

Community Health Needs Assessment

2019



Dunn, Mercer, and Oliver Counties, North Dakota



Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

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Executive Summary



To help inform future decisions and strategic planning, Sakakawea Medical Center (SMC), Coal Country Community Health Center (CCCHC), Custer Health (CH), Southwestern District Health Unit (SDHU), Knife River Care Center (KRCC), and Mercer County Ambulance (MCA) (collectively “Local Health Providers”) conducted a community health needs assessment (CHNA) in 2018/2019, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. There were 332 SMC service area residents who completed the survey. Additional information was collected through six key informant interviews with community members. The input from the residents, who primarily reside in Dunn County, Mercer County, and Oliver County, represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

With regard to demographics, Dunn County’s population from 2010 to 2017 increased 21.3%, Mercer County’s population during that time increased by 0.5%, and Oliver County’s population increased by 5.1%. The average of residents under age 18 (23.1%) for Dunn County is about the state average, Mercer County comes in 0.7 percentage points lower than the North Dakota average (23.3%), and Oliver County is above the state average at 24.8%. The percentage of residents ages 65 and older is about equal to the North Dakota average (15.0%) for Dunn County (15.5%), higher in Mercer County (18.5%), and much higher in Oliver County (21.5%). The rates of education are slightly lower for all counties considered, Dunn County (91.0%), Mercer County (90.6%), and Oliver County (87.9%), than the North Dakota average (92.0%). The median household incomes in Dunn County (\$68,594), Mercer County (\$80,337), and Oliver County (\$71,500) are higher than the state average for North Dakota (\$61,285).

Data compiled by County Health Rankings show Dunn County, Mercer County, and Oliver County are doing better than North Dakota in health outcomes/factors for 10 categories; Dunn County is doing better than North Dakota in health outcomes/factors for 16 categories, Mercer County is doing better than North Dakota in health outcomes/factors for 21 categories, and Oliver County is doing better than North Dakota in health outcomes/factors for 15 categories.

Dunn, Mercer, and Oliver Counties, according to County Health Rankings data, are performing poorly relative to the rest of the state in two outcome/factor categories; Dunn County is performing worse than the state average in 12 categories, Mercer County is performing worse than the state average in 9 categories, and Oliver County is performing worse than the state average in 11 categories.

Of the 82 potential community and health needs set forth in the survey, the 332 SMC service area residents who completed the survey indicated the following 13 needs as the most important:

- Adults not getting enough exercise/physical activity
- Alcohol use and abuse – Youth and Adult
- Attracting and retaining young families
- Availability of mental health services
- Availability of resources to help the elderly stay in their homes
- Cost of health insurance
- Cost of long-term/nursing home care
- Depression/anxiety – Youth and Adult

- Drug use and abuse – Youth and Adult
- Not enough affordable housing
- Not enough activities for children and youth
- Youth smoking and tobacco use (second-hand smoke) or vaping/juuling

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included no insurance or limited insurance (N=83), not enough evening or weekend hours (N=71), and not affordable (N=58).

When asked what the best aspects of the community were, respondents indicated the top community assets were:

- Active faith community
- Family-friendly, good place to raise kids
- Healthcare
- People are friendly, helpful, and supportive
- Quality school system
- Recreational and sports activities
- Safe place to live, little/no crime

Input from community leaders, provided via key informant interviews, and the community focus group echoed many of the concerns raised by survey respondents. Concerns emerging from these sessions were:

- Assisted living options
- Attracting and retaining young families
- Availability of mental health services
- Depression/anxiety
- Drug use and abuse (including prescription drug use and abuse)
- Youth alcohol use and abuse

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, local health providers completed a CHNA of their service area. The local health providers identify their service area as Dunn, Mercer, and Oliver counties in their entirety. Many community members and stakeholders worked together on the assessment.

Sakakawea Medical Center (SMC) consists of a 13-bed critical access hospital and a 34-bed licensed basic care facility located in Hazen. SMC is a state-designated Level V trauma center and employs more than 140 people. The non-profit hospital is community owned and governed by a volunteer board of directors.

Agriculture and the energy industry are the backbone of Dunn, Mercer and Oliver counties. Also known as “The Energy Trail” the area contains the United States’ only coal-to-synthetic natural gas plant and the nation’s largest lignite mine. The tri-county area is also home to several electric generating stations, wind farms and power plants that are capable of producing enough energy to power over 5 million households daily. In addition, the area hosts the expansion and exploration of the oil drilling operations that have expanded since the tapping of the Bakken Shale deposit. Mercer and Dunn counties border the southern shore of Lake Sakakawea; Oliver County borders the Missouri River and tourism is a major industry during the summer season.

Local health providers serve the communities, residents and visitors of Dunn, Mercer and Oliver counties, which encompasses over 3,900 square miles and a population of approximately 14,694 residents, according to U.S. Census data.

Major communities located in the tri-county area are as follows:

Hazen, located in west central North Dakota, is considered the “heart” of Mercer County. The area is primarily focused on agriculture and mining industries. The school district provides K-12 educational services. Nearby Lake Sakakawea and the Missouri River provides many recreational activities. The community has a swimming pool, indoor ice arena, tennis courts, ball diamonds, walk/bike path, movie theater, golf course, and city parks.

Beulah, located 10 miles from Hazen, is sometimes called the “Energy Capital of North Dakota,” with the three largest employers being part of the energy industry. Beulah has a K-12 school system and an active parks and recreation organization. Beulah also offers a full-service wellness/fitness center, golf course, swimming pool, walk/bike path, skateboard park, outdoor sports complex, and a myriad of recreational activities at Lake Sakakawea, including fishing, camping, boating, and water sports.

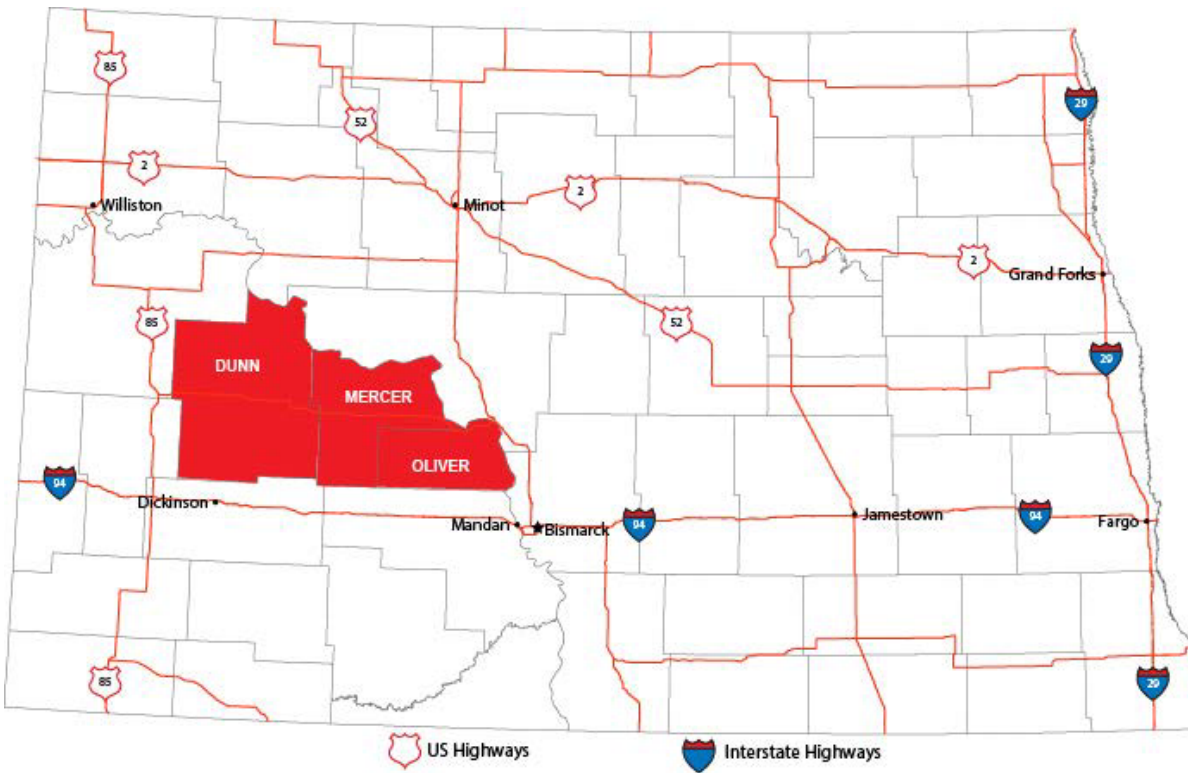
Center is the only incorporated city in Oliver County and has a K-12 school system. It offers an indoor junior Olympic size pool that is open year-round, a golf course, and several parks with available camping including Cross Ranch State Park and the Cross Ranch Preserve, which are only a short drive from the city. There are many fishing opportunities in the area, including nearby Nelson Lake, which is the only lake in the state that does not freeze in the winter due to the water being warmed by the nearby power plant.

Killdeer, centrally located in Dunn County, is the largest city in the county and is known as the “hub” of cowboy country. Highway 22 and 200 intersect on the south edge of the city and Interstate 94 is only 34 miles south. Killdeer is home to many area ranchers and the oil industry is an integral part of the economy with the Little Knife Field located only 15 miles west of the city. Killdeer has a K-12 school system, golf course and is the gateway to the beautiful Killdeer Mountains which features; the Little Missouri State Park; the Badlands Trail Rides, Eastview Campgrounds, and the Lewis & Clark Trail.

Each major town in the tri-county area has public transportation, grocery stores, pharmacies, and other valued community assets.

Figure 1 illustrates the location of the counties.

Figure 1: Dunn, Mercer, and Oliver Counties



Sakakawea Medical Center (SMC)

SMC dates back to 1941. The original hospital consisted of about a dozen beds on the second floor of one of the original main street buildings. The hospital was a private undertaking by a Beulah woman who ran the facility for several years until Hazen's plans for a new, modern hospital facility were well underway. Community effort continued to keep the hospital open for a time, but the hospital closed in 1946 due to difficulty finding competent personnel. Pursuant to an agreement with Lutheran Hospital and Homes Society for operation of a hospital, construction began on a new facility in 1946. The hospital, with 23 beds, opened in 1948. By the late 1960s, it was apparent that either major remodeling or a new facility was needed. With local donations and Hill-Burton federal funds, a 39-bed, 8-bassinet hospital was built at the east edge of Hazen, opening in 1970. The Hazen Memorial Hospital Association took over the hospital from Lutheran Hospitals Homes Society in 1969. In 1982, the hospital embarked on a \$1.2 million expansion and renovation. The hospital changed its name to Sakakawea Medical Center in 1988. Senior Suites at Sakakawea (licensed basic care facility) was added to the hospital campus in 1997.

In the fall of 2015, directly south of the hospital, the Board of Directors broke ground to begin the construction of a replacement facility. The retiring facility was closed, and a new \$30.5 million replacement facility opened on April 5, 2017.

The new medical center houses a health clinic attached within the hospital, an expanded emergency room and surgical area, handicapped-accessible patient rooms, a centralized registration area, a centralized nurse's station, and a myriad of other needed changes and technology updates. The new facility is designed to increase staff efficiency and accommodate changes underway in the delivery of healthcare as well as assisting healthcare providers to meet growing demands within the service area.



Mission

SMC's stated mission is to:

- Provide high quality care that is measured and continuously improved.
- Provide individualized care that exceeds expectations of those we serve.
- Strengthen partnerships with providers to enhance coordination of care and improve system performance.
- Be a steward of resources.
- Commit to service excellence.
- Be a vital contributor to our area communities.
- Recognize the value of each employee and provide opportunities for personal growth and development that complement the needs of the organization.

Services offered locally by SMC include:

General and Acute Services

- Blood pressure checks
- Cardiac rehab
- Convenience Clinic
- Education - patient
- Education – staff
- Emergency department
- Trauma care
- Hospital (acute care)
- Hospital (observation)
- Hospital (swing bed skilled)
- Hospital (swing bed intermediate)
- Hospital (respite care)
- Infection prevention
- Pharmacy
- Surgical services – CRNA
- Surgical services – endoscopies
- Surgical services – general
- Interventional radiology

Screening/Therapy Services

- Chronic disease management
- EKG
- Functional dry needling
- Holter monitoring
- Laboratory services
- Lower extremity circulatory assessment
- Occupational therapy
- Pediatric services
- Physical therapy
- Respiratory care
- Home sleep studies
- Social services
- Stress testing
- Sports medicine
- Cardiac rehab
- Pulmonary rehab
- Functional capacity evaluations and pre-work screens
- Women’s pelvic health
- Ergonomic assessments
- Splint fabrication

Radiology Services

- Bone density
- CT scan
- 3-D Digital mammography
- Echocardiograms
- General x-ray
- Nuclear medicine (mobile unit)
- MRI (mobile unit)
- Ultrasound
- Interventional Radiology (visiting specialist)

Laboratory Services

- Hematology
- Blood Banking-Transfusion Service
- Coagulation studies
- Chemistry
- Urine testing
- Serology
- SAT/BAT 3rd party collections
- Phlebotomy

Other/Additional Services

- Health screenings
- Hospice care
- Licensed basic care facility
- Respiratory home services
- Wellness

Contracted Services

- Avera eEmergency
- Bismarck State College – Practical Nurse Program
- Bismarck Radiology Associates
- CHI Virtual ePharmacy
- Great Plains Rehab Services
- LifeSource - (organ, tissue and eye procurement organization)
- North Dakota Public Health Laboratories
- North Dakota VFC Immunization Program

- Northern Plains Lab
- Pathology Consultants
- Pharmacist
- Speech therapy
- United Blood Services
- Virtual radiology
- Nutrition counseling

Coal Country Community Health Center (CCCHC)

CCCHC is a local, non-profit healthcare provider with clinics in Beulah, Hazen, Center, and Killdeer. As a Federally Qualified Health Center (FQHC), Coal Country improves access to care by serving all residents, including low income and medically underserved people. Generally, Community Health Centers' costs of care rank among the lowest, and their focus on prevention reduces the need for more expensive in-patient and specialty care, which, on a national basis, saves billions of dollars for taxpayers. CCCHC is governed by a board of members from the communities it serves.



The team of providers delivers primary care for the entire community. Funded by a federal grant, the CCCHC's sliding fee scale allows patients to pay according to their individual ability. This and other efforts help ensure that no one in the community goes without proper healthcare services.

Services offered locally by Coal Country Community Health Center include:

General Medical and Integrated Care Services

- Infant, child, adolescent, and adult exams
- Mole/wart/skin lesion removal
- Nutrition counseling including diabetes self-management education
- Consultant pharmacy
- Physicals; D.O.T., sports, pre-employment & insurance
- Sports medicine and concussion management
- Addiction counseling including drug & alcohol evaluations
- DUI seminars
- Mental health first aid
- Geriatrics
- Infusion therapy
- Medicare annual wellness visits
- Medication assisted therapy - Suboxone
- Mental/Behavioral health services including school integration services
- Occupational health medicine
- Outreach and enrollment services
- Care coordination services guided under the patient-centered medical home principles

- Pediatrics
- Physical therapy
- Prenatal care
- Visiting nurse services
- Women's health

Screening and Preventive Care Services

- Chronic disease management
- Infant, child, adolescent, and adult preventive exams and immunizations
- Laboratory and basic radiology services including visiting diagnostic ultrasound
- Physical therapy
- Health and wellness screenings

Contracted Services

- Bismarck Radiology Associates
- North Dakota Public Health Laboratories
- Northern Plains Lab
- Pathology Consultants

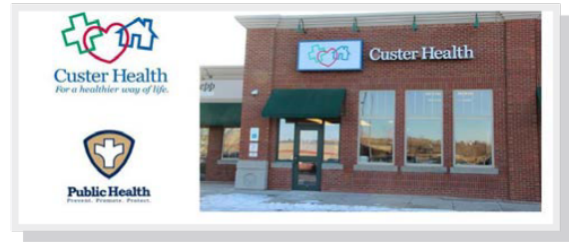
Visiting Specialists

- Audiology
- Cardiology
- Hearing consultant
- OB/GYN
- Orthopedist
- Orthopedic surgeon
- Podiatry
- Psychology

Custer Health

Founded in 1950, Custer Health is a five-county multi-district health unit providing health services to the people of Mercer, Oliver, Grant, Morton, and Sioux counties.

Public health services provided are environmental health, nursing services, and WIC (Women, Infants, and Children) program. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to assure that North Dakota is a healthy place to live and each person should have an equal opportunity to enjoy good health. To accomplish this mission, Custer Health is committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality healthcare services for the people of North Dakota.



Mission

Custer Health's mission is:
Ensuring a healthy community through promotion, protection and prevention.

Services offered locally by Custer Health include:

- Babysitters course
- Beyond Birth Education (newborn home visits)
- Bicycle helmet safety education
- Blood pressure checks
- Breastfeeding lactation counseling
- Car seat safety program
- HIV, Hepatitis C, STI testing
- Emergency preparedness services
- Environmental health services including water, sewer, food and beverage
- Flu shots
- Foot clinics
- Health maintenance clinics
- Health Tracks (child health screening)
- Home health services
- Immunizations
- Child Protective Services
- School health
- Tobacco prevention
- Tuberculosis testing and management
- WIC (Women, Infants & Children) Program
- Women's Way Program

Southwestern District Health Unit (SDHU)



SDHU has been caring for their community’s health since 1945 and is a multi-district health unit responsible for public health in Stark, Dunn, Adams, Billings, Bowman, Golden Valley, Hettinger, and Slope counties.

The health unit provides a variety of services and programs that maintain or improve the health status of the general population and their environment through community health nursing, environmental health/ sanitation, and nutritional services.

- Alcohol prevention
- Blood pressure checks
- Child health (well-baby checks)
- Community health program
- Diabetes screening
- Dental health
- Emergency Preparedness and Response Program
- Environmental health services
 - o Education and information
 - o Food service and institution inspections
 - o In-home health and safety investigations
 - o Water testing
 - o Sewer system inspections
 - o Radon testing and information
- West Nile Virus – surveillance and education
- Flu shots
- Health Maintenance Program
- HIV / AIDS counseling
- Immunizations
- Newborn postpartum home visits
- ND Health Tracks
- Preschool education programs and screening
- School Health Services
- Skin and scalp conditions
- Suicide Prevention and screening
- Tobacco Prevention and Control
- Tuberculosis testing and management
- WIC (Women, Infants & Children) Program
- Women’s Way Program

In each of the counties, the SDHU has a presence in the form of a public health nurse that lives within the community.

Knife River Care Center (KRCC)

Originally called the Beulah Community Nursing Home, KRCC was incorporated in 1962. Over the years, it has grown to 86 skilled nursing care beds. After various remodeling and expansion projects, KRCC broke ground for a replacement facility in 2006 and moved in on January 26, 2008. KRCC is exploring the possibility of adding assisted living and senior independent living programs.



Mission

The KRCC, is a long-term care facility in Beulah and has the following as its mission statement:

“Knife River Care Center is dedicated to the preservation of dignity and respect to those we serve and employ. With great compassion, we strive to make excellence our standard.”

Hill Top Home of Comfort

Hill Top Home of Comfort, a non-profit public organization located in Killdeer, is a 58 bed skilled nursing care facility with a 20 unit assisted living facility attached.



The establishment of Hill Top Home of Comfort made it possible for people in the community and surrounding areas to remain 'at home' while receiving nursing care. Hill Top offers post acute care, assisted living, and long term care at the facility.

Mission

The mission of Hill Top Home of Comfort is: Provide an atmosphere of warmth and caring to the people that call it home. It has been said that home is where the heart is and we are proud that Hill Top has earned the reputation of being known as "the Home with Heart".

In addition to caring for the individual, recognizing that to age is a natural part of the life process, Hill Top Home of Comfort has set-up continuing goals as follows:

- To provide care that extends and enhances the quality of life for residents.
- To contribute in every way we can to the fullest possible development of his/her potential by preventative, corrective or supportive care.
- Above all, respect the dignity of the individual.

Mercer County Ambulance

With a fleet of four ambulances – two in Hazen and two in Beulah – Mercer County Ambulance serves an area of more than 1,000 square miles, with an on-call crew in each community 24-hours a day.

Mercer County Ambulance has 8 full-time employees, 2 part-time, 3 PRN, and 30 active volunteers consisting of paramedics, advance emergency medical technicians (A-EMTs), emergency medical technicians (EMTs), emergency medical responders (EMRs), and cardiopulmonary resuscitation (CPR) drivers. Together, these emergency medical services providers cover more than 35,000 hours of call time and approximately 850 ambulance runs per year.



Other Services

Additionally, medical specialists, visiting specialists, and other professionals come to the area to see patients and provide treatment and/or service for the following:

- Audiology
- Cardiology
- Chiropractic services
- Dental services
- Employee assistance
- Interventional radiology
- Mental health

These specialists may see patients at CCCHC, SMC, or rent space from SMC, or have private practices established at their own facility.

Assessment Process

The purpose of conducting a CHNA is to describe the health of local people, identify areas for health improvement, identify use of local healthcare services, determine factors that contribute to health issues, identify and prioritize community needs, and help healthcare leaders identify potential action to address the community’s health needs.

A CHNA benefits the community by:

- 1) Collecting timely input from the local community members, providers, and staff;
- 2) Providing an analysis of secondary data related to health-related behaviors, conditions, risks, and outcomes;
- 3) Compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan;
- 4) Engaging community members about the future of healthcare; and
- 5) Allowing the community hospital to meet the federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a CHNA at least every three years, as well as helping the local public health unit meet accreditation requirements.

This assessment examines health needs and concerns in Dunn, Mercer, and Oliver Counties, which are all included in the local health providers service area. In addition to Hazen, located in this service area are the communities of Beulah, Center, Dodge, Dunn, Golden Valley, Halliday, Killdeer, Pick City, Stanton, and Zap.

The CRH, in partnership with local health providers, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between the CRH and Hazen. A small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from the CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. There were 29 people, representing a cross section demographically, who attended the community group meeting. The meeting was highly interactive with good participation. SMC staff and board members were in attendance as well, but largely played a role of listening and learning.

Figure 2: Steering Committee

Marie Mettler	Public Relations, Sakakawea Medical Center
Darold Bertsch	CEO, SMC/Coal Country Community Health Center
Chastity Dolbec	RN, Coal Country Community Health Center
Kara Pulver	Marketing, Coal Country Community Health Center
Autumn Schaan	PHN, Custer Health
Gerry Leadbetter	Administrator, Hill Top Home of Comfort

The original survey tool was developed and used by the CRH. In order to revise the original survey tool to ensure the data gathered met the needs of hospitals and public health, the CRH worked with the North Dakota Department of Health’s public health liaison. CRH representatives also participated in a series of meetings that garnered input from the state’s health officer, local North Dakota public health unit professionals, and representatives from North Dakota State University.

As part of the assessment's overall collaborative process, the CRH spearheaded efforts to collect data for the assessment in a variety of ways:

- A survey solicited feedback from area residents;
- Community leaders representing the broad interests of the community took part in one-on-one key informant interviews;
- The community group, comprised of community leaders and area residents, was convened to discuss area health needs and inform the assessment process; and
- A wide range of secondary sources of data were examined, providing information on a multitude of measures, including demographics, health conditions, indicators, outcomes, rates of preventive measures; rates of disease; and at-risk behavior.

The CRH is one of the nation's most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. The CRH is the designated State Office of Rural Health and administers the Medicare Rural Hospital Flexibility (Flex) program, funded by the Federal Office of Rural Health Policy, Health Resources Services Administration, and Department of Health and Human Services. The CRH connects the UNDSMHS and other necessary resources, to rural communities and their healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, the CRH works at a national, state, and community level.

Detailed below are the methods undertaken to gather data for this assessment by convening a community group, conducting key informant interviews, soliciting feedback about health needs via a survey, and researching secondary data.

Community Group

A community group consisting of 29 community members was convened and first met on October 29, 2018. During this first Community Group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again on March 7, 2019 with 31 community members in attendance. At this second meeting the Community Group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data relating to the general health of the population in Dunn, Mercer, and Oliver Counties. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the community group represented the broad interests of the community served by SMC, Custer Health, KRCC, Mercer County Ambulance, CCCHC, and SDHU. They included representatives of the health community, business community, law enforcement, education, social services, and faith community. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with six key informants were conducted in person in Hazen on October 29, 2018. Representatives from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

Topics covered during the interviews included the general health needs of the community, the general health of the community, community concerns, delivery of healthcare by local providers, awareness of health services

offered locally, barriers to receiving health services, and suggestions for improving collaboration within the community.

Survey

A survey was distributed to solicit feedback from the community and was not intended to be a scientific or statistically valid sampling of the population. It was designed to be an additional tool for collecting qualitative data from the community at large – specifically, information related to community-perceived health needs. A copy of the survey instrument is included in Appendix A.

The community member survey was distributed to various residents of Dunn, Mercer, and Oliver Counties, which are all included in the SMC service area. The survey tool was designed to:

- Learn of the good things in the community and the community's concerns;
- Understand perceptions and attitudes about the health of the community and hear suggestions for improvement; and
- Learn more about how local health services are used by residents.

Specifically, the survey covered the following topics:

- Residents' perceptions about community assets;
- Broad areas of community and health concerns;
- Awareness of local health services;
- Barriers to using local healthcare;
- Basic demographic information;
- Suggestions to improve the delivery of local healthcare; and
- Suggestions for capital improvements.

Approximately 300 community member surveys were available for distribution in Dunn, Mercer, and Oliver Counties. The surveys were distributed by community group members and at SMC, Custer Health, KRCC, Mercer County Ambulance, SDHU, and Dunn and Mercer County Social Services.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling any of the CHNA partners. The survey period ran from October 5, 2018 to November 15, 2018. There were 45 completed paper surveys returned.

Area residents were also given the option of completing an online version of the survey, which was publicized via flyers at all area school districts and grocery stores. There were 287 online surveys completed. Eight of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 332 community member surveys were completed, equating to an 18.3% response rate. This response rate is slightly above the average for this type of unsolicited survey methodology and indicates an engaged community.

Secondary Data

Secondary data was collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data was collected from a variety of sources, including the U.S. Census Bureau; Robert Wood Johnson Foundation’s County Health Rankings, which pulls data from 20 primary data sources (www.countyhealthrankings.org); the National Survey of Children’s Health, which touches on multiple intersecting aspects of children’s lives (www.childhealthdata.org/learn/NSCH); and North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org).

Social Determinants of Health

According to the World Health Organization, social determinants of health are, “*The circumstances in which people are born, grow up, live, work, and age and the systems put in place to deal with illness. These circumstances are in turn shaped by wider set of forces: economics, social policies and politics.*”

Income-level, educational attainment, race/ethnicity, and health literacy all impact the ability of people to access health services. Basic needs such as clean air and water and safe and affordable housing are all essential to staying healthy and they are also impacted by the social factors listed previously. The barriers already present in rural areas, such as limited public transportation options and fewer choices to acquire healthy food can compound the impact of these challenges.

Healthy People 2020, (<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>) illustrates that health and healthcare, while vitally important, play only one small role (approximately 20%) in the overall health of individuals and ultimately of a community. Social and community context, education, economic stability, neighborhood and built environment play a much larger part (80%) in impacting health outcomes. Therefore, as needs or concerns were raised through this CHNA process, it was imperative to keep in mind how they impact the health of the community and what solutions can be implemented. See Figure 3.

