall 2002
## CATEGORY: Service Delivery Systems

### TOPIC: ELIMINATE THE DISPARITIES

The strategies below can be used to work on this topic. Organizations that may play a role in implementing each strategy are indicated.

<table>
<thead>
<tr>
<th>Ensure a standard data collection system to document the health status of populations of color in Minnesota.</th>
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<th>Hospitals &amp; Clinics</th>
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<th>Include race, ethnicity, socioeconomic status and primary language in all assessments of utilization of health care services and use that information to improve health care delivery.</th>
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The health of the nation appears to have improved over the past 35 years. Within that time, we have experienced an overall decline in death rates from all causes. In Minnesota, in particular, the health and life expectancy of our people consistently rank number one in the nation. But despite this overall health improvement, populations of color continue to experience poorer health and disproportionately higher rates of illness and death.

Recent data show some of the wide gaps and disparities in the overall health status of populations of color as compared to that of the white population. The report, *Populations of Color in Minnesota Health Status Report*, was published in the spring of 1997 by the Office of Minority Health at the MDH and focused on economic profiles, birth-related health indicators, mortality rates, causes of death, illness, injury, and access to health care. While these gaps and disparities did not develop over a short period of time and will not be resolved quickly, a concerted effort throughout the health system must address the following gaps and disparities in health outcomes and profiles of people of color in Minnesota:

- The incidence of low birth weight among African American women is two and a half times greater than the incidence found in the white population and higher than any other major racial or ethnic group. Infant mortality rates for American Indian and African American babies are more than twice as high (13.5 deaths and 13.2 deaths, respectively, per 1,000 live births) as those in the white population (5.5). The rates for Asian and Hispanic (7.1 and 7.0/1000 respectively) also remain higher than that for Whites. Furthermore, women of color are less likely to receive adequate or no prenatal care. American Indian women are six times more likely to receive inadequate prenatal care or no care at all than their white counterparts. All other racial and ethnic groups are three times more likely to receive inadequate care or no care at all than white women.
- Mortality information concerning populations of color leads to one immediate and overarching conclusion: from adolescence through adulthood, African Americans and American Indians in Minnesota die at much higher rates (two to three and a half times higher) than other racial and ethnic groups. The large disparities between these populations and other racial and ethnic groups call for strong community and government action.
- There is a gap in available data on morbidity or health status and diseases of populations throughout the lifespan. Also, there is a lack of quality-of-life data, as affected by illness or injury, for populations of color. The lack of comprehensive information is a major concern in public health surveillance activities across the nation and in Minnesota.

In examining barriers of cultural competency, the *Populations of Color* report noted that some people of color prefer to be treated by someone of their own racial or ethnic group, feeling that a physician, nurse, or other professional from their own group can understand them better, be more aware of their culture, and be easier to talk to. The report further noted that people of color are under-represented in several health-related occupations and that access to quality health care for people of color can be enhanced by increasing the representation of populations of color in the health professions. For related strategies, see the section in this category called, “Eliminate Barriers and Improve
Access to Health Care - Promote Access to Health Care”. For more information about the MDH Office of Minority and Multicultural Health, see the website for strategies resources at: [www.health.state.mn.us/strategies](http://www.health.state.mn.us/strategies). Click on “Minority Health”.

Collecting data and sharing information are necessary prerequisites to developing strategies designed to reduce or eliminate the health status disparities between populations of color and the white population. Obtaining information and focusing statistical research on minority health issues are essential for developing sound policies, implementing appropriate services, and assessing whether the services provided are achieving stated goals and objectives.

Race and ethnicity information must be collected in needs assessments conducted by public health agencies, health care plans, and the health system in general. The strategies presented here provide support for achieving these outcomes.

**Strategy:** Ensure a standard data collection system to document the health status of populations of color in Minnesota.

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**Background:**
Populations of color and American Indians in Minnesota experience poorer health and disproportionately higher rates of illness and death than do whites. In addition, the 1997 Report, *Populations of Color in Minnesota Health Status Report*, found that the health priorities and needs of populations of color are not identical to those of the general population. The report constructed a health profile of populations of color based primarily on information obtained from birth and death certificates. The reasons for this were several. First, data on illness, injury, and other aspects of health status of populations of color are somewhat limited. Second, organizations that collect these types of data adhere to no consistent standard for identifying the race and ethnicity of the persons whom they serve. Third, in some instances, the race and ethnicity question remains unasked.

In order to set the right priorities and develop effective health programs for populations of color and American Indians, more accurate and comprehensive information is needed. The following steps are recommendations for collecting race and ethnicity data:

- **Categorization of race and ethnicity.** A standard race and ethnic classification scheme should be used when collecting health-related data on populations of color. The federal Office of Management and Budget (OMB), through *Statistical Policy Directive Number 15*, sets the standard for race and ethnic classification. These categories should be used for all tracking functions. The categories outlined are:
  - Race: White, Black, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander.
  - Ethnicity: Hispanic Origin, Not of Hispanic Origin.

- **Categorization within race and ethnicity.** It is important to note that
the OMB standard is a minimum, and that it is recommended that agencies collect and report additional race and ethnic detail within the groups described, as long as the population detail can be aggregated into the five minimum groups. In Minnesota, many diverse populations with distinct characteristics exist within the standard categories recommended by OMB. The following are examples of specific populations that could be collected along with the standard categories:

- Black/African American.
- Ethiopian, Somali, Sudanese.
- Asian: Hmong, Vietnamese, Asian American, Chinese (except Taiwanese), Korean, Laotian, Filipino, Camodian
- Hispanic/Latino: Mexican, Puerto Rican, Guatemalan.

Identification of multiracial individuals.
It is recommended that individuals should be offered the option of selecting one or more racial designations. The OMB recommends that, when using the Race and Ethnic Standard Categories, the instructions, “mark one or more and select one or more” accompany the question.

Collection of data by self-reporting.
Race and ethnicity data should be collected by voluntary self-reporting, whenever possible. In the event that staff must identify the race/ethnicity of the person, a method must be provided to verify “self-reported vs. staff reported.” Community education is necessary to stress the importance of self-reporting. In addition, extensive training is needed to ensure staff are asking individuals to report their race and ethnicity, or are asking parents to report on behalf of their children or a close relative to report on behalf of a deceased person.

Additional resources:

Evidence for strategy:
Former President Clinton had committed the nation to eliminating the disparities experienced by racial and ethnic minority populations in six areas of health status by the year 2010. According to the President’s Initiative on Eliminating Racial and Ethnic Disparities in Health, “Eliminating disparities will require improved collection and use of standardized data to correctly identify all high risk populations and monitor the effectiveness of health interventions targeting these groups.” At the federal level, the Department of Health and Human Services (HHS) has adopted a policy that requires all HHS-sponsored data collection and reporting systems to include standard racial and ethnic categories. The OMB provides a standard classification of federal data by race and ethnicity for these data collection and reporting systems. The standard classification scheme ensures a “common language to promote uniformity...
and comparability for data on race and ethnicity...”

**Has this strategy been implemented in Minnesota?**
No.

**Indicators for this strategy:**
- State grantees are required to use standard race and ethnic categories.
- Legislation enacted to require health plans to use standard race and ethnic categories.

**For more information contact:**
MDH, Office of Minority and Multicultural Health, at (651) 297-5813. For more information see the website for strategies resources at: [www.health.state.mn.us/strategies](http://www.health.state.mn.us/strategies). Click on “Minority Health”.

**Strategy: Train providers to provide culturally competent care.**

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**Background:**
Populations of color and American Indians in Minnesota experience poorer health and disproportionally higher rates of illness and death than whites. In addition, the report found the health priorities, needs and concerns of populations color are not identical to those of the general population. To construct a health profile of people of color, the 1997 *Populations of Color in Minnesota Health Status Report* used information from the birth and death certificates, as well as, the U.S. Census records of 1990.

While data on illness, injury and other aspects of health status of people of color was somewhat limited, we know cultural competency is one of the cross-cutting issues which affect the quality of health and health care for populations of color and American Indians and is a factor in the wide health disparities between populations and the general population.

The tactics used to accomplish this strategy are intended to provide a broad framework for increasing the cultural competence of health care professionals in the health care setting, as well as those involved in public health program development and implementation.

For the purposes of this strategy, a standard definition of cultural competence will be used. Cultural competence used here is defined as “a set of congruent behaviors, attitudes and policies that are present in a system, agency, or individual to enable that system, agency or individual to function effectively in trans-cultural interactions.” The word culture refers to an integrated pattern of human behavior that includes the thought, communication, action, customs, beliefs, values, and institutions of a group. Competency refers to the capacity to function effectively (Cross et al., 1989).

In order to become culturally competent, providers must continue to acquire skills, areas of knowledge, and personal attributes, including an understanding of the major
social and economic conditions affecting specific populations served, that enable them to work effectively in transcultural situations. While understanding cultural patterns is important, it is vital to recognize that they do not always apply to every member of a cultural group. Diversity exists within diversity, and every individual must be dealt with based on his or her own personal history, values, and experiences ("cultural common sense").

Because no system, program, or individual can ever know everything about every person of every group, cultural competence is never fully achieved. Rather, it is an ongoing process of development on systemic, programmatic, and individual levels. It is an understanding that cultural competency is not a one-size fits all model.

Some of the contributing factors to the disparities in the health status of populations of color and American Indians are the lack of culturally competent health providers in the health care system, and the failure of health professionals to recognize the impact of cultural patterns and their affects on health outcomes. While this strategy was developed to address the barriers regarding race and ethnicity individuals encounter, there are other groups that have not been socially included based on varying religious beliefs, physical and mental disabilities, age, sexual orientations, socioeconomic positions, geographic regions, and other subcultural characteristics. This strategy can also be applied to fostering an understanding of all cultures.

