



# Report to the Community

## The Journey to a Community Health Center

*Planning Phase – Year One*

*September 2012*



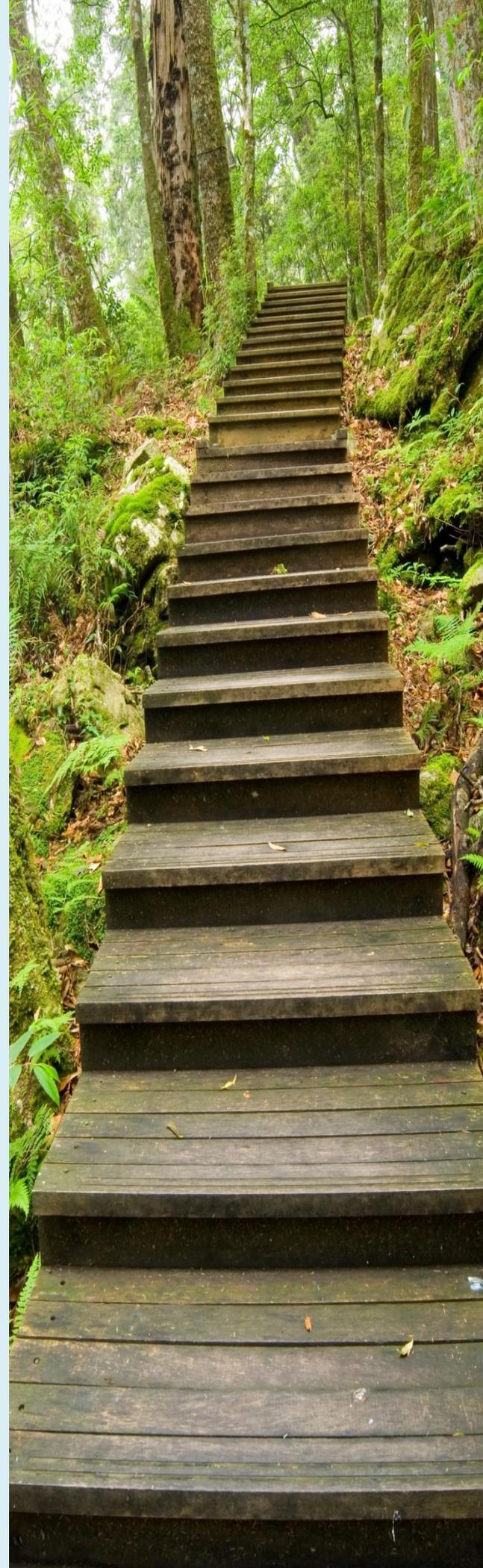
**Northern Dental**  
ACCESS CENTER

**Bemidji, Minnesota**



# Table of Contents

<b>Executive Summary</b>	2
<b>Background</b>	3
Overview of FQHC	3
Why a Planning Process Grant	5
The Planning Process	6
<b>What We Learned</b>	12
Community Health Needs Assessment	12
The FQHC Landscape	13
<b>Future Actions and Conclusions</b>	15
<b>Appendix</b>	25
<i>Northern Dental Access Center Timeline</i>	26
<i>Community Health Needs Assessment</i>	27





# Executive Summary

In 2011, area health care providers in and around Bemidji-Beltrami County, Minnesota set out to determine if the community should pursue the development of a Federally Qualified Health Center (FQHC) or some version of a community health center. This is an economically depressed area, with high poverty rates and alarming health disparities. Recent citing of Beltrami County as 84<sup>th</sup> out of 85 ranked counties in the state for health factors (Robert Wood Johnson Foundation) inspires us to find solutions to better serve low income, uninsured and marginalized people.

Federally Qualified Health Centers receive a number of attractive benefits and for more than a decade, the Minnesota Association of Community Health Centers has identified Bemidji and Beltrami County as having an unmet healthcare needs and no such community health center to meet that need.

In September 2011, a federal planning grant was received, with the goal of positioning the community for a FQHC New Access Point Grant submission, or to develop a unique community-based solution that would better address the community's needs.

Exhaustive efforts were made to include all aspects of the community in the conversation. Two tracks of activities occurred in tandem—a comprehensive community health needs assessment (required by the grant) and a planning process to design an effective approach to address the needs identified in the assessment. Some envisioned construction of a new clinic; others were not so sure.

The health care needs assessment was completed and distributed in early April 2012, outlining health priorities and determinant factors for health care for the target population. The assessment results demonstrated that our community has a robust health care delivery infrastructure in place for primary and dental care, with some capacity issues for mental health services—none of which dictates a necessary solution of another building.

Planning team members concede that the ultimate “dream” would be a new, all encompassing clinic—but recognize the reality that, not only is it not financially feasible or sustainable at this time, there is little evidence that it would address the core disparities and access issues raised by the assessment. Rather, the report points to the fragmentation of current systems and lack of continuity among providers. Additional barriers such as transportation, health literacy, mistrust of the system—challenge us to look at *how* we, as a community, deliver care, not necessarily how we increase the number of facilities that provide care.

The conversation took a different course when, in February of 2012, the landscape of the projected federal funding for Community Health Centers shifted dramatically, with the hope of new FQHC access point funding essentially gutted by Congress. Not to be deterred, in the final weeks of the planning, the Planning team focused on those things that could be accomplished with local resources and that could keep the community on the path toward the vision of a community health center in years to come.

The concept of phases to development emerged, as a way to pursue the larger goal in incremental steps that are manageable and sustainable. The completion of the community health assessment is our foundation for formulating those next steps and will boost efforts to secure additional grant funds for service expansions.

The work ahead will require service providers, who have an interest in the target population, to put their heads together to determine what CAN be done with existing resources, to address the needs outlined in the assessment.

The journey to create something this substantial is long and arduous, but will be highly rewarding when our community health outcomes improve.

Special thanks must be extended to all those individuals and organizations who invested time, energy, expertise and moral support to this process. We submit that this report does not constitute the end of the process, rather the beginning, a roadmap for reaching the vision of a community health center.





# Background

In 2011, area health care providers in and around Bemidji, Minnesota set out to determine if the community should pursue the development of a Federally Qualified Health Center (FQHC) or some version of a community health center. At the urging of state officials, Northern Dental Access Center requested that a community conversation begin. This report outlines the background, process and findings of a ten month planning effort.

## • Overview of FQHC

Health centers are community-based and patient-directed organizations that serve populations who typically have limited access to health care. **Federally Qualified Health Centers (FQHC)** are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act) and receive funds under the Health Center Program Section 330 of the Public Health Service Act. **Federally Qualified Health Center Look-Alikes (FQHC Look-alikes)** are health centers that meet the same Department of Health criteria, but they do not receive grant funding under Section 330.<sup>1</sup>

According to federal guidelines, Section 330 Health Centers must:

- Be located in or serve a high-need community (designated Medically Underserved Area<sup>2</sup> or Population) or serve a specific high-risk target population
- Be a non-profit or public organization
- Have a governing board, majority of whose members are patients
- Provide services regardless of inability to pay and offer a sliding fee scale to patients with incomes below 200% of Federal Poverty Guidelines
- Offer comprehensive medical, dental, mental health and enabling services to all age groups, either directly or through established written arrangements and referral



<sup>1</sup> US Department of Health and Human Services, Health Resources and Services Administration, About Health Centers, What is a Health Center?, <http://bphc.hrsa.gov/about/index.html>, Accessed August 16, 2012.

<sup>2</sup> Medically Underserved Areas/Populations are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population.

Federally Qualified Health Centers receive a number of benefits:

- Section 330 grant funds to offset the costs of uncompensated care and other key enabling services
- Access to medical malpractice coverage under Federal Tort Claims Act (FTCA)
- Prospective Payment System reimbursement for services to Medicaid patients
- Cost-based reimbursement for services to Medicare patients
- Drug Pricing Discounts for pharmaceutical products under the 340B Program
- Federal loan guarantees for capital improvement
- Access to on-site eligibility workers to provide Medicaid and Child Health Insurance Program (CHIP) enrollment services
- Reimbursement by Medicare for “first dollar” of services because deductible is waived if FQHC is providing services
- Access to Vaccines for Children Program for uninsured children
- Access to National Health Service Corps (NHSC) medical, dental, and mental health providers
- National network of similar organizations committed to improving the health of the Nation’s underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services<sup>3</sup>

Federally Qualified Health Centers’ largest source of revenue comes from Medicaid (37% of total revenue and 63% of all patient-related revenue) – followed by federal grants – only about 6% comes from Medicare and remainder comes from private health insurance, state grants, private contributions.<sup>4</sup>

Nationwide there are 1,131 FQHCs delivering care at more than 8000 sites, serving approximately 20 million people. In Minnesota, there are 17 Federally Qualified Health Centers with 70 delivery sites, serving 170,000 people.

Today, Community Health Centers provide one-quarter of all primary care visits for the nation’s low-income population, and generate \$24 billion in annual savings. According to the *Community Health Centers: The Local Prescription for Better Quality and Lower Cost* report (March 2011, National Association of Community Health Centers), preventive and primary care services that community health centers provide reduces unnecessary, avoidable, and wasteful use of health resources, including reducing the rate of preventable hospitalizations, inpatient days and emergency department use. Health Centers meet or exceed national practice standards for chronic condition treatment and they produce economic “ripple effect,” creating jobs and fueling additional economic activity. Because of their success in delivering high-quality, cost-effective care, the Health Centers Program was rated one of the most effective federal programs by the Office of Management and Budget (OMB). In 2009 alone, a federal investment of \$2.2 billion generated \$20 billion in total economic benefits to resource-poor rural and

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<sup>3</sup> US Department of Health and Human Services, Health Resources and Services Administration, About Health Centers, Program Benefits, <http://bphc.hrsa.gov/about/benefits/index.html>. Accessed August 16, 2012

<sup>4</sup> Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Healthcare Delivery System, June 2011, Chapter 6 Federally Qualified Health Centers.

urban communities. They also produced 189,158 jobs in the nation's most economically challenged areas. By 2015, Health Care Centers are projected to save the health care system \$63 billion dollars annually and yield \$54 billion in economic gains for low income communities.

- **Why a planning process grant?**

Community Health Center Planning Grants are provided through the US Department of Health, Health Resources and Services Administration. Public or private non-profit organizations are eligible to apply for a planning grant to assist them with planning for the development of a comprehensive primary Health Care Center under Section 330 of the Public Health Service Act. The grant provides funding to explore the steps for opening a health care center, including conducting a needs assessment, identifying appropriate short- and long-term goals, developing coordination and collaborations with other providers of care, assessing organizational capability, and determining cost-effectiveness.<sup>5</sup>

For more than a decade, the Minnesota Association of Community Health Centers has identified Bemidji and Beltrami County as having an unmet healthcare needs and no such Community Health Center to meet that need. Less than 1% of the county's low-income population is served by an existing FQHC, the nearest of which is Scenic Rivers Health Services in Itasca County.<sup>6</sup> Within the Scenic Rivers system, the closest access point is located in the small town of Northome, Minnesota, more than 40 miles northeast of Bemidji (50 minutes when roads conditions are good). Services there are limited to medical only. Dental and behavioral health services through Scenic Rivers are located even further away in Floodwood or Bigfork, Minnesota, about 75 miles from Bemidji.

In addition, Beltrami County holds several designations related to health care access issues that meet Section 330 requirements, including:

- 1) Medically Underserved Area;
- 2) Mental Health Care Health Professional Shortage Area (HPSA);
- 3) Dental Health HPSA; and
- 4) Primary Care HPSA (for northern and eastern portions of Beltrami County).<sup>7</sup>

Ten years ago a federal application was submitted by North Country Regional Hospital to develop a Federally Qualified Health Center (FQHC) in the former Northern Medical Clinic in downtown Bemidji. While the application scored extremely well, it was not funded. For the following ten years, federal funding sources for new community health centers remained dormant. In 2010, the Affordable Care Act established the Community Health Center Fund, providing \$11 billion over 5 a year period for the operation, expansion, and construction of health centers throughout the nation; the intent was to create hundreds of new clinics.<sup>8</sup>

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<sup>5</sup> HRSA-11-012, FY 2011 Health Center Planning Grant Funding Opportunity Frequently Asked Questions <http://www.hrsa.gov/grants/apply/assistance/Planning/faqs.pdf>

<sup>6</sup> UDS Mapper, <http://www.udsmapper.org>. Accessed Dec.27, 2011

<sup>7</sup> HRSA, Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations, <http://bhpr.hrsa.gov/shortage/>

<sup>8</sup> US Department of Health and Human Services, Health Resources and Services Administration, The Affordable Care Act and Health Centers, <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>. Accessed August 16, 2012.

In 2011, the Minnesota Association of Community Health Centers approached North Country Regional Hospital (now Sanford Hospital) about reviving the original proposal and they were directed to Northern Dental Access Center which, as a new community agency, has been making strides toward creating a community-based and patient-centered health center serving underserved and low income people in the region.

At the same time, Northern Dental Access Center was being encouraged by Minnesota Departments of Health and Human Services, along with elected officials, to consider the FQHC model as a direction to pursue, because of its long-term viability and its similar goals of providing culturally competent care to the most vulnerable families in a community. While Northern Dental Access Center staff and Board of Directors remained open to the idea, it was unclear if Northern Dental Access Center was the appropriate venue for a full community health center.

Northern Dental Access Center recognized that a solution ultimately needed to be developed by the community, not one single entity, so they partnered with Sanford Health, United Way, Community Resource Connections, Northwest Minnesota Area Health Education Center, Beltrami County Public Health, and Beltrami Area Service Collaborative to submit the planning grant proposal. These partners were keenly aware that if the grant was awarded, additional community stakeholders, experts and partners would be welcomed and necessary to effectively plan, explore and develop a community based model that would meet the needs of the target population.