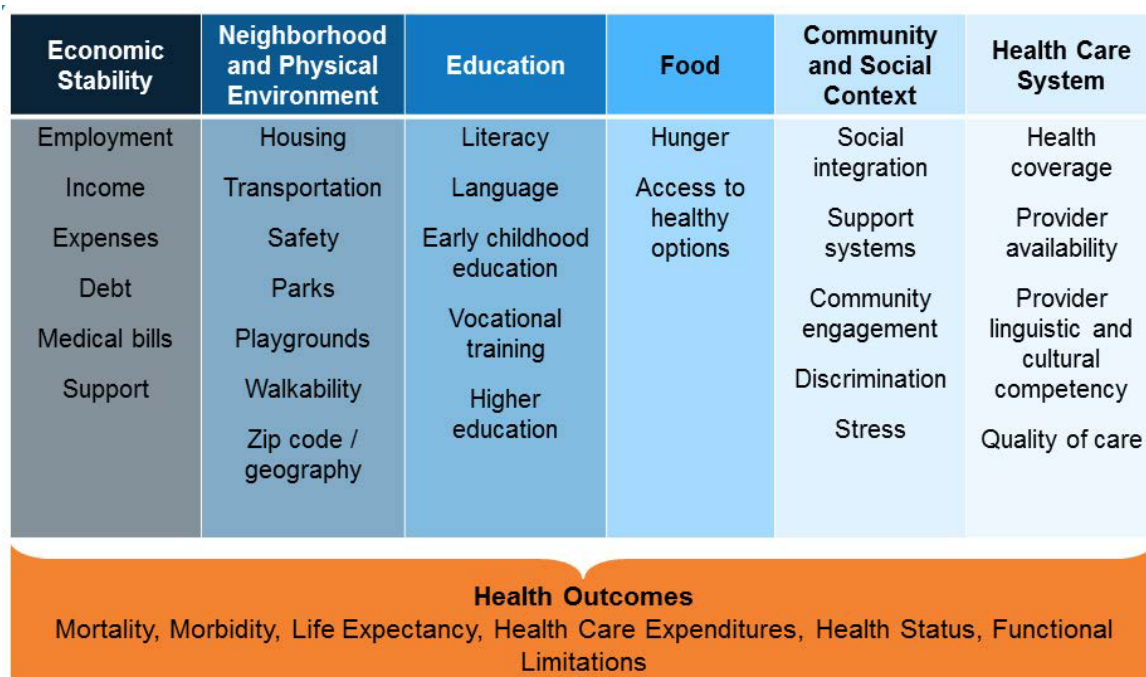
Figure 3: Social Determinants of Health



Figure 4 (Henry J. Kaiser Family Foundation, <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>), provides examples of factors that are included in each of the social determinants of health categories that lead to health outcomes.

For more information and resources on social determinants of health, visit the Rural Health Information Hub website, <https://www.ruralhealthinfo.org/topics/social-determinants-of-health>.

Figure 4: Social Determinants of Health



Demographic Information

Table 1 summarizes general demographic and geographic data about Dunn, Oliver, and Mercer Counties.

(From 2010 Census/2017 American Community Survey; more recent estimates used where available)

	Dunn County	Mercer County	Oliver County	North Dakota
Population (2017)	4,289	8,465	1,940	755,393
Population change (2010-2017)	21.3%	0.5%	5.1%	12.3%
People per square mile (2010)	1.8	8.1	2.6	9.7
Persons 65 years or older (2016)	15.5%	18.5%	21.5%	15.0%
Persons under 18 years (2016)	23.1%	22.6%	24.8%	23.3%
Median age (2016 est.)	39.9	44.5	49.2	35.2
White persons (2016)	84.8%	94.6%	94.9%	87.5%
Non-English speaking (2016)	6.9%	5.7%	3.9%	5.6%
High school graduates (2016)	91.0%	90.6%	87.9%	92.0%
Bachelor's degree or higher (2016)	20.5%	20.7%	17.4%	28.2%
Live below poverty line (2016)	9.8%	6.6%	10.3%	10.7%
Persons without health insurance, under age 65 years (2016)	12.4%	6.3%	6.8%	8.1%

Source: <https://www.census.gov/quickfacts/fact/table/ND,US/INC910216#viewtop> and https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml#

With the population of North Dakota growing in recent years, Dunn, Mercer, and Oliver Counties have also seen an increase in population since 2010. The U.S. Census Bureau estimates show that Dunn County’s population increased from 3,536 (2010) to 4,289 (2017), Mercer County’s population increased from 8,424 (2010) to 8,465 (2017), and Oliver County’s population increased from 1,846 (2010) to 1,940 (2017).

County Health Rankings

The Robert Wood Johnson Foundation, in collaboration with the University of Wisconsin Population Health Institute, has developed County Health Rankings to illustrate community health needs and provide guidance for actions toward improved health. In this report, Dunn, Mercer, and Oliver Counties are compared to North Dakota rates and national benchmarks on various topics ranging from individual health behaviors to the quality of healthcare.

The data used in the 2019 County Health Rankings are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the “healthiest.” Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county’s rank.

A model of the 2019 County Health Rankings – a flow chart of how a county’s rank is determined – is found in Appendix B. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Table 2: County Health Rankings

<p>Health Outcomes</p> <ul style="list-style-type: none"> • Length of life • Quality of life <p>Health Factors</p> <ul style="list-style-type: none"> • Health behavior <ul style="list-style-type: none"> - Smoking - Diet and exercise - Alcohol and drug use - Sexual activity 	<p>Health Factors (continued)</p> <ul style="list-style-type: none"> • Clinical care <ul style="list-style-type: none"> - Access to care - Quality of care • Social and Economic Factors <ul style="list-style-type: none"> - Education - Employment - Income - Family and social support - Community safety • Physical Environment <ul style="list-style-type: none"> - Air and water quality - Housing and transit
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Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Dunn, Mercer, and Oliver Counties. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county’s residents, not necessarily the patients and clients of SDHU, CH, and SMC or of any particular medical facility.

For most of the measures included in the rankings, the County Health Rankings’ authors have calculated the “Top U.S. Performers” for 2017. The Top Performer number marks the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (such as high school graduation) or negatively (such as adult smoking).

Dunn County, Mercer County, and Oliver County rankings within the state are included in the summary following. For example, Dunn County ranks 30th out of 49 ranked counties in North Dakota on health

outcomes and 40th on health factors. Mercer County ranks 10th out of 49 ranked counties in North Dakota on health outcomes and 10th on health factors. Oliver County is not ranked in health outcomes or health factors. The measures marked with a with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a square (■) indicates that the county is faring better than the North Dakota average but is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored checkmark but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Dunn County, Mercer County, and Oliver County are doing better than many counties compared to the rest of the state on all but three of the outcomes, landing at or above rates for other North Dakota counties. However, all counties, like many North Dakota counties, are doing poor in many areas when it comes to the U.S. Top 10% ratings. One particular outcome where Dunn and Mercer Counties do not meet the U.S. Top 10% ratings is the rate of premature deaths.

On *health factors*, Dunn, Mercer, and Oliver Counties perform below the North Dakota average for counties in several areas as well.

Data compiled by County Health Rankings show Dunn County, Mercer County, and Oliver County are doing better than North Dakota in health outcomes and factors for the following indicators:

- Adult smoking
- Air pollution (particulate matter)
- Drinking water violations
- Excessive drinking
- Poor mental health days
- Poor or fair health
- Poor physical health days
- Severe housing problems
- Social associations
- Violent crime

Data compiled by County Health Rankings show Dunn County is doing better than North Dakota in health outcomes and factors for the following indicators:

- Adult smoking
- Air pollution (particulate matter)
- Children in single-parent households
- Drinking water violations
- Excessive drinking
- Low birth weight
- Physical inactivity
- Poor mental health days
- Poor or fair health
- Poor physical health days
- Severe housing problems
- Sexually transmitted infections
- Social associations
- Teen birth rate
- Unemployment
- Violent crime

Data compiled by County Health Rankings show Mercer County is doing better than North Dakota in health outcomes and factors for the following indicators:

- Access to exercise opportunities
- Adult obesity
- Adult smoking
- Air pollution – particulate matter

- Children in poverty
- Children in single-parent households
- Drinking water violations
- Excessive drinking
- Food environment index
- Income inequality
- Number of dentists
- Poor mental health days
- Poor or fair health
- Poor physical health days
- Premature death
- Preventable hospital stays
- Severe housing problems
- Sexually transmitted infections
- Social associations
- Teen birth rate
- Uninsured
- Violent crime

Data compiled by County Health Rankings show Oliver County is doing better than North Dakota in health outcomes and factors for the following indicators:

- Adult smoking
- Air pollution – particulate matter
- Drinking water violations
- Excessive drinking
- Income inequality
- Low birth weight
- Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- Poor mental health days
- Poor or fair health
- Poor physical health days
- Preventable hospital stays
- Severe housing problems
- Social associations
- Uninsured
- Violent crime

Outcomes and factors in which Dunn County, Mercer County, and Oliver County were performing poorly relative to the rest of the state include:

- Access to exercise opportunities
- Adult obesity
- Alcohol-impaired driving deaths
- Children in poverty
- Flu vaccinations (% of Medicare enrollees)
- Food environment index
- Income inequality
- Injury deaths
- Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- Premature death
- Preventable hospital stays
- Uninsured

Outcomes and factors in which Dunn County was performing poorly relative to the rest of the state include:

- Alcohol-impaired driving deaths
- Flu vaccinations (% of Medicare enrollees)
- Injury deaths
- Low birth weight
- Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)
- Number of mental health providers
- Number of primary care physicians
- Physical inactivity
- Unemployment

Outcomes and factors in which Oliver County was performing poorly relative to the rest of the state include:

- Access to exercise opportunities
- Adult obesity
- Alcohol-impaired driving deaths
- Children in poverty
- Children in single-parent households
- Flu vaccinations (% of Medicare enrollees)
- Food environment index
- Number of dentists
- Number of primary care physicians
- Physical inactivity
- Unemployment

● = Not meeting North Dakota average
 ■ = Not meeting U.S. Top 10% Performers
 + = Meeting or exceeding U.S. Top 10% Performers
 Blank values reflect unreliable or missing data

	Dunn County	Mercer County	Oliver County	U.S. Top 10%	North Dakota (of 49)
Ranking: Outcomes	30th	10th	No rank		
Premature death	10,800 ●■	6,600 ■		5,400	6,700
Poor or fair health	13% ■	11% +	11% +	12%	14%
Poor physical health days (in past 30 days)	2.8 +	2.6 +	2.6 +	3.0	3.0
Poor mental health days (in past 30 days)	2.7 +	2.6 +	2.5 +	3.1	3.1
Low birth weight	5% +	7% ●■	6% +	6%	6%
Ranking: Factors	40th	10th	No rank		(of 49)
<i>Health Behaviors</i>					
Adult smoking	17% ■	15% ■	15% ■	14%	20%
Adult obesity	36% ●■	31% ■	34% ●■	26%	32%
Food environment index (10=best)	8.4 ●■	9.4 +	8.2 ●■	8.7	9.1
Physical inactivity	20% ■	23% ●■	24% ●■	19%	22%
Access to exercise opportunities	37% ●■	77% ■	44% ●■	91%	74%
Excessive drinking	25% ■	25% ■	23% ■	13%	26%
Alcohol-impaired driving deaths	71% ●■	63% ●■	100% ●■	13%	46%
Sexually transmitted infections	344.4 ■	180.7 ■		152.8	456.5
Teen birth rate	23 ■	17 ■		14	23
<i>Clinical Care</i>					
Uninsured	12% ●■	6% +	7% ■	6%	8%
Primary care physicians		1,450:1 ●■	1,870:0 ●■	1,050:1	1,320:1
Dentists		1,210:1 +	1,940:1 ●■	1,260:1	1,530:1
Mental health providers		2,820:1 ●■		310:1	570:1
Preventable hospital stays	4,905 ●■	3,579 ■	2,323 +	2,765	4,452
Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)	40% ●■	46% ●■	51% ■	49%	50%
Flu vaccinations	28% ●■	20% ●■	32% ●■	52%	47%
<i>Social and Economic Factors</i>					
Unemployment	2.1% +	4.0% ●■	4.2% ●■	2.9%	2.6%
Children in poverty	13% ●■	6% +	14% ●■	11%	11%
Income inequality	4.7 ●■	4.1 ■	3.8 +	3.7	4.4
Children in single-parent households	25% ■	13% +	30% ●■	20%	27%
Social associations	20.6 ■	25.3 +	37.4 +	21.9	16.0
Violent crime	186 ■	126 ■	54 +	63	258
Injury deaths	105 ●■	83 ●■		57	69
<i>Physical Environment</i>					
Air pollution – particulate matter	4.4 +	5.1 +	4.8 +	6.1	5.4
Drinking water violations	No +	No +	No +		
Severe housing problems	8% +	8% +	6% +	9%	11%

Source: <http://www.countyhealthrankings.org/app/north-dakota/2018/rankings/outcomes/overall>

Children’s Health

The National Survey of Children’s Health touches on multiple intersecting aspects of children’s lives. Data are not available at the county level; listed below is information about children’s health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child’s family, neighborhood, and social context. Data is from 2016-17. More information about the survey is found at www.childhealthdata.org/learn/NSCH.

Key measures of the statewide data are summarized below. The rates highlighted in red signify that the state is faring worse on that measure than the national average.

Table 3: Selected Measures Regarding Children’s Health (For children aged 0-17 unless noted otherwise)

TABLE 3: SELECTED MEASURES REGARDING CHILDREN’S HEALTH (For children aged 0-17 unless noted otherwise)		
Health Status	North Dakota	National
Children born premature (3 or more weeks early)	10.8%	11.6%
Children 10-17 overweight or obese	35.8%	31.3%
Children 0-5 who were ever breastfed	79.4%	79.2%
Children 6-17 who missed 11 or more days of school	4.6%	6.2%
Healthcare		
Children currently insured	93.5%	94.5%
Children who had preventive medical visit in past year	78.6%	84.4%
Children who had preventive dental visit in past year	74.6%	77.2%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	20.7%	30.8%
Children aged 2-17 with problems requiring counseling who received needed mental healthcare	86.3%	61.0%
Family Life		
Children whose families eat meals together 4 or more times per week	83.0%	78.4%
Children who live in households where someone smokes	29.8%	24.1%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	58.9%	54.1%
Children living in neighborhoods with poorly kept or rundown housing	12.7%	16.2%
Children living in neighborhood that’s usually or always safe	94.0%	86.6%

Source: <http://childhealthdata.org/browse/data-snapshots/nsch-profiles?geo=1&geo2=36&rpt=16>

The data on children’s health and conditions reveal that while North Dakota is doing better than the national averages on a few measures, it is not measuring up to the national averages with respect to:

- Obese or overweight children ages 10-17;
- Children with health insurance;
- Preventive primary care and dentist visits;
- Developmental/behavioral screening for children 10 months to 5 years of age;
- Children ages 2-17 years who have received needed mental healthcare; and
- Children living in smoking households.

Table 4 includes selected county-level measures regarding children’s health in North Dakota. The data come from North Dakota KIDS COUNT, a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation. KIDS COUNT data focuses on the main components of children’s well-being. More information about KIDS COUNT is available at www.ndkidscount.org. The measures highlighted in blue in the table are those in which the counties are doing worse than the state average. The year of the most recent data is noted.

The data show that Dunn County is performing more poorly than the North Dakota average on all of the examined measures except the percentage of uninsured children below 200% of poverty and the percentage of the population who are Supplemental Nutrition Assistance Program (SNAP) recipients. The most marked difference was on the measure of licensed childcare capacity (a 27.1% lower rate in Dunn County).

Mercer County is only performing more poorly than the North Dakota average in one factor, licensed childcare capacity. The county has an 18.8% lower rate than the state average.

Oliver County is performing more poorly than the North Dakota average on only two factors: children enrolled in Healthy Steps and licensed childcare capacity (a 24.8% lower rate in Oliver County).

Table 4: Selected County-Level Measures Regarding Children’s Health

	Dunn County	Mercer County	Oliver County	North Dakota
Uninsured children (% of population age 0-18), 2016	14.9%	7.5%	8.6%	9.0%
Uninsured children below 200% of poverty (% of population), 2016	32.7%	27.3%	41.5%	41.9%
Medicaid recipient (% of population age 0-20), 2017	28.6%	17.8%	22.7%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	3.3%	2.1%	3.1%	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	15.2%	9.5%	8.7%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	14.8%	23.1%	17.1%	41.9%
4-Year High School Cohort Graduation Rate, 2017	84.8%	95.9%	90.0%	87.0%

Source: <https://datacenter.kidscount.org/data#ND/5/0/char/0>

Another means for obtaining data on the youth population is through the Youth Risk Behavior Survey (YRBS). The YRBS was developed in 1990 by the Centers for Disease Control and Prevention (CDC) to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability and social problems

among youth and adults in the United States. The YRBS was designed to monitor trends, compare state health risk behaviors to national health risk behaviors and intended for use to plan, evaluate and improve school and community programs. North Dakota began participating in the YRBS survey in 1995. Students in grades, 7-8 & 9-12 are surveyed in the spring of odd years. The survey is voluntary and completely anonymous.

North Dakota has two survey groups, selected and voluntary. The selected school survey population is chosen using a scientific sampling procedure which ensures that the results can be generalized to the state’s entire student population. The schools that are part of the voluntary sample, selected without scientific sampling procedures, will only be able to obtain information on the risk behavior percentages for their school and not in comparison to all the schools.

Table 5 depicts some of the YRBS data that has been collected in 2013, 2015, and 2017. At this time, the North Dakota-specific data for 2017 is not available, so data for 2013 and 2015 are shown for North Dakota. They are further broken down by rural and urban percentages. The trend column shows a “=” for statistically insignificant change (no change), “h” for an increased trend in the data changes from 2013 to 2015, and “i” for a decreased trend in the data changes from 2013 to 2015. The final column shows the 2017 national average percentage. For a more complete listing of the YRBS data, see Appendix C.

As noted previously, 226 community members completed the survey in communities throughout the counties in the CMC service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 147 did, revealing that the large majority of respondents (86%, N=127) lived in Carrington. These results are shown in Figure 5.

TABLE 5: Youth Behavioral Risk Survey Results

North Dakota High School Survey

Sources: <https://www.nd.gov/dpi/uploads/1298/2015NDHStatewideYRBSReport20151110FINAL2NoCover.pdf>;
<https://www.nd.gov/dpi/uploads/1298/2015NDHTrendReportUpdated42016.pdf>; <https://www.cdc.gov/healthyouth/data/yrbs/results.htm>

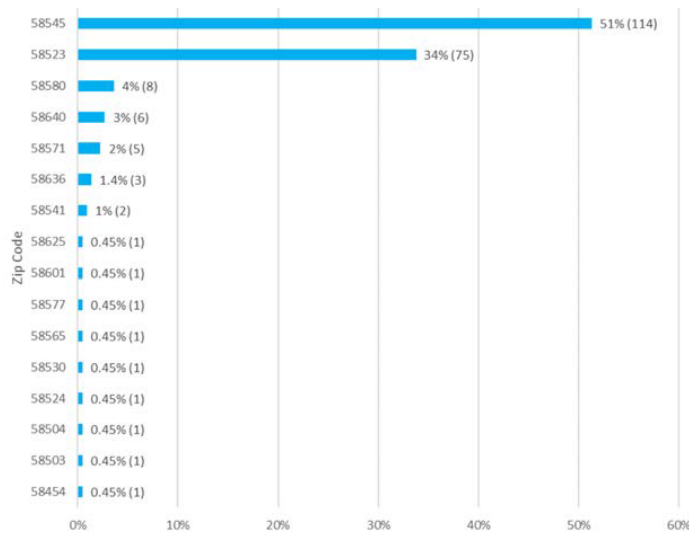
	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
% of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	21.9	17.7	↓	21.1	15.2	16.5
% of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey)	67.9	61.4	↓	60.7	58.8	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey)	59.3	57.6	=	56.7	54.4	39.2
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
% of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
% of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
% of students who were electronically bullied (includes e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6
Tobacco, Alcohol, and Other Drug Use						
% of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0

% of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
% of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0
Weight Management, Dietary Behaviors, and Physical Activity						
% of students who were overweight (\geq 85th percentile but $<$ 95 th percentile for body mass index)	15.1	14.7	=	15.4	14.6	15.6
% of students who were obese (\geq 95th percentile for body mass index)	13.5	14.0	=	16.3	12.9	14.8
% of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
% of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
% of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	3.1	2.2	=	2.4	2.8	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	50.6	51.3	=	51.7	50.1	46.5
% of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0
Other						
% of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
% of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
% of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	NA

Survey Results

As noted previously, 332 community members completed the survey in communities throughout the counties in the SMC service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 222 did, revealing that about half of respondents (51%, N=114) lived in Hazen. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 222



Survey results are reported in six categories: demographics; healthcare access; community assets, challenges; community concerns; delivery of healthcare; and other concerns or suggestions to improve health.

Survey Demographics

To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required to answer all questions.

With respect to demographics of those who chose to complete the survey:

- 33% (N=82) were age 55 or older.
- The majority (85%, N=209) were female.
- Slightly under half of the respondents (44%, N=108) had bachelor's degrees or higher.
- The number of those working full time (70%, N=172) was much higher than those who were retired (0%, N=1).
- 97% (N=241) of those who reported their ethnicity/race were white/Caucasian.
- 18% of the population (N=46) had household incomes of less than \$50,000.

Figures 6 through 12 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment took into account input from parties who represent the varied interests of the community served, including a balance of age ranges, those in diverse work situations, and community members with lower incomes. A comprehensive list of the "Other" responses for all survey questions is located in Appendix D at the end of this report.

Figure 6: Age Demographics of Survey Respondents
Total respondents = 249

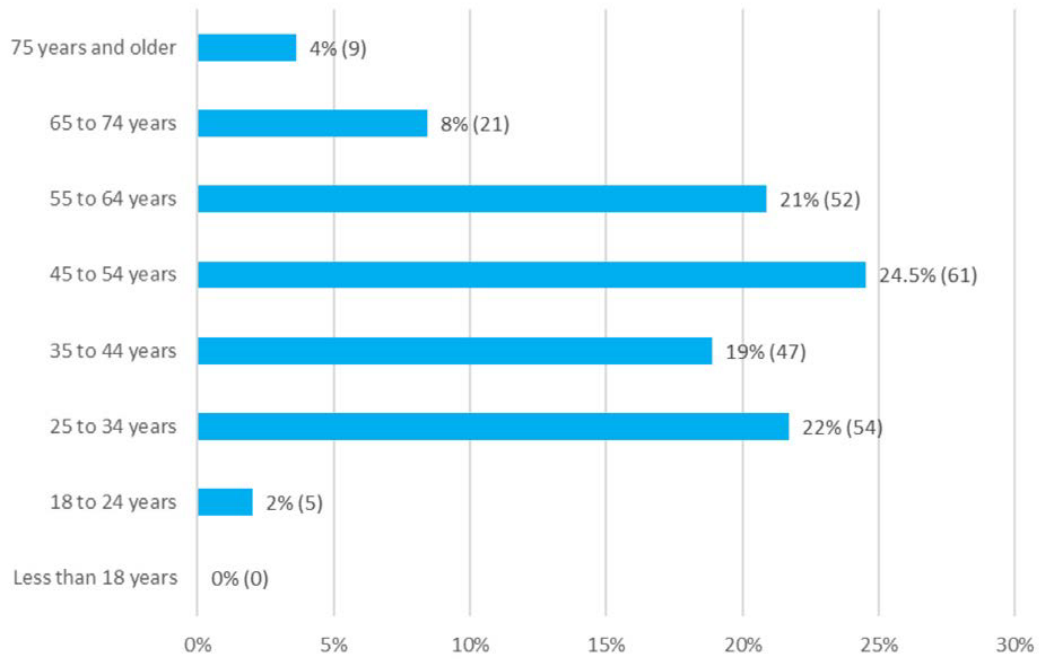


Figure 7: Gender Demographics of Survey Respondents
Total respondents = 247

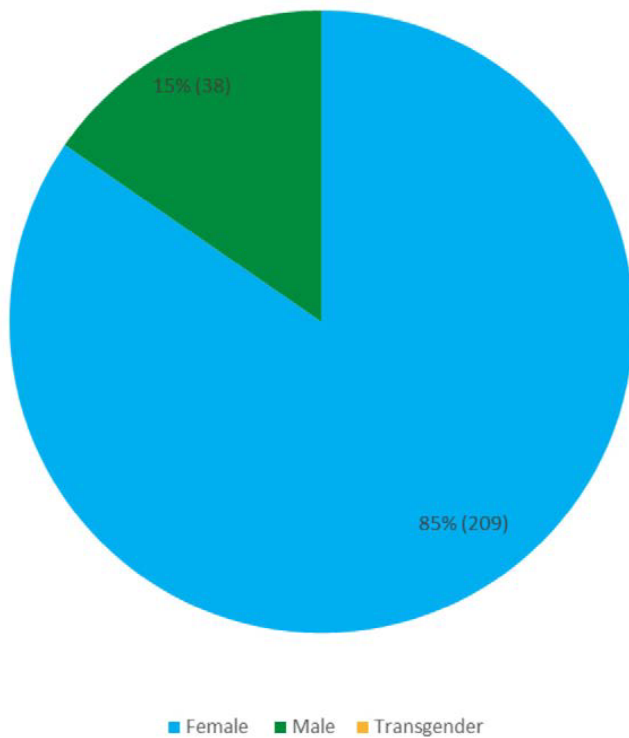


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 249

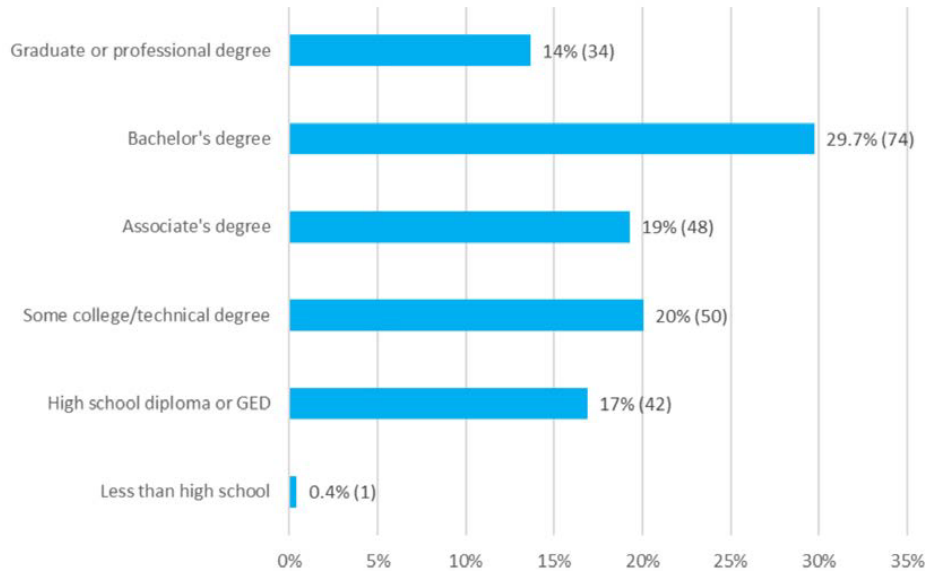
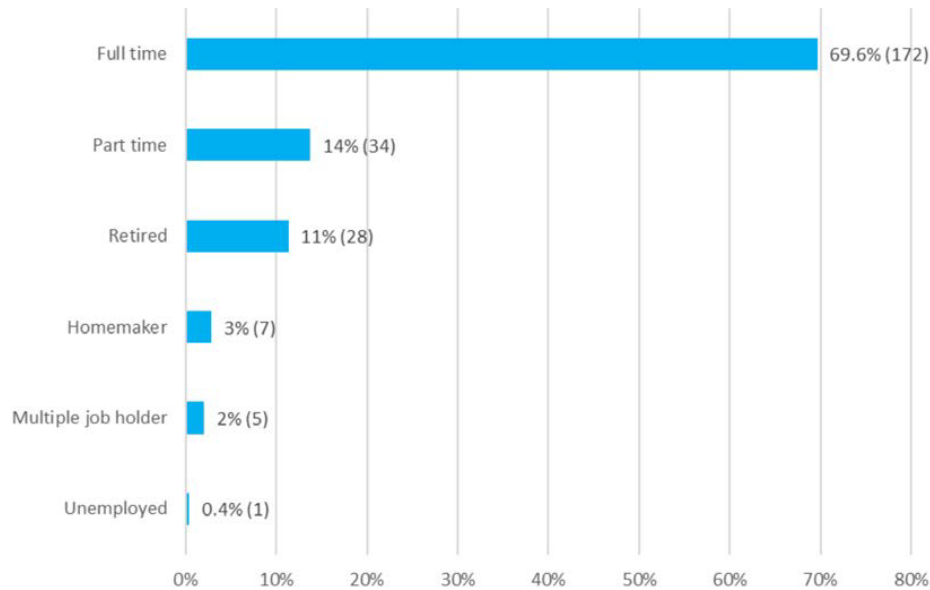
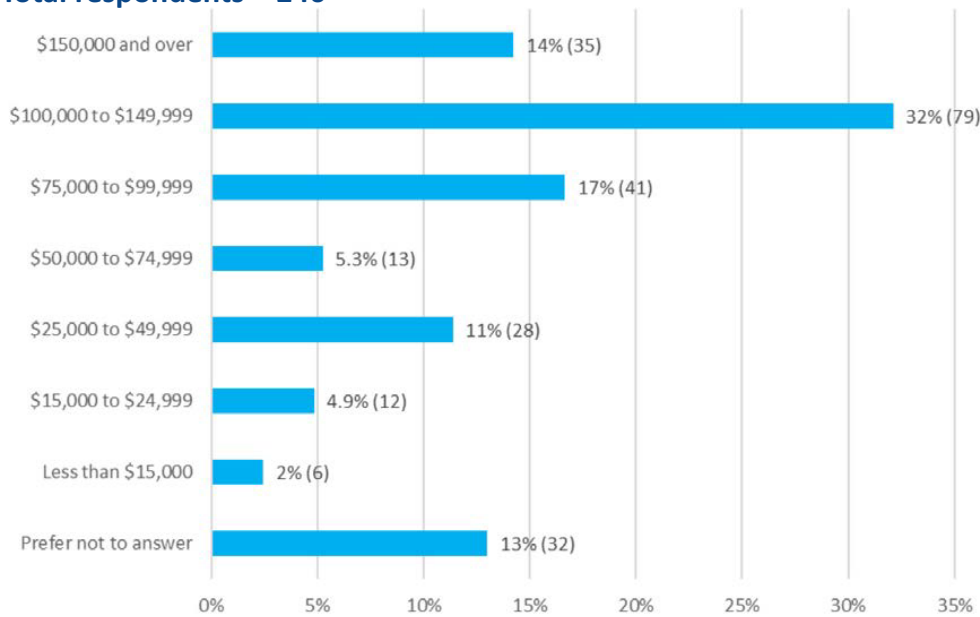


