Community Health Needs Assessment

Sakakawea Medical Center, Custer Health, Coal Country Community Health Center, Hill Top Home of Comfort, Inc., and Knife River Care Center Service Area

Hazen, North Dakota

2022

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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, Hill Top Home of Comfort, and Knife River Care Center (KRCC) (collectively "Local Health Providers") conducted a Community Health Needs Assessment (CHNA) in 2021, the previous CHNA having been conducted in 2019. 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. Four hundred fifty-six SMC service area residents completed the survey. Additional information was collected through seven key informant interviews with community members. The input from the residents, who primarily reside in Dunn, Mercer, and Oliver Counties, 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 2019 increased by over 25%, while Mercer County's population decreased 2.8%, and Oliver County had a population increase of 6%. The average number of residents younger than age 18 (25.1%) for Dunn County comes in 1.5 percentage points higher than the North Dakota average (23.6%), Mercer County's population younger than age 18 (23.2%) is 0.4 percentage points lower than the state average, and Oliver County (25.3%) comes in 1.7 percentage points higher than the state average for population younger than age 18. The percentage of residents, ages 65 and older, is 0.4% higher for Dunn County (16.1%) than the North Dakota average (15.7%), 4.4% higher for Mercer County, and 7% higher for Oliver County. The rate of education is slightly lower for Dunn County (91.1%), Mercer County (91.4%), and Oliver County (91.3%) than the North Dakota average (92.6%). The median household income in all three counties is much higher than the state average for North Dakota ($64,894), with Dunn County at $76,719, Mercer County at $82,181, and Oliver County at $78,929.

Data, compiled by County Health Rankings, show Dunn, Mercer, and Oliver counties are doing better collectively than North Dakota in health outcomes/factors for six categories; Dunn County is doing better than North Dakota in health outcomes/factors for 12 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 12 categories.

Dunn, Mercer, and Oliver counties, according to County Health Rankings data, are collectively performing poorly, relative to the rest of the state in two outcome/factor categories; Dunn County is performing worse than the state average in 16 categories; Mercer County is performing worse than the state average in 10 categories; and Oliver County is performing worse than the state average in 13 categories.

Of 106 potential community and health needs set forth in the survey, the 456 local health provider service area residents who completed the survey indicated the following nine needs as the most important:

- Extra hours for appointments (evenings/weekends)
- Attracting and retaining young families
- Ability to retain primary care providers in the community
- Alcohol use and abuse – adult
- Availability of resources to help the elderly stay in their homes
- Cost of long-term/nursing home care
- Depression/anxiety – youth and adult
- Drug use and abuse – youth and adult
- Not enough jobs and livable wages

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included: don't know about local services (N=79), confidentiality (N=73), and distance from health facility (N=68).

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

- Feeling connected to people who live here
- Recreational sports activities
- Family-friendly
- Healthcare
- People are friendly, helpful, and supportive
- Safe place to live
- Active faith community

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:

- Alcohol use and abuse - adult
- Drug use and abuse - adult and youth
- Availability of resources to help the elderly stay in their homes
- Depression/anxiety - adult and youth
- Attracting and retaining young families

Overview and Community Resources

With assistance from the Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS), local health providers completed a Community Health Needs Assessment (CHNA) of their service area, which is identified as Dunn, Mercer, and Oliver Counties. Many community members and stakeholders worked together on the assessment. This service area encompasses over 3,900 square miles and a population of approximately 14,322 residents, according to U.S. Census data.

Mercer and Dunn Counties border the southern shore of Lake Sakakawea, and Oliver County borders the Missouri River. While tourism is a major industry during the summer season, agriculture and the energy industry are the backbone of the area. Also known as "The Energy Trail," the area contains the U.S.'s 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. 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.

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 provide 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, dog park, walk/bike path, skateboard park, outdoor sports complex, and a myriad of recreational activities at Lake Sakakawea, including fishing, camping, boating, and water sports.

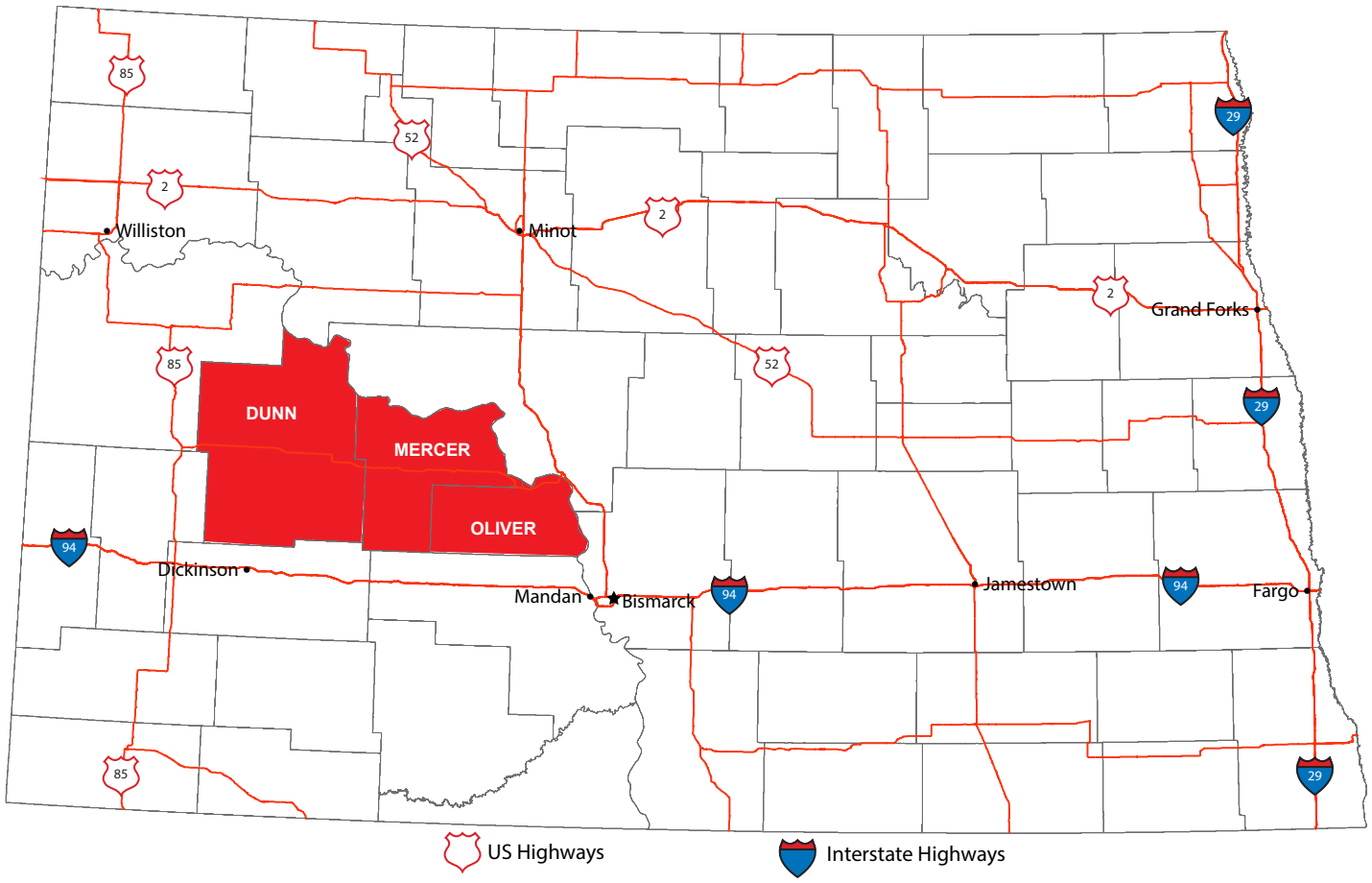
Center is the only incorporated city in Oliver County and has a K-12 school system. It offers an indoor junior Olympic size pool that is open year-round, a golf course, and several parks with available camping, including Cross Ranch State Park and the Cross Ranch Preserve, which are only a short drive 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 Highway 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, Killdeer Aquatics & Wellness Center, 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 and Clark Trail.

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

Figure 1: Dunn, Mercer, and Oliver Counties



Sakakawea Medical Center

Located in Hazen, Sakakawea Medical Center (SMC) consists of a 13-bed Critical Access Hospital and a 34-bed licensed basic care facility. SMC is a state-designated Level V trauma center and employs more than 140 people. The nonprofit hospital is community-owned and governed by a volunteer board of directors.

SMC's 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.

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 SMC 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.

A federally qualified health center operated by Coal Country Community Health Center, an expanded emergency room and surgical area, handicapped-accessible patient rooms, a centralized registration area and nurse's station, and a myriad of other needed changes and technology updates. The new facility was 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.

Services offered locally by Sakakawea Medical Center (SMC), include:

General and Acute Services

- Blood pressure checks
- Education – patient
- Education – staff
- Emergency department
- Hospital (acute care)
- Hospital (observation)
- Hospital (respite care)
- Hospital (swing bed intermediate)

- Hospital (swing bed skilled)
- Infection prevention
- Pharmacy
- Surgical services – CRNA
- Surgical services – endoscopies
- Surgical services – general
- Trauma care
- Urgent care

Screening/Therapy Service

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

Radiology Services

- 3-D digital mammography
- Bone density
- CT scan
- Echocardiograms
- General X-ray
- MRI (mobile unit)
- Nuclear medicine (mobile unit)
- Ultrasound

Laboratory Services

- Blood banking-transfusion service
- Chemistry
- Coagulation studies
- Hematology
- Phlebotomy
- SAT/BAT 3rd party collections
- Serology
- Urine testing

Other/Additional Services

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

Contracted Services

- Avera eEmergency
- Bismarck Radiology Associates
- Bismarck State College – Practical Nurse Program
- Altru Virtual ePharmacy
- Great Plains Rehab Services
- LifeSource - (organ, tissue and eye procurement organization)
- North Dakota Public Health Laboratories
- Northern Plains Lab
- Nutrition counseling
- Pathology consultants
- Pharmacist
- Speech therapy
- United Blood Services
- Virtual radiology

Coal Country Community Health Center

Coal Country Community Health Center (CCCHC) is a local, nonprofit 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 Center'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 health care services.

In 2017, CCCHC Hazen and Killdeer relocated into newly constructed facilities. In June of 2019, CCCHC Beulah completed a construction and remodel project. This project enhanced the way CCCHC provides integrated medical care by doubling the clinic space to accommodate patient and staff needs. In 2022, CCCHC Center will undergo a remodeling project of their current space.