It should be recognized that individual bias among health care providers and public health practitioners negatively affects the quality of care people receive and discourages people from seeking health care when they need it or from participating in programs designed to protect, maintain, and improve health. Additionally, the delivery of culturally competent care is critical to the health system’s ability to assess and respond appropriately to the health needs of diverse populations.

To improve cultural competency in health care delivery systems basic elements should include:

< Fostering an awareness of the practitioner’s own understanding of race, ethnicity, and power.
< Understanding how race and ethnicity have an impact on health care. It is important to recognize that there may be incongruence between the cultural patterns of groups and the processes by which health care is offered.
< Understanding the complexities among populations with which providers may not be familiar. As with all populations, one individual is just that: one individual with their own needs and requirements.

Fundamental strategies include:

< Increasing the number of health care professionals of color, which will enhance an organization’s cultural competency.
< Employing bilingual healthcare providers or using medical interpreters as needed for limited English-speaking persons, which will increase the accessibility of care, thereby increasing the organization’s cultural competence.

Further, cultural competency is more than the use of interpreters alone. Each population (American Indian, African American, Asian American, Latino) has cultural patterns to be considered that affect health outcomes. Steps that can be taken to achieve this strategy include:
Create an environment where developing cultural competence is valued. Top management of any organization must establish an expectation that cultural competence is relevant to the work of every individual in the organization and communicate that expectation broadly. This can be accomplished by:

- Ensure upper management sets the tone by participating in learning opportunities that foster cultural understanding.
- Evaluate managers’ and supervisors’ performances on the basis of their efforts to increase the cultural competence of their staff and themselves.
- Introduce new employees to the concept of cultural competence and the role it plays in their work.
- Invest the organization’s resources to provide opportunities for training, whether in-service or outside of the organization. Require participation as a valuable part of staff development.
- Ensure staff’s efforts to increase cultural understanding are rewarded.
- Integrate dimensions of cultural competence into other staff development opportunities, such as annual meetings, staff retreats, and conferences.

Assess the cultural competence of the system, agency, and individuals to identify needs and opportunities for relevant cultural learning, by issuing a report card. This would highlight the specific learning needs within the organization in terms of organization wide, program-specific, and individual development needs. Based on available data related to the demographic make-up of the client base, the following steps should be taken:

- Determine, within each organization, the opportunities for further development relating to cultural competence.
- Determine, within each program area, its current capacity for understanding, and responding to, the needs of a diverse client base.
- Assess the needs of clients through focus groups, surveys, and other assessment methods, to determine if there are any barriers to effective service delivery.
- Provide staff with opportunities to assess their own cultural competence, including a reflection of their own culture and experience.

Provide non-threatening opportunities for learning. Opportunities for staff to increase their knowledge, skills, and abilities to work with diverse constituents should be offered. Examples include:

- Collaborate with existing community programs that have “firsthand” understanding of cultural patterns, especially those targeted at addressing health related issues.
- Facilitate internal dialogues among staff to combine efforts for reaching diverse populations.
- Use experience of clients in the learning opportunities. Develop training in partnership with the input of people who are part of the population being addressed. Compensate these individuals appropriately.
- Make use of alternative learning strategies, such as distance learning, computer-aided training, workshops, and dialogues, as well as traditional classroom learning.
- Utilize the vast cultural training opportunities external to the
organization by providing training funds for attendance at learning opportunities outside of the organization. Publicize these learning opportunities to staff.

- Provide a centralized location, such as a library or diversity resource center, for self-study learning.

**Additional resources:**

**Bibliographic resources:**


- Rider, ME., and Mason, JL. 1990. *Issues in Culturally Competent Service Delivery: An Annotated Bibliography*. Contact: Research and Training Center on Family Support and Children’s Mental Health, at (503) 725-4040, Portland State University, P.O. Box 751, Portland, OR 97297-0751.


**Organizational resources:**

- American Society for Training and Development, at (800) 628-2783, 1640 King Street, Box 1443, Alexandria, VA 22313-2043.

- Bridge to Wellness Partial Hospitalization Program, at (415) 284-9154, 645 Harrison Street, Ste. 100, San Francisco, CA 94107.

Evidence for strategy:
This strategy has been tested in a variety of organizations, such as hospitals and clinics, health management organizations, community support programs, and public health agencies. Surveys of training participants indicate an increased sense of confidence in working with diverse populations and a desire to continue in the cultural learning process. In all organizations surveyed, the effectiveness of increasing cultural competence is contingent upon management’s support of the endeavor.

According to the Centers for Disease Control and Prevention’s Task Force on Community Preventive Services, there is insufficient evidence to recommend or strongly recommend the following strategies: staffing to reflect cultural diversity of served community; use of interpreters or bilingual providers; and cultural sensitivity training programs for healthcare providers. A determination by this Task Force of insufficient evidence does not mean evidence of ineffectiveness. A recommendation of insufficient evidence means that available studies do not provide sufficient evidence to assess the strategy’s effectiveness. For more information see The Preamble section of the Introduction to this document, under “Evidence-based Strategies,” and The Community Guide at http://www.thecommunityguide.org.

Has this strategy been implemented in Minnesota?
Yes, currently there are a number of community clinics that use the strategies named here to serve the increasingly diverse populations in Minnesota. Also, the Center for Cross Cultural Health opened in January 1997. It was designed to help health care providers and institutions meet the health
needs of ethnically, linguistically, spiritually, and culturally diverse patients. HealthPartners has engaged in successful diversity training efforts, and Hennepin County Medical Center has actively educated their practitioners in cultural competency. For example, forums are hosted on a periodic basis to invite different groups to highlight various strategies that have improved the quality of health care for patients.

**Indicators for this strategy:**
- Changes in staff perceptions about diverse populations before and after the training.
- Changes in staff perceptions that cultural competence is valued within the organization.
- Changes over time in cultural learning needs.
- Numbers of participants who report that the training was beneficial in relating to a diverse client base.
- Numbers of learning opportunities offered and the participation rate of staff.
- Numbers of clients and patients who report satisfaction with the service they receive.
- Numbers of partnerships with community resources to provide ongoing guidance in the cultural learning process.
- Increased staff from populations of color and American Indians.
- Numbers of translation services available.
- Overall increase in indicators listed above noted through biennial reports.

**Strategy:** Include race, ethnicity, socioeconomic status and primary language in all assessments of utilization of health care services and use that information to improve health care delivery.

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**Background:**
Populations of color and American Indians in Minnesota experience poorer health and disproportionately higher rates of illness and death than do whites. A crucial component of improving the health status of populations of color and American Indians is to improve access to, and utilization of, health care services. The 1997 *Populations of Color in Minnesota Health Status Report* found that, where statewide data are available, people of color in Minnesota do not have the same access to health care. They are less likely to have health insurance of any kind or protective vaccinations and they have fewer population members working in health professions. Unfortunately, these findings do not provide a complete picture of access and utilization of health care services of populations of color because of the lack of data.

Information on race and ethnicity should be included in all community health assessments by governmental public health agencies, health plans, hospitals and clinics, educational systems, community-based organizations, and other agencies that provide health care services. The questions of race and ethnicity should be based on the OMB *Statistical Policy Directive 15* for race.
and ethnicity standards, with the identity of race and ethnicity self-reported. (See the previous strategy, “Ensure a standard data collection system to document the health status of populations of color in Minnesota” for a description of the race and ethnicity standards.) These assessments should identify barriers to serving populations of color related to transportation, primary language, ethnicity, culture, age, disability, educational information, socioeconomic status, and service delivery systems that affect access to, and utilization of, services. For related strategies, see “Health Care Coverage” in this category.

Additional resources:


Evidence for strategy:
At the federal level, the HHS has adopted a policy that requires all HHS-sponsored data collection and reporting systems to include standard racial and ethnic categories. The OMB provides a standard classification of federal data by race and ethnicity for these data collection and reporting systems.

Has this strategy been implemented in Minnesota?
No.

Indicators for this strategy:
< Number of governmental public health agencies, health plans, hospitals and clinics, educational systems, community-based organizations, business or work sites, and other agencies that provide race, ethnicity, socioeconomic status and primary language data in their assessments of utilization of health care services.
< Changes in utilization rates by populations of color.

For more information contact:
MDH, Office of Minority and Multicultural Health, at (651) 297-5813. For more information see the website for strategies resources at: www.health.state.mn.us/strategies. Click on “Minority Health”.

Strategy: Create an effective reporting mechanism for culturally insensitive encounters Minnesotans experience with the health care system.

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Background:
“My daughter was suffering from a kidney infection when we visited her pediatrician for tests. I interacted with the pediatrician
and various lab technicians in the exam room for almost an hour. At the end of the exam the pediatrician suggested to my husband that I couldn’t speak English. English is my first and only language.” –An Asian American mother and public health professional, sharing her recent encounter with the health care system in Minnesota.

“As soon as they look at the patient and see he’s an African-American or Latino, they assume automatically that he doesn’t have insurance at all.” –An Hispanic/Latino physician, sharing perceptions about his colleagues.

How often do these biases occur? The most recent evidence in a report entitled, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, conducted by the Institute of Medicine in 2002 (See “Additional resources” below) suggests that these biases occur far too frequently. Although several factors contribute to existing racial and ethnic disparities in health care, evidence suggests that bias, prejudice, and stereotyping on the part of the health care providers may contribute to differences in care. This report provides strong evidence that minorities tend to receive lower-quality health care than whites, even when insurance status, income, age and severity of conditions are comparable. This report also emphasized that differences in treating heart disease, cancer, and HIV infection partly contribute to higher death rates for minorities.

