What does access truly mean?

<table>
<thead>
<tr>
<th>Access Measure</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable</td>
<td>People can afford the health care services they need</td>
</tr>
<tr>
<td>Available</td>
<td>Providers exist in the community with adequate staffing and resources</td>
</tr>
<tr>
<td>Accessible</td>
<td>People can get to the provider and services; technology has the ability to redefine this.</td>
</tr>
<tr>
<td>Accommodating</td>
<td>Services are organized to meet the needs and preferences of the people and community. For example: focusing on the health needs of the greater community; convenient hours of operation; building capacity</td>
</tr>
<tr>
<td>Acceptable</td>
<td>People are comfortable with the characteristics of the provider. For example, bedside manner and cultural competence of providers.</td>
</tr>
<tr>
<td>RANK</td>
<td>STATE</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
<td>Washington</td>
</tr>
<tr>
<td>2</td>
<td>New Hampshire</td>
</tr>
<tr>
<td>3</td>
<td>Minnesota</td>
</tr>
<tr>
<td>4</td>
<td>Utah</td>
</tr>
<tr>
<td>5</td>
<td>Vermont</td>
</tr>
</tbody>
</table>

Health Care Spending in MN Rises Continuously

Health Insurance Coverage in MN is Costly

Source: MDH analysis of data for private employers from AHRQ, Medical Expenditure Panel Survey-Insurance Component. Family coverage excludes employee-plus-one coverage. Data presented are weighted averages of two years of data.
Access to Care: Health Care Workforce Challenges

• Many areas of the state are considered ‘shortage areas’ for primary care or other services
• Health care workforce is aging
• Labor market is tightening
• New provider types are emerging; but we don’t always know how to use them
The large majority of Minnesota physicians are practicing in densely-populated urban areas.

<table>
<thead>
<tr>
<th>Region</th>
<th>Number Practicing</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twin Cities, Rochester, Saint Cloud, Duluth, and Moorhead</td>
<td>14,590</td>
<td>83.4%</td>
</tr>
<tr>
<td>Balance of state</td>
<td>2,895</td>
<td>16.6%</td>
</tr>
</tbody>
</table>

Data source: Minnesota Board of Medical Practice, 2019. Data geocoded and analyzed by Minnesota Department of Health, Office of Rural Health and Primary Care. Excludes 7,158 physicians who are either working out of state or did not report an address to the BMP.
We are losing rural physicians to retirement more quickly than urban physicians.

Data source: Minnesota Department of Health Physician Workforce Survey, 2018. Note that 84 percent of physicians who indicate they plan to leave the workforce soon say they intend to retire. Another 8 percent say they plan to leave because of burnout.
Workforce Development Efforts

Investing in Clinical Training Capacity

- Clinical training subsidy (MERC - $59 million)
- Health Professional Clinical Training Expansion Grant ($500k, APRNs/PAs)
- Primary Care Residency Grant Program ($1.5m)
- Rural Family Med Residency Grant Program ($1m)
- IIMG preparation grants

Using Data to Inform Workforce Policies

- Collect workforce data on 23 licensed providers
- Participate in workforce policy academies/multi-state learning efforts
- Objective, credible workforce policy research
- RHAC

Incenting Practice in High-Need Settings

- Loan Forgiveness & repayment programs
- J-1 visa waivers

Redesigning Healthcare Delivery

- Supporting emerging professions (CHWs, CPs, DTs, Doulas)
- Healthcare Home Certifications/Medicaid ACO demonstrations/ telehealth & broadband access
Economic and structural issues continue for EMS in rural Minnesota

- Low transport volumes (median call volume is nearly one call per day)
- Low and sparse populations served
- Large geographical primary service areas to cover
- Availability of a sustainable EMS workforce, including dependence on volunteers
- Need for fully engaged medical directors
- Need for non-transport revenue (all payments are tied to transports)
Rates of Health Care Amenable Mortality, 2011 to 2015

Areas of Minnesota with high diversity and poverty were two to three times the risk of health care amenable mortality

Source: Minnesota Department of Health analysis of Minnesota death records and US Census data from 2011 to 2015. Rates are directly standardized using the Minnesota statewide population.
*Only half of heart disease cases were included. 
Source: Minnesota Department of Health analysis of Minnesota death records and US Census data from 2011 to 2015. Rates are standardized using the Minnesota statewide population.
Risk of Underlying Cause of Death Relative to Statewide Rates

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS
Added economic cost from amenable mortality in areas of concentrated poverty: $114 million per year
Pathways to Health Equity

Source: Bay Area Regional Health Inequities Initiative website, Accessed July 12, 2019 at http://barhii.org/framework/
The structure

• People
• Opportunity
• Nature
• Belonging
• About 14% of all children in Minnesota live in poverty.

• About 9% of Minnesotans 18-64 have a disability; almost 1 in 5 families with children have a child with special health needs.

• Racial and ethnic diversity is expected to increase to about 25% by 2035.

• The LGBTQ population in Minnesota faces many challenges and barriers to health.

• The population over 65 is growing rapidly.
Opportunity: education

• Education is one of the clearest and strongest predictors of lifelong health.