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 247



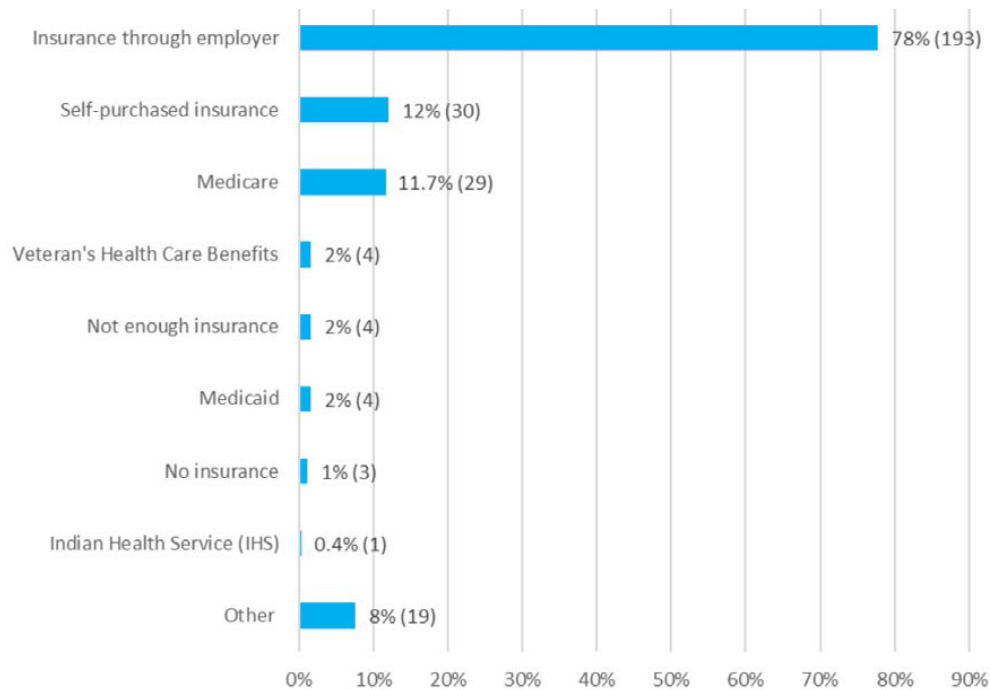
Of those who provided a household income, 7% (N=18) community members reported a household income of less than \$25,000. Forty-six percent (N=114) indicated a household income of \$100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 246



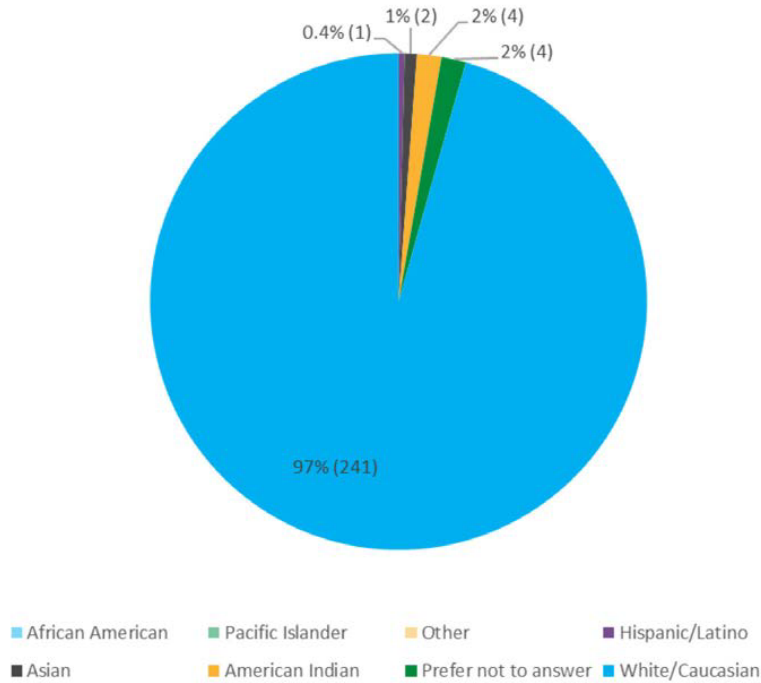
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. One percent (N=3) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one’s employer (N=193), followed by self-purchased (N=30) and Medicare (N=29). The majority of “Other” responses were “insurance through spouse employer.”

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 248



As shown in Figure 12, nearly all of the respondents were white/Caucasian (97%). This was in-line with the race/ethnicity of the overall population of Dunn, Mercer, and Oliver Counties; the U.S. Census indicates that 84.8% of the population is white in Dunn County, 94.6% in Mercer County, and 94.9% in Oliver County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 249



Community Assets and Challenges

Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. If more than three choices were selected, their responses were not included. The results indicate there is consensus (with at least 164 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=264);
- Feeling connected to people who live here (N=166); and
- People who live here are involved in their community (N=164).

Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 312

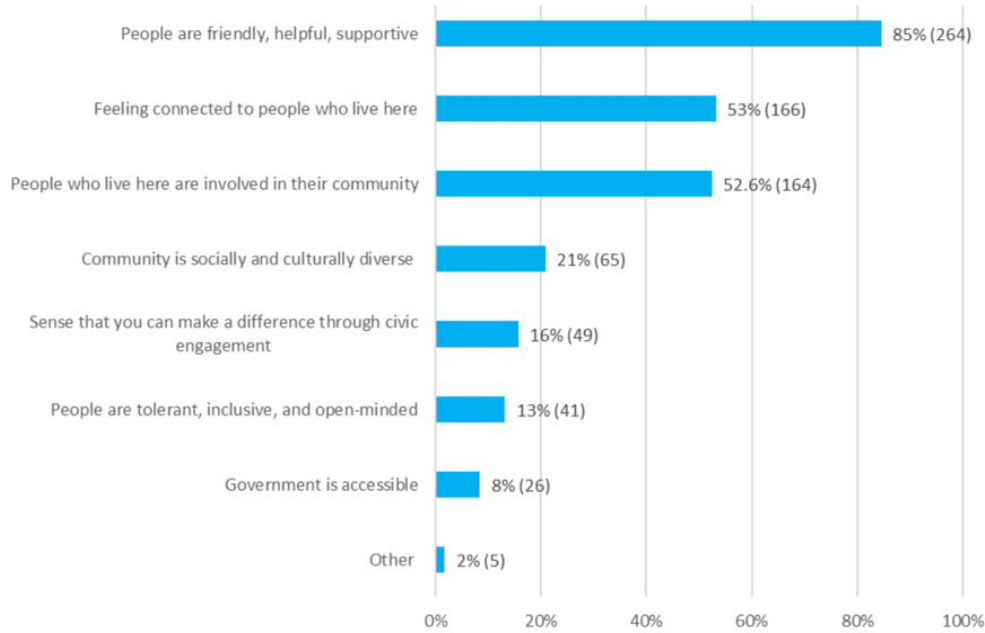


Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 313

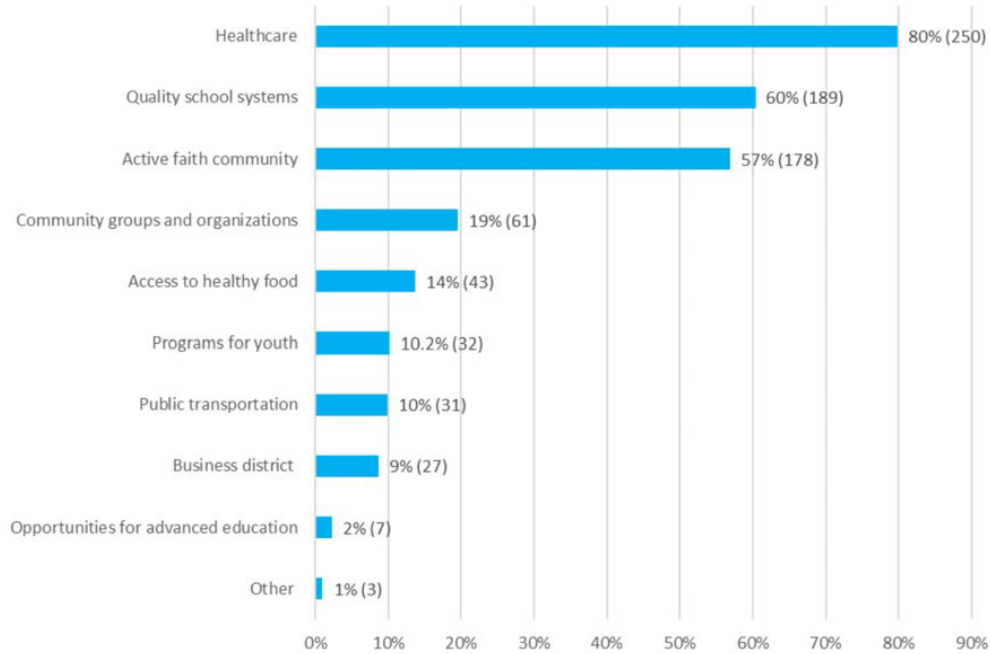


Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 317

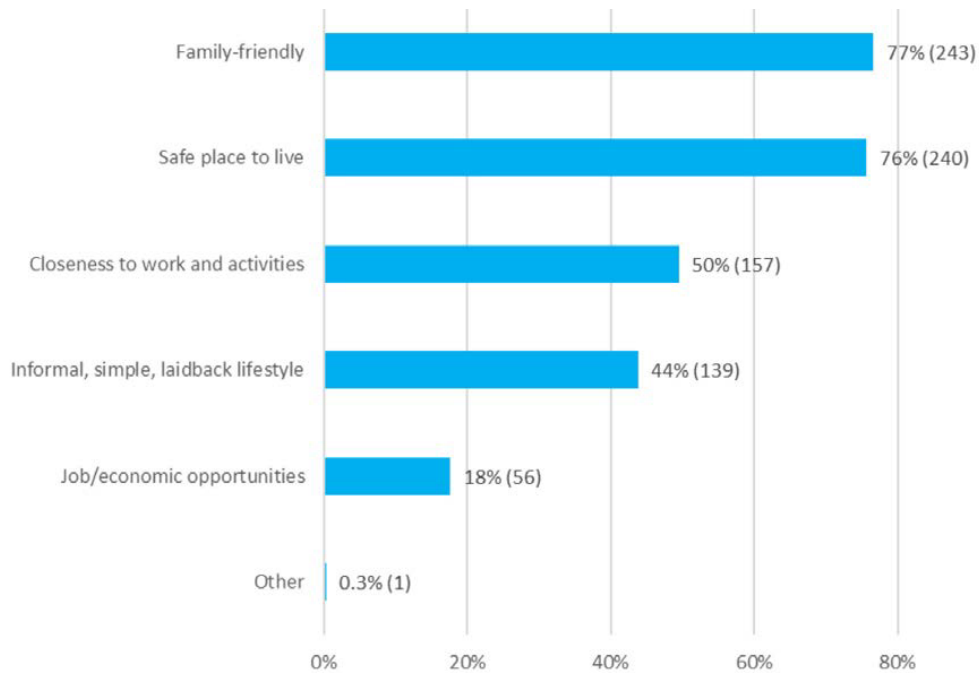
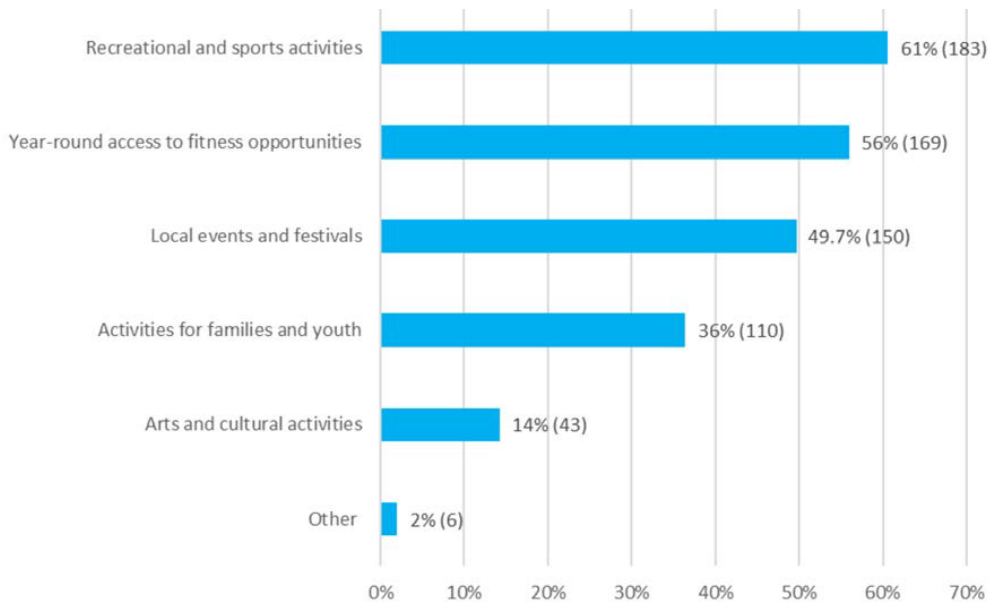


Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 302



“Other” activities indicated by respondents included entertainment, theater, hunting, fishing, swimming pool, and school sports.

Community Concerns

At the heart of this community health assessment was a section on the survey asking survey respondents to review a wide array of potential community and health concerns in five categories and pick their top three concerns. The five categories of potential concerns were:

- Community/environmental health;
- Availability/delivery of health services;
- Youth population;
- Adult population; and
- Senior population.

With regard to responses about community challenges, the most highly voiced concerns (those having at least 94 respondents) were:

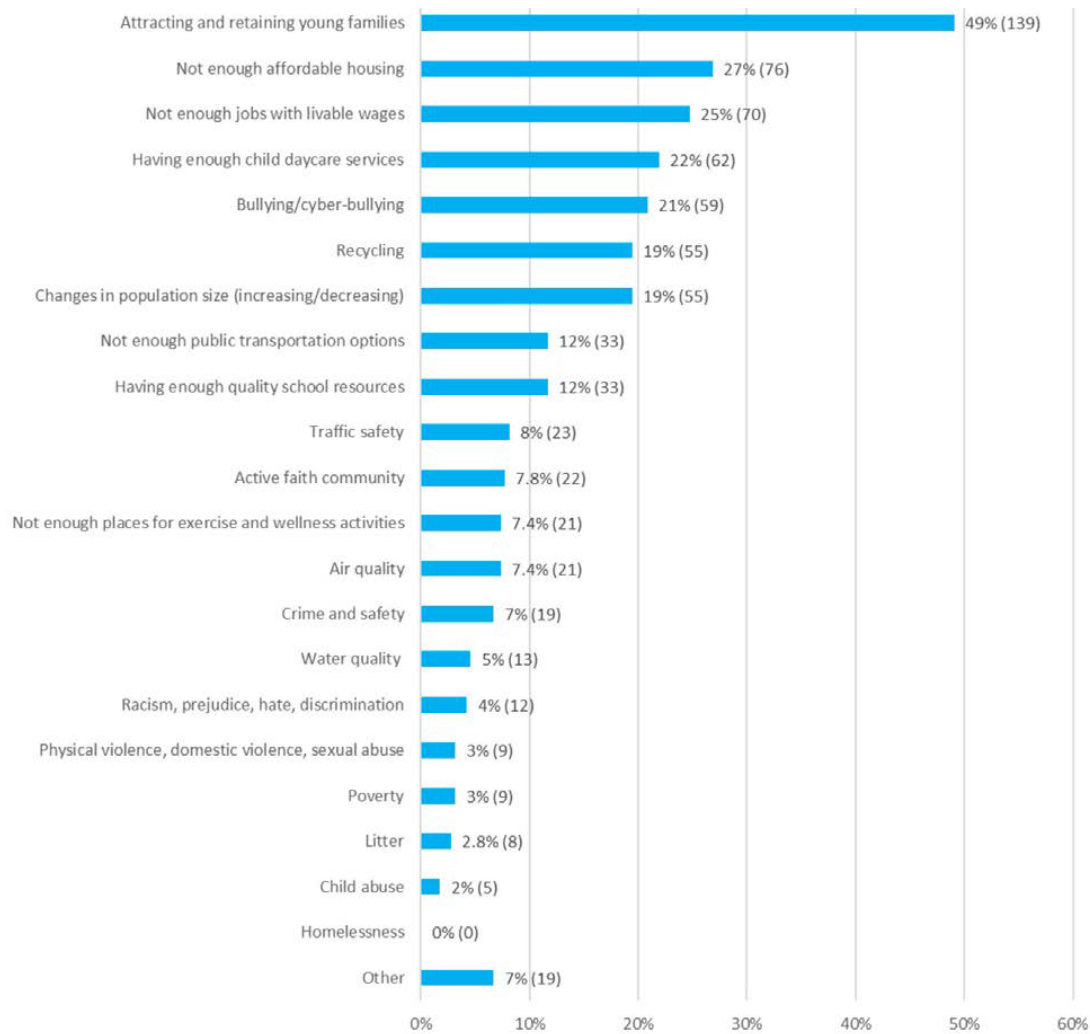
- Drug use and abuse – Youth (N=166);
- Attracting and retaining young families (N=139);
- Alcohol use and abuse – Youth (N=131);
- Cost of long-term/nursing home care (N=131);
- Drug use and abuse – Adult (N=129);
- Alcohol use and abuse – Adults (N=106);
- Availability of mental health services (N=96);
- Depression/ Anxiety – Adults (N=96);
- Depression/ Anxiety – Youth (N=96);
- Smoking and tobacco use (second-hand smoke) or vaping/juuling – Youth (N= 94);

The other issues that had at least 60 votes included:

- Not enough activities for children and youth (N=84);
- Availability of resources to help the elderly stay in their homes (N=83);
- Cost of health insurance (N=76);
- Not enough affordable housing (N=76);
- Assisted living options (N=74);
- Not enough jobs with livable wages (N=70);
- Obesity/ overweight - Adults (N=70);
- Having enough child daycare services (N=62); and
- Ability to meet needs of older population (N=60).

Figures 17 through 22 illustrate these results.

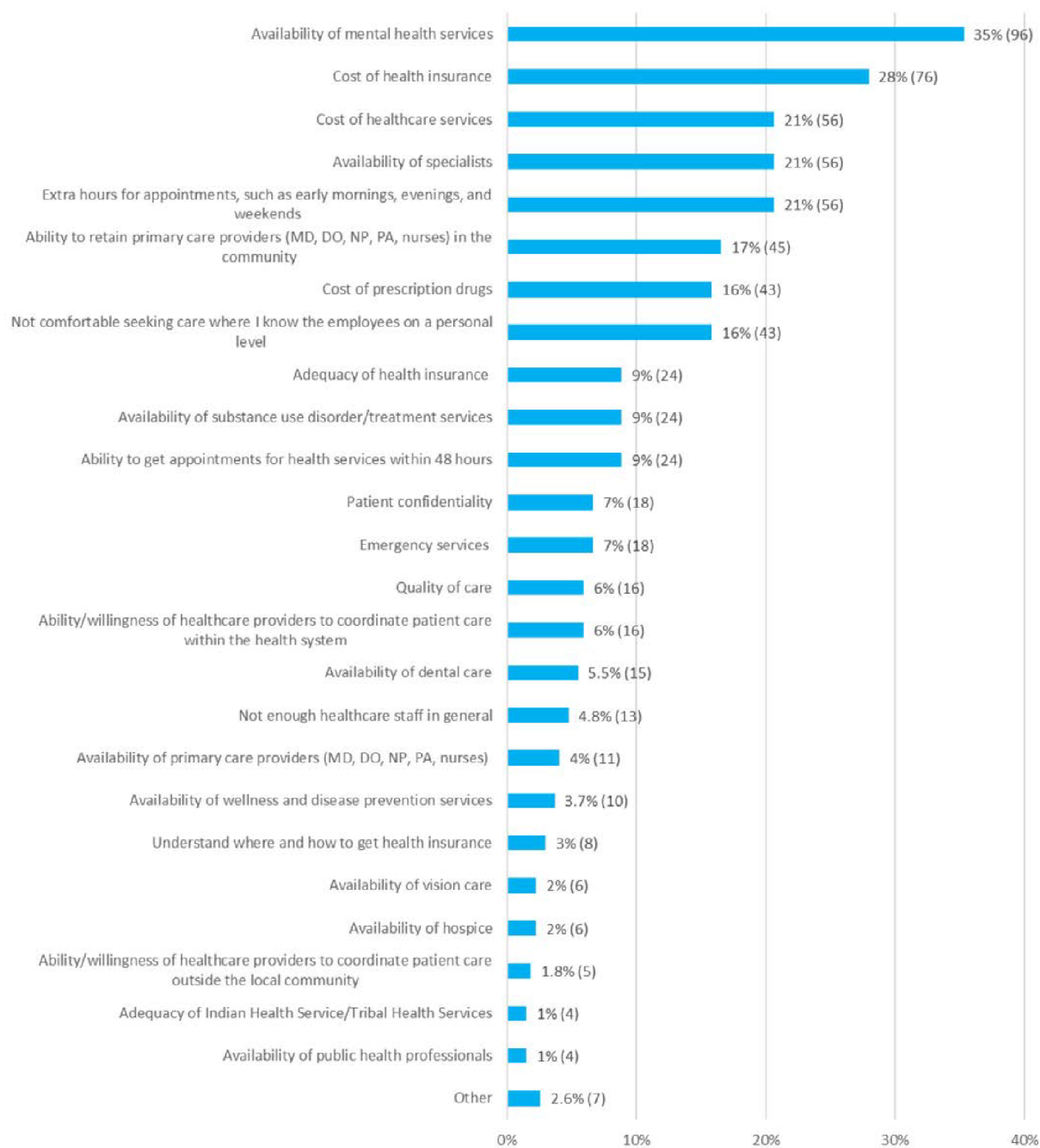
Figure 17: Community/Environmental Health Concerns
Total responses = 283



Some of the responses indicated in “Other” include drug and alcohol abuse, high property taxes, not enough jobs with livable wages, limited healthy food options, lack of shopping venues and restaurants, and lack of home health resources/staff.

