DEPARTMENT OF HEALTH

Charting our course: Minnesota's next steps

Commissioner of Health Jan Malcom

Greetings

- Welcome!
- Charting a course for change

Agenda

1. Response: We've been through a lot.
2. Recovery: Where are we now?
3. Resiliency: Coming back from COVID-19.
4. Re-design: What comes next?

Our response to uncharted territory

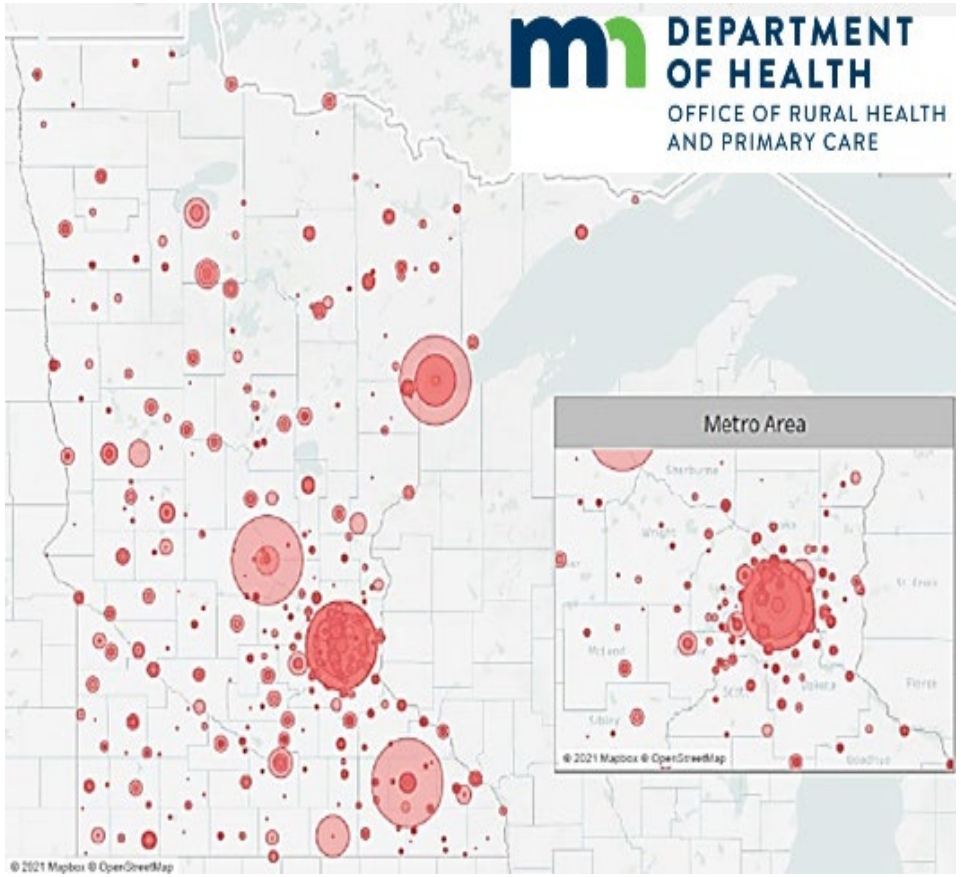
DEPARTMENT OF HEALTH

Global COVID-19 pandemic

The pandemic tested our:

- state's emergency preparedness system
- state's public health infrastructure
- collaborative relationships

COVID-19 Response Funding



In March, 2020, the Minnesota Legislature authorized the Commissioner of Health to award $200 million as grants to support the capacity of eligible organizations to:

- plan for
- prepare for and
- respond to

the outbreak of COVID-19.

