February 28, 2014

Stefan Gildemeister
Director, Health Economics Program
Minnesota Department of Health
85 E. Seventh Place, Suite 220
St. Paul, MN 55101

Dear Mr. Gildemeister:

This correspondence is in response to the letter received by Sanford Health Thief River Falls from the Minnesota Department of Health requesting further information on a proposed exception to the moratorium on hospital beds for the purposes of establishing and licensing a new 25 bed psychiatric hospital in Thief River Falls, MN. I will address each question in the following sections.

1. Charity Care Policy:

   We will maintain the same charity care policy that the rest of Sanford Health uses system wide in accordance with the agreement between Sanford Health and the Attorney General of Minnesota. If suitable, the policy also requires us to follow NHCS discount policies, which meet or exceed the Attorney General agreement. Both policies are attached in the appendices.

2. Chemical Dependency Services at the New Facility:

   We cannot commit to provision of chemical dependency services at this point. We have posted a job opening for an LADC, and are in the process of recruiting with the hopes that we can build upon this position to offer outpatient and potentially detox programming. In any event, we wouldn't use the 25 beds for this purpose, but the chemical dependency programming available may allow us to keep some people that we currently cannot serve on the inpatient unit because they are dually diagnosed with a psychiatric and chemical dependency malady.

3. Methodology for Population Projections:

We had commissioned a consultant to conduct a market survey for us in 2009. It is attached in the appendices. The general summary is that some of our secondary market is shrinking, and Thief River Falls is growing slowly. The net impact is relatively flat, so we've not really based any of the potential growth on demographic changes. I had connected with the Office of the State Demographer of Minnesota prior to submitting the proposed exception to the moratorium, as it appeared the Office was intending to update projections at the end of 2013. At the time of my correspondence, there were no projections available despite the deadline listed on their own website had passed. I see now that the information is updated. It appears that the demographer for the State of Minnesota views things a little more positively in terms of population growth. As you can see in the appendices, it looks like we could assume about a 4-5% growth above and beyond our original projections due to population growth between the years 2015 and 2020, which is very pertinent to our project timeline.

4. Explain the Admissions Criteria:

   The admission criteria will not change. The policy is attached. We still require the patients to be what we consider to be medically stable, which is always a point of contention with those that refer to us, or any other psychiatric facility. We have been working with county social service agencies and hospital emergency rooms in the area recently to make sure we aren't being overly aggressive in our screening, and that they are on the same page in terms of legitimate concerns we have regarding our ability to provide appropriate care in the appropriate environment for the patient. We will still be able to provide medical consultations for patients on the psychiatric inpatient unit, depending on the need.

   That being said, we turn away some patients today because we don't have an appropriate bed, meaning that our programming is probably suitable for the patient, but other factors prevent us from admitting for the well-being of the patient. This is usually because we don't have the flexibility in the current space and given the current limitation on beds available. A common example of this would be turning down an admission for a child because we have a patient with a history of sexual predation currently on the unit that would not be able to be separated from the rest of the patients. This change will make many more of these admissions possible because of our potential to design more segregated areas, and it will certainly feel like admissions criteria are loosening in terms of the region's perceptions.

   In addition, it's important to note that we do take on many admissions that other facilities won't, including admitting forensic patients given they meet all of our admissions criteria.

5. Medical Services at the New Psychiatric Facility:

   The current plans for the services that are offered under the license of the newly formed psychiatric facility are articulated on a draft of a potential organizational chart attached. It is labeled as such that you can see which services are existing and which are potential services that could be offered. Currently, all these services are offered under the Critical Access

Hospital license. No services will be lost in the transition. Again, medical consultations from medical professionals that are able to be provided will certainly be done for patients requiring those consultations.

6. Occupancy Rates:

   I have attached our occupancy rates historically, and projections derived from the impact on admissions volumes we're anticipating based on market based information already provided. More specific notes on historical and projected occupancy rates are included on the attachment. As a special note, when you get up to 8 beds full in a 10 bed unit, you're already thinking about limiting access because of looming admissions and urgent needs of the region. We do anticipate variability will increase when we eventually have 25 beds open and an average daily census of around 16, as you may notice in the graphic.

7. Assess Adequacy of Outpatient and Community Based Services in the Area and the Impact on Utilization of Psychiatric Inpatient Services, AND Discuss why the rates of admission in your market area would be the same as the average state admission rate, given your unique demographic and health care environmental factors:

   I find these two questions very much related, and very important to the question of need, so I addressed them together.

   What makes us think we need expansion of these services from a demographic or health environment perspective, and how can we be sure the issue couldn't be improved by simply providing more effective lower cost interventions? I agree that these are both fundamental questions that need answers. I will also admit that I have no empirical evidence that suggests that one demographic factor is more strongly tied to psychiatric need than another, but I can tell you the following:

   Our region is poorer, and more sparsely populated than the state, on average. Outside of Pennington County, where Sanford Thief River Falls is located, mental health providers are harder to come by than the rest of the state on average. Half of our population has a less than a high school diploma in terms of the highest level of education achieved while the state average is at 37%. Focus groups organized in the past year across the region for a health needs assessment survey required by the IRS for non-profit health care and public health providers indicated repeatedly that mental health, substance abuse, and transportation were key needs of their respective communities. I've attached excerpts from our Community Health Needs Assessment report supporting these in the appendices, and I can provide a full copy (100+ pages) of the report if you'd like.

   Do any of these contribute to the psychiatric needs? I honestly can't say for sure to what extent any of these factors contribute to the need for psychiatric care, but it seems logical that they would contribute to the need, and that given this information, the need would be at least as great, if not more, than the state average.

That being said, why can't we strive to simply get better at preventing hospitalization for patients with psychiatric diagnoses? We all agree that the best form of care is preventative, and it would be difficult to find an organization in the state that has put as much time and money into that notion as Sanford Thief River Falls when it comes to mental health. Currently, we offer an array of outpatient and community based services. For children, we have a 15 bed residential facility certified as a rehab center; crisis response and stabilization services; in home rehabilitative services; as well as psychiatrists and psychologists that serve children. For adults, we have another 15 bed IRTS and Crisis Stabilization residential facility; crisis response and stabilization services; case management, ARMHS, ICRS, and CSP services to keep people in their homes; work therapy services; as well as psychiatrists and psychologists that serve adults. We offer these in many of these services in the many of the counties that we list in our proposed primary service area.

The goal is to get and keep people well and preferably without the use of an acute inpatient setting. We are not perfect, and we have many ideas and initiatives in the works now to coordinate better with services offered in other counties, expand our current offerings, and engage in more proactive discussions about programming with counties and other referring agencies. As we improve our services, we will reduce admissions. We also strive to use these services to reduce the length of inpatient stays, which statistically we have in the last several years. Based on internal data, the average length of stay has dropped from 8 to 6 over the last five years. Some of that is related to the increase in 72 hour hold admissions, but again, those services allow for step down services for those patients as well as an alternative to staying in the inpatient unit for longer stays. Even as we improve, we are seeing patients leave the region for inpatient services, and it becomes more difficult to get them back in their communities and connected to the rehabilitative services that can keep them from returning to an inpatient unit.

From an economic perspective, I think what we've laid out already paints a clear picture. Our project is not really adding any significant capital expense that we would not otherwise incur to expand beds, relatively speaking. If our census is at 12 or 22, the difference in cost is strictly variable for us. We have documented large volumes of turnaways due to lack of access or availability of the service. One of the most poor, sparsely populated, and underserved areas of the state is seeking to expand the capacity at an organization that currently represents about 50% of the supply side of the marketplace. This region is already well under the state average in terms of incidence of admissions. As stated initially, our referrals typically come from ERs and county social service agencies. Given the nature of the service, it seems unlikely that any supplier would be able to create artificial demand, as most of the referrals are generated by parties that have a vested interest in not referring the patient for inpatient psychiatric services; in fact the counties typically have a strong financial disincentive to refer. It would all lead one to believe the risk of adversely impacting the competitiveness or equilibrium of the marketplace or the overall cost of the service seems minimal to non-existent.

8. Why do we get referrals from outside our traditional primary market, and even from the far reaches of the state?

   We believe there are three main reasons we receive referrals from patients at a great distance.

   i. Access issues: The state is strapped for resources. If there is a need in any corner of the state, depending on the day, we may be the only facility with a free bed. It seems as though this is happening state-wide, as the state run facility in Anoka either is contemplating or has already added an 18 bed unit. I have also attached an article in the appendices discussing the lack of access to these services in the state.
   ii. Continuum of care: In Thief River, we do have the luxury of being one of the few facilities that have offered over a long time frame the varying levels of services that we do. Some referral sources are more comfortable referring to an organization that has residential and other rehabilitative service offerings, as it typically lends itself to less time on the inpatient unit, and more focus on re-acclimating into the community.
   iii. Admissions criteria: We do see patients that most other non-state-run facilities will not. We will see forensic patients, as we stated before. The flexibility usually pleases potential referral sources, and when a distant county or ER has a good experience with a difficult placement, they tend to come back to you if they see you have an opening.

9. Provide information about the staffing needs for the new facility and the process for recruiting the remaining needed staff with appropriate qualifications.

   The general idea behind meeting our staffing needs would be to ramp up about 6 months ahead of the anticipated need, and planning on a ramp up over the first year or so to our eventual average census levels of 15 or more patients. Currently, the staffing is comprised of 11 people making up 9.5 FTEs worth of RNs, and 11 people making up 6 FTEs of LPNs and care tech positions. We have adequate psychology and psychiatry at this point. We'll probably start ramping up in a year or so to increase RN and LPN coverage by 25%, and increase further from there as we see volumes increasing. We have typically found success in recruiting RNs by bringing in new graduates from Fargo, Grand Forks or Thief River Falls programs and orienting them to our unit slowly. We have also found success in recruiting RNs looking to move to the area that are currently employed at psych units in Fargo or Grand Forks. For our LPN staff, we have had less trouble finding adequate staff. We have a rather robust LPN program at Northland Technical College in Thief River Falls, which helps bolster the labor pool.

10. Provide information on how many of the anticipated future staff are currently employed at neighboring facilities in the region and the extent to which they will continue to provide care at other facilities.

We do not anticipate finding much of the needed staff from area hospitals. As stated, we typically see our candidates come from the sources identified above. Typically, established RNs and LPNs in other facilities in our area have not been open to the idea of practicing in a psych facility because their experience predisposes them to other fields of nursing. This is why, in my belief, so many facilities signed letters of support for the project, including the nearest state-run psych facility in Bemidji.

Thank you again for your attention in this matter. Please contact me using the information listed below should you have any questions.

Sincerely,

Casey R. Johnson
CFO, Sanford Health - TRF
120 LaBree Ave S
Thief River Falls, MN 56701
E: casey.johnson@sanfordhealth.org
P: (218) 683-4636

Appendices

1. Charity Care Discount Policy
2. NHSC Discount Policy
3. Wipfli Market Analysis
4. Correspondence with State of Minnesota's Office of the Demographer
5. State Demographer's Office Extrapolations
6. Admissions Criteria Policy
7. Occupancy Rates Graphic
8. Demographic and Health Environment Statistics from Community Health Needs Assessment
9. Article: *The Mental Health Discussion: A Mixed Bag*

SANFORD PATIENT FINANCIAL SERVICES POLICY	**Financial Assistance Policy** **NUMBER:** C-421
CREATED: 3/93	**SCOPE:** All Sanford Facilities
REVIEWED: 1/96	**APPROVED BY:** Chief Financial Officer
REVISED: 11/94, 2/95, 9/97, 1/00, 4/02, 7/05, 8/05, 9/05, 7/06, 3/07, 4/08, 3/09, 5/10, 2/11, 5/12, 6/12, 4/13; 7/13	**FORMULATED BY:** Finance and Compliance

Replaces: C-421 Community Care Assistance (Charity) – Sioux Falls 7/13
30.3552-008 Uncompensated Care Policy I 030112 (2) – Bemidji 7/13
Community Care Policy (Patient Account) – Bismarck 7/13
Community Care Program – Fargo 7/13

PURPOSE

Sanford is committed to provide emergency and medically necessary care to all patients without regard to race, creed, sex, national origin, disability, age, or ability to pay. This policy sets forth the Sanford policy and procedures to offer and provide financial assistance to all qualified patients receiving emergency and medically necessary care at Sanford's hospitals and clinics.

POLICY

Patients receiving emergency or medically necessary care and services at Sanford have the opportunity to apply for financial assistance. For patients who meet the eligibility criteria established in this policy, Sanford will offer financial assistance that can reduce their financial obligations for payment of these services.