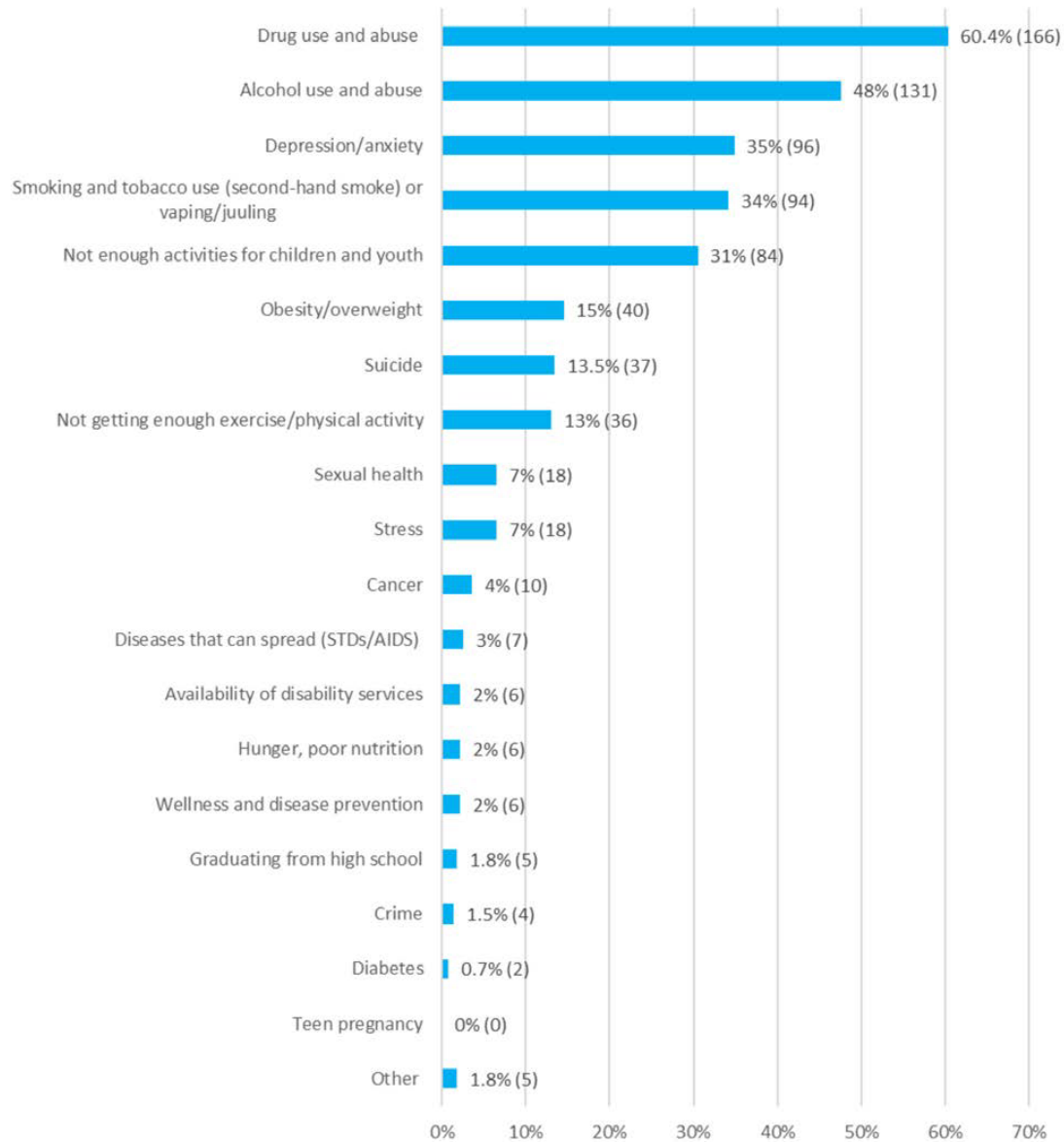
Figure 18: Availability/Delivery of Health Services Concerns

Total responses = 272



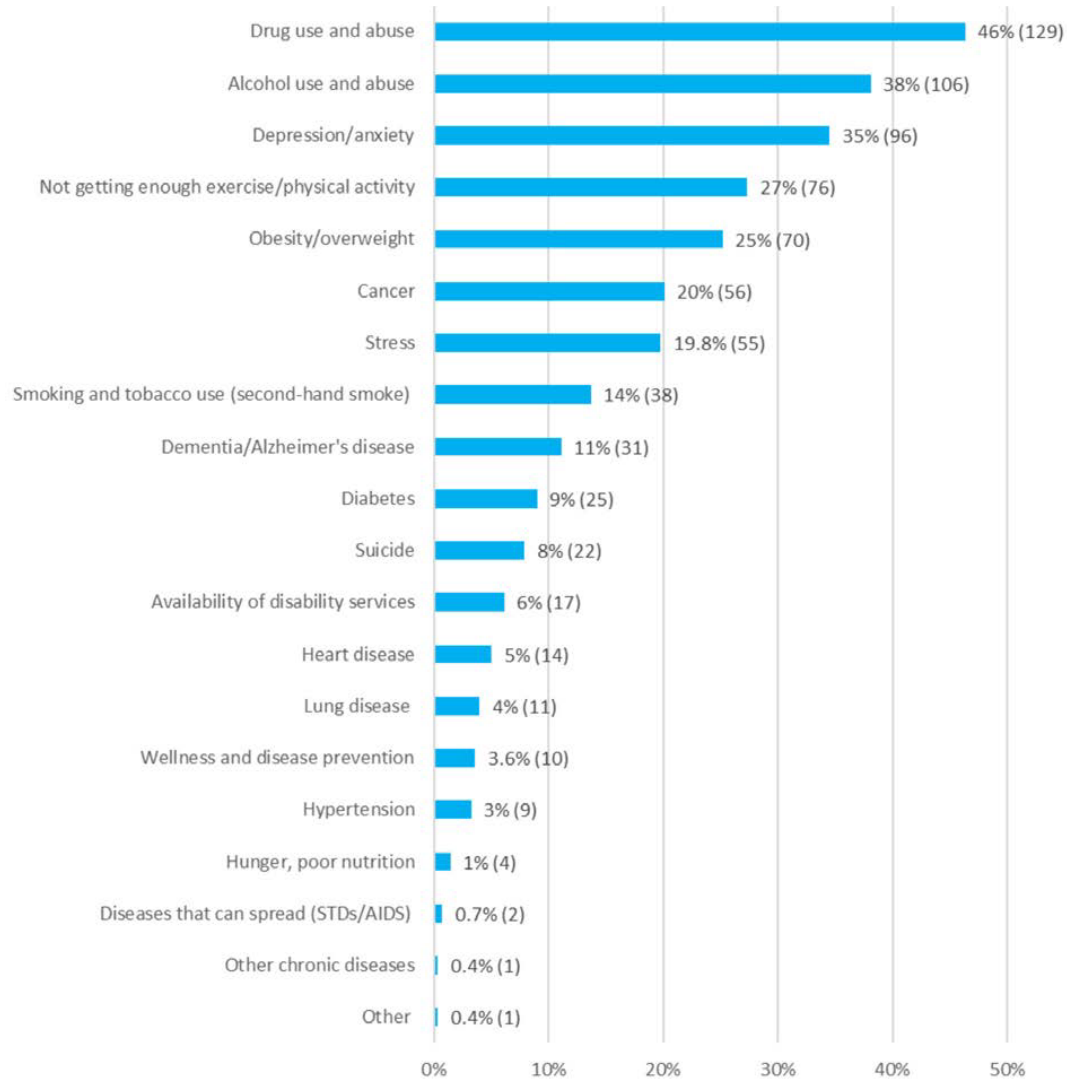
“Other” responses included a lack of alternative medicine options (massage therapy, acupuncture), not enough workers in general, and lack of in-home adult care.

Figure 19: Youth Population Health Concerns
Total responses = 275



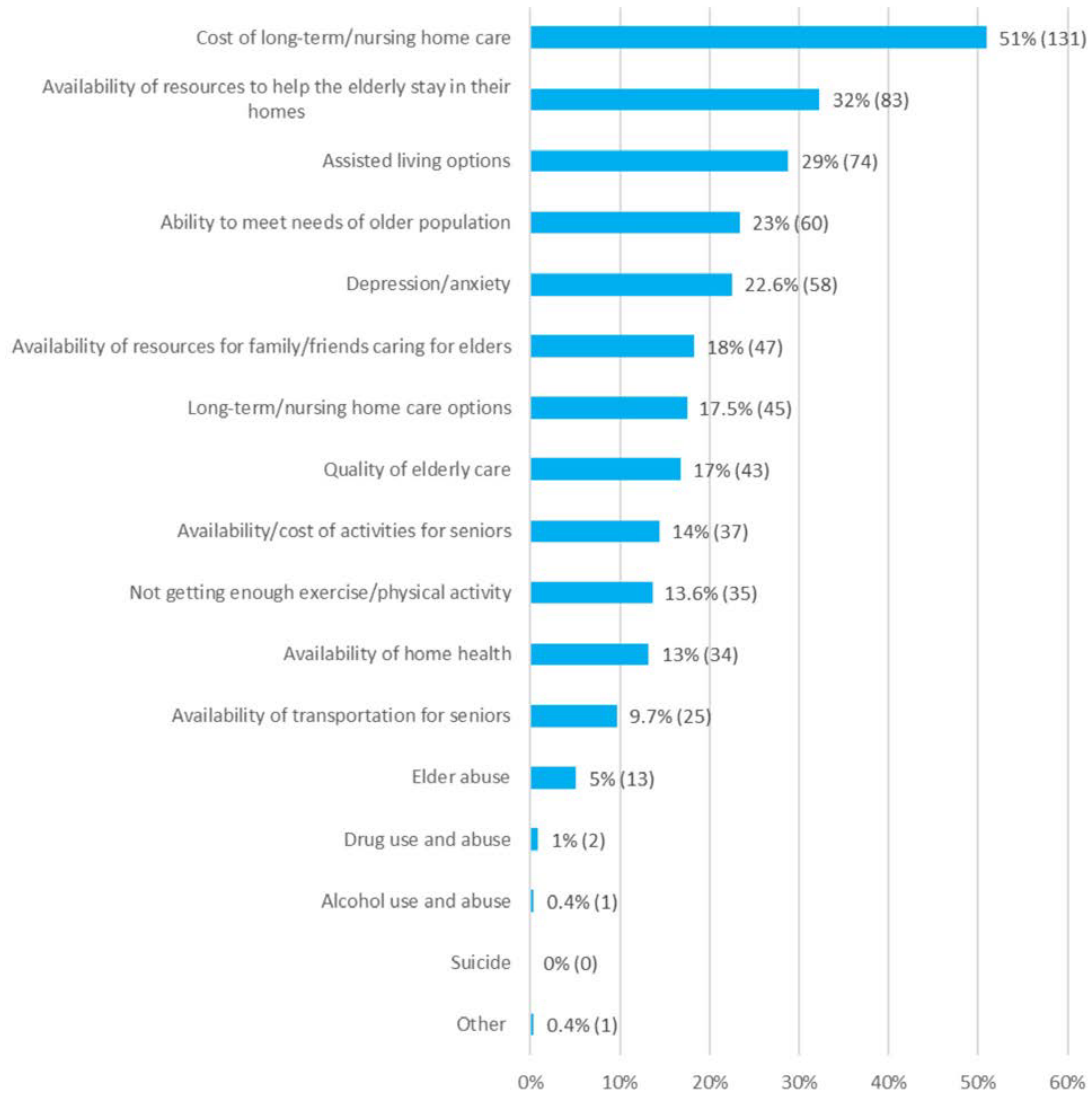
“Other” responses included bullying, lack of respect, and no quality job opportunities for the youth.

Figure 20: Adult Population Concerns
Total responses =278



Domestic violence was the only “Other” response indicated.

Figure 21: Senior Population Concerns
Total responses = 257



The single “Other” response was availability of in-home caregivers.

In an open-ended question, respondents were asked what single issue they feel is the biggest challenge facing their community. Two categories emerged above all others as the top concerns:

1. Lack of mental health services, especially in emergency situations; and
2. Drug/alcohol/substance abuse

Other biggest challenges that were identified were the population decline/inability to attract families to live in the community, increasing cost of living, sustaining local businesses, lack of safe activities for youth, lack of assisted living facilities, need for more restaurants, and ability to meet the needs of the older population.

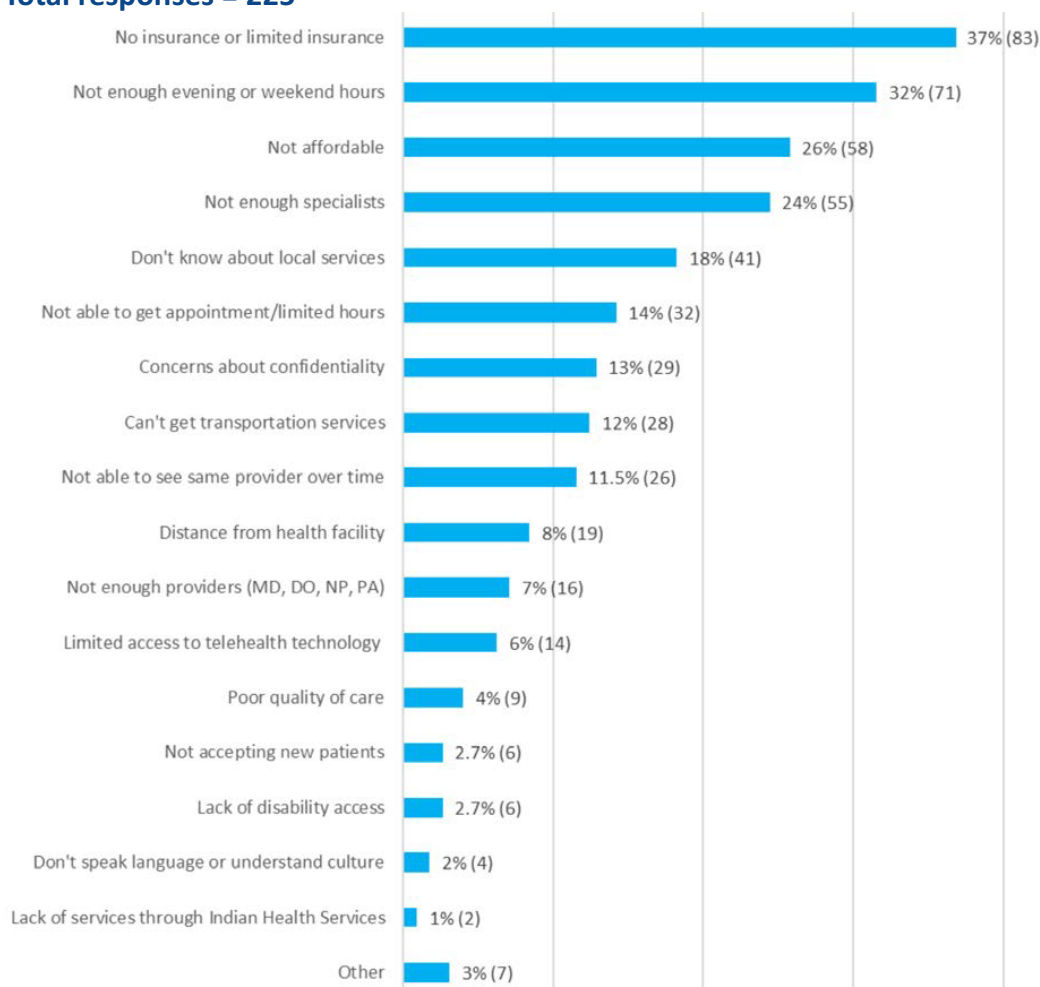
Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier perceived by residents was no insurance or limited insurance (N=83), with the next highest being not enough evening or weekend hours (N=71). After these, the next most commonly identified barriers were not affordable (N=58), not enough specialists (N=55), and don't know about local services (N=41). The majority of concerns indicated in the "Other" category were in regards to lack of promotion of evening or weekend hours and bad attitudes by medical staff.

Figure 22 illustrates these results

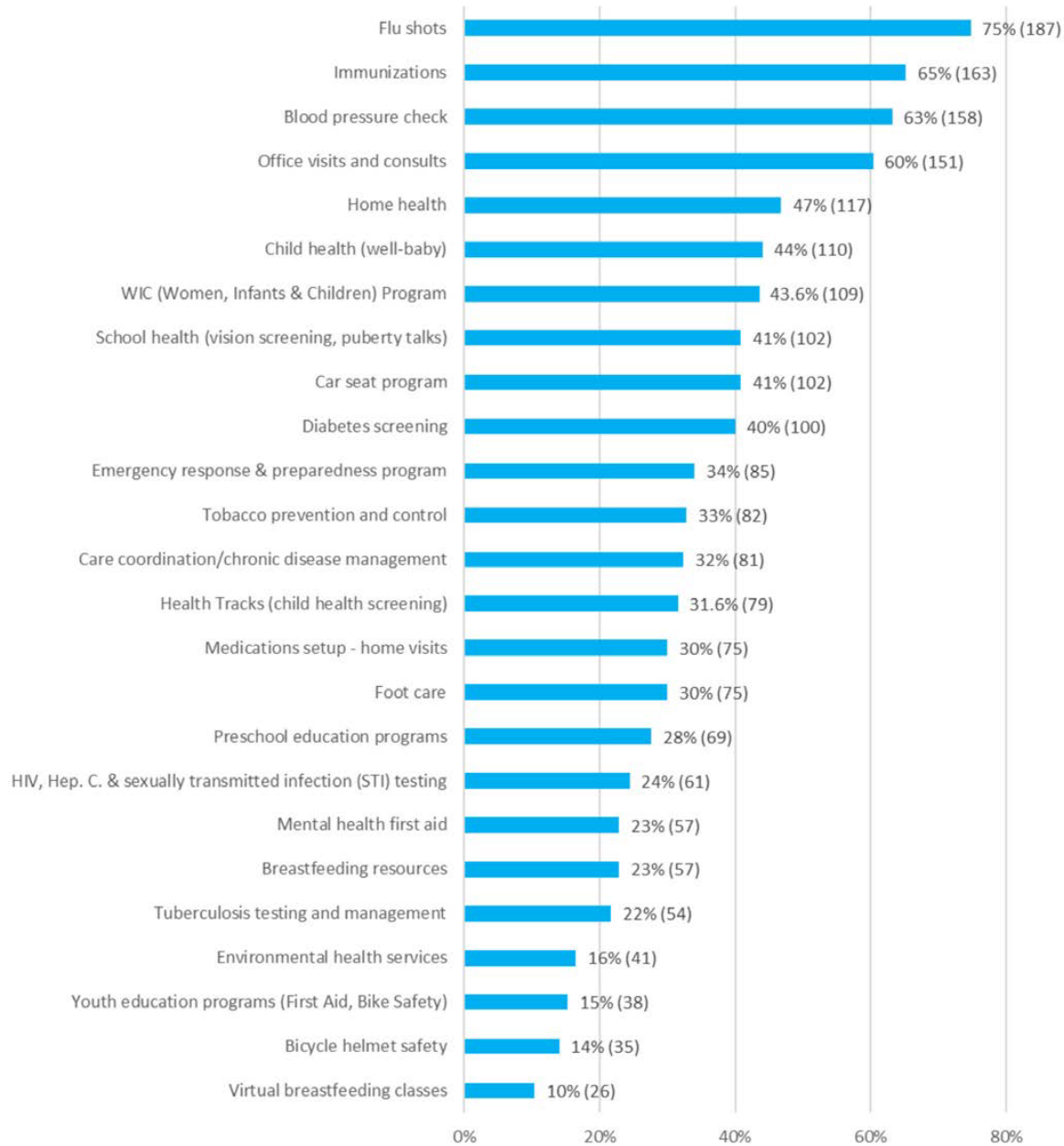
Figure 22: Perceptions about Barriers to Care

Total responses = 225



Considering a variety of healthcare services offered by the county public health units, respondents were asked to indicate if they were aware that the healthcare service is offered through public health or if they have used the service in the past year. (See Figure 23).

Figure 23: Awareness and Utilization of Public Health Services



In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was mental health services. Other services requested are noted below.

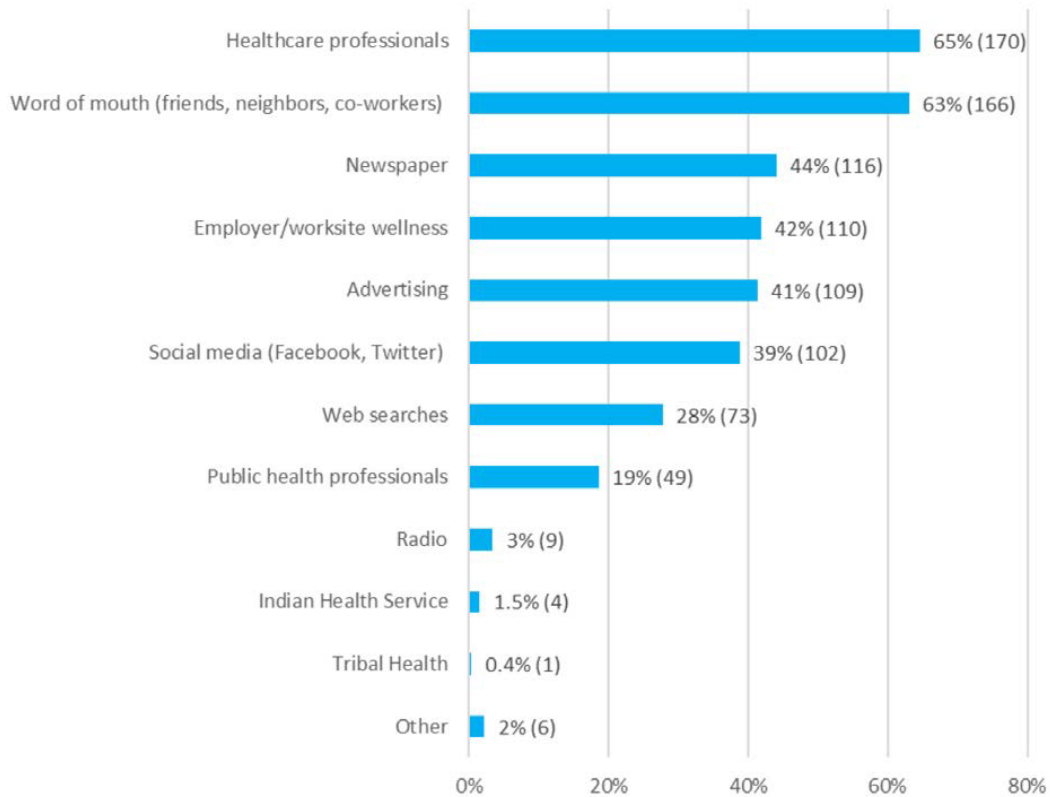
- Acupuncture
- Bone and joint
- Addiction services
- Cancer center for chemo and radiation
- Asthma specialist
- Cardiology
- Better mental healthcare
- Dental in Dunn County
- Birthing facility
- Dermatological services such as facials, IPL, fillers
- Bladder/kidney therapists, dialysis

- Dermatologist
- Endocrinologist
- ENT
- Extended appointment availability
- GI specialist
- Gynecology, women’s health
- Holistic massage therapists and medicines
- More advertising about the CCCHC Marketplace assistance
- MRI/CT available every day
- Naturopathic options
- Ophthalmology
- Orthopedics
- Podiatry
- Prenatal
- Psychiatric care
- Rheumatologist
- Sports-focused training, diet and exercise
- Traveling OB
- VA clinic

While not a service, many respondents indicated that they would like holistic and naturopathic options added.

The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a number of services where they felt the hospital should increase marketing efforts, these included the sliding fee scale, men’s health screenings, OB services, mental health services, diabetes management, 3D mammogram services and including information for the patient to know if the services is covered by their insurance.

Figure 24: Sources Used to Find Out About Local Health Services
Total responses = 263



Responses included in the “Other” category include mail flyers, health meetings, and work.

Considering a variety of healthcare, screening/therapy, and radiology services offered by SMC and CCCHC, respondents were asked to indicate if they were aware that the healthcare, screening/therapy, or radiology service is offered though SMC or CCCHC or have used the service in the past year. (See Figures 25, 26, 27).

Figure 25: Awareness of General and Acute Services at Sakakawea Medical Center and Coal Country Community Health Center

Total responses = 255

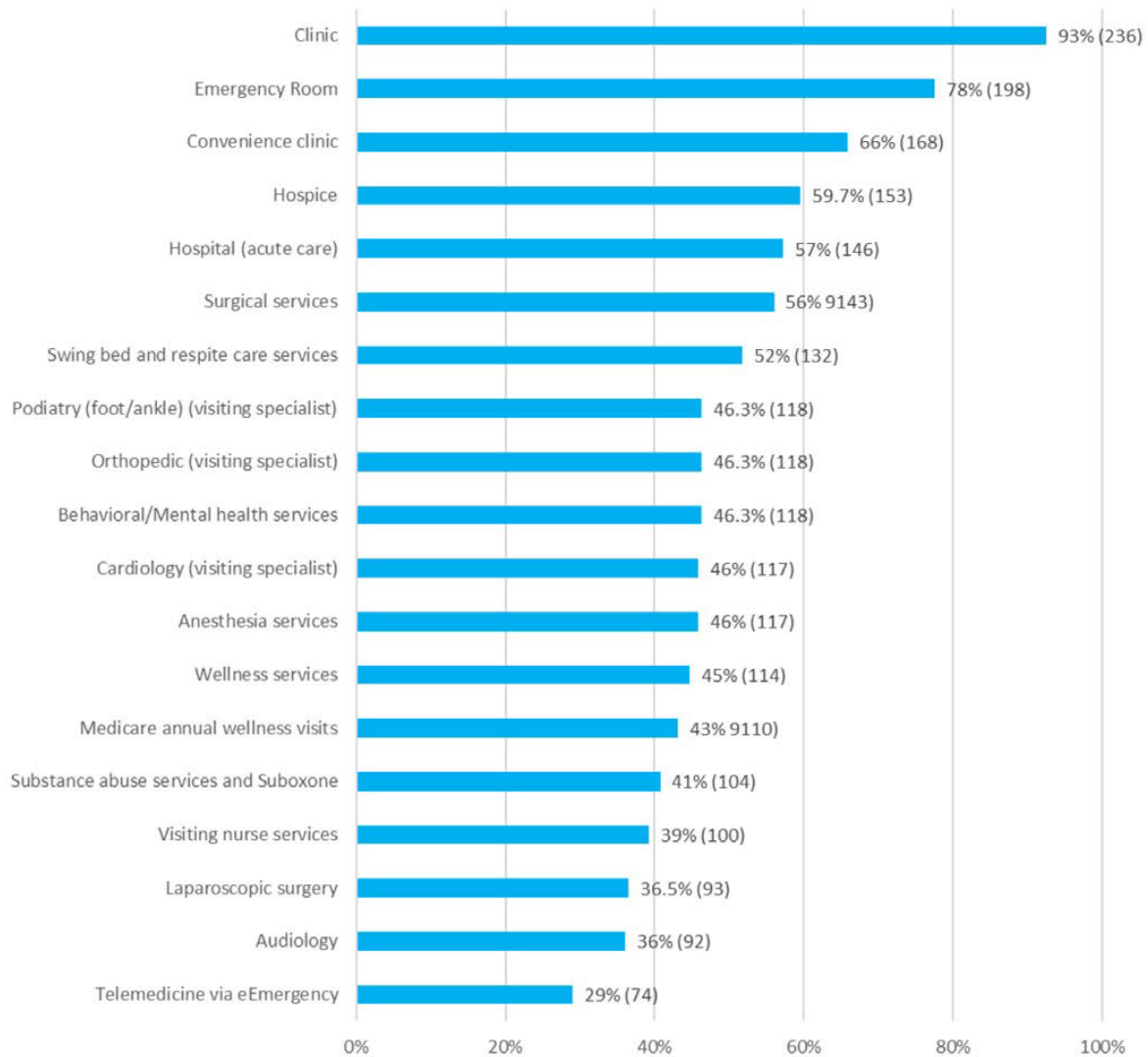


Figure 26: Awareness of Screening/Therapy Services at Sakakawea Medical Center and Coal Country Community Health Center
Total responses = 240

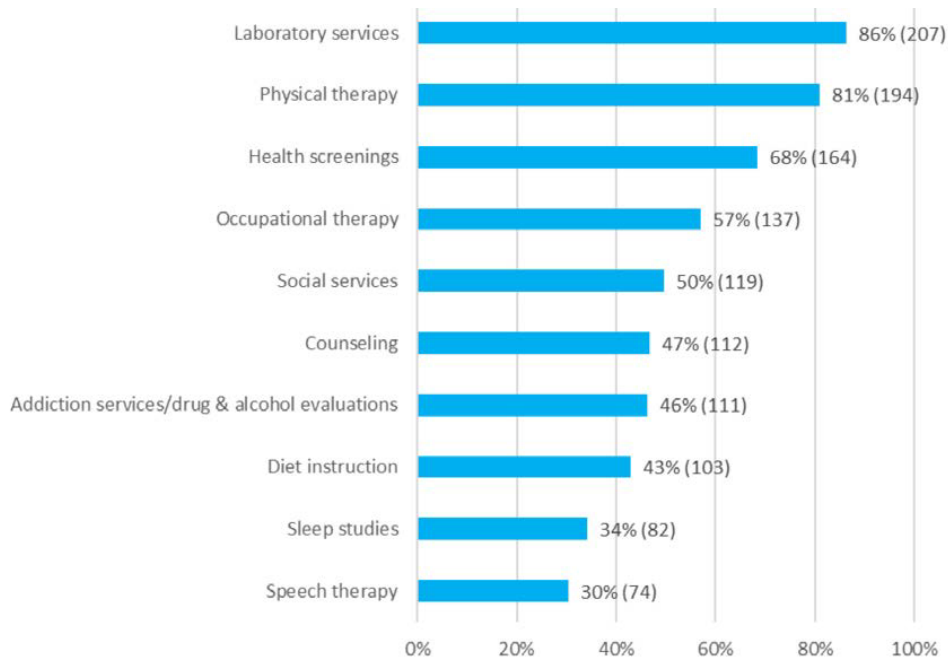
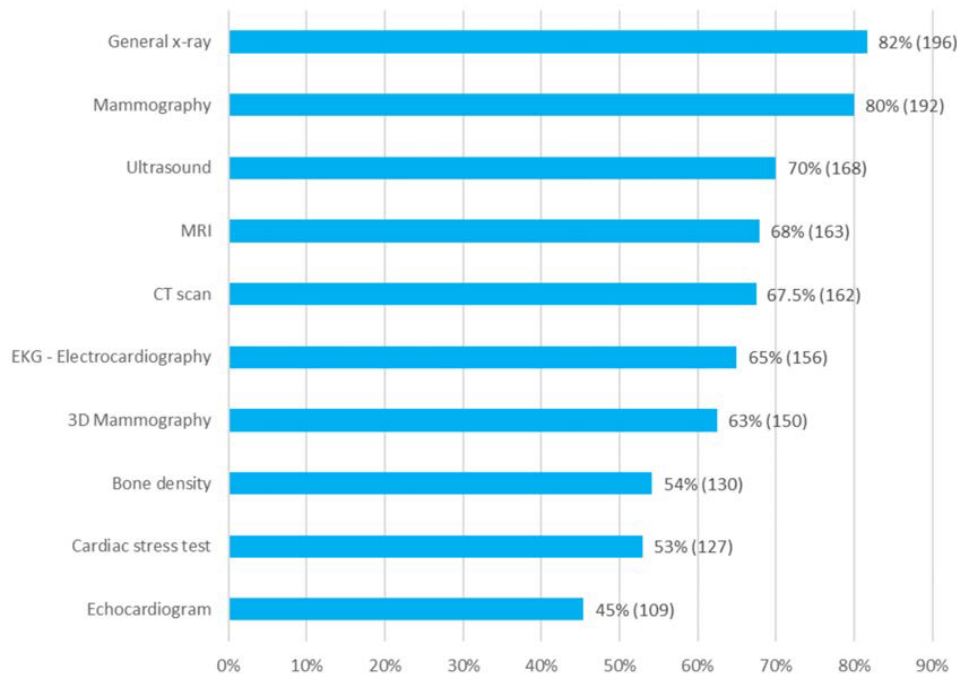
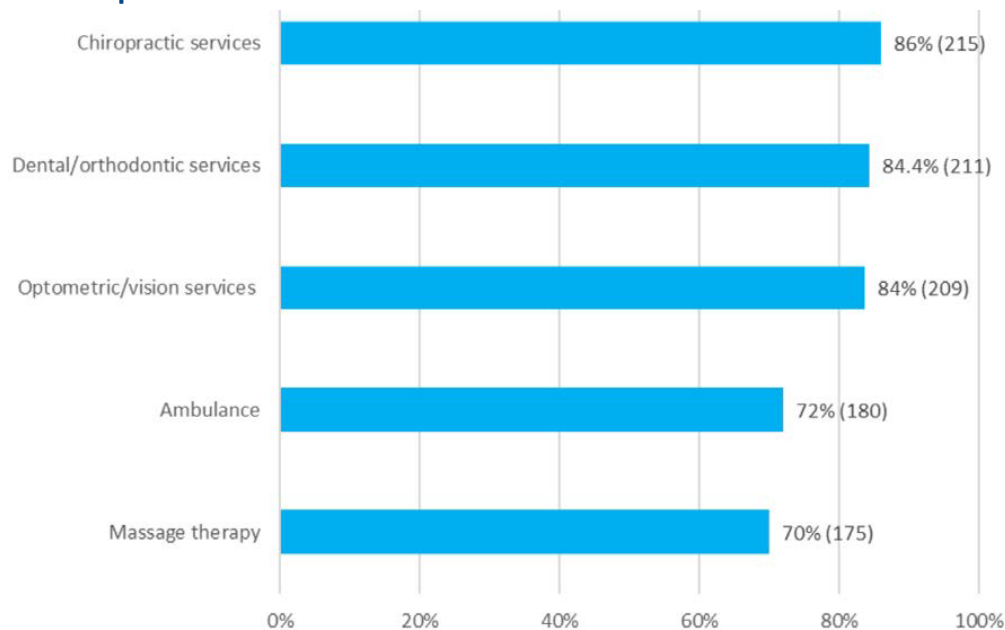


Figure 27: Awareness of Radiology Services at Sakakawea Medical Center and Coal Country Community Health Center
Total responses = 240



Considering the variety of services offered locally by other providers/organizations, respondents were asked which services they were aware of or had used in the past year (Figure 28).