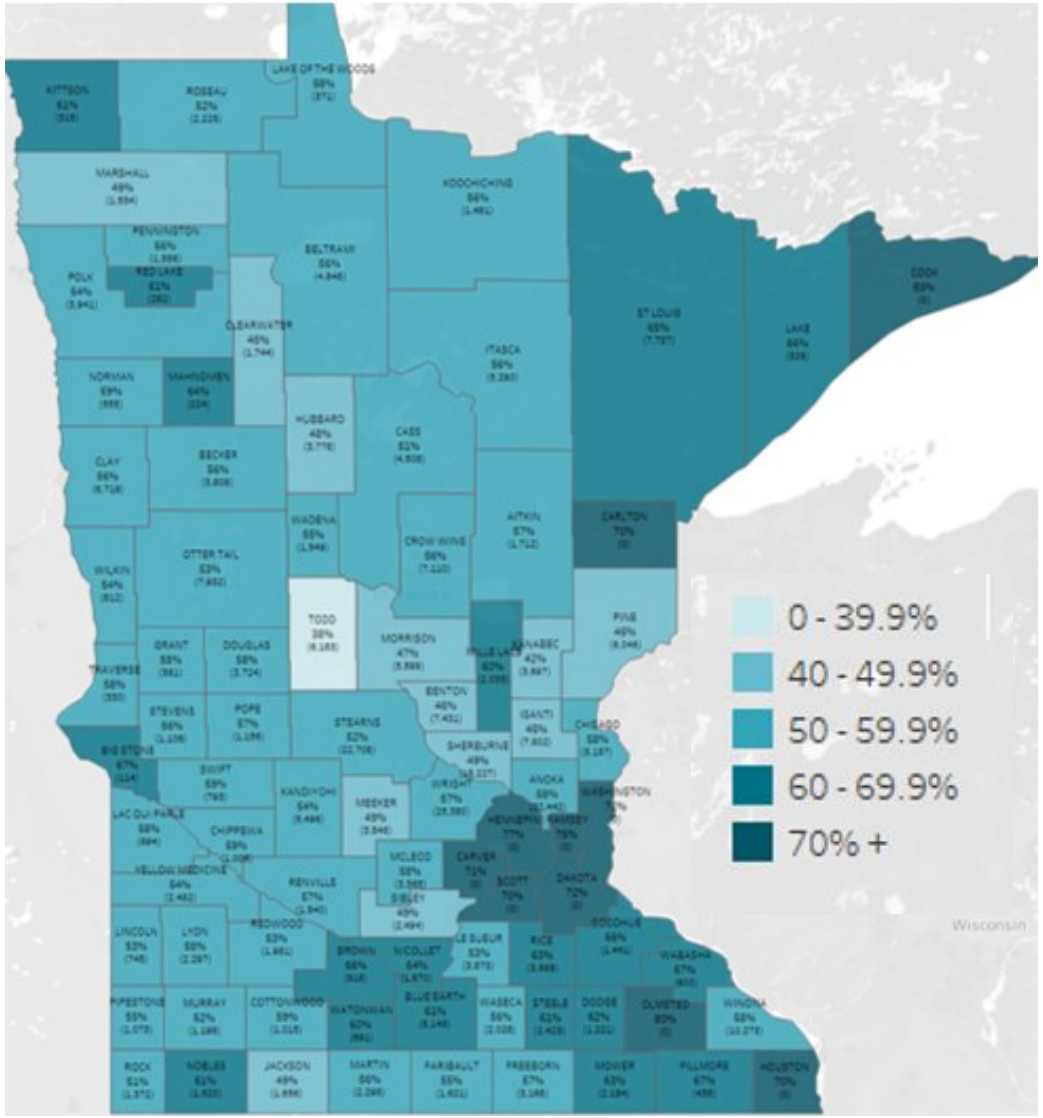
Minnesota Urban/Rural

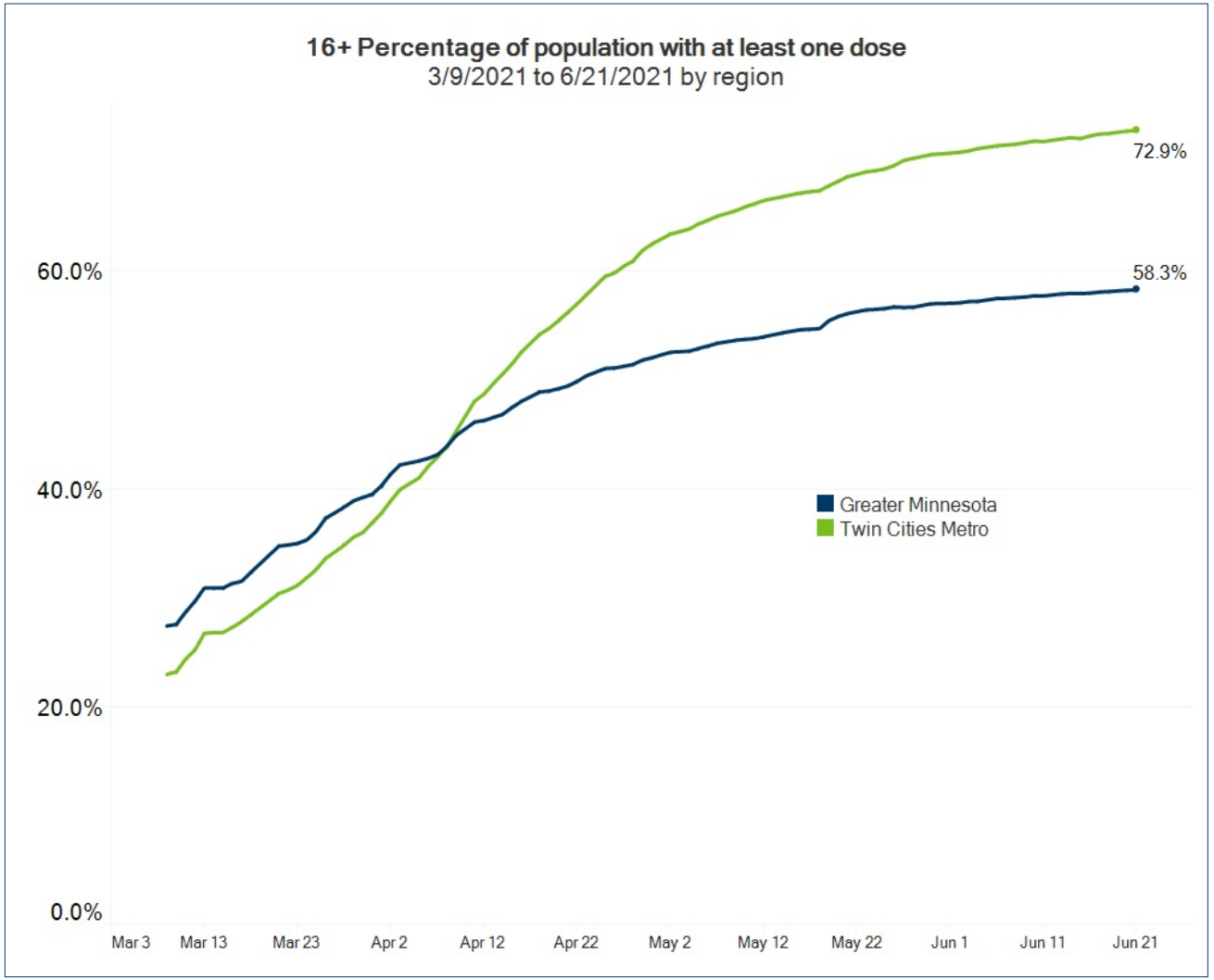
73% of our state's population lives in urban areas.

27% of the state's population resides in non-metro areas, and 8% live in isolated rural areas.

Generally, rural Minnesota fared similarly to Minnesota's urban areas even though it took a little longer for COVID-19 to reach parts of rural Minnesota.

Vaccine roll out





Percentage of population ages 16+ with at least one dose

Recovery: Where are we now?