## • **The Planning Process**

In September 2011, the planning grant was awarded by the U.S. Department of Health and Human Services, with Northern Dental Access Center as fiscal host. For ten months, a team would determine the health care needs of the population through a comprehensive community health needs assessment (*a key requirement of the grant agreement*), and gather stakeholders to develop solutions to the identified unmet needs. At the end of the 10-month planning period, the goal was to be positioned to apply for a U.S. Department of Health FQHC New Access Point grant, should funding be available; apply for a FQHC Look-alike designation; or develop a unique community-based solution that would better address the community's needs.

Two consultants were contracted to guide the ten-month work plan: Ashli Bowen, to facilitate and oversee project management; and Wendy Thompson, to coordinate and complete the community health needs assessment. The original partners who applied for the grant met with the consultants to review the work plan, develop position descriptions for a Needs Assessment Advisory team and a Planning team; they also developed a communication plan, and prepared for a community forum to begin the public discussion.

Bowen and Thompson attended the National Association of Community Health Center's *Developing a Great Federally Qualified Health Center* three day training in early December to learn how to competitively develop an FQHC program model, from the comprehensive health needs assessment, through the development of a scope of services, and creating a business plan. With this background, consultants were able to guide and inform the planning process.

Additional support for planning were provided by the Minnesota Association of Community Health Centers (MNACHC), with a technical assistance professional assigned to monitor progress, connect with information and expertise from around the state, inform on best practices, and provide updates on the political and financial landscapes.

The first community conversation/forum was held in Bemidji on December 2, 2011. The purpose was to inform the community about the process, gather input and gain interest. Aggressive promotion efforts garnered 55 community people from a broad spectrum of healthcare, education, business and civic groups. Fundamental visioning questions were discussed through a structured process for prioritization, resulting in the following:



**Who should we serve?**

- Uninsured and underinsured
- Access for all people - preventive services
- Anybody that has access barriers
- Working class poor
- Substance abusers

**What health outcomes would result?**

- Getting healthcare when needed not only when able to afford it - early intervention, diagnose, treatment
- Healthier community
- Reduced emergency room visits and hospitalizations
- Holistic prevention focused healthcare practices
- Improved community vitality
- Increase number of citizens seeking and receiving preventive care
- Reduction of costs - more efficient delivery

**What kind of patient experience and care would be provided?**

- Feeling affirmed and validated
- Patient and family centered care
- Non intimidating, positive experience through seamless access, with centralized location and elimination of duplicated forms
- Holistic and wellness focused
- Integrated care between providers

Participants were invited to continue the conversation throughout the subsequent planning process, either through direct participation, or by staying connected through updates. A robust website was developed to assure transparency and access to all, regardless of ability to attend meetings. Two work teams were created: a Community Health Needs Assessment Advisory team and a Planning team. Community members self-identified or were invited by stakeholders and within a few weeks, more than 50 community members from diverse backgrounds made a commitment to serve on one or both teams.

## The Community Health Needs Assessment Advisory Team

The **Community Health Needs Assessment Advisory team** was charged with defining the target population(s) and service area for the health center and then identifying, given the target population(s), what the service needs the health center should be prepared to meet. The 20 members met monthly December 2011-April 2012, providing the consultant Wendy Thompson, with guidance, personal and professional insights, along with advice on data-gathering methods and reliable resources that led to the development of a comprehensive assessment.

The team identified data sources and a list of stakeholders whose diverse expertise and experiences needed to be included in the assessment through focus groups, surveys or interviews. Members of the Assessment team and the consultant conducted 25 interviews and focus groups with more than 140 stakeholders in February and March. Stakeholders included:

- Indian Health Services
- Sanford Medical Hospital & Clinic administrators, physicians and nurses
- Bemidji State University Nursing Department
- Upper Mississippi Mental Health Center
- Stellher Human Services
- Beltrami County Health & Human Services
- Bi-County Community Action
- Head Start Policy Council
- Indian Education
- School district nursing program
- Homeless service and housing providers
- Lutheran Social Services
- Mennonite community
- Chemical dependency treatment program
- Mother-Infant Action Team, and others
- Paul Bunyan Senior Activity Center

To specifically explore the health disparities among the Native American population, the team consulted with Upper Mississippi Mental Health Center, Indian Health Services and Tribal Health, and individuals within the Native American community. Members of the Shared Vision group (a regional race relations initiative) served on the Assessment team and shared insights along the way.

Additional vulnerable populations were identified and described in interview and focus group notes, including the homeless, chemically dependent, those with mental illness, and pregnant/parenting young women and their children.

In the meetings, interviews and focus groups held with stakeholders, the Assessment team and consultant asked about services, population needs, barriers/challenges, gaps in services and suggestions to address the identified gaps, needs and barriers.

Potential patients were invited to respond to a health needs survey; specifically targeted were underinsured, uninsured, and vulnerable people (those in poverty, living in remote areas of county, the disabled and elderly of all races). The survey was available in paper format and on a web-based system. It was promoted through media and through contact with service providers who work with clients in the target population. A modified, shorter paper survey geared to senior citizens was also developed. Both surveys were pre tested and revised based on feedback.

81 senior citizens completed the survey and 250 people completed the longer paper and web-based survey. Those assisting with survey administration included: Northern Dental Access Center, Senior Center, Meals on Wheels, Bi-County Community Action, Minnesota Workforce Center, Early Childhood Family Education, a private business whose employees are uninsured, Village of Hope Homeless Shelter, Evergreen Youth and Family Services, Habitat for Humanity, and the Bemidji Public Library—among others.

Data was also gathered from a variety of resources, including:

- National Association of Community Health Centers
- Minnesota Association of Community Health Centers
- Minnesota Department of Health Office of Rural Health and Primary Care
- Beltrami County Health and Human Services
- Bemidji State University Nursing Department
- U.S. Census Bureau
- Sanford Medical

Health priorities and determinant factors for health care were identified for the target population and the health care needs assessment was completed in early April 2012. (*The full Community Health Needs Assessment is included as an attachment to this document.*)

## **Planning Team**

Planning team members met twice per month December through May and once per month in June and July, working through an ambitious work plan that included benchmarking various delivery models, determining community interest, setting priorities, developing a long-term strategic plan and exploring delivery models.

Team members accessed and shared resources through the Bemidji area community health center website, [www.bemidjichc.com](http://www.bemidjichc.com), and a Wikispace. In addition to the team meetings, the National Association of Community Health Centers held eight webinars specific for planning grantees (Billing and Sliding Fee Scale, Provider Recruitment, Utilizing Collaborations...) which various team members attended. Technical assistance and support was provided throughout the planning by Minnesota Association of Community Health Centers, National Association of Community Health Centers and Minnesota Department of Health.

The team agreed that their goal was to consider delivery models that could increase access and provide medical, dental, and behavioral health care services for the low income population in Beltrami County who are not currently accessing or being served by the existing health care infrastructure. Team members envisioned a high-quality, comprehensive health care system that was patient-centered, provided care coordination, eliminated/addressed disparities and barriers, aligned with Healthy People 2020, and embraced the cultural competence of Ruby Payne’s “Framework for Understanding Poverty” and “Bridges Out of Poverty.”

The team recognized that understanding patient barriers and the realities of living in poverty would be essential to providing care to the target population and will require deliberate attention to cultural competency. On April 30, the planning team partnered with Northwest Minnesota Area Health Education Center and North Homes Children and Family Services to host a full day Ruby Payne *Bridges Out of Poverty* training with nationally renowned presenter Jodi Pfarr. The workshop was open to the community and offered participants a deeper understanding of the challenges, strengths and barriers faced by people who live, or have lived, in poverty. For additional insight and training, some planning team members attended Ruby Payne *Bridges Into Health: Strategies to Reduce Inequities and Improve Health Outcomes* workshop; the *Many Faces of Community Health* conference (MNACHC); Upper Mississippi Mental Health's *Tribal Cultural Competency* workshop; and Northwest Minnesota Area Health Education Center's workshop: *Native American Cultural Competency and Understanding I.H.S./Tribal Health*.

The planning team researched Section 330 Community Health Centers and their service delivery models as well as other health care delivery models including: Health Leads ([www.healthleadsusa.org](http://www.healthleadsusa.org)), Medical Neighborhood, Health Care Home and Rural Health Centers to benchmark best practices. Planning team members visited two Community Health Centers: CommUnity Care in Austin, TX in December 2011 and Scenic Rivers Health Center in Big Fork, MN in March 2012. Team members conducted phone interviews with the directors at Lake Superior Community Health Center, Duluth, MN; and Sawtooth Mountain Clinic, Grand Marais, MN.

Minnesota Department of Health's Jean Larson, Health Care Home Regional Nurse Consultant, attended several team meetings to inform the team about Health Care Home model and provide assistance in the planning process. *A "health care home," (also called a "medical home"), is an approach to primary care in which providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities. The development of health care homes in Minnesota is part of the health reform legislation passed in May 2008. The legislation includes payment to primary care providers for partnering with patients and families to provide coordination of care.*<sup>9</sup>



Turning to the local landscape, the planning team met with organizations and health care providers in the community to learn more about the services they offered, to gather input and share information about the planning process and objectives. The team met with Sanford Clinic's Medical Home nurses, Indian Health Services, Sanford Medical's administration team and community needs assessment team, Community Resource Connection's executive director, Northwoods Coalition for Family Safety's Health and Wellness Program coordinator, Beltrami County, Upper Mississippi Mental Health staff, Sanford Medical providers, Sanford Health's Integrated Native American Health

<sup>9</sup> Minnesota Department of Health, Health Reform, Health Care Home, <http://www.health.state.mn.us/healthreform/homes/index.html>

Initiative, and a local mental health collaborative. In addition, several of the planning team members represented health care and service organizations throughout the community and, as needed, they provided guidance to the planning team on specific discussion points.

In March, a Reimbursement Fiscal Agent from the Minnesota Department of Health Office of Rural Health and Primary Care, conducted an in-service to explain FQHC reimbursement and funding models, along with the challenges and opportunities that they offer.

By April, 2012, the needs assessment was complete and shared with the planning team. Based on the results, the team explored several approaches to service delivery that would best address the specific needs evident in our community. These models ranged from dispersing a cadre of care coordinators at various agencies and government offices throughout the community to provide patient navigation and other enabling services—to having one, centralized and accessible location for people to receive assistance with care coordination, navigation, enabling services, and such. Also discussed was possible expansion of an existing organization which already provides a component of health care (mental, dental or primary care) to act as the “community health center”.

In this context, the team heard from Northern Dental Access Center about the variety of services they provide to the target population through partnerships with Beltrami County Health, Beltrami Area Service Collaborative, Community Resource Connections and others. And, while the planning team generally agreed that Northern Dental Access Center would be a logical location or access point for a community health center, Northern Dental Access Center’s Board of Directors were apprehensive that the rigid, prescribed federal FQHC model may dampen its current success and stability.

And yet, Northern Dental Access Center’s “dental home” approach, its continuum of services beyond dental care, and its connection to 15,000 low income patients—makes it a logical prospect for community health center development.

After much discussion and consideration, the team concluded that it was too soon to apply for FQHC Look-alike designation or FQHC Section 330 funding. They agreed that a multi-year, phased approach and incremental progress toward goals would be manageable, especially with the strength of a collaborative approach among providers.

A phased approach would allow more time to be responsive to the community health assessment; allow for manageable growth at a sustainable pace; provide partners time to build trust and negotiate agreements at a pace that allows for their internal structures to adapt; provide time to demonstrate integrated care successes and resulting improved health outcomes, and to prepare for a competitive application for New Access Point or FQHC Look-alike. This approach would allow Northern Dental Access Center time to deliberate on possible structure, or to determine if a new nonprofit entity would be a better option for a community health center (which takes up to a year for IRS approval). More details on planning conclusions are provided later in this report.



# What we learned

- **Community Health Needs Assessment**

The completed Community Health Needs Assessment published in April 2012 identified considerable health determinants, disparities and barriers currently faced by the low-income population in Beltrami County. Navigating a complex health care system and maintaining health care coverage presents significant barriers. Low income individuals and families receive fragmented care and lack of continuity of care, due to those barriers (transportation, cost of care, shortage of behavioral health services, etc.).

In addition, the assessment revealed a strong desire and energy within the broader community to change the trajectory of health outcomes for this population by launching innovative, collaborative solutions.



Findings tell the story of the complex web of barriers faced by the target population, including (*in no particular order*):

- |   |  |
|---|--|
| <i>Cost of care</i>                                       | <i>Challenge of self advocacy</i>                            |
| <i>Issues with health care coverage</i>                   | <i>Feeling judged or sensing prejudice</i>                   |
| <i>Shortage of dental health services</i>                 | <i>Mental health stigma</i>                                  |
| <i>Shortage of mental health services</i>                 | <i>Untreated mental health issues</i>                        |
| <i>Complexity of health care systems</i>                  | <i>Unrecognized or undiagnosed mental health issues</i>      |
| <i>Wait times for primary care</i>                        | <i>Substance abuse</i>                                       |
| <i>Navigating supportive services</i>                     | <i>Mistrust of the system</i>                                |
| <i>Transportation</i>                                     | <i>Desire for holistic and traditional treatment options</i> |
| <i>Work obligations and child care</i>                    | <i>Underfunding of Indian Health Service</i>                 |
| <i>Missed appointments</i>                                | <i>Emergency Room use</i>                                    |
| <i>Illiteracy and low level of educational attainment</i> | <i>Continuity of care and fragmentation of care</i>          |
| <i>Health literacy issues</i>                             |  |

These, as well as the supporting data, are outlined in detail in the attached, full version of the completed Community Health Needs Assessment.

While the concept of a community health center or FQHC exists as an image of a physical clinic building housing a continuum of coordinated health care and support services, the assessment results remind our community that a robust health care delivery infrastructure is generally in place, with some capacity issues remaining for dental and mental health services. None of which dictates a necessary solution of another building.

Planning team members concede that the ultimate “dream” would be a new, all encompassing clinic—but recognize the reality that, not only is it not financially feasible or sustainable at this time, there is little evidence that it would address the core disparities and access issues raised by the assessment.