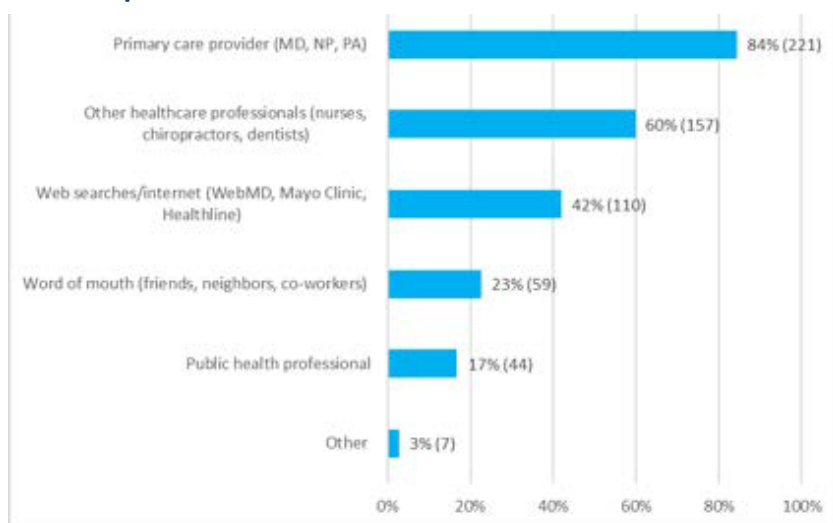
Figure 28: Awareness of Services Offered by Other Providers/Organizations
Total responses = 250



Respondents were asked where they go to for trusted health information. Primary care providers (N=221) received the highest response rate, followed by other healthcare professionals (N=157), and then web/Internet searches (N=110). “Other” responses included chiropractor, larger city doctors/specialists, local ambulance service, and insurance agents.

Results are shown in Figure 29.

Figure 29: Sources of Trusted Health Information
Total responses = 262



In an effort to gauge the interest in other healthcare services, respondents were asked about their interest in having local access to alternative/holistic healthcare services (Figure 30).

Figure 30: Interest in Alternative/Holistic Healthcare Services
Total responses = 260

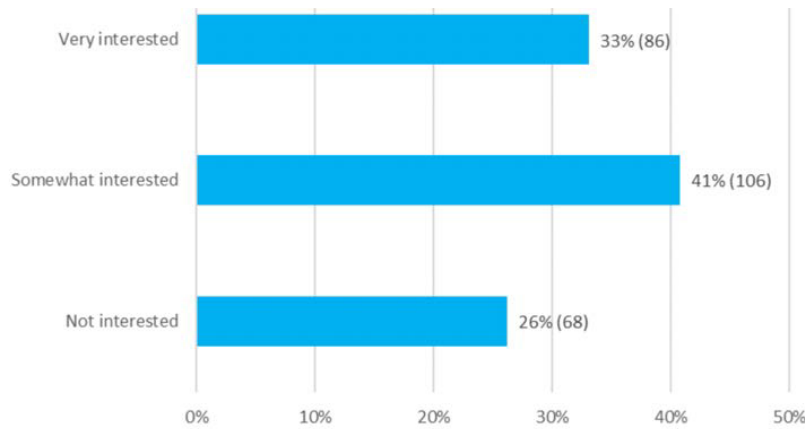
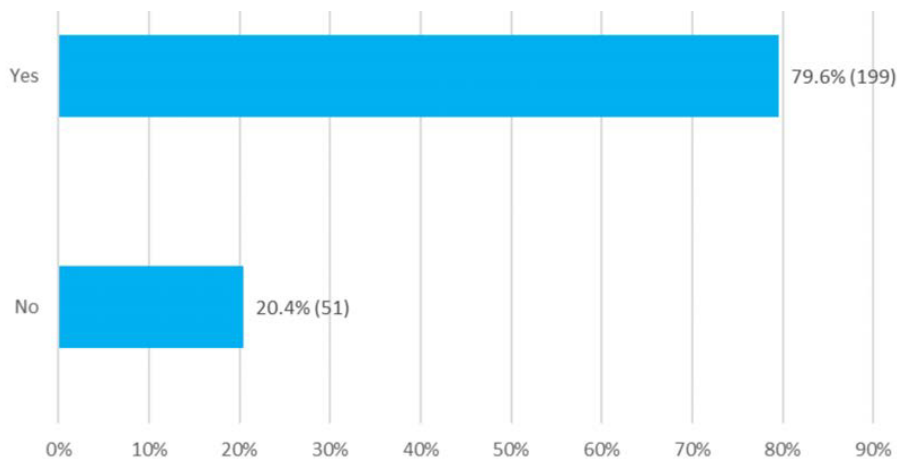


Figure 31: Establishment of Primary Care Provider in the Community
Total responses = 250



Of the community members that answered no in Figure 31, 29 provided reasoning. The majority of respondents indicated they had a primary care provider out of the area, with other popular reasons including that they do not know who to go to/are not aware of the providers locally, and that they see different providers every time they go to the hospital.

Figures 32 through 34 represent responses to questions geared at gaining an understanding of the community's awareness of and desire for specific services and resources to be available locally.

Figure 32: Awareness of the Patient Centered Medical Neighborhood Provided by Sakakawea Medical Center and Coal Country Community Health Center
Total responses = 255

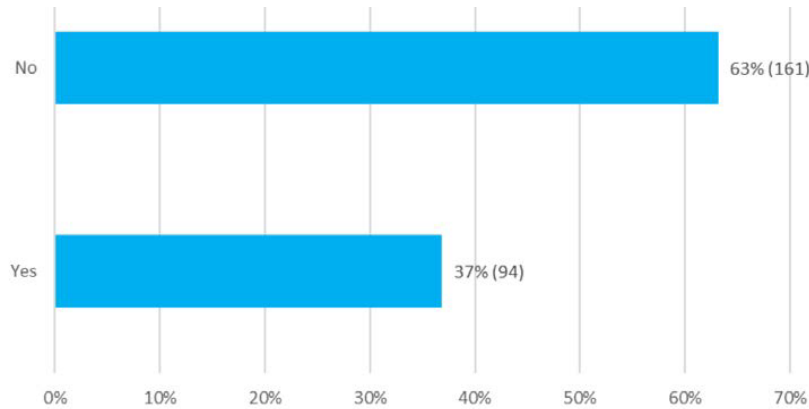


Figure 33: Awareness of Health Insurance Marketplace Enrollment Assistance Provided by Coal Country Community Health Center
Total responses = 254

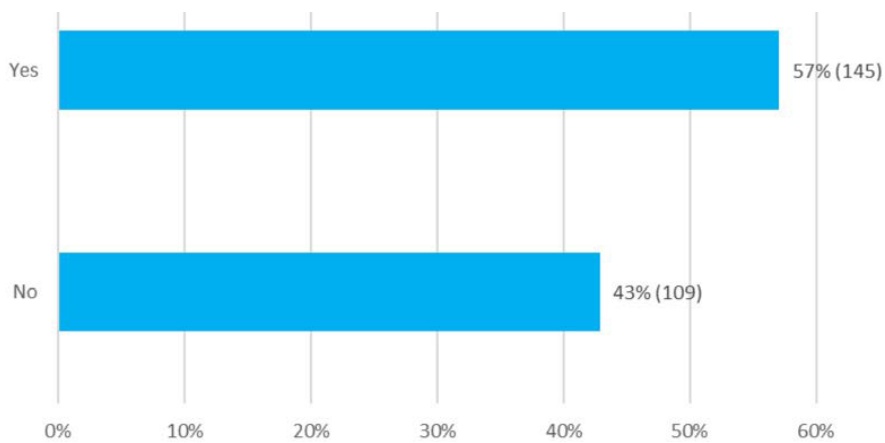
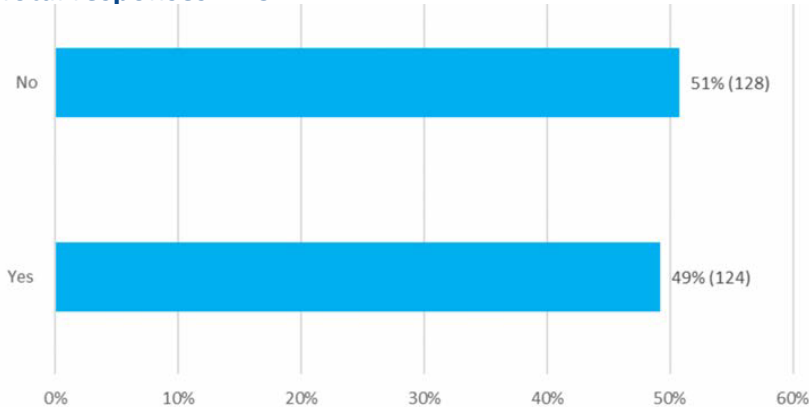
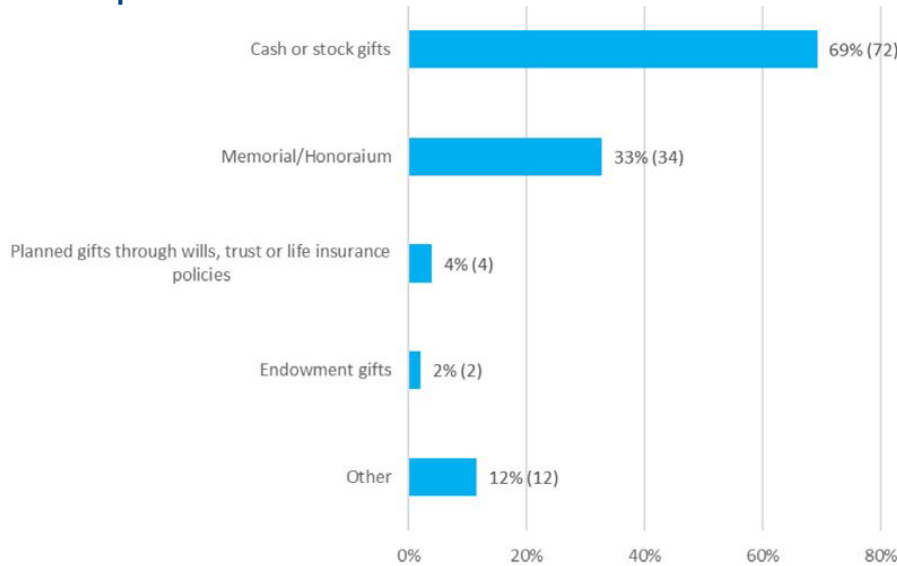


Figure 34: Awareness of Local Healthcare Foundations
Total responses = 252



In an effort to gauge ways that community members' would be most likely to financially support facility improvements/new equipment they would most likely support, a question was included asking them to select ways they have supported facility improvements/new equipment at local healthcare facilities (see Figure 35). "Other" responses included donations, supporting local fundraisers, hospital auxiliary, and volunteering.

Figure 35: Means of Providing Financial Support for Facility Improvements/New Equipment
Total responses = 104



To gather more information about Dunn County services specifically, questions were included that only applied to community members from Dunn County. These questions focused on the Hill Top Home of Comfort and potential service expansions. They are represented in Figures 36-40.

Figure 36: Expectations Immediate Family Will Utilize Assisted Living Services Within a Timeline
Total responses = 190

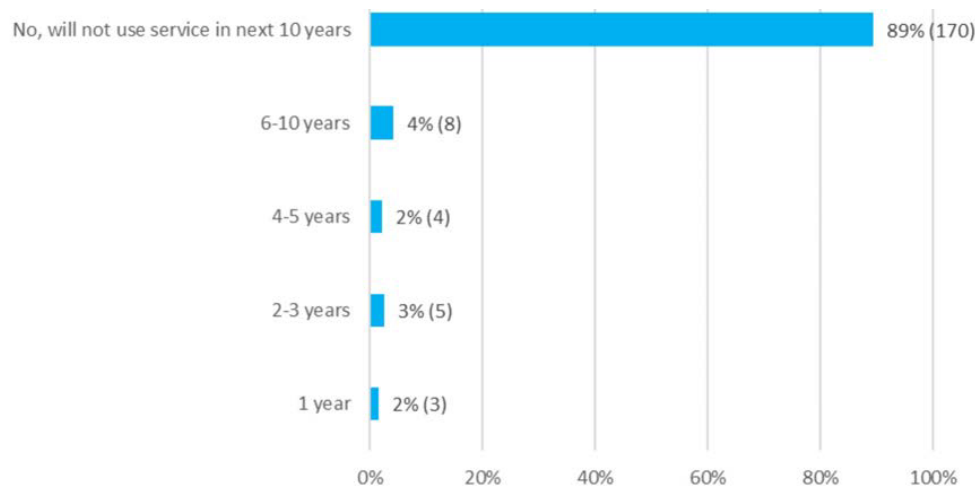
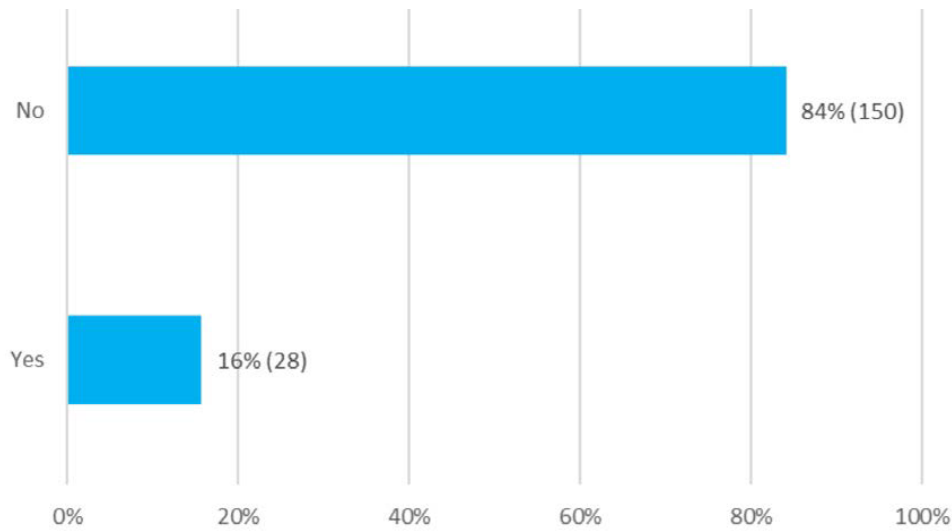
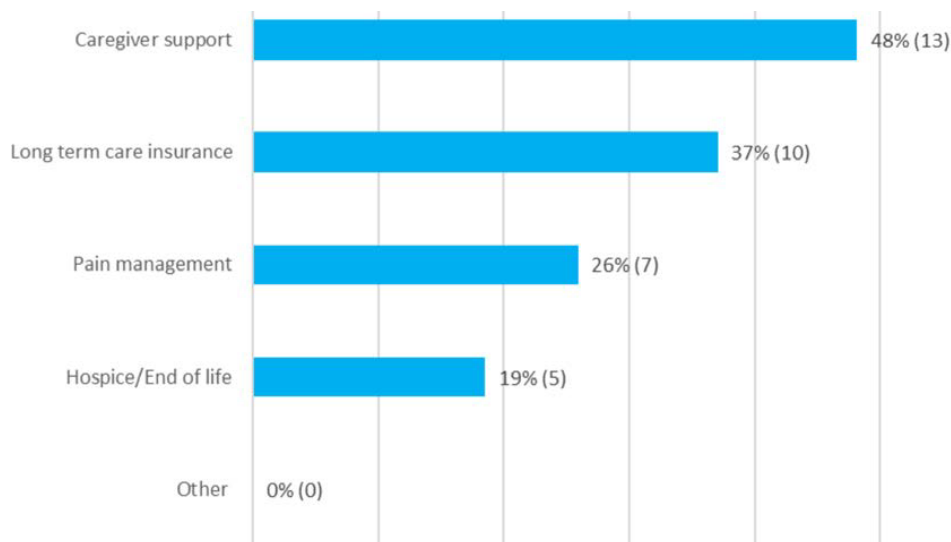


Figure 37: Potential Utilization of Community Health Education if Offered
Total responses = 178



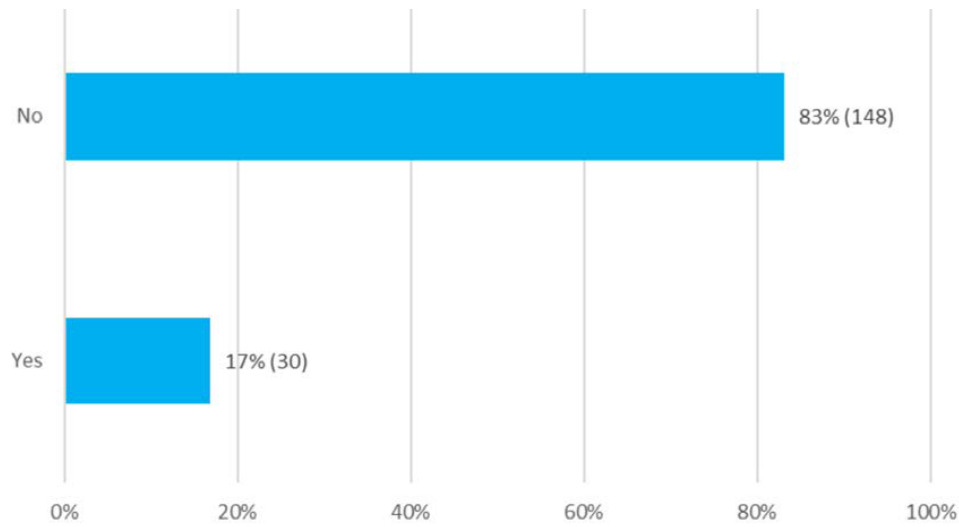
The community members that answered yes in Figure 37, Potential Utilization of Community Health Education if Offered, were asked what specific kinds of education they or their family would find beneficial. The results are presented in Figure 38.

Figure 38: Beneficial Potential Educations
Total responses = 27



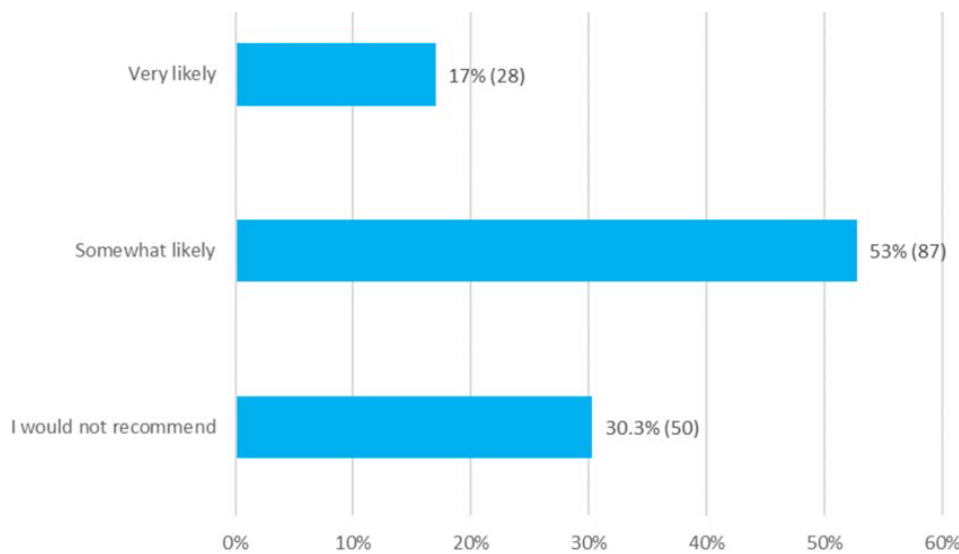
The large majority of Dunn County residents (83%) were unaware that Therapy Solutions provided outpatient therapy services at Hill Top Home of Comfort. Figure 39 represents these findings.

Figure 39: Awareness of Therapy Solutions Outpatient Therapy Services at Hill Top Home of Comfort Total responses = 178



Half of the respondents said that they would likely recommend Hill Top Home of Comfort to others, as shown in Figure 40.

Figure 40: Likelihood to Recommend Services Offered at Hill Top Home of Comfort Total responses = 165



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The majority of responses focused on need for additional workforce, extended clinic hours, and concerns related to costs.

Regarding workforce, there were many that indicated that more employees should be hired. One indicated that they feel there would be benefit to having a doctor on staff at SMC in addition to physician assistants and nurse practitioners. Respondents also want enough staffing to meet the demand, for example, less wait time in the emergency room. Another said that their primary care provider is always full so they can never get in and would like other providers available that can see them. Others indicated more providers, less waiting time to see specialists, and having a health “advisor” to help find access to information among providers, locations, insurance, etc. Killdeer was specifically indicated as an area lacking access to appointments and needing services such as chiropractors, dentists, and counselors. There is concern regarding the high turnover of Knife River Care Center management as well as the level of care given.

Several expressed a desire for additional clinic hours.

Concerns related to cost included a need for less cost of health insurance for seniors, letting the health market compete, less deductible and out of pocket rates, and informing patients about what the costs of their services will be before scheduling an appointment. The sliding fee scale needs to project the reality of single parents and take into consideration rent and utilities as well as other common household bills, such as groceries. Transportation cost and other general costs for seniors living independently in home to get to/from appointments, pharmacy/medications, and overall cost to get supplies purchase as well as how to get to the supplies are a concern.

Transportation is a problem for some. The community has busing systems, but they do not cover all of the needs. It was suggested that there be transportation access in the community to get patients to radiology, physical therapy, respiratory therapy, etc. at SMC.

There were also some concerns over confidentiality. This was both in relation to violation of patient privacy (HIPAA) and not wanting to see a provider that they know they will see on a day-to-day basis.

Finally, it was suggested that increases should be made in the marketing of services that are locally available and encouraging the public to utilize those services.

Findings from Key Informant Interviews & the Community Meeting

Questions about the health and well-being of the community, similar to those posed in the survey, were explored during key informant interviews with community leaders and health professionals and with the community group at the first meeting. The themes that emerged from these sources were wide-ranging, with some directly associated with healthcare and others more rooted in broader social and community matters.

Generally, overarching issues that developed during the interviews and community meeting can be grouped into five categories (listed in alphabetical order):

- Attracting and retaining young families
- Availability of mental health services
- Depression/anxiety
- Drug use and abuse (including prescription drug abuse)
- Not enough public transportation options, especially for seniors

To provide context for the identified needs, following are some of the comments made by those interviewed about these issues:

Attracting and retaining young families

- Coal is going to be phased out, and unless the carbon capture gets under control it will be phased out sooner than later. The number of people related to the coal industry here is extremely high.
- There are only bars here, no nightlife, no good restaurants open in the evening. Limited things to do to attract and keep them here. In the winter they put skating rinks up, but not everyone skates.
- We can't grow as a community if we don't have young people coming in.

Availability of mental health services

- Could technology be used to access these services? Someone in a crisis situation isn't able/willing to wait 2 weeks or more and the only way they are immediately able to receive services is if they say that they are going to commit suicide.
- There are so few mental health beds available to send patients to if the patient needs help.
- How do you get the population to mental health services? Suicidal ideations are an after effect of drug and alcohol abuse, depression, and anxiety. If we could get those people to utilize the services before it becomes too much of an issue, a lot of problems could be avoided.

Depression/anxiety

- Parents have a stigma of mental health services for their kids.
- Mental health services aren't very available, it takes a long time to get in.

Drug use and abuse (including prescription drug abuse)

- Drug use and abuse comes first and then health problems, or health problems and then drug use.
- A high number of students are using drugs, alcohol, and tobacco.
- There are many kids that could use a lot of help. The ones that really need the help are not the ones coming in for sports physicals.
- I think adults are on too many prescription drugs, they go doctor hopping.
- Need things to do after school for kids to help them stay away from drugs and alcohol.

