

SOLUTIONS FOR RURAL HEALTH CARE

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INTRODUCTION

Wherever you go in Minnesota, the underlying health care concern is the same: We need to make affordable, meaningful health care available to all Minnesotans. Nonetheless, Minnesotans who live in Greater Minnesota face a number of unique challenges that get in the way of reaching that common goal.

To make sure that health reform works in all parts of our state, we have listened over the past year to hundreds of Minnesotans about the state of health care in rural Minnesota. The messages we heard are clear.

Rural Minnesotans are deeply concerned that rising health care costs will leave them without access to the high quality of care they have generally come to expect. They are also worried that a deteriorating health care infrastructure will be yet another reason for younger generations to leave rural towns and small cities for regional centers or the Twin Cities.

The people with whom we spoke also offered a concrete assessment of the unique health care challenges rural Minnesotans face. The most common concern was attracting and keeping doctors, nurses and other health care professionals. We also heard that affordable and accessible health care options were increasingly unavailable in Greater Minnesota. Rural Minnesotans recognize that investment in the health care infrastructure is required in order to maintain a high quality of care. Finally, particular concern was expressed about the fragile state of long-term care.

Most important, we heard innovative solutions to these challenges. We have included some of those ideas in this report.

This report is not a final product. Instead, it should spark additional discussion about how we can work together to address the health care challenges in Greater Minnesota.

A special note of recognition is in order. Mark Schoenbaum and the Minnesota Department of Health's Office of Rural Health have been strong and creative advocates on rural health issues for many years. Their ideas and participation in these discussions have been vital.

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THE HEALTH CARE CHALLENGES IN RURAL MINNESOTA ARE UNIQUE

Minnesotans who live in rural counties are older than Minnesotans overall. In eleven rural Minnesota counties, twenty percent of the residents are 65 years old or older. The coming “silver tsunami” has already made landfall in large swaths of Greater Minnesota.

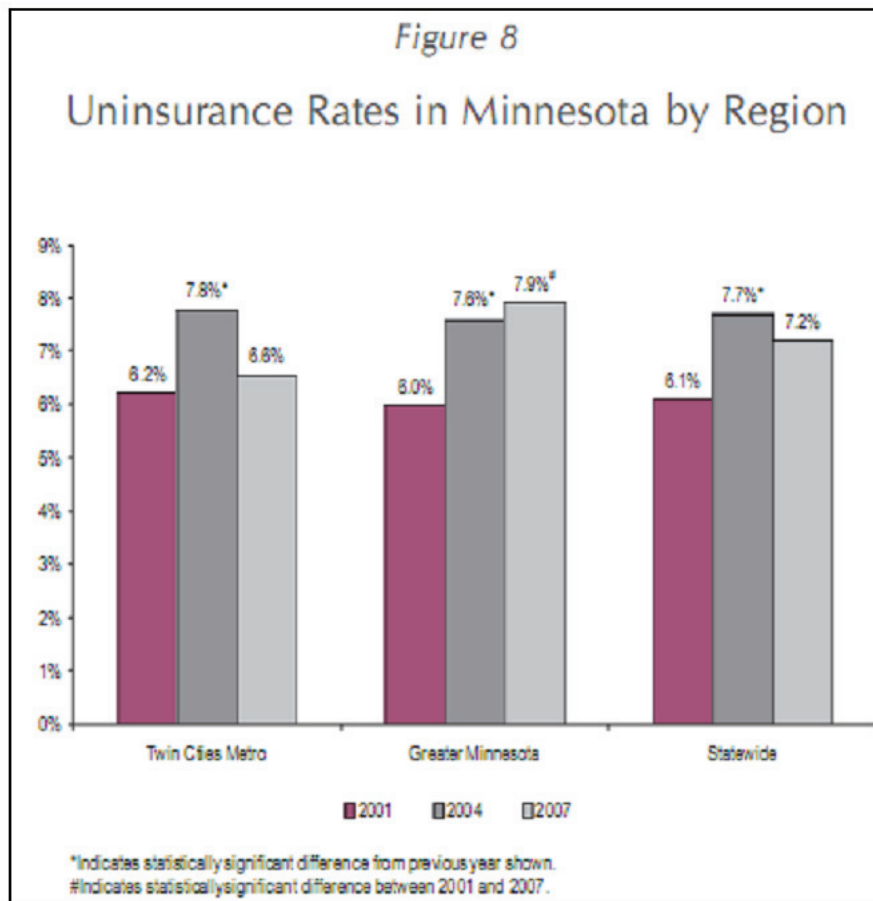
COUNTY	PERCENTAGE OF POPULATION 65+
Traverse	27.3%
Lincoln	24.4%
Aitkin	24.2%
Big Stone	24.0%
Grant	22.8%
Lac qui Parle	22.7%
Kittson	22.7%
Faribault	22.0%
Pipestone	21.9%
Cottonwood	21.6%
Murray	21.6%
STATEWIDE AVERAGE	12.1%
[2005 Population Estimates from Minnesota State Demographer's Office]	