DEFINITIONS

For purposes of this policy, the following definitions apply:

Emergency Care and Services: Individuals who present to emergency departments seeking emergency care shall receive a medical screening examination by a qualified medical person to determine if an emergency medical condition exists. An emergency medical condition is one manifesting symptoms, including severe pain, psychiatric disturbances and/or symptoms of substance abuse, that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to a bodily organ or function, or serious jeopardy to the health of the individual or unborn child. With respect to a pregnant woman having contractions, an emergency medical condition also includes situations where there is not enough time to safely transfer the woman prior to the delivery, or a transfer would pose a threat to the individual or her unborn child. (See Sanford Policy C-855, Standards of Conduct Relating to EMTALA Compliance).

Medically Necessary Care and Services: Medically necessary care and services include procedures and treatments necessary to diagnose and provide curative or palliative treatment for physical or mental conditions in accordance with professionally recognized standards of health care. The term "medically necessary" does **not** include for example cosmetic procedures, birth

control or fertility treatments, gastric by-pass procedures, non-emergency dental services, experimental or non-traditional care, tests, or treatment, hearing aids, and retail services such as pharmacy, optical shop, or durable or home medical equipment. For purposes of this policy, Sanford reserves the right to determine, on a case-by-case basis, whether the care and services meet the definition and standard of "medically necessary" for the purpose of eligibility for financial assistance.

Eligibility Criteria for Financial Assistance: Upon Sanford's determination that the patient's care and services meet either the definition of "emergency care and services" or "medically necessary care and services" a patient (whether uninsured or insured by a third party) is eligible to receive full or partial financial assistance subject to the following criteria:

1. A patient (or patient guarantor) with a household income of 225% or less of the Federal Poverty Level (FPL) is eligible for full financial assistance.

2. A patient (or patient guarantor) with a household income between 226% and 375% of the FPL is eligible for partial financial assistance on a sliding scale.

3. Eligibility for full or partial financial assistance is contingent upon the completion of a Financial Assistance Application and submission of sufficient documentation requested by Sanford to demonstrate financial need. Exceptional circumstances may influence a patient's (or guarantor's) eligibility for financial assistance and may be considered on a case-by-case basis. These circumstances include, but are not limited to:
    - Employment status
    - Total amount of debt (medical and non-medical)
    - Assets (liquid and non-liquid) in excess of liabilities[1]
    - Terminal illness
    - Total monthly expenses

4. Minnesota residents receiving emergency and medically necessary care and services at Sanford's Minnesota hospital facilities are also eligible to apply for a discount under the policy for the Minnesota Discount Program.

PROCEDURE

Availability of Financial Assistance

1. Sanford takes reasonable efforts to fully inform all patients and the public of the availability of financial assistance, including the following means of communication:
    - Posting of signs in all patient registration areas and in other public areas of the facility
    - Posting of information, including policies and the Financial Assistance Application on the Sanfordhealth.org website
    - Providing written notification on patient billing statements

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[1] For example, exceptional circumstances may apply to applicants who own significantly valued real estate. Sanford may consider the value of an individual's assets in determining eligibility for financial assistance for care and services delivered at any of Sanford's facilities, except facilities that are designated as National Health Service Corps (NHSC).

- Mentioning the availability of financial assistance when discussing the bill over the telephone with patients or guarantors
- Providing written notification in brochures and other information that is provided to the patient upon admission or discharge
- Providing information to local social services agencies

2. Sanford takes reasonable efforts to help overcome any language or disability barrier that may serve as an impediment to informing patients and guarantors about the availability of financial assistance, including:
    - Multi-lingual signs in English and in any other language that constitutes the primary language of at least 10% of the population in the community where the facility is located
    - Multi-lingual information on the Sanfordhealth.org website in English and any other language that constitutes the primary language of at least 10% of the population in the local communities where Sanford facilities are located
    - Providing interpreters upon request of the patient or patient's companion to accommodate either language or disability needs

3. Sanford's Financial Assistance Policy, the Financial Assistance Application, and a plain language summary are available free of charge, in English (or in other languages that constitute the primary language of at least 10% of the population in communities where Sanford facilities are located). Individuals may obtain these documents through the following means:
    - Hard copies can be provided in person or can be mailed to the patient upon request
    - Hard copies can be accessed, downloaded, and printed from the website (Sanfordhealth.org)

4. Once Sanford has provided emergency or medically necessary services, a patient or guarantor may submit a Financial Assistance Application. The right to apply for financial assistance consideration begins on the date of service and extends through the 240th day after the first billing statement is sent to the patient or guarantor. However, patients and guarantors are encouraged to submit their Financial Assistance Applications as soon as possible.

Financial Assistance Application Process

1. Patients (or patients' guarantors) seeking financial assistance have the following obligations:
    - Complete, sign, and submit a Financial Assistance Application
    - Submit sufficient documentation to establish financial need, including documents such as the latest filed IRS tax return, the two most recent pay stubs, and property tax statements for owned real property
    - Respond to follow up questions and further requests for information so that Sanford can accurately and promptly assess eligibility for financial assistance
    - Resolve and finalize any pending matters with applicable insurers and third party payers so that Sanford can proceed with the processing of a Financial Assistance Application

- Cooperation in applying for other financial assistance available through state or local agencies if qualified under the eligibility criteria of such programs

2. Patients (or guarantors) are expected to cooperate and to submit requested documents and information in a timely manner. Financial Assistance Applications will not be deemed complete until such time that the patient or guarantor submits all required documents. Sanford allows patients and guarantors a reasonable amount of time to submit the supporting documentation and to respond to follow up requests. A pending or incomplete Financial Assistance Application will be cancelled if the patient or guarantor:
   - Fails to submit all required supporting documentation within 30 days, or
   - Fails to respond to any follow-up questions and requests within 30 days.

3. In the event that the patient or guarantor applies for financial assistance after an unpaid account has been referred to an external collection agency, Sanford will refrain from any extraordinary collection actions while the application remains incomplete and awaiting all required documents. However, in the event that a pending Financial Assistance Application is cancelled for a reason stated in the above paragraph, the unpaid account shall be subject to the terms and provisions of Sanford's Collections Policy.

4. Upon receipt of a Financial Assistance Application that is deemed "complete", Sanford will:
   - Suspend all collection activity until such time that Sanford makes a final determination on the eligibility for financial assistance
   - Make a determination of the eligibility for financial assistance within 30 days of receipt of a completed Financial Assistance Application
   - Notify the patient (or guarantor) by mail within 30 days of Sanford's determination to approve or deny the Financial Assistance Application
   - In cases where full or partial financial assistance is approved, make appropriate adjustments in the account to reflect the percentage and amount of financial assistance

5. Subject to Sanford's discretion, once a patient or guarantor has qualified for financial assistance, the eligibility can be extended up to a maximum of six months from the approval date to cover future qualified care or services. To be eligible for this extended term, Sanford may require patients or guarantors to provide updated financial information.

6. Financial assistance can be granted solely for services and care performed by Sanford providers. Services provided by non-Sanford physicians, providers, facilities or organizations are not eligible for financial assistance granted through this policy.

7. Sanford shall maintain confidentiality for all Financial Assistance Applications and supporting documents and may share this information outside of Sanford only upon written or verbal request from the patient or guarantor, or upon request by Sanford's external auditors, collection agencies, or law firms.

Granting Full or Partial Financial Assistance

1. For patients or guarantors who are deemed qualified for full financial assistance, Sanford will send a written notification by mail within 30 days of that determination.

2. For patients (or guarantors) who are deemed qualified for partial financial assistance, Sanford (or its external collection agency if the patient account has been referred to collections) will submit a bill to the patient or guarantor reflecting the discount for the partial financial assistance. In these cases, the amount accepted for payment for emergency or other medically necessary care will not exceed the amount Sanford accepts as "payment in full" for the same services provided to patients who are insured by third party payers (including Medicare and all private health insurers).
    - "Payment in full" for insured patients has two components: the amount required to be paid by the third party insurer **plus** the amount required to be paid by the patient.
    - The "payment in full" amount is established by Sanford by calculating the weighted average of discounts provided to Medicare and all private commercial health insurers. The "payment in full" calculation is established every twelve months by analyzing the actual claims paid to Sanford by insured patients and their third party payers for the previous twelve months.

Collections Practices

Sanford expects payment from patients and guarantors who have the ability to pay. In the event such patients or guarantors fail or refuse to fulfill their financial obligation, Sanford may engage in collections action including the referral of unpaid accounts to external collections agencies. Sanford will not engage in extraordinary collection actions before taking reasonable efforts to determine whether an individual who has an unpaid account is eligible for financial assistance.

Administration of this Policy

It is the responsibility of each Sanford facility to develop local operating procedures to administer this policy, including the following:

- Determination of local multi-lingual requirements for signage and other documents, and arrangements for interpreters
- Education and training of staff for communicating financial assistance availability for patients served in their facility
- Tracking procedures and account adjustment codes for Sanford facilities that do not utilize Sanford's centralized billing function

JoAnn Kunkel
Chief Financial Officer

7.02.2013
Date

SANFORD PATIENT FINANCIAL SERVICES POLICY	**Sanford Health National Health Service Corp (NHSC) Discount Fee Program**
CREATED: 12/13	**SCOPE:** Sanford owned NHSC Certifies Facilities
REVIEWED:	**APPROVED BY:** Chief Financial Officer
REVISED:	**FORMULATED BY:** Finance and Compliance

PURPOSE

Sanford is committed to providing emergency and medically necessary care to all patients without regard to race, creed, sex, national origin, disability, age, or ability to pay. For purposes of this policy, "medically necessary" care is defined as healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms that meet accepted standards of medicine.

This policy sets forth the Sanford policy to offer and provide a discount to qualified patients receiving emergency and medically necessary care at a Sanford NHSC-certified facilities.

This policy applies solely to care and services delivered at a NHSC-certified facility, and includes laboratory and x-ray services provided in the facility.

This policy does not apply to care and services delivered at non-NHSC Sanford facilities. This policy also does not apply to services purchased outside, including reference laboratory testing, drugs, and x-ray interpretations by consulting radiologists and other such services.

POLICY

Discounts are offered based upon family/household size and annual income. A 100% discount is offered to patients who are at or below 225% of the current year's Federal Poverty Level (FPL).

Subject to Sanford's discretion, once a patient has qualified for a discount under this policy, the eligibility can be extended up to a maximum of six months from the approved date to cover future qualified care or services. To be eligible for this extended term, Sanford may request updated information from patients.

_____ _____

JoAnn Kunkel
Chief Financial Officer

Date

WIPFLi CPAs and Consultants

Market/Demand Assessment

Service Area

x Market Share

\+ Allowance for Inmigration

= POPULATION SERVED

- **Primary Service Area (PSA)**

Primary Service Area
56701 - Thief River Falls

- **Secondary Service Area (SSA)**

Secondary Service Area	
56715 - Brooks	56748 - Plummer
56738 - New Folden	56750 - Red Lake Falls
56754 - St. Hilaire	

