

Minnesota

Minnesota’s noteworthy successes include substantial funding of injury prevention programs and a comprehensive approach to effective disaster planning, but the Medicaid reimbursement rate for office visits and the state’s *Medical Liability Environment* present ample opportunities for improvement.

Strengths. Minnesota has undertaken multiple efforts to increase its capacity in the event of a disaster. The state has an all-hazards medical response plan and receives public health and emergency physician input into the state planning process. Minnesota has established a statewide medical communication system with one layer of redundancy, a real-time notification system, and statewide patient and victim tracking systems. The state ranks fourth with regard to the number of nurses who are registered with the state-based Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program. Minnesota also ranks 6th overall for the number of preparedness drills and exercises conducted with hospital personnel and equipment and 13th for the number of physicians registered with ESAR-VHP.

Minnesota also fared well with regard to *Public Health and Injury Prevention*. The state invests heavily in injury prevention programs: Total injury prevention funding is nearly \$600 per 1,000 people compared to an average of \$455 per 1,000 across the states. The state also has high immunization rates for both children and adults and relatively low rates of traffic fatalities and unintentional fatalities from fires and firearms. Minnesota has one of the lowest infant mortality rates in the nation (5.1 per 1,000 live births compared to 6.9 per 1,000 nationally). Obesity and cigarette smoking among adults (24.7 and 18.3 percent, respectively) are slightly lower than the nation as a whole (25.1 and 20.1 percent, respectively).

Minnesota must address numerous issues that severely impact access to emergency care.

Minnesota’s *Quality and Patient Safety Environment* benefits from mandatory quality reporting requirements, a statewide trauma registry, and the development of a stroke system of care. The state has a funded EMS medical director, ranks 14th for the number of emergency medicine residents per capita, and has Enhanced 911 capability in every county. Most notably, Minnesota is ranked first in the nation for the proportion of eligible patients with acute myocardial infarction receiving PCI within 90 minutes of hospital arrival (83 percent).

Challenges. Minnesota’s *Medical Liability Environment* is ranked 26th overall due to a paucity of liability reforms. The state has abolished joint and several liability but lacks pretrial screening panels, medical liability caps on non-economic damages, and additional liability protections for EMTALA-mandated emergency care. The state also has a relatively high average malpractice award (\$347,708) compared to the average across the states (\$285,218).

Regarding *Access to Emergency Care*, Minnesota is ranked 29th for the number of emergency physicians per capita, has no accredited chest pain centers, and is ranked 40th for access to substance abuse treatment. The state also has disproportionately low Medicaid fee levels for office visits (68.4 percent of the national average), which is the result of a 13.0 percent decline since 2004.

Recommendations. While the state has taken some steps, including collecting data on ambulance diversions, Minnesota must address numerous issues that severely impact *Access to Emergency Care*. Emergency physicians in Minnesota have identified crowding and boarding in the state’s more urban areas, as well as the resulting ambulance diversion, as a serious concerns. These complex issues are likely exacerbated by the relatively high daily




	RANK	GRADE
ACCESS TO EMERGENCY CARE	20	C
QUALITY & PATIENT SAFETY ENVIRONMENT	19	B-
MEDICAL LIABILITY ENVIRONMENT	26	C-
PUBLIC HEALTH & INJURY PREVENTION	10	B
DISASTER PREPAREDNESS	7	A-
OVERALL	6	C+

hospital occupancy rate in the state and the lack of on-call specialists available to provide timely emergency care. Additionally, emergency physicians report that the state’s shortage of psychiatric care beds is resulting in psychiatric patients being increasingly boarded in emergency departments while they await placement in an appropriate facility to receive the psychiatric treatment they need.






Minnesota could further improve the *Quality and Patient Safety Environment* with funding for EMS quality improvement, implementing a uniform system for providing pre-arrival instructions, and requiring reporting of hospital-based infections.

The lack of liability reform is also a continuing issue, and policymakers should work with the medical community to enact legislation, such as special liability protections for providers of EMTALA-mandated care, which might encourage more specialists to provide on-call emergency services.


ACCESS TO EMERGENCY CARE C

Board-certified emergency physicians per 100,000 pop.	 7.6
Emergency physicians per 100,000 pop.	11.1
Neurosurgeons per 100,000 pop.	1.8
Orthopedists and hand surgeon specialists per 100,000 pop.	10.7
Plastic surgeons per 100,000 pop.	1.9
ENT specialists per 100,000 pop.	3.4
Registered nurses per 100,000 pop.	 1,022.2
Additional primary care FTEs needed	51.2
Additional mental health FTEs needed	17.4
Level I or II trauma centers per 1M pop.	1.4
% of population within 60 minutes of Level I or II trauma center	82.4
Accredited chest pain centers per 1M pop.	0.0
% of population with an unmet need for substance abuse treatment	9.0
Pediatric specialty centers per 1M pop.	3.3
Physicians accepting Medicare per 100 beneficiaries	3.2
Medicaid fee levels for office visits as a % of the national average	68.4
% change in Medicaid fees for office visits (2004-05 to 2007)	-13.0
% of adults with no health insurance	9.5
% of children with no health insurance	8.3
% of adults with Medicaid	9.1
Emergency departments per 1M pop.	 19.6
Hospital closures in 2006	1
Staffed inpatient beds per 100,000 pop.	351.1
Hospital occupancy rate per 100 staffed beds	69.9
Psychiatric care beds per 100,000 pop.	14.8
State collects data on diversion	Yes