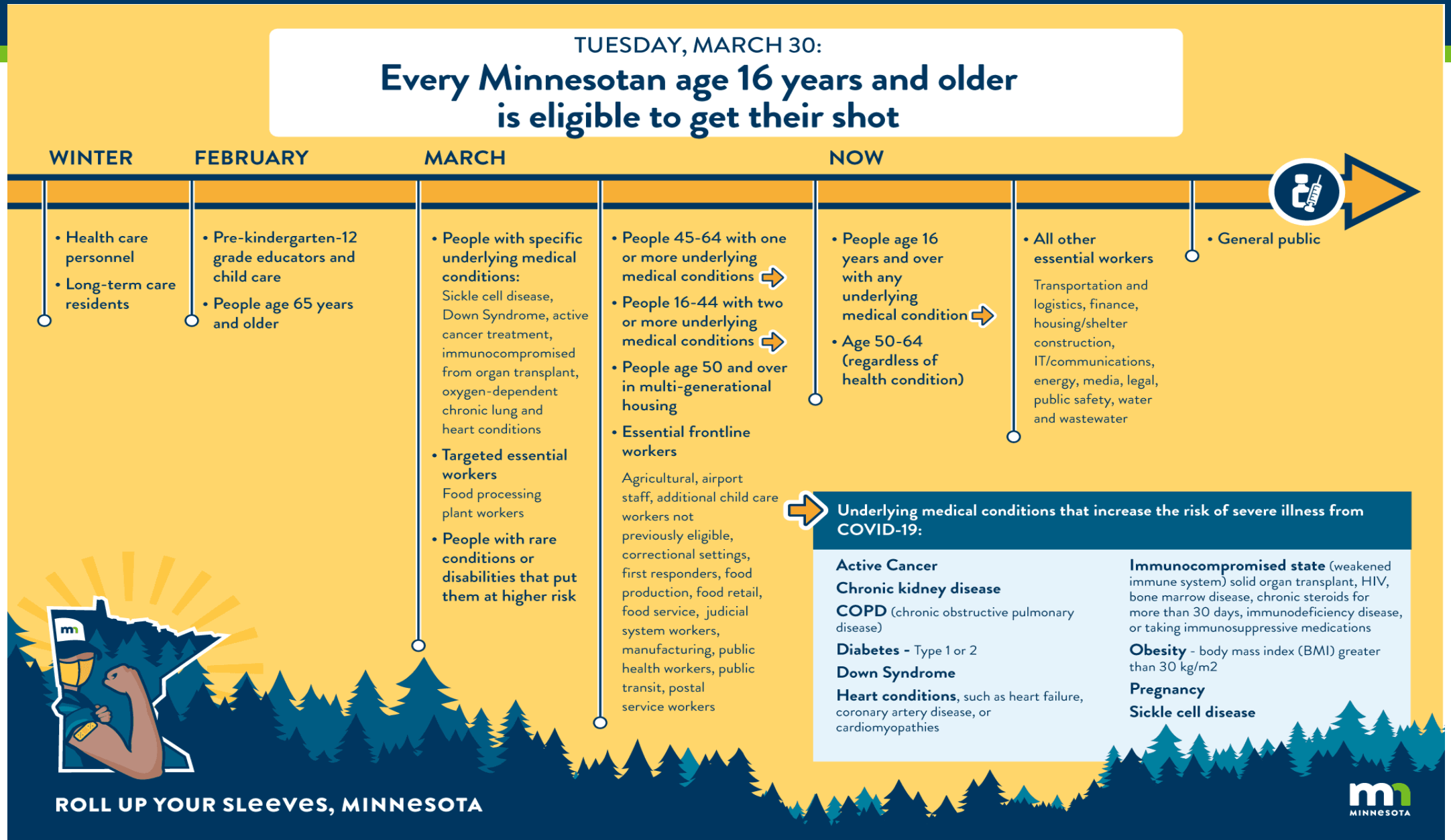
After one year of COVID-19

June 17, 2021

Minnesota's first official COVID patient develops symptoms. Since then, we have seen staggering loss.

- 7,531 Minnesotans died
- 604,000 cases
- 25,500 hospitalized
- Declining case numbers and the arrival of vaccines brought hope

Vaccination schedule



Vaccination numbers 6/13/2021

Our plan is to keep working on getting everyone vaccinated even when we reach the goal of 70%. We need to keep ahead of variants.

Vaccine website: COVID-19 Vaccine Data / COVID-19 Updates and Information - State of Minnesota (mn.gov)

Health inequities stood out during COVID-19

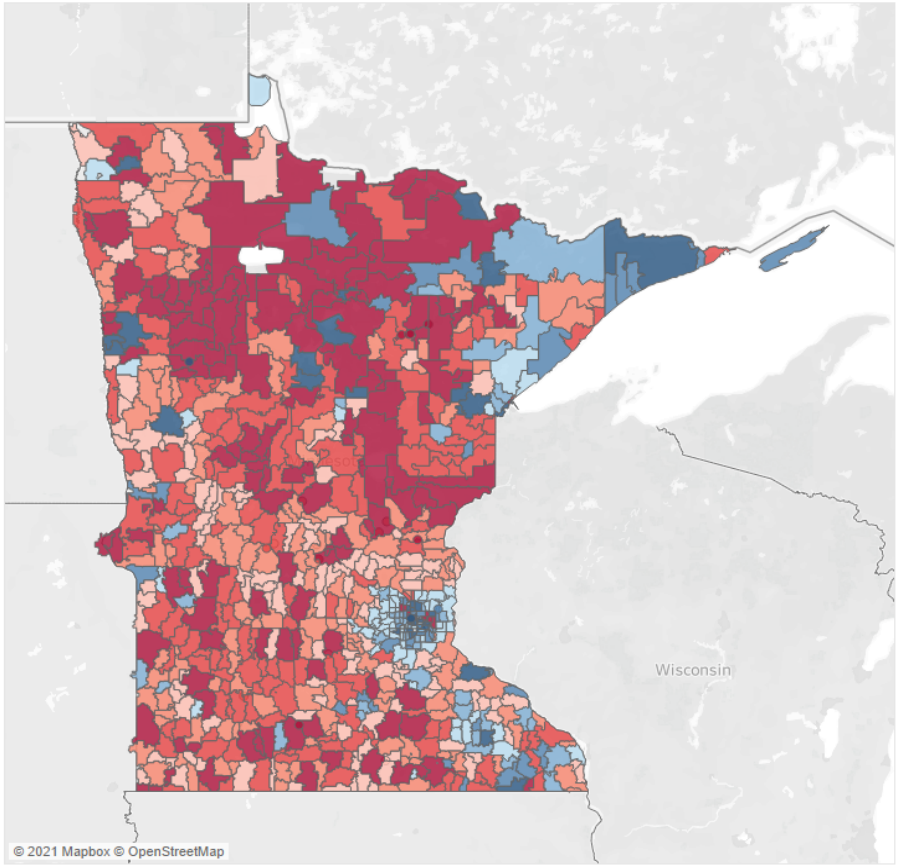
Each Minnesota community has health barriers and needs that are specific to that community. The pandemic hit **older populations**, **low-income** and **certain race/ethnicities** especially hard.

Statewide COVID-19 Vaccination by SVI Zip Code Quartile

STAY SAFE MN

Vaccine Coverage and Social Vulnerability Index

By Zip Code

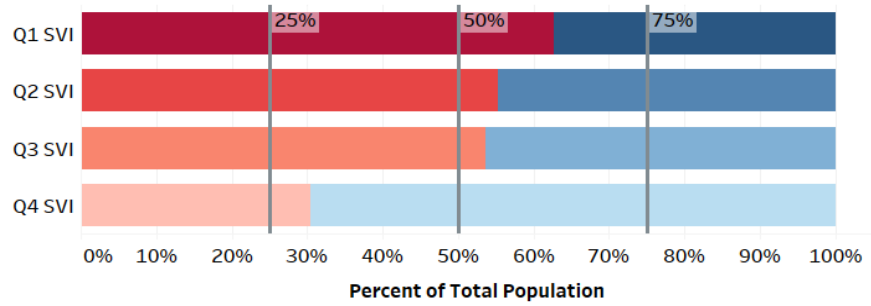


Q1 SVI-High Vax Q2 SVI-High Vax Q3 SVI-High Vax Q4 SVI-High Vax
Q1 SVI-Low Vax Q2 SVI-Low Vax Q3 SVI-Low Vax Q4 SVI-Low Vax

Distribution of Total Population living in Social Vulnerability Index Quartiles

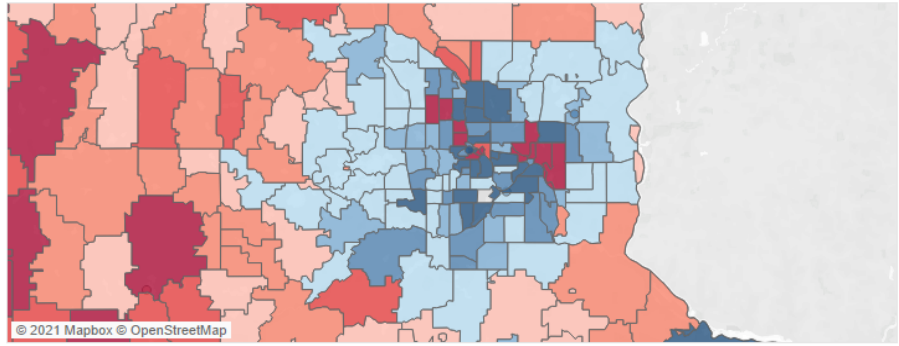
Above or Below First Dose Statewide Vaccine Coverage

By Zip Codes



Vaccine Coverage and Social Vulnerability Index in the Seven County Metro Area

By Zip Code



Dashboard last updated: 6/15/2021 10:15:48 AM

Health care workforce

Health care providers have played an essential role in the State of Minnesota's response to COVID-19.