Services provided by CCCHC:

General Medical and Integrated Care Services

- Infant, child, adolescent, and adult exams
- Mole/wart/skin lesion removal
- Nutrition counseling
- Diabetes Self-Management Education and Support (DSMES) Services and National Diabetes Prevention Program, including diabetes self-management education, diabetes prevention program, continuous blood glucose monitoring
- Consultant pharmacy
- Physicals; D.O.T., sports, pre-employment, and insurance
- Sports medicine and concussion management
- Substance use disorder services - drug and alcohol evaluations, intensive outpatient program, Medication Assisted Treatment, and aftercare
- DUI seminars, MIP/MIC seminars
- Employee Assistance Program
- Family planning, including implanted and oral contraception
- Geriatrics
- Infusion therapy

- Joint injections
- Medication assisted therapy - Suboxone
- Mental/behavioral health services, including school integration services
- Occupational health medicine
- Outreach and enrollment services, including certified Senior Health Insurance Counselors
- Care coordination services guided under the patient-centered medical home principles
- Pediatrics
- Prenatal and post-partum care
- Psychiatry via telehealth
- Sliding fee scale – health discount program
- Tobacco/nicotine cessation services, including youth program "Catch My Breath"
- Transportation services
- Visiting nurse services
- Welcome to Medicare and Medicare annual wellness visits
- Women's health
- 340B Drug Pricing Program

Screening and Preventive Care Services

- Chronic disease management
- Electrocardiograms
- Infant, child, adolescent, and adult preventive exams and immunizations
- Moderate complexity laboratory and basic radiology services, including visiting diagnostic ultrasound
- Health and wellness screenings
- NIOSH Coal Workers' Health Surveillance Program
- Pulmonary Function Tests
- NOWCAP Black Lung & Respiratory Diseases

Contracted Services

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

Visiting Specialists

- Audiology
- Cardiology
- Hearing Consultant
- OB/GYN
- Orthopedist
- Podiatry
- Psychology
- Rehabilitation

Custer Health

Founded in 1950, Custer Health is a five-county multidistrict 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, tobacco/substance abuse prevention, 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.

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

Specific services that Custer Health provides are:

- Beyond Birth Education
- Bicycle helmet safety education
- Blood pressure checks
- Breastfeeding resources
- Car seat program
- Child health (well-baby checks)
- CPR and First Aid
- Emergency preparedness services – work with community partners as part of local emergency response team
- Harm reduction – Good Neighbor Program
- Health Tracks (child health screening)
- Environmental Health Services (water, sewer, health hazard abatement, food/beverage, public swimming pools, body art)
- Home visiting – health maintenance
- Immunizations
- Infection control (HIV/AIDS, Hep C, STIs, TB testing, and management)
- Nurse-Family Partnership
- School health – vision, hearing, scoliosis screenings in schools, health education, and resource to the schools
- Substance abuse prevention
- Tobacco prevention and control
- WIC (Women, Infants, and Children) Program
- Women's Way

Knife River Care Center (KRCC)

Originally called the Beulah Community Nursing Home, Knife River Care Center 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 a long-term care facility in Beulah and has the following text 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."

Services provided by Knife River Care Center:

- Skilled nursing services
- Short-term and long-term rehab
- Long-term placement
- Memory care unit
- Nurse Aide Training Program for the Community
- Bariatric services
- Medication Aide Training Program for the Community

Hill Top Home of Comfort

Hill Top Home of Comfort, a nonprofit 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.

The mission of Hill Top Home of Comfort is to "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 and 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

Services provided by Hill Top Home of Comfort:

- Skilled nursing services
- Basic care
- Assisted living
- Memory care locked unit

Assessment Process

The purpose of conducting a Community Health Needs Assessment (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.
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.

The health center must assess the unmet need for health services in the catchment or proposed catchment area of the center based on the population served, or proposed to be served at a minimum every 3 years following the Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act; and 42 CFR 51c.104(b)(2-3), 42 CFR 51c.303(k), 42 CFR 56.104(b)(2), 42 CFR 56.104(b)(4), and 42 CFR 56.303(k)

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 Center, Golden Valley, Halliday, Killdeer, Pick City, Stanton, and Zap.

The Center for Rural Health (CRH), in partnership with local health providers, facilitated the CHNA process. Community representatives met regularly by video teleconference and communicated by email. A CHNA liaison was selected locally who served as the main point of contact between CRH and Hazen. A steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from CRH met and corresponded regularly by 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 26 people, representing a cross section demographically, who attended the community group meeting. The meeting was highly interactive with good participation.

Figure 2: Steering Committee

Chastity Dolbec	Director of Patient Care and Innovation	Coal Country Community Health Center
Carley Haugen	Public Relations	Sakakawea Medical Center
Blake Kragnes	Administrator	Knife River Care Center
Gerry Leadbetter	Administrator	Hill Top Home of Comfort
Heidi Moore	Public Health Nurse	Custer Health
Kara Pulver	Director of Community and Patient Engagement	Coal Country Community Health Center
Rachel Sem	Director of Nursing	Sakakawea Medical Center
Amber Staigle	Public Health Nurse	Custer Health
Brian Williams	Chief Executive Officer	SMC and CCCHC

The original survey tool was developed and used by CRH. In order to revise the original survey tool to ensure the data gathered met the needs of hospitals, FQHC's, and public health, 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 (NDSU).

As part of the assessment's overall collaborative process, 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.

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. 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. CRH connects the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) and other necessary resources to rural communities and other healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, 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 26 community members was convened and first met on December 2, 2021. 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 January 18, 2022, with 23 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 Sakakawea Medical Center (SMC), Custer Health, Knife River Care Center (KRCC), and Coal Country Community Health Center (CCCHC). They included representatives of the health community, business community, economic development, political, and education leaders. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with seven key informants were conducted by phone or Zoom during the week of December 2, 2021. Senior program staff from CRH conducted the interviews. Interviews were held with selected members of the community group as well as other key informants who could provide insights into the community's health needs.

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 C, and a full listing of direct responses provided for the questions that included "Other" as an option are included in Appendix G.

The community member survey was distributed to various residents of Dunn, Mercer, and Oliver Counties, which are all included in the SMC and CCCHC 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.
- 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

Approximately 50 community member surveys were available for distribution in Dunn, Mercer, and Oliver Counties. The surveys were distributed by the local health providers through agency programs and to patients. To help make the survey as widely available as possible, residents also could request a survey by calling SMC or CCCHC.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. The survey period ran from December 1, 2021 to December 15, 2021. There were no completed paper surveys returned.

Area residents also were given the option of completing an online version of the survey. To promote awareness of the assessment process and the survey, advertisements were printed in three newspapers in the communities of Center, Hazen, and Beulah. Additionally, information was published and distributed by local area Chambers of Commerce to their membership via email. Local health providers also published information on their social media pages and websites. Four hundred fifty-six online surveys were completed. Nineteen of those online respondents used the QR code to complete the survey. In total, the 456 community member surveys were completed, equating to a 11% response rate. This response rate is just slightly under par for this type of unsolicited survey methodology and indicates a somewhat 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 were collected from a variety of sources, including the United States 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); 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); and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

Social Determinants of Health

Social determinants of health are, according to the World Health Organization, "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 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.

There are numerous models that depict the social determinants of health. While the models may vary slightly in the exact percentages that they attribute to various areas, the discrepancies are often because some models have combined factors when other models have kept them as separate factors.

For Figure 3, data has been derived from the County Health Rankings model (https://www.countyhealthrankings.org/resources/county-health-rankings-model) and it illustrates that healthcare, while vitally important, plays only one small role (approximately 20%) in the overall health of individuals and ultimately of a community. Physical environment, social and economic factors, and health behaviors play a much larger part (80%) in impacting health outcomes. Therefore, as needs or concerns were raised through this Community Health Needs Assessment process, it was imperative to keep in mind how they impact the health of the community and what solutions can be implemented.

Figure 3: Social Determinants of Health

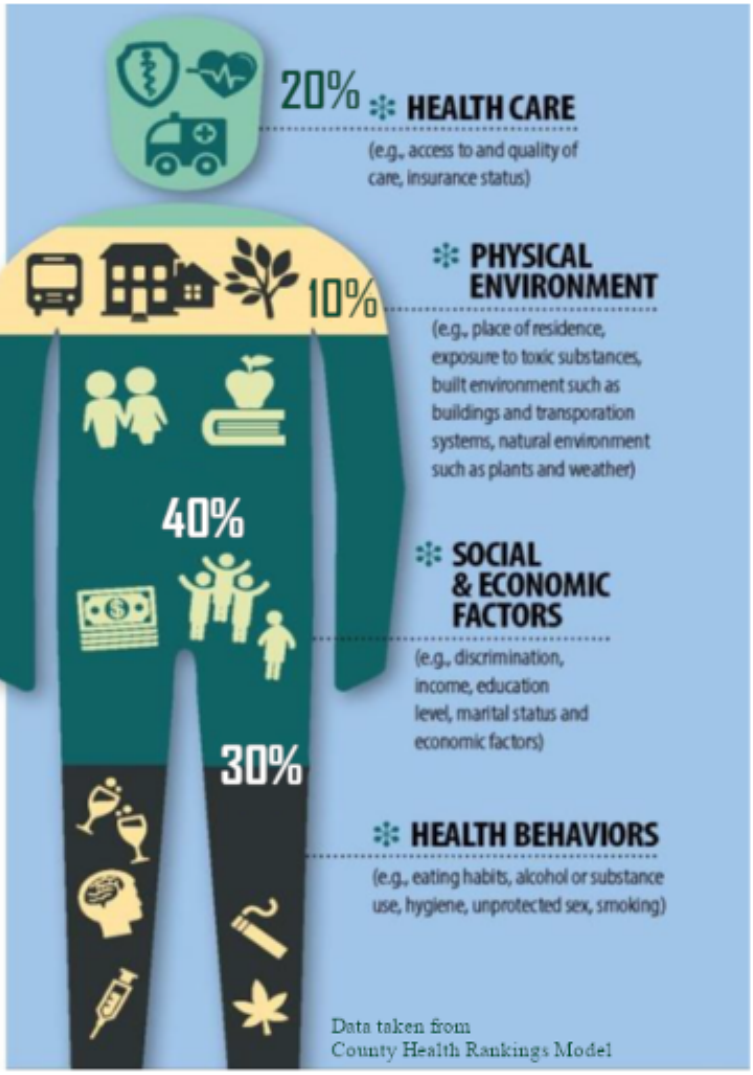


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
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Health Equity and COVID-19 Assessments for Mercer and Oliver Counties

The COVID-19 pandemic has brought social and racial injustice and inequity to the forefront of public health. It has highlighted that health equity is still not a reality, as COVID-19 has unequally affected many minority groups, putting them more at risk of getting sick and dying from COVID-19. Many factors, such as poverty and healthcare access, are intertwined and have a significant influence on the people's health and quality-of-life. "Essential workers" are those who conduct a range of operations and services in industries that are essential to ensure the continuity of critical functions in the U.S., from keeping us safe, to ensuring food is available at markets , and to taking care of the sick. A majority of these workers belong to and live within communities disproportionately affected by COVID-19. Essential workers are inherently at higher risk of being exposed to COVID-19 due to the nature of their work, and they are disproportionately representative of racial and ethnic minority groups.