MEDICAL LIABILITY ENVIRONMENT C-

Lawyers per 10,000 pop.	20.1
Lawyers per physician	0.7
Lawyers per emergency physician	17.9
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	1.0
Average malpractice award payments	\$347,708
Databank reports per 1,000 physicians	7.9
Patient compensation fund	 No
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	3.5
Average medical liability insurance premium for primary care physicians	\$5,611
Average medical liability insurance premiums for specialists	\$22,940
Pretrial screening panels	 No
Are pretrial screening panels' findings admissible as evidence?	N/A
Periodic payments	At judge's or court's discretion
Medical liability cap on non-economic damages	 No
Additional liability protection for EMTALA-mandated emergency care	 No
Joint and several liability abolished	 Yes
State provides for case certification	Yes
Expert witness required to be of the same specialty as the defendant	No
Expert witness must be licensed to practice medicine in the state	No

QUALITY & PATIENT SAFETY ENVIRONMENT B-




Funding for quality improvement within the EMS system	No
Funded state EMS medical director	Yes
Emergency medicine residents per 1M pop.	 15.2
Adverse event reporting required	Yes
Hospital-based infections reporting required	No
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	100.0
Uniform system for providing pre-arrival instructions	No
State has or is working on a stroke system of care	Yes
State has or is working on a PCI network or a STEMI system of care	No
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	23.8
% of hospitals with electronic medical records	48.3
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	83
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	19

PUBLIC HEALTH & INJURY PREVENTION B

Traffic fatalities per 100,000 pop.	9.6
% of traffic fatalities alcohol related	 37.0
Front occupant restraint use (%)	87.8
Helmet use required for all motorcycle riders	 No
Child safety seat/seat belt legislation (10 points possible)	0
% of children immunized, aged 19-35 months	 84.7
% of adults aged 65+ who received flu vaccine in the last 12 months	 73.8
% of adults aged 65+ who ever received pneumococcal vaccine	 71.1
Fatal occupational injuries per 1M workers	29.4
Homicides and suicides (non-motor vehicle) per 100,000 pop.	13.4
Unintentional fall-related fatal injuries per 100,000 pop.	11.4
Unintentional fire/burn-related fatal injuries per 100,000 pop.	0.7
Unintentional firearm-related fatal injuries per 100,000 pop.	0.1
Gun-purchasing legislation (8 points possible)	1
% of tobacco settlement funds spent on health-related services and programs	0.0
Total injury prevention funds per 1,000 pop.	\$598.81
Unintentional injury prevention funds per 1,000 pop.	\$28.86
Intentional injury prevention funds per 1,000 pop.	\$157.16
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	5.1
% of adults with BMI > 30	24.7
Current smokers, % of adults	18.3
Binge alcohol drinkers, % of adults	17.6

DISASTER PREPAREDNESS A-

Per capita federal disaster preparedness funds	\$9.08
Disaster preparedness funds used specifically for health care-related preparedness are tracked	Yes
All-hazards medical response plan or ESF-8 plan?	Yes
Plan shared with all EMS and essential hospital personnel?	Yes
Public health and emergency physician input into the state planning process	Yes, Yes
Public health and emergency physician input into the daily operations of the SEOC	Yes, No
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	No
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	681
Accredited by the Emergency Management Accreditation Program	No
Written plan specifically for special needs patients	NR
Written plan to supply medications for chronic conditions	NR
Written plan to supply dialysis for patients	NR
Real-time notification system in place to notify identified health care providers of an event	Yes
"Just-in-time" training systems in place	Statewide
Statewide medical communication system with one layer of redundancy	Yes
Statewide patient tracking system	Yes
Statewide victim tracking system	Yes
Statewide real-time or near real-time syndromic surveillance system	No
Real-time surveillance system in place for common ED presentations	Yes
Bed surge capacity per 1M pop.	714.6
Burn unit beds per 1M pop.	9.4
ICU beds per 1M pop.	242.7
Verified burn centers per 1M pop.	0.4
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	390.2
Physicians registered in ESAR-VHP per 1M pop.	33.3
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	Yes, Yes
State or regional strike teams or medical assistance teams	Yes
Additional liability protections for health care workers during a disaster	Yes, civil
% of RNs that received any emergency training	46.0
State requires EMS and essential ED personnel to be NIMS compliant	Yes

	Improved since 2006
	Worsened since 2006
	No change since 2006
NR	Not reported
N/A	Not applicable
See Summary Statistics for State Comparisons	