[Diagram showing on-time graduation rate by race/ethnicity:]
- White (Non-Hispanic): 87%
- Asian: 84%
- Hispanic: 65%
- Black: 65%
- American Indian: 53%

Source: Minnesota Compass
Connecting education to health

**Diabetes**
Adults (18+) diagnosed with diabetes by educational attainment, Minnesota, 2015
SOURCE: MINNESOTA COMPASS / BRFSS

**Inadequate Prenatal Care**
Adequacy of prenatal care (Kessner Index), Minnesota, 2011
SOURCE: CDC / PRAMS

**Smoking**
Current smoking by education in Minnesota, 2015
SOURCE: MINNESOTA PUBLIC HEALTH DATA ACCESS / BRFSS
Opportunity: income

MINNESOTANS BELOW POVERTY LEVEL, 2010-2012

- **White (Non-Hispanic)**: 8%
- **Asian**: 10%
- **Two or More Races**: 22%
- **Hispanic**: 24%
- **Asian (Southeast)**: 27%
- **Other Race**: 27%
- **Black (Foreign Born)**: 35%
- **American Indian**: 40%
- **Black (U.S. Born)**: 41%

**Source:** Minnesota Compass

**MINNESOTANS WHO LIVE OUTSIDE URBAN AREAS AND WORK FULL TIME ARE 2X AS LIKELY TO LIVE IN POVERTY AS URBAN RESIDENTS WHO WORK FULL TIME.**

**Source:** Minnesota State Demographic Center
THREE TIMES AS MANY WHITE MINNESOTANS OWN HOMES AS AFRICAN-AMERICAN MINNESOTANS.

WHITE MINNESOTANS: 77%
AFRICAN-AMERICAN MINNESOTANS: 25%

SOURCE: MINNESOTA COMPASS
Financial stress about housing, adults 18-64 only | Usually or always | Sometimes | Rarely or never |
--- | --- | --- | --- |
Ever had cancer (other than skin cancer) | 8% | 4% | 4% |
Ever had COPD1 | 10% | 4% | 2% |
Ever had arthritis | 29% | 16% | 14% |
Ever had a depressive disorder | 49% | 24% | 15% |
Ever had diabetes | 9% | 5% | 5% |
Currently have asthma | 14% | 9% | 6% |
Currently smoke cigarettes | 39% | 23% | 14% |
Report binge drinking in past 30 days | 25% | 24% | 22% |
Are obese | 35% | 30% | 24% |
Consistency in opportunity inequities

• Populations of color and American Indians in Minnesota experience consistently lower opportunities in education, employment, income, housing, transportation, paid leave, health insurance, health care

• Persons with disabilities and LGBTQ populations also experience inequities in education, employment, and access to care.
Inequities in recreational opportunity

White Minnesotans are twice as likely to use regional parks and rarely note safety concerns.

Populations of color are more likely to note safety concerns about being in regional parks.

Source: Metropolitan Council
Belonging linked to infant mortality

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Infant Mortality Rate (per 1,000 births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>12.5</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>12.4</td>
</tr>
<tr>
<td>Black</td>
<td>10.4</td>
</tr>
<tr>
<td>Hispanic (Any Race)</td>
<td>6.1</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>4.7</td>
</tr>
<tr>
<td>White</td>
<td>4.1</td>
</tr>
</tbody>
</table>

**Source:** Minnesota Department of Health, Minnesota Center for Health Statistics

If white babies in Minnesota died at the same rate as American Indian babies, **2,134** more white babies would have died between 2012 and 2016.
Connecting belonging and health

**Racial and Ethnic Disparities in Prisons and Jail in Minnesota**

- **White:** 83%
- **Black:** 34%
- **American Indian:** 10%
- **Hispanic:** 6%

- **Minnesotan Population:**
  - White: 83%
  - Black: 5%
  - American Indian: 10%
  - Hispanic: 1%

- **Prison/Jail Population:**
  - White: 53%
  - Black: 34%
  - American Indian: 10%
  - Hispanic: 6%

Source: Minnesota Department of Corrections

Black, Hispanic and American Indian Minnesotans are overrepresented among those incarcerated.

**11th-Graders Using Substances by Number of Adverse Childhood Experiences, 2016**

- **Number of ACEs:**
  - 0: 10%, 9%
  - 1: 17%, 6%
  - 2: 21%, 9%
  - 3: 26%, 13%
  - 4 or more: 34%, 21%

- **Substances:**
  - Marijuana: 43%
  - Binge Drinking: 32%
  - Pain Killers: 29%

Source: Minnesota Department of Health, Minnesota Student Survey

Hardships in childhood can cause youth to turn to drugs and alcohol as teens.
Despair and disconnection

DEATHS IN MINNESOTA FROM SUICIDE, HOMICIDE, ALCOHOL AND DRUG OVERDOSE, 2000-2016

- Suicide
- 100% Alcohol Related
- Opioids (including heroin)
- Other drugs
- Homicide

SOURCE: MINNESOTA DEPARTMENT OF HEALTH, INJURY AND VIOLENCE PREVENTION UNIT

DEATHS FROM SUICIDE, ALCOHOL, AND DRUG OVERDOSES HAVE BEEN STEADILY INCREASING OVER THE LAST 16 YEARS.
Barriers

• Evidenced-based medicine
• What we get paid for
• Feeling helpless
• Afraid to ask
• What if we don’t have all the answers?
• Losing power
Role as Leaders

• Unique opportunity as physicians/practitioner community

• Convener, communicator, and leader

• Convening in the largest sense unites people in a common vision that is larger than what an single entity could achieve on its own

• How are we working in partnership with communities to create their vision of health

• Learn, adapt, lead, and instruct
Thank you!

Courtney Jordan Baechler, MD, MS
Assistant Commissioner of Health