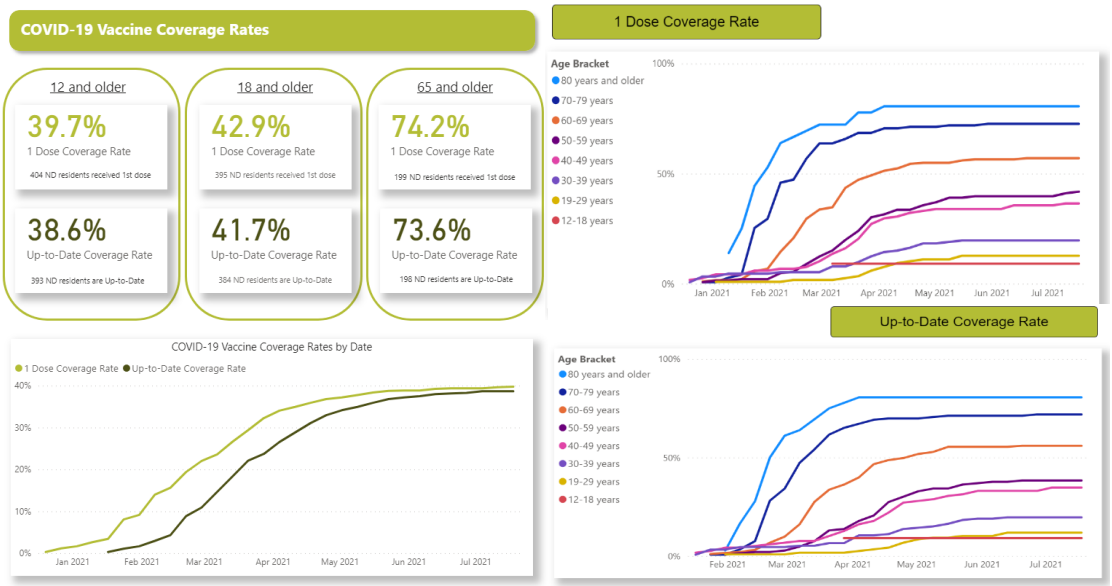
On July 6, 2021, a focus group was held via Zoom to assess the COVID-19 perceptions and immunization needs of Oliver and Mercer Counties. Four focus groups were planned, but one was cancelled due to poor attendance. The focus groups were organized by Custer Health and facilitated by CRH at the UNDSMHS. This report contains the findings from the focus groups as well as secondary data, related to demographics, COVID-19, and immunization rates.

The COVID-19 vaccine data dashboard is administered by the North Dakota Department of Health (NDDOH) and provides daily vaccine doses administered and weekly vaccine coverage rates for North Dakota. Dashboard data is based on COVID-19 vaccine doses reported to the North Dakota Immunization Information System (NDIIS). North Dakota immunization providers who are not receiving COVID-19 vaccine allocations through the North Dakota Department of Health Division of Immunizations, including Indian Health Services (IHS), Veteran's Affairs, and Department of Defense facilities, may not be entering COVID-19 vaccine information into the NDIIS, and their doses administered will not be accounted for in this data.

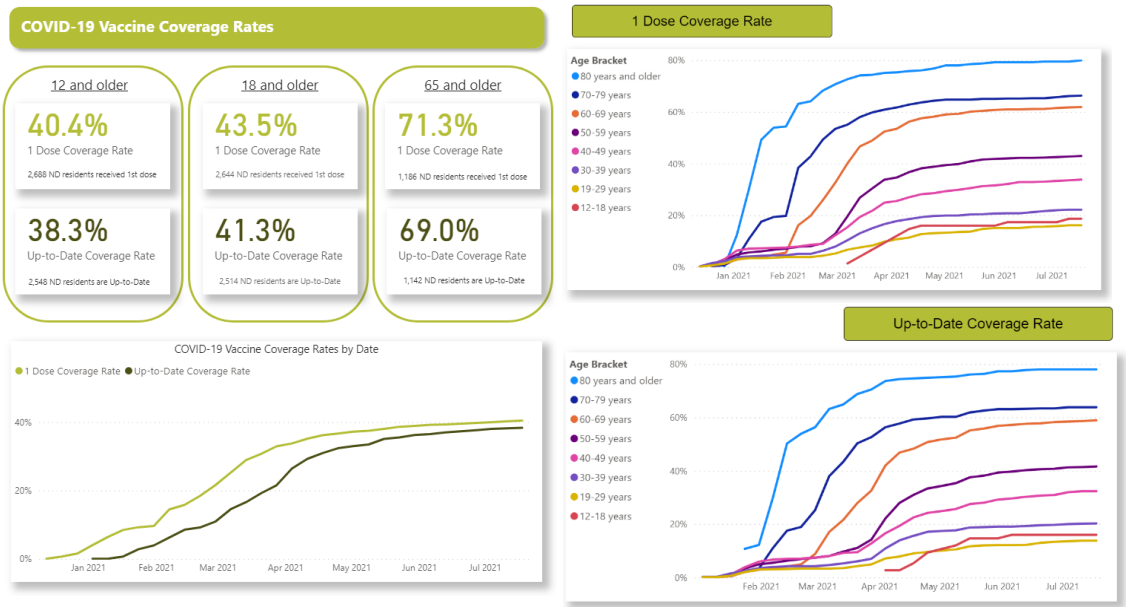
County-level doses administered, and coverage rate data are based on the vaccine recipient's county of residence, not the location of the administering provider site.

As of July 22, 2021, in North Dakota, 638,503 doses of the COVID-19 vaccine have been administered. In Oliver County, 751 doses were administered, and 4,960 doses were administered in Mercer County. Statewide, the one dose coverage rate is 48.7%, and 45.8% were fully immunized. See Figure 2 for the Sioux, Grant, Morton, Oliver, and Mercer Counties breakdown by age of one dose coverage and fully vaccinated (up-to-date coverage). As of July 22, 2021, Oliver County has a 38.6% up-to-date coverage rate, and Mercer County has a 38.3% up-to-date coverage rate.

Oliver County



Mercer County



In July 2021, there were five COVID-19 vaccine-enrolled provider sites in Mercer County, one in Oliver County, two in Dunn County, and 419, total, in North Dakota.

Immunization Rates for the Custer Health Service Area

The following chart (Figure 3) depicts immunization rates for Sioux, Grant, Morton, Oliver, and Mercer County during the 2021 first quarter for children, ages 19-35 months by the last day of the quarter who are up-to-date with the selected vaccine by the end of the quarter.

Figure 3. Percent of Oliver and Mercer County Children 19-35 Months of Age for 2021 Q1[3]

Vaccine	Oliver County Rate (%)	Mercer County Rate (%)
4:3:1:3:3:1:4 Series	60.00	66.14
DTap	60.00	70.08
Hepatitis A	60.00	62.20
Hepatitis B	66.67	88.19
Hib UTD	60.00	74.80
MMR	66.67	84.25
PCV	63.33	73.23
Polio	66.67	85.04
Varicella	66.67	82.68

The following chart (Figure 4) depicts immunization rates for Sioux, Grant, Morton, Oliver, and Mercer County during the 2021 first quarter, for Sioux, Grant, Morton, Oliver, and Mercer County teens, ages 13-17 years by the last day of the quarter who received the specified number of doses of the selected vaccine by the end of the quarter.

Figure 4. Percent of Oliver and Mercer County Teens 13-17 Years of Age for 2021 Q1[3]

Vaccine	Oliver County Rate (%)	Mercer County Rate (%)	ND Average
HPV Female Start	69.44	69.46	74.56
HPV Female UTD	58.33	60.25	62.29
HPV Male Start	59.57	66.01	72.63
HPV Male UTD	42.55	52.57	58.90
MCV4 dose 1	91.67	90.16	88.60
MCV4 dose 2	51.52	68.78	60.65
Men B dose 1	30.30	3.41	46.29
Men B UTD	12.12	1.46	19.65
Td/Tdap	91.67	93.57	88.77
Varicella	92.86	91.97	89.61

The following chart (Figure 5) depicts immunization rates for Oliver and Mercer County during the 2021 first quarter for adults, 19 years of age and older who received the specified number of doses of the selected vaccine by the end of the quarter.

Figure 5. Percent of Oliver and Mercer County Adults 19 Years of Age and Older for 2021 Q1[3]

Vaccine	Oliver County Rate (%)	Mercer County Rate (%)	ND Average
PCV13 after 65 years	65.26	63.63	59.97
PPSV23 after 65 years	55.44	59.09	52.95
Shingrix® dose 1 after 50 years	33.78	29.38	29.38
Shingrix® UTD after 50 years	27.48	23.34	22.77
Tdap after 19 years	75.27	80.62	70.76
Zostavax after 60 years	34.46	30.04	34.41
Men B dose 1	30.30	3.41	46.29
Men B UTD	12.12	1.46	19.65
Td/Tdap	91.67	93.57	88.77
Varicella	92.86	91.97	89.61

Focus Group Discussion for Oliver and Mercer County

Focus groups were held virtually on July 6, 2021, to assess the COVID-19 perceptions and immunization needs of the Custer Health service area of Oliver and Mercer Counties. Custer Health invited members of the community with varying backgrounds and opinions to join in the focus group that was facilitated by CRH at the UNDSMHS. Responses were also collected via online survey for those who could not make it to the meetings.

Present at the meetings were representatives from local public health, the North Dakota State University (NDSU) extension, faith community, child daycare organizations, local colleges, various city employees, healthcare volunteers, local school districts, ambulance services, healthcare employees, behavioral health professionals, and members of the tribal community.

Effects of COVID-19 and the Introduction of the COVID-19 Vaccine on the Community

COVID-19 affected many people in the community, even those who thought it was "all made up." There were quite a few COVID-19-related deaths, and that fact hits everybody hard in small communities. Some community members felt the vaccine was actually well-received by the community. There are quite a few

people that do not even get flu vaccines, so it was assumed they would not be interested in COVID-19 vaccines; however, they did get the COVID-19 vaccine.

When the COVID-19 vaccine was first rolled out, the older generation was on board and wanted to get on the recipient list, but it seemed from the start, people had already made up their minds as to whether or not they wanted to get vaccinated. Some minds were changed, but for the most part people fell into the two separate sides – wanting the vaccine or not wanting the vaccine. Community members noted that the vaccine created some division within healthcare staff, and the division between those who are vaccinated and those who are not still exists to this day.