Minnesota's health care providers have been severely impacted by the pandemic. It's been a struggle to meet the financial and emotional burdens the pandemic has placed on them.

Resiliency: How do we come back from COVID-19?

Health care strengths

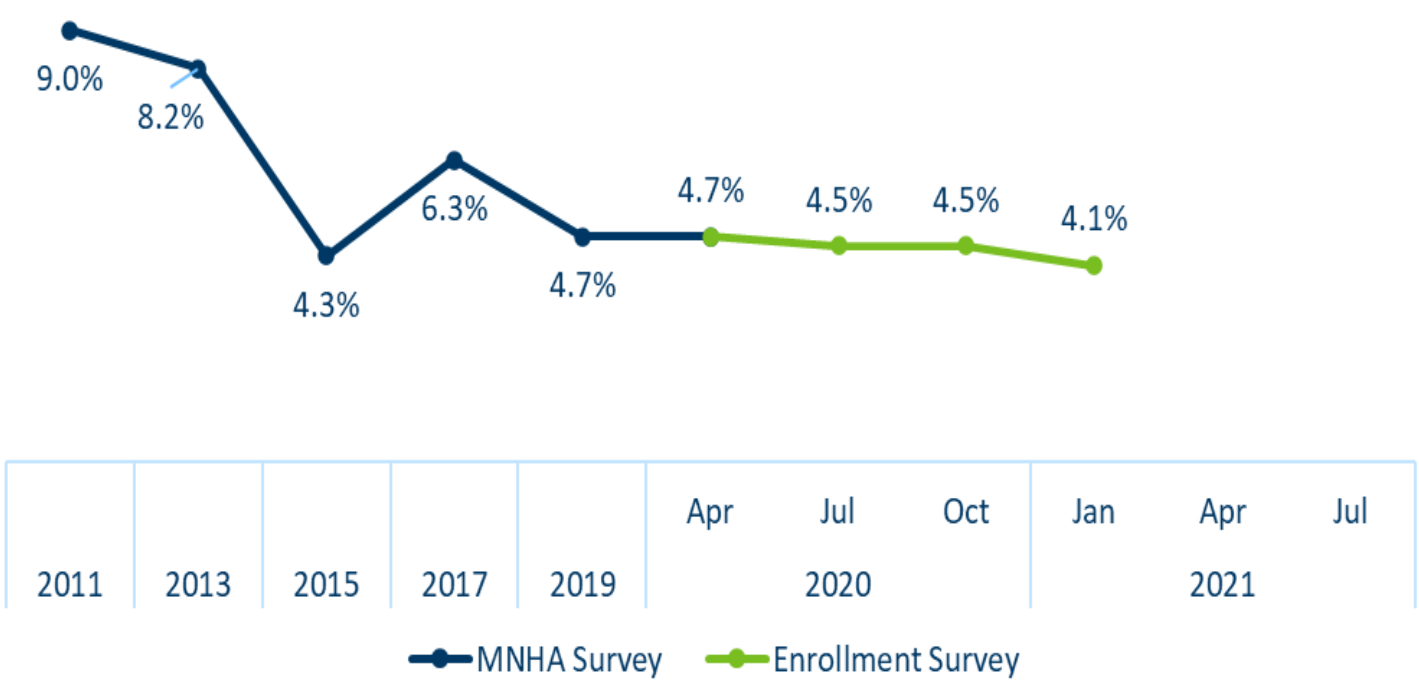
The pandemic pushed us to do things better and helped highlight strengths in the health care system. Providers in all regions of the state worked together to make sure they were:

- Working efficiently
- Able to move patients to the level of care they needed,
- Coordinating their vaccination efforts to ensure equity and efficiency

We created some strong working partnerships that we think will help us move forward in addressing other rural health care needs in the future.

Expanded Insurance Coverage

- Special efforts were made to keep people covered during the pandemic, including:
  - Special enrollment period for MNSure
  - Expanded Medicaid eligibility
  - No additional charge for state-sponsored testing and vaccinations
- Minnesota did not experience an increase in uninsured people during the pandemic



Areas to work on

The pandemic did expose some weaknesses.

COVID-19 definitely called attention to our health care workforce shortages, especially in congregate care settings or in hospitals that needed additional staff to continue operating.

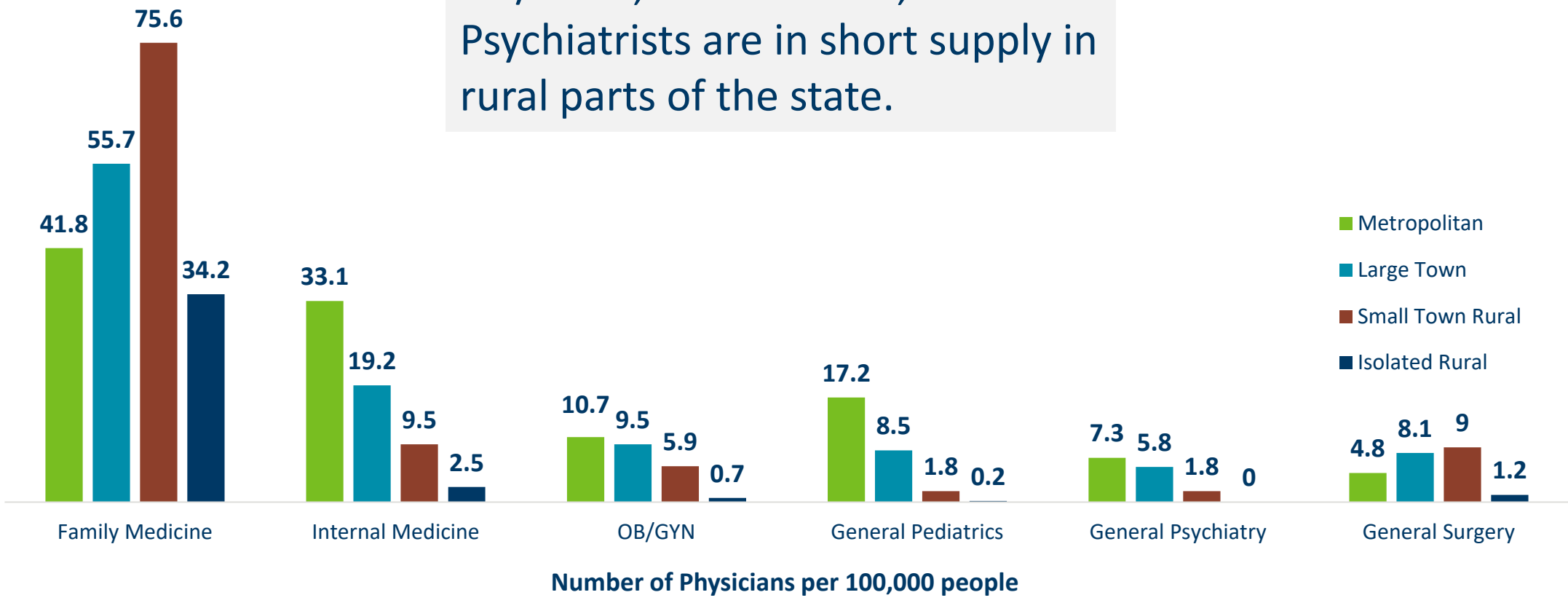
Smaller health care facilities especially struggled to keep their workforce going.