Because many young people have left rural communities for careers in the Twin Cities and elsewhere, nearby family support networks for the frail elderly are not as common as they once were. The proportion of Minnesota seniors receiving long-term care services from a family caregiver dropped from 97 percent in 1990 to 88 percent in 2005.

Businesses in rural areas are typically smaller and often offer lower salaries and more part time and seasonal work. Three quarters of the businesses in Greater Minnesota employ less than 10 employees. As a result, employers in rural Minnesota are less likely to offer health insurance to employees.

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One consequence of the lower proportion of employer-based coverage is a higher uninsured rate. The proportion of Minnesotans in Greater Minnesota who lack health insurance grew from 6% in 2001 to nearly 8% in 2007. Moreover, while the statewide percentage of Minnesotans without health insurance dropped between 2004 and 2007, the percentage of uninsured in Greater Minnesota continued to grow. Indeed, a community assessment reported that 15% of Hibbing's residents were uninsured in 2006.



Source: Minnesota Department of Health, *Health Insurance Coverage in Minnesota, Results for 2007* (Apr. 2008).

Rural Minnesotans with health insurance are much more likely to purchase individual policies rather than employer-sponsored policies. Such policies typically include higher premiums, deductibles and co-payments. Medical debt has become a serious problem. A recent study suggests that 20% of farm and ranch families carry outstanding debt that resulted from medical bills.

Health care providers often face greater challenges in rural Minnesota. There is a marked shortage of doctors, dentists, registered nurses, pharmacists and other medical professionals. Rural hospital and clinic administrators repeatedly expressed frustration at the difficulty of attracting new medical professionals to their area. Even adjusting for variation in population,

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there are three times the numbers of physicians in metro areas as in rural areas where there is just 1 physician for every 1,000 people. Rural ambulance services are likewise having difficulty in recruiting personnel. Many small rural hospitals and nursing homes are at financial risk of closure or obsolescence. Since 1987, 34 hospitals in the state have closed, but 82 percent of the closures occurred in Greater Minnesota.

On the other hand, primary care physicians make up a larger portion of the physician workforce in rural Minnesota than in the metro region. Studies show that areas with a higher portion of primary care doctors also have higher-quality, lower-cost health care.

Up to twenty percent of the workforce in many rural areas is employed in health care. That creates opportunities for economic development if we pursue policies that strengthen the health care sector. But it also carries risk since stress on health care providers has ripple effects on the entire economy in those communities.

The lack of broadband availability, a rural technical support workforce and the need to travel greater distances to receive care, especially specialty care, are additional challenges facing the rural health delivery system.



RECENT HEALTH CARE REFORM LEGISLATION HELPED RURAL MINNESOTA

The 2007-08 legislature passed important health care legislation that will lower costs and make health care more affordable for those with and without insurance. Many of the reforms build on the strengths of Greater Minnesota.

A central feature of a reformed Minnesota health care system is increased use of primary care physicians and clinics who focus on prevention and coordination of health care services. That fairly describes the current system in much of Greater Minnesota. Unfortunately, the current system simply does not pay doctors and nurses to perform the coordination and outreach needed to serve Minnesotans, particularly those with chronic diseases.

The **health care home model** will provide a financial reward to those medical professionals who do the hard work of prevention and care coordination and who work in partnership with patients to improve their health. The additional money for primary care should particularly help bolster health care in rural Minnesota.

MinnesotaCare is our state's program for working families whose employers do not offer health insurance. Individuals and families on MinnesotaCare pay a premium in accordance with their income and the state subsidizes the difference. Rural Minnesotans are twice as likely to be enrolled in MinnesotaCare as their counterparts in more urban or suburban areas.