Initially, many people who wanted the vaccine were frustrated about waiting for it because of the tiered roll out, and the more they were waiting, the more information came out about side effects; it caused people to change their minds and become more hesitant. If the vaccine had been available to the general public earlier, community members feel that more people would have taken it.

Reasons People in the Community Want to be Vaccinated

Community members want to be vaccinated because of incentives; some employers have been giving cash bonuses to vaccinated employees. People also get vaccinated due to travel requirements - vaccination requirements for leaving the country. People also want to protect their families. If families have high-risk individuals, they want to get vaccinated, so they can see those individuals, not worry about COVID-19, and to prevent or decrease the chances of disease. Another big determinant in vaccination will be what's required for school sports and other events. Quarantine requirements may influence whether people want to get the vaccine or not. Young people likely will only get vaccinated if they need it to get into places.

Reasons People in the Community Do Not Want to be Vaccinated

People in the community do not want to be vaccinated because they are concerned about the safety of the vaccine and think it was made too quickly. People in the community also may not regularly go to the clinic and do not get vaccinated for anything and won't get the COVID-19 vaccine either. Some community members have heard that a person can get sick from the vaccine and don't have time to be sick, although they noted that they'll get the vaccine eventually.

Community members expressed that politics played a big role in the vaccine roll out. The community hears much conflicting information from social media and the news. People also don't understand why they need to be vaccinated if they've already had COVID-19. Conspiracy theories, such as the government trying to poison the public and fear of tracking devices in the vaccine, are also prominent.

Sources of COVID-19 Information

COVID-19 information is primarily found on social media. Some of the local providers have made a video as a source of trusted information. Community members feel that the community has lost much of its trust in the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) because information has been changing so rapidly. Other people do still get information from the CDC or NDDOH. There have been some webinars from NDSU on the subject.

Barriers to Receiving the COVID-19 Vaccination

Community members noted that there was some issue with COVID-19 vaccine scheduling in the community. There have been extended hours clinics and NDDOH pop-up clinics at events, but some people still have gone outside of the community for vaccines because there was more scheduling flexibility. There have also been vaccine clinics on the reservations. Work schedules have been a big barrier, especially with oil companies, as companies are shorthanded, and workers can't get time off to get the vaccine. There often aren't clinics offering extended hours in rural areas. Community transportation is available, and local public health will come to people's homes if they are homebound.

Ways to Increase Confidence and Vaccination Rates

At some companies, employees no longer need to wear a mask or be in full PPE if they've been vaccinated. There were many challenges with public health, working with local healthcare providers – such as they couldn't give each other's vaccine doses. Local public health units have limited resources but couldn't help each other out because of reimbursement or compliance issues. Community members pointed out that NDDOH should travel out to community events with the ice cream trucks, so they could offer free ice cream for vaccines. By comparison, IHS made the vaccine very accessible by frequently posting about vaccine clinics online, doing clinics on weekends, and much publicity was by word of mouth. One community member noted that in other states, they have had COVID-19 vaccination trailers set up on the side of the road and do "drive-through" vaccinations. More education is key; educating the community about the efficacy of the vaccine and showing real-time data may help.

The vaccination vans that NDDOH sends are often not well-communicated with the public. The van isn't well-publicized, and the public doesn't know what it is doing there. Efforts are sometimes duplicated when the van shows up, and local services are already offering vaccines that day. Local public health has been trying to give feedback and let them know how things work in small towns.

Focus Group Discussion for Dunn County

Southwestern District Health Unity (SWDHU) conducted meetings to determine the COVID-19 perceptions and immunization needs of Stark, Adams, Billings, Bowman, Golden Valley, Hettinger, Slope, and Dunn Counties.

When the COVID-19 vaccine became available at the end of December 2020, the partners worked diligently together to get the vaccine out to the priority groups. SWDHU helped coordinate with providers to make sure the limited vaccine doses were available throughout the region.

The groups had similar findings with just a few variances. The group members were very calm, informed, and engaged in the discussion. Below are the findings to the questions:

Concerns that were heard, regarding COVID-19 vaccine

- Want to have children – worried causes infertility
- It was made too fast/not enough safety measures
- Worried will have long-term side effects from the vaccine
- It causes myocarditis
- New way of making the vaccine not done before
- Bad side effects
- Tribal thinking – "remember smallpox"

Misinformation about COVID-19 vaccine

- You can get COVID from the vaccine
- It changes your DNA
- Implanting a chip to track you
- I had COVID; I don't need the shot
- Don't need it – government ploy
- A+ blood type – can't get COVID

- Too many heavy metals in vaccine – magnets can stick to your arm
- No one really died from COVID – just from underlying conditions

Why did people want to get vaccinated?

- Tired of isolation and tired of masks
- Loved one died from COVID or seriously ill from it
- Want life to be "normal"
- Want to travel
- Know "long-haulers"
- Want to see family
- Get away from lockdown
- Be a good example to my community

Why are people against the COVID-19 vaccine?

- Politics trumped science
- "You are vaccinated, so I don't need to"
- It was made too fast and not studied enough
- Better to have natural immunity
- Young can fight it off – no need to vaccinate
- Against all vaccines
- Too bad of side effects
- Want children
- Don't want to be ostracized by community or family – politically
- COVID has a 99.98% survival rate – doesn't make you that sick

Current Strategies

To date, 13,364 doses of COVID-19 have been given throughout the eight-county region. (See Attachment B)

Current strategies that have been implemented to have worked well to date:

- The southwest region has worked well together throughout the process – initially referring clients to each other to make sure all doses were used. Later as vaccine became available, the providers worked together to stagger clinic days, so more days were available. Providers also made sure to refer to clinics that had certain vaccine available. They also worked together to make sure various locations were available and covered, such as the university or Wal-Mart
- SWDHU worked very closely with county emergency managers and leaders to set up rotating clinics throughout the eight counties. Emergency Managers helped get various locations and supported the various clinics. The providers took the guidance and lead from what their communities wished and made vaccines available
- SWDHU worked with Public Transit to provide free rides to any vaccine clinics. Providers also worked together to offer vaccinations to any home-bound person wanting a dose

- Utilizing all avenues of media to get the word out about the various clinics was also a tool used. It was found, though, the large COVID-19 listserv group was a good source of getting information out as well as advertising on the radio stations every week
- Some of the minority populations were reached through their employers or through word of mouth. SWDHU was a great avenue for many of the minority groups, as no insurance was needed. Having handouts in Spanish and a translator system in place did help tremendously
- Having consistent clinics that communities knew to expect also did help, as people knew of dates and times. Allowing for a variety of times also was beneficial
- Working with each school in the region in May to see if they wanted a vaccine clinic in their school, in their specific town, or using current clinics, but being the messenger also worked well as it gave them the power to decide
- Staff called businesses multiple times, offering SWDHU to vaccinate at their business or informing them of clinics. Many agencies were receptive – if they were not pressured
- SWDHU worked with all LTC agencies that didn't have a provider and was able to get all the residents/staff vaccinated – returning several times
- Setting up a walk-in/no appointment system helped increase the number of vaccinations, especially with those who didn't have computer access
- Having the National Guard and many staff trained on the PrepMod system helped when there were many people waiting for vaccine. It helped speed up registration
- Medical providers continue to educate and encourage vaccinations with visits

Barriers

Even though the vaccine has been made available throughout the region, there continues to be vaccine hesitancy among many and in many areas of the southwest. Some identified barriers are as follows:

- Social perception – being seen going to "get a COVID" vaccine is perceived as giving in to the system
- With everything opening up, and lower cases – perception is that the pandemic is over
- Especially summer in ND – last thing on people's minds is getting a COVID shot
- Our biggest barrier is that people in the region are against anything related to COVID, so whether it is testing, masking, or vaccinating, they do not want to hear about it. Politics has overridden science

Next Steps

Discussion suggested that it may, unfortunately, just take time for people to trust taking the vaccine – such as full FDA approval. Others suggest some may never sway for getting vaccinated due to strong political/family or religious beliefs. With that population, just continuing to promote the clinics via the various media outlets and continuing to educate may be the only thing that can be continued.

Demographic Information

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

	Dunn County	Mercer County	Oliver County	North Dakota
Population (2020)	4,095	8,350	1,877	762,062
Population change (2010-2020)	+15.8%	-0.88%	+1.65%	13.3%
People per square mile (2010)	1.8	8.1	2.6	9.7
Persons age 65 or older (2019)	16.1%	20.1%	22.7%	15.7%
Persons younger than age 18 (2019)	25.1%	23.2%	25.3%	23.6%
Median age (2019 est.)	39	44	42	35.1
White persons (2019)	80.2%	94.2%	95.2%	86.9%
High school graduates (2019)	91.1%	91.4%	93.1%	92.6%
Bachelor's degree or higher (2019)	21.3%	21.7%	21.1%	30.0%
Live below poverty line (2019)	10.0%	8.0%	10.7%	10.6%
Persons without health insurance, younger than age 65 (2019)	11.5%	5.1%	7.8%	8.1%
Households with a broadband internet subscription (2019)	80.7%	83.6%	77.1%	80.7%

Source: https://www.census.gov/quickfacts/fact/table/ND,US/INC910216#viewtop and https://data.census.gov/cedsci/profile?g=0400000US38&q=North%20Dakota

While the population of North Dakota has grown in recent years, the U.S. Census Bureau estimates show Mercer County has seen a slight decrease from 8,424 (2010) to 8,350 (2020), and Oliver County has seen a small increase from 1,846 (2010) to 1,877 (2020). However, Dunn County has seen an increase of 15% from 3,536 (2010) to 4,095 (2020).

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 2021 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 counties 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 2021 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix D. For further information, visit the www.countyhealthrankings.org.