Not enough public transportation options, especially for seniors

- The transportation services that CCCHC is supposed to provide isn't provided to the patients in outlying communities.
- Need to be able to get elderly patients from outside the town to their appointments.

Community Engagement and Collaboration

Key informants and focus group participants were asked to weigh in on community engagement and collaboration of various organizations and stakeholders in the community. Specifically, participants were asked, "On a scale of 1 to 5, with 1 being no collaboration/community engagement and 5 being excellent collaboration/community engagement, how would you rate the collaboration/engagement in the community among these various organizations?" This was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to rank. According to these participants, the hospital, pharmacy, public health, and other long-term care (including nursing homes/assisted living) are the

most engaged in the community. The averages of these rankings (with 5 being “excellent” engagement or collaboration) were:

- Hospital (healthcare system) (4.5)
- Emergency services, including ambulance and fire (4.0)
- Public Health (4.0)
- Schools (4.0)
- Business and industry (3.75)
- Long-term care, including nursing homes and assisted living (3.75)
- Economic development organizations (3.5)
- Faith-based (3.5)
- Law enforcement (3.5)
- Other local health providers, such as dentists and chiropractors (3.5)
- Pharmacy (3.5)
- Social Services (3.25)
- Human services agencies (2.75)

Priority of Health Needs

A community group met on March 7, 2019. There were 31 community members who attended the meeting. Representatives from the CRH presented the group with a summary of this report’s findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings, and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed on large poster boards and each member was given four stickers to place next to each of the four needs they considered the most significant.

The results were totaled and the concerns most often cited were:

- Availability of mental health services (17 votes)
- Availability of resources to help elderly stay in their homes (12 votes)
- Youth drug use and abuse (including prescription drugs) (10 votes)
- Youth depression/ anxiety (9 votes)
- Attracting and retaining young families (8 votes)

From those top five priorities, each person put one sticker on the item they felt was the most important. The rankings were:

1. Availability of mental health services (11 votes)
2. Drug use and abuse (including prescription drugs) (8 votes)

- 3. Availability of resources to help elderly stay in their homes (2 votes)
- 4. Youth depression/ anxiety (2 votes)
- 5. Attracting and retaining young families (0 votes)

Following the prioritization process during the second meeting of the Community Group and key informants, the number one identified need was the availability of mental health services. A summary of this prioritization may be found in Appendix C.

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
Adequate childcare services	Availability of mental health services
Availability of mental health and substance abuse treatment services	Youth drug use and abuse (including prescription drugs)
Lack of employees to fill positions	Availability of resources to help elderly stay in their homes
Obesity/ overweight	Youth depression/ anxiety
Public transportation	Attracting and retaining young families
Delivery and availability of health services to include expanded appointment hours and cost of healthcare services	

The current process identified one identical common need from 2016. The availability of mental health services was again listed as a top need in 2019.

Recruitment and retention of staff continues to be an ongoing challenge at all healthcare facilities. Whether it's providers, professional staff, support staff, or administrative staff, the retention and recruitment of personnel in all positions is vital. It continues to be a challenge to fill nursing, ancillary, and support staff positions at healthcare facilities not only in North Dakota, but nation-wide. In the Hazen/Beulah area, the need for recruitment of these types of professionals has significantly increased at the beginning of 2019, due to vacancies in positions. There is also a continued search to fill a physician opening that has been open for over a year-and-a-half.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2016

In response to the needs identified in the 2016 CHNA process, the following actions were taken:

Need 1: Adequate childcare services – Energy Capital Cooperative Child Care’s (ECCCC) New Bethel Center opened on May 30, 2017 and was founded by eight employers that recognized the childcare struggle that their employees and the community faced. ECCCC’s founding partners include Sakakawea Medical Center (SMC); Coal Country Community Health Center (CCCHC); Knife River Care Center (KRCC); Dakota Gasification Company (lead agency); North American Coal Corporation; Union State Bank; Coyote Station; and Hazen Public Schools. The New Bethel Center is a licensed childcare center with a capacity of 72 children ages infant to 12 years. The partners have guaranteed spots for their employees, but many spots are available for the members of the community as well. The center offers extended hours of operation to accommodate shift-working parents.

Need 2: Availability of behavioral health services (mental health and substance abuse/treatment) – CCCHC spearheads the effort to address mental health and substance abuse issues and relies on the partners to assist by providing additional resources for programming, education, as well as tapping into financial and staffing availability. In addition, CCCHC, SMC, and KRCC continue to screen all clinic, emergency room, hospital, basic care, long-term care, and visiting nurse admits for depression by incorporating the PHQ2 and PHQ9 screening criteria for all initial patient encounters. Should a patient screen positive on the PHQ9, referrals are made for appropriate follow-up and/or intervention.

Medication assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of addiction/substance use disorders; and can help some people to sustain recovery. CCCHC offers and has expanded the MAT program offered to three days per week in Beulah and two days per month at Killdeer.

With the increase in demand for drug and alcohol evaluation and intervention, an additional full-time licensed addiction counselor (LAC) was hired by CCCHC in 2018. The additional staffing of a LAC allows substance use disorders, as-well-as mental health services to be available daily at the CCCHC Beulah Clinic. CCCHC anticipates that two additional part-time LAC's will begin employment in the spring of 2019 upon completion of construction of a new behavioral health unit facilitating expansion of services and co-location with primary care. CCCHC also partners with several organizations through a consortium for training addiction counselors in both rural and urban North Dakota. TAAP, Training Academy of Addiction Professionals, prepares addiction trainees to demonstrate minimum competence and skill set for addiction counseling leading to a LAC.

In addition, CCCHC has increased the availability of visiting psychologists from four days per month to six days per month in Beulah and is currently exploring tele-behavioral health services to assist in meeting the additional needs of the community.

Custer Health manages and operates a syringe exchange program (SEP) in North Dakota called the "Mandan Good Neighbor Project." The program is a community-based public health program that provides comprehensive harm reduction services for people who inject drugs (PWID). In addition to needle exchange, Custer Health has provided training and Nasal Narcan (when available) for local law enforcement to include the City of Beulah and the Oliver County Sheriff's Department.

In 2016-2017, Beulah Public School District contacted CCCHC for assessment and assistance with behavioral health for the school and a pilot project was implemented for case management of behavioral health issues within the walls of the school. The project increased access to students in grades K - 12. Since then, CCCHC is facilitating resource mapping and development framework for sustainability and replication of the program in additional school districts for the 2019-2020 school year.

Integrating Mental Health Physical Health and Continuity of Care Together (IMPACT) program, has been implemented within the Beulah School District to include the purchase of a license to implement BIMAS-2. BIMAS-2 offers universal screening through an online web-based data management system that measures social, emotional and behavioral functioning in youth and adolescents, and allows users to manipulate data in real time to assist in evidence-based decision-making within a comprehensive behavior healthcare model of service delivery. Areas assessed within the BIMAS-2 include conduct, negative affect, cognitive/attention, social and academic functioning. Beulah School District has now completed 75% of all universal screenings. In addition, a needs assessment was completed with the Hazen School District and a license for BIMAS-2 purchased with the implementation of IMPACT; universal screening is now in progress for the Hazen School District.

Additionally, education and training has been delivered for the implementation of a Multi-tiered Systems of Support (MTSS) for youth and adolescents. MTSS is a framework used to provide targeted support to struggling students. It focuses on the "whole" child and supports academic growth and achievement including behavior, social and emotional needs, and attendance.

Joint task force meetings have been implemented between Beulah and Hazen school districts with CCCHC's team for further implementation of the IMPACT program. A full-time LSW /IMPACT program coordinator is providing care coordination and case management for Beulah and will be expanding into Hazen in 2019. A psychologist and LICSW are currently providing mental health services at the Beulah school district as part of MTSS.

Need 3: Lack of employees to fill positions – All agencies are addressing the workforce shortage by actively supporting local programs such as the Dakota Practical Nursing Program that is offered in Hazen. The Dakota Nursing Program allows local individuals to achieve a personal career goal through non-traditional means and eliminates the need for students to travel away from home to obtain a career in nursing. The program directly address the region's nursing workforce shortage and is offered through Bismarck State College. During the program, students are on campus at SMC four days a week. Clinicals begin in December and go through the completion of the program in July and are held at multiple healthcare facilities within the area, providing students with the best learning experience possible. Since the implementation of the program in 2012, 25 students have graduated with an additional three students that will potentially graduate in the summer of 2019.

Each local health provider within the collaborative actively participates to present health occupations at the Dunn, Mercer, and Oliver County Scrubs Camp, which is a one-day, hands-on opportunity for high school students designed to increase awareness, interest, and understanding of health careers available. Through creative and interactive activities, Scrubs Camp provides an opportunity for students to experience first-hand, the challenges, opportunities, and rewards of health careers while learning about the skills and education that are required to become a health professional.

In order to increase efficiency in hiring and retention and to ensure consistency and compliance in the recruitment and selection process, a collaborative effort between SMC, CCCHC, and KRCC has resulted in the combining of resources to provide for a shared human resource professional. This person coordinates the recruitment of professional healthcare staff for the area and administers formal agreements initiated with recruitment firms for physicians.

Furthermore, SMC and CCCHC have partnered together to locally facilitate the medical assistant program offered through Dakota College at Bottineau and had two medical assistants graduate in the summer of 2016. One of the medical assistants is currently employed full-time at CCCHC.

In 2018, CCCHC hired two additional full-time mid-level family practice providers to their team of healthcare professionals. Kelsey Striefel, DNP, is practicing at the CCCHC Hazen Clinic; and Kayla Ternes, PA-C, sees patients at the CCCHC Beulah Clinic site.

Need 4: Obesity/overweight – Physical inactivity, obesity, and overweight are being addressed cooperatively and with individual campaigns. All of the local health providers offer worksite wellness programs for employees and their families. In addition, CCCHC, SMC, and Custer Health participate in corporate and community wellness events by offering health screenings, health awareness, and educational seminars for individuals and community groups.

On April 30, 2018, the Energy Wellness Center opened in Beulah and offers a full range of activities to include wellness and fitness classes for individuals and groups. The state-of-the-art facility enables the community to become healthier in all aspects of life and provides year-round recreation to the citizens of the tri-county area delivering new exercise and education programs for the community. Amenities include basketball court, cardio deck, community room, daycare, golf simulator, group exercise studio, lobby, locker rooms, racquetball court, indoor walking/running track, and weight room.

In an effort to improve the overall health of the population that we serve, the local health providers continue to facilitate the Population Health Committee with representatives from each agency where the main objective is to improve population health through innovative and engaging projects. Through the Population Health Committee, the "JumpStart to Wellness" campaign was implemented and remains strong, addressing obesity and physical activity with various successful projects facilitated throughout the year (5K Color Walk/Run,

Healthy Halloween Bash, Women’s World of Wellness, Mercer County Fair, Mercer County parade, etc.).

Breastfeeding has been identified as one of the six focal points of the CDC’s Childhood Obesity Prevention Plan identifying that the duration of exclusive breastfeeding was inversely associated with the risk of elevated weight gain. To engage young families and teach successful breastfeeding techniques, local public health has trained a public health nurse as a certified lactation consultant (CLC). The CLC provides counseling and lactation management during WIC, Beyond Birth Education, and Maternal and Child Health services.

Need 5: Transportation – Access to transportation contributes to the economic development, health, and quality of life of rural communities. Reliable transportation is needed for rural residents to access healthcare services, employment, educational opportunities, and social services. It is also important for accessing recreation and other activities of daily life. Though the local health providers do not have the resources or expertise to address all transportation needs, we have come up with some viable solutions to address the transportation needs for patients seeking local healthcare services.

CCCHC offers free transportation services to and from appointments at the Hazen and Beulah clinic sites; with a full-time driver on staff, CCCHC owns and operates three agency vans. Patients can schedule transportation services when they schedule their next appointment.

SMC works cooperatively with local transportation services to provide patients with vouchers that can be used for free rides to and from the medical center; once the patient uses the voucher, the transportation service turns the voucher into SMC for payment. SMC works with West River Transit to provide transportation services for the Beulah and Center communities, while Hazen Busing serves the community of Hazen.

Need 6: Delivery and availability of health services to include expanded appointment hours and cost of healthcare services – Patient centered medical home (PCMH) model of healthcare has been incorporated into the operations of both SMC and CCCHC. The PCMH model proposes to improve primary care by focusing on the patient-provider relationship and strengthen this dynamic through a more comprehensive team approach to patient care and more active patient involvement. PCMH provides comprehensive care coordination to all patients at all points of care whether seen in the emergency room, admitted to the hospital, or seen in the clinics for primary care. A comprehensive care coordination committee has been formed by the local health providers and meets monthly to review repeat admission and repeat emergency room visits with care coordination intervention from Custer Health, SMC, KRCC, and CCCHC including community care coordination. Outcome data signifies a decrease in Blue Cross Blue Shield and Medicare unnecessary emergency room visits and potentially preventable admissions. The local health providers continue to expand and enhance a patient centered medical neighborhood of care delivery throughout the tri-county service area.

Health Tracks, a public health program, is for children birth to 20 years of age who are on Medicaid. It is a preventive health program that can pay for many things including counseling, hearing and vision care, developmental screenings, immunizations, lab tests, dental care, and referrals to specialists. In 2018, Custer Health enhanced the community engagement of this program and increased their Health Tracks screenings by 58%.

In addition, Custer Health and CCCHC have increased the provision of immunizations by working together to offer immunization clinics for students during local parent/teacher conferences. Upon the completion of two successful years, Custer Health and CCCHC have expanded the program and now offer both fall and spring clinics for the Beulah and Hazen school districts.

FluFIT programs increase colorectal cancer screening rates by providing a take home fecal immunochemical test to eligible patients when they receive their annual flu shot. Therefore, the annual flu shot campaign creates an opportunity to reach people who are also due for colorectal screening. Custer Health in conjunction with CCCHC and local area pharmacists, provide the FluFIT kits during October. They also offer flu shot clinics within the service area. In 2018, 89 patients were screened on FluFit clinic day.

To help remove barriers to the delivery and availability of health services, CCCHC is expanding the Beulah Clinic site. When completed, this project will enhance the way CCCHC provides medical care by doubling the clinic space to accommodate patient and staff needs. The expansion will also allow CCCHC to co-locate

behavioral health and primary care and host additional visiting specialists to the area. The anticipated completion date of the clinic expansion is May 2019. In addition, CCCHC has extended clinic hours available for appointments. CCCHC Beulah Clinic now sees patients beginning at 7:30 a.m. on Mondays and Wednesdays. Phone lines are open at 7:00 a.m. for patients to call providing enhanced primary care access.

The 2016 implementation plan for SMC, CCCHC, Custer Health, SDHU, Knife River Care Center, Hill Top Home of Comfort, and Mercer County Ambulance is posted on the SMC website at https://www.smcnd.org/assets/docs/implementation_plan.pdf.

Next Steps – Strategic Implementation Plan

Although a CHNA and strategic implementation plan are required by hospitals and local public health units considering accreditation, it is important to keep in mind the needs identified, at this point, will be broad community-wide needs along with healthcare system-specific needs. This process is a first step to identify needs and determine areas of priority. The second step will be to convene the steering committee, or other community group, to select an agreed upon prioritized need on which to begin working. The strategic planning process will begin with identifying current initiatives, programs, and resources already in place to address the identified community need(s). Additional steps include identifying what is needed and feasible to address (taking community resources into consideration) and what role and responsibility the hospital, clinic, and various community organizations play in developing strategies and implementing specific activities to address the community health need selected. Community engagement is essential for successfully developing a plan and executing the action steps for addressing one or more of the needs identified.

“If you want to go fast, go alone. If you want to go far, go together.” Proverb

Community Benefit Report

While not required, the CRH strongly encourages a review of the most recent Community Benefit Report to determine how / if it aligns with the needs identified, through the CHNA, as well as the Implementation Plan.

The community benefit requirement is a long-standing requirement of nonprofit hospitals and is reported in Part I of the hospital’s Form 990. The strategic implementation requirement was added as part of the ACA’s CHNA requirement. It is reported on Part V of the 990. Not-for-profit healthcare organizations demonstrate their commitment to community service through organized and sustainable community benefit programs providing:

- Free and discounted care to those unable to afford healthcare.
- Care to low-income beneficiaries of Medicaid and other indigent care programs.
- Services designed to improve community health and increase access to healthcare.

Community benefit is also the basis of the tax-exemption of not-for-profit hospitals. The Internal Revenue Service (IRS), in its Revenue Ruling 69–545, describes the community benefit standard for charitable tax-exempt hospitals. Since 2008, tax-exempt hospitals have been required to report their community benefit and other information related to tax-exemption on the IRS Form 990 Schedule H.

What Are Community Benefits?

Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They increase access to healthcare and improve community health.

A community benefit must respond to an identified community need and meet at least one of the following criteria:

- Improve access to healthcare services.
- Enhance health of the community.
- Advance medical or health knowledge.
- Relieve or reduce the burden of government or other community efforts.

A program or activity should not be reported as community benefit if it is:

- Provided for marketing purposes.
- Restricted to hospital employees and physicians.
- Required of all healthcare providers by rules or standards.
- Questionable as to whether it should be reported.
- Unrelated to health or the mission of the organization.

Appendix A – CHNA Survey Instrument



Dunn, Mercer, and Oliver County Health Survey

Healthcare providers in Dunn, Mercer and Oliver Counties are interested in hearing from you about community health concerns.

The focus of this effort is to:

- Learn of the good things in your community as well as concerns in the community
- Understand perceptions and attitudes about the health of the community, and hear suggestions for improvement
- Learn more about how local health services are used by you and other residents



Scan here to take the survey!

If you prefer, you may take the survey online at <http://tinyurl.com/DMOcounties18> or by scanning on the QR Code at the right.

Surveys will be tabulated by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Your responses are anonymous, and you may skip any question you do not want to answer. Your answers will be combined with other responses and reported only in total. If you have questions about the survey, you may contact Kylie Nissen at 701.777.5380.

Surveys will be accepted through November 15, 2018. Your opinion matters – thank you in advance!

Community Assets: Please tell us about your community by **choosing up to three options** you most agree with in each category below.

1. Considering the **PEOPLE** in your community, the best things are (choose up to THREE):

- | | |
|--|--|
| <input type="checkbox"/> Community is socially and culturally diverse or becoming more diverse | <input type="checkbox"/> People who live here are involved in their community |
| <input type="checkbox"/> Feeling connected to people who live here | <input type="checkbox"/> People are tolerant, inclusive, and open-minded |
| <input type="checkbox"/> Government is accessible | <input type="checkbox"/> Sense that you can make a difference through civic engagement |
| <input type="checkbox"/> People are friendly, helpful, supportive | <input type="checkbox"/> Other (please specify) _____ |

2. Considering the **SERVICES AND RESOURCES** in your community, the best things are (choose up to THREE):

- | | |
|---|---|
| <input type="checkbox"/> Access to healthy food | <input type="checkbox"/> Opportunities for advanced education |
| <input type="checkbox"/> Active faith community | <input type="checkbox"/> Public transportation |
| <input type="checkbox"/> Business district (restaurants, availability of goods) | <input type="checkbox"/> Programs for youth |
| <input type="checkbox"/> Community groups and organizations | <input type="checkbox"/> Quality school systems |
| <input type="checkbox"/> Healthcare | <input type="checkbox"/> Other (please specify) _____ |

3. Considering the **QUALITY OF LIFE** in your community, the best things are (choose up to THREE):

- | | |
|--|--|
| <input type="checkbox"/> Closeness to work and activities | <input type="checkbox"/> Job opportunities or economic opportunities |
| <input type="checkbox"/> Family-friendly; good place to raise kids | <input type="checkbox"/> Safe place to live, little/no crime |
| <input type="checkbox"/> Informal, simple, laidback lifestyle | <input type="checkbox"/> Other (please specify) _____ |

4. Considering the **ACTIVITIES** in your community, the best things are (choose up to THREE):

- | | |
|--|---|
| <input type="checkbox"/> Activities for families and youth | <input type="checkbox"/> Recreational and sports activities |
| <input type="checkbox"/> Arts and cultural activities | <input type="checkbox"/> Year-round access to fitness opportunities |
| <input type="checkbox"/> Local events and festivals | <input type="checkbox"/> Other (please specify) _____ |

Community Concerns: Please tell us about your community by choosing up to three options you most agree with in each category.

5. Considering the **COMMUNITY /ENVIRONMENTAL HEALTH** in your community, concerns are (choose up to THREE):

- | | |
|--|--|
| <input type="checkbox"/> Active faith community | <input type="checkbox"/> Having enough quality school resources |
| <input type="checkbox"/> Attracting and retaining young families | <input type="checkbox"/> Not enough places for exercise and wellness activities |
| <input type="checkbox"/> Not enough jobs with livable wages, not enough to live on | <input type="checkbox"/> Not enough public transportation options, cost of public transportation |
| <input type="checkbox"/> Not enough affordable housing | <input type="checkbox"/> Racism, prejudice, hate, discrimination |
| <input type="checkbox"/> Poverty | <input type="checkbox"/> Traffic safety, including speeding, road safety, seatbelt use, and drunk/distracted driving |
| <input type="checkbox"/> Changes in population size (increasing or decreasing) | <input type="checkbox"/> Physical violence, domestic violence, sexual abuse |
| <input type="checkbox"/> Crime and safety, adequate law enforcement personnel | <input type="checkbox"/> Child abuse |
| <input type="checkbox"/> Water quality (well water, lakes, streams, rivers) | <input type="checkbox"/> Bullying/cyber-bullying |
| <input type="checkbox"/> Air quality | <input type="checkbox"/> Recycling |
| <input type="checkbox"/> Litter (amount of litter, adequate garbage collection) | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Having enough child daycare services | <input type="checkbox"/> Other (please specify) _____ |

6. Considering the **AVAILABILITY/DELIVERY OF HEALTH SERVICES** in your community, concerns are (choose up to THREE):

- | | |
|--|--|
| <input type="checkbox"/> Ability to get appointments for health services within 48 hours | <input type="checkbox"/> Emergency services (ambulance & 911) available 24/7 |
| <input type="checkbox"/> Extra hours for appointments, such as early mornings, evenings and weekends | <input type="checkbox"/> Ability/willingness of healthcare providers to work together to coordinate patient care within the health system |
| <input type="checkbox"/> Availability of primary care providers (MD, DO, Nurse Practitioner, Physician Assistant) and nurses | <input type="checkbox"/> Ability/willingness of healthcare providers to work together to coordinate patient care outside the local community |
| <input type="checkbox"/> Ability to retain primary care providers (MD, DO, NP, PA) and nurses in the community | <input type="checkbox"/> Patient confidentiality (inappropriate sharing of personal health information) |
| <input type="checkbox"/> Availability of public health professionals | <input type="checkbox"/> Not comfortable seeking care where I know the employees at the facility on a personal level |
| <input type="checkbox"/> Availability of specialists | <input type="checkbox"/> Quality of care |
| <input type="checkbox"/> Not enough health care staff in general | <input type="checkbox"/> Cost of health care services |
| <input type="checkbox"/> Availability of wellness and disease prevention services | <input type="checkbox"/> Cost of prescription drugs |
| <input type="checkbox"/> Availability of mental health services | <input type="checkbox"/> Cost of health insurance |
| <input type="checkbox"/> Availability of substance use disorder/treatment services | <input type="checkbox"/> Adequacy of health insurance (concerns about out-of-pocket costs) |
| <input type="checkbox"/> Availability of hospice | <input type="checkbox"/> Understand where and how to get health insurance |
| <input type="checkbox"/> Availability of dental care | <input type="checkbox"/> Adequacy of Indian Health Service or Tribal Health Services |
| <input type="checkbox"/> Availability of vision care | <input type="checkbox"/> Other (please specify) _____ |

7. Considering the **YOUTH POPULATION** in your community, concerns are (choose up to THREE):

- | | |
|--|--|
| <input type="checkbox"/> Alcohol use and abuse | <input type="checkbox"/> Diseases that can spread, such as sexually transmitted diseases or AIDS |
| <input type="checkbox"/> Drug use and abuse (including prescription drug abuse) | <input type="checkbox"/> Wellness and disease prevention, including vaccine-preventable diseases |
| <input type="checkbox"/> Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling | <input type="checkbox"/> Not getting enough exercise/physical activity |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Obesity/overweight |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hunger, poor nutrition |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Crime |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Graduating from high school |
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Availability of disability services |
| <input type="checkbox"/> Not enough activities for children and youth | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Teen pregnancy | |
| <input type="checkbox"/> Sexual health | |

8. Considering the **ADULT POPULATION** in your community, concerns are (choose up to THREE):

- | | |
|---|--|
| <input type="checkbox"/> Alcohol use and abuse | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Drug use and abuse (including prescription drug abuse) | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Smoking and tobacco use, exposure to second-hand smoke | <input type="checkbox"/> Diseases that can spread, such as sexually transmitted diseases or AIDS |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Wellness and disease prevention, including vaccine-preventable diseases |
| <input type="checkbox"/> Lung disease (i.e. emphysema, COPD, asthma) | <input type="checkbox"/> Not getting enough exercise/physical activity |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity/overweight |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hunger, poor nutrition |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Availability of disability services |
| <input type="checkbox"/> Dementia/Alzheimer's disease | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Other chronic diseases: _____ | |
| <input type="checkbox"/> Depression/anxiety | |

9. Considering the **SENIOR POPULATION** in your community, concerns are (choose up to THREE):

- | | |
|---|---|
| <input type="checkbox"/> Ability to meet needs of older population | <input type="checkbox"/> Availability of transportation for seniors |
| <input type="checkbox"/> Long-term/nursing home care options | <input type="checkbox"/> Availability of home health |
| <input type="checkbox"/> Assisted living options | <input type="checkbox"/> Not getting enough exercise/physical activity |
| <input type="checkbox"/> Availability of resources to help the elderly stay in their homes | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Availability/cost of activities for seniors | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Availability of resources for family and friends caring for elders | <input type="checkbox"/> Alcohol use and abuse |
| <input type="checkbox"/> Quality of elderly care | <input type="checkbox"/> Drug use and abuse (including prescription drug abuse) |
| <input type="checkbox"/> Cost of long-term/nursing home care | <input type="checkbox"/> Availability of activities for seniors |
| | <input type="checkbox"/> Elder abuse |
| | <input type="checkbox"/> Other (please specify) _____ |

10. What single issue do you feel is the biggest challenge facing your community?

Delivery of Healthcare

11. What **PREVENTS** community residents from receiving healthcare? (Choose ALL that apply)

- | | |
|---|--|
| <input type="checkbox"/> Can't get transportation services | <input type="checkbox"/> Not able to get appointment/limited hours |
| <input type="checkbox"/> Concerns about confidentiality | <input type="checkbox"/> Not able to see same provider over time |
| <input type="checkbox"/> Distance from health facility | <input type="checkbox"/> Not accepting new patients |
| <input type="checkbox"/> Don't know about local services | <input type="checkbox"/> Not affordable |
| <input type="checkbox"/> Don't speak language or understand culture | <input type="checkbox"/> Not enough providers (MD, DO, NP, PA) |
| <input type="checkbox"/> Lack of disability access | <input type="checkbox"/> Not enough evening or weekend hours |
| <input type="checkbox"/> Lack of services through Indian Health Services | <input type="checkbox"/> Not enough specialists |
| <input type="checkbox"/> Limited access to telehealth technology (patients seen by providers at another facility through a monitor/TV screen) | <input type="checkbox"/> Poor quality of care |
| <input type="checkbox"/> No insurance or limited insurance | <input type="checkbox"/> Other (please specify) _____ |