Rather, the report points to the fragmentation of current systems and lack of continuity among providers. Additional barriers such as transportation, health literacy, mistrust of the system—challenge us to look at how we, as a community, deliver care, not necessarily how we increase the number of facilities that provide care.

## • The FQHC Landscape

At the time of writing (and receiving) the federal planning grant (fall, 2011), there was every reason to believe that the process would conclude with a plan to prepare a solid proposal for the \$650,000 initial investment for a FQHC New Access Point—if, indeed, it was determined that an FQHC was the right model for the community.

In February of 2012, the landscape of the projected federal funding for Community Health Centers shifted dramatically. The original projected expansion through the Federal Trust Fund was scaled back by \$600 million, or half the regular 2011 appropriation (to \$1.58 billion), after the federal budget compromise reached in March 2011 trimmed government spending.<sup>10</sup> This discretionary trust fund was shifted to back-fill and support existing FQHCs. In 2011, New Access Point awards were scaled back from a projected 300, to only 67.

For 2012, the base level funding was \$1.57 billion; and again, Trust Fund dollars went to support continuation of previously funded FQHCs.

Future funding for FQHCs is subject to the same uncertainty; current projections for 2013 is for only 25 New Access Point grants to be awarded. This information, combined with learning that only existing clinics with proven results are competitive in the New Access Point process—makes it clear that this is not the time to prepare a proposal.

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<sup>10</sup> SHOTS NPR Health Blog, Budget Cuts Deal Setbacks to Community Health Centers, <http://www.npr.org/blogs/health/2011/10/06/141115528/budget-cuts-deal-setbacks-to-community-health-centers>, Accessed August 16, 2012.

In addition to the funding challenges, the Planning Team heard over and over throughout this process, that developing a FQHC is difficult and complicated. Some of the operational and clinical challenges include:

- Third party billing complications
- Technology and significant shifts in Electronic Health Records (EHR) requirements
- Prescribed governance model
- Uncertainty of health care reform and its impact on FQHCs
- Extensive and massive bureaucratic and reporting requirements
- Adequate and complex performance measurement
- Overall financial viability

Furthermore, the complicated design of FQHCs has been expanded recently, adding a number of clinical and bureaucratic requirements that are essentially untried. Community Health Centers that were benchmarked during the planning process reported that they were “grandfathered in” and not mandated to take on these additional requirements, which include the complex “medical home/health care home” requirements—making best practices elusive at best; indicating that more time is definitely needed to determine if FQHCs operating under these new requirements will remain financially viable and achieve the expected patient outcomes.





## Future Actions and Conclusions



Not to be deterred, in the final weeks of the planning, the Planning team focused on those things that could be accomplished with local resources and that could keep the community on the path toward the vision of a community health center in years to come.

The development process can be broken into smaller steps, or phases, that continue momentum and that can make an immediate impact on health outcomes for the target population (these phases are outlined in more detail, later in this report). The challenge is to create an operational delivery model that can be competitive in the grant process and locally sustainable, should federal funding opportunities become available in the future.

Toward the end of the planning process, Northern Dental Access Center was informed of a separate federal grant award that continues patient support services and integrated care that it has had in place since opening in 2009. The grant continuation was considered highly unlikely, and there was every reason to believe that those ‘enabling services’ would have no longer been funded after April 2012. Fortunately, another three years of funding (through 2015) allows Northern Dental to continue those patient support services (insurance counseling, transportation, child supervision, immunizations, well child exams, and more) and expand to include mental health screening and referrals through Beltrami Area Service Collaborative. Because mental health issues are a serious deterrent to successful dental treatment, this has been on Northern Dental Access Center’s radar for some time. *(At the very minimum, these services comprise the baseline requirements for FQHC consideration.)*

Rather than end the planning initiative in August with no hope of creating the dream of a community health center, the enabling and other services currently available at Northern Dental Access Center offer a stepping stone to the larger community health center vision.

With the community assessment affirming that efforts to reduce the fragmentation of care are needed, the partners currently working together within Northern Dental Access Center can look to expansion through a multi-year, phased approach (described below). In addition, the model has the potential to a spin off to a new or expanded nonprofit that provides the foundation for a community clinic in years to come. The community health assessment will boost efforts to secure additional grant funds for service expansions; the unpredictability of those resources will either speed up or slow down the process.

## • Phase One

**Expand on what is working/what is feasible - continue to keep big picture in mind – focus on patient support services and reducing the fragmentation of care**

The **target population** of phase one includes low income children, individual and families who present at Northern Dental Access Center for dental care or other community services available.

**Services:** Northern Dental Access Center provides dental care to the target population, along with a myriad of other services to help patients address barriers to care. These are provided through multiple agency partnerships and include:

- information and referral for community support services
- patient advocacy and treatment plan coordination
- insurance counseling
- primary care referrals
- child and teen exams and immunizations
- patient transportation
- child supervision for dental/advocate appointments
- MAC/food distribution, and more

Additional grant funds allow this to expand for three years, to include a health coordinator on site and expanded patient advocacy to include some billable services:

- Mental Health Screenings for children and adults, along with scoring, care coordination and community mental health referrals in conjunction with Beltrami Area Service Collaborative (this will require active recruiting of patients to consent to screenings, with the ultimate goal of universal screening).
- Complex Case Management to support patients seeking mental health diagnoses and treatment.
- Medical Nutrition Therapy to support patients with co-existing medical conditions that require management in order for dental treatment to be successful (i.e., hypertension, diabetes, heart disease, pregnancy).
- Chemical Dependency Assessments, in conjunction with Beltrami County Health and Human Services.
- Smoking Cessation support.

This unique, comprehensive approach to care comprises Northern Dental Access Center's efforts to pursue its mission of providing a dental home to those in need.

*The American Academy of Pediatric Dentists defines a dental home as “a place where oral health care is managed in a comprehensive, continuously accessible, coordinated and family-centered way.”*

Northern Dental Access Center has been recognized for this innovative approach to care, being named the 2010 Rural Health Team by the Minnesota Department of Health, and receiving two Rural Health awards from the National Association of Counties.

**Resources:** Northern Dental Access Center has received a three year grant to support patient outreach and support activities that can sustain integrated services for three years (May 2012 to April 2015). These resources support involvement from Beltrami Area Service Collaborative (a consortium of mental health providers), Community Resource Connections (a council of area nonprofits), and Beltrami County Public Health.

**Technology:** An integrated and web-based shared information system will be designed and implemented to help consortium partners communicate with each other about the unique needs of a patient or family. With cross-consent forms for patients, the three consortium members, along with staff advocates, community health workers and Beltrami County Public, will pilot a central database, sharing information regarding patient support services. This will help create a seamless delivery of services for the patient, reduce overlaps and redundant paperwork, and increase efficiency and improve the ability of providers to identify unique circumstances that affect care.

With a single patient identifier, dentists can know if a patient is currently under the care of a mental health professional, or that the patient is working with QuitPlan to stop smoking; or our front desk staff can know that transportation assistance is necessary; or if one patient advocate is helping a family who was helped by another before, she can know that a Medicaid application is pending, or a ruling on energy assistance eligibility is due any day...all things that will help us wrap around a patient or family with the support they need to succeed. The web-based system allows for easy, yet secure access among multiple agencies, all of whom work within different software of their own. This system does not require us to share patient charts, rather we will share PATIENT SUPPORT SERVICES.

**Staffing:**

- Part time outreach worker (Beltrami County Public Health)
- Periodic nurses (Beltrami County Public Health)
- Full time service advocate (Community Resource Connections)
- Part time shared care coordinator-mental health screener (Beltrami Area Service Collaborative)
- Patient advocate team (Northern Dental Access Center)
- Part time RN/Health Coordinator (Northern Dental Access Center)
- Dental providers (Northern Dental Access Center)

**Leadership:** Northern Dental Access Center Executive Director and Dental Practice Director

**Governance:**

Northern Dental Access Center Board of Directors; advisory group of Beltrami County Public Health, Community Resource Connections, Beltrami Area Service Collaborative and Northern Dental Access Center and Sanford Health.

## Postscript

During the final months of planning, Northern Dental Access Center staff were concurrently developing an operational plan to augment the agency's recently-completed two year Strategic Plan. The identified expansion of services would now have action steps and accompanying timelines and resource development efforts to sustain them. A number of planned initiatives will further augment Phase One of community health center development.



- Expansion to full time attention to patient advocacy efforts, including cross-training multiple staff members as advocates to assure seamless delivery to patients. A patient advocacy team meets monthly to assess and improve advocacy efforts.
- An Emergency Room Diversion initiative is in development stage, which incorporates a partnership with Sanford Health's Emergency Room and Walk-In Clinic staff and physicians with the objective of reducing the inappropriate and costly use of the ER for dental issues.
- Maternal Child Health efforts are under expansion to promote oral health care for children 0-3 and pregnant women, as a means of intervening in the cycle of oral pain, disease and neglect. This will connect patients to other support services, coming full circle to well child exams, immunizations, food support referrals and more.
- Oral cancer screening efforts are ramping up to include all new patients. Working with Sanford Health's Cancer Committee, Northern Dental Access Center can aid in early detection and care referral that will save lives. Tobacco cessation and education are currently being expanded to assist patients who want them. 60% of Northern Dental Access Center patients self-report that they use tobacco, 40% of whom wish to quit...this amounts to almost 3,000 people at risk who can be reached.
- Expansion of patient advocacy efforts to the Community Health Worker model is underway, working with educators to identify training methods to gain staff certification so that patient advocacy efforts can be billable, thereby sustainable over the long term.
- Performance measurement has become a focus, led by a performance management team who are entrusted with data gathering and analysis of over 50 data points so far. Results show that more than inputs and outputs can now be measured, and the clinic is poised to demonstrate true patient outcomes and community impact.
- Quality assurance and quality improvement methods have transcended basic standard operating procedures and risk management systems to pursue full accreditation. While it will take significant time and energy, pursuit of accreditation will assure the clinic is prepared to take on significant federal involvement, if necessary; the added benefit will be building even greater community trust and confidence.
- Northern Dental Access Center's Board of Directors is creating a facility/building subcommittee to prepare a specific plan and timelines that will address the current space limitations. The exploration of options will undoubtedly include discussions of expansion of health care services under one roof.



Once fully implemented, this array of services, in conjunction with the dental care, can provide a basis to measure impact and demonstrate smaller-scale results for use in future development proposals, including FQHC.

## • Future phases...

Looking into the future beyond phase one has disadvantages because internal and external forces change so rapidly and dramatically in this environment, especially considering the political motivations by policy makers. That being said, the Planning Team identified the most logical path to a community health center in the following, future phases:

### Phase Two

It is here that the activities a unique, community health center identity may need to be created

**Target Population:** Same as Phase One, with the inclusion of clients of residential and shelter programs that serve vulnerable people in the community: Northwoods Coalition for Family Safety, Ours To Serve House of Hospitality, Servants of Shelter, Evergreen Community Services, and others.

#### Services:

- All noted in Phase One
- Outreach efforts to additional target population. Could include bringing advocates to shelters for consultations and referrals, transportation to appointments, child supervision during appointments, and such.
- Basic screening services related to oral health may be conducted, for early identification and referral for: oral cancer, HIV/HPV, smoking cessation, unmanaged diabetes, unmanaged hypertension, medication therapy management.
- Mental health screenings will expand to include the screening of adults of all ages. The Patient Health Questionnaire (PHQ-9) will be available, a powerful tool for assisting in diagnosing depression. The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).
- Coordination with Sanford Health social workers, medical home staff, emergency room and walk in staff to support patients in navigating primary care needs.
- Replicate aspects of Northwoods Coalition for Family Safety model of wellness services to provide: fitness center access, recreational activities, etc.

**Rationale:** further expansion of care coordination needs to be contained to a manageable target population size. The clients of the noted agencies, and others, represent many of the most vulnerable people in our community.

**Resources:** In addition to resources available in Phase One, additional investment into personnel will be required to support patient advocacy and care coordination efforts.

The grant resources noted in Phase one include funding for a Community Health Worker in year three (2014-2015); funds for nurse or other health professional to oversee will be necessary. Facility challenges remain for any added personnel.

**Technology:** Same

**Staffing:**

Same as above, plus:

Full time Community Health Worker(s)

Full time Nurse/Nurse Practitioner

**Governance:**

Unchanged



### Phase Three

**Target Population:** Same as Phase One and Two, with the addition of a focused maternal and child health program that targets pregnant women and infants and children in the target population.

**Services:**

- All noted in Phase One and Two
- FAS screening and referral?
- Partnerships with providers to support prenatal care services and help women navigate through them
- Car seat giveaways/checks
- Literacy and reading program connections
- Early childhood learning program access, help with child care support, headstart enrollment, WIC enrollment, parenting classes and more
- Identification of midwives or other supportive options for women

**Rationale:** the next layer of most vulnerable people in the target population are pregnant women and small children. It is here that we have the greatest chance for prevention and early identification of health issues that will impact a lifetime.

**Resources:** In addition to resources available in Phase One and Two, grant funds will be required to develop and staff a maternal/child health initiative, and will require partnerships from area agencies who share interest in this target population.

**Technology:** Same

**Staffing:**

Same as above two phases, plus:

Full time maternal/child health coordinator

Additional patient advocate

**Governance:**

Unchanged

## Phase Four

### Here is where a facility/central access point will be necessary

**Target Population:** All low income children, individuals, and families in the service area.

#### Services:

- All noted in Phase One, Two & Three (except that dental care will be reduced to screening and basic preventive...perhaps some simple restorative through mid-level provider, with full referral to Northern Dental Access Center)
- Basic primary care screening services through NP or PA, (physician would be nice)
- Mental health practitioner(s) on site
- Direct access to Sanford Health practitioners, as needed
- All services available on sliding fee schedule

**Rationale:** the next layer of most vulnerable people in the target population are pregnant women and small children. It is here that we have the greatest chance for prevention and early identification of health issues that will impact a lifetime.