Health Outcomes

- Length of life
- Quality of life

Health Factors

- Health behavior
  - Smoking
  - Diet and exercise
  - Alcohol and drug use
  - Sexual activity

Health Factors (continued)

- Clinical care
  - Access to care
  - Quality of care
- Social and Economic Factors
  - Education
  - Employment
  - Income
  - Family and social support
  - Community safety
- Physical Environment
  - Air and water quality
  - Housing and transit

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 Custer Health and Sakakawea Medical Center (SMC) and Coal Country Community Health Center (CCCHC) 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 2021. 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, Mercer, and Oliver Counties' rankings within the state are included in the summary following. For example, Dunn County ranks 15 out of 49 ranked counties in North Dakota on health outcomes and Mercer County ranks 4th. Dunn County ranks 33 and Mercer County 15 out of 45 ranked counties in North Dakota on health factors. There is no rank for Oliver County on either measure. The measures, marked 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 not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape 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 show that Dunn, Mercer, and Oliver Counties, similar to many North Dakota counties, are doing poorly in many areas, when it comes to the U.S. Top 10% rankings and the rest of the state. One particular outcome where Dunn, Mercer, and Oliver Counties do not meet the U.S. Top 10% ratings is alcohol-impaired driving 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 is doing better than North Dakota in health outcomes and factors for the following indicators:

- Low birth weight
- Poor mental health days (in past 30 days)
- Sexually transmitted infections
- Preventable hospital stays
- Unemployment
- Children in single-parent households
- Violent crime
- Air pollution – particulate matter
- Severe housing problems

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

- Poor physical health days (in past 30 days)
- Poor mental health days (in past 30 days)
- Low birth weight
- Sexually transmitted infections
- Teen birth rate
- Uninsured
- Preventable hospital stays
- Children in poverty
- Income inequality
- Children in single-parent households
- Social associations
- Violent crime
- Air pollution – particulate matter
- Severe housing problems

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

- Poor mental health days (in past 30 days)
- Adulty obesity
- Uninsured
- Preventable hospital stays
- Mammography screening
- Violent crime
- Air pollution – particulate matter
- Severe housing problems

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

- Premature death
- Poor or fair health
- Adult smoking
- Adult obesity
- Uninsured
- Flu vaccinations
- Alcohol-impaired driving deaths
- Teen births
- Income inequality
- Social associations
- Access to exercise opportunities
- Excessive drinking
- High school completion rate
- Children in poverty
- Food environment index
- Mammography screening
- Injury deaths
- Drinking water violations

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

- Adult obesity
- Food environment index
- Excessive drinking
- Alcohol-impaired driving deaths
- Primary care physicians, dentists, and mental health providers
- Injury deaths
- Flu vaccinations
- Unemployment

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

- Poor or fair health
- Poor physical health days (in past 30 days)
- Food environment index (10=best)
- Physical inactivity
- Access to exercise opportunities
- Primary care physicians and dentists
- Flu vaccinations
- Unemployment
- Children in poverty
- Children in single-parent households
- Social associations

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021 – DUNN, MERCER, AND OLIVER COUNTIES

● = 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

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2021 – DUNN, MERCER, AND OLIVER COUNTIES					
	Dunn County	**Mercer County**	**Oliver County**	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**15th**	**4th**	**No rank**		**(of 49)**
Premature death	8,200 ●■	5,500 ■		5,400	6,600
Poor or fair health	15% ●■	14% +	15% ●■	14%	14%
Poor physical health days (in past 30 days)	3.4 +●	3.2 +	3.4 +●	3.4	3.2
Poor mental health days (in past 30 days)	3.5 +	3.6 +	3.6 +	3.8	3.8
Low birth weight	5% +	6% +		6%	6%
Ranking: Factors	**33rd**	**15th**	**No rank**		**(of 45)**
Health Behaviors					
Adult smoking	21% ●■	19% ■	20% ■	16%	20%
Adult obesity	38% ●■	36% ●■	31% ■	26%	34%
Food environment index (10=best)	8.6 ●■	9.5 +	8.0 ●■	8.7	8.9
Physical inactivity	23% ■	23% ■	31% ●■	19%	23%
Access to exercise opportunities	37% ●■	77% ■	40% ●■	91%	74%
Excessive drinking	25% ●■	27% ●■	24% ■	15%	24%
Alcohol-impaired driving deaths	42% ■	57% ●■	75% ●■	11%	42%
Sexually transmitted infections	186.5 ■	129.9 +		161.2	466.6
Teen birth rate	21 ●■	18 ■		12	20
Clinical Care					
Uninsured	14% ●■	6% +	7% ■	6%	8%
Primary care physicians		1,380:1 ●■	1,950:0 ●■	1,030:1	1,300:1
Dentists		1,170:1 ●■	1,960:1 ●■	1,210:1	1,510:1
Mental health providers		2,050:1 ●■		270:1	510:1
Preventable hospital stays	3,735 ■	3,085 ■	7,921	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	50% ●■	54% +	67% +	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	27% ●■	22% ●■	35% ●■	55%	50%
Social and Economic Factors					
Unemployment	1.6% +	4.2% ●■	3.7% ●■	2.6%	2.4%
Children in poverty	12% ●■	8% +	17% ●■	10%	11%
Income inequality	4.6 ●■	4.0 ■	4.2 ■	3.7	4.4
Children in single-parent households	15% ■	11% +	27% ●■	14%	20%
Social associations	9.2 ●■	21.8 +	15.4 ●■	18.2	16.0
Violent crime	186 ■	126 ■	54 +	63	258
Injury deaths	100 ●■	80 ●■		59	71
Physical Environment					
Air pollution – particulate matter	4.4 +	2.2 +	3.2 +	5.2	4.7
Drinking water violations	Yes	No	No		
Severe housing problems	8% +	7% +	9% +	9%	12%

Source: http://www.countyhealthrankings.org/app/north-dakota/2021/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 are from 2018-19. More information about the survey may be 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 ages 0-17 unless noted otherwise), 2019

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.9%	11.2%
Children 10-17 overweight or obese	26.9%	32.1%
Children 0-5 who were ever breastfed	86.1%	80.8%
Children 6-17 who missed 11 or more days of school	2.9%	3.9%
Healthcare		
Children currently insured	93.6%	93.1%
Children who spent less than 10 minutes with the provider at a preventive medical visit	16.0%	18.1%
Children (1-17 years) who had preventive a dental visit in the past year	73.7%	77.5%
Children (3-17 years) received mental healthcare	10.5%	11.0%
Children (3-17 years) with problems requiring treatment did not receive mental healthcare	2.3%	2.5%
Young children (9-35 mos.) receiving standardized screening for developmental problems	31.1%	36.9%
Family Life		
Children whose families eat meals together 4 or more times per week	79.2%	75.2%
Children who live in households where someone smokes	16.1%	14.0%
Neighborhood		
Children who live in neighborhood with a park, sidewalks, a library, and a community center	81.1%	74.9%
Children living in neighborhoods with poorly kept or rundown housing	9.1%	13.3%
Children living in neighborhood that's usually or always safe	97.3%	94.6%

Source: https://www.childhealthdata.org/browse/survey

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:

- Children (1-17 years) who had a preventative dental visit in the past year
- Young children (9-35 mos.) receiving standardized screening for developmental problems
- Children who live in households where someone smokes

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 Dunn, and Oliver County is performing more poorly than the North Dakota average for 4-year high school graduation rate. Dunn County's victims of child abuse and neglect requiring services was considerably higher than the North Dakota average. Mercer County child food insecurity is higher than the North Dakota average as well.

Table 4: Selected County-Level Measures Regarding children's Health

	Dunn County	Oliver County	Mercer County	North Dakota
Child food insecurity, 2019	6.5%	4.6%	**10.4%**	9.6%
Medicaid recipient (% of population age 0-20), 2019	24.6%	NA	NA	26.0%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2020	1.0%	NA	NA	1.7%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	12.6%	NA	NA	17.0%
Licensed childcare capacity (# of children), 2020	53	42	278	37,701
4-year high school cohort graduation rate, 2019/2020	**86.1%**	**≥80%**	93.2%	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2019	**27.51**	NA	NA	9.98

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 and 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 2015, 2017, and 2019. They are further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2017 to 2019, and "↓" for a decreased trend in the data changes from 2017 to 2019. The final column shows the 2019 national average percentage. For a more complete listing of the YRBS data, see Appendix E.

TABLE 5: Youth Risk Behavior Survey Results

North Dakota High School Survey
Rate Increase ↑, rate decrease ↓, or no statistical change = in rate from 2017-2019.

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Injury and Violence							
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
% 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)	17.7	16.5	14.2	=	17.7	12.7	16.7
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	NA	56.2	59.6	=	60.7	60.7	NA
% of students who texted or e-mailed while driving a car or other vehicle (on at least one day during the 30 days before the survey)	57.6	52.6	53.0	=	56.5	51.8	39.0
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
% of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
% of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
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 one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	NA	18.1	12.2	**NA**	15.1	10.9	10.5
% of students who currently were binge drinking (four or more drinks for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7
% of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Weight Management, Dietary Behaviors, and Physical Activity							
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	14.7	16.1	16.5	=	16.6	15.6	16.1
% of students who had obesity (>= 95th percentile for body mass index)	13.9	14.9	14.0	=	17.4	14.0	15.5
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9

% 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 seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
% of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
% of students who did not eat breakfast (during the seven days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.seven
% 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)	NA	2.seven	2.8	=	2.1	2.9	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 seven days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9
% of students who watched television 3 or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
% of students who played video or computer games or used a computer three or more hours per day (for something that was not schoolwork on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
% of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
% of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
% of students who brushed their teeth on seven days (during the seven days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA

Sources: https://www.cdc.gov/healthyyouth/data/yrbs/results.htm; https://www.nd.gov/dpi/districtsschools/safety-health/youth-risk-behavior-survey

Low Income Needs

The North Dakota Community Action Agencies (CAAs), as nonprofit organizations, were originally established under the Economic Opportunity Act of 1964 to fight America's war on poverty. CAAs are required to conduct statewide needs assessments of people experiencing poverty. The most recent statewide needs assessment study of low-income people in North Dakota, sponsored by the CAAs, was performed in 2020. The needs assessment study was accomplished through the collaboration of the CAAs and North Dakota State University (NDSU) by means of several kinds of surveys (such as online or paper surveys, etc., depending on the suitability of these survey methods to different respondent groups) to low-income individuals and families across the state of North Dakota. In the study, the survey data were organized and analyzed in a statistical way to find out the priority needs of these people. The survey responses from low-income respondents were separated from the responses from non-low-income participants, which allows the research team to compare them and then identify the similarity, difference, and uniqueness of them in order to ensure the validity and accuracy of the survey study and avoid bias. Additionally, two comparison methods were used in the study, including cross-sectional and longitudinal comparisons. These methods allow the research team not only to identify the top specific needs under the seven need categories, including Employment, Income and Asset-Building, Education, Housing, Health and Social/Behavior Development, Civic Engagement, and Other Supports, through the cross-sectional comparison but also to be able to find out the top specific needs, regardless to which categories these needs belong through the longitudinal comparison.