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The 2007-2008 legislature **improved MinnesotaCare** and **expanded coverage** to 120,000 uninsured Minnesotans, including 37,000 children. More people with moderate incomes will be covered and the application process was streamlined to avoid waste.

More directly, the legislature changed state law so that reported depreciation amounts are no longer added back to farmers' income for purposes of MinnesotaCare eligibility. That will make it easier for Minnesota farm families to access affordable insurance. Unfortunately, the Bush Administration has delayed giving Minnesota permission to implement this change. Fifteen months after enactment, Minnesota's farmers are still waiting for the chance to obtain affordable health care.

The Minnesota Office of Rural Health reported in 2005 that rural residents are more likely to smoke, be overweight and not participate in leisure-time physical activity. The situation can improve through targeted health promotion efforts. The 2007-2008 health care reform includes significant new investments in **public health** focused on improving health at the community level. The plan is designed to build on local perspectives and expertise so each community is working to address its own needs. The initiative is based on the Steps to a Healthier MN program which was successful in Willmar, Rochester and other communities.

Access to **mental health and dental services** are major concerns in Greater Minnesota. The legislature made mental health care and dental access a priority in 2007-2008. The 2007 Mental Health Initiative provided new funding and implemented reform of the state's mental health services. The legislature also preserved funding for the Critical Access Dental program, appropriating \$9.2 million in new funds in 2008-09 and \$13 million the following years.

Long-term care funding was another top priority. In 2008, the state increased reimbursement rates for nursing homes despite the pressures of a budget deficit.



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ENHANCING RURAL MINNESOTA'S HEALTH CARE WORKFORCE

Recruiting and retaining high quality doctors, nurses, dentists and other medical professionals is the biggest health care challenge facing smaller communities in all parts of the state. Many hospital and clinic administrators told us that they never stop their recruitment efforts since shortages never disappear. But it is not just a worry for health care providers. Chambers of Commerce and local political leaders also get in the act because they know how important a vibrant health clinic and nearby hospital means to the community as a whole. As one southwestern Minnesotan put it: "One mark of a thriving community is if the doctors there can do surgery."

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Minnesota has taken steps to make sure rural communities have enough doctors and nurses to provide needed medical services. We heard very positive comments about the University of Minnesota's Rural Physician Associate Program (RPAP), which places 30 to 40 medical students in rural communities each year. Over sixty percent of the RPAP students practice in rural communities upon graduation, although that percentage decreases if the medical student pursues a specialty.

Nonetheless, recruitment and retention challenges remain. Additional creative and common sense solutions should be pursued.

Allowing Health Professionals to Practice to the Top of their License: Minnesota licensing rules often put up unnecessary barriers that prevent health care professionals from providing treatment that they are trained to provide safely. In addition, a doctor performing a procedure is often reimbursed at a significantly higher rate than a nurse, chiropractor or other health care professional performing precisely the same procedure. Many of those distinctions make no sense when we are facing workforce shortages and limitations on access to care.

The state legislature should conduct a top to bottom review of its licensing laws to eliminate outdated limitations that have nothing to do with patient safety. And until fundamental payment reform is implemented that would move away from procedure-by-procedure reimbursement, the legislature should require that payments be based on the procedure rather than the title of the practitioner performing the procedure.

Targeted Education and Training in Greater Minnesota: In our conversations, rural Minnesotans emphasized that it is easier to keep or attract people who grew up in small towns than to draw people who grew up elsewhere. We also know that health care practitioners made their decision to enter the field fairly soon after graduating from high school.

The State should support targeted marketing and education efforts about rural health care opportunities aimed at rural and small town high school students and undergraduate students in health occupations training.

In addition, the State should encourage the creation and expansion of Educational Centers for Health Careers in rural communities across the state. The Luverne Educational Center for Health Careers, a joint effort between Minnesota West Community and Technical College, Sanford Health Systems and the City of Luverne, is a model for such centers. Both traditional and non-traditional students, most of them local, are offered programs in Radiologic Technology and Surgical Technology, as well as Liberal Arts classes and customized training. Students can pursue an Associate of Arts (A.A.) Degree that allows the student to either pursue a career in that field or to build toward a Bachelors Degree by transferring to other higher learning institutions.