WIPFLi CPAs and Consultants

Competition

Service Area Map

Service Area

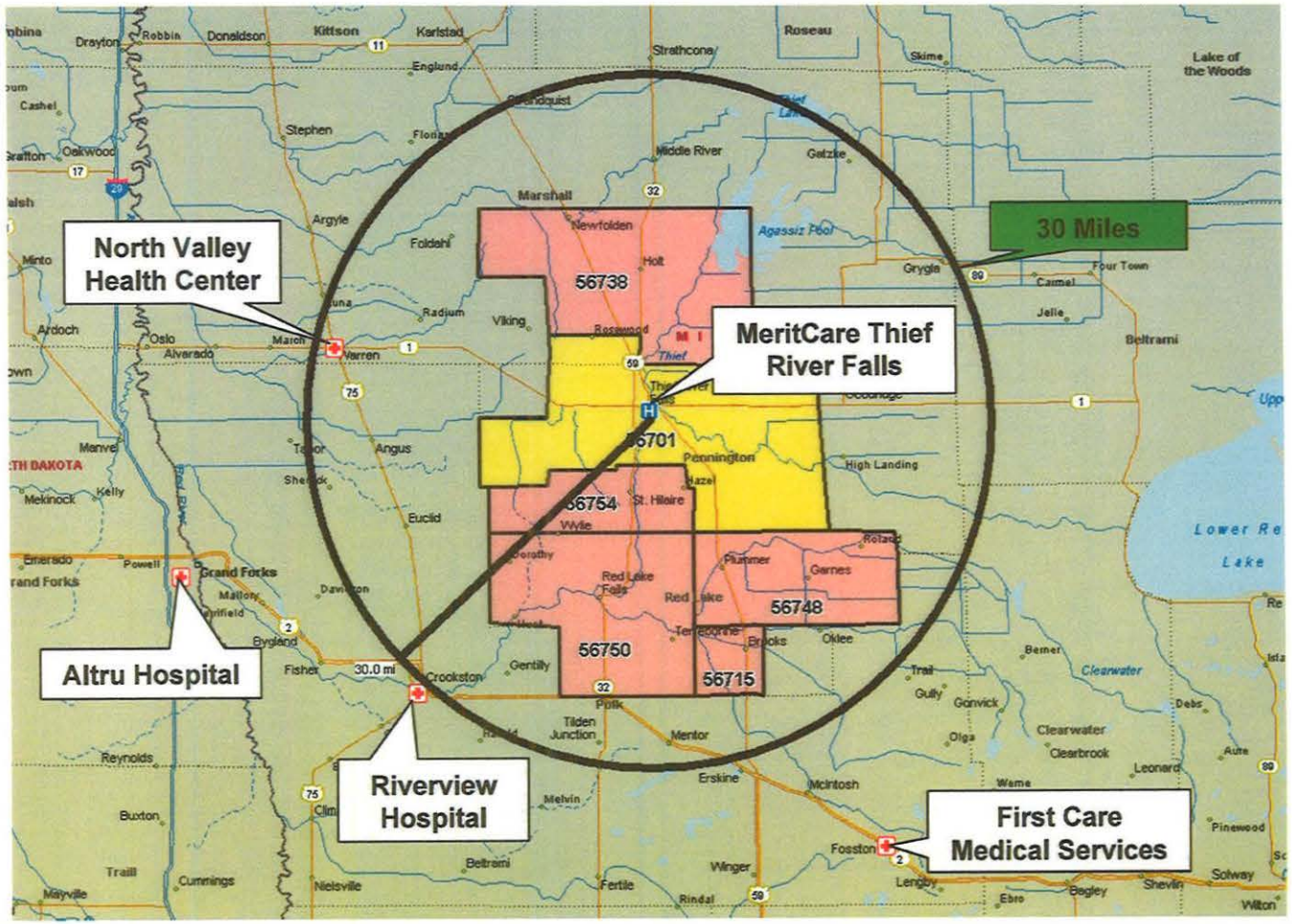
x Market Share

\+ Allowance for Inmigration

= POPULATION SERVED

= PSA

= SSA



WIPFLi CPAs and Consultants

Market/Demand Assessment

Population Analysis

Service Area

x **Market Share**

\+ **Allowance for Inmigration**

= **POPULATION SERVED**

- **PSA has remained relatively flat over the past 5 years**
  - Most CAH areas are experiencing a flat to declining population
- **SSA has experienced slight decline**

	2004	2005	2006	2007	2008	2009	Variance (2004-2009)	% Change (2004-2009)
Primary Service Area (PSA)								
56701 - Thief River Falls	12,311	12,339	12,368	12,396	12,425	12,467	156	1.3%
PSA Total	***12,311***	***12,339***	***12,368***	***12,396***	***12,425***	***12,467***	**156**	**1.3%**
Secondary Service Area (SSA)								
56715 - Brooks	258	256	255	253	251	250	-8	-3.2%
56738 - New Folden	1,551	1,541	1,532	1,522	1,513	1,508	-43	-2.7%
56754 - St. Hilaire	742	740	738	736	734	735	-7	-1.0%
56748 - Plummer	712	708	705	701	697	695	-17	-2.4%
56750 - Red Lake Falls	2,680	2,676	2,673	2,669	2,665	2,659	-21	-0.8%
SSA Total	***5,943***	***5,922***	***5,901***	***5,881***	***5,860***	***5,846***	**-96**	**-1.6%**
Total Service Area	**18,253**	**18,261**	**18,269**	**18,277**	**18,285**	**18,313**	**60**	**0.3%**

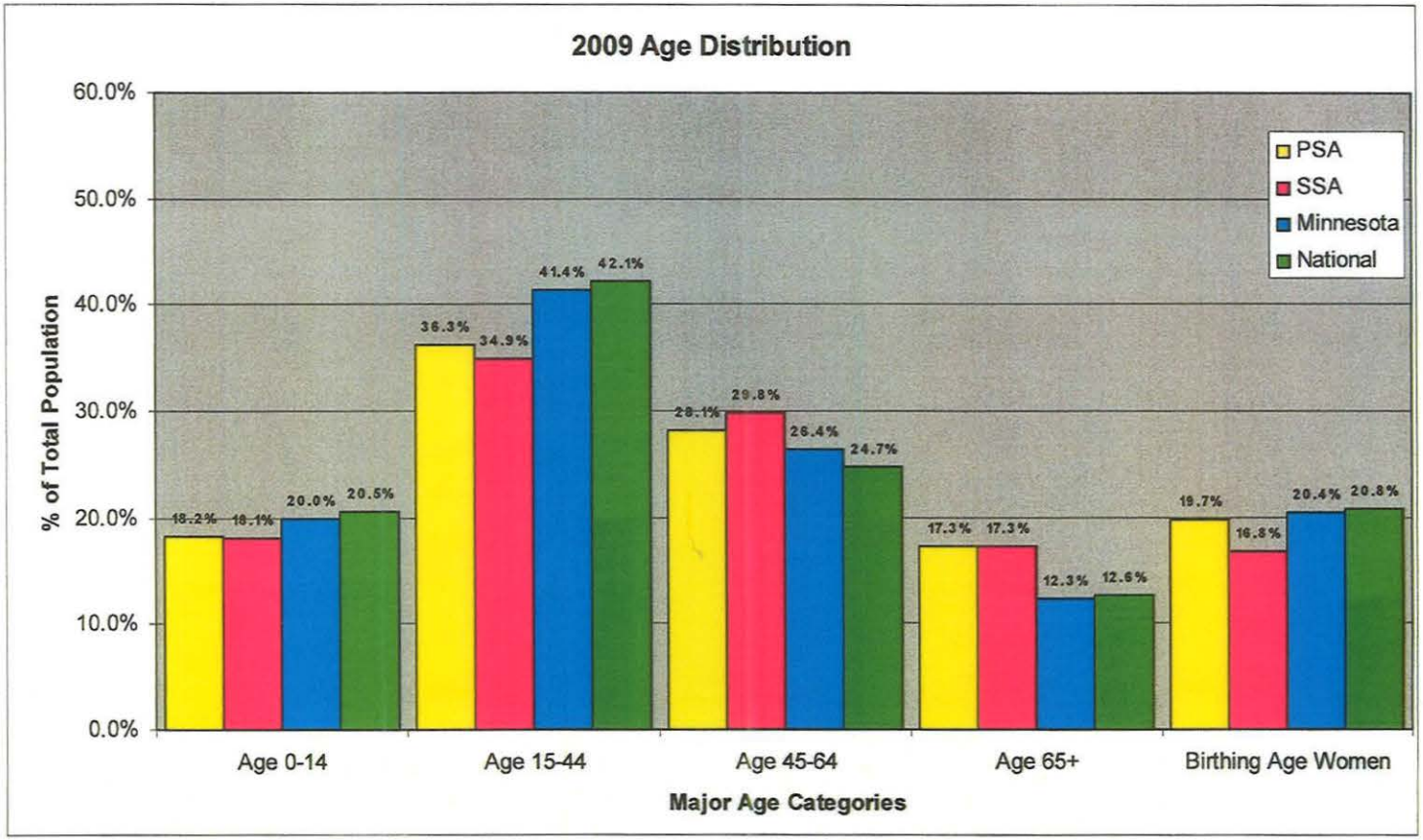
Source: ESRI Business Information Solutions

WIPFLi CPAs and Consultants

Market/Demand Assessment

2009 Age Distribution

- **PSA and SSA have a significantly older population**
  - 65+ age cohort is 5 percentage points higher than state and national averages



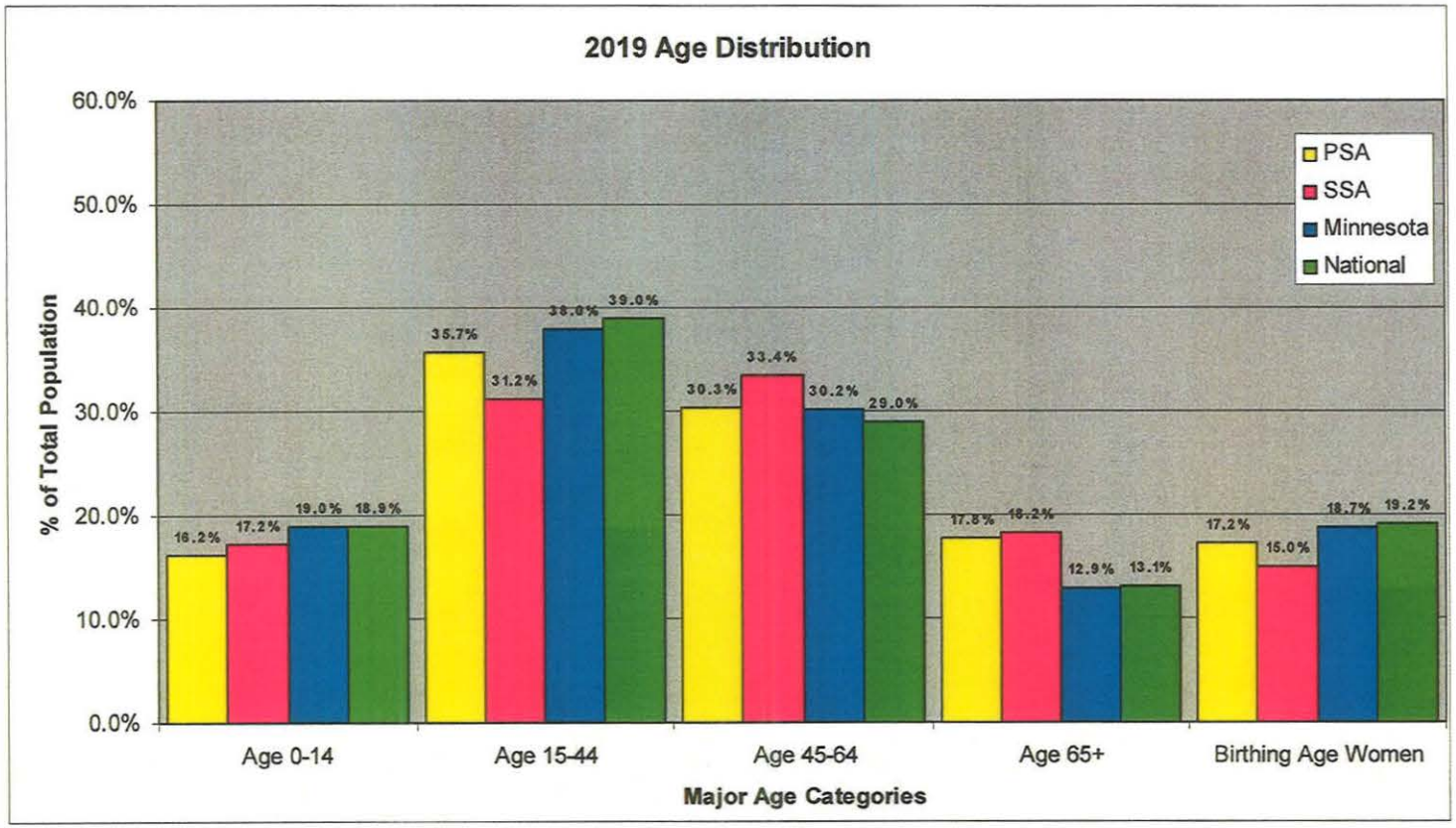
Source: ESRI Business Information Solutions

WIPFLi CPAs and Consultants

Market/Demand Assessment

2019 Age Distribution

- **Older age cohorts anticipated to grow in size over the next 10 years**
  - Utilization rates should increase as population ages