Top Needs Identified by People Experiencing Poverty Across North Dakota

Category	Need
Housing	Rental Assistance
Income	Financial Issues
Employment	Finding a job
Health	Dental Insurance/Affordable Dental Care
Education	Cost

2020 North Dakota LOW INCOME COMMUNITY NEEDS

Helping People. Changing Lives. Community Action Partnership — America's Poverty Fighting Network

NDSU North Dakota State University

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

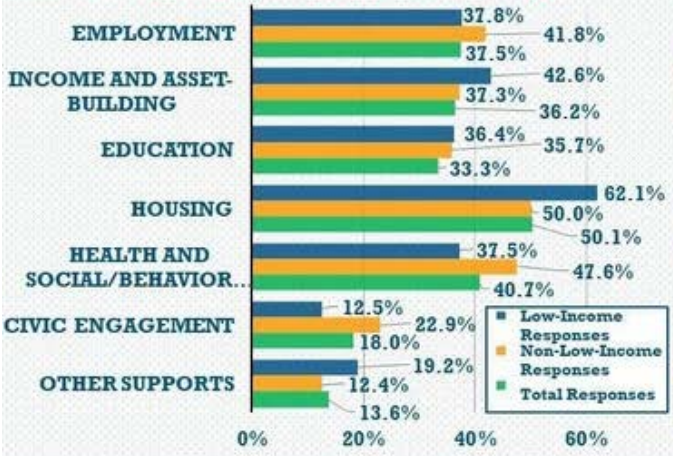
3,458 Total Survey Responses

- **1,086** Low-Incomes
- **2,084** Non- Low-Incomes
- **288** Others (roles cannot be identified)

"***Rental Assistance***" becomes the 1st priority need of people experiencing poverty across the state under the category of "***Housing***". This need, however, would represent their immediate (short-term) need, which could be partially or significantly affected by the pandemic of COVID-19.

- The 1st priority need for the non-low-income respondents is "***Mental Health Service***".
- For the community (including both low-income and non-low-income people), the 1st priority need is "***Dental Issuance/Affordable Dental***".

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

Low-Incomes

- **Housing** - Rental Assistance
- **Health and Social/Behavior Development** - Dental Insurance/Affordable Dental
- **Other Needs** - Food

Non-Low-Incomes

- **Health and Social/Behavior Development** - Mental Health Service
- **Health and Social/Behavior Development** - Health Insurance/Affordable Health Care
- **Income and Asset-Building** - Budget/Credit/Debit Counseling

Community (Low-Income & Non-Low-Income)

- **Health and Social/Behavior Development** - Dental Insurance/Affordable Dental
- **Health and Social/Behavior Development** - Health Insurance/Affordable Health Care
- **Health and Social/Behavior Development** - Mental Health Service

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

ACKNOWLEDGMENTS

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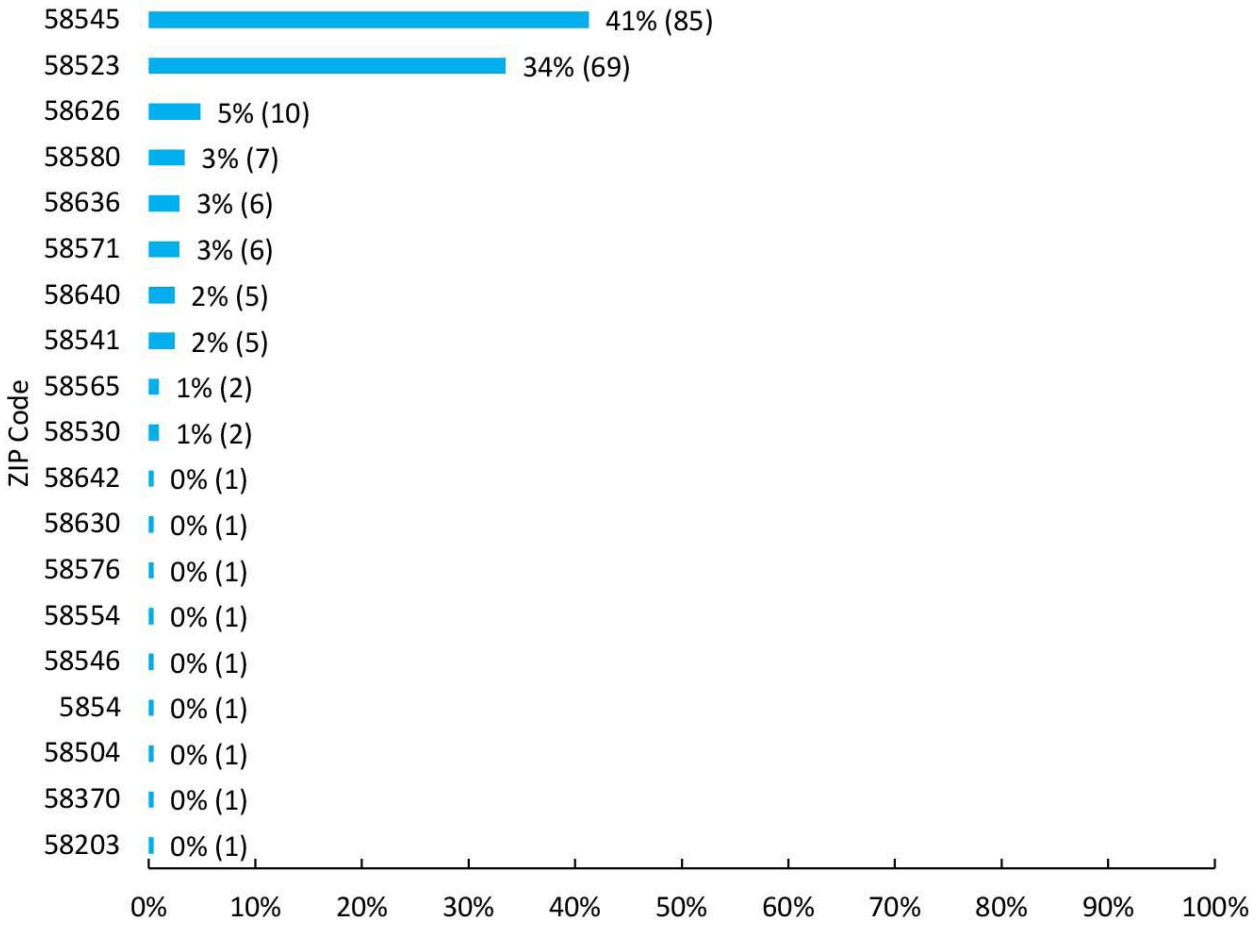
Survey Results

As noted previously, the 456 community members completed the survey in communities throughout the counties in the Sakakawea Medical Center (SMC) and Coal Country Community Health Center (CCCHC) service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question, and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response).

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 206 did, revealing that a large majority of respondents lived in Hazen (41%, N=85) and Beulah (34%, N=69). These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 206



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

Survey Demographics

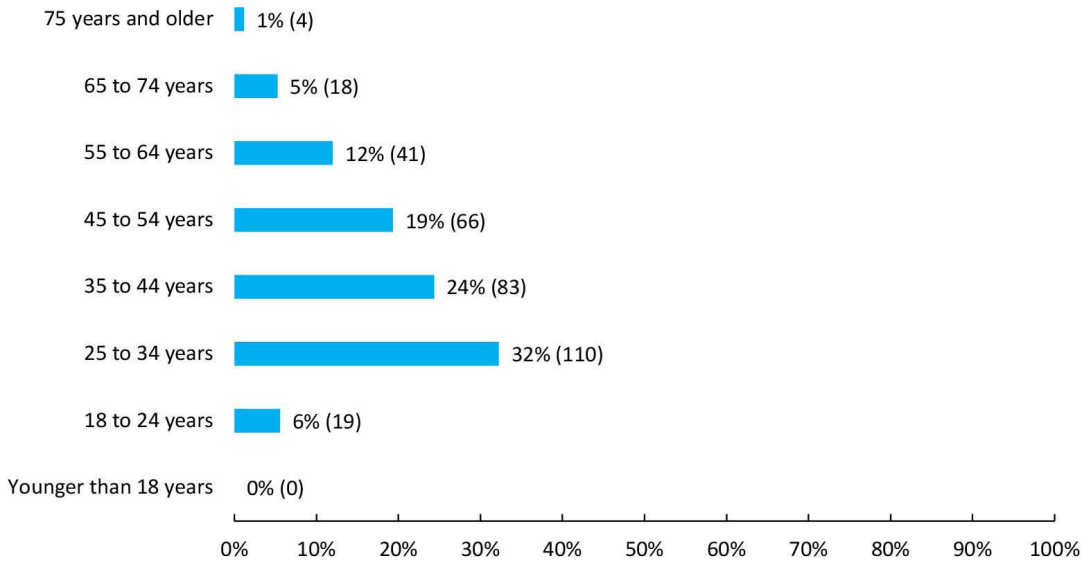
To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 32% (N=341) were age 25 to 34 years
- The majority (66%, N=340) were female
- 37% (N=340) had bachelor's degrees or higher
- The number of those working full time (71%, N=240) was about six times higher than those who were retired (8%, N=26)
- 86% (N=292) of those who reported their ethnicity/race were White/Caucasian
- 31% of the population (N=102) 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 considered 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.

Figure 6: Age Demographics of Survey Respondents
Total respondents = 341



For the CHNA, children under age 18 are not questioned, using this survey method.