Communicating through community partnership

- All of Minnesota, including the 11 Tribal Nations that share its geography, must have the opportunity to be fully informed about COVID-19 testing, vaccine, and risk factors. Materials must be:
  - Culturally relevant
  - Linguistically appropriate
  - Accurate and timely
- Community partners and multi-faceted approaches through a variety of media channels are key.

Rural areas face severe shortages of primary care physicians

OB/GYNs, Pediatricians, and Psychiatrists are in short supply in rural parts of the state.



Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Board of Medical Practice, June 2019. Counts by region are based on primary practice address that physicians report to the Board.

Summary of Slide

Expanding resources to promote the rural workforce

In an environment of persistent and pervasive health care workforce shortages, there are solutions we continue to explore and promote:

- Expanding the scope of practice for professionals working in shortage areas.
- Creating new professions that meet rural needs; community paramedics and dental therapists show great promise in promoting rural health.
- Developing more clinical training sites in rural areas. We know that health care professionals tend to practice where they train.
- Offering a range of health care loan forgiveness and repayment programs.

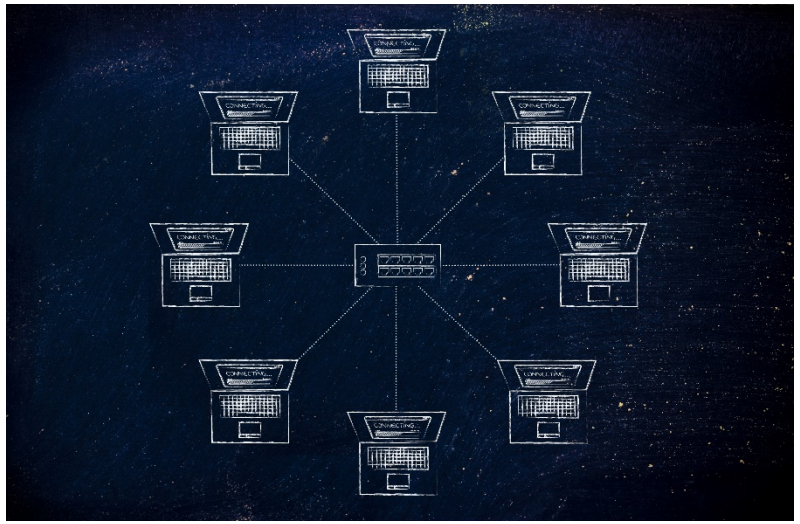
Infrastructure Issues

We've advanced nine years in our technology in the first six months of the pandemic

Now we need to spend some time reviewing which uses were effective and which should be adapted to a different standard going forward.

We have seen firsthand how that telemedicine holds great promise for some types of services that have been hard to sustain in many rural parts of our state—some support services for chronic conditions may be particularly well-suited to telemedicine.

Telemedicine



- Telemedicine holds great promise for some types of services that have been hard to sustain in many rural parts of our state.
- Support services for chronic conditions may be particularly well-suited to telemedicine.

- The efficacy of telemedicine will depend on statewide broadband availability.
- Quality of care will depend on balancing consumer preferences with medically appropriate use of telemedicine or telehealth.

Re-design: Where do we go from here?

Global community

We truly are a global community—pandemic preparedness needs to be revamped based what we now know

Partnership is essential—within and between public and private sectors

Public Health infrastructure gaps existed; state and local public health need to be ready to respond to public health emergencies.

Rural health care needs support and attention to ensure adequate resources are available to sustain them.

Equity has to be at the center of all we do.

Managing on-going preparation

COVID is going to become an endemic disease that we will need to continue to manage, much like we manage other diseases.

Other diseases are going to circle the globe, so we must keep the infrastructure in place to recognize them, slow their spread, help our health care system stay ready to minimize their health impact.

Public health infrastructure

Disaster preparedness has been a hallmark of public health.

COVID showed us that being well prepared for one type of disaster isn't enough.

Shore up and take action to maintain a public health response infrastructure that is ready to:

- Respond to Isolated outbreaks in a nursing home or school as well as those that span the globe
- Handle emergencies that threaten our drinking water as well as emergencies that threaten the ability of employees across the state being unable to report to work
- Ensure community and health care disaster preparedness plans are updated and rehearsed

Rural health care structure and financing

Explore value-based funding mechanisms

Expand primary care options and sustainability

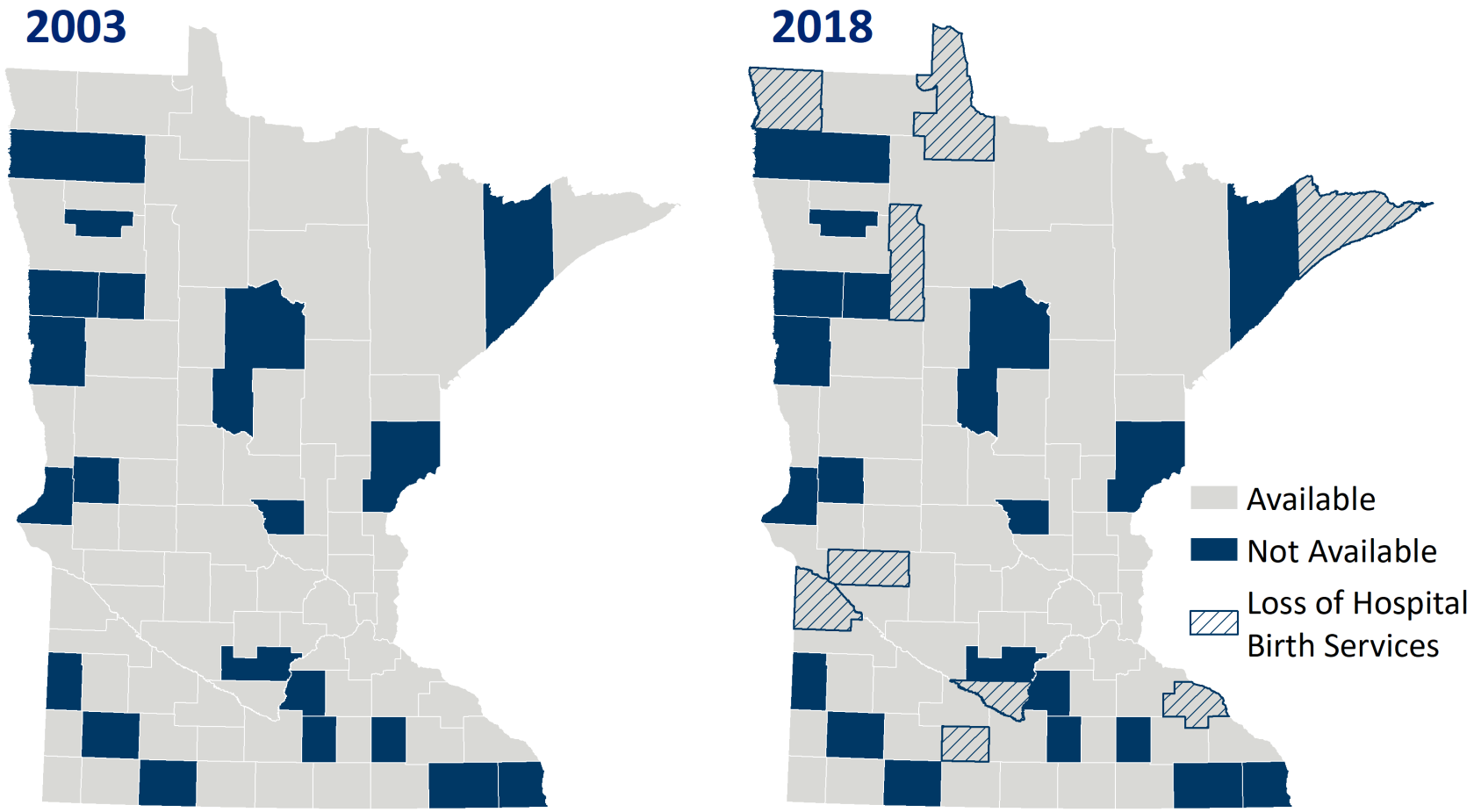
Explore options for supporting OB services in rural areas at risk of losing them