12. Where do you turn for trusted health information? (Choose ALL that apply)

- | | |
|--|--|
| <input type="checkbox"/> Other healthcare professionals (nurses, chiropractors, dentists, etc.) | <input type="checkbox"/> Web searches/internet (WebMD, Mayo Clinic, Healthline, etc.) |
| <input type="checkbox"/> Primary care provider (doctor, nurse practitioner, physician assistant) | <input type="checkbox"/> Word of mouth, from others (friends, neighbors, co-workers, etc.) |
| <input type="checkbox"/> Public health professional | <input type="checkbox"/> Other (please specify) _____ |

13. Considering the **GENERAL** and **ACUTE SERVICES** at Sakakawea Medical Center and Coal Country Community Health Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Medicare Annual Wellness Visits |
| <input type="checkbox"/> Anesthesia services | <input type="checkbox"/> Orthopedic (visiting specialist) |
| <input type="checkbox"/> Behavioral/Mental health services | <input type="checkbox"/> Podiatry (foot/ankle – visiting specialist) |
| <input type="checkbox"/> Cardiology (visiting specialist) | <input type="checkbox"/> Substance abuse services and Suboxone |
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Surgical services |
| <input type="checkbox"/> Convenience clinic | <input type="checkbox"/> Swing bed and respite care services |
| <input type="checkbox"/> Emergency room | <input type="checkbox"/> Telemedicine via eEmergency |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Visiting nurse services |
| <input type="checkbox"/> Hospital (acute care) | <input type="checkbox"/> Wellness services |
| <input type="checkbox"/> Laparoscopic surgery | |

14. Considering **SCREENING/THERAPY SERVICES** at Sakakawea Medical Center and Coal Country Community Health Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Addiction services/drug & alcohol evaluations | <input type="checkbox"/> Occupational therapy |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Diet instruction | <input type="checkbox"/> Sleep studies |
| <input type="checkbox"/> Health screenings | <input type="checkbox"/> Social services |
| <input type="checkbox"/> Laboratory services | <input type="checkbox"/> Speech therapy |

15. Considering **RADIOLOGY SERVICES** at Sakakawea Medical Center and Coal Country Community Health Center, which services are you aware of (or have you used in the past year)? (Choose ALL that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Bone density | <input type="checkbox"/> General x-ray |
| <input type="checkbox"/> Cardiac stress tests | <input type="checkbox"/> Mammography |
| <input type="checkbox"/> EKG-Electrocardiography | <input type="checkbox"/> 3D Mammography |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Ultrasound |

16. Considering available **COMMUNITY AND PUBLIC HEALTH SERVICES**, which services are you aware of (or have you used in the past year)? (Choose ALL that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Bicycle helmet safety | <input type="checkbox"/> Home health |
| <input type="checkbox"/> Blood pressure check | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Breastfeeding resources | <input type="checkbox"/> Medications setup-home visits |
| <input type="checkbox"/> Car seat program | <input type="checkbox"/> Mental health first aid |
| <input type="checkbox"/> Care coordination/chronic disease management | <input type="checkbox"/> Office visits and consults |
| <input type="checkbox"/> Child health (well-baby) | <input type="checkbox"/> Preschool education programs |
| <input type="checkbox"/> Diabetes screening | <input type="checkbox"/> School health (vision screening, puberty talks, school immunizations) |
| <input type="checkbox"/> Emergency response & preparedness program | <input type="checkbox"/> Tobacco prevention and control |
| <input type="checkbox"/> Foot care | <input type="checkbox"/> Tuberculosis testing and management |
| <input type="checkbox"/> Flu shots | <input type="checkbox"/> WIC (Women, Infants & Children) Program |
| <input type="checkbox"/> Environmental health services (water, sewer, health hazard abatement) | <input type="checkbox"/> Virtual breastfeeding classes |
| <input type="checkbox"/> Health Tracks (child health screening) | <input type="checkbox"/> Youth education programs (First Aid, Bike Safety) |
| <input type="checkbox"/> HIV, Hep. C. & Sexually transmitted infection (STI) testing | |

17. Considering services offered locally by **OTHER PROVIDER/ORGANIZATIONS**, which services are you aware of (or have you used in the past year)? (Choose ALL that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Massage therapy |
| <input type="checkbox"/> Chiropractic services | <input type="checkbox"/> Optometric/vision services |
| <input type="checkbox"/> Dental/orthodontic services | |

18. How interested are you in having local access to alternative/holistic health care services?

- Very interested Somewhat interested Not interested

19. Where do you find out about **LOCAL HEALTH SERVICES** that are available in your area? (Choose ALL that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Social Media (Facebook, Twitter, etc.) |
| <input type="checkbox"/> Employer/worksite wellness | <input type="checkbox"/> Indian Health Services/Tribal Health |
| <input type="checkbox"/> Health care professionals | <input type="checkbox"/> Web searches |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Word of mouth, from others (friends, neighbors co-workers, etc.) |
| <input type="checkbox"/> Public health professionals | <input type="checkbox"/> Other (Please specify) _____ |
| <input type="checkbox"/> Radio | |

20. Considering the availability of physicians and mid-level providers (nurse practitioners, physician assistants) in your community, have you established a Primary Care Provider (PCP)?

- Yes No, if no, why not? _____

21. Are you aware of the Patient Centered Medical Neighborhood (PCMN) of services provided by Sakakawea Medical Center and Coal Country Community Health Center?

- Yes No

22. The Affordable Care Act (ObamaCare) established the Health Insurance Marketplace to provide health plan option and enrollment in affordable health insurance for all. Are you aware of the Health Insurance Marketplace enrollment assistance provided by Coal Country Community Health Center?

- Yes No

23. What specific healthcare services, if any, do you think should be added locally?

Healthcare Foundations

24. Are you aware of local healthcare foundations, which exist to financially support a specific organization?

- Yes No

25. Have you supported a local healthcare foundation in any of the following ways? (Choose ALL that apply.)

- Cash or stock gift Planned gifts through wills, trusts or life insurance policies
 Endowment gifts Other: (please specify) _____
 Memorial/Honorarium

Additional Dunn County Services

26. In Dunn County, Hill Top Home of Comfort offers Assisted Living and skilled nursing services. Do you expect that you or anyone within your immediate family (parents, grandparents, etc.) will use these services, and if so, when?

Within the next:

- 1 year 4-5 years No, will not use service in next 10 years
 2-3 years 6-10 years

27. If Hill Top Home of Comfort offered community health education, would you utilize it?

- Yes No

If yes, what education would you or your family find beneficial? (Choose ALL that apply.)

- Caregiver Support Pain Management
 Hospice/End of Life Other: _____
 Long Term Care Insurance

28. In Dunn County, are you aware that Therapy Solutions from Dickinson provides outpatient therapy services (physical therapy, occupational therapy, speech therapy) at Hill Top Home of Comfort?

- Yes No

29. If you needed therapy or know someone who does, how likely would you be to recommend the services offered at Hill Top Home of Comfort?

- Very likely Somewhat likely I would not recommend

Demographic Information: Please tell us about yourself.

30. Do you work for the hospital, clinic, or public health unit?
 Yes No

31. Health insurance or health coverage status (choose ALL that apply):

<input type="checkbox"/> Indian Health Service (IHS)	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Veteran’s Healthcare Benefits
<input type="checkbox"/> Insurance through employer	<input type="checkbox"/> Medicare	<input type="checkbox"/> Other (please specify):
<input type="checkbox"/> Self-purchased insurance	<input type="checkbox"/> No insurance	_____

32. Age:

<input type="checkbox"/> Less than 18 years	<input type="checkbox"/> 35 to 44 years	<input type="checkbox"/> 65 to 74 years
<input type="checkbox"/> 18 to 24 years	<input type="checkbox"/> 45 to 54 years	<input type="checkbox"/> 75 years and older
<input type="checkbox"/> 25 to 34 years	<input type="checkbox"/> 55 to 64 years	

33. Highest level of education:

<input type="checkbox"/> Less than high school	<input type="checkbox"/> Some college/technical degree	<input type="checkbox"/> Bachelor’s degree
<input type="checkbox"/> High school diploma or GED	<input type="checkbox"/> Associate degree	<input type="checkbox"/> Graduate or professional degree

34. Gender:

<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Transgender
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35. Employment status:

<input type="checkbox"/> Full time	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Part time	<input type="checkbox"/> Multiple job holder	<input type="checkbox"/> Retired

36. Your zip code: _____

37. Race/Ethnicity (choose ALL that apply):

<input type="checkbox"/> American Indian	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Other(please specify):
<input type="checkbox"/> African American	<input type="checkbox"/> Pacific Islander	_____
<input type="checkbox"/> Asian	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Prefer not to answer

38. Annual household income before taxes:

<input type="checkbox"/> Less than \$15,000	<input type="checkbox"/> \$50,000 to \$74,999	<input type="checkbox"/> \$150,000 and over
<input type="checkbox"/> \$15,000 to \$24,999	<input type="checkbox"/> \$75,000 to \$99,999	<input type="checkbox"/> Prefer not to answer
<input type="checkbox"/> \$25,000 to \$49,999	<input type="checkbox"/> \$100,000 to \$149,999	

39. Overall, please share concerns and suggestions to improve the delivery of local healthcare.

Thank you for assisting us with this important survey!

Appendix B – County Health Rankings Explained

Source: <http://www.countyhealthrankings.org/>

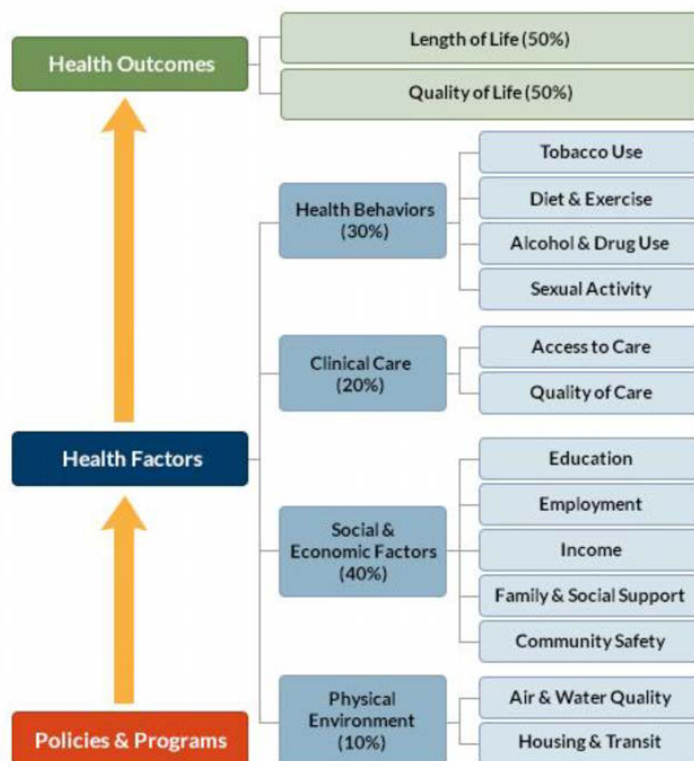
Methods

The County Health Rankings, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, measure the health of nearly all counties in the nation and rank them within states. The Rankings are compiled using county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights.

What is Ranked

The County Health Rankings are based on counties and county equivalents (ranked places). Any entity that has its own Federal Information Processing Standard (FIPS) county code is included in the Rankings. We only rank counties and county equivalents within a state. The major goal of the Rankings is to raise awareness about the many factors that influence health and that health varies from place to place, not to produce a list of the healthiest 10 or 20 counties in the nation and only focus on that.

Ranking System



The County Health Rankings model (shown above) provides the foundation for the entire ranking process.

Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, e.g. 1 or 2, are considered to be the “healthiest.” Counties are ranked relative to the health of other counties in the same state. We calculate and rank eight summary composite scores:

1. **Overall Health Outcomes**
2. Health Outcomes – **Length of life**
3. Health Outcomes – **Quality of life**
4. **Overall Health Factors**
5. Health Factors – **Health behaviors**
6. Health Factors – **Clinical care**
7. Health Factors – **Social and economic factors**
8. Health Factors – **Physical environment**

Data Sources and Measures

The County Health Rankings team synthesizes health information from a variety of national data sources to create the Rankings. Most of the data used are public data available at no charge. Measures based on vital statistics, sexually transmitted infections, and Behavioral Risk Factor Surveillance System (BRFSS) survey data were calculated by staff at the National Center for Health Statistics and other units of the Centers for Disease Control and Prevention (CDC). Measures of healthcare quality were calculated by staff at The Dartmouth Institute.

Data Quality

The County Health Rankings team draws upon the most reliable and valid measures available to compile the Rankings. Where possible, margins of error (95% confidence intervals) are provided for measure values. In many cases, the values of specific measures in different counties are not statistically different from one another; however, when combined using this model, those various measures produce the different rankings.

Calculating Scores and Ranks

The County Health Rankings are compiled from many different types of data. To calculate the ranks, they first standardize each of the measures. The ranks are then calculated based on weighted sums of the standardized measures within each state. The county with the lowest score (best health) gets a rank of #1 for that state and the county with the highest score (worst health) is assigned a rank corresponding to the number of places we rank in that state.

Health Outcomes and Factors

Source: <http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank>

Health Outcomes

Premature Death (YPLL)

Premature death is the years of potential life lost before age 75 (YPLL-75). Every death occurring before the age of 75 contributes to the total number of years of potential life lost. For example, a person dying at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost to a county's YPLL. The YPLL measure is presented as a rate per 100,000 population and is age-adjusted to the 2000 US population.

Reason for Ranking

Measuring premature mortality, rather than overall mortality, reflects the County Health Rankings' intent to focus attention on deaths that could have been prevented. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of premature death.

Poor or Fair Health

Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. This measure is based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported in the County Health Rankings is the percentage of adult respondents who rate their health "fair" or "poor." The measure is modeled and age-adjusted to the 2000 US population. Please note that the methods for calculating this measure changed in the 2016 Rankings.

Reason for Ranking

Measuring HRQoL helps characterize the burden of disabilities and chronic diseases in a population. Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures that consider how healthy people are while alive.

Poor Physical Health Days

Poor physical health days is based on survey responses to the question: "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their physical health was not good. The measure is age-adjusted to the 2000 US population. Please note that the methods for calculating this measure changed in the 2016 Rankings.

Reason for Ranking

Measuring health-related quality of life (HRQoL) helps characterize the burden of disabilities and chronic diseases in a population. In addition to measuring how long people live, it is also important to include measures of how healthy people are while alive – and people's reports of days when their physical health was not good are a reliable estimate of their recent health.

Poor Mental Health Days

Poor mental health days is based on survey responses to the question: "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported in the County Health Rankings is the average number of days a county's adult respondents report that their mental health was not good. The measure is age-adjusted to the 2000 US population. Please note that the methods for calculating this measure changed in the 2016 Rankings.

Reason for Ranking

Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represents an important facet of health-related quality of life.

Low Birth Weight

Birth outcomes are a category of measures that describe health at birth. These outcomes, such as low birthweight (LBW), represent a child’s current and future morbidity — or whether a child has a “healthy start” — and serve as a health outcome related to maternal health risk.

Reason for Ranking

LBW is unique as a health outcome because it represents multiple factors: infant current and future morbidity, as well as premature mortality risk, and maternal exposure to health risks. The health associations and impacts of LBW are numerous.

In terms of the infant’s health outcomes, LBW serves as a predictor of premature mortality and/or morbidity over the life course.[1] LBW children have greater developmental and growth problems, are at higher risk of cardiovascular disease later in life, and have a greater rate of respiratory conditions.[2-4]

From the perspective of maternal health outcomes, LBW indicates maternal exposure to health risks in all categories of health factors, including her health behaviors, access to healthcare, the social and economic environment the mother inhabits, and environmental risks to which she is exposed. Authors have found that modifiable maternal health behaviors, including nutrition and weight gain, smoking, and alcohol and substance use or abuse can result in LBW.[5]

LBW has also been associated with cognitive development problems. Several studies show that LBW children have higher rates of sensorineural impairments, such as cerebral palsy, and visual, auditory, and intellectual impairments.[2,3,6] As a consequence, LBW can “impose a substantial burden on special education and social services, on families and caretakers of the infants, and on society generally.”[7]

Health Factors

Adult Smoking

Adult smoking is the percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime. Please note that the methods for calculating this measure changed in the 2016 Rankings.

Reason for Ranking

Each year approximately 443,000 premature deaths can be attributed to smoking. Cigarette smoking is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birthweight and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs.

Adult Obesity

Adult obesity is the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m².

Reason for Ranking

Obesity is often the result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, osteoarthritis, and poor health status.[1,2]

Food Environment Index

The food environment index ranges from 0 (worst) to 10 (best) and equally weights two indicators of the food environment:

1) Limited access to healthy foods estimates the percentage of the population that is low income and does not live close to a grocery store. Living close to a grocery store is defined differently in rural and nonrural areas; in rural areas, it means living less than 10 miles from a grocery store whereas in nonrural areas, it means less than 1 mile. "Low income" is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size.

2) Food insecurity estimates the percentage of the population who did not have access to a reliable source of food during the past year. A two-stage fixed effects model was created using information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey.

More information on each of these can be found among the additional measures.

Reason for Ranking

There are many facets to a healthy food environment, such as the cost, distance, and availability of healthy food options. This measure includes access to healthy foods by considering the distance an individual lives from a grocery store or supermarket; there is strong evidence that food deserts are correlated with high prevalence of overweight, obesity, and premature death.[1-3] Supermarkets traditionally provide healthier options than convenience stores or smaller grocery stores.[4]

Additionally, access in regards to a constant source of healthy food due to low income can be another barrier to healthy food access. Food insecurity, the other food environment measure included in the index, attempts to capture the access issue by understanding the barrier of cost. Lacking constant access to food is related to negative health outcomes such as weight-gain and premature mortality.[5,6] In addition to asking about having a constant food supply in the past year, the module also addresses the ability of individuals and families to provide balanced meals further addressing barriers to healthy eating. It is important to have adequate access to a constant food supply, but it may be equally important to have nutritious food available.

Physical Inactivity

Physical inactivity is the percentage of adults age 20 and over reporting no leisure-time physical activity. Examples of physical activities provided include running, calisthenics, golf, gardening, or walking for exercise.

Reason for Ranking

Decreased physical activity has been related to several disease conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality, independent of obesity. Inactivity causes 11% of premature mortality in the United States, and caused more than 5.3 million of the 57 million deaths that occurred worldwide in 2008.[1] In addition, physical inactivity at the county level is related to healthcare expenditures for circulatory system diseases.[2]

Access to Exercise Opportunities

Change in measure calculation in 2018: Access to Exercise Opportunities measures the percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Parks include local, state, and national parks. Recreational facilities include YMCAs as well as businesses identified by the following Standard Industry Classification (SIC) codes and include a wide variety of facilities including gyms, community centers, dance studios and pools: 799101, 799102, 799103, 799106, 799107, 799108, 799109, 799110, 799111, 799112, 799201, 799701, 799702, 799703, 799704, 799707, 799711, 799717, 799723, 799901, 799908, 799958, 799969, 799971, 799984, or 799998.

Individuals who:

- reside in a census block within a half mile of a park or
- in urban census blocks: reside within one mile of a recreational facility or

- in rural census blocks: reside within three miles of a recreational facility
- are considered to have adequate access for opportunities for physical activity.

Reason for Ranking

Increased physical activity is associated with lower risks of type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality, independent of obesity. The role of the built environment is important for encouraging physical activity. Individuals who live closer to sidewalks, parks, and gyms are more likely to exercise.[1-3]

Excessive Drinking

Excessive drinking is the percentage of adults that report either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than one (women) or 2 (men) drinks per day on average. Please note that the methods for calculating this measure changed in the 2011 Rankings and again in the 2016 Rankings.

Reason for Ranking

Excessive drinking is a risk factor for a number of adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes. [1] Approximately 80,000 deaths are attributed annually to excessive drinking. Excessive drinking is the third leading lifestyle-related cause of death in the United States.[2]

Alcohol-Impaired Driving Deaths

Alcohol-impaired driving deaths is the percentage of motor vehicle crash deaths with alcohol involvement.

Reason for Ranking

Approximately 17,000 Americans are killed annually in alcohol-related motor vehicle crashes. Binge/heavy drinkers account for most episodes of alcohol-impaired driving.[1,2]

Sexually Transmitted Infection Rate

Sexually transmitted infections (STI) are measured as the chlamydia incidence (number of new cases reported) per 100,000 population.

Reason for Ranking

Chlamydia is the most common bacterial STI in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain.[1,2] STIs are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, infertility, and premature death.[3] STIs also have a high economic burden on society. The direct medical costs of managing sexually transmitted infections and their complications in the US, for example, was approximately 15.6 billion dollars in 2008.[4]

Teen Births

Teen births are the number of births per 1,000 female population, ages 15-19.

Reason for Ranking

Evidence suggests teen pregnancy significantly increases the risk of repeat pregnancy and of contracting a sexually transmitted infection (STI), both of which can result in adverse health outcomes for mothers, children, families, and communities. A systematic review of the sexual risk among pregnant and mothering teens concludes that pregnancy is a marker for current and future sexual risk behavior and adverse outcomes [1]. Pregnant teens are more likely than older women to receive late or no prenatal care, have eclampsia, puerperal endometritis, systemic infections, low birthweight, preterm delivery, and severe neonatal conditions [2, 3]. Pre-term delivery and low birthweight babies have increased risk of child developmental delay, illness, and mortality [4]. Additionally, there are strong ties between teen birth and poor socioeconomic, behavioral, and mental outcomes. Teenage women who bear a child are much less likely to achieve an education level at or

beyond high school, much more likely to be overweight/obese in adulthood, and more likely to experience depression and psychological distress [5-7].

Uninsured

Uninsured is the percentage of the population under age 65 that has no health insurance coverage. The Small Area Health Insurance Estimates uses the American Community Survey (ACS) definition of insured: Is this person CURRENTLY covered by any of the following types of health insurance or health coverage plans: Insurance through a current or former employer or union, insurance purchased directly from an insurance company, Medicare, Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability, TRICARE or other military healthcare, Indian Health Services, VA or any other type of health insurance or health coverage plan? Please note that the methods for calculating this measure changed in the 2012 Rankings.

Reason for Ranking

Lack of health insurance coverage is a significant barrier to accessing needed healthcare and to maintaining financial security.

The Kaiser Family Foundation released a report in December 2017 that outlines the effects insurance has on access to healthcare and financial independence. One key finding was that “Going without coverage can have serious health consequences for the uninsured because they receive less preventative care, and delayed care often results in serious illness or other health problems. Being uninsured can also have serious financial consequences, with many unable to pay their medical bills, resulting in medical debt.”[1]

Primary Care Physicians

Primary care physicians is the ratio of the population to total primary care physicians. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. Please note this measure was modified in the 2011 Rankings and again in the 2013 Rankings.

Reason for Ranking

Access to care requires not only financial coverage, but also access to providers. While high rates of specialist physicians have been shown to be associated with higher (and perhaps unnecessary) utilization, sufficient availability of primary care physicians is essential for preventive and primary care, and, when needed, referrals to appropriate specialty care.[1,2]

Dentists

Dentists are measured as the ratio of the county population to total dentists in the county.

Reason for Ranking

Untreated dental disease can lead to serious health effects including pain, infection, and tooth loss. Although lack of sufficient providers is only one barrier to accessing oral healthcare, much of the country suffers from shortages. According to the Health Resources and Services Administration, as of December 2012, there were 4,585 Dental Health Professional Shortage Areas (HPSAs), with 45 million people total living in them.[1]

Mental Health Providers

Mental health providers is the ratio of the county population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental healthcare. In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure.

Reason for Ranking

Thirty percent of the population lives in a county designated as a Mental Health Professional Shortage Area. As the mental health parity aspects of the Affordable Care Act create increased coverage for mental health services, many anticipate increased workforce shortages.

Preventable Hospital Stays

Preventable hospital stays is the hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. Ambulatory care-sensitive conditions include: convulsions, chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, hypertension, angina, cellulitis, diabetes, gastroenteritis, kidney / urinary infection, and dehydration. This measure is age-adjusted.

Reason for Ranking

Hospitalization for diagnoses treatable in outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal. The measure may also represent a tendency to overuse hospitals as a main source of care.

Diabetes Monitoring

Diabetes monitoring is the percentage of diabetic fee-for-service Medicare patients ages 65-75 whose blood sugar control was monitored in the past year using a test of their glycated hemoglobin (HbA1c) levels.

Reason for Ranking

Regular HbA1c monitoring among diabetic patients is considered the standard of care. It helps assess the management of diabetes over the long term by providing an estimate of how well a patient has managed his or her diabetes over the past two to three months. When hyperglycemia is addressed and controlled, complications from diabetes can be delayed or prevented.

Mammography Screening

Mammography screening is the percentage of female fee-for-service Medicare enrollees age 67-69 that had at least one mammogram over a two-year period.

Reason for Ranking

Evidence suggests that mammography screening reduces breast cancer mortality, especially among older women.[1] A physician's recommendation or referral—and satisfaction with physicians—are major factors facilitating breast cancer screening. The percent of women ages 40-69 receiving a mammogram is a widely endorsed quality of care measure.

Unemployment

Unemployment is the percentage of the civilian labor force, age 16 and older, that is unemployed but seeking work.

Reason for Ranking

The unemployed population experiences worse health and higher mortality rates than the employed population.[1-4] Unemployment has been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors, which in turn can lead to increased risk for disease or mortality, especially suicide.[5] Because employer-sponsored health insurance is the most common source of health insurance coverage, unemployment can also limit access to healthcare.

Children in Poverty

Children in poverty is the percentage of children under age 18 living in poverty. Poverty status is defined by family; either everyone in the family is in poverty or no one in the family is in poverty. The characteristics of the family used to determine the poverty threshold are: number of people, number of related children under 18, and whether or not the primary householder is over age 65. Family income is then compared to the poverty threshold; if that family's income is below that threshold, the family is in poverty. For more information, please see Poverty Definition and/or Poverty.

In the data table for this measure, we report child poverty rates for black, Hispanic and white children. The rates for race and ethnic groups come from the American Community Survey, which is the major source of data used by the Small Area Income and Poverty Estimates to construct the overall county estimates. However, estimates for race and ethnic groups are created using combined five year estimates from 2012-2016.

Reason for Ranking

Poverty can result in an increased risk of mortality, morbidity, depression, and poor health behaviors. A 2011 study found that poverty and other social factors contribute a number of deaths comparable to leading causes of death in the US like heart attacks, strokes, and lung cancer.[1] While repercussions resulting from poverty are present at all ages, children in poverty may experience lasting effects on academic achievement, health, and income into adulthood. Low-income children have an increased risk of injuries from accidents and physical abuse and are susceptible to more frequent and severe chronic conditions and their complications such as asthma, obesity, and diabetes than children living in high income households.[2]

Beginning in early childhood, poverty takes a toll on mental health and brain development, particularly in the areas associated with skills essential for educational success such as cognitive flexibility, sustained focus, and planning. Low income children are more susceptible to mental health conditions like ADHD, behavior disorders, and anxiety which can limit learning opportunities and social competence leading to academic deficits that may persist into adulthood.[2,3] The children in poverty measure is highly correlated with overall poverty rates.

Income Inequality

Income inequality is the ratio of household income at the 80th percentile to that at the 20th percentile, i.e., when the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20% of households have higher incomes, and the 20th percentile is the level of income at which only 20% of households have lower incomes. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum. Please note that the methods for calculating this measure changed in the 2015 Rankings.

Reason for Ranking

Income inequality within US communities can have broad health impacts, including increased risk of mortality, poor health, and increased cardiovascular disease risks. Inequalities in a community can accentuate differences in social class and status and serve as a social stressor. Communities with greater income inequality can experience a loss of social connectedness, as well as decreases in trust, social support, and a sense of community for all residents.

Children in Single-Parent Households

Children in single-parent households is the percentage of children in family households where the household is headed by a single parent (male or female head of household with no spouse present). Please note that the methods for calculating this measure changed in the 2011 Rankings.