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 340

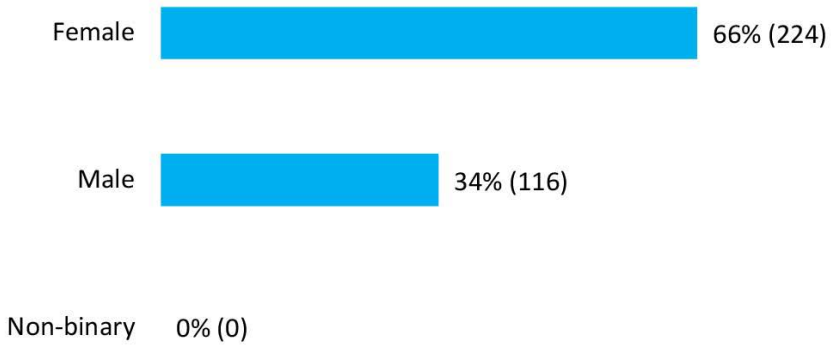


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 340

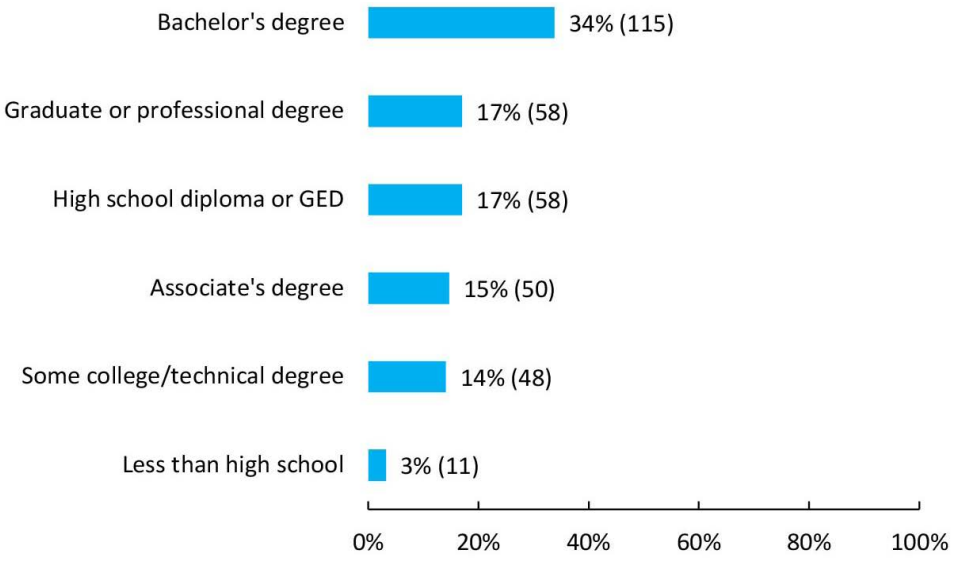
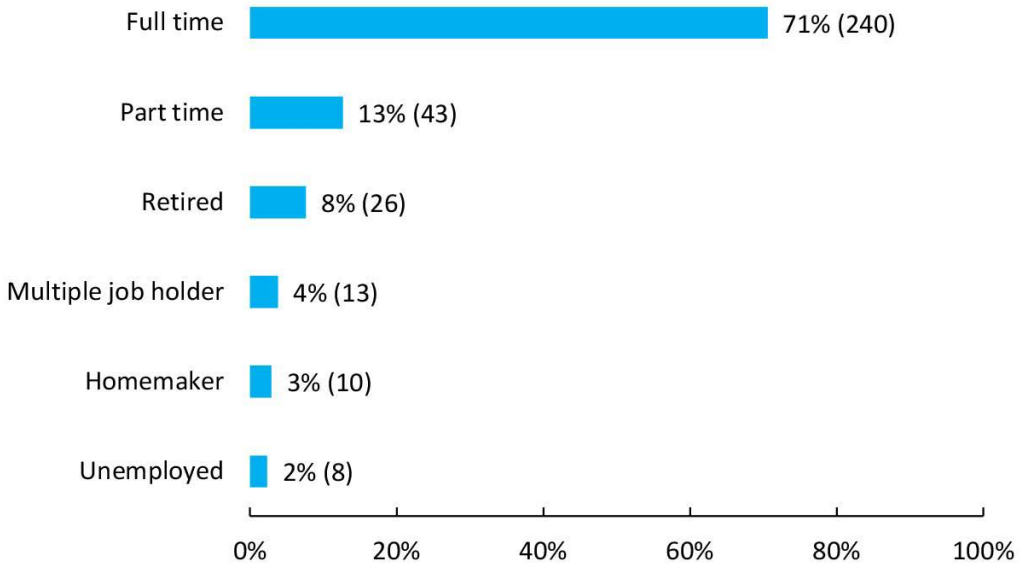
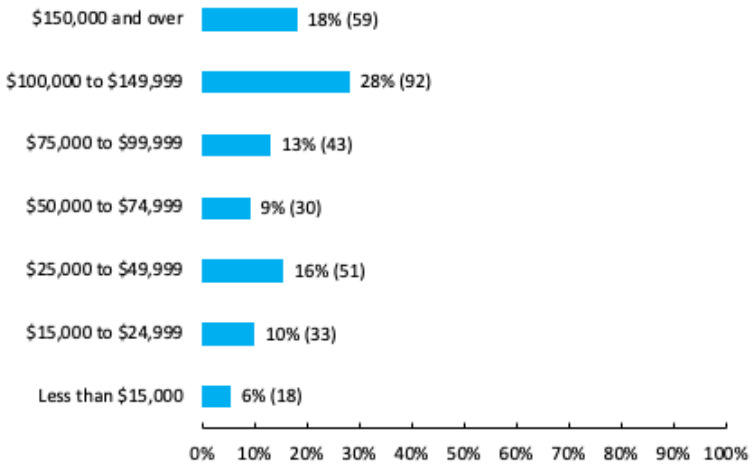


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 340



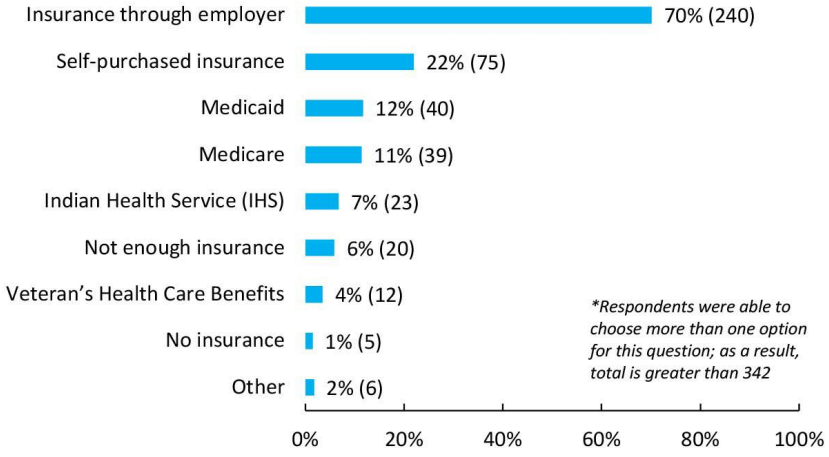
Of those who provided a household income, 10% (N=33) of the community members reported a household income of less than $25,000. Forty-six percent (N=151) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 326



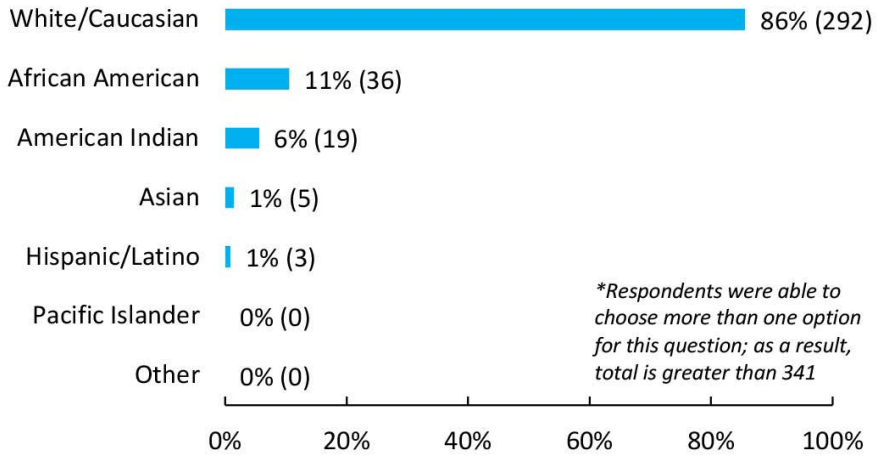
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. One percent (N=5) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=240), followed by self-purchased (N=75), and Medicare (N=39).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 342



As shown in Figure 12, nearly all of the respondents were White/Caucasian (86%). This percentage was in-line with the race/ethnicity of the overall population of Dunn, Mercer, and Oliver Counties; the U.S. Census indicates that 80.2% of the population is White in Dunn County, 92.2% in Mercer County, and 93.3% Oliver County.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 341*



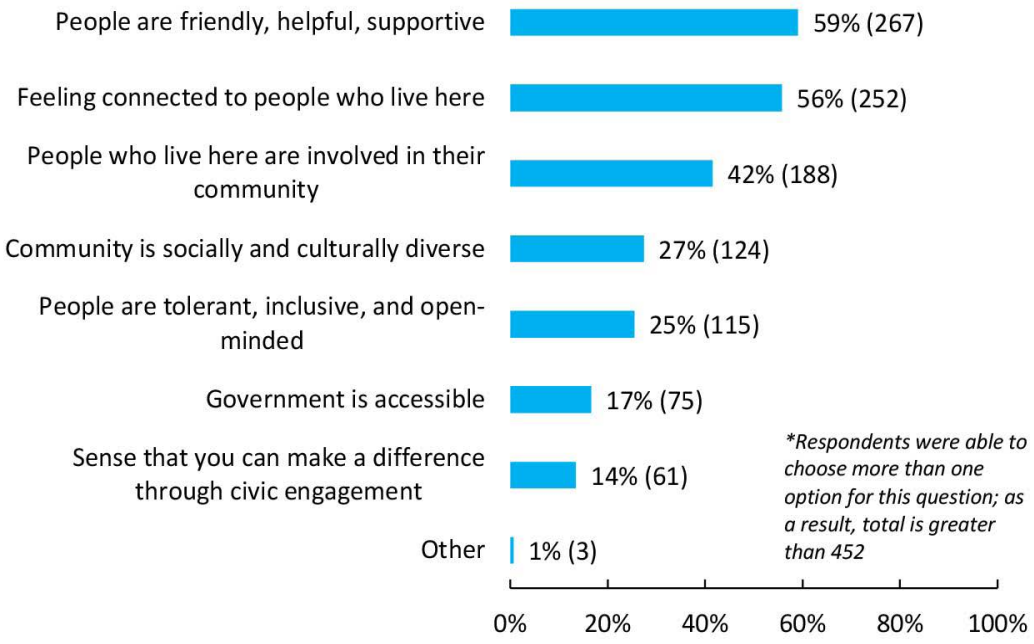
Community Assets and Challenges

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 249 respondents agreeing) that community assets include:

- Family-friendly (N=335)
- Safe place to live (N=276)
- People are friendly, helpful, supportive (N=267)
- Feeling connected to people who live here (N=252)
- Recreational and sports activities (N=249)