Address nursing home services

Telehealth

Hospital and EMS infrastructure

Nine Minnesota counties lost hospital birth services between 2003 and 2018

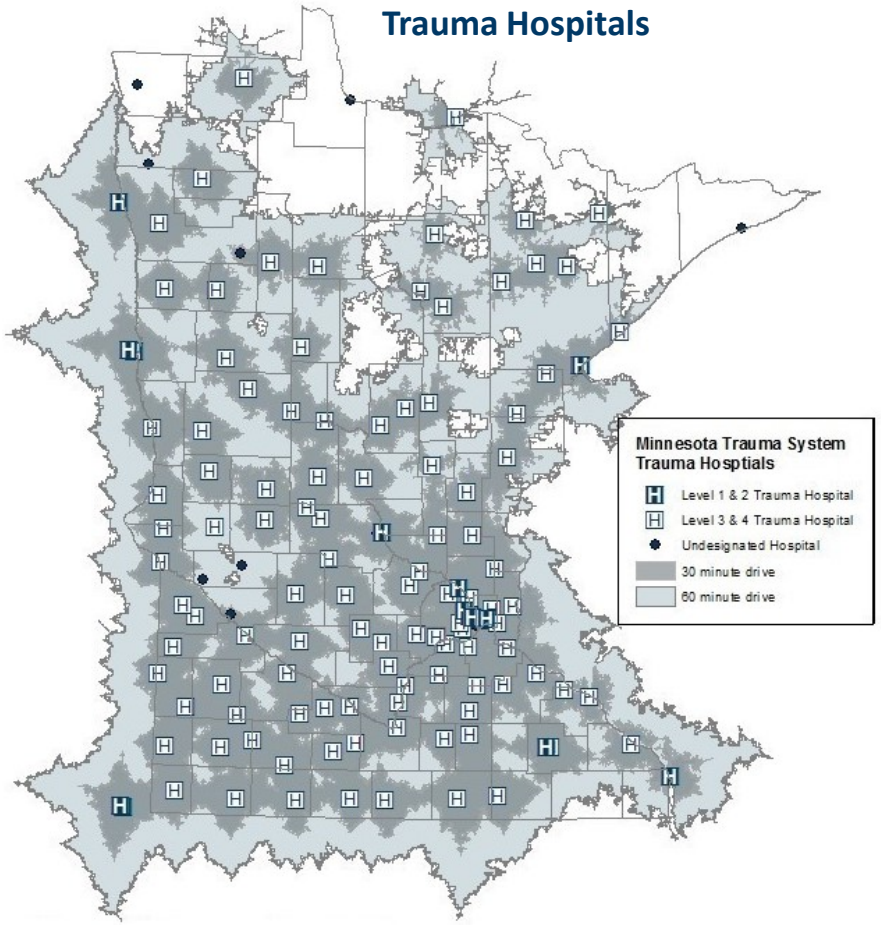


Increases in pre-term births have been associated with the loss of hospital birth services in rural areas.

Note: Due to a merger, the hospital in Mower was no longer an independent licensed entity as of the end of 2014; however birth services were offered at that site under the license of the remaining corporate entity.
Source: Minnesota Department of Health, Health Economics Program Analysis of Hospital Annual Reports; U.S. Census Bureau (County Designations)
Definition: Community hospitals were categorized as not offering birth services if they did not have at least one routine birth, had no licensed bassinets, or stated that services were not available.
Summary of Slide

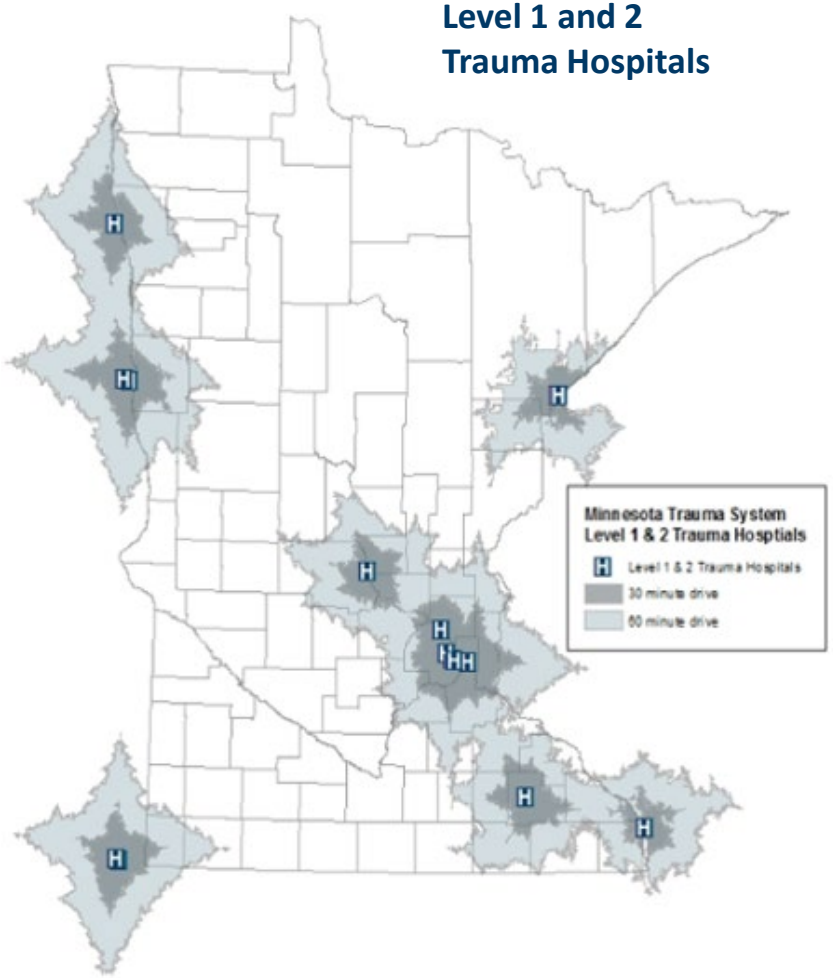
Access to critical trauma care is available throughout the state

Drive Times to Designated Trauma Hospitals



121 of 130 hospitals have a trauma designation. 98% of Minnesotans live within 60 minutes of a designated trauma hospital.