Matching Grant Programs for Health Care Professionals' Spouses: A constant refrain in our discussions in Greater Minnesota was the reality that recruiting a doctor or dentist also meant ensuring that professional opportunities were available for his or her spouse. For instance, we learned about one community's effort to redevelop a storefront on Main

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Street for an artist-spouse's gallery and workshop. Unfortunately, such additional efforts are often hit or miss and strain the capacity of smaller towns, especially if the spouse's career is unique. The State could help by providing technical assistance and a small revolving loan or grant fund that communities could tap to support career opportunities for medical recruits' spouses. We should prioritize our existing rural business development funds to maximize the positive impact that attracting highly-trained doctors can have on small communities.

Support for Coordinated Capital Improvements: The current level of hospital construction and expansion all across the state is striking. Some of the construction is driven by the fact that many facilities have not been fundamentally updated since the last round of significant investment a generation ago. Consumer expectations around privacy and user experience have changed a lot in that time period. Old facilities do not attract patients.

But hospital administrators and medical professionals will also tell you that state-of-the-art medical facilities are an important recruiting and retention tool. Recent medical school graduates as well as long-serving doctors and nurses want to practice in a facility that allows them to take advantage of all the tools of modern medicine.

The state can help rural hospitals and communities compete for highly trained medical professionals by authorizing matching grants for needed capital improvements that improve the quality of practice for the doctors and the quality of outcomes for the patient.

But building and technology investments cannot be driven solely by perceived competitive necessity. To avoid duplication of services, the grants should be distributed on a regional basis to create an incentive for cooperation among providers. The grants should be tied to participation in a regional planning process for new facilities and improvements.

Enhancing Telehealth Opportunities: Advances in communications technology have the potential to improve availability of medical services and increase quality. But as the Minnesota Department of Health's Rural Health Advisory Committee recently noted, a number of obstacles exist including the fact that telehealth networks do not communicate with one another. The Rural Health Advisory Committee recommends statewide planning and coordination among telehealth networks to help overcome those implementation challenges. That recommendation should be adopted.

MAKING HEALTH CARE AFFORDABLE

Health care is not affordable for too many Minnesotans. According to a recent Families USA study, 276,000 Minnesotans with health insurance pay more than 25% of their income on health care. Due to the economic and demographic realities of rural Minnesota, however, health care affordability is a particularly acute problem.

Enact a Reasonable Affordability Standard: The idea behind an affordability standard is simple: We should set an expectation in our state that no Minnesotan should be expected to pay more than a reasonable percentage of his or her income on health care. If a person cannot through his employer or in the individual insurance market obtain coverage that meets the standard, the community will step in and help the person bridge the gap between what is

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affordable and what is available. In many ways it is establishing for health care what has long existed regarding housing -- a family should not pay more than 30% of its income on housing.

Table 1

Minnesotans in Families with High Health Care Costs, 2000 to 2008

Share of Pre-Tax Family Income Spent On Health Care	2000		2008		Increase
	Number	Percent of Pop.	Number	Percent of Pop.	
More than 10 Percent	603,000	13.8%	1,093,000	23.4%	490,000
More than 25 Percent	140,000	3.2%	276,000	5.9%	136,000

Note: Numbers may not add due to rounding.

Source: Estimates prepared by The Lewin Group for Families USA.

Source: Families USA, *Too Great a Burden: Minnesota's Families at Risk* (December 2007)

Improve MinnesotaCare: Residents of Greater Minnesota use MinnesotaCare in larger numbers than the rest of the state and expressed general satisfaction with the program. But two features of the program prompted significant negative comment.

First, MinnesotaCare only covers the first \$10,000 for inpatient hospital care. The cost of one hospital visit often exceeds that amount. Rural providers and consumers strongly urged that the so-called “hospital cap” be removed. As an alternative, the Minnesota legislature should allow persons on MinnesotaCare to purchase supplemental catastrophic insurance to cover hospital costs in excess of \$10,000.

Second, rural residents are uniquely impacted by MinnesotaCare’s asset limitations. An individual cannot qualify for the program if his or her assets exceed \$10,000. Certain assets like a homestead and retirement savings do not count toward the asset limit. Capital and operating assets of a trade or business are excluded up \$200,000. But farmland does count which means many farm families cannot qualify for MinnesotaCare even though their annual incomes are too low to afford meaningful insurance.

The legislature should consider alternative asset limitation requirements (or eliminating the asset limitation altogether) for working family farms. The legislature should also extend the exclusion of depreciated assets from income granted to farmers in 2007 for small business owners. Finally, the state should adjust the trade or business asset exclusion for inflation. It has remained at \$200,000 since being enacted in 2001 even though simply adjusting for inflation would require that be raised to \$240,000.