**Resources:** funds will be necessary for a building, medical staff, mental health staff and related equipment, furnishings, supplies and technology needs.

**Technology:** integrated charting and billing system will be required.

#### Staffing:

Full time Medical Services Director (not necessarily an M.D., but would be nice)

Full time nurse (perhaps under contract)

Full time nurse practitioner or physician assistant (perhaps under contract)

Mental health provider(s) (perhaps under contract)

Community Health Workers

Front desk staff/patient schedulers

Billing/coding specialist

Outreach workers

Technology support

Administrative and finance personnel

Fund development or executive director

Dental hygienist or advanced dental therapist

Dental assistants

Service advocates (information and referral, insurance counseling, patient navigation)

Policy, compliance and infrastructure developer/manager

#### Governance:

Unchanged



## Phase Five

Further expansion of all the above, as manageable and responsive to what has been proven to be most effective for patient outcomes.

Integration into single, formal entity for nonprofit application to the IRS.



## Phase Six

Application for FQHC Look-Alike Status



## Phase Seven

Application for full FQHC Status



## • Conclusion

The work ahead will require service providers, who have an interest in the target population, to put their heads together to determine what CAN be done with existing resources, to address the needs outlined in the assessment.

The work, discussion, education, and dreaming of the planning and assessment teams has been and is extremely important; it provides evidence of the community's long term commitment to improving the health of its citizens. Without this, it is unlikely that any future grant proposals to support the dream could be successful.

The journey to create something this substantial is long and arduous, but will be highly rewarding when our community health outcomes improve.

*This report does not constitute the end of the process,  
rather the beginning,  
a roadmap  
for reaching the vision  
of a  
Community Health Center.*



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1405 Anne Street NW  
 Bemidji, MN 56601  
 218.444.9646  
[www.northerndentalaccess.org](http://www.northerndentalaccess.org)

**GRANT SUPPORT AND ASSISTANCE:**

Minnesota Association of Community Health Centers  
 Minnesota Department of Health  
 Minnesota Department of Human Services  
 National Association of Community Health Centers  
 US Department of Health and Human Services

# Planning Team Partners

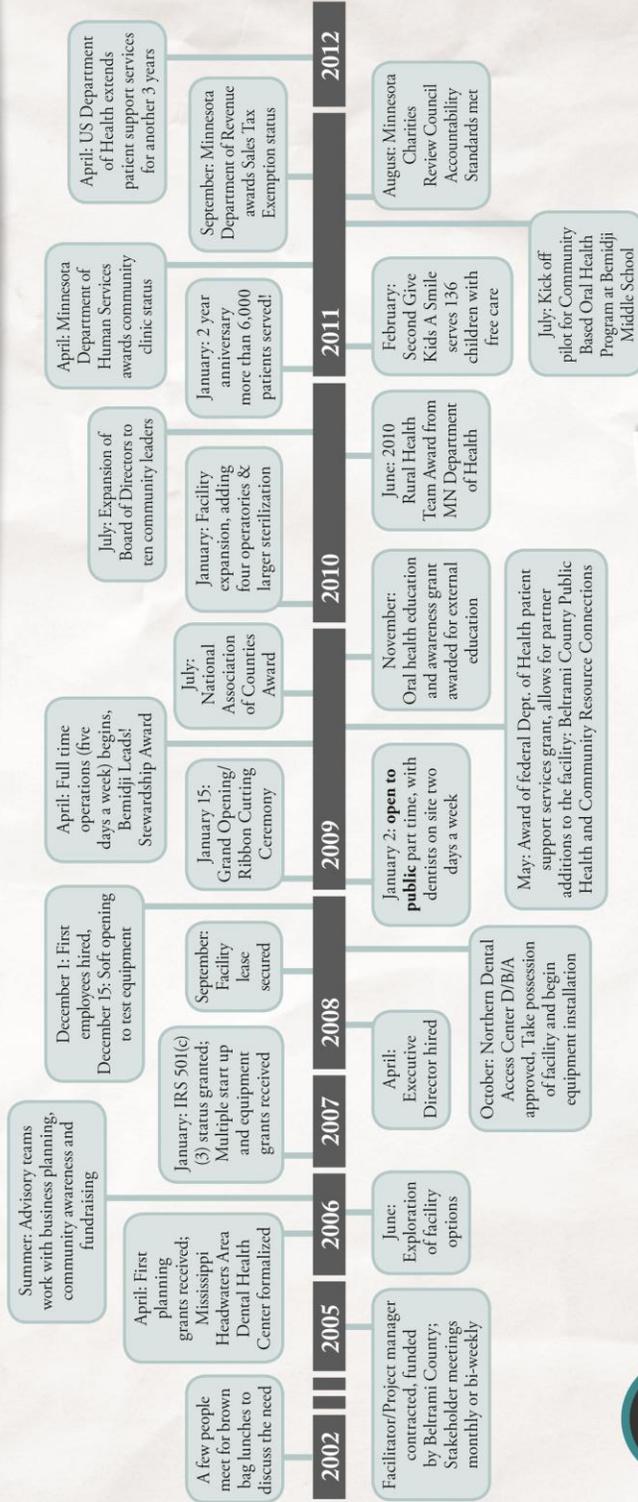
Project Coordinator/Facilitator	Ashli Bowen
North Homes Children and Family Services	Amy Lindahl
Beltrami Area Service Collaborative	Becky Secore
Community Member	Bob Verchota
Peoples Church	Carol Kelly
Bemidji State University, Nursing Dept.	Carolyn Townsend
Northern Dental Access Center	Colleen Falk
Community Member	Craig Kinsella
Beltrami County Health and Human Services	Diane Boben
Bemidji State University, Psychology Dept.	Dr. Dwight Fultz
JMD Psychiatric Nursing Services, PA	Jan Dickson
Minnesota Dept of Health, Health Care Homes	Jean Larson
Northern Dental Access Center	Jeanne Edevold Larson
Bemidji State University, Physical Education, Health and Sport Dept.	Dr. Jim White
Northwest Minnesota Area Health Education Center	Joan Tronson
Minnesota Association Community Health Centers	Laura Lipken
Upper Mississippi Mental Health Center	Lenore Barsness and Deb Miller
Beltrami County Health and Human Services	Linda Yourczek
Beltrami County Health and Human Services	Lindsay Linde
Cardinal of Minnesota	Marshall Goughnour
Community Member	Rose Fogerstrom
Community Resource Connections	Ruth Sherman
Community Member	Susan Dobbelstein
Community Member	Tam Mahaffey
Community Member	Torry Swedberg
Sanford Health	Warren Larson
Community Member	Wendy Potratz



# APPENDIX



# Northern Dental Access Center *Timeline*



...providing access to a dental home for those in need

A nonprofit agency operated by  
Mississippi Headwaters Area Dental Health Center

[www.northerndentalaccess.org](http://www.northerndentalaccess.org)





# 2012

## Community Health Needs Assessment

### Beltrami County, MN

Mississippi Headwaters Area Dental Health Center  
BPHC Community Health Center Planning Grant  
HRSA 11-021

# Introduction

The area in and around Beltrami County, Minnesota has been noted as lacking in adequate community health center care for low-income populations. To determine whether the pursuit of such a project makes sense for the region, it is necessary to assess the current health condition of the target population, along with existing health care services.

The purpose of this community health needs assessment is to accurately portray the current health situation and to inform the possible design of a health center project that meets the identified needs. This assessment reflects the process and format recommended by the U.S. Department of Health, Health Resources and Services Administration (HRSA), which would be the primary administrator of any funding resources available for a community health center. HRSA provided funding for this assessment through a one-time grant to support community health center planning.

The findings presented in this document will comprise the needs assessment section for any future grant proposals to support a community health center concept.

# Methodology

An independent consultant with professional experience in community assessment was identified to oversee the assessment process. Involvement and input from the community was a key goal in the assessment plan. A well-attended community forum officially launched the process. A community health needs assessment advisory team was established through a publicized call for volunteers and by direct recruitment to ensure broad representation within the group. This 30-member team provided ongoing guidance, insight and support in creating and carrying out the assessment plan. Key informants were identified by the assessment team and over 140 individuals were interviewed. Input from those interviews was recorded and analyzed. A health needs and barriers survey was created and tested with the target population. Over 300 surveys were completed and responses were analyzed along with qualitative data (input) gained through target population interviews. A literature review was conducted and relevant data was gathered from reliable sources following guidelines established by HRSA.

# Acknowledgements

This document was made possible through the efforts of many contributors. Funding was provided by the U.S. Department of Health, Health Resources and Services Administration (HRSA) with Northern Dental Access Center serving as the lead agency and fiscal agent. Special thanks to the **Community Health Needs Assessment Team**, who provided project guidance, excellent insight, and their valuable time and energy; the **key informants** who were interviewed and generously offered their expertise; the **organizations and agencies** who were involved in the survey process; and finally, the **target population members** who shared their personal experiences and perspectives.

# Community Health Needs Assessment

## I. Service Area

The focus of this community health needs assessment is Beltrami County in rural, northwestern Minnesota. Located 100 miles south of the Canadian border and about four hours northwest of Minneapolis/St. Paul, Beltrami County is noted for its remote location, abundantly beautiful natural resources and harsh winters. More than 275 lakes and extensive wetlands dot the county map and several streams and rivers meander through, including the Mississippi River. Much of the county's land is forested. Along the 2,000 miles of roads and highways, Beltrami County's topography varies, with rolling hills in the southern townships gradually giving way to flatter, low-lying areas in the north. Northwest Minnesota is subject to extreme weather conditions with long, frigid winters where air temperatures and wind chill drop well below zero, sometimes causing school closings as a precaution. Average annual snowfall is 37 inches, with snowstorms making travel treacherous at times, especially for those who live in outlying, remote areas. In the summer, temperatures hover around the high 70s, but can hit the 90s.<sup>11</sup>

Beyond the challenging climate and notable natural beauty of the area lies another distinct characteristic of Beltrami County—a persistent, high concentration of poverty. Year after year, the county consistently ranks as the 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> poorest in the state. In 2010, the poverty rate was 20.8%<sup>12</sup> and the low income rate was 39.1%.<sup>13</sup> Beltrami County's median

### Placing Focus on Beltrami County

The community partners who submitted the HRSA planning grant to fund this assessment decided to focus on Beltrami County as the service area, as this is where most of the potential patients of a Community Health Center project would reside.

In this remote, sparsely populated region, a Community Health Center service area could *eventually* include a massive 75 to 100-mile radius around the Beltrami County's largest community, Bemidji, crossing into several counties. In general, surrounding counties have similar demographics to Beltrami County.

<sup>11</sup> National Climatic Data Center, NOAA Satellite and Information Service

<sup>12</sup> U.S. Census Bureau, 2010 Small Area Income and Poverty Estimates, <http://www.census.gov/hhes/www/saie.html>

<sup>13</sup> UDS Mapper, 2010, <http://www.udsmapper.org>

household income of \$43,394 is 24% lower than that of the state of Minnesota (\$57,243).<sup>14</sup> In 2011, the annual average unemployment rate for the county was 8%, while the rate for Minnesota was 6.4%.<sup>15</sup>



Minnesota’s fourth largest county, Beltrami County covers 2,500 square miles and shares a border with eight other Minnesota counties. Some of those counties also share similar poverty demographics and all face challenges due to their remote location. Red Lake Indian Reservation is located almost entirely within Beltrami County, while a small portion of Leech Lake Indian Reservation extends into the southeast portion of the county.

According to the 2010 U.S. Census, the county’s population is 44,442, an increase of 12.1% when compared to the 2000 Census data, outpacing the 7.6% increase in Minnesota’s population. During that same period, the racial and age distribution of the population remained stable. Note that Hispanics account for 1.5% of the county population and in the table below are included in the White population. When compared to the state’s racial distribution, Beltrami County is actually more diverse, with American Indians making up over 1/5 of the population.

**Table 1: Racial Distribution of Population**

	Beltrami County %	Beltrami County #	Minnesota %
White	75.1%	33,359	85.3%
American Indian	20.3%	9,004	1.1%
Asian	0.7%	309	4.0%
Black or African American	0.6%	262	5.2%
Native Hawaiian or other Pacific Islander	0%	18	0%
Two or More Races	3.1%	1,377	2.4%

Source: U.S. Census Bureau, 2010

<sup>14</sup> U.S. Census Bureau, 2010

<sup>15</sup> Bureau of Labor Statistics, Local Area Unemployment Statistics, December 2010–January 2012 (not seasonally adjusted)

**Table 2: Age Distribution**

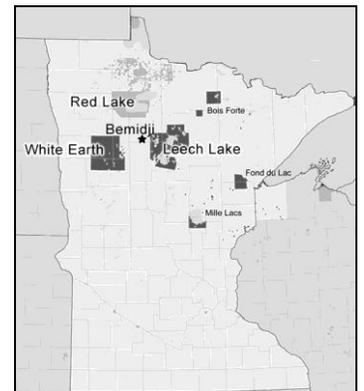
	Beltrami County %	Beltrami County #	Minnesota
Persons Under 5 years	7.6%	3,378	6.7%
Persons Under 18 years	17.4%	7,733	24.2%
Persons 18–64 years	62.1%	27,598	56.2%
Persons 65 years and over	12.9%	5,733	12.9%

*Source: U.S. Census Bureau, 2010.*

Beltrami County is sparsely populated with 17.7 people per square mile, while the state of Minnesota averages 66.6 per square mile.<sup>16</sup> A significant concentration of the population lies within a 10 to 15-mile radius of the city of Bemidji, located in the southern part of the county. Bemidji serves as the Beltrami County Seat and a regional center for health care, retail, education, finance and employment. Within Bemidji’s city limits the population is only 13,431,<sup>17</sup> but retailers such as Walmart, Target and Home Depot draw in consumers from an area with a population over 40,000.<sup>18</sup> Bemidji Public School District enrolls more than 5,100 students drawn from a district area that is almost the geographical size of Rhode Island. Northwest Technical College, Bemidji State University and Oak Hills Christian College are also located in Bemidji.