Level 1 and 2 Trauma Hospitals

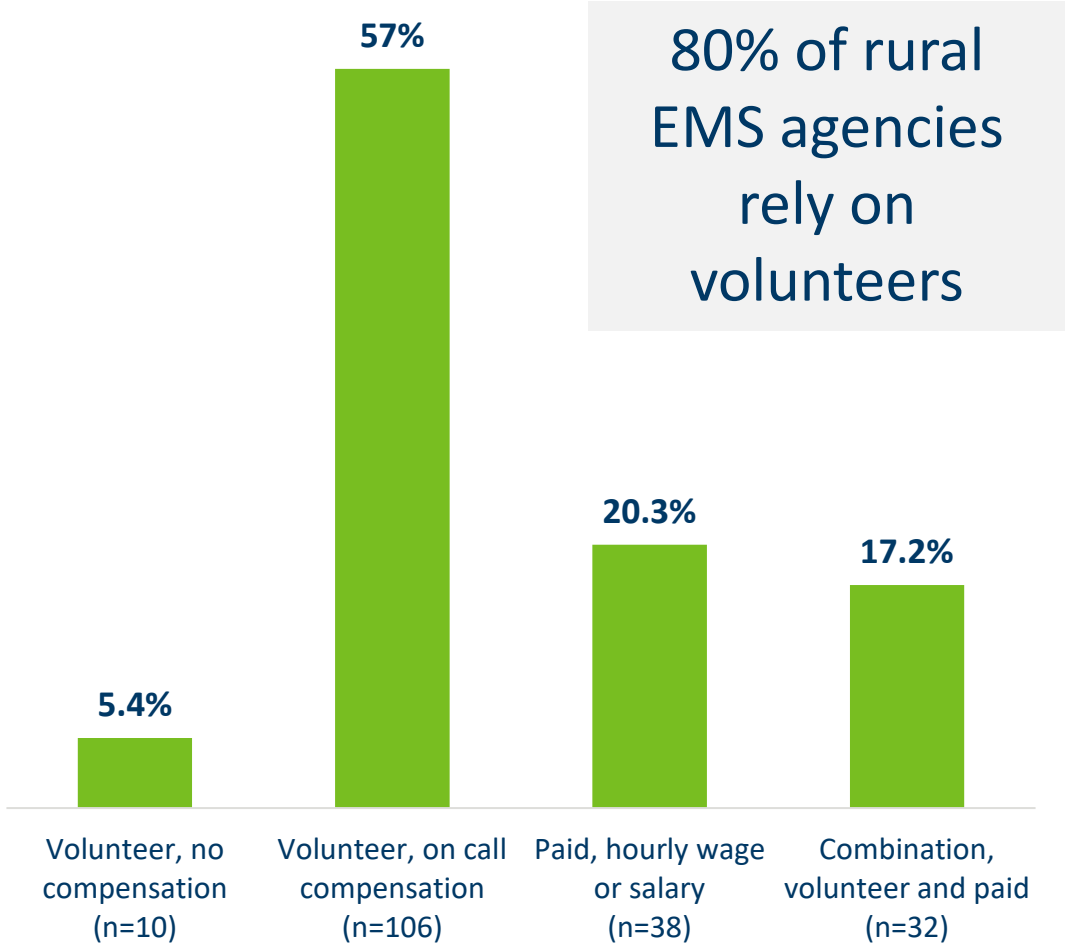


74% of Minnesotans live within 60 minutes of a Level 1 or Level 2 trauma hospital.

Source: MDH Trauma System February 2019.

Summary of Slide

Rural Emergency Medical Services (EMS) reliance on volunteerism is unsustainable



80% of rural EMS agencies rely on volunteers

- Rural EMS agencies rely on volunteers, but face decreasing volunteer roster sizes, and many shifts (weekdays, weekends, holidays) are difficult to fill.
- About 60% of agencies have inadequate staff to cover their call schedule without undue burden.
- 59% of agencies do not have all of their shifts covered at least 24 hours in advance.
- 88% of agencies provide Basic Life Support (not paramedic level services) to their communities.

Source: https://www.health.state.mn.us/facilities/ruralhealth/flex/docs/pdf/2016ems.pdf
Summary of Slide

American Rescue Plan plans

Minnesota's Share of ARP Funds

Local Fiscal Recovery Fund (flexible)

$2.132 Billion

State Fiscal Recovery Fund (flexible)

$2.833 Billion

Federal Program Funds (program-specific)

$3.505 Billion

Rural health care workforce

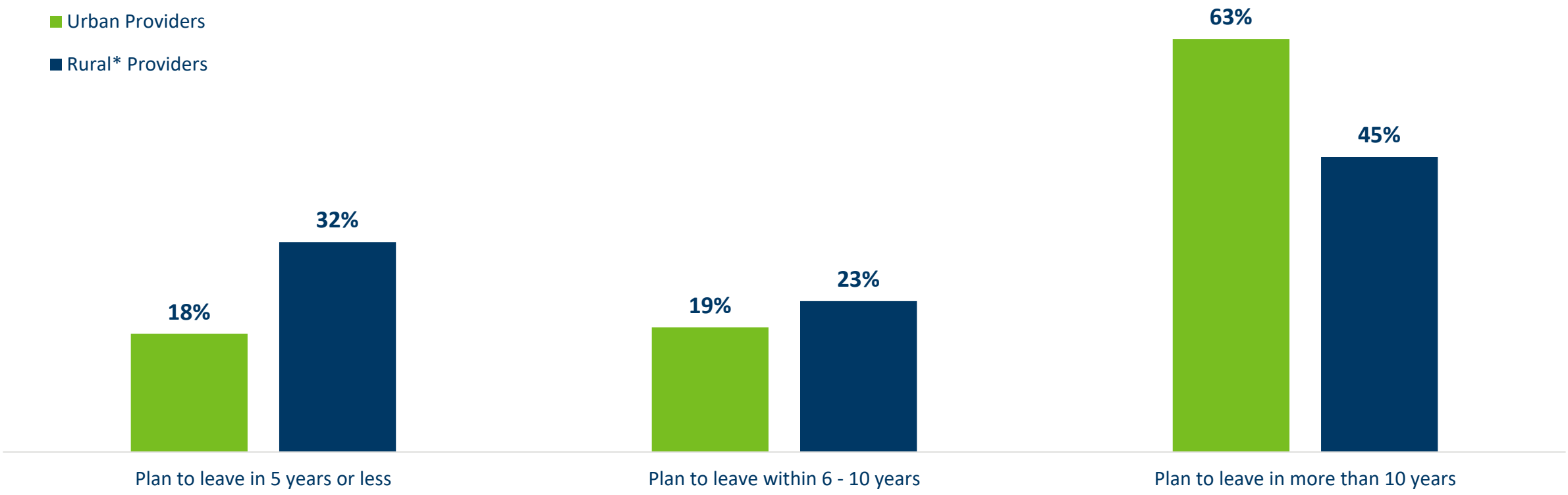
Health care providers disproportionately practice in large urban centers

The COVID-19 pandemic threatens to worsen this problem.