“Disparities in the health care delivered to racial and ethnic minorities are real and are associated with worse outcomes in many cases, which is unacceptable,” said committee chair Alan Nelson, a retired physician, former president of the American Medical Association, and current special advisor to the chief executive officer of the American College of Physicians-American Society of Internal Medicine, Washington, D.C. “The real challenge lies not in debating whether disparities exist, because the evidence is overwhelming, but in developing and implementing strategies to reduce and eliminate them.” Even well meaning people who are not overtly biased or prejudiced typically demonstrate unconscious negative racial attitudes and stereotypes. In addition, the time pressures that characterize many clinical encounters, as well as complex thinking and decision-making they require, may increase the likelihood that stereotyping will occur (Institute of Medicine, 2002).

In order to better understand the prevalence and influence of bias, prejudice, and stereotyping on the part of health care providers/workers, and to ensure that Minnesota can track its progress in reducing disparities, clinics, hospitals, and counties must create plans to, without violating patients/clients’ privacy, collect and report data on health care access and utilization by patients’ race, ethnicity, socioeconomic status, and primary language.

However, given the limitations of quantitative data collection methods, the aforementioned entities should create an effective mechanism for racial/ethnic minority patients/clients to report and document any culturally insensitive experiences they may have with specific providers/workers within Minnesota’s health care system. These strategies are necessary and crucial in tracking Minnesota’s progress towards eliminating health disparities.

Additional Resource:

Evidence for strategy:
None.

Has this strategy been implemented in Minnesota?
No.

Indicators for this strategy:
< Number of governmental public health agencies, health plans, hospitals and clinics, educational systems, community-based organizations, business or work sites, and other agencies with a mechanism for patients to report culturally insensitive encounters.
< Existence of culturally sensitive methods to ensure all clients are verbally and literally informed of this reporting mechanism.

For more information contact:
MDH, Office of Minority and Multicultural Health, at (651) 297-5813. For more information see the website for strategies resources at: www.health.state.mn.us/strategies. Click on “Minority Health”.

Strategy: Enhance services to reflect the health needs of all populations in the community.

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Background:
A key strategy to reforming community health care is to establish services that are consumer-driven and that represent the community’s diverse cultures. Communities are composed of diverse cultures seeking ways to maintain or preserve their health or to restore their well-being. Health policies and priorities must reflect the unique needs of communities with diverse cultures and be based on a systems approach involving health care providers, organizations, educational institutions, and communities.

With input from the diverse cultures within the community, modifications of existing services can be made as well as new services designed. Theoretical assumptions on which service modification should be based (Leininger, 1991) include:
< Care is essential for human growth, development, survival, and facing death.
< Care is essential to curing and healing; there can be no curing without caring.
< Forms, expressions, patterns, and processes of human care vary among all cultures of the world.
< Every culture has lay, folk, or naturalistic care and usually professional care practices.
< Cultural care values and beliefs are embedded in religious, kinship, social, political, cultural, economic, and historical dimensions of the social structure and in language and environmental contexts.
< Effective services can occur only when the cultural values, expressions, or practices of the clients regarding care are known and used explicitly in the promotion and provision of health care services.
< Differences in expectations between providers and receivers of services or care need to be understood in order to
provide beneficial, satisfying, and congruent services and care.

< Provision of services or care in culturally and linguistically congruent methods is necessary to the health or well-being of people from diverse backgrounds.

Additional resources:
Bibliographic resources:

Organizational resources:
< Hennepin County Medical Center, Social Services Division. Contact: Ellen Rau, at (612) 347-2248.
< Mayo Clinic, Language and Cultural Services Department. Contact: Colette Namyst-Goldberg, at (507) 266-4161.
< Regions Hospital, International Services. Contact: Elizabeth Anderson, at (651) 221-8928.

Web Pages:

Evidence for strategy:
Leininger’s (1991) research findings support her theory that the diversity and universality of culturally relevant care have a bearing upon quality of life. She holds that since quality of life is culturally constituted and patterned, it needs to be studied and understood from a transcultural perspective. She studied five major cultures to illustrate culturally constituted dominant care patterns related to quality of life. These comparative data reflect more diversity than universality among cultures. Therefore, it is critical that the diversity of different cultures be reflected in modifications made to the delivery of health services.

Has this strategy been implemented in Minnesota?
Yes, most of the major hospitals in Minnesota have modified some of their services to meet the needs of an increasingly diversified clientele. For example, the Hennepin County Medical Center (HCMC) in Minneapolis and Regions Hospital in St. Paul hold regular International Clinics. These two hospitals, as well as the Mayo Clinic in Rochester and Children’s Hospital in St. Paul, have developed their own systems for interpreter services and employ a considerable number of full-time staff interpreters.

Indicators for this strategy:
< Numbers and kinds of ways in which services are updated to be inclusive of the diverse clients in the community.
< Increase in the number of customer-provider interactions.
< Degree of client (from all cultures in the community) satisfaction with the services.
< Number of customers from diverse cultures who utilize services.
< Degree of intra-organizational diversity awareness and service delivery.
< Numbers of staff from populations of color in decision-making positions to
better serve their communities.

- Numbers of times and ways that populations of color are consulted regarding modifications of services and processes.
- Amounts, methods and numbers of clients of color that are compensated as valued members of the process for their advice and input.

For more information contact:
- Sheila Brunelle, at (651) 282-3853, sheila.brunelle@health.state.mn.us, MDH, Office of Rural Health and Primary Care.
- MDH, Office of Minority and Multicultural Health, at (651) 297-5813.
For more information see the website for strategies resources at: www.health.state.mn.us/strategies. Click on “Minority Health”.

**Strategy:** Encourage the use of professional interpreters as needed for limited English-speaking and hard-of-hearing persons.

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**Background:**
Communication is essential in delivering health care services, but often difficult to achieve with limited-English speakers and hard-of-hearing persons. The responsibility for securing an interpreter falls primarily on health institutions and those institutions are responsible for providing the necessary means for patients and clinicians to communicate. Title VI of the Civil Rights Act of 1964 says that it is illegal for recipients of federal funding (i.e. Medicaid and Medicare reimbursement) to discriminate on the basis of national origin, which includes language. In other words, an institution not providing trained interpreter services could be in danger of losing its federal funds. Other laws that require or imply interpreter provision include the Hill-Burton Act, Medicaid Law, the EMTALA (federal anti-dumping law), and, in various states, several provisions of state law and Medicaid managed-care regulations. Similar anti-discrimination laws require institutions to secure sign-language interpreters at no cost to the client. This strategy is intended to provide support for health care organizations in implementing the laws, as well as to help eliminate disparities in health care.

The properly trained interpreter can be a valuable member of the health care team. As of January 1999, there is no formal certification or accreditation of interpreters in Minnesota. However, the Minnesota Interpreter Standards Advisory Committee issued its recommendations in a report, *Bridging the Language Gap* (see “Additional resources” below), about training, certification, and use of foreign language interpreters in Minnesota. Its members consisted of 75 individuals representing academia, health care, government, business, law, advocacy, community, and interpreter organizations. In addition, the University of Minnesota offers training for interpreters in the medical and legal fields.

**Additional resources:**
Bibliographic resources:
Evidence for strategy:

More and more health care organizations are required by state and federal laws to provide professional interpreter services for their clients. Correspondingly, more research is being conducted within the different fields of the social sciences to determine the cost-effectiveness of professional community interpreters. A number of professional journal papers emphasize the importance of quality translation and interpretation, its long-run cost-effectiveness in terms of diagnostic accuracy, increased preventive visits, and decreased urgent care visits and the ease and comfort level of communication between the patient and the physician.

According to the Centers for Disease Control and Prevention’s Task Force on Community Preventive Services, there is insufficient evidence to recommend or
strongly recommend the use of interpreters or bilingual providers. A determination by this Task Force of insufficient evidence does not mean evidence of ineffectiveness. A recommendation of insufficient evidence means that available studies do not provide sufficient evidence to assess the strategy’s effectiveness. For more information see The Preamble section of the Introduction to this document, under “Evidence-based Strategies,” and The Community Guide at http://www.thecommunityguide.org.

Has this strategy been implemented in Minnesota?
Yes, health care organizations use a wide spectrum of strategies for overcoming linguistic and cultural barriers to care. These strategies include the use of bilingual providers, bilingual/bicultural community health workers, interpreters, and translated written materials. Certain models may work best in a particular health care setting, while others have wide application and can be useful in all settings. The HCMC in Minneapolis, Regions Hospital in St. Paul, the Mayo Clinic in Rochester, the Minnesota Department of Human Services, and the MDH have well-established systems for language assistance. For further information, contact the Social Services divisions at HCMC, Regions Hospital, and Mayo Clinic (see the above resources section for contact information).

Indicators for this strategy:
< Identification of needed interpreter services.
< Number of interpreters hired to provide these services.
< Increase in the number of interactions between health care delivery systems and providers and limited English-speaking clients and hard-of-hearing persons.

< Patient satisfaction with the communications.

For more information contact:
Sally Sabathier, at (651) 215-1300, MDH Communications Office.

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Strategy: Increase the number of practicing health professionals who are members of under-represented racial and ethnic groups.

Background:
Populations of color and American Indians in Minnesota experience poorer and disproportionally higher rates of illness and death than the white population. In addition, the report found the health priorities, needs and concerns of populations of color are not identical to those of the general populations. To construct a health profile of people of color, the 1997 Populations of Color in Minnesota Health Status Report (see Additional resources” below) used information from the birth and death certificates, as well as the U.S. Census records of 1990. While data on illness, injury and other aspects of health status of people of color was somewhat limited, we know that there is an under-representation of qualified persons of color in health professions. This under-representation in health related occupations is mainly among African Americans, American Indians, and Latino/Chicano populations, and has a direct bearing on the health outcomes of those people. Also, access to quality health care
for people of color can be enhanced by increasing the representation of populations of color in the health professions.