Support Innovative Health Care Delivery and Purchasing Proposals: Residents of Greater Minnesota have developed several innovative proposals to address the unique needs of their communities and regions.

For example, PrimeWest Health in west central Minnesota developed the Values Health Project proposal to both cover the uninsured and give those with insurance a better value

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for their health dollar through a cooperative collaboration among individuals, communities, businesses and the government.



Another example is the Fairview Community Health Assessment in St. Louis and Itasca Counties. Working in partnership with the local communities, Fairview conducted a survey to identify and prioritize health needs on the Iron Range. As a result, Fairview directs its local resources to addressing the most pressing local health care needs including teenage chemical use, access to health care for local seniors, reduced health education due to school budget cuts and alcohol related traffic injuries and deaths.

The state should encourage these and other local initiatives designed to improve the health of the residents of Greater Minnesota.

BUILDING A BETTER HEALTH CARE INFRASTRUCTURE

Uniform Billing and Administrative Simplification: The administration of health care – processing forms, entering codes and exchanging information – is burdensome and expensive. Those burdens fall especially hard on smaller providers without access to technical expertise.

To reduce such waste, the Minnesota legislature recently required that clinics, hospitals and payers adopt uniform standards for the exchange of claims information. The legislature also took steps to streamline the cost and quality data reporting requirements for submission of information to government, health plans and quality assessment entities.

In time, rural providers should benefit significantly from those changes. Nonetheless, rural and small providers expressed concern that they lack capacity to make the needed changes in the short term. The state should provide technical assistance as well as incentives for collaboration among providers to share resources to ensure a smooth transition. The state must also continue to fund grant and loan programs that will enable rural providers to make the transition to interoperable electronic records systems.

Supporting Medical Transportation in Greater Minnesota: Minnesota's medical transportation system is under stress. We know that the number of Minnesotans in need of transportation assistance to get to a medical appointment or to move from a hospital to a rehabilitation center is growing and will continue to grow. In Greater Minnesota, the stress on the system is exacerbated by the long distances that providers must travel to pick up a client. Under the current system, providers are not reimbursed until a client is being

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transported in the vehicle. Greater distances means more “dead head” time that is not reimbursed. Rising fuel and other costs only make the problem worse.

To address the problem and support rural medical transportation, the state should add a scarcity supplement to its reimbursement rate for providers who work in sparsely populated counties.

MEETING THE CHALLENGES OF AN AGING POPULATION

An aging population is perhaps the most significant long-term challenge facing rural Minnesota. The financial woes of small town nursing homes and other long-term care facilities was top of mind in nearly every community we visited and rightly so. The needs of people working long hours to provide care to our parents and grandparents are great, and we must do better by them. As important, in many Minnesota towns, the nursing home and other long-term care facilities are pillars around which the community is sustained. Nonetheless, our current state policy of forcing nursing homes and other long-term care providers to come to the state to beg for dollars every year must be changed.

Regional Solutions for Long-Term Care: There are many different ways to serve older Minnesotans and the types of available services are constantly evolving. Yet, the right mix of long-term care services will differ from one region and one community to the next. A top-down, one-size-fits-all state policy is no longer viable. The state should empower local communities by removing restrictions on how they can spend public long-term care dollars. The responsibility for developing the right combination of long-term services within a set budget should occur at the regional level.

Support for Informal Caregivers: The vast majority of older Minnesotans are cared for by friends and family members. Such informal caregiving is by far the most cost-effective way to care for older Minnesotans and, many times, it is the most desirable. But informal caregivers pay a high price in reduced wages, slowed career advancement and increased family stress and health problems. The result is caregiver “burnout.” The state should adopt policies to delay or avoid caregiver burnout including tax credits for families and friends who provide informal care and state support for respite programs and caregiver support groups.



CONCLUSION

As Minnesota goes about the work of improving health care, it is important that no part of the state be left behind. To make sure that happens, state policymakers will do well to continue to listen carefully to the voices of rural Minnesota as they debate future reform efforts. Average citizens are the ones feeling the impact of rising health care costs and seeing the consequences of a deteriorating health care infrastructure. They are also seeking out common-sense, innovative solutions. We look forward to continuing a productive discussion.