Reason for Ranking

Adults and children in single-parent households are at risk for adverse health outcomes, including mental illness (e.g. substance abuse, depression, suicide) and unhealthy behaviors (e.g. smoking, excessive alcohol use).[1-4] Self-reported health has been shown to be worse among lone parents (male and female) than for parents living as couples, even when controlling for socioeconomic characteristics. Mortality risk is also higher among lone parents.[4,5] Children in single-parent households are at greater risk of severe morbidity and all-cause mortality than their peers in two-parent households.[2,6]

Violent Crime Rate

Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, rape, robbery, and aggravated assault. Please note that the methods for calculating this measure changed in the 2012 Rankings.

Reason for Ranking

High levels of violent crime compromise physical safety and psychological well-being. High crime rates can also deter residents from pursuing healthy behaviors, such as exercising outdoors. Additionally, exposure to crime and violence has been shown to increase stress, which may exacerbate hypertension and other stress-related disorders and may contribute to obesity prevalence.[1] Exposure to chronic stress also contributes to the

increased prevalence of certain illnesses, such as upper respiratory illness, and asthma in neighborhoods with high levels of violence.[2]

Injury Deaths

Injury deaths is the number of deaths from intentional and unintentional injuries per 100,000 population. Deaths included are those with an underlying cause of injury (ICD-10 codes *U01-*U03, V01-Y36, Y85-Y87, Y89).

Reason for Ranking

Injuries are one of the leading causes of death; unintentional injuries were the 4th leading cause, and intentional injuries the 10th leading cause, of US mortality in 2014.[1] The leading causes of death in 2014 among unintentional injuries, respectively, are: poisoning, motor vehicle traffic, and falls. Among intentional injuries, the leading causes of death in 2014, respectively, are: suicide firearm, suicide suffocation, and homicide firearm. Unintentional injuries are a substantial contributor to premature death. Among the following age groups, unintentional injuries were the leading cause of death in 2014: 1-4, 5-9, 10-14, 15-24, 25-34, 35-44.[2] Injuries account for 17% of all emergency department visits, and falls account for over 1/3 of those visits.[3]

Air Pollution-Particulate matter

Air pollution-particulate Matter is the average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) in a county. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers. These particles can be directly emitted from sources such as forest fires, or they can form when gases emitted from power plants, industries and automobiles react in the air.

Reason for Ranking

The relationship between elevated air pollution (especially fine particulate matter and ozone) and compromised health has been well documented.[1,2,3] Negative consequences of ambient air pollution include decreased lung function, chronic bronchitis, asthma, and other adverse pulmonary effects.[1] Long-term exposure to fine particulate matter increases premature death risk among people age 65 and older, even when exposure is at levels below the National Ambient Air Quality Standards.[3]

Drinking Water Violations

Change in measure calculation in 2018: Drinking Water Violations is an indicator of the presence or absence of health-based drinking water violations in counties served by community water systems. Health-based violations include Maximum Contaminant Level, Maximum Residual Disinfectant Level and Treatment Technique violations. A “Yes” indicates that at least one community water system in the county received a violation during the specified time frame, while a “No” indicates that there were no health-based drinking water violations in any community water system in the county. Please note that the methods for calculating this measure changed in the 2016 Rankings.

Reason for Ranking

Recent studies estimate that contaminants in drinking water sicken 1.1 million people each year. Ensuring the safety of drinking water is important to prevent illness, birth defects, and death for those with compromised immune systems. A number of other health problems have been associated with contaminated water, including nausea, lung and skin irritation, cancer, kidney, liver, and nervous system damage.

Severe Housing Problems

Severe housing problems is the percentage of households with at least one or more of the following housing problems:

- housing unit lacks complete kitchen facilities;
- housing unit lacks complete plumbing facilities;
- household is severely overcrowded; or

- household is severely cost burdened.
- Severe overcrowding is defined as more than 1.5 persons per room. Severe cost burden is defined as monthly housing costs (including utilities) that exceed 50% of monthly income.

Reason for Ranking

Good health depends on having homes that are safe and free from physical hazards. When adequate housing protects individuals and families from harmful exposures and provides them with a sense of privacy, security, stability and control, it can make important contributions to health. In contrast, poor quality and inadequate housing contributes to health problems such as infectious and chronic diseases, injuries and poor childhood development.

Appendix C – Youth Behavioral Risk Survey Results

Appendix C – Youth Behavioral Risk Survey Results

North Dakota High School Survey

*2017 YRBS North Dakota Data is not yet available, so the 2015 data was used.

Rate Increase ↑, rate decrease ↓, or no statistical change = in rate.

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Injury and Violence						
Percentage of students who rarely or never wore a seat belt.	11.6	8.5	↓	10.5	7.5	5.9
Percentage of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	21.9	17.7	↓	21.1	15.2	16.5
Percentage of students who talked on a cell phone while driving (on at least 1 day during the 30 days before the survey, among students who drove a car or other vehicle)	67.9	61.4	↓	60.7	58.8	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)	59.3	57.6	=	56.7	54.4	39.2
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	29.8	28.7	=	32.8	24.7	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least 1 day during the 30 days before the survey)	6.4	5.2	=	6.6	4.5	3.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	8.8	5.4	↓	6.9	6.1	8.5
Percentage of students who were ever physically forced to have sexual intercourse (when they did not want to)	7.7	6.3	=	6.5	7.4	7.4
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)	9.7	7.6	=	6.9	8.0	8.0
Percentage of students who have been the victim of teasing or name calling because someone thought they were gay, lesbian, or bisexual (during the 12 months before the survey)	9.6	9.7	=	10.4	9.7	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	25.4	24.0	=	27.5	22.4	19.0
Percentage of students who were electronically bullied (including being bullied through e-mail, chat rooms, instant messaging, websites, or texting during the 12 months before the survey)	17.1	15.9	=	17.7	15.8	14.9
Percentage of students who felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	25.4	27.2	=	24.9	28.9	31.5
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.1	16.2	=	15.8	16.7	17.2
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	13.5	=	12.8	13.7	13.6
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	11.5	9.4	↓	10.3	11.3	7.4

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Tobacco Use						
Percentage of students who ever tried cigarette smoking (even one or two puffs)	41.4	35.1	↓	37.3	32.5	28.9
Percentage of students who smoked a whole cigarette before age 13 years (for the first time)	7.9	7.2	=	7.3	6.7	9.5
Percentage of students who currently smoked cigarettes (on at least 1 day during the 30 days before the survey)	19.0	11.7	↓	13.2	11.8	8.8
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	6.6	4.3	↓	4.3	4.7	2.6
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.9	3.2	=	3.2	3.2	2.0
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	7.8	16.9	↑	0.2	1.0	NA
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	55.5	47.4	=	49.1	52.7	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least 1 day during the 30 days before the survey)	NA	22.3	↑	19.7	22.8	13.2
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least 1 day during the 30 days before the survey)	13.8	10.6	↓	12.6	9.5	5.5
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey)	11.7	9.2	↓	9.7	9.7	8.0
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	27.5	20.9	↓	22.9	19.8	14.0
Alcohol and Other Drug Use						
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least 1 day during their life)	65.8	62.1	=	64.5	59.9	60.4
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	15.2	12.4	=	15.3	12.9	15.5
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least 1 day during the 30 days before the survey)	35.3	30.8	↓	32.8	29.3	29.8
Percentage of students who drank five or more drinks of alcohol in a row (within a couple of hours on at least 1 day during the 30 days before the survey)	21.9	17.6	↓	19.8	17.0	13.5
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	37.0	41.3	=	41.1	40.4	43.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.6	6.3	=	5.8	5.8	6.8
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.9	15.2	=	13.2	17.1	19.8
Percentage of students who ever took prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life)	17.6	14.5	↓	13.2	16.0	14.0
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	14.1	18.2	↑	15.9	19.9	19.8

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	9.9	8.6	=	7.9	9.0	NA
Sexual Behaviors						
Percentage of students who ever had sexual intercourse	44.9	38.9	↓	39.3	39.1	39.5
Percentage of students who had sexual intercourse before age 13 years (for the first time)	3.8	2.6	=	3.3	3.3	3.4
Weight Management and Dietary Behaviors						
Percentage of students who were overweight (>= 85th percentile but <95 th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	15.1	14.7	=	15.4	14.6	15.6
Percentage of students who were obese (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.5	14.0	=	16.3	12.9	14.8
Percentage of students who described themselves as slightly or very overweight	32.0	32.2	=	34.2	31.5	31.5
Percentage of students who were trying to lose weight	45.4	44.7	=	45.0	43.0	47.1
Percentage of students who did not eat fruit or drink 100% fruit juices (during the 7 days before the survey)	3.4	3.9	=	4.3	4.1	5.6
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the 7 days before the survey)	64.7	62.5	=	8.5	8.8	60.8
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	6.0	4.7	=	4.5	5.2	7.2
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the 7 days before the survey)	62.8	58.5	↓	61.2	60.0	59.4
Percentage of students who did not drink a can, bottle, or glass of soda or pop (not including diet soda or diet pop, during the 7 days before the survey)	25.3	25.6	=	23.5	21.7	27.8
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the 7 days before the survey)	23.4	18.7	=	21.4	18.0	18.7
Percentage of students who did not drink milk (during the 7 days before the survey)	11.1	13.9	↑	11.6	13.7	26.7
Percentage of students who drank two or more glasses per day of milk (during the 7 days before the survey)	42.4	35.8	↓	36.6	35.3	17.5
Percentage of students who did not eat breakfast (during the 7 days before the survey)	10.5	11.9	=	10.7	11.8	14.1
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	3.1	2.2	=	2.4	2.8	NA
Physical Activity						
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	50.6	51.3	=	51.7	50.1	46.5
Percentage of students who watched television 3 or more hours per day (on an average school day)	21.0	18.9	=	20.7	18.2	20.7
Percentage of students who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day)	34.4	38.6	↑	39.4	38.0	43.0

	ND 2013	ND 2015*	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2017
Other						
Percentage of students who had 8 or more hours of sleep (on an average school night)	30.0	29.5	=	34.5	28.7	25.4
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	71.5	71.0	=	67.8	70.1	NA
Percentage of students who most of the time or always wear sunscreen (with an SPF of 15 or higher when they are outside for more than one hour on a sunny day)	11.2	12.5	=	10.3	12.8	NA
Percentage of students who used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	19.6	12.2	↓	13.3	12.8	NA

Appendix D – Prioritization of Community’s Health Needs

Community Health Needs Assessment Hazen, North Dakota Ranking of Concerns

The top four concerns for each of the seven topic areas, based on the community survey results, were listed on flipcharts. The numbers below indicate the total number of votes (dots) by the people in attendance at the second community meeting. The “Priorities” column lists the number of yellow/green/blue dots placed on the concerns indicating which areas are felt to be priorities. Each person was given four dots to place on the items they felt were priorities. The “Most Important” column lists the number of red dots placed on the flipcharts. After the first round of voting, the top five priorities were selected based on the highest number of votes. Each person was given one dot to place on the item they felt was the most important priority of the top five highest ranked priorities.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	8	0
Having enough child daycare services	3	
Not enough affordable housing	2	
Not enough jobs with livable wages	4	
Not enough public transportation options/cost of transportation	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of specialists	0	
Cost of prescription drugs	3	
Cost of health insurance	4	
Availability of mental health services	17	11
Cost of healthcare services	2	
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse	4	
Drug use and abuse (including prescription drugs)	10	8
Depression/anxiety	9	2
Smoking and tobacco use (second-hand smoke) or vaping/juuling	5	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	3	
Drug use and abuse (including prescription drugs)	7	
Depression/anxiety	3	
Not getting enough exercise/physical activity	0	
Dementia/Alzheimer’s Disease	0	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	0	
Availability of resources to help elderly stay in their homes	12	2
Assisted living options	1	
Ability to meet needs of older population	3	
Availability/cost of activities for seniors	0	
Availability of transportation for seniors	0	
Depression/Anxiety	4	

Appendix E – Survey “Other” Responses

Community Assets: Please tell us about your community by choosing up to three options you most agree with in each category below.

1. Considering the PEOPLE in your community, the best things are: “Other” responses:
 - None of the above people here only have their best interest in mind
 - People are clickish and some like to bully (adults)
 - Some people who live here are involved in their community
 - This community is full of stuck up people who think they are privileged because they work at the plants and are overpaid morons.
2. Considering the SERVICES AND RESOURCES in your community, the best things are: “Other” responses:
 - Healthcare is overpriced, especially dental and there is nothing here for people to do. Most of us do not want to belong to the new Rec Center because it is overpriced like everything else here.
 - Nice walking path
 - Small town
3. Considering the QUALITY OF LIFE in your community, the best things are: “Other” responses:
 - People only like you if you are rich.
4. Considering the ACTIVITIES in your community, the best things are: “Other” responses:
 - Entertainment theater
 - Fishing, hunting
 - Needs a year round pool
 - School sports
 - Some of us do not do lake activities and that is all that is here other than the overpriced Rec Center.
 - Swimming pool

Community Concerns: Please tell us about your community by choosing up to three options you most agree with in each category.

5. Considering the COMMUNITY / ENVIRONMENTAL HEALTH in your community, concerns are: “Other” responses:
 - Addiction issues
 - Alcohol abuse
 - Assisted living
 - Businesses leaving and hard to attain affordable buildings in good shape for businesses
 - Community creator events (e.g. ‘art in the park’)
 - Drug abuse
 - (2) Drug usage
 - Drugs
 - Healthy Food Options
 - Help disability-limited people and vets
 - Home health resources / staff

- Illegal drug activity
 - Lack of assisted living facility
 - Law enforcement does not actively enforce laws; our youth is in crisis due to this
 - McDonalds or Starbucks or Shopping place like TJ Maxx, Target, Walmart
 - Not enough livable jobs other than plant jobs
 - Property taxes
 - Teen drugs use
6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: “Other” responses:
- Chiropractor
 - Huge gap in primary health providers to work hand in hand with alternative medicine. Example... chiropractors...Etc.
 - In-home adult care
 - Massage Therapy, Acupuncture, non-traditional services
 - No concerns
 - Not enough workers in general
 - We have great healthcare services
7. Considering the YOUTH POPULATION in your community, concerns are: “Other” responses:
- (2) Bullying
 - Lack of Respect
 - Not sure
 - Quality job opportunities for youth
8. Considering the ADULT POPULATION in your community, concerns are: “Other” responses:
- Domestic violence
9. Considering the SENIOR POPULATION in your community, concerns are: “Other” responses:
- Availability of in-home care givers
10. What single issue do you feel is the biggest challenge facing your community?
- Access to advanced mental health services
 - Access to services for those who live in rural areas- ambulance, internet, newspapers, weather alerts, telemedicine
 - Affordable day care
 - Affordable housing
 - Attracting people to our community. There are a ton of houses for sale and not enough jobs to attract people here.
 - Attracting young families to Beulah. Doesn’t seem like there are enough professional jobs for spouses. We have lots of high paying jobs and low paying jobs, but not many middle of the road jobs.
 - Attracting young families. Not only people who want to work here but want to live here and raise their families here.
 - Attracting/retaining families
 - Availability of resources to help the elderly stay in their homes as long as possible safely and comfortably.
 - Big city minded wanting small town living. Expensive city “fathers”
 - Boredom
 - Bullying. Kids may deny bullying issues due to embarrassment, but bullying is definitely a problem. Kids in school are at a vulnerable point in life, and they are learning who they are. Bullying brings on depression/anxiety/self-esteem issues that can lead to issues within family and friend relationships. It also can affect their daily living and functioning at school/work/home. I think we need to keep

pushing for REAL bullying presentations that stick in the kid's minds regarding how their careless and thoughtless actions/ words can really affect other's lives immensely.

- Cost of insurance, living options, and prescriptions.
- Cost of living continues to increase, but wages aren't increasing at the same rate. Lack of healthy, fun activities for families and children year round.
- Daycare availability
- Declining population/job loss
- Decreasing population due to the reduction in available jobs
- Distance from available healthcare, hospital and availability of appointments at local clinic with doctors
- (2) Drug abuse
- Drug abuse among teens/kids and adults. There is a lot going on in the schools.
- (3) Drugs
- Economy- ups and downs
- Families tend to move to more populated areas!
- For KRCC at Beulah to hire and retain quality employees. KRCC poor 2 star rating. KRCC employees and administration need to be more proactive rather than reactive to situations that have caused harm to residents and families. There needs to be accountability.
- Funding for our facilities.
- Good paying jobs
- Helping people with limited resources without all red tape and restriction or taking away everything from them! Or their furniture! They get help if you are 55 - get medical, own your home they attack and take your home for help! But if you're younger they don't! Wow!
- Holding young middle income families
- Hours of convenience for the public for people that work later shifts
- Housing and resources available for low income families. The scale provided for low income goes off of what was made before taxes and not what was brought home. I don't get the money that was taken for taxes, I don't see it until tax season which doesn't help if I need health coverage for myself or my son now. Everything looks good on paper but if you look at what is actually coming in versus what is coming out as a single parent, it doesn't add up to much take home. I can't afford insurance for myself or my son and I make too much to qualify for government assistance, but I'm struggling each month to get bills paid, my child fed, and our healthcare taken care of.
- I believe we have some of the best medical providers in the region for community our size including medical doctors, PAs, chiropractors, masseuse's and nutrition advisers. Would be amazing if the team of all of these could meet regularly and work together for the benefit of the patient. The atmosphere is as a patient you have to hide the fact that you may be seeing a different healthcare provider for the same problem.
- I feel our community is failing the population that may need a little help day to day but are not quite ready for the nursing home. Those individuals are having to move to larger communities to access this kind of care. We are also failing the aging couples where one person may need care and the other can live more independently. A combined independent/assisted facility would allow those couples to stay together without the added stress of the healthy spouse needing to be the care giver for the spouse who needs the assistance.
- I feel there isn't any emergency mental contact availability locally for citizens and not enough education for teenagers regarding mental health. Also not enough restaurants.
- I think that if you need help, there is always help
- In healthcare, I feel it is the lack of confidentiality throughout the healthcare system in our area - including nurses, doctors, and support staff (billing, etc.)
- Inefficient city & county government....out of touch with the needs of the city and poor budget management.....we have excellent schools but not much in the way of activities except seasonal sports to keep young people & families here.
- Infrastructure of city for safety reasons, taxes to pay for needed community use and activities
- Involvement of young adults in community
- It isn't an inclusive community- wanting things for all ages and financial things

- It seems so negative about growing and bringing in outside businesses. We need to grow to make it possible for people to come here.
- Job security
- Keeping young families here
- Keeping young people on the community.
- Lack of community engagement from city government
- Lack of diversity
- Lack of restaurants
- Lack of specialists serving community
- Lack of things for youth aged 13-17 to do during the summer or after school - not enough quality job opportunities, activity opportunities, things to keep them out of trouble. The community could use a mentoring program or some kind of safe youth hangout.
- Lack of aftercare/transitional/sober living care
- Local & county officials getting nothing done.
- Loss of jobs
- Meeting the needs of the older population
- Mental Health
- Mental health issues
- Mental/trauma health care for kids
- Middle class families finding jobs to support their family and keeping them living in the community.
- No safe place/activities for youth/teens to go to hang out. Instead many go party instead of something like learn to shoot pool or bowling.
- Not enough evening/night activities for teenagers/young adults other than bars
- Not enough staff for home health
- Not growing with young people, doing things to keep young people here in our community.
- Not having enough activities for youth. Youth have nowhere or nothing to do or go to after school
- Obesity
- Only having one option, mediocre at best, for nursing-home services.
- Our community is going to be stressed by the reduction in staff that Basin Electric has done. Houses, population, the young people having to move to find work. Those were the ones who were going to be the active part in events.
- Our law enforcement personnel in the community of Hazen seem to be very unwilling to enforce the law, especially with teens. We have a community of teenagers engaging in very risky behaviors and they verbalize that law enforcement has been told not to pull them over.
- People leaving Hazen. Jobs are less. Not enough opportunities for people to stay.
- Population decline
- Population decrease
- Reaching people who “fall through the cracks” and those who need services and are unwilling to admit that they need help with issues like: alcohol abuse, gambling, mental health issues, abuse
- Retaining people in the area. Nothing to do, nowhere to eat and everything costs more than a place less than an hour away.
- The acceptance and use of youth chewing tobacco or using juuls and adults chewing tobacco.
- The amount of drug use increasing with mental health resources
- The cost of both groceries and health care cause people to resource in Bismarck instead of Hazen.
- The cost of everything going up, our income is not going up
- The cost of nursing home
- The growing senior population
- These power plants are going to close, and the people staying behind will be on the hook for all the money being spent by community leaders.

- To continue to grow and expand mental health services, and attracting and retaining healthcare staff (from doctors, to therapists, to counselors, to nurses, etc.).
- To keep city running, lot of people on low income taxes
- Transportation for the elderly to and from their appointments - Clinic van is often not available. WRT only runs for them certain times. (School children are priority). Would benefit from another bus or separate services
- Truthful and transparent law enforcement agency.
- Unable to keep cafes, restaurants adequately staffed and paid/open to the public
- We need a health community center
- When it comes to seniors, the costs of healthcare.
- With the recent layoffs at Basin Electric how it will affect housing, businesses, population and just about all aspects of life as we know it in Mercer County

Delivery of Healthcare

11. What PREVENTS community residents from receiving healthcare? “Other” responses:

- Bad attitudes
- Getting pressured to take medical action that was not asked for or for what I’m being seen for.
- Lack of promotion of evening or weekend hours available to be seen by healthcare providers
- N/A
- No problems getting health treatment here.
- None of above
- Rude doctors

12. Where do you turn for trusted health information? “Other” responses:

- Bismarck - specialists
- Chiropractor
- Larger city with more doctors. Not just PA’s and someone with wide spread experience. Not a young or isolated person... been out there and seen things and knows new things.
- Local ambulance service
- My insurance agent
- Very careful, read and look and listen and dis-learn information before making decisions on health

19. Where do you find out about LOCAL HEALTH SERVICES available in your area? “Other” responses:

- Mail flyers
- Pop health meetings
- (2) Work

23. What specific healthcare services, if any, do you think should be added locally?

- A list of holistic massage therapists and medicines.
- Access to psychiatric care, better mental health care.
- Actual physicians, mental health services and extended appointment availability
- Acupuncture, core synchronization, more massage therapists, dermatological services such as facials, IPL, fillers
- Addition mental health services
- Asthma specialist, bladder/kidney therapists, dialysis
- Birthing facility
- Bone and joint
- Cancer center for chemo and radiation
- Cardiology

- Care for the people who fall between the cracks
- Chemotherapy
- Dental in Dunn County
- Dermatologist
- (2) Dermatology
- Detox unit
- Dialysis
- Endocrinologist & rheumatologist
- ENT, orthopedics, podiatry
- GI specialist
- Holistic natural options
- Holistic/naturopathic services
- I think the hospital should have labor facilities.
- I would love to see more naturopathic help available. I would also like to see more massage/self-care services available.
- I would love to see specialists perform services in our area
- Inpatient drug and alcohol treatment
- Inpatient treatment center
- It would be nice to have access to MRI and CT scan services every day. I had a head injury last spring, and couldn't get a scan.
- Kidney/dialysis center, more dispensary care of people with ongoing conditions that need interventions
- Longer, flexible hours, more providers, minor emergency services
- Mental health
- Mental health physician or nurse practitioner
- More care of holistic nature, such as acupuncture, herbal, etc.
- More days for availability with a counselor
- More mental health services
- More mental health services, and alternative therapies like acupuncture, more massage options, etc.
- More psychology/psychiatry
- More regular mental health counseling
- Natural health
- Natural homeopathic practitioner
- Need for more mental health and substance abuse professionals.
- Ophthalmology
- Sports-focused training, diet and exercise, prenatal
- Team of Eastern and Western medicine together
- The Health Marketplace sucks
- There should be more advertising about the CCCHC Marketplace assistance. No one seems to know about it.
- Traveling OB
- VA clinic
- Walk in clinics- weekdays and weekends
- Well baby
- Women's health (specialize in gynecology)
- Yes they take your house if you are over 55 years of age! No way will died 1st check the rules

25. Have you supported your local healthcare foundation in any of the following ways? "Other" responses:

- Donations
- I work full time to the best of my ability
- I'm a retired vet
- Local fundraisers
- (2) No
- None
- Supporting an event fundraising for them
- Through organization- Hospital auxiliary
- Volunteer
- Worked at funding activities

39. Overall, please share concerns and suggestions to improve the delivery of local healthcare.

- A PA or such, does not understand anxiety, or depression or how to really treat it.
- Everyone knows everyone in these small towns so we won't go to certain screenings (breast, colon) because we know the people doing them and see them the next day at the grocery store....
- Adequate staff for the activity going on. Less wait time for ER. Available Doctors to see patients in ER or be able to contact them
 - Confidentiality. I do not utilize local healthcare for anything more than cold or flu due to the lack of confidentiality that occurs in this area. Which is very sad because my rights should be protected through HIPAA. I have had various hospital and clinic employees tell me about people and their illnesses and ailments that come through the facility. I have lost all confidence in our healthcare system locally. So now I drive to Bismarck. And to be honest, I'm not entirely sure how you can gain that trust back. I also feel that it would be beneficial to have a doctor on staff at SMC. While I know PA's and NP's are very knowledgeable as well, it puts a patient at ease knowing that a doctor is evaluating them when come into the emergency room.
 - I am comfortable with the health care available to us in Mercer county
 - I believe our health care system in Mercer County is very good.
 - I rarely go to the doctor in the area because I feel my HIPAA is violated and have heard people who work in the health care locally talk about diagnosis of others so I basically go to Bismarck as much as I can
 - I think our healthcare in our area is very good whenever I need it
 - In our area health care and professionals are very good
 - Less cost of health insurance for seniors!
 - Less waiting time to see specialists, improve overall quality & accuracy (reliability) extended clinic hours
 - Let the health market compete and stop trying to swindle sick people out of their last dime because you can. I think you should tell people how much this stuff is going to cost instead of automatically doing it and scheduling appointment, because you don't have to pay for it.
 - Make public aware of services available locally and encourage them to use them as much as possible
 - May exist but not familiar with health "advisors" to help find access to info among providers, locations, insurance, etc. (Cindy Peterson from Beulah Drug is such an expert limited to that store and gives advice/info re: RX and insurances)
 - More available clinic hours. More providers, if possible. My PCP is always filled up, so I can never get in to see her.
 - More choices with providers and more choices with clinic hours.
 - More coverage for employees, less deductible and out of pocket rates.
 - More employees
 - Need more in Killdeer and open until 5 for better access to appointments, need chiropractor, dentist, etc. Need counseling available in Killdeer.
 - Sliding fee scale needs to project the reality of single parents and take into consideration rent and utilities as well as other common household bills, such as groceries. I personally make too much for any state assistance, for myself or my son, however, I cannot afford health insurance through work. I am due to renew my sliding fee, and as I got a new job and make more than I did at my previous job I feel like I

will not be eligible for affordable health care with the sliding fee scale.

- The constant turnover at KRCC management as well as the level of care given concern me.
- Transportation cost and other costs in general for seniors living independently in home to get to /from appointments, pharmacy / medications, and overall cost to get supplies purchase as well as how to get to the supplies
- Transportation is a problem. We have busing systems, but they do not cover all of the needs. Would be nice to have transportation access in the community to get patients to radiology, PT, RT, etc. at SMC.
- We have a very talented medical providers in our region but I wish they would work together for the concern of the patient
- We have been very pleased
- We have good health care. It would be good if we had more specialists
- Why are you doing a healthcare survey of Dunn Co. sponsored by Mercer County Ambulance? We have excellent ambulance services in Dunn County that are not included and you haven't asked about them.
- Will only use medical services if necessary due to administration
- Would like daycare center in Beulah