Source: ESRI Business Information Solutions

WIPFLi CPAs and Consultants

Market/Demand Assessment

2019 Pop. % Change

Service Area

x **Market Share**

\+ **Allowance for Inmigration**

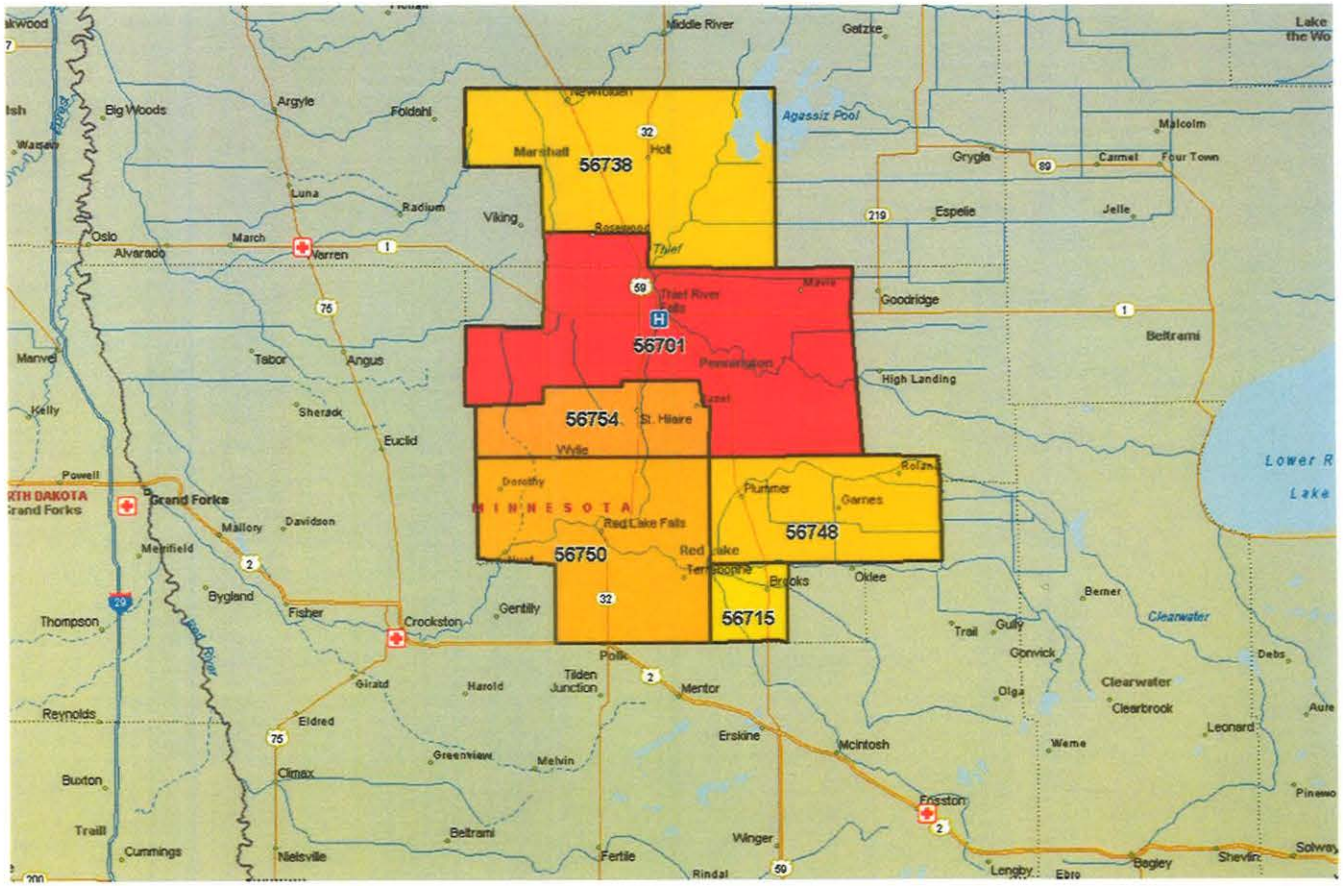
= **POPULATION SERVED**

4%

-1%

-6%

- **Expected growth varies throughout the region**
  - Strongest future growth expected in Thief River Falls



WIPFLi CPAs and Consultants

Market/Demand Assessment

Population Analysis

Service Area

x **Market Share**

\+ **Allowance for Inmigration**

= **POPULATION SERVED**

- **Population growth scenarios were developed to provide sensitivity to volume estimates**
  - 5% over / under growth factors were applied to Medium projections to provide sensitivity
  - Low scenario reflects a slight decline in population
  - High scenario purposefully more aggressive to test capacities

	Reference % Change (2004-2009)	Low % Change (2009-2019)	Medium % Change (2009-2019)	High % Change (2009-2019)
Primary Service Area (PSA)				
56701 - Thief River Falls	1.3%	-2.0%	3.0%	8.0%
PSA Total	**1.3%**	**-2.0%**	**3.0%**	**8.0%**
Secondary Service Area (SSA)				
56715 - Brooks	-3.2%	-10.5%	-5.5%	-0.5%
56738 - New Folden	-2.7%	-9.4%	-4.4%	0.6%
56754 - St. Hilaire	-1.0%	-5.4%	-0.4%	4.6%
56748 - Plummer	-2.4%	-8.8%	-3.8%	1.2%
56750 - Red Lake Falls	-0.8%	-7.0%	-2.0%	3.0%
SSA Total	**-1.6%**	**-7.8%**	**-2.8%**	**2.2%**
Total Service Area	**0.3%**	**-3.9%**	**1.1%**	**6.1%**

Source: ESRI Business Information Solutions

WIPFLi CPAs and Consultants

Market/Demand Assessment

Population Analysis

Service Area

x **Market Share**

\+ **Allowance for Inmigration**

= **POPULATION SERVED**

- **Service area population anticipated to grow by 208 under the Medium scenario**
  - Low scenario projects decline of 708
  - High scenario projects growth of 1,124

	2009 Population	2019 Estimated Population Low	Medium	High	Variance (2009-2019) Low	Medium	High
Primary Service Area (PSA)							
56701 - Thief River Falls	12,467	12,213	12,837	13,460	-253	370	993
PSA Total	**12,467**	**12,213**	**12,837**	**13,460**	***-253***	***370***	***993***
Secondary Service Area (SSA)							
56715 - Brooks	250	224	236	249	-26	-14	-1
56738 - New Folden	1,508	1,367	1,442	1,518	-141	-66	10
56754 - St. Hilaire	735	695	732	768	-40	-3	34
56748 - Plummer	695	634	669	703	-61	-26	8
56750 - Red Lake Falls	2,659	2,473	2,606	2,739	-186	-53	80
SSA Total	**5,846**	**5,392**	**5,684**	**5,977**	***-454***	***-162***	***130***
Total Service Area	**18,313**	**17,605**	**18,521**	**19,437**	**-708**	**208**	**1,124**

Source: ESRI Business Information Solutions

Johnson,Casey

From: Johnson,Casey
Sent: Thursday, January 02, 2014 5:43 PM
To: Robertson, Megan (ADM)
Subject: RE: when will projections be available?

Understandable.

Casey J.

From: Robertson, Megan (ADM) [mailto:Megan.Robertson@state.mn.us]
Sent: Thursday, January 02, 2014 4:28 PM
To: Johnson,Casey
Subject: Re: when will projections be available?

It makes sense to wait but I cannot guarantee similarity for any counties from earlier datasets. The methodology for the dataset is entirely new from the last release, as are the data inputs.

Megan

On Jan 2, 2014, at 4:24 PM, "Johnson,Casey" <Casey.Johnson@sanfordhealth.org> wrote:

> I understand the time crunch. I'm in the same boat. I will include in my report to DHS for public review some information that we put together during a market study back in 2010, but will include the context that we're waiting for approval to use latest projections from the state demographer's dataset, which will be more accurate, but likely not a significant departure from previous projections, which are relatively flat, for our counties.
>
> That make sense from your perspective?
>
> Casey J.
>
> ---
>
> **From:** Robertson, Megan (ADM) [mailto:Megan.Robertson@state.mn.us]
> **Sent:** Thursday, January 02, 2014 4:12 PM
> **To:** Johnson,Casey
> **Subject:** Re: when will projections be available?
>
> Casey.
>
> I'm nearly finished with the dataset but have been delayed about a week for approval. How about I email you when they're available.
>
> Does that work?

I apologize for the delay. I'm working as fast as I can.

Kind regards,

Megan

On Jan 2, 2014, at 3:14 PM, "Johnson,Casey" <Casey.Johnson@sanfordhealth.org> wrote:

> It says they should be available as of 2013, but are not on the site, at least not that I can find. Could I get access to prior projections if these are not completed. Please let me know as soon as possible, as we are planning moratorium legislation to be presented possibly January 13th.

Casey R. Johnson
CFO, Sanford Health - TRF
120 LaBree Ave S
Thief River Falls, MN 56701
E: casey.johnson@sanfordhealth.org
P: (218) 683-4636

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privileged and confidential information. Any unauthorized review, use,
disclosure or distribution is prohibited. If you are not the intended
recipient, please contact the sender by reply e-mail and destroy
all copies of the original message.

City/Township	County total

State Demographer's Revised Extrapolations
for Proposed Primary Service Area

	Data						
County	Sum of 2006	Sum of 2010	Sum of 2015	Sum of 2020	Sum of 2025	Sum of 2030	Sum of 2035
Beltrami	43,094	46,590	49,720	52,380	54,750	56,430	57,900
Clearwater	8,453	8,790	9,060	9,270	9,410	9,470	9,530
Kittson	4,723	4,420	4,190	4,000	3,870	3,720	3,620
Lake of the Woods	4,360	4,410	4,420	4,500	4,550	4,530	4,500
Mahnomen	5,068	5,120	5,110	5,100	5,110	5,060	5,020
Marshall	9,955	9,860	9,900	9,990	10,060	10,010	9,960
Pennington	13,668	14,050	14,410	14,760	15,090	15,210	15,350
Polk	31,115	31,850	32,610	33,370	34,060	34,280	34,530
Red Lake	4,195	4,350	4,440	4,520	4,590	4,600	4,610
Roseau	16,361	17,080	17,700	18,330	18,840	19,170	19,430
Grand Total	140,992	146,520	151,560	156,220	160,330	162,480	164,450
Growth Rate		**3.9%**	**3.4%**	**3.1%**	**2.6%**	**1.3%**	**1.2%**

TRF Mental Health Inpatient

Mental Health Inpatient Admission Protocol MHITX00011.

Approved By:	MHI Director	Written By:	MHI Staff
Original Date:	07/10	Effective Date:	07/10
Review Date:	08/11	Revised Date:	07/10, 10/10, 08/13

SCOPE:

Sanford Thief River Falls Medical Center Mental Health Inpatient personnel.

PURPOSE:
To provide a protocol for Mental Health Inpatient admissions to ensure patient safety and provide the best possible care.

Admission Procedure: Refer to Admission Flow Chart

POLICY/PROCEDURE:

MEDICAL:

1. Questions about the patient's physical health should be limited to questions pertaining to physical symptoms that are relevant to safe admission and treatment on the inpatient unit. If a medical condition does not pose a clear and compelling need for the patient to be treated on a medical unit, the patient shall be admitted to our inpatient unit with referrals for medical care coordinated by inpatient staff when necessary.

2. Unless lab or other diagnostic testing is clearly needed to determine whether a patient is medically safe to transfer or whether the patient can be safely managed on our unit, such testing will be done at Sanford Medical Center following rather than preceding admission.

3. If the patient being referred has psychiatric symptoms that could be caused by a medical condition or if the psychiatric condition caused a medical condition (example: overdose), the charge nurse shall seek medical clearance approval from the psychiatric provider prior to accepting to ensure medical stability is reached. The referring facility shall fax all pertinent information, including labs and assessments, to the IP unit for review.

4. When a referral source calls with a referral for inpatient services, the Charge Nurse will not require that the patient be screened first in the emergency room unless the symptoms described indicate that admission to the psychiatric unit would likely compromise patient's medical safety.

INABILITY TO ACCEPT:

1. If a secure room is not available and a non-secure room is available, the patient being referred will be accepted unless **both** the charge nurse and the psychologist on call determine that it would be unsafe to admit the patient to a non-secure room or to transfer a patient in a secure room to a non-secure room in order to facilitate the admission.

2. Priority will be given to patients from our region (patients from Roseau, Kittson, Pennington, Polk, Norman, Mahnomen, Red Lake, and Marshall Counties). Second priority will be given to patients referred from outside our region but within our general catchment area (patients from Beltrami, Clearwater, Becker, and Lake of the Woods Counties). The lowest priority will be given to patients outside our catchment area.