Seven other incorporated “cities” lie within Beltrami County, but would be more fittingly referred to as small towns or villages. Blackduck (population 785) and Kelliher (population 262)<sup>19</sup> each have their respective K-12 public school systems enrolling students from a larger, sparsely populated area, a small main street district, a modest grocery store, and limited employment options. Funkley, Solway, Tenstrike, Turtle River and Wilton each consist of not much more than a cluster of homes, a church, a convenience store and one or two small businesses.

Red Lake Indian Reservation’s population is 5,896, which accounts for just under 2/3 of Beltrami County’s American Indian population.<sup>20</sup> Its southern border lies 25 miles north of Bemidji. The Red Lake Nation is unique in that it is a “closed” reservation, where land is held in common by



<sup>16</sup> U.S. Census Bureau, 2010

<sup>17</sup> Ibid

<sup>18</sup> Greater Bemidji Joint Economic Development Commission at <http://www.bemidjiusa.com/index.htm>

<sup>19</sup> U.S. Census Bureau, 2010

<sup>20</sup> Ibid

Band members. Red Lake's people strive to honor their Anishinaabe traditions, culture and language and maintain their sovereignty. Communities on the Reservation include Red Lake and Redby, both located on the south shore of Lower Red Lake; Little Rock; and Ponemah, a community tucked between Lower and Upper Red Lake more than an hour's drive from Bemidji (when road and weather conditions are good). The Reservation's education options include a K-12 public school system and Red Lake Nation Tribal College. An Indian Health Service hospital/clinic and tribal health services are also found there. Employment options are quite limited, as is access to retail goods including groceries. The Reservation population must travel to Bemidji for their county service needs. They are governed by an elected Tribal Government and currently represented on the Beltrami County Board of Commissioners by an enrolled Red Lake tribal member.

### **Federal Designations**

Beltrami County holds several designations related to health care access issues, including: 1) Medically Underserved Area; 2) Mental Health Care Health Professional Shortage Area (HPSA); 3) Dental Health HPSA; 4) Primary Care HPSA (for northern and eastern portions of Beltrami County).<sup>21</sup>

There are no Federally Qualified Health Centers in Beltrami County. Less than 1% of the county's low-income population is served by an existing FQHC, the nearest of which is Scenic Rivers Health Services in Itasca County.<sup>22</sup> Within the Scenic Rivers system, the closest access point is located in the small town of Northome, Minnesota, more than 40 miles northeast of Bemidji (50 minutes when roads conditions are good). Services there are limited to medical only. Dental and behavioral health services through Scenic Rivers are located even farther away in Floodwood or Bigfork, Minnesota, about 75 miles from Bemidji. Beyond the barriers presented by these long distances, Beltrami County residents very rarely travel in the direction of Scenic Rivers access points. Rather, they converge at the regional center of Bemidji to access retail, employment, health care, education and government services.

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<sup>21</sup> HRSA, Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations, <http://bhpr.hrsa.gov/shortage/>

<sup>22</sup> UDS Mapper, <http://www.udsmapper.org>. Accessed Dec.27, 2011

## II. Target Population

This snapshot of need is focused on the low-income population living in the service area. Estimates show that more than 17,300 residents of Beltrami County are low income (below 200% poverty)<sup>23</sup> and over 8,300 residents live below the poverty level (below 100% poverty).<sup>24</sup>

In 2009, the uninsured rate for Beltrami County citizens under age 65 was 14.4% and the rate for Minnesota was 10.2%. Among low-income Beltrami County residents under age 65, the uninsured rate was 17.3%. Over 1/5 of the county's uninsured, low-income population was under age 19.<sup>25</sup>

One phenomenon unaccounted for in uninsured data is the large number of *underinsured*, particularly in remote geographical areas like Beltrami County. A study funded by the federal Office of Rural Health Policy found that “individuals living in rural counties not adjacent to an urban area are almost twice as likely as urban residents to be underinsured.”<sup>26</sup> Throughout this assessment process, both members of the target population and key informants who work with this population repeatedly expressed concern about high insurance deductibles, high co-pays, and health insurance with very limited coverage. As a result of having such costly and limited plans, underinsured households report making tough decisions about when to access care based the burden it will place on their already stretched budget. Referencing the underinsured, low-income population, one stakeholder noted, “Is health care really accessible if they can't pay for it?”

**Medical Assistance (MA)** is Minnesota's expanded Medicaid program for children and adults in poverty. **MinnesotaCare** is a publicly subsidized program for Minnesota residents who do not have access to affordable health care coverage and meet low-income guidelines and asset limits. Enrollees pay a monthly fee (with a few exceptions) based on a sliding fee determined by family size and income. A household is not eligible if their current employer offers health insurance and pays half or more of the monthly cost of insurance. **General Assistance Medical Care** ended in February 2011 and enrollees (single adults without children)

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<sup>23</sup> U.S. Census, American Community Survey 2006–2010, “Poverty Status in the Past 12 Months” (Table S1701)

<sup>24</sup> U.S. Census Bureau, American Community Survey 2006–2010 “Selected Characteristics of People in Poverty” (Table S1703)

<sup>25</sup> U.S. Census Bureau, Small Area Health Insurance Estimates for Counties and States, 2009  
<http://www.census.gov/did/www/sahie/data/2009/tables.html>. Released Oct. 2011

<sup>26</sup> University of Southern Maine, Muskie School of Public Service, “Rural Residents More Likely to Be Underinsured,” 2006

were automatically moved to Medical Assistance (MA), Minnesota’s Medicaid program. Please see Table 3 for enrollment data.

**Table 3: Public Insurance Enrollment**

	<b>Beltrami County</b>
Medical Assistance or MA	12,482
MinnesotaCare	2,500
General Assistance Medical Care	1,286
Medicare	7,278

*Source: MN Department of Human Services, Reports and Forecasts Division. “Medical Assistance, General Assistance and Minnesota Care Eligible Persons in Calendar Year 2010.” May 26, 2011. <http://www.dhs.state.mn.us>*

*Source: Center for Medicare and Medicaid Services, “Medicare Aged and Disabled by State and County,” July 2010. <https://www.cms.gov/MedicareEnrpts/>*

### Poverty/Low-Income Status and Race

The preponderance of poverty and low-income status is homogeneous in the region, affecting both the Caucasian and American Indian populations. This is evident in the data displayed in Tables 4 and 5.

**Table 4: Racial Distribution of Population in Poverty (Below 100%)**

	<b>Beltrami County</b>		<b>Minnesota</b>
	<b>Racial Distribution of Population in Poverty</b>	<b># in Poverty</b>	<b>Racial Distribution of Population in Poverty</b>
<b>White</b>	<b>45%</b>	<b>3,739</b>	<b>67%</b>
<b>American Indian</b>	<b>48%</b>	<b>3,985</b>	<b>4%</b>
<b>Two or More Races</b>	<b>5%</b>	<b>487</b>	<b>5%</b>
<b>Asian</b>	<b>1%</b>	<b>84</b>	<b>6%</b>
<b>Black or African American</b>	<b>&lt;1%</b>	<b>69</b>	<b>16%</b>
<b>Other</b>	<b>&lt;1%</b>	<b>19</b>	<b>3%</b>
<b>Native Hawaiian or Pac. Isl.</b>	<b>0%</b>	<b>0</b>	<b>&lt;1%</b>

*Source: U.S. Census Bureau, American Community Survey, “Selected Characteristics of People at Specified Levels of Poverty,” 2006–2010. Note: Population for whom poverty status was determined for Beltrami County was 42,043.*

**Note:** Hispanic/Latino is included in “White” data in the table above.

- In Beltrami County, White/Hispanics account for 1.7% of the population in poverty.
- In Minnesota, White/Hispanics account for 10% of the population in poverty.

**Table 5: Racial Distribution of Low-Income Population (Below 200% Poverty)**

	Beltrami County	
	Racial Distribution of Low-Income Population	# Low Income
<b>White</b>	<b>57%</b>	<b>9,903</b>
<b>American Indian</b>	<b>34%</b>	<b>5,843</b>
<b>Two or More Races</b>	<b>6%</b>	<b>951</b>
<b>Asian</b>	<b>2%</b>	<b>187</b>

*Source: U.S. Census Bureau, American Community Survey, “Selected Characteristics of People at Specified Levels of Poverty,” 2006–2010. Note: Population for whom poverty status was determined for Beltrami County was 42,043.*

**Note:** Hispanic/Latino is included in “White” data in the table above.

As noted, both the Caucasians and American Indians are represented within the poor and low-income populations of Beltrami County. However, the high incidence of poverty within the American Indian population is striking. Consider that:

- **50%** of American Indians in Beltrami County live below the poverty line, while only **12%** of Caucasians (Whites) in the county live below the poverty line.<sup>27</sup>
- Only **26%** of American Indians in Beltrami County are above 200% poverty (not in poverty or low income), while **68%** of Caucasians (Whites) in the county are above 200% poverty.<sup>28</sup>

### III. Health Determinants

“The context of people’s lives determines their health,” states the World Health Organization.<sup>29</sup>

Biological, social, economic, and environmental factors—and their interrelationships— influence the ability of individuals and communities to make progress on health outcomes.<sup>30</sup> In the following section, health determinants that impact the service area’s target population are explored.

<sup>27</sup> US Census Bureau, American Community Survey 2006–2010

<sup>28</sup> US Census Bureau, American Community Survey, “Selected Characteristics of People at Specified Levels of Poverty,” 2006–2010. Special data request. Received April 6, 2012

<sup>29</sup> World Health Organization, “Health Impact Assessment: The determinants of health,” <http://www.who.int/hia/evidence/doh/en/> Accessed Nov. 22, 2011

<sup>30</sup> <http://www.healthypeople.gov/2020/about> Accessed April 17, 2012

## **Poverty and lack of education**

As noted, Beltrami County has a high concentration of poverty, a factor inextricably linked to poorer health. Daily struggles for those in poverty are many-layered and the personal resources available to address those struggles are limited. As a result, target population members develop a keen focus on the present as a means to survive the challenges that life presents.

The impact of poverty begins at a young age. Nearly one in three Beltrami County children under age 5 live in poverty and 28% of those under 18 are living in poverty.<sup>31</sup> 60.5% of Beltrami County children and teens are enrolled in the Free and Reduced Lunch program. This is the third highest rate in the state. When children live in poverty, their education is in jeopardy; without a solid education their prospects for climbing out of poverty diminish.

- Four-year graduation rate: Beltrami County's is the lowest in the state at 58.4%.
- Student Mobility: Beltrami County ranks 4<sup>th</sup> among Minnesota counties for the rate at which students transfer from school to school during the academic year. This greatly impacts learning and development.
- Special Education rate: 16.3% of Beltrami County's students are enrolled in Special Education in Beltrami County. Out of Minnesota's 87 counties, Beltrami has the 15<sup>th</sup> highest Special Education rate.<sup>32</sup>
- Educational attainment: On average, people in poverty have a much lower level of educational attainment than the general population. This affects whether one can climb out of poverty, and, in turn, affects health and health care access in multiple ways. Sixty-one percent of those in poverty in Beltrami County either do not have a high school diploma or their education ended when they received a high school diploma (or equivalent).<sup>33</sup>

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<sup>31</sup> U.S. Census Bureau, American Community Survey 2006–2010

<sup>32</sup> Minnesota Department of Education, 2010

<sup>33</sup> US Census Bureau, American Community Survey 2006–2010

## **Employment and housing**

As noted, poverty is linked to poor health status. Climbing *out* of poverty is far from easy in this region. Economic challenges include a lack of living wage jobs and a shortage of affordable housing.

The top industries for employment in Beltrami County are Education and Health Services (32% of jobs); Trade, Transportation and Utilities (22%); Leisure and Hospitality (11%); Public Administration (9.5%); Construction (6.4%); and Manufacturing (5.7%).<sup>34</sup> The logging industry played a significant role in the settlement of the area, but since then, its role has diminished. The area suffered the loss of 150 jobs in 2009 when a wood products manufacturer closed its doors. Although Bemidji is considered a region of economic growth, the rewards of that growth are not seen by all. In particular, the availability of living wage jobs for less skilled workers is quite limited. A recent study of wages and cost of living in the Headwaters Region (which includes Beltrami and four neighboring counties) calculated that “the annual cost of basic needs for a single person with one child is \$31,500—more than twice the federal poverty guideline. To cover these costs, a person must earn \$15.14 per hour.” In the Headwaters Region, 61% of jobs pay less than that. In fact, 29% of jobs pay less than \$9.95 per hour.<sup>35</sup> In calculating the cost of “basic needs,” the study makes no allowance for items such as education or training beyond high school; debt payments; life insurance; retirement and other savings; down payments for a home mortgage; vacations, pets, movies, gifts, and restaurant meals; or big ticket items such as washers, dryers or refrigerators.

For those without living wage jobs, finding affordable housing is also a challenge. Of the county’s households who rent, 42% spent more than 30% of their income on housing, and are technically considered “housing burdened.” Twenty percent of households who rent spend more than 50% of their income on housing, and are considered “extremely housing burdened.”<sup>36</sup> Local housing assistance providers report a high rate of substandard housing and difficulty in finding units that will pass inspection for participation in rental subsidy programs. The Housing

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<sup>34</sup> MN Department of Employment and Economic Development, *Quarterly Census of Employment and Wages*, 2010, [http://www.positivelyminnesota.com/Data\\_Publications/Data/All\\_Data\\_Tools/Quarterly\\_Census\\_of\\_Employment\\_Wages\\_QCEW\)\\_2.aspx](http://www.positivelyminnesota.com/Data_Publications/Data/All_Data_Tools/Quarterly_Census_of_Employment_Wages_QCEW)_2.aspx).

<sup>35</sup> Jobs Now Coalition, “Key Region 2 Findings and Analysis,” March 2010

<sup>36</sup> Minnesota Housing Partnership, “Housing Affordability in Beltrami County 2011”

and Redevelopment Authority of Bemidji (HRA) reports an approximate 9-month wait for Section 8 rental assistance housing.