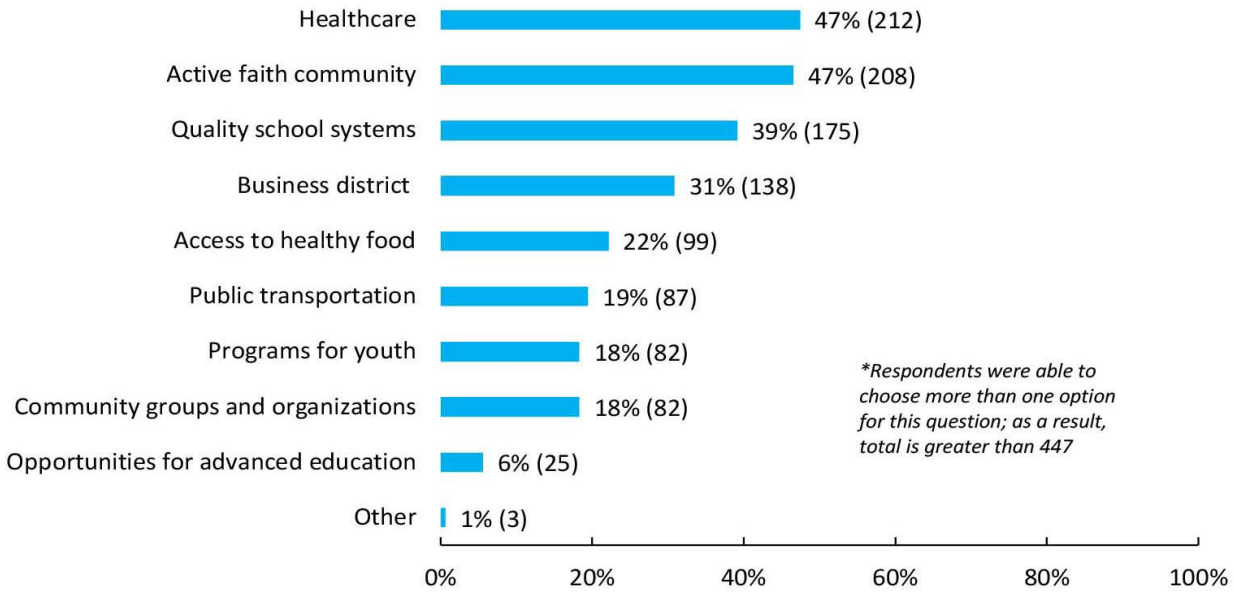
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 452*



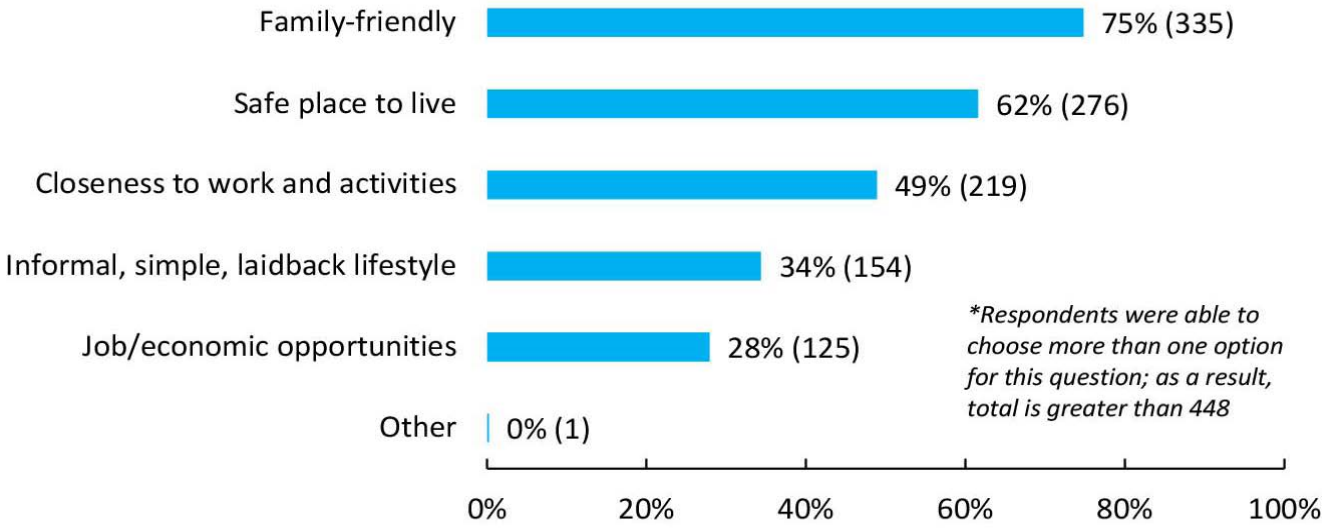
The "Other" category of the best things about the people can be found in Appendix G.

Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 447*



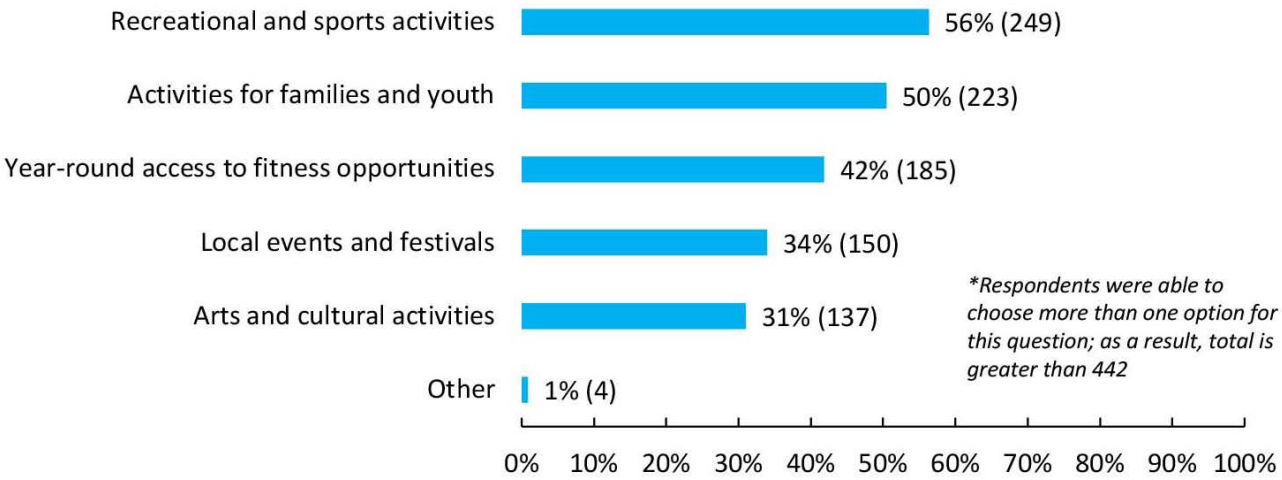
The "Other" category of the best things about the services and resources can be found in Appendix G.

Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 448*



The one "Other" response, regarding the best things about the quality of life in the community, was left blank.

Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 442*



Respondents who selected "Other" specified that the best things about the activities in the community included fishing and boating nearby and the county fair.

Community Concerns

At the heart of this CHNA 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
- Senior population

With regard to responses about community challenges, the most highly voiced concerns (those having at least 130 respondents) were:

- Attracting and retaining young families (N=173)
- Drug use and abuse – youth (N=162)
- Depression/anxiety – youth (N=152)
- Drug use and abuse – adult (N=148)
- Smoking and tobacco use – youth (N=144)
- Alcohol use and abuse – youth (N=130)

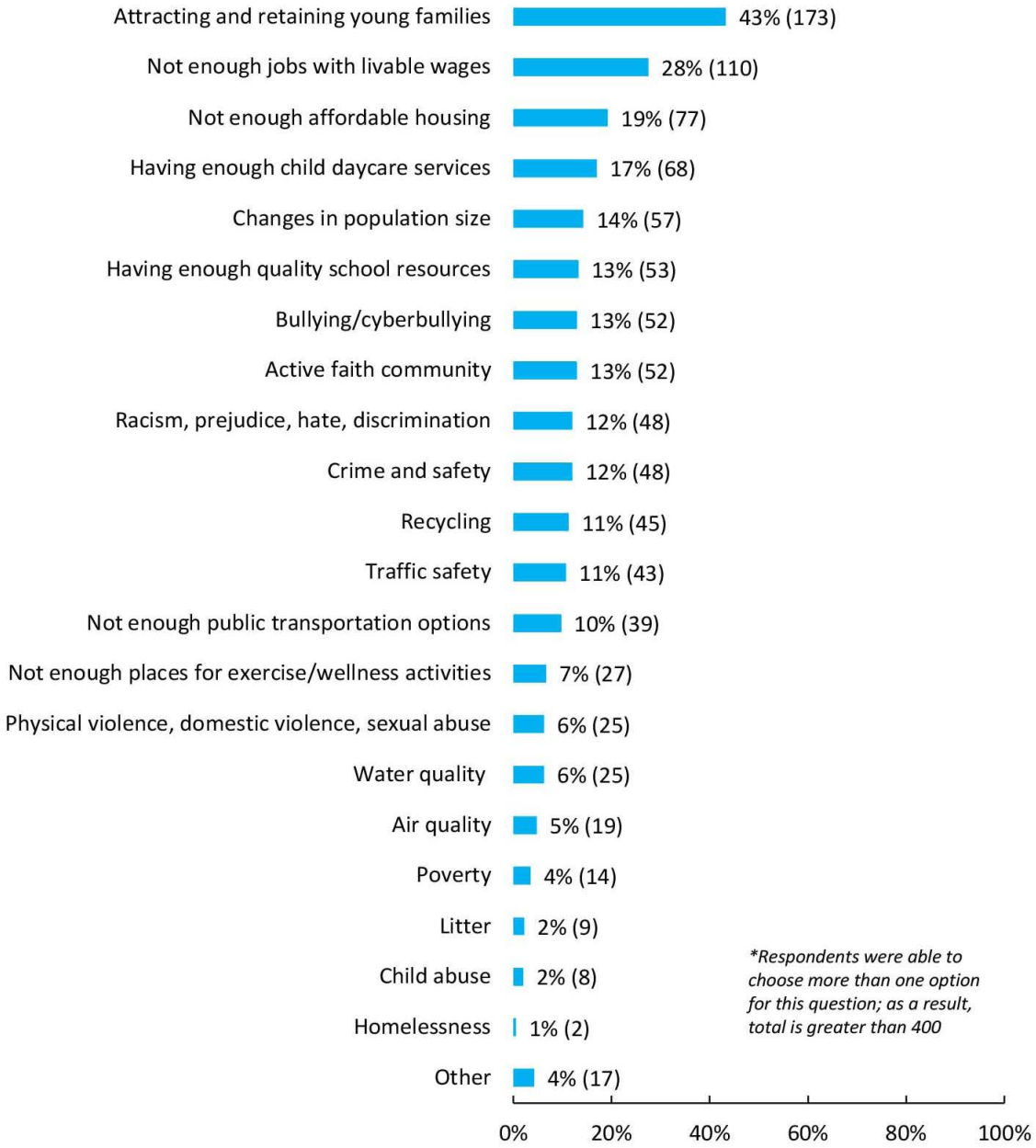
The other issues that had at least 70 votes included:

- Not enough jobs with livable wages (N=110)
- Cost of long-term/nursing home care (N=94)
- Assisted living options (N=92)
- Long-term/nursing home care options (N=90)

- Extra hours for appointments (evenings/weekends) (N=82)
- Not enough affordable housing (N=77)
- Not getting enough exercise/physical activity – adults (N=75)
- Ability to retain primary care providers in the community (N=73)
- Not getting enough exercise/physical activity – youth (N=70)