3. Special Circumstances: Admission may be declined for reasons other than outlined criteria in incidences where patient safety is an issue **or** the specialized treatment required is unavailable and a referral is more appropriate. Situations may include, but not limited to: forensic patients with increased security needs, rival gang members, child with high-risk sex offenders (appropriate room must be considered), care needs of an individual beyond our capacity or victim/perpetrator relationship between patients. This decision should be made by Mental Health Inpatient Manager, Director, and/or Treatment Team.

4. Children under the age of 12 will not be admitted without special approval from the attending psychiatrist.

CHEMICAL DEPENDENCY:

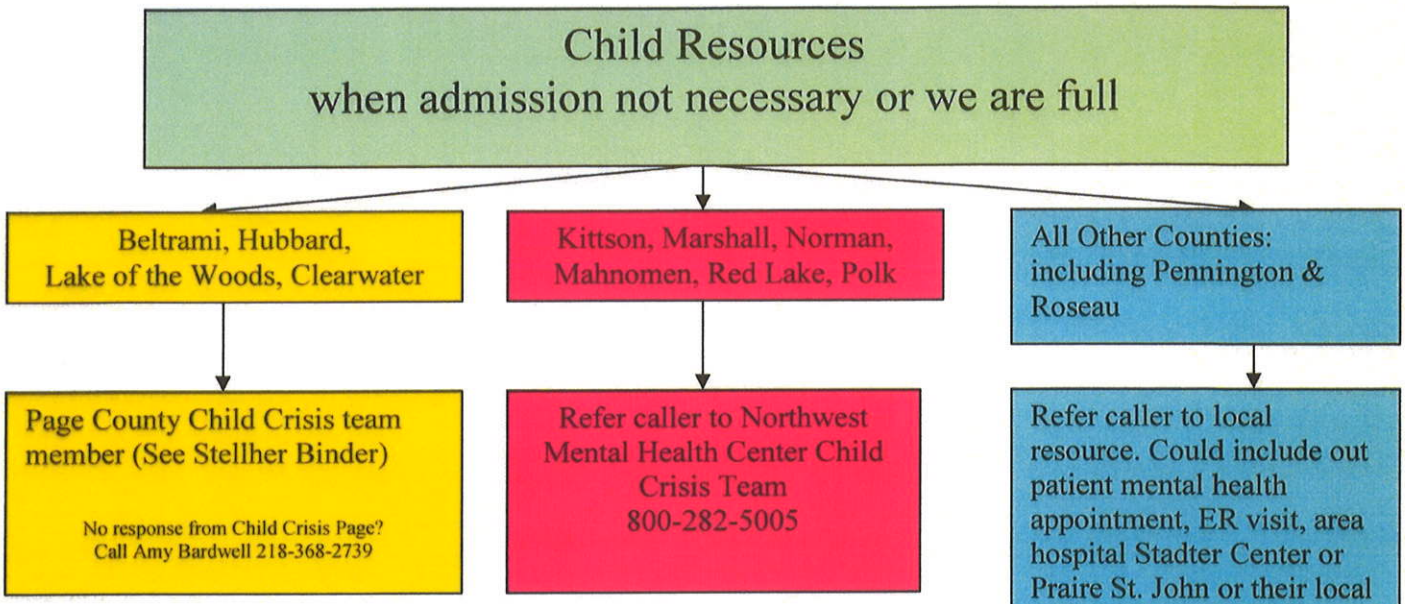
1. (A) Patients referred with a BAL of .20 or higher will not be admitted to the Psychiatric Unit until their BAL is below .20.

2. (B) Inpatients must have a psychiatric diagnosis or mental health symptoms to admit to inpatient. Refer as appropriate to Emergency Department, Detox, or a Chemical Dependency Unit, etc.

OTHER:

1. (A) Security staff or Mental Health worker responding to Emergency Department may relieve Law Enforcement when appropriate.

Admission Flow Chart



Other Counties Crisis Numbers
Not specifically Child Crisis Lines

Kittson, Mahnomen, Marshall, Norman, Red Lake, Polk	1-800-282-5005
Blue Earth	1-800-233-9929
Carver, Scott	1-952-442-7601
Benton, Sherburne, Stearns, Wright	1-320-253-5555
Hennepin, Brown, Faribault/Martin, Freeborn, Le Sueur, Mower, Nicollet, Rice, Sibley, Watonwan	1-612-596-1223
Jackson, Nobles, Pipestone, Rock	1-800-642-1525
Aitkin, Cass, Crow Wing, Morrison, Todd, Wadena	1-800-462-5525
Dodge, Steele, Waseca	1-507-451-1202
Dakota	1-952-891-7171
Douglas	1-320-762-1511
Itasca, Koochiching	1-218-326-8565
Chisago, Isanti, Kanabec, Mille Lacs, Pine	1-800-523-3333
Houston, Wabasha, Winona	1-507-454-4341
Wilkin	1-800-450-7223
Cook, Lake, St. Louis	1-800-634-8775
Washington	1-651-777-5222
McLeod	1-320-587-5502
Becker, Clay, Grant, Otter Tail	1-800-223-4512
Anoka	1-763-755-3801
Ramsey	1-651-266-7900
Cottonwood	1-800-642-1525
Carlton	1-218-723-0099
Big Stone, Stevens, Traverse	1-800-568-5955
Lincoln, Lyon, Murray, Redwood	1-800-658-2429
Chippewa, Kandiyohi, Lac Qui Parle, Meeker, Pope, Renville, Swift, Yellow Medicine	1-800-992-1716
Olmsted, Fillmore, Goodhue	1-507-281-6248
Beltrami, Pennington, Roseau, Clearwater,	

Altru Psychiatry Services
(Psychiatric Floor Nurses Station) 701-780-3440
1200 S Columbia Road Grand Forks, ND 58201

Sanford Hospital Psychiatry Services
"Physician 1 Call" 877-647-1225
Front Desk: 800-437-4010
1720 University Dr S Fargo, ND 58103

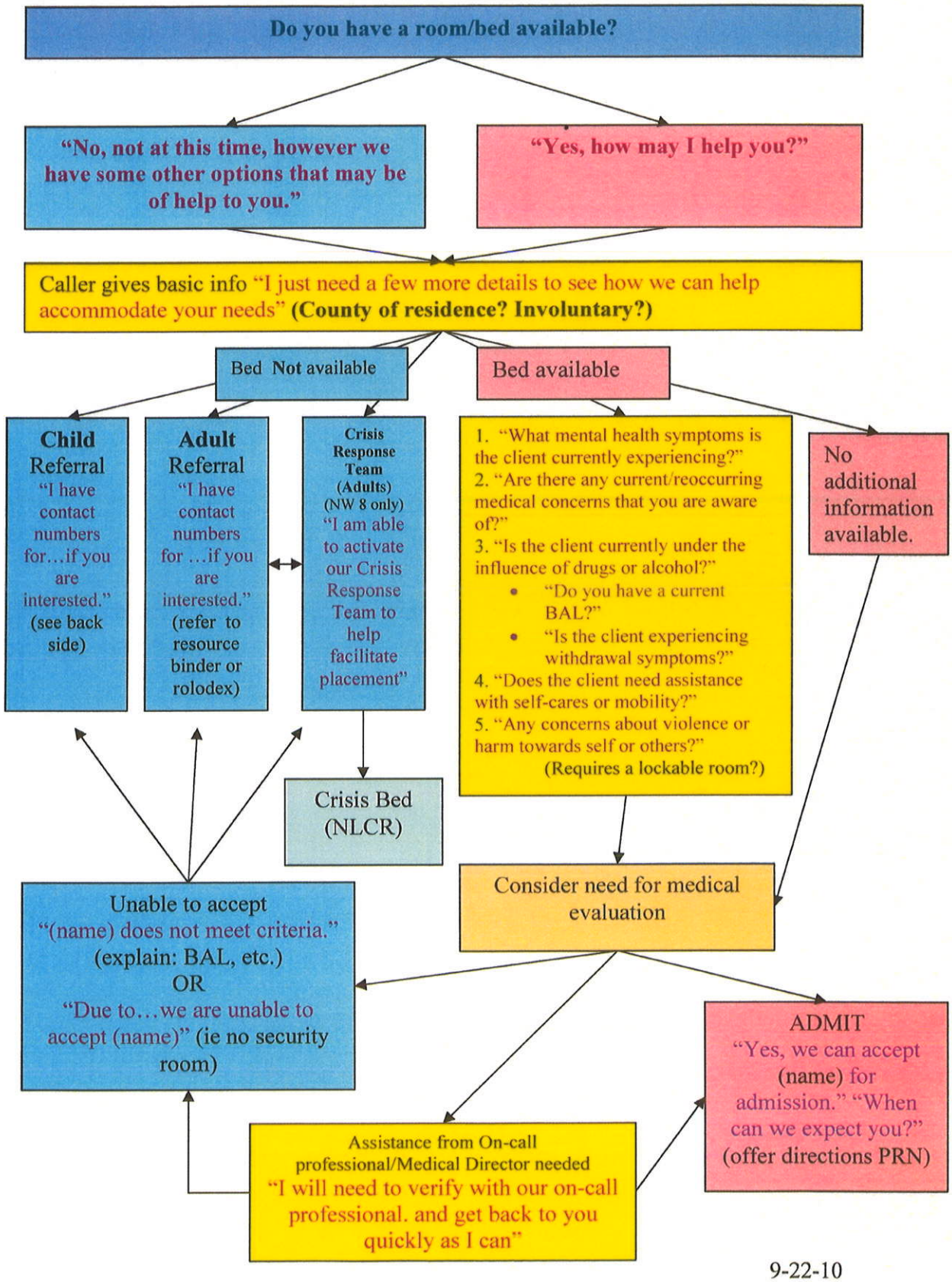
Prairie St. Johns
877-333-9565, 701-476-7216
510 4th Street South Fargo ND 58103

Stadter Center
866-772-2500, 701-772-2500
1451 44th Avenue South Grand Forks, ND 58201

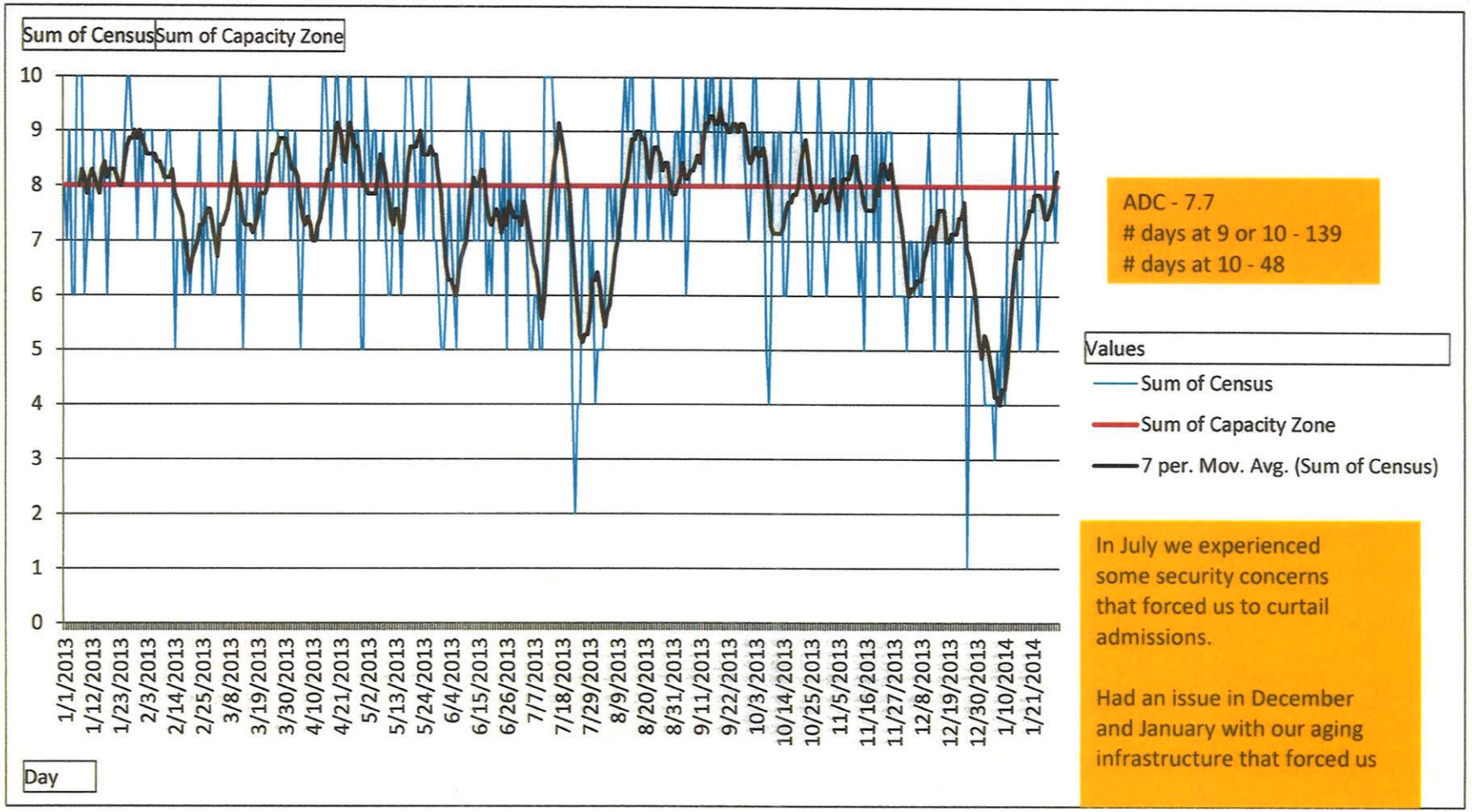
State Operated Services (S.O.S)
Central Pre-Admissions
866-966-BEDS (2337)