Wilder Research of St. Paul has documented that northwest Minnesota has a high rate of “doubling up” or “couch hopping,” where people are taken in by friends or family when they cannot afford their own permanent housing. Conditions for those who are doubled up are often unstable, more likely to be sub-standard, overcrowded, lacking in privacy, and ripe for spreading communicable disease.<sup>37</sup>

Homelessness is more prevalent than one might imagine in this remote, rural area. During the annual Northwest Minnesota Point in Time Homeless Count, 301 adults and children were identified as homeless on the night of January 25, 2012.<sup>38</sup> This figure does not include those who were doubled up. The limited inventory of available Emergency Shelter includes a 10-bed youth shelter and two Emergency Shelters (one on Red Lake Reservation for families and individuals and the other in Bemidji for families only) with a total of only 44 beds. A seasonal emergency shelter program operating at various churches on a rotating basis provides beds for up to 20 individuals during frigid winter months. Every year, hundreds of homeless households are turned away from Emergency Shelters in Beltrami County due to capacity issues. In 2011, Bemidji’s shelter reported turning away families that included 717 children (unduplicated count).

### **Family composition and births to teenage mothers**

According to the Robert Wood Johnson Foundation, single parent homes are “susceptible to chronic stress due to economic factors, social isolation and stigma.” More than half (57%) of the children born in Beltrami County are born to unmarried mothers, and for nearly 1/5 of those births no father is listed on the birth certificate. In Minnesota, single people are almost twice as likely to be uninsured.<sup>39</sup>

An alarming 15% of all births in Beltrami County are to teen mothers (ages 15–19), the second highest rate for Minnesota counties. Beltrami County’s rate of births to teen mothers per 1,000 is *triple* the statewide rate.<sup>40</sup> Given the extreme financial and emotional pressures of

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<sup>37</sup> Northwest Minnesota Continuum of Care, “Heading Home Northwest Minnesota,” November 2008.

<sup>38</sup> Northwest Minnesota Continuum of Care, Point in Time Summary for MN-506, January 25, 2012.

<sup>39</sup> Minnesota Department of Health, “Health Insurance Coverage in Minnesota,” January 2011

<sup>40</sup> Minnesota Department of Health, MN County Health Tables 2010

parenting, these young mothers struggle to complete their basic education. Over 15% of all county births in 2010 were to mothers with a low Maternal Education Status,<sup>41</sup> a statistically noted setback to the health and development of children.

### **Nutrition**

Throughout the assessment process, community members expressed concern about the area's high rate of obesity (28.9% for adults<sup>42</sup>) brought on by a lack of physical activity and poor nutrition. For some households, financial stressors put healthy foods out of reach. For others living in remote areas of the county, getting access to groceries that include healthy options requires money for transportation. Only 44% of the Beltrami County population has easy access to healthy foods.<sup>43</sup> A frozen pizza at the nearby convenience store might be the answer. Meanwhile, the demand on local food shelves is ever-increasing as household incomes are stretched in the current economic downturn. Not surprisingly, Bemidji School's District Health Nurse reported that children return to school hungry after the weekend.

### **Mental health**

People in poverty are often managing daily crises brought about directly or indirectly by their socio-economic status and lack of power in the larger community. A profound shortage of resources creates high levels of stress that can lead to depression, anxiety, a cycle of poor health behaviors, violence, and substance use.

- Beltrami County consistently has one of the highest rates of suicide in the state.
- MN Department of Health youth survey results for Beltrami County:<sup>44</sup>
  - 28% of ninth grade girls and 17% of ninth grade boys reported that in the last 30 days they are often unhappy, depressed or tearful (Minnesota rates=22% and 14%)

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<sup>41</sup> Minnesota Department of Health, MN County Health Tables 2010. Note: Definition of Maternal Education Status takes into account the age of mother as a variable

<sup>42</sup> CDC National Diabetes Surveillance System, 2008

<sup>43</sup> University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, County Health Rankings 2011, [www.countyhealthrankings.org](http://www.countyhealthrankings.org)

<sup>44</sup> Minnesota Department of Health, "Minnesota Student Survey: Beltrami County," 2010

- 21% of ninth grade girls and 12% of ninth grade boys reported feeling so discouraged or hopeless that they wondered if anything was worthwhile extremely often or quite a bit in the last 30 days (Minnesota rates=16% and 11%)
- 41% of ninth grade girls and 17% of ninth grade boys reported thinking about killing themselves (Minnesota rates=29% and 18%)
- 18% of ninth grade girls and 8% of ninth grade boys reported having tried to kill themselves (Minnesota rates=8% and 5%)

## **Substance use**

### **Smoking in Beltrami County:**

- **17%** are current smokers.<sup>45</sup> This rate is likely far higher for the target population, as smoking is more prevalent for those in poverty.
- **61%** of Northern Dental Access patients (target population) report that they are smokers.<sup>46</sup>
- **30.6%** of women smoked during pregnancy (4<sup>th</sup> highest rate in the state)<sup>47</sup>

### **Alcohol use:**

- Acute Drinking: **20.2%** of the county population over age 18 consumed five or more drinks on an occasion, one or more times in the last month.<sup>48</sup>
- Youth Survey: **17%** of Beltrami County ninth graders reported that alcohol use by a family member has *repeatedly caused* family, health, job or legal problems.<sup>49</sup>
- Medical and behavioral health professionals express concern over the high incidence of Fetal Alcohol Syndrome in the service area.

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<sup>45</sup> Minnesota Department of Health, MN County Health Tables 2010 (MDH synthetic estimate of 2009 BRFSS data by age and gender)

<sup>46</sup> Northern Dental Access Center Survey

<sup>47</sup> Ibid

<sup>48</sup> Ibid

<sup>49</sup> Minnesota Department of Health, "Minnesota Student Survey: Beltrami County," 2010

### **Illegal Substance Use:**

- Recent drug users (within the past month): 3,293 Beltrami County residents<sup>50</sup>
- Youth Survey: **13%** of Beltrami County ninth graders reported that drug use by a family member has *repeatedly caused* family, health, job or legal problems.<sup>51</sup>
- Medical and behavioral health professionals express concern over prescription drug abuse in the service area. Both Red Lake and White Earth Reservations have declared public health emergencies with respect to abuse of prescription medication.

Noting the epidemic of untreated substance abuse in the region, an Emergency Room physician remarked that substance abuse leads to poor judgment, violence, and unplanned pregnancy.

### **Out of Home placements**

Beltrami County has one of the highest rates of out-of-home placement of any county in Minnesota at 18.6 per 1,000 compared to the state rate of 9.3 per 1,000.<sup>52</sup> Traumatic and sometimes violent events can occur before a child is removed from the home and can have a lasting impact on the child's wellbeing. On the 2010 Minnesota Student Survey, 17% of Beltrami County ninth grade girls reported "being hit so hard or so often by an adult in their home that they had marks on their body or were afraid of that person." This compares to 12% of 9<sup>th</sup> grade girls statewide.<sup>53</sup>

### **Crime and perceptions of safety**

Among all Minnesota counties, Beltrami County has the fourth highest Serious Crime Rate at 3,731 per 100,000 residents.<sup>54</sup> The implications of this in daily life are different depending on one's socioeconomic status. County residents whose incomes are below \$60,000 were three times more likely to report that they "feel it is unsafe to walk on their street after dark." They were also more likely to be a victim of violent crime in the last 12 months (2.6% for those below \$60,000 compared to 0.3% for those making over \$60,000 per year).<sup>55</sup> Obviously,

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<sup>50</sup> U.S. Department of Health and Human Services, Community Health Status Indicators, 2008

<sup>51</sup> Ibid

<sup>52</sup> The Annie E. Casey Foundation, KIDS COUNT Data Center, 2009, [datacenter.kidscount.org](http://datacenter.kidscount.org)

<sup>53</sup> Minnesota Department of Health, "Minnesota Student Survey: Beltrami County," 2010

<sup>54</sup> Minnesota Department of Safety, 2010

<sup>55</sup> MNCompass, Minnesota State Survey, 2009

violent crime affects health in that it involves bodily injury and sometimes death. Beyond that, when people feel unsafe in their neighborhood, anxiety levels are heightened, social connection and support is impeded, and the ability to be physically active is limited.

### **Occupational and environmental hazards**

A portion of the target population has been exposed to pesticides and other chemicals through agricultural labor. Others are employed in sectors such as logging that require hard physical labor in harsh climate conditions that tax the body and can compromise health. A federal Super Fund site is located in nearby Cass Lake, Minnesota on the Leech Lake Indian Reservation. Wood-preserving activities from decades ago contaminated the site with arsenic and dioxin.

### **Veteran disparities**

The county's estimated Veteran population is 3,548 or 11.2% of the adult civilian population,<sup>56</sup> slightly higher than the state of Minnesota. The age distribution of this group shifts somewhat with the aging of World War II and Korean Vets and ongoing conflict deployments.

During the community assessment process, a local Veterans group shared a deep concern about the unmet needs for behavioral health services for both substance abuse and mental health issues within this population. They noted that the social stigma around mental health issues is particularly strong and that Veterans fear career repercussions that might occur if they are labeled with Post-Traumatic Stress Disorder.

A Veteran's Administration (VA) Outpatient Clinic located in Bemidji provides primary care services for Veterans in the area, including behavioral health. Veterans indicated that the wait time is long for an appointment and that they dislike the mental health tele-medicine option, referring to it as impersonal and noting technology glitches that can interrupt sessions. Another barrier to effective mental health services noted by Veterans is that some therapists do not have military experience. When that "culture" and experience is not held in common, Veterans noted that it leaves a gap in the connection between client and counselor. In addition, they also indicated that transportation and getting time off from work is a barrier, as they must travel more than 2½ hours to Fargo, North Dakota for VA specialty care.

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<sup>56</sup> U.S. Census Bureau, American Community Survey, 2006-2010

## **American Indian disparities**

Research recently published by the Minnesota Department of Health revealed health disparities for racial and ethnic groups in the state. According to the report, **Minnesota’s American Indian population faces a disparity for all 16 of the indicators** that the study measured and was the only population without at least one indicator for which they ranked best in the state. The indicators included (in order of the degree of disparity for American Indians ranked highest to lowest): homicide, prenatal care initiated at 3<sup>rd</sup> trimester or none, teen births, gonorrhea incidence, diabetes mortality, suicide, motor vehicle mortality, unintentional injury mortality, Chlamydia incidence, heart disease mortality, Chronic Lower Respiratory Disease mortality, infant mortality, cancer mortality, stroke mortality, low birth weight, and preterm births. The level of these disparities is striking. Consider the following examples. In Minnesota, American Indians are approximately 4 times more likely to die from diabetes, 4½ times more likely to die by suicide, and greater than 3 times more likely to die from heart disease than those in the state’s White population.<sup>57</sup> Nationally, about 1 in 5 (18%) American Indian individuals have two or more chronic conditions, making regular access to care even more critical.<sup>58</sup>

These alarming disparities are a result of complex, inter-related social determinants that American Indians have faced for generations. Along with a persistently high poverty rate and all of the barriers associated with that significant variable, this population has experienced historical trauma that continues to negatively affect their health outcomes and increase their barriers to health care.

Research shows that experiencing discrimination can increase blood pressure, heart rate, and stress, as well as undermine self-esteem and self-efficacy.<sup>59</sup> Far beyond scattered incidents of discrimination, American Indians have endured a succession of traumatic events over generations.

Researcher Maria Yellow Horse Braveheart provides a concise explanation of historical trauma and its impact: “Historical trauma (HT) is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences; the historical trauma response (HTR) is the constellation of features in reaction to

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<sup>57</sup> Minnesota Department of Health, “Health Disparities by Racial/Ethnic Populations in Minnesota,” December 2009

<sup>58</sup> Kaiser Family Foundation, “A Profile of American Indians and Alaska Natives the Their Health Coverage,” September 2009

<sup>59</sup> U.S. Department of Health and Human Services Office of the Surgeon General, National Prevention Council National Prevention Strategy 2011

this trauma. The HTR often includes depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions. It may include substance abuse, often an attempt to avoid painful feelings through self-medication.”<sup>60</sup>

#### IV. Health Indicators/Outcomes

Health outcomes underscore the disparities faced in this high poverty county. Below is list of outcomes, most of which are required by the Health Resources and Services Administration (HRSA), the federal agency that provided funding for this assessment. For many of the health indicator categories, Beltrami County outcomes are considered worse than the national benchmark set by HRSA, and are, in some cases, worse than the “severe” benchmark set by HRSA.<sup>61</sup> Where HRSA benchmarks are established, they are noted below.

##### Health Indicator Categories:

##### **Prenatal and perinatal health**

##### **Late entry into prenatal care (after first trimester as a percent of all births)**<sup>62</sup>

Beltrami County	<b>28.1%</b> did not initiate care in the 1 <sup>st</sup> trimester
Minnesota statewide	<b>14%</b> did not initiate care in the 1 <sup>st</sup> trimester
HRSA “severe” benchmark	Anything over <b>20%</b>

##### **Adequacy of prenatal care**

Beltrami County	<b>67.8%</b> received adequate or better care
Minnesota statewide	<b>80%</b> received adequate or better care

##### **Infant Mortality Rate**

Beltrami County	<b>7.7</b> per 1,000 births <sup>63</sup>
Minnesota statewide	<b>5.3</b> per 1,000 births <sup>64</sup>
HRSA benchmark	Anything over <b>6.9</b> per 1,000 births

##### **Pre-term births**<sup>65</sup>

Beltrami County	<b>10%</b>
Minnesota statewide	<b>8.1%</b>

<sup>60</sup> Yellow Horse Braveheart, Maria, “The Historical Trauma Response among Natives and Its Relationship with Substance Abuse,” Sept 7, 2011. Available at <http://www.tandfonline.com/doi/abs/10.1080/02791072.2003.10399988>

<sup>61</sup> HRSA, “Required Indicators Service Area Competition Funding FY 2011”

<sup>62</sup> Minnesota Department of Health, Center for Health Statistics, “Nativity Beltrami,” 2006–2010

<sup>63</sup> Minnesota Department of Health, Center for Health Statistics, 2005–2009

<sup>64</sup> Kaiser Family Foundation, 2000–2005, Statehealthfacts.org

<sup>65</sup> Minnesota Department of Health, Center for Health Statistics, 2005–2009

### **Births to teenage mothers<sup>66</sup>**

Beltrami County	<b>15%</b> of all births
HRSA “severe” benchmark	<b>9.2%</b> of all births

### **Cigarette use during pregnancy<sup>67</sup>**

Beltrami County	<b>30.6%</b> of all births
HRSA “severe” benchmark	<b>14.3%</b> of all births

### **Suicide rate**

Beltrami County	<b>18.0</b> per 100,000 <sup>68</sup>
Minnesota statewide	<b>10.7</b> per 100,000
HRSA “severe” benchmark	Anything over <b>16</b> per 100,000

For the period 2000–2009, Beltrami County had the 2<sup>nd</sup> highest suicide rate among Minnesota counties.