The strategies summarized in this section are highly complex and must be addressed on many levels. They focus on increasing the representation of qualified people of color within the public health professions as well as in the direct health care occupations.

In order to effectively eliminate the under-representation of people of color who work in professional health care positions, there must be a multifaceted approach that encompasses the creation of an environment conducive to change, recruitment of new resources for use, and modification of selection processes to be inclusive, as well as work to retain diverse talent. Focusing on one of these areas without addressing the others will result in a revolving door syndrome where people leave at a greater rate than they enter the workforce. Additionally, recruitment without training managers and supervisors in cultural competency will result in turning a number of people away from the hiring process, often leaving them frustrated and mistrusting the system as a whole.

Strategies to increase the numbers of under-represented groups within the health care industry begin at the primary stages of career development and end at the actual process of retaining health care professionals already employed in the industry. The following action steps represent interventions at the primary prevention level and target individuals, communities, and systems. Taken together, they are intended to achieve the strategies set forth here.

Inspire youth to consider careers in the health care industry. Children begin to develop interests in careers as early as the elementary school level. Many children have not been exposed to certain occupations as a result of the pervasive under-representation of their own role models within those fields. Children who have never met people employed in the health care industry with whom they can identify cannot visualize themselves employed in that field. In order to instill in them a sense of hope and inspiration, efforts must be made to expose them to people with whom they can identify who have been successful in those occupations. There are a variety of approaches that public health agencies and direct health care employers can take to inspire youth to consider careers in the health care industry. Developing outreach initiatives and partnering with school systems that educate diverse student populations are effective methods through which the following can be achieved:

< Promote messages from practitioners already employed in these fields that inform students of the critical need for diversity within the health care professions. For example, African American epidemiologists can tell students, “There are not many epidemiologists that are African American and we need more.”

< Find creative ways, such as contests, science fairs, and other “fun” activities, to spark the interests of students and hold the attention of young learners.

< Provide mentoring initiatives that match talented health care practitioners with young students to help inspire youth. It is particularly important for those mentors to have the ability to relate to the student by sharing a common understanding about cultural patterns and challenges unique to certain
communities. This will avoid the dynamics present in some mentoring relationships in which the student feels inferior and the mentor superior.

- Offer incentives for learning, such as internships that offer stipends applied toward continued academic development in the health care industry. Other incentives include academic credit for work and learning experiences in the field.

- Work to expand existing programs in schools by offering resources and ideas so that learning is congruent with the expectations of employers beyond the academic environment.

- Provide role models, such as athletes, to whom children gravitate, to talk about the importance of the role of health care professionals.

- Introduce cultural healing as part of the health service system to help students understand the “real life” context of health care while embracing their own cultural values and traditions.

Increase the enrollment of students of color in higher education programs, such as schools of public health and medical schools. According to 1995 national graduation rates in schools of public health, the rate of graduation for students of color is 20.6 percent of the total graduating class. In Minnesota, the rate of people of color who graduate from the school of public health is only 3 percent of students (based on USDHHS statistics). The Minnesota Center for Research in Health Statistics offers financial support for doctoral dissertations focusing on statistical health research on racial and ethnic populations. For more information see the website for strategies resources at: www.health.state.mn.us/strategies. Click on “Dissertation”.

While there are a number of factors that determine where a student will choose to obtain higher education, a school’s environment can have a great impact on its ability to attract students of color from anywhere in the country. Here are some of the ways that educational institutions can create a welcoming environment for students of color:

- Increase the representation of faculty, administrators, and support staff of color within the institution.

- Assess the under-representation of faculty of color in comparison to the availability of educators in those areas and take affirmative action to eliminate that underutilization.

- Recruit faculty and administrators of color actively, on a national level, from areas where there are higher concentrations of people of color.

- Provide incentives for faculty of color within institutions by offering tenured position opportunities and the same benefit packages available to majority faculty members who may have other ties to the institution.

- Provide support mechanisms for students of color who are studying in health-related fields.

- Encourage employers to provide mentors who can relate to students on a variety of levels to help them maneuver throughout the academic system and connect them with hiring supervisors within their own institutions.

- Offer mentors for students through internships that offer stipends or other forms of compensation for students while they are gaining practical application of their theoretical learning.

- Urge academic institutions to encourage students to utilize available support resources present on many campuses.

- Encourage educators within those
institutions to serve as catalysts for student organizing activities to push the institution to become more inclusive in the administration of programs.

< Provide information about available community resources that embrace the cultural values and traditions of students, particularly those who are unfamiliar with that geographic location.

< Look broadly at a variety of disciplines for potential candidates in the health care field.

< Acknowledge that, beyond the training available through schools of public health and medical school environments, technical and vocation training programs can often lead to further pursuit of specialized health care occupations.

< Increase the number of applicants selected for positions in the health care field. In order for an employer to effectively increase the number of individuals from under-represented groups employed in their organizations, a multifaceted approach must be employed. Beginning by creating an environment conducive to change, an employer can set the tone and develop a workplace that is aware of, accepts, and appreciates the value of diversity. This will have residual effects on the actual hiring process, as individuals who are responsible for making hiring decisions will be more aware of their own biases and how they affect their decision-making. These persons will then be more open to seeking out potential employees who do not fit one particular gender, age group, or ethnic category.

A key strategy to having an effective impact on an organizational culture in terms of embracing differences is to have solid and consistent support from upper management throughout the process. Leadership must clearly communicate an expectation that all employees understand that diversity is a core value and directly linked to the mission and vision of the organization. In many cases, employees must be given “permission” to seek understanding of cultural differences and be provided incentives for doing so. Once the foundation has been laid, there are a number of activities in which employers can engage to increase the representation in their applicant pools and within their workforce. They include:

< Assess the representation within the organization to identify underutilization where it exists and focus initiatives in those areas.

< Identify, by conducting underutilization analysis, job categories where under-represented individuals are trained and skilled. Goals should be set in direct correlation to the availability of qualified individuals for positions based on the requisite knowledge, skills, and abilities needed to perform the essential functions of those positions.

< Measure the progress of achieving goals to eliminate underutilization by each segment of the organization and hold individual hiring supervisors accountable for meeting those goals. This does not imply the use of quotas. Goals should be flexible, realistic, and related to objective labor market data.

< Reward individuals who, and sections of the organization which, demonstrate a commitment to achieving a diverse workforce.

< Communicate progress to organizational leaders so that they can celebrate successes and establish
strategies where additional progress is needed.

- Broaden recruitment resources.
- Establish relationships with community-based organizations designed to provide employment-based services to under-represented populations.
- Advertise in publications read by populations of color.
- Be present at community activities and events where under-represented populations will be present. Ensure that this presence is not sporadic.
- Establish relationships with professional associations that are networks for populations of color in the variety of health care fields.
- Utilize the expertise, connections, input and constructive criticism of staff of color within the organization.
- Empower them to serve as representatives of the organization in outreach activities.
- Serve on advisory councils and boards of directors, and as volunteers, in organizations that serve populations of color.
- Select individuals based on objective, job-related criteria.
- Assure that hiring supervisors and managers examine their hiring decisions to determine if biases are subconsciously affecting their decisions, always recognizing the hiring process can be somewhat subjective.
- Establish clear criteria by which to measure an applicant’s suitability for a position before the hiring process begins to increase the objectivity of the decision.
- Use the same interview questions for each candidate interviewed and retain the notes for subsequent review. This will ensure that all applicants are evaluated according to the same standards.
- Consider the value that the diverse attributes of the hired individual will add to the mission of the organization. Also, consider the ability of that individual to relate effectively to diverse cultures and groups as a factor in the hiring decision.
- Work to retain talented employees of color. Let them know that they are important and valued members of the organization.
- Assess the rate of separation of employees of color in proportion to their overall representation within the organization. Identify the personal or systemic reasons that employees of color voluntarily resign, are terminated, or do not pass probationary periods, particularly when their separation exceeds their overall representation within the organization.
- Establish remedies that correlate with the reasons for employee turnover, such as mentorship initiatives and other support programs.
- Create an organizational culture that is open to discussions about diversity and institutional barriers to access for employees. Create a mechanism that deals with employees’ perceptions directly.
- Promptly and thoroughly investigate allegations of discrimination when they are presented.
- Offer conflict intervention techniques such as mediation.
- Clarify expectations for satisfactory job performance and provide recognition to employees who are
meeting those expectations. Reward them with wage increases and promotional and training opportunities.

Additional resources:
Bibliographic resource:

Resources for inspiring youth to consider careers in the health care industry:
< Minnesota Hispanic Education Program, (651) 222-6014, 245 East 6th Street #467, St. Paul, MN 55101.
< Minnesota Minority Education Partnership. Contact: Bruce Vandal, at (612) 330-1645, 2211 Riverside Avenue, Minneapolis, MN 55454.
< Urban Coalition Education Initiative. Contact: Claudia Fuentes, at (612) 348-8550, 2610 University Ave W, Ste. 201, St. Paul, MN 55114-1090.