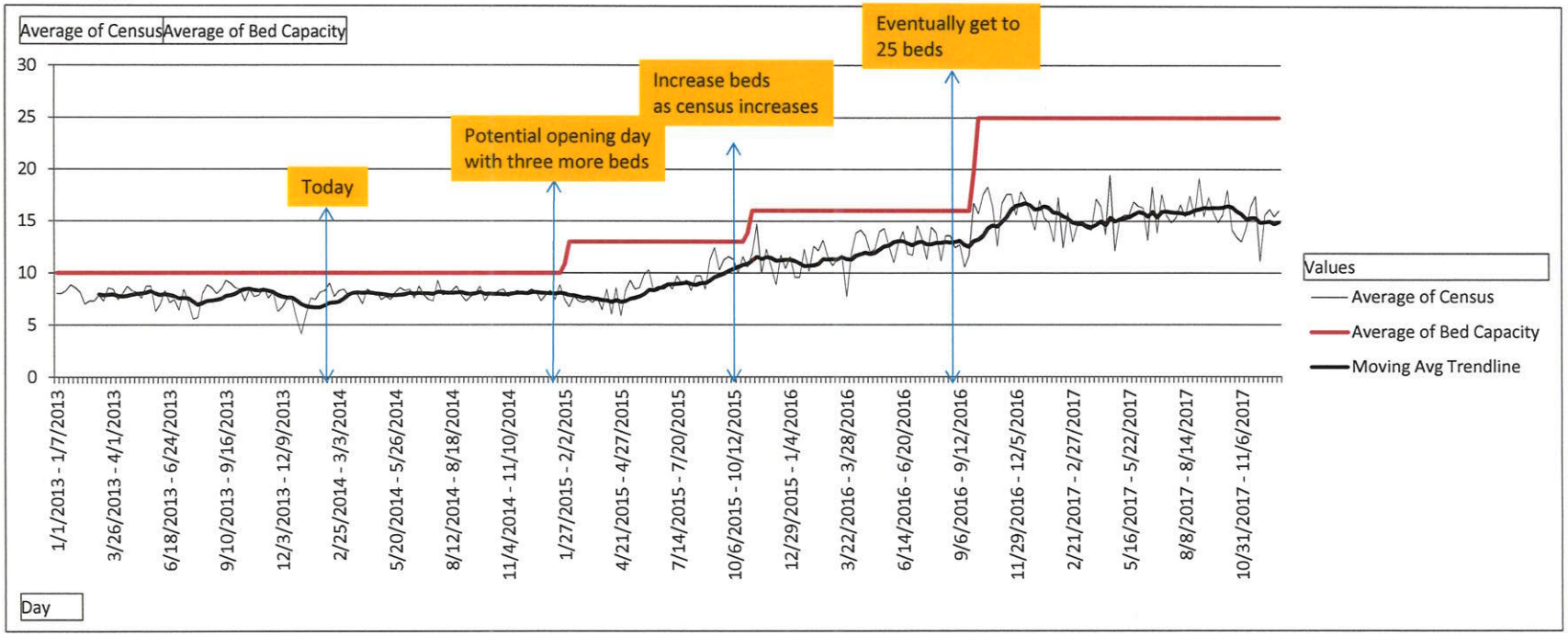
9-22-10
Lisa Holter

Admission Flow Chart



9-22-10
Lisa Holter


Sum of Census
Sum of Capacity Zone
10
9
8
7
6
5
4
3
2
1
0
1/1/2013
1/12/2013
1/23/2013
2/3/2013
2/14/2013
2/25/2013
3/8/2013
3/19/2013
3/30/2013
4/10/2013
4/21/2013
5/2/2013
5/13/2013
5/24/2013
6/4/2013
6/15/2013
6/26/2013
7/7/2013
7/18/2013
7/29/2013
8/9/2013
8/20/2013
8/31/2013
9/11/2013
9/22/2013
10/3/2013
10/14/2013
10/25/2013
11/5/2013
11/16/2013
11/27/2013
12/8/2013
12/19/2013
12/30/2013
1/10/2014
1/21/2014
Day
ADC - 7.7
days at 9 or 10 - 139
days at 10 - 48
Values
Sum of Census
Sum of Capacity Zone
7 per. Mov. Avg. (Sum of Census)
In July we experienced some security concerns that forced us to curtail admissions.
Had an issue in December and January with our aging infrastructure that forced us


Average of Census
Average of Bed Capacity
Today
Potential opening day with three more beds
Increase beds as census increases
Eventually get to 25 beds
30
25
20
15
10
5
0
1/1/2013 - 1/7/2013
3/26/2013 - 4/1/2013
6/18/2013 - 6/24/2013
9/10/2013 - 9/16/2013
12/3/2013 - 12/9/2013
2/25/2014 - 3/3/2014
5/20/2014 - 5/26/2014
8/12/2014 - 8/18/2014
11/4/2014 - 11/10/2014
1/27/2015 - 2/2/2015
4/21/2015 - 4/27/2015
7/14/2015 - 7/20/2015
10/6/2015 - 10/12/2015
12/29/2015 - 1/4/2016
3/22/2016 - 3/28/2016
6/14/2016 - 6/20/2016
9/6/2016 - 9/12/2016
11/29/2016 - 12/5/2016
2/21/2017 - 2/27/2017
5/16/2017 - 5/22/2017
8/8/2017 - 8/14/2017
10/31/2017 - 11/6/2017
Day
Values
Average of Census
Average of Bed Capacity
Moving Avg Trendline

- Excerpt from Community Health Needs Assessment (5)

Background

The NWCAC was formed as a result of the requirement for local public health agencies to conduct an assessment and strategic planning process patterned after NAACHO….more here

Participating Individuals/Agencies
Five public health agencies and two hospital administrators representing the counties of Roseau, Kittson, Marshall, Pennington and Red Lake in Northwest Minnesota convened in 2012 to complete a regional assessment of health needs.

Members of the committee were as follows

Name	Title	Agency	County
Rachel Green	Quin CHS Administrator	Quin Community Health Services	5-county region
Julie Pahlen	Public Health Administrator	Life Care Medical Center-Warroad	Roseau
Sue Grafstrom	Development Coordinator		Roseau
Casey Johnson	CEO	Sanford Medical Center-Thief River Falls	Pennington
Kevin Smith	CEO	North Valley Health Center	Marshall
Anita Cardinal	Public Health Administrator		Pennington/Red Lake
Gail Larson	Public Health Administrator	North Valley Health Center	Marshall
Paula Hedlund		Life Care Medical Center-Roseau	Roseau
Betty Younggren	NVHC Representative		
Cindy Urbaniak			
Garth Kruger		EvaluationGroup, LLC	

How many times group met

Purpose

Two research questions were addressed: 1) What do archival statistics collected on regional health indicators reveal as problem areas? 2) What do people around the region think are pressing health concerns?

Methods

Quantitative

A wide range of available archival statistical data was reviewed and analyzed, including those from:

- Behavioral Risk Factor Surveillance Survey (BRFSS) 2004-2010
- Minnesota Student Survey 2010
- Kids Count 2012
- Census 2010
- Minnesota Vital Statistics 2005-2009 Trends

- Minnesota County Health Tables 2011
- Atlas Online 2012
- U.S. Environmental Protection Agency
- Minnesota Public Health Data Access 2000-2008
- Minnesota Department of Health

Data throughout this report will be reported by ZIP code where possible in order to allow the greatest degree of resolution in pinpointing geographic and sociologic disparities. School district data is also used where available and deemed useful. Both these boundaries are presented in the following two figures along with corresponding county boundaries in order to provide a geo-referenced context for the information provided herein.

BRFSS Analysis

This report provides the most recent available state and county data on important behavioral risks including physical activity levels, consumption of fruits and vegetables, excessive alcohol consumption, tobacco use, exposure to second hand smoke, preventive cancer screenings, overweight and obesity levels. The report also provides prevalence rates for debilitating chronic conditions and life threatening events such as heart disease, diabetes and stroke.

All state and county data have been extracted from the Behavioral Risk Factor Surveillance Survey (BRFSS) database (see Appendix 1 for additional methodological details).
Specifically, indices of tobacco use, excessive alcohol consumption, overweight and obesity, chronic conditions and cancer screenings were obtained from the 2010 BRFSS database. Optional modules on physical activity and fruit and vegetable consumption were used in the Minnesota survey in 2009. Thus these statistics were derived from the 2009 BRFSS database. Finally data on secondhand smoke policy refers to the 2004 BRFSS administration when this optional module was last used in Minnesota.

Furthermore out of 5 counties of interest (Kittson, Marshall, Pennington, Roseau and Red Lake) BRFSS data was only available for the first three. No data was available for either Red Lake or Roseau Counties. While the number of individuals surveyed in the remaining counties in the most representative year of 2010 were still fairly low (65 participants in Kittson County, 27 participants in Marshall county and 58 individuals in Pennington county), prevalence estimates for specific risks and conditions in these counties were further adjusted using combined weights derived by the Centers for Disease Control (CDC) during national BRFSS administration.

Specifically the final weights used in statistical estimation on the state and county levels take into consideration the *Stratum weight* (number of records in a stratum divided by the number of records selected), *Raw weighting factor* (number of adults in the household divided by the imputed number of phones), and the *Post-stratification weight* (Population estimate for race/gender/age categories divided by the weighted sample frequency by race/gender/age). Adjustment by the final weight is thus thought to render more accurate estimates of population statistics which are presented in this report with 95% confidence (a range of values that is 95% likely to contain the true population value).

MNSS Analysis

The description of behavioral health risk in youth and young adults for individual MN counties is based on the 2007 and 2010 Minnesota Student Surveys which were conducted by approximately 91% of public operating school disThreects. The Minnesota Student Survey encompasses a number of health risk behaviors including tobacco use, diet, physical activity and prevalence of obesity and is administered to public school students in

Grades 6, 9, and 12. Only responses from 12th-grade students were used in the statistical analysis presented in this report. EvaluationGroup, LLC staff contacted the MN Student Survey administrators and obtained a copy of the raw dataset for further analysis which were used in this report. We are indebted to their generosity for permitting us use of this data in pursuit of the mission of improving health throughout Minnesota.