### **Unintentional injury deaths**

Beltrami County	<b>54.3</b> per 100,000 <sup>69</sup>
Minnesota statewide	<b>36.0</b> per 100,000
HRSA benchmark	Anything over <b>35</b> per 100,000 (no “severe” benchmark established)

### **Diabetes**

#### **Adult prevalence of obesity<sup>70</sup>**

Beltrami County	<b>28.9%</b>
HRSA “severe” benchmark	Anything above <b>24.5%</b>

#### **Percentage of Adults with diagnosed diabetes<sup>71</sup>**

Beltrami County	<b>7%</b>
County Rank in MN	<b>83<sup>rd</sup></b> out of 87 counties
HRSA benchmark	Anything over <b>6.5%</b>

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<sup>66</sup> Minnesota Department of Health, MN County Health Tables 2010

<sup>67</sup> Ibid

<sup>68</sup> Minnesota Department of Health, MN County Health Tables 2010

<sup>69</sup> Minnesota Department of Health Center for Health Statistics, Minnesota Vital Statistics Interactive Queries, 2005-2009 (age-adjusted)

<sup>70</sup> CDC National Diabetes Surveillance System, 2008

<sup>71</sup> Centers for Disease Control and Prevention: National Diabetes Surveillance System, <http://apps.nccd.cdc.gov/DDTSTRS/default.aspx> (age-adjusted rate; adult= 20 years and older)

## Cancer

**Percent of women 18 and older with No Pap test in past 3 years**<sup>72</sup>  
Beltrami County 21.7% NO pap test in past 3 years  
Minnesota statewide 17.2% NO pap test in past 3 years  
HRSA “severe” benchmark Anything above 16%

**Percent of women 40 and older with NO Mammogram in past 2 years**<sup>73</sup>  
Beltrami County 34.7% NO mammogram in past 2 years  
Minnesota statewide 27.1% NO mammogram in past 2 years  
HRSA “severe” benchmark is established for 3 year period

## Age-Adjusted Death Rates

<sup>74</sup>

Beltrami County 2006-2010	765 per 100,000
Beltrami County American Indian 2006-2010	1,529 per 100,000
MN statewide 2006-2010	663 per 100,000
HRSA benchmark (no “severe” benchmark)	870 per 100,000

## Sexually Transmitted Diseases

<sup>75</sup>

### Gonorrhea

Beltrami County 61 per 100,000

Only Hennepin and Ramsey Counties (Minneapolis/St. Paul metro area) had a higher Gonorrhea rate per 100,000.

### Chlamydia

Beltrami County 361 per 100,000

Only Hennepin, Ramsey and Blue Earth Counties had a higher Chlamydia rate per 100,000.

## Three Year Average Pneumonia Death Rate

Beltrami County 12.7 per 100,000 (1.27 per 10,000)<sup>76</sup>  
HRSA benchmark Anything over 1 per 10,000

<sup>72</sup> State Cancer Profiles 2000–2003, [www.statecancerprofiles.cancer.gov](http://www.statecancerprofiles.cancer.gov) (Bias-adjusted Modeled Estimate Combining Behavioral Risk Factor Surveillance System and National Health Interview Survey)

<sup>73</sup> Ibid

<sup>74</sup> Minnesota Department of Health, Center for Health Statistics. MN Vital Statistics Interactive Queries and Vital Statistics Summary

<sup>75</sup> MN Department of Health, 2010 MN Sexually Transmitted Disease Statistics

<sup>76</sup> Minnesota Department of Health, Center for Health Statistics, 2008-10. (Data analysis by Kim Edelman. March 8, 2012)

## Child Health

**Percent of children not receiving recommended immunizations (\*4-3-1-3-3)**<sup>77</sup>  
4-3-1-3-3 = 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hepatitis B

Beltrami County    **30.5%** of children 24-36 months NOT complete for (4-3-1-3-3)  
HRSA “severe” benchmark    Anything over **21.4%**

**Cases of vaccine preventable disease morbidity, 2009**<sup>78</sup>

30 cases of Pertussis in Beltrami County  
Only 8 other MN counties had a higher incidence

## Preventable Hospitalization Rates<sup>79</sup>

**Diabetes Short-Term Complication Potentially Preventable Hospitalization Rate**

Beltrami County    **61** per 100,000  
MN Statewide    **34** per 100,000  
HRSA benchmark    **46.7** per 100,000

**Bacterial Pneumonia Potentially Preventable Hospitalization Rate**

Beltrami County    **408** per 100,000  
MN Statewide    **291** per 100,000

## V. Service Area Providers

As referenced earlier in the assessment, Beltrami County is a Medically Underserved Area, designated as a Health Professional Shortage Area countywide in Mental Health, Dental Health and in Primary Care (north and east parts of the county). There are no Federally Qualified Health Centers in the county.

By far the largest provider of health care in Beltrami County is Sanford Health, a nonprofit system. Within the last two years, Sanford Health acquired the Bemidji-based clinic system (formerly part of MeritCare), and the regional hospital (formerly known as North Country Health Services). “Three quarters of the hospital’s patients reside in Beltrami County, the hospital’s primary service area. An additional 10 percent reside in northern Cass County,

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<sup>77</sup> Minnesota Department of Health Data (Data analysis by Epidemiologist Karen E. White, MPH. March 9, 2012)

<sup>78</sup> Minnesota Department of Health, County Health Tables 2010

<sup>79</sup> Minnesota Department of Health, Health Economics Program, “Rates of Potentially Preventable Hospitalizations by County, 2007”

Hubbard, Clearwater, Itasca, Koochiching, and Polk counties. The population of the primary and secondary service area approaches 100,000.”<sup>80</sup>

Sanford Bemidji Medical Center and Sanford Health patient care services include: acute inpatient rehabilitation, apartment living for seniors, cardiac rehabilitation, catered living apartments for seniors, chaplaincy and spiritual care, Diabetes Resource Center, emergency services, food and dining services, general and vascular surgeries, home care and hospice, hospitalist program, imaging/radiology, intensive care, laboratory, medical equipment and supplies, medical nutritional therapy, medical-surgical, memory care, nursing home, obstetrics, gynecology, nursery, pediatrics, pharmacy, quality care and social services, rehabilitation: physical and occupational therapies, and speech pathology, respiratory therapy, Senior Behavioral Health Unit, sleep medicine, and urology.<sup>81</sup> Beyond services in Bemidji, Sanford has one other location within Beltrami County—a small satellite clinic in Blackduck. According to Sanford administration, there are 26.6 Primary Care Physician FTEs for direct patient care and follow-up of primary care in inpatient settings (hospital and nursing homes). Just over 19% of the patients cared for by these primary care physicians are on Medicaid.<sup>82</sup>

Physicians Clinic of Minnesota is a small private provider in Bemidji with one .75 FTE Primary Care physician on staff.<sup>83</sup>

Indian Health Services and Tribal Health Comprehensive Services are located on Red Lake Reservation. Services available include: behavioral health, dental, optometry, physical therapy, radiology, nutrition therapy, diabetes education, outpatient department, and Emergency Department. The Emergency Department is a Level IV Trauma Center.<sup>84</sup> Leech Lake Reservation Tribal Health Services operates a small clinic in Bemidji.

In addition to the behavioral health options provided through IHS and Tribal Health, mental health service provider organizations in Beltrami County include Upper Mississippi Mental Health Center; a private non-profit, Rule 29, community mental health center; and three private mental health clinics.

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<sup>80</sup> <http://www.nchs.com/history> Accessed April 16, 2012

<sup>81</sup> <http://www.nchs.com/services> Accessed March 25, 2012

<sup>82</sup> Sanford Bemidji, “Physician FTE Survey,” submitted February 9, 2012

<sup>83</sup> Physician’s Clinic, Administrative manager, phone interview on March 20, 2012

<sup>84</sup> [http://www.ihs.gov/bemidji/index.cfm?module=bmj\\_health\\_facs\\_fdsp\\_redlake](http://www.ihs.gov/bemidji/index.cfm?module=bmj_health_facs_fdsp_redlake) on March 25, 2012

Several years ago, the community spearheaded a project to address the dental professional shortage in our area. While private dentists in the area accept patients on Medicaid, the availability of appointments for this high need population is quite limited. Northern Dental Access Center opened three years ago and serves 10,000 patients per year from a 100-mile radius of Bemidji. Patients are either enrolled in a Minnesota Health Care Plan (Medicaid) or access a discounted rate for services based on income levels. An integrated and collaborative approach to care combines dental care with patient advocacy and other health services available on site. The clinic's unique and culturally competent approach has led to numerous state and national awards.

Beltrami County Health and Human Services provides programs aimed at improving overall health outcomes in the community. Health services are provided at the Community Service Center in Bemidji, the Blackduck Resource Center, and in Kelliher (northern Beltrami County), and include: car seat inspections, child and teen checkups, health education, health screenings, home care, immunizations, maternal and child health services, basic health in the jail, and nutritional support through WIC.

A number of community nonprofit agencies exist to serve low-income individuals and families, and their work certainly impacts the health of the target population. Examples of these agencies include: Bi-County Community Action Program for Head Start, housing, heat assistance, and case management; Adult Day Services for seniors; Day Activity Center and Occupational Development Center for developmentally disabled adults; Red Lake and Bemidji Boys & Girls Clubs; Evergreen Youth and Family Services; Hope House for adult mental health support; Planned Parenthood; and Village of Hope for homeless families. While these agencies provide helpful services, it is difficult for those in poverty to determine which agencies might meet their needs and to get information about how to access these programs.

## **VII. Health Care Barriers**

As a part of the assessment process, a 30-member community health needs assessment advisory team was assembled, more than 140 key informants were interviewed, and the target population was surveyed to gain insight on a variety of topics. Among the many topics covered in

interviews, forums and the survey was a very basic but important question—“What prevents the target population [you] from receiving the health care that they [you] need?” In other words, what are the barriers?

The following section summarizes findings related to health care barriers for the target population in the service area. Beneath each heading is an explanation of how the barrier impacts the target population. Barriers are listed in the order that allows the “story” to unfold without redundancy.

- **Cost of care**

The target population resoundingly reported that they cannot afford to pay for needed health care services—whether it’s due to high deductibles, a lack of insurance, or a need for services that are not covered. Many reported that this is causing them to ration their family’s care. Some target population members said that they were trying to pay off large medical bills and could not seek care for new health issues. This factor cannot be underestimated as a major barrier to the target population’s health.

- **Issues with health care coverage**

The complexity of getting on and staying on Medicaid is a major barrier to care. College-degreed professionals who assist clients with completing Medicaid enrollment forms and navigating the application process attest to the complexity. With that said, it is not surprising that members of the target population express extreme frustration, confusion and hopelessness with the enrollment process. The illiteracy rate of Beltrami County is 6.4%,<sup>85</sup> the level of educational attainment for the target population is low, and many who are Medicaid-eligible suffer from mental illness or substance abuse issues that impact their ability to process information. With such high needs, there is simply not enough assistance available to guide them successfully through the enrollment process.

When people go on and off Medicaid or other health coverage, it leads to inconsistent access, which impacts health. During lapses in health care coverage, necessary prescriptions are not re-filled and chronic illnesses are not well managed. Preventive care visits become an unaffordable luxury.

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<sup>85</sup> U.S. Department of Education, Institute of Education Sciences, 2003 National Assessment of Adult Literacy

- **Shortage of dental health services**

In Beltrami County, private dental clinics accept a limited number of Medicaid patients, but appointments for this high needs population are extremely limited. Prior to 2009, this region experienced significant dental access challenges for low-income families, so much so that for seven years, a broad community coalition worked tirelessly to plan, design, fund and launch a nonprofit community access dental clinic—Northern Dental Access Center. In 2011, Northern Dental Access Center served over 9,900 patients with excellent outcomes.

Even with the addition of Northern Dental to the service area, target population members indicate that they have difficulty accessing the oral health services that they need. After serving more than 15,000 people in three years at the new Northern Dental Access Center, wait times for dental appointments still amount to 4-6 weeks for routine or preventive care, with 15-20 new patients registered every day.

When people face barriers to accessing dental health, the pain they experience leads to absences from work and school, self-medication using alcohol and illegal substances to relieve pain, and expensive visits to Emergency Departments. As the American Dental Association states, “Untreated dental disease can lead to serious health problems: infection, damage to bone or nerve, and tooth loss. Infection from tooth disease can spread to other parts of the body and may even lead to death. Clearly, oral health is just as important as the health of the rest of your body.”<sup>86</sup>

- **Shortage of mental health services**

Resoundingly, this assessment process revealed a shortage of mental health service professionals as a barrier to care, given the target population’s high incidence of mental health issues. The service area’s mental health system was described as “inundated and overwhelmed” by what one local physician characterized as a “preponderance of mental health issues.” Although region has highly competent mental health agencies and professionals, it is challenging to recruit enough mental health providers in this remote location where salaries rarely reach market levels. In particular, more psychiatrists are needed, and more specifically, *child psychiatrists* with a strong developmental background.

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<sup>86</sup> American Dental Association, “Access to Dental Care/Oral Health Care,” <http://www.ada.org/2961.aspx>

Primary care providers noted that they do not have adequate time to address the growing demand for mental health medication, nor do they feel adequately trained to do so in some cases.

Behavioral health providers face an extreme challenge in that Medicaid reimbursements are low and the target population needs are high—a difficult equation to effectively solve in a way that keeps the provider’s doors open and client outcomes met.

The result of this mental health professional shortage is a long wait time for appointments, especially for diagnostic assessments and medication management. During that wait, the client’s urgency for help may temporarily subside, leading them to cancel or miss their appointment only to have the unaddressed issue re-emerge at another time. To alleviate some of this need, Upper Mississippi Mental Health Center recently added an Open Access Clinic where clients can be seen on the same day with no appointment. Through this program, clients can receive a diagnostic assessment or crisis therapy. Chronic no-show clients can also use the Open Access Clinic for their therapy needs, although this would not be an ideal practice over the long term.

- **Complexity of behavioral health and primary care systems**

Health care and supportive service providers reported that the behavioral health system is complex to navigate. The mix of private, government, tribal and faith-based providers along with layers of requirements and parameters for various programs confuse the potential client. Stakeholders note that it is difficult for the target population to find the “front door” and to advocate for what is needed, especially considering the state of hopelessness and anxiety that target population members are experiencing in these circumstances.

Senior citizens surveyed reported that their most significant barrier to medical care was that “the health care system is confusing,” with one survey respondent commenting that there are “too many locations.”

- **Wait times for primary care**

Some target population members and providers noted that long wait times for appointments are a barrier to receiving adequate primary care. Scheduling a preventive care appointment with some physicians can mean a 3-month wait. A few physicians in the Sanford system are no longer accepting new patients. Some households reported having a difficult time scheduling an appointment to see a primary care provider in a timely manner, which led to

usage of the Walk-In Clinic and ER (although overuse of the ER is a many-layered issue). With the recent entry of Sanford Health into our community, a renewed surge of provider recruitment may alleviate wait times to some degree.

- **Navigating supportive services**

Living in poverty often means moving through crisis after crisis. A barrage of barriers emerges, each directly or indirectly linked to one's lack of resources. Although existing supportive service programs could alleviate some of these stressors, accessing these programs can be a complex process that would be more easily navigated with assistance from an advocate who can match their needs to existing programs.

- **Transportation**

Resoundingly, transportation was noted as one of the most significant barriers to health care. Getting to appointments is extremely difficult for the target population due to long distances to care providers, a lack of affordable/reliable vehicles, the high cost of gasoline, a lack of public transportation outside the city of Bemidji, and four to five months of extreme winter weather conditions. The senior citizen population noted that transportation was a barrier to health care for their age group. They expressed dissatisfaction with the minimal public transportation available and dismay about the cost of taxi fare and Medi-Van.

- **Work obligations and child care**

Target population members report that their jobs do not allow them to take time off work for personal and family appointments. Those with young children expressed difficulty finding childcare. Health care providers reported that patient/clients sometimes bring young children along for appointments, which can interfere with the level of quality care that can be provided in some cases.

- **Missed appointments**

Providers noted the high rate of missed appointments by the target population. In some cases, patients exceed a maximum number of missed appointments and can no longer receive care at that provider. A mental health therapist noted that given the complex, chaotic world of poverty “a thousand things could have kept them from getting there that day.”

- **Illiteracy and low level of educational attainment**

A segment of the target population lacks the literacy skills and education needed to understand instructions presented to them by their care providers. A Registered Nurse in family practice recalled a 27-year-old who was struggling with paperwork. Fortunately, she realized that this was a literacy issue and guided him. The literacy barrier is challenging for educated health care providers to keep in mind and detect, and time-consuming (but important) to address. The formal education of nearly 1/3 of Beltrami County's adult population living in poverty stopped before they received a high school diploma (or the equivalent).<sup>87</sup> Thus, even if they are not technically considered illiterate, members of the target population struggle with the complex jargon of medical care, and this can impede their ability to comprehend their diagnosis, instructions about use of prescription medicines and follow-up care—all of which impacts their health. Care coordination at Northern Dental Access Clinic has helped alleviate this barrier for their patients.

- **Health literacy issues**

It is clear that the target population is not receiving adequate levels of preventive care, screenings, prenatal care, dental care, mental health care and uninterrupted access to necessary prescription medicines. Many do not have a primary care provider and some have not visited a dentist in many years. Some part of this is due to a lack of health literacy, but it is difficult to parse out how much education and public awareness campaigns would change behavior given the magnitude of other barriers to health care that they face. It is certainly a part of the equation.

Health literacy topics that surfaced during the assessment process included but were not limited to: the need for preventive care, the importance of oral health, the need for and definition of adequate perinatal care, risk behaviors and their consequences during pregnancy, family planning/pregnancy prevention, STD prevention, nutrition, reducing the stigma surrounding mental health and understanding how to utilize the service area's health care systems.

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<sup>87</sup> U.S. Census Bureau, American Community Survey 2006–2010, “Selected Characteristics of People at Specified Levels of Poverty”

- **Challenge of self-advocacy**

For a variety of reasons, people in poverty are uncomfortable and unaccustomed to advocating for their health care needs. Their experience is that of having little control or power in the wider community. Target population members expressed that they don't know what to ask for and one forum participant shared that he did not believe that he deserved quality care.

- **Feeling judged or sensing prejudice**

Target population members reported feeling judged by care providers and support staff at times, which was intimidating for them. Some American Indians within the target population shared that they have experienced cultural insensitivity and prejudice when getting care.

- **Mental health stigma**

Segments of the target population are stymied by the stigma surrounding mental health, frozen in their fear of being labeled. More public awareness is needed to build acceptance around getting care for depression, anxiety and other mental health diagnoses.

- **Untreated mental health issues**

The high rate of untreated mental health issues in Beltrami County is, in itself, a barrier to accessing other health care. Mental illness “may prevent or diminish self-advocacy due to such symptoms as limited insight, low motivation, disorganized thinking, poor judgment, inadequate finances, lack of transportation, and other unmet psychosocial factors. Patients often exhibit disorganization in daily affairs and lack of follow-through—creating a significant barrier to attention to primary and secondary preventive measures or chronic care management.”<sup>88</sup>

According to assessment interviews, untreated chronic mental health issues are resulting in visits to the Emergency Room (ER)—hardly the most effective or cost-efficient way to treat these needs. Cases range from mild depression to suicidal ideation. Emergency Room medical staff expressed concern over how young some of these patients in need of mental health services are. Due to this surge of ER patients with mental health issues, a 24-hour Mobile Crisis Team is now available to the Sanford Medical Center Emergency Room. ER

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<sup>88</sup> Dickerson, Faith, “Health Status of Individuals with Serious Mental Illness,” <http://schizophreniabulletin.oxfordjournals.org/content/32/3/584.full.pdf+html>

staff can call in this team of therapists who evaluate patients with mental health issues to determine whether they are safe to return home. If so, a safe plan is developed and if not, arrangements are made for in-patient placement. Patients also receive assistance in finding ongoing mental health care. Even with this and other efforts in place, the need is still great and the barriers to receiving care are resulting in visits to the ER.

- **Unrecognized or undiagnosed mental health issues**

Target population members are sometimes unaware that they have a need for mental health services. “I didn’t know that I had a problem,” commented one survey respondent. Families in this region have experienced generations of persistent mental health issues, and this “way of being” becomes the norm. They have become accustomed to the feelings and thoughts that they are living with; or, as parents, they become conditioned to their child’s depressed, angry or anxious demeanor.

- **Substance abuse**

Like persistent mental health issues, untreated substance abuse is a barrier to accessing health care. In some cases, patients feared that if they revealed their substance abuse issues they would face harsh judgment or denigration from health care providers. During the assessment process, supportive service and health care providers repeatedly noted their belief that some pregnant mothers avoid prenatal care when they have a substance use issue. In this circumstance, the pregnant mothers may fear the loss of their infant or other children or a myriad of other consequences if they bring their addictions to light.

The reported high rate of substance abuse is linked to a shortage of mental health care access. Some members of the target population self-medicate with alcohol, prescription drugs and illegal substances.

- **Mistrust of the system**

An element of mistrust toward the health care system pervades segments of the target population. This plays out in several ways. Some find contemporary health care impersonal and high-volume; they always feel rushed and unable to make a connection with the provider. Others expressed a sense of doubt about whether they or their families were getting proper screenings, medications and care—wondering if being on Medicaid was adversely affecting the type of care they were offered and questioning whether it also

affected the attitude and effort put forth by the provider. These perceptions may make the target population less likely to return for follow-up care.

- **Desire for holistic and traditional treatment options**

Some target population members expressed an aversion to medication as treatment for health issues and noted that they thought providers “pushed pills.” Some preferred more holistic methods or Anishinaabe (Ojibwe) traditional ways of healing. Upper Mississippi Mental Health recently received a grant that will allow more integration of Anishinaabe culture as an optional element in the care that clients receive. Other providers noted that they are constantly working on building trust and cultural competence, as this is widely recognized as vital to reducing barriers to health care.

- **Underfunding of Indian Health Service**

Although treaties and laws established that the federal government is responsible for American Indian health care through the Indian Health Service, a myriad of issues including chronic underfunding and bureaucratic processes have hindered and limited the scope and effectiveness of IHS. Of the 12 IHS areas in the nation, the Bemidji Indian Health Service Area is historically the most underfunded. “The Bemidji Area was funded at only 45% of need in 2009. In comparison, the average funding of IHS nationwide was only 55.2% of what was necessary to provide parity in healthcare.” Federal prisoners receive twice as much per capita for health care than Indian Health Service does.<sup>89</sup> Also grossly underfunded is the Contract Health Service Program that is designed to cover costs for IHS patient referrals to other providers. As a result, appropriations run out before the end of the fiscal year and patients have to wait for care they need.

- **Emergency Room use**

The reasons why the target population may seek Emergency Room care for non-emergency issues are many. According to Sanford Bemidji, 11% of ER visits at their facility are Level I and II, which is non-urgent care. In 2007, the nationwide rate of non-urgent visits to Emergency Rooms was approximately 8%.<sup>90</sup> When patients access care for non-emergency issues in the ER setting, the cost is seven times more than that for a community health center

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<sup>89</sup> Great Lakes Inter-Tribal Epidemiology Center, “Community Health Data Profile: Michigan, Minnesota and Wisconsin Tribal Communities,” 2010

<sup>90</sup> Government Accountability Office, “Hospital Emergency Departments: Health Center Strategies That May Help Reduce Their Use.” April 11, 2011

visit.<sup>91</sup> The cost to their personal health is also notable. It is unlikely that these patients are receiving preventive care with a primary care physician who could better direct their care.

Patients with chronic illnesses who cannot access ongoing health care experience a degradation of their condition or disease. When their symptoms reach a crisis level, the Emergency Room treats their complications, but cannot provide the necessary long-term, ongoing care that is needed for improved chronic disease management.

- **Continuity of care and fragmentation of care**

During the assessment, key stakeholders noted the need to focus on continuity of care and efforts to reduce fragmentation of care for the target population. These phenomena are pervasive in the U.S. health care system, especially for poor and low-income underserved populations.

“Better **continuity of care** is a hallmark and primary objective of family medicine and is consistent with quality patient care. The continuity of care inherent in family medicine helps family physicians gain their patients’ confidence and enables family physicians to be more effective patient advocates. It also facilitates the family physician's role as a cost-effective coordinator of the patient's health services by making early recognition of problems possible. Continuity of care is rooted in a long-term patient-physician partnership in which the physician knows the patient’s history from experience and can integrate new information and decisions from a whole-patient perspective efficiently without extensive investigation or record review.”<sup>92</sup>

“**Fragmentation** means having multiple decision makers making a set of health care decisions that would be better made through unified decision making. When individuals are only responsible for one fragment of a relevant set of health care decisions, they may fail to understand the full picture, may lack the power to take all the appropriate actions given what they know, or may even have affirmative incentives to shift costs onto others.”<sup>93</sup>

When the target population does get care in our service area, they move in and out of different systems (IHS, tribal health, Sanford Health, substance abuse treatment programs, mental health providers, different pharmaceutical providers, jail, public health) and in and

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<sup>91</sup> Ibid

<sup>92</sup> American Academy of Family Physicians, “Continuity of Care”  
<http://www.aafp.org/online/en/home/policy/policies/c/continuityofcaredefinition.html>

<sup>93</sup> Elhuage, Einer. *Why We Should Care about Health Care Fragmentation and How to Fix It*. 2010

out of various parts of any one system (Urgent Care, family practice, ER department, chronic disease management). Communication between and within systems is critical to the target population's health outcomes, especially given the health disparities they face. Having a regular, primary care provider guide their care is ideal—someone who the patient trusts and who knows their health history.

Sanford Health only recently established its presence in the service area, and they are working on several initiatives related to these issues. Of note, the relatively new hospitalist program at Sanford Medical is reducing fragmentation for patients through better communication between systems.

## **VIII. Conclusion**

This assessment process revealed the significant health determinants, disparities and barriers faced by the low-income population in Beltrami County. It also revealed a strong desire and energy within the broader community to change the trajectory of health outcomes for this population by launching innovative, collaborative solutions. Fixing broad systemic issues with the health care system is far beyond the scope of our regional efforts; however, by keeping a keen focus on the needs of the target population, effective responses that will affect health outcomes can be found.

It is clear that navigating the complex health care system and maintaining health care coverage are two significant barriers for the low-income population. The care that they do receive is often fragmented and lacks continuity due to the sporadic access they experience as a result of barriers addressed in this assessment.

## **IV. Next Steps**

Upon publication, the Community Health Needs Assessment findings are to be analyzed by a Planning Team charged with determining how best to respond to the health needs and barriers experienced by the target population.