On average, rural physicians are nearly 10 years older than urban physicians.

Providers who had received loan forgiveness awards are more likely than non-recipients to practice in rural and small town communities.

Nearly one-third of rural physicians plan to leave the workforce within the next five years



Source: MDH Office of Rural Health and Primary Care, Physician Workforce Survey, 2018.
*Rural = isolated rural from Rural-Urban Commuting Area codes.
Summary of Slide

Workforce Needs

- **Preceptor support!!**
- Align training and incentives with needs
  - Expansion of training in rural areas & ambulatory centers (RTTs)
  - Targeted training for Primary Care Providers with integrated models & teams
  - GME funding for new sites
  - De-stigmatize & incentivize primary care careers
- Coordinate workforce polices & priorities
- Ensure all practice at the top of their license, training & scope
- Medical/dental/behavioral health integration
- Uncover innovation. Adapt, adopt & scale locally

MDH Workforce Development Efforts

Investing in Clinical Training Capacity

- Clinical training subsidy (MERC)
- Health Professional Clinical Training Expansion Grant
- Primary Care Residency Grant Program
- Rural Family Med Residency Grant Program
- IMG preparation grants

Incenting Practice in High-Need Settings

- Loan Forgiveness & repayment programs
- J-1 visa waivers
- Rural Training Tracks

Using Data to Inform Workforce Policies

- Workforce data collected on 23 licensed health providers
- Multi-state learning efforts promote new ideas
- Rural Health Advisory Committee identifies issues and policy recommendations

Redesigning Healthcare Delivery

- Primary Care Coalition
- Supporting emerging professions
- Healthcare Home Certifications
- Medicaid ACO demonstrations
- Telehealth & broadband access

Health Equity

- We need to continue working to strengthen connections and build up trust with communities of all sorts, particularly those who have historical trauma, suffer persistent health disparities, and have limited access to health care.
- This pandemic has shown how harmful persistent disparities can be, and we need to continue efforts to advance health equity in our state.

CDC COVID-19 Health Equity Grant – Work Plan by Strategy

Strategy 1: Expand or develop new mitigation & prevention **resources & services** to reduce COVID-19 related disparities

- 1.1: Expand testing and contact tracing populations in jails, prisons, and ICE detainees
- 1.2: Monitor Post-COVID symptoms, sequelae, & complications in Minnesotans, especially high risk BIPOC, rural, chronic condition, and disabled individuals

Strategy 2: Improve **data collection & reporting** for populations experiencing a disproportionate burden of COVID-19 infection, severe illness, & death

- 2.1: Improve data collection and reporting for testing and contact tracing
- 2.2: Establish a Health Equity Data Community of Practice
- 2.3: Establish a Community Based Participatory Action Research Panel
- 2.4: Improve public facing COVID dashboards and reports
- 2.5: Use data to develop community informed public facing materials and messages
- 2.6: Contract to Minnesota EHR Consortium to develop a common data model
- 2.7: Hire a MDH project manager to coordinate agency activities with MEHRC

Strategy 3: Build, leverage, & expand **infrastructure support** for COVID-19 prevention & control among populations that are at higher risk & underserved

- 3.1: Expand infrastructure to improve testing and contact tracing
- 3.2: Hire and embed diverse communications positions to co-create messaging
- 3.3: Embed community liaisons from across the agency into Center for Health Equity
- 3.4: Form regional health equity networks (hubs)
- 3.5: Create Infection Control and Response Program (ICAR) Regional Positions
- 3.6: Create a MDH Office of Indian Health
- 3.7: Develop a Tribal Community Health Services Advisory Committee
- 3.8: Engage Community Health Equity Coaches to support local projects
- 3.9: Advance Systems Change that Supports Creating an Anti-Racist Organization
- 3.10: Create a culture of diversity, equity and inclusion within MDH
- 3.11: Develop rural residency and training opportunities for rural and BIPOC residents
- 3.12: Hire a Diverse Media Materials and Accessibility Coordinator

Strategy 4: Mobilize partners and collaborators to advance health equity and address social determinants of health as they relate to COVID-19 health disparities

- 4.1: Build community capacity to reach disproportionately affected populations with effective culturally & linguistically tailored programs & practices for testing & contact tracing, & quarantine
- 4.2: Support Tribal Public Health Infrastructure
- 4.3: Fund and build power of Urban American Indian Organizations
- 4.4: Align, stagger & collaboratively build on efforts to conduct community health needs assessments done by rural hospitals & local/county PH

Strategy 5: Evaluation

- 5.1: Evaluate all grant strategies & activities

Source: 4/27 Work Plan submitted to CDC

Health Equity in all things

Evaluate the effectiveness of proven pipeline programs to diversify the medical workforce

Screen for Success

Rethink Privilege/Reallocate Power/Reorient Systems

Rethink medical school rankings

One Minnesota Priorities and Goals

Manage COVID Spread

Improve access to health care

- Reduce the number of Minnesotans who report going without care
- Increase the incentives and accountability factors that drive improvement in health equity

Early lessons from COVID-19

- Pandemic preparedness needs to be revamped based on actual experience
- Responsibilities of public and private sectors need clarification
- Defunding Public Health infrastructure left significant gaps in ability to respond
- Lack of health care coverage and lack of paid sick leave fuels disease spread and creates inequitable outcomes
- Health care system efficiencies can also mean a lack of health care surge capacity
- COVID-19 has exacerbated all known inequities and revealed fractures in our system

Conclusion

Our #1 priority is still addressing COVID-19

- COVID-19 variants are already in Minnesota
  - some variants, such as the B.1.1.7 variant, are highly contagious
  - some variants may be associated with more severe disease and a higher death rate
- More research is needed to confirm these findings and determine what it will mean for vaccination effort
- Until you are vaccinated, wear a mask, socially distance, and wash your hands frequently.
- We'll keep the public apprised of new developments.

Responding to rural health care needs

Changes in health care delivery :

- Shifts from volume to value-based care;
- Cost centers moving from inpatient to outpatient care
- Recognizing the value telemedicine holds for improving access and addressing shortages
- Re-prioritizing primary care
- Promoting team-based care and health care homes
- Deepening focus on ensuring more options for provider-patient cultural concordance.
- Increasing recognition of the need for health equity

Communities coming together in innovative ways

The pandemic created many new challenges, but once again we've seen communities all around the state come together in innovative ways to support the important work of public health.

Thank you.