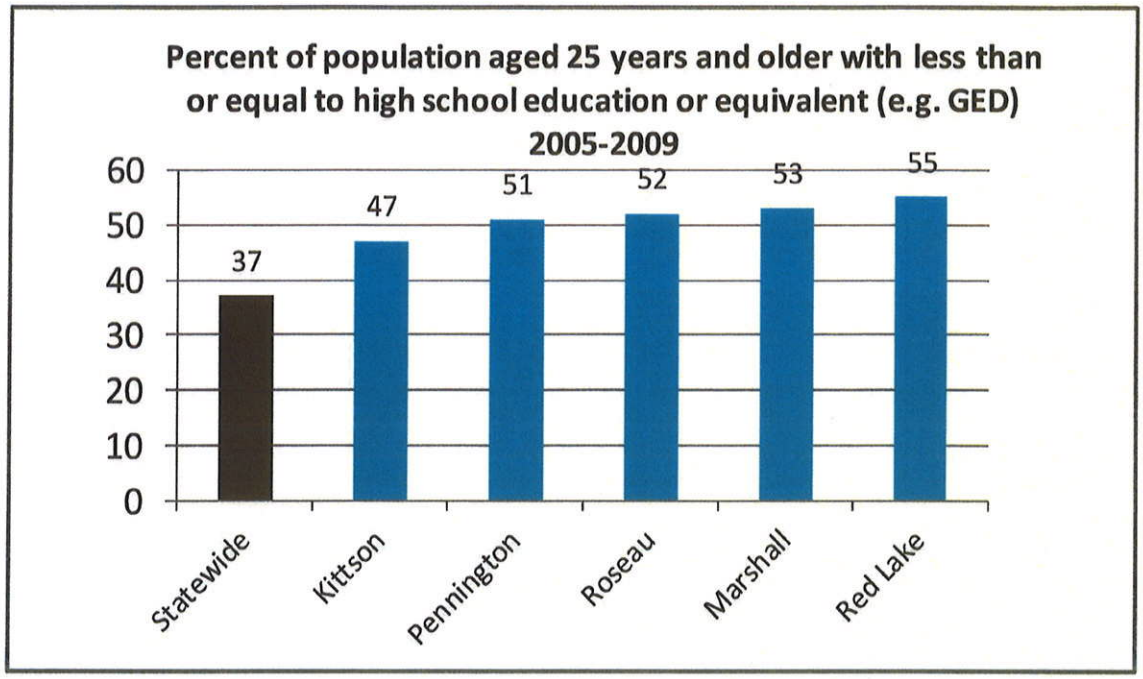
Qualitative

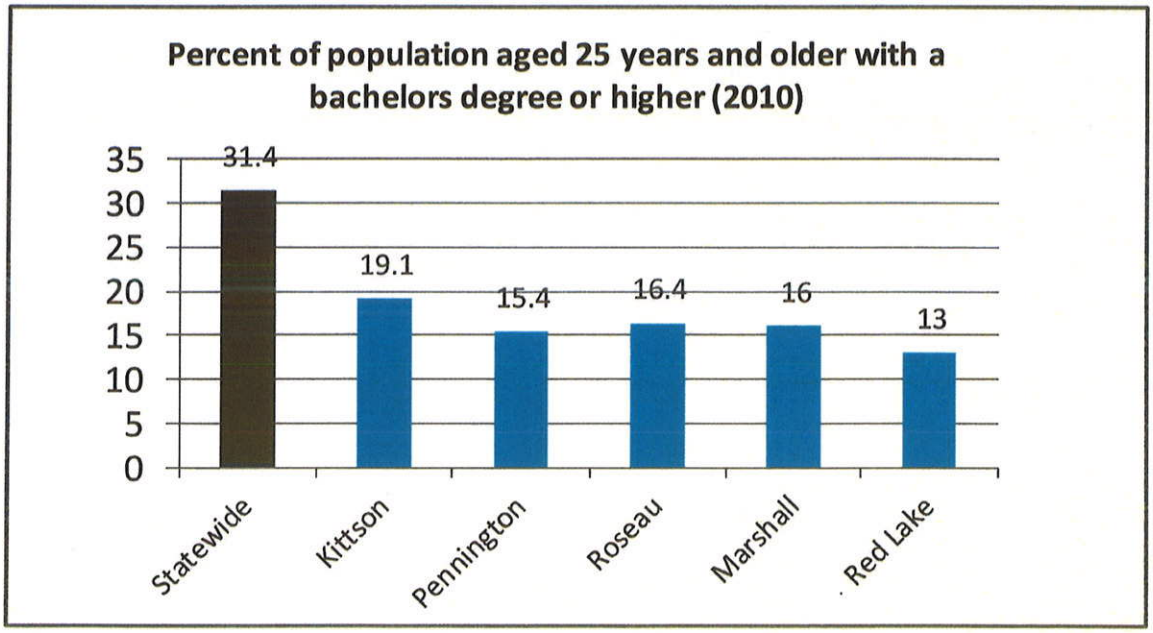
Additionally, qualitative input was gathered from two meetings of the Northwest Community Assessment Committee (NWCAC). Telephone and in-person interviews were also conducted with 8 individuals from across the region with years of experience in healthcare provision.

Educational Levels

Educational levels of area residents are substantially lower than in comparison to the rest of the state.

Indicator #8





Regional Income and Poverty

Median Income

The U.S. Median income from 2006-2010 was $51,914. In Minnesota during the same time frame it was $57,243 (http://quickfacts.census.gov/qfd/states/27000.html). Statistics show that median income in the NWCAC region ranges between 14-22% lower ($7,843 to $12,317) than the statewide average. Across a working lifetime of 40 years this means that a household in the middle of the income distribution brings home $300,000 to $500,000 less than other households across the state.

County	Median Household Income
Pennington	$44,926
Kittson	$47,568
Red Lake	$47,835
Marshall	$48,565
Roseau	$49,400
Minnesota	$57,243
USA	$51,914
World	$7,000*

***Average income**

Income relative to ZIP code is presented in Figure 5 and shows that the median household income in the NWCAC region is lowest across a large swath of the area spanning from the northwest corner to the southeast, cutting through Kittson, Roseau and Marshall Counties. While the population is this area is generally the most sparse, they may also be considered higher risk given their proportionally lower incomes compared to the rest of the region.

Per Capita Income

Per capita income or income per person is a measure of mean income within an economic aggregate, such as a country, city or county. It is calculated by taking a measure of all sources of income in the aggregate (such as GDP or Gross National Income) and dividing it by the total population. It does not attempt to reflect the distribution of income or wealth. http://en.wikipedia.org/wiki/Per_capita_income
Per capita income has several weaknesses as a measurement of prosperity, including:

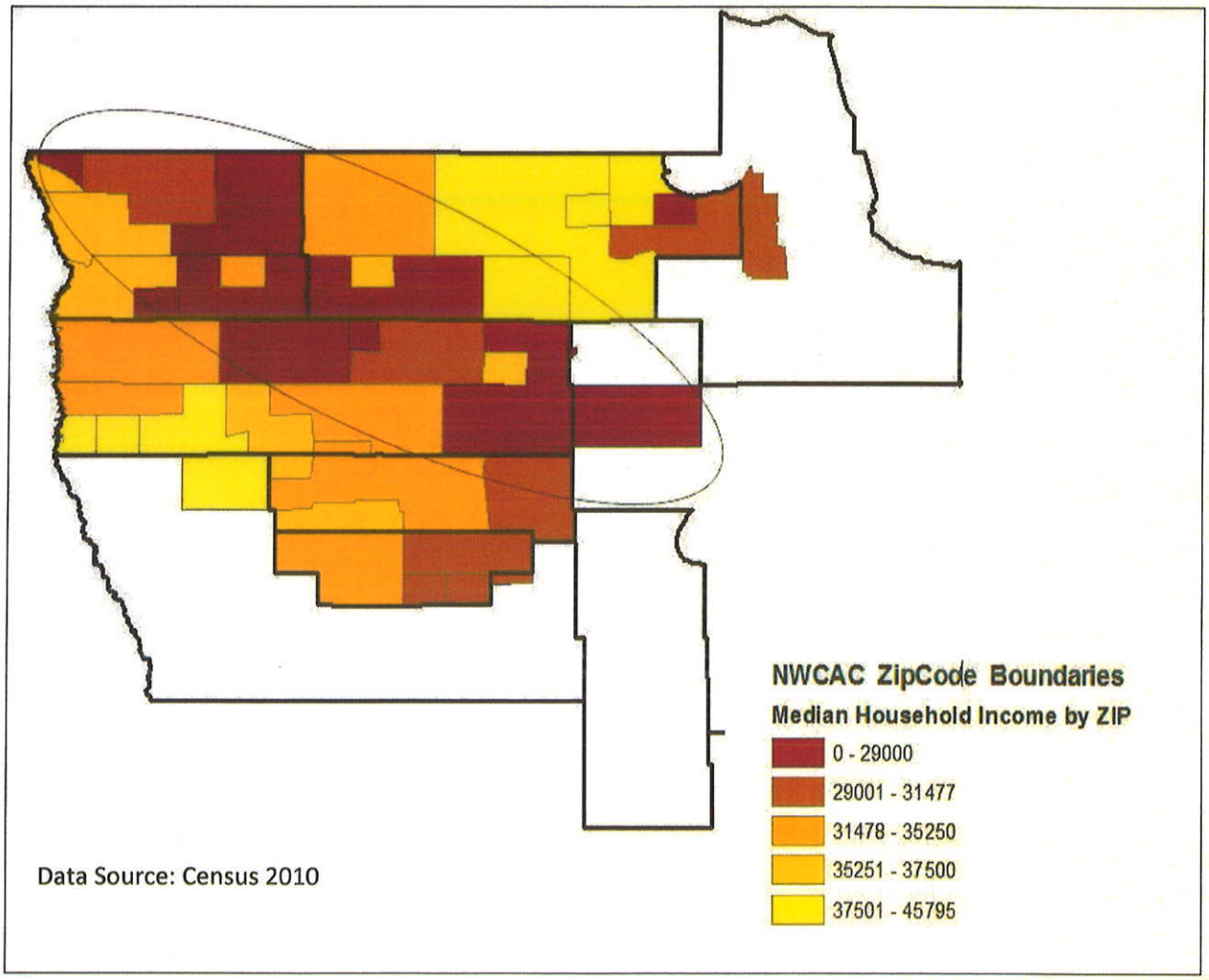
- As it is a mean value, it does not reflect income distribution. If the distribution of income within a country is skewed, a small wealthy class can increase per capita income far above that of the majority of the population. In this respect Median income is a more useful measure of prosperity than per capita income, because it is less influenced by the outliers.

- Economic activity that does not result in monetary income, such as service provided within the family, or for barter, are usually not counted. The importance of these services varies widely among different economies.

Indicator #72

Total per capita income 2004-2008					
	2004	2005	2006	2007	2008
Red Lake	$21,970	$23,698	$24,243	$28,206	$29,707
Pennington	$31,225	$33,671	$33,250	$35,873	$38,607
Roseau	$28,413	$31,495	$32,742	$35,150	$39,434
Marshall	$26,019	$26,894	$28,447	$31,624	$43,631
Kittson	$27,731	$27,766	$28,798	$31,322	$52,127
Statewide	$36,184	$37,290	$38,859	$41,105	$42,953

Figure 5: Median household income for NWCAC region



Qualitative Findings

NWCAC Meeting Notes/Surveys

On June 5th, 2012the NWCAC met in Newfolden, MN with 12 people attending. Participants were asked to think broadly about the different recurring needs and concerns of clients and the general population served by them and their organizations. Overall, responses were grouped into the following issue areas below.

- Recurring public health needs are the cumulative effects of low income. Little money, lack of knowledge, dental problems, and behavioral issues create a cycle of problems that the families cannot get control of.
  - There are many working poor in the region
  - Financial problems can be extreme
  - Money management skills may be a concern

- Declines in two-parent families and parent skills
  - Not all parents are interested in fixing a problem if it is pointed out
  - Lots of single head of household
    - How does public health address this/overcome these barriers?

- Drug problems in school
  - Especially prescription drugs

- Major chronic diseases are believed to be a problem, especially cardiovascular and diabetes
  - Are these higher in our area than in the rest of the state.

- Mental Health needs are high
  - Hospital Emergency Rooms are bearing the brunt of mental health needs
  - Elevated rates of 72 hour holds.
  - Difficult to get people to access mental health services appropriately.
  - Individuals in need of mental health services are spending inordinate amount of time in emergency rooms. They need to get to a behavioral health unit but no one wants to transport them.
    - Law enforcement doesn't want them, and ambulances don't want them because they won't get paid.
  - Mental health HPSA-we don't have providers.
  - Average psychiatric enrollment days have dropped from 9 to 5 because of the increase in the number of 72 hour holds by law enforcement

- Personal Care Assistant (PCA) training needs
  - There is a desperate need for training for behavioral health aides. They need training for more effective health interventions. In-home/home based services (PCA's)
  - Expanding behavior health services
  - Some concerns that parents/individuals may be 'gaming' the PCA system.

- Chemical dependency

- People who have diabetes and care about it address the problem. Those who have diabetes and don't care end up costing the system

- ❖ Don't look at health insurance rates in Roseau County because there is a high rate of factory workers who are covered by insurance.

- ❖ Transportation is an intermittent problem.