Resources to increase the enrollment of students of color in higher education programs, such as schools of public health and medical schools:
< Association of American Indian Physicians. Contact: Margaret Knight, at (405) 946-7072, http://www.aaiip.com, 1235 Sovereign Row, Suite C-9, Oklahoma City, OK 73108.
< University of Minnesota Academic Health Sciences, Multi-Cultural Services, Academic Health Center, Contact: Jacqui Cottingham-Zierdt, at (612) 625-9940, cotti001@maroon.tc.umn.edu, I-125 Moos Tower, 515 Delaware Street SE, Minneapolis, MN 55455.
< University of Minnesota Duluth Center for American Indian and Minority Health, School of Medicine, Room 182, 10 University Drive, Duluth, MN 55812-2487, http://www.d.umn.edu/medweb/caimh.
< University of New York, Under Represented Graduate Fellowship
Program, State University Plaza, Albany, NY 12246. Contact: Ms. Jacqueline Davis Ohwevwo.

Resources for increasing the number of applicants who are selected for positions in the health care field:


< Hubbard, EE. *Measuring Diversity Results* (Vol. 1).


**Evidence for strategy:**

In terms of inspiring youth to consider careers in the health care industry, many of the strategies listed above have been proven to increase the interest of children in the health care field. Measurement of the effectiveness of this strategy is difficult, as it is a long-range endeavor and the effects may take years to manifest.

According to the Centers for Disease Control and Prevention’s Task Force on Community Preventive Services, there is insufficient evidence to recommend or strongly recommend a strategy of staffing to reflect cultural diversity of the served community. A determination by this Task Force of insufficient evidence does not mean evidence of ineffectiveness. A recommendation of insufficient evidence means that available studies do not provide sufficient evidence to assess the strategy’s effectiveness. For more information see The Preamble section of the Introduction to this document, under “Evidence-based Strategies,” and The Community Guide at http://www.thecommunityguide.org.

Evidence for increasing the number of students of color in higher education programs, such as schools of public health and medical schools, includes the fact that Affirmative Action has helped draw students of color into higher education programs. Evidence of the decline in enrollment rates for students of color absent such initiatives has been observed in California’s higher education system after the passage of Proposition 209 (an anti-affirmative action bill that passed in 1996). A report entitled *Opportunities Lost: The State of Public Sector Affirmative Action in Post Proposition 209 California* reveals details of the rapid decline in enrollment rates for students of color.

Evidence for increasing the number of applicants who are selected for positions in the health care field includes the fact that this strategy has been tested in a variety of employment settings. The MDH has made progress in increasing the representation of people of color working in the agency. With mechanisms that ensure inclusion in the hiring process, the Department has had a steady increase in the number of employees of color over the last seven years. Currently, a study of employee retention is underway to pinpoint the reasons for employee separation.

**Has this strategy been implemented in Minnesota?**

Yes, in terms of inspiring youth to consider careers in the health care industry, a collaborative project between St. Paul Public
School’s Minority Encouragement Program and Regions Hospital is one example of exposing youth to careers in the health care field at early ages. The MDH employees also conduct outreach efforts, targeting under-represented students in schools throughout the metropolitan area.

Regarding increasing the enrollment of students of color in higher education programs, such as schools of public health and medical schools, the Multi-Cultural Institute of the Academic Health Center of the University of Minnesota has worked diligently to increase the number of under-represented students enrolled in public health and medical schools in Minnesota. The American Indian Science and Engineering Society has, in addition, successfully promoted, sponsored, and graduated hundreds of American Indian students since its inception.

In terms of increasing the number of applicants who are selected for positions in the health care field, HealthPartners diversity director, Trudy Buford, has been instrumental in the integration of people of color into health care occupations within their organization. The MDH’s Human Resource Management Division has worked with hiring managers and supervisors to select qualified individuals from diverse backgrounds for a variety of positions in the department.

**Indicators for this strategy:**

Indicators for inspiring youth to consider careers in the health care industry:

< Number of students who participate in health-related activities.
< Degree of student interest in health care careers.

Indicators for increasing the enrollment of students of color in higher education programs, such as schools of public health and medical schools:

< Number of students of color over time who enroll in higher education programs.
< Number of students of color over time who complete higher education programs.
< Correlation between these initiatives and the internal demographics of higher education programs.

Indicators for increasing the number of applicants who are selected for positions in the health care field:

< Increase in the number of people of color who apply and are selected for positions over time in a place of employment.
< Number of and length of time that employees of color stay at places of employment.
< Correlation between these initiatives and the internal demographics of places of employment.

**For more information contact:**

< MDH, Office of Minority and Multicultural Health, at (651) 297-5813. For more information see the website for strategies resources at: [www.health.state.mn.us/strategies/](http://www.health.state.mn.us/strategies/). Click on “Minority Health”.
< MDH, Office of Workforce Diversity, at (651) 215-1258.
The strategies below can be used to work on this topic. Organizations that may play a role in implementing each strategy are indicated.

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<tr>
<th>Strategy</th>
<th>Governmental Public Health Agencies</th>
<th>Health Plans &amp; Clinics</th>
<th>Educational Systems</th>
<th>Community-based Organizations</th>
<th>Businesses/Work Sites</th>
<th>Other</th>
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<tr>
<td>Assess models of comprehensive trauma systems as they affect emergency medical services (EMS) provided for the state of Minnesota.</td>
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<td>Provide information and education for the general public on the recognition of emergency medical situations.</td>
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<td>Eight Regional EMS Programs</td>
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<td>Develop strong community systems that support the physical and psychological needs of children throughout the continuum of care, including a particular focus on services to children with special health care needs.</td>
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<td>Assure that programs are in place to educate the general public on proper access to the enhanced 911 emergency telephone system.</td>
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<td>Implement a statewide EMS information system.</td>
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It is imperative that all of Minnesota’s population, both resident and transient, has access to emergency medical service (EMS) resources. Minnesotans should be able to summon help rapidly in emergency situations. Following a resident’s call for help, a local EMS system must access and provide rapid response from public safety, fire and rescue (first responders), ambulance, and other appropriate emergency aid. This rapid response must occur without confusion and without a need for familiarity with a particular community or geographic location.

The Minnesota Emergency Medical Services Regulatory Board (EMSRB) consists of 19 members, most appointed by the Governor and serve as volunteers. These public officials represent emergency care providers, EMS organizations and consumers, and are responsible for developing public policy for the delivery of emergency care in Minnesota. EMSRB staff members implement these policies. The EMSRB is committed to an efficient, accessible, safe and modern emergency medical services system for Minnesota communities. The Board provides leadership to improve the quality of emergency medical care for the people of Minnesota through policy development, regulation, systems design, education, and medical direction.

The current EMS system in Minnesota relies heavily on trained and dedicated volunteers, as well as on trained paid personnel. It is vital to this industry that recruitment and retention of personnel be an ongoing effort. This includes not only response personnel, but also recruitment of physicians for medical direction of EMS systems and resources. These personnel must be properly trained and have access to appropriate equipment to meet the needs of all residents, including various age and risk groups.

The vital role of dispatch in any local system serves as the communication link with EMS resources. This includes effective public outreach to encourage the public to use the 911 emergency telephone system, instruct the public on what information is necessary to provide to the 911 dispatch center, and education to help reduce the number of nuisance or unnecessary calls to the 911 dispatch center.

The population of the entire state is affected by EMS. Users of the spectrum of EMS services range from the casual citizen on the street accessing EMS services or in need of service, to those with disabilities or chronic patients in long-term care facilities who depend upon EMS providers for medically assisted transportation for extended treatment regimens. Certain age groups can be considered a higher risk than others, for example, young adults (from injuries), high-risk employment populations (e.g. construction, mines, public safety, and farm work) and the aged (from falls and chronic illness). The strategies presented here are intended to strengthen the EMS system throughout Minnesota.

**Strategy: Assess models of comprehensive trauma systems as they affect emergency medical services (EMS) provided for the State of Minnesota.**

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**Background:**
Minnesota does not have a formal, organized system of trauma care. However, many facilities have a strong commitment to providing high-quality care for trauma patients. Four hospitals have received American College of Surgeons (ACS) verification as Level One Trauma Centers: Hennepin County Medical Center, Minneapolis; Regions Hospital, St. Paul; St. Mary’s Hospital, Rochester; and North Memorial Health Care, Robbinsdale. Three hospitals have received ACS verification as Level Two Trauma Centers: St. Luke’s Hospital, Duluth; St. Mary’s Medical Center, Duluth; and St. Cloud Hospital, St. Cloud. Other facilities with an interest in trauma care participate in a trauma registry alliance. In 1993, the MDH established a Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) registry in which all hospitals in the state must participate; however, participation in a comprehensive trauma registry is not required nor does one exist.

To provide a high-quality, effective system of trauma care, Minnesota must have a fully functional EMS system in place, and trauma components must be clearly integrated with the overall EMS system. Legislation enabling the development and implementation of the trauma care component of the EMS system should also be in place. This should include trauma center designation (using national standards as guidelines), triage and transfer guidelines for trauma patients, data collection and trauma registry definitions and mechanisms, mandatory autopsies, and quality improvement for trauma patients. Information and trends from the trauma registry should be reflected in public information and education and injury prevention programs. Rehabilitation is an essential component of any statewide trauma system, and these services should be considered as part of the designation process.

**Additional resources:**
< Minnesota Department of Health Trauma Care Task Force. 1995. *Model Criteria for Trauma Stabilization Facilities and Community Trauma Facilities.* Minneapolis, MN: MDH Trauma Care Task Force. [For copies, contact the MDH Library, (612) 676-5091.]
< Minnesota Department of Health Trauma Care Task Force. 1995. *Model Protocols for Triage and Transfer of the Trauma Patient.* Minneapolis, MN: MDH Trauma Care Task Force. [For copies, contact the MDH Library, (612) 676-5091.]
< Minnesota EMS Regulatory Board Trauma Care Work Group. Contact: (612) 627-6000.

**Evidence for strategy:**
It stands to reason that in order to provide a high-quality, effective system of trauma care, Minnesota must have a fully functional EMS system with clearly integrated trauma components. This strategy is an integral part of the current work plan of the Minnesota Emergency Medical Services Regulatory Board (EMSRB), which includes collaboration with the MDH in developing a statewide trauma system.

**Has this strategy been implemented in Minnesota?**
No, but the State of Minnesota and many communities are moving in this direction. The Minnesota EMS Regulatory Board has established a Trauma Work Group to develop and implement strategies for a statewide trauma system. Linkages with many agencies and organizations have been
established, utilizing the Model Protocols for Triage and Transfer of the Trauma Patient, and Model Criteria for Trauma Stabilization Facilities and Community Trauma Facilities as the bases for discussion. These agencies and organizations include the Minnesota Medical Association, Minnesota Hospital and Healthcare Partnership, Emergency Medical Services for Children Resource Center, Minnesota Chapter of the American College of Surgeons' Committee on Trauma, Minnesota Chapter of the American College of Emergency Physicians, Minnesota Ambulance Association, Emergency Nurses Association, Minnesota Trauma Registry Alliance, the MDH, and the departments of Transportation, Public Safety, and Administration (911 emergency telephone service), as well as other state, public, and private organizations with interest in trauma care in Minnesota. Many hospitals in Greater Minnesota also maintain an active interest in assessing emergency capabilities and developing appropriate trauma care protocols and procedures.

Indicators for this strategy:
< Description of Minnesota trauma care system components.
< Comprehensive listing of partners and stakeholders.
< Definition of primary responsibilities; analysis of need; and convention of any necessary state, regional, and local meetings to identify resources and obstacles to implementation of a state trauma system.

For more information contact:
Wayne Carlson, at 651-296-9725 or wayne.carlson@health.state.mn.us, Minnesota’s Trauma/Emergency Medical Services System.

Strategy: Provide information and education for the general public on the recognition of emergency medical situations.

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Background:
Many people unintentionally access the EMS system inappropriately, for reasons other than immediate need for a medical or traumatic injury. For the system to work, it must be used as intended, for emergency medical situations. Conversely, others do not access the EMS system when they should, such as, in the case of chest pain and other symptoms of cardiac arrest. This lack of understanding requires that the general public learn to recognize emergency medical situations and to use the system appropriately in response to them. An EMS public information, education, and relations program can be developed and implemented for the general public. It should emphasize access to the EMS system and be based upon recognition of emergency medical situations. This can be accomplished collaboratively with public and private agencies.

Additional resources:
< The EMS for Children (EMS-C) Resource Center is the primary contact for pediatric EMS activities in Minnesota. It provides information, coordinates education, performs research, and provides technical assistance in pediatric medical emergencies. See contact information below for address and phone number.
The eight EMS Regional Programs provide many educational programs for the EMS community throughout the state. Addresses are available through the EMSRB website: http://www.emsrb.state.mn.us.

Local Boards of Health also consider EMS through community health plans, which address EMS issues, such as, public education, access to emergency care, and support of community-based ambulance service training and continuing education. Contact your local public health agency for this information.

Evidence for strategy:
In Minnesota, there has not been a statewide public information, education, or relations campaign designed and implemented specifically for the recognition of emergency medical situations. Nevertheless, much research has been done on the effectiveness of such campaigns in teaching the general public about health conditions and behaviors. When designed and implemented well, they are highly effective.

Has this strategy been implemented in Minnesota?
Yes, the EMSRB has the authority to establish a statewide public information and education system. The Board’s web site currently offers general information about the Board and links to other EMS web sites. A monthly bulletin is distributed statewide to providers and other interested persons. No staff personnel currently are designated to coordinate statewide public information and education efforts. At the local level, several programs are offered by EMS providers. They include CPR classes, clinics for babysitters, latchkey classes, first aid for little people, basic first aid, advanced first aid, CPR for day care providers, and first aid for business and industry. Many providers throughout the state provide professional and community-based EMS education classes and programs. Community Health Services Agencies have provided public awareness programs, citizen access programs, and other prevention programs directed toward citizen response and access of the local EMS system.

Indicators for this strategy:
- Expanded web site with information of general interest to the public.
- Expanded public information and education efforts by regional programs focusing on public access of EMS.
- Expanded collaborative efforts by the Board and Community Health Agencies to provide local educational opportunities for citizens.

For more information contact:
- Emergency Medical Services Regulatory Board, Trauma Project Manager, (612) 813-7534 http://www.emsrb.state.mn.us Provides information on current regulatory activities affecting pediatric EMS in the state.
- Emergency Medical Services Children Resource Center (EMSCRC), Court International Bldg., 2550 University Avenue West Suite 216, St. Paul, MN 55104, at (612) 813-7534.
Strategy: Develop strong community systems that support the physical and psychological needs of children throughout the continuum of care, including a particular focus on services to children with special health care needs.

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Background:
Through the collaborative efforts between the Emergency Medical Services for Children (EMSC) Resource Center and the Emergency Medical Services Regulatory Board, Minnesota has made great strides to improve the care critically ill and injured children receive throughout the state. The EMSC Resource Center is a collaborative effort of the Emergency Medical Services Regulatory Board, Children’s Hospitals and Clinics and the University of Minnesota Emergency Medicine Program. Through this effort pediatric emergency training has been made available through locally developed programs and nationally recognized courses. Since 1998 the EMSC Resource Center has provided pediatric training as a result of the fully or partially supported application of EMSC grant monies to 1,885 EMS providers, 782 nurses and physicians, 243 EMS instructors and 1,522 other individuals.

Through a Pediatric EMS Needs Assessment of Basic Life Support (BLS) and Advanced Live Support (ALS) completed in 1996 and 2000 we have gained valuable information to assist us in the development and implementation of improved EMS systems for children and supporting children’s needs within communities. The 2000 survey focused on four primary areas including: equipment and protocols; education and training; quality assurance and continuous quality improvement; and public education and injury prevention.

The following activities have been or will be utilized to address the needs identified in the four areas:

- Revise pediatric guidelines and disseminate to ambulance services with a focus on those services not using pediatric guidelines.
- Develop a pediatric equipment assessment tool to assist EMS Specialists who perform inspections for ambulance licensing and provide nationally recognized essential and desirable pediatric equipment lists to BSL and ALS services.
- Encourage EMS Regional programs to assume a leadership role by collaborating with EMSRB and EMSC to increase quality assurance and continuous quality improvement activities.
- Assist EMS Regions to identify existing injury prevention programs/coalitions to foster opportunities for collaboration and increase resource allocation.
- Develop a fact sheet on pediatric education and distribute to all medical directors, managers and EMS education centers to describe methods and curricula to be used for training.

Children with special health care needs are another priority in the EMSC program. The EMSC Resource Center has developed a program for children with special health care needs to notify EMS agencies and hospitals about children within their communities and their emergency information plans. The program is called, PERK (Plan for Emergency Response for Kids). Education

This information is current as of Fall 2002
has been provided to many BLS and ALS providers on how to care for children with special health care needs. Also, a three-year federal targeted issues grant is funding the development of a web-based Emergency Information Form (EIF) for post-cardiac surgery children. This will provide access to life-saving emergency information to a physician caretaker unfamiliar with the patient’s history in an emergency setting.

Developing partnerships is another priority for the EMSC Resource Center. The EMSC Resource Center has partnered with the MDH Violence and Injury Prevention Unit to complete a study on Pediatric Traumatic Brain Injury. Just recently, the EMSC Resource Center began a partnership with the Hennepin County Poison System to provide poison prevention education to EMS providers and the public. Also, a partnership is underway with the Wisconsin EMS-C to duplicate their Basic Emergency Life Saving Skills in Schools (BELSS) in Minnesota. This course is targeted to high school students. It requires cooperation from various state agencies and school district leaders. Additional organizations that have partnered with the EMSC Resource Center to work toward improving emergency medical services for children include: America Heart Association, Hennepin County Trauma Services, St. Cloud Hospitals, North Memorial Medical Center, Allina Hospitals and Clinics, EMS Regional programs, Office of Traffic Safety, Emergency Nurses Association, and the American Academy of Pediatrics.

Additional resources:

Bibliographic resources:

Organizational resources:
< Emergency Medical Services Regulatory Board, Trauma Project Manager, (612) 813-7534 http://www.emsrb.state.mn.us

Evidence for strategy:
The need to establish standards for emergency vehicle pediatric equipment and for comprehensive training programs in Minnesota is well documented and the method of developing and implementing a plan to do so is effective. Although the
EMSRB routinely checks for appropriate pediatric equipment during ambulance inspections, there are no minimum required standards for pediatric Basic Life Support and Advanced Life Support equipment in Minnesota. A minimum standard is being developed by a workgroup of the Emergency Medical Services for Children Resource Center of Minnesota. Until a standardized list is formalized, information is available from other sources. These recommendations were developed by a consensus of individuals interested in providing high-quality pediatric emergency care to communities and implemented in various communities in the U.S.

Has this strategy been implemented in Minnesota?
No, currently, there are multiple levels of emergency care in Minnesota, each with its own curriculum and training requirements for pediatric care. These training requirements may or may not include a pediatric emphasis, but do not include an emphasis on children with special needs. A survey has been conducted to assess the need and mechanisms for coordination of the training on pediatric emergency care. Based on this needs assessment and its recommendations, plans are being developed for the training of emergency staff in pre-hospital care of children. Information on the current training and plans for future training is available.

Indicators for this strategy:
< Development of minimum requirements for equipment guidelines of first responder units and ambulance services within the state.
< Development and implementation of pediatric training courses for all levels of EMS personnel responding to medical emergencies within the state.

For more information contact:
< Emergency Medical Services Regulatory Board, at (612) 627-6000 or (800) 747-2011, www.emsrb.state.mn.us, 2829 University Ave SE # 310, Minneapolis, Minnesota 55414-3222. Provides information on current regulatory activities affecting EMS in the state.
< Emergency Medical Services for Children Resource Center, Court International Bldg., 2550 University Avenue West Suite 216, St. Paul, MN 55104, at (612) 813-7534, www.emscmn.org

Strategy: Assure that programs are in place to educate the general public on proper access to the enhanced 911 emergency telephone system.

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Background:
The Minnesota 911 program provides technical assistance to the cities and counties implementing, maintaining, and improving 911 systems; enforces rules that set system standards; and pays a share of 911 costs from the funds collected through a monthly statewide telephone surcharge. The 911 emergency number is designed to provide immediate access to emergency services. It saves time for the caller, reducing overall response time for emergency service.
providers. More time is potentially saved with enhanced 911 systems, which provide location information of the caller to the 911 center. Legislation enacted in 1994 provided funding to bring enhanced 911 to rural areas. This accelerated the start-up of enhanced 911 services by promoting collaboration among legislators, regulators, state and local government administrators, and the telephone industry. Minnesota currently has virtually 100 percent enhanced 911 emergency telephone service coverage.

EMS regional projects, CHS agencies, local ambulance providers, and local public safety agencies have the expertise and knowledge to arrange and/or present educational programs on citizen access and usage of the 911 emergency telephone system.

Additional resources:
< Minnesota Department of Administration, Telecommunications Division of the InterTechnologies Group, www.admin.state.mn.us. [Click on "Services Index," and then click on "Telecommunications."]
< EMS regional programs: See the EMSRB Website for contact information. www.emsrb.state.mn.us.

Evidence for strategy:
Minnesota is one of 14 states in which people who dial 911 receive immediate access to emergency help, regardless of where in the state they make the phone call. To maintain effectiveness in local communities, use of the 911 emergency telephone system requires ongoing public educational efforts. Likewise, county and city agencies that receive 911 calls need standard operating procedures, comprehensive training for dispatch, and proper telecommunications equipment to best serve local community emergency needs.

Has this strategy been implemented in Minnesota?
Yes, with Minnesota among the handful of states with statewide-enhanced 911, educational efforts on the proper access of the 911 system have been an ongoing process for many years. With enhanced 911, programs will continue to promote an understanding of how enhanced 911 works, thus justifying its increased costs to the consumer. Of particular interest should be specific outreach efforts to groups, such as, the elderly, those with special health needs, or the chronically ill, who may access 911 more often than the general public.

Indicators for this strategy:
< Achievement of 100-percent enhanced 911 coverage (87 counties) within Minnesota.
< Presentation of targeted 911 education programs to specific population groups by CHS agencies.
< Integration of 911 calls from wireless systems into the statewide enhanced 911 network.

For more information contact:
< Jim Beutelspacher, (651) 296-7104, Minnesota Department of Administration, Minnesota 911 Program.
Strategy: Implement a statewide EMS information system.

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Background:
The National Highway Traffic Safety Administration has recommended that all states develop a reliable, valid, and integrated EMS information system that will meet the goals set forth in its report, *EMS Agenda for the Future*. These goals are:

- Describe an entire EMS event.
- Adopt uniform data elements and definitions and incorporate them into information systems.
- Develop mechanisms to generate and transmit data that are valid, reliable, and accurate.
- Develop integrated information systems with other health care providers, public safety agencies, and community resources.
- Provide feedback to those who generate data.

The reports generated from this statewide data collection system will include:

- Patient care enhancement - identify trends and issues in treatment and outcomes. An understanding and acceptance of evidence-based medicine recognizes that appropriate medical care in the pre-hospital setting is best determined by patient outcomes. An EMS information system grounded in sound data collection will enhance the capability to analyze clinical outcomes and effect change to assure high quality emergency medical care.
- EMS education program development. Training programs for EMS personnel can be tailored to advance learning skills by using innovative methodologies based upon current EMS pre-hospital data.
- Research opportunities. Reliable, accurate EMS pre-hospital data will attract research efforts to analyze and study, for example, ways to improve emergency patient care, develop injury prevention strategies, and chart future decision-making strategies for EMS policy development.
- Data linkage within the continuum of other data systems. Integrate EMS data with other key stakeholders who collect and analyze data to measure the impact of health care delivery from first call for help through rehabilitation.
- Finding resources. Reliable and valid data can advocate the distribution of limited resources for pre-hospital delivery of emergency medical services and direct policy decisions within health care financing reform strategies.

Additional Resources:

- Minnesota Emergency Medical Services Regulatory Board (EMSRB) Data Project Manager. Contact: (612) 627-6000.

Evidence for strategy:
Minnesota Statute 144E.123 mandates the collection of statewide EMS prehospital data from licensed ambulance services. This data must be submitted to the EMSRB to enable implementation of a statewide EMS data collection system. The data collection
Currently under development during 2002-2003 promises to be an effective method for EMS to gather and store statewide EMS prehospital data, as well as query and export this data to important state databases maintained by the Minnesota Department of Public Safety (Crash Outcomes Data Evaluation System) and the MDH (Traumatic Brain and Spinal Cord Injury Registry).

Has this strategy been implemented in Minnesota?
Yes, the EMSRB and local stakeholders are in the final stages of implementing this strategy statewide. Minnesota’s stakeholders in emergency medical services, in concert with the EMSRB, firmly believe that a comprehensive EMS information system is essential for our state. Thoughtful implementation of this goal will enhance sound EMS policy debate and decisions as we move forward with a statewide system of emergency medical services for the State of Minnesota.

Indicators for this strategy:
< Numbers and kinds of entire EMS events that are described using data from the information system.
< The existence of a set of uniform data elements and definitions and their incorporation into information systems.
< Numbers and kinds of mechanisms to generate and transmit data that are valid, reliable, and accurate.
< The numbers and kinds of health care providers, public safety agencies and community resources that have integrated this information system with theirs.
< Numbers and kinds of contributors to the data system that receive feedback from it.

For more information contact:
< EMSRB, Data Collection Project Manager, Phone: (612) 627-6000 or (800) 747-2011, www.emsrb.state.mn.us, 2829 University Ave SE #310, Minneapolis, Minnesota 55414-3222.
**CATEGORY: Service Delivery Systems**

**TOPIC: HEALTH CARE COVERAGE**

The strategies below can be used to work on this topic. Organizations that may play a role in implementing each strategy are indicated.

<table>
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<tr>
<th>Strategy</th>
<th>Governmental Public Health Agencies</th>
<th>Health Plans</th>
<th>Hospitals &amp; Clinics</th>
<th>Educational Systems</th>
<th>Community-based Organizations</th>
<th>Businesses/Work Sites</th>
<th>Other</th>
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<tr>
<td>Advocate for adequate health insurance coverage in either public or private programs for all community members.</td>
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<td>Minnesota Medical Association, Faith Communities, Social Service Agencies, Minnesota Public Health Association</td>
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<td>Encourage development of regional and community health insurance options for small employers and self-employed individuals.</td>
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One important aspect of the quality of life in Minnesota is the health status of all Minnesotans. While numerous studies have shown that Minnesota is one of the healthiest states in the country, Minnesota faces a growing threat to the health of its residents. That threat is manifest in national trends toward more uninsured individuals and individuals whose coverage is inadequate, as indicated by higher deductibles and co-pays, and limitations on health care options. Individuals without adequate health insurance (under-insured), or any insurance at all (uninsured), are less likely to seek the medical care they need than are individuals with insurance. Likewise, the under-insured and uninsured are more likely to delay necessary care, particularly preventive care, than are the insured and thereby incur worse health outcomes than insured populations.

In the past, the uninsured that were seriously ill have been able to get uncompensated or charity care from hospitals, clinics, and individual physicians. However, concerns over cost have caused the health care market to become increasingly competitive. Insurance companies, health plans, hospitals, and physicians have sought to cut any and all excess costs. Because in the past, it was a portion of these excess costs that helped to provide charity care to an uninsured individual, it is becoming increasingly difficult for health care providers to provide the same level of uncompensated care.

Changes in the mechanisms through which Minnesotans obtain health coverage could also affect the number of uninsured Minnesotans. In 2001, 70 percent of Minnesotans were insured through employer-sponsored insurance. However, numerous reports have questioned the long-term stability of this source of insurance.

State policy decisions (e.g., MinnesotaCare) have been successful in lowering the number of uninsured children in Minnesota. In particular, the percentage of uninsured children in Minnesota has fallen from 5.3 percent in 1990 to 4.4 percent in 2001.

Likewise, policy decisions have been successful in reducing the rate of low-income uninsured. In 1990, 62 percent of the state’s uninsured had incomes below 200 percent of the federal poverty guidelines. As a result, MinnesotaCare was designed to focus not only on children, but also on the working poor who might not have access to Medical Assistance. By 2001, the percentage of uninsured Minnesotans with incomes below 200 percent of the federal poverty guidelines had declined to 51 percent.

Although Minnesota is one of the healthiest states, boasts one of the lowest uninsurance rates in the country, and has implemented effective programs to reduce the uninsured, some populations in the state have not fared as well as others. Large disparities in uninsurance rates exist among populations of color and American Indians. In 2001, 4.6 percent of white Minnesotans were uninsured, while 6.7 percent of Asian, 15.6 percent of Black, 16.2 percent of American Indian, and 17.4 percent of Hispanic Minnesotans were uninsured.

In 2001, the overall rate of uninsurance in Minnesota was 5.4 percent (or approximately 266,000 people). No segment of the population is immune to this problem. It spans all ages, income levels, and regions of the state. Even those individuals with insurance could be affected by this issue in the future, as they change employers or as
employers elect to eliminate employer-sponsored insurance. Likewise, increases in the number of uninsured puts added burdens on Minnesota’s health system and public programs, and generally reduces the state’s overall health. Thus, the number of uninsured in the state is a problem that affects everyone in the state, either directly or indirectly. For related strategies, see the strategies on “Eliminate the Disparities” and “Promote Access to Health Care” in this category.

**Strategy: Advocate for adequate health insurance coverage in either public or private programs for all community members.**

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**Background:** Individuals without adequate health insurance, or any insurance at all, are less likely to seek the medical care they need than are individuals with insurance. Likewise, those with inadequate coverage and the uninsured are more likely to delay necessary care, particularly preventive care, than are the insured and thereby incur worse health outcomes than insured populations, and incurring greater expenses.

Populations of color, low income people and people living in rural communities are more likely to have difficulty accessing health care coverage. In 2001, a total of 4.4 percent, or 56,000, Minnesota children under 18 were uninsured. The unemployment rates for children by race/ethnicity were 3.4 percent for white, 5.8 percent for Asian, 9.2 percent for American Indian, 11.0 percent for Black, and 15.6 percent for Hispanic/Latino children. Rural children were more likely to be uninsured than urban children (5.6 percent versus 3.9 percent), and most (76 percent) were income-eligible for government supported health care coverage already in place.

Many families are not aware that they are eligible for health insurance programs or do not understand and appropriately utilize their coverage options. Many assume that if they are not receiving cash assistance, they are ineligible for health care programs. Similarly, many participants think they cannot qualify if they are employed.

Research shows that children and adolescents who are uninsured are:

- 70 percent more likely to not receive medical care for common illnesses, such as ear infections.
- 30 percent less likely to receive medical care for injuries.
- less likely to receive preventive services;
- in danger of not receiving or delaying treatment which can lead to more serious illness and health problems.

Some children do not receive health care coverage because:

- Parents may lack knowledge of available health care coverage options; experience cultural and language barriers; and/or choose to not provide coverage for their children.
- Government programs may have eligibility rules that can act as barriers, e.g., lack of continuity of coverage; complicated enrollment processes and verifications; and/or be unaffordable.
- Private insurance may not be affordable.
Health problems that are discovered early are more likely to have good outcomes. Healthy kids do better in school, improving their chances to succeed in life. Getting kids health care coverage is not only important to children, but also to families, communities and to Minnesota’s future.

Assuring that all community members have adequate health insurance coverage is an important step in protecting and promoting the health of all Minnesotans, including children and adolescents. Ways to accomplish this include:

- Simplify application, enrollment, and verification procedures for health insurance programs.
- Conduct public awareness and outreach programs to promote the importance and value of coverage as well as to increase awareness of eligibility criteria and understanding and appropriate utilization of coverage options. These can occur at township, county and state fairs; via local media such as newspapers, radio and local cable TV programs; at schools, health fairs, hospitals, worksites, centers of worship, community centers and gathering places. Messages and information and their dissemination must be culturally sensitive and appropriate and available in different languages as well as for limited-English-proficiency communities.
- Conduct health care coverage enrollment events in hospitals, centers of worship, schools, community centers and organizations, gathering places, child care centers, health fairs, etc.
- Put enrollment workers on site in clinics, community and gathering locations so that when eligible, uninsured families come in for services, they can be enrolled for coverage.
- Establish an environment throughout the community in which coverage is important and encouraged. In addition to making information about coverage options readily available to all community members (see above), additional activities include: promote free and low-cost health insurance programs as health coverage rather than handouts for working families; encourage families who are covered at work to take advantage of their coverage, and to take advantage of family coverage; and in interacting with families, ask if they have coverage and assure that they know when and how to use it.
- Work closely with schools to become active community leaders in assuring coverage of families, children and adolescents.
- Develop financial incentives for completed enrollment applications.
- Create a single, toll-free hotline that community members can call to get information on ways to obtain public or private health care coverage and other information.
- Facilitate participation of eligible families in programs and services that can refer them for health care coverage such as Early Childhood Health and Developmental Screening; Child and Teen Checkups; Head Start; Women, Infants and Children supplemental food programs; Minnesota Children with Special Health Needs clinics; and home visiting programs.
- Promote 1-877-kidsnow, a national referral line for referrals to state health insurance programs including MnCare in Minnesota.
- Offer express lane eligibility, e.g., if eligible for food stamps or free lunch, assume eligibility for Medical Assistance.
- Talk with your legislators about health care coverage policies, their accessibility and their impact.

**Additional resources:**

**Bibliographic resources:**


- Putting Express Lane Eligibility into Practice (A Briefing Book and Guide for Enrolling Uninsured Children who Receive Other Public Benefits into Medicaid and CHIP). Published by the Children’s Partnership and the Kaiser Commission on Medicaid and the Uninsured. Copies are available at: [www.childrenspartnership.org](http://www.childrenspartnership.org).


**Organizational resources:**

- Children’s Defense Fund, *Minnesota Low-Cost Health Care Directory*. This directory explains the health care options for uninsured or poorly insured families with children. The directory includes information on Medical Assistance; MinnesotaCare; and other low cost or free health services available in each county in Minnesota. The directory is available at: [http://www.cdf-mn.org/healthdirect.html](http://www.cdf-mn.org/healthdirect.html).

- Cover All Kids Coalition. Contact: 866-489-4899, [www.coverallkids.org](http://www.coverallkids.org). Members of this public-private coalition work to promote health care coverage and preventive care for Minnesota children. Members work together to increase public awareness of insurance options for children, find new ways to reduce health disparities, and make it easier for parents to get preventive care for their children.

**Evidence for strategy:**

As the sources cited above demonstrate, people desire direct education about programs and seminars in their communities at which they can engage in conversations and ask questions; in addition, they consider personal contact important. Applicants perceive the enrollment process for health care programs as complex and time consuming, and lengthy enrollment forms and extensive documentation may keep families from applying. Participants’ lives also alter frequently, and job changes are common.

It is well documented in the literature that public information campaigns can increase awareness and change attitudes about issues. It is also documented in the literature that combining public information activities with other community-wide activities can influence changes in behavior, in this case increased enrollment rates.

**Has this strategy been implemented in Minnesota?**

Yes, components of this strategy have been implemented by public and private sector organizations in many counties throughout the state, with varying degrees of success.
**Indicators for this strategy:**

- Ways in which application, enrollment, and verification procedures for health insurance programs have been simplified.
- Numbers and kinds of outreach programs, including enrollment assistance, conducted.
- Numbers of community members and families contacted through the outreach programs.
- Increased understanding of community members of enrollment options, their coverage and how and when to use it.
- Increased value placed on having insurance coverage.
- Kinds and numbers of financial incentives developed for completed enrollment applications.
- Existence and use of a single, toll-free hotline.
- Numbers of families that receive referrals for health care coverage from other programs and services in the community.
- Numbers of community members using 1-877-kidsnow.
- Existence and utilization of an express lane eligibility process.
- Increase in enrollment in public and private health insurance programs.
- Decrease in disenrollment in public and private insurance programs.
- Decrease in the number of Minnesotans, including children and adolescents, who experience a lapse in their health care coverage.

**For more information contact:**

- Children’s Defense Fund, [http://www.cdfmn.org/HealthCare/programs_MN.htm](http://www.cdfmn.org/HealthCare/programs_MN.htm) for information about eligibility criteria and how to apply for Minnesota programs.

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**Strategy: Encourage development of regional and community health insurance options for small employers and self-employed individuals.**

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**Background:**

Lack of access to affordable health insurance coverage is becoming an increasing reality for many Minnesotans as health care costs rise at double-digit rates. This is particularly true for small business employees or self-employed individuals. Rural areas, where small businesses and self-employment is common and choices are limited, are especially affected. Under-insurance shows up in higher deductibles and co-pays, and limitations on health care options. Ways that local organizations can do this include:

- Explore ways that members of communities and regions can pool resources to help small employers and self-employed individuals purchase affordable, quality health insurance products.
- Engage members of the community, including policy makers, community...
leaders, employers, health care providers, and consumers in developing strategies that balance affordable health insurance coverage with quality of care.

- Assist community members in accessing available resources for planning and execution of strategies.

**Additional resources:**
Organizational resources:
- Minnesota Department of Commerce, at (651) 296-6789 or (800) 657-3602 or www.commerce.state.mn.us/. [Regulates insurance companies or indemnity products.]
- Minnesota Department of Health, Health Economics Program, at (651) 215-5800. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Health Economics Program”.
- Minnesota Department of Human Services, at (651) 296-1256 or (800) 657-3729, ext. 61256 or www.dhs.state.mn.us.
- Minnesota Insurance Healthline, at (612) 222-3800 or (800) 642-6121.

**Evidence for strategy:**
The data indicate that increasing numbers of Minnesotans are either uninsured or underinsured.

**Has this strategy been implemented in Minnesota?**
Yes, health care purchasing alliances are being developed in five regions of the state: northwest, southwest, north central, and northeast regions of the state.

**Indicators for this strategy:**
- Development of community and regional health care purchasing alliances that are available to small employers and individuals.

**Measurements of uninsurance and underinsurance exhibit downward trend.**

**For more information contact:**
Minnesota Department of Health, Office of Rural Health & Primary Care, at (651) 282-3838. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Office of Rural Health & Primary Care”.

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