The group was also asked "*Where might there be problems but no data to back it up? In other words, what "hunches" do you have? Have you heard hunches from others?"* Responses to this question included the following:

- There seems to be a LOT of people with Multiple Sclerosis who live in the area. We are aware that as you get farther away from the equator it gets worse, but seems particularly bad around here.
- Rates of Autism also seem to be really high. Is it just that we're diagnosing it more?
- In jail/incarcerated at men who are 20 years old or are 50-60. There are no middle aged men in jail. Why?
- Look at the different cancer rates-Breast cancer esp. Marvin's has recently required more screenings, so it made the cancer numbers look worse because they were catching it more often. Look at survival rates
- Pain management and medication seekers-Casey- thinks there are people trying to circumnavigate the systems to get pain med drugs.
- Testicular cancer/prostate cancer in a very concentrated small area by Strandquist.
- Elderly-depression and falls.

At the conclusion of the June 5th meeting, participants were provided with a lengthy list of public health concerns and then asked to choose what they believed to be 10 of the greatest concerns for the NWCAC region on the list. The top ten issues with the number of votes it received were as follows:

# of votes	Top 10 issues
10	Obesity/overweight
6	Depression
5	Lack of physical activity
5	Cardiovascular
5	Diabetes
4	Smoking
4	Low access to dentists
4	Cancer
3	Chewing tobacco
3	Alcohol/binge drinking

The group was then asked to vote for the top three issues of greatest concern from the list of 10. The top three issues in order of importance were identified as: 1) Obesity/Overweight, 2) Lack of physical activity, and 3) two items tied for third: Depression and Cardiovascular.

A review analysis of 24 interviews conducted by SHIP staff in the fall of 2010 was conducted. EvaluationGroup,LLC staff reviewed the numerous interviews, because many of them had gone unanalyzed due to a lack of time and resources with the SHIP 1.0 effort. It was hoped that a review of these interviews would help shed additional and useful information as a part of this study.

1. *What do you think are the most pressing health issue(s) facing (community name)?*

In no particular order of importance, the following areas were described as the most pressing health concerns in their respective communities.

- Alcohol
- Drugs
- Not enough activities
- Obesity
- Eating Habits (bad)
- Diabetes/ Health
- Elderly (greater need for resources)
- Transportation (getting to healthcare providers)
- Cancer (all kinds)
- Health Insurance (lack of)
- Provider recruitment/retention
- Income (low)

2. *To what extent is unhealthy eating and physical inactivity a problem in (community name)?*

Responses to this question fell into three broad themes below:

- In rural areas, fast food access may be more limited (e.g. no McDonald's), but so is access to physical fitness facilities and opportunities for participation in group activities (such as fewer community ed. offerings.)
- The climate (cold, lack of sunshine), culture (Scandinavian where everything revolves around food), coupled with busy schedules (lack of time for preparing nutritious foods) all contribute greatly to the obesity problem
- Poor eating environments exist for kids at some schools (pizza at game events becomes a meal for kids, juniors and seniors eat uptown at the convenience store instead of school lunch, lunches still not that healthy and full of carbs).

3. *To what extent is tobacco use a problem in (community name)?*

- Sentiments were split among interviewees. For some tobacco use was viewed as an issue of decreasing concern. These individuals' believe that no smoking ordinances have worked in helping people quit, but that if people want to smoke it is their right as long as they are not hurting anyone else with their smoke. Other respondents felt strongly that smoking was on the increase both in youth and adults. A number of individuals felt that chewing tobacco use was also on the rise.

4. *Are there any <u>activities or policies</u> within your organization that encourage physical fitness (i.e., healthy diet, physical activity) or tobacco cessation? If so, what are they?*

- Most commonly, tobacco cessation was encouraged by a no smoking policy within any work or school buildings. Program activities such as participation in Quitline/Quitplan programs and healthy lifestyle

speakers were also commonly mentioned. A wide range of physical activity/healthy eating policies and activities were discussed, including: no pop vending machines, closed lunch hour at noon for students, free membership to fitness centers, and the formation of school wellness committees; the latter of which was a focus of SHIP grant efforts.

5. *Are you aware of any policies (rules or codified procedures) within the larger community designed to encourage physical fitness or tobacco cessation?*

   - Great awareness existed regarding no smoking policies at work places, restaurants, and in school buildings. Several grants were mentioned as well regarding the encouragement of physical fitness, including school fresh fruit and vegetable grant, Our children Succeed Initiative, and the Carol White Physical Education Program (PEP) grant.

6. *What systems (groups of people, organizations, businesses, etc. working together) in (community name) encourage physical fitness or tobacco cessation?*

   - School athletic programs and community hospital were mentioned most frequently as collaborators in promoting health/physical fitness in the overall community by opening up their exercise room facilities to community members. Weight watchers, kick-boxing and other community education were also mentioned as groups that promoted the health and well-being of community members.

7. *What environmental structures (sidewalks, building designs, parks, recreational facilities) in (community name) encourage physical fitness or tobacco cessation?*

   - Most communities tended to have access to a fitness center or weight room and public parks/walking areas. On the other hand, the concept of 'complete streets' (environmentally designing streets to encourage walking and bicycling) was unknown to all interviewees.

Community Themes and Strengths Discussion Groups

Over 20 NWCAC community forum meetings and individual interviews occurred across the five county region and involved over 100 individuals. A series of questions was generally asked of all participants. This interview protocol is located in Appendix J. The three overarching questions analyzed across all counties in this study are below:

1. What do you believe are the 2-3 most important issues that should be addressed in order to help further improve the quality of life for people in our community (county)?
2. What types of actions, policies or funding priorities would you support in order to build a better community?
3. What if anything is holding our community back from doing what needs to be done to improve health and quality of life for residents of our community (county)?

What do you believe are the 2-3 most important issues that should be addressed in order to help further improve the quality of life for people in our community (county)?

Mental Health/Illness

Mental Health concerns were discussed at length across most all meetings. Participants indicated that distance to services, inappropriate service utilization, problems at home, school, and work were problems. Additionally, county jails were believed to be housing large populations of the regions mentally ill.

Distance to Services

- Access to closer mental health facilities -distances are far to travel to get help

Inappropriate/Lack of Access to Services

- Access and cost of mental health services can be prohibitive.
- The first six months of 2012 there were 47 incidences of needing 72 hour holds. Many were new patients.
  - Because of new state mandates, regional treatment centers are no longer available and smaller, community centers are to take the place but communities don't want them and therefore a reduction in # of beds. Treatment centers that take behavioral problems are especially difficult to replace.
  - When people seek out mental health treatment either at ER or elsewhere it's important for them to have a positive experience so that they will continue to seek treatment. Bad experience – they're done.
- Lack of access to mental health services, waited over 4 months to have a student seen who should have been in immediately. No resources for ongoing appointments or treatment follow up because of the lack of mental health services locally and even regionally.
- Need quality, experienced outpatient services, especially those serving adolescence patients for intensive services.
- Mental health issues in both parents and students. Many undiagnosed and untreated. Households living in a constant state of turmoil

Prison Population

- Most if not all jailed locally are on meds for mental illness, many end up in jail because they lack access to their meds or aren't taking them when they have them.
  - Some participants believed that upwards of 90% of inmates have a mental illness.
  - People are struggling in silence, seems like they can get to the right resources and into professionals if they need to.

> ***"Mental health issues are a quiet disease/affliction. People aren't on the prayer list. It's an underlying reason for outward problems."***

Mental Health Concerns at Home

- Undiagnosed mental illness among parents. Single moms caring for young children in the home are depressed but don't seek help. Leads to other problems such of nutrition, behavior, sleep habits, etc. of their children because they are allowed to do what they want. Social Media becomes their outlet and they don't have any Social connectedness outside of Facebook, texting, etc. Children don't learn how to handle social situations because they don't leave home.

Mental Health Concerns in Schools

- Mental illness occurring among children.
  - We are seeing severely, challenging behaviors in the classroom that have not been seen before and teachers not equipped to deal with them.
  - The number of children with behavioral problems has increased significantly in recent years. Factors that may be causing these include stressful home environments, lack of proper nutrition, poor sleep habits, lack of parenting skills by caregiver, parental self-esteem, and access to violent video games, TV and media.
  - More undiagnosed depression among students

Mental Health Concerns at Work

- Mental health issues are very prevalent as it causes a lot of absenteeism and terminations. We have the resources of Village EAP and therefore a referral source.
  - Depression seems to be a big problem and much of it is untreated. Employees don't realize they are depressed; view it as a condition if someone is "suicidal".

Obesity

Obesity was mentioned at each meeting/interview as one of the major health concerns of the region. Attendees advocated for education starting very young regarding diabetes, nutrition, caloric needs and exercise.

Issues that Matter > Health Care

The Mental Health Discussion: a Mixed Bag

By Annalise McGrail, Undergraduate Research Fellow July 17, 2013

Few medical issues are as widely misunderstood as mental illness. As many as 1 in 4 Americans experience a mental illness or substance abuse disorder each year, yet we still approach the topic with fear and confusion.

This year's tragic shootings have given unprecedented attention to mental health. While the state of mental health has long been in desperate need of this focus, the reason for the spotlight is troublesome. Highlighting mental health in context of the shootings gives the impression that individuals with mental illness are by in large dangerous. This is false. "Only about 4 percent of violence in the United States can be attributed to people with mental illness," according to a New York Times commentary quoting an American Journal of Psychiatry article. In these cases, weapons are used only 2 percent of the time, according to another Times article published after the Sandy Hook shooting. Furthermore, individuals with mental illness are 11 times more likely than the general population to have violent crimes perpetrated on them.

Mental health care is broken in more ways than one. That is why last month President Obama called for a new national conversation about mental health. We need improved access to care, more research, and a national dialogue that seeks to understand the issues.

One of the most complicated components to mental health is the stigma accompanying it.

One survey found that 90% of young adults with a mental health concern report experiencing negative treatment as a result of their illness; and as many as 40% of those experience that treatment on a daily basis. Lisa Lambert, executive director for the Parent/ Professional Advocacy League and mother to a child with a mental illness, explains:

> "We all live in a society where the stigma around mental illness can stop us in our tracks. It's far more serious than a lack of understanding. People repeat things to you that cut you to the quick and you learn not to tell them what you are going through."

This stigmatization is a major barrier to accessible care. Mary Brainerd, the CEO and president of HealthPartners explains in a May press release, "most people live with the symptoms of a mental illness for up to 10 years before seeking treatment, largely due to stigma." A significant portion of the American population goes without care, because society has not created a safe enough environment for accessible care.

Minnesota has set out to change this. A little over a month ago a collaboration between the Minnesota chapter of the National Alliance on Mental Illness (NAMI-MN), HealthPartners, Regions Hospital, and many metro community organizations launched the Make it OK campaign, seeking to normalize the mental health discussion, create understanding, and make it easier for individuals to access necessary care.

Sue Abderholden, executive director for NAMI-MN explains, "'This is really about ... how do we create empathy and respect for somebody who is going through this, how do we make people more comfortable? What we're talking about is different than raising awareness. It's the next step.'"

In addition to the Make it OK campaign, Abderholden explains how the legislature recently passes 17 new measures to improve children's mental health services in the state, which includes doubling funding for school-based mental health grants.

What makes these new initiatives different than their predecessors is the much needed inclusion of individuals with mental illness in the discussion. Instead of enacting programs for individuals with mental illness, the reforms are made with them.

No individual should go without proper medical care, especially on account of fear. "Like any other medical condition, mental illnesses are biological in nature, and should be treated with the same urgency as diabetes or heart disease," says Abderholden.

In addition, mental illness has severe affects on general health. A 20-year study examining people in Western Australia found men with mental illness die on average 16 years earlier, and women die 12 years earlier, a mortality difference on par with life-long smoking.

Lastly, current mental health care, or lack there of, creates inequality. Individuals with serious mental illness on average earn $16,000 less and are at a greater risk for poverty. This affects us all, as it costs the country a $193 billion annual loss of earnings, $150 billion on direct care that is ineffective or incorrect for their condition up to half of the time, and over $140 billion on indirect public safety-net services, according to a NY Times article citing a 2008 American Journal of Psychiatry study. By continuing research and implementing effective policies that highlight outreach, a cost effective solution that betters the livelihood of individuals with mental illness and improves society as a whole could be found.

Minnesota has a mental health care shortage in all but the counties surrounding the Twin Cities and Rochester, with many of these areas having little to no psychiatry care for youth. Many of the changes in the state will certainly have substantial effects for those in the metro, but will still leave those in rural communities underserved.

Minnesota is most certainly on the right track, but more needs to be done to help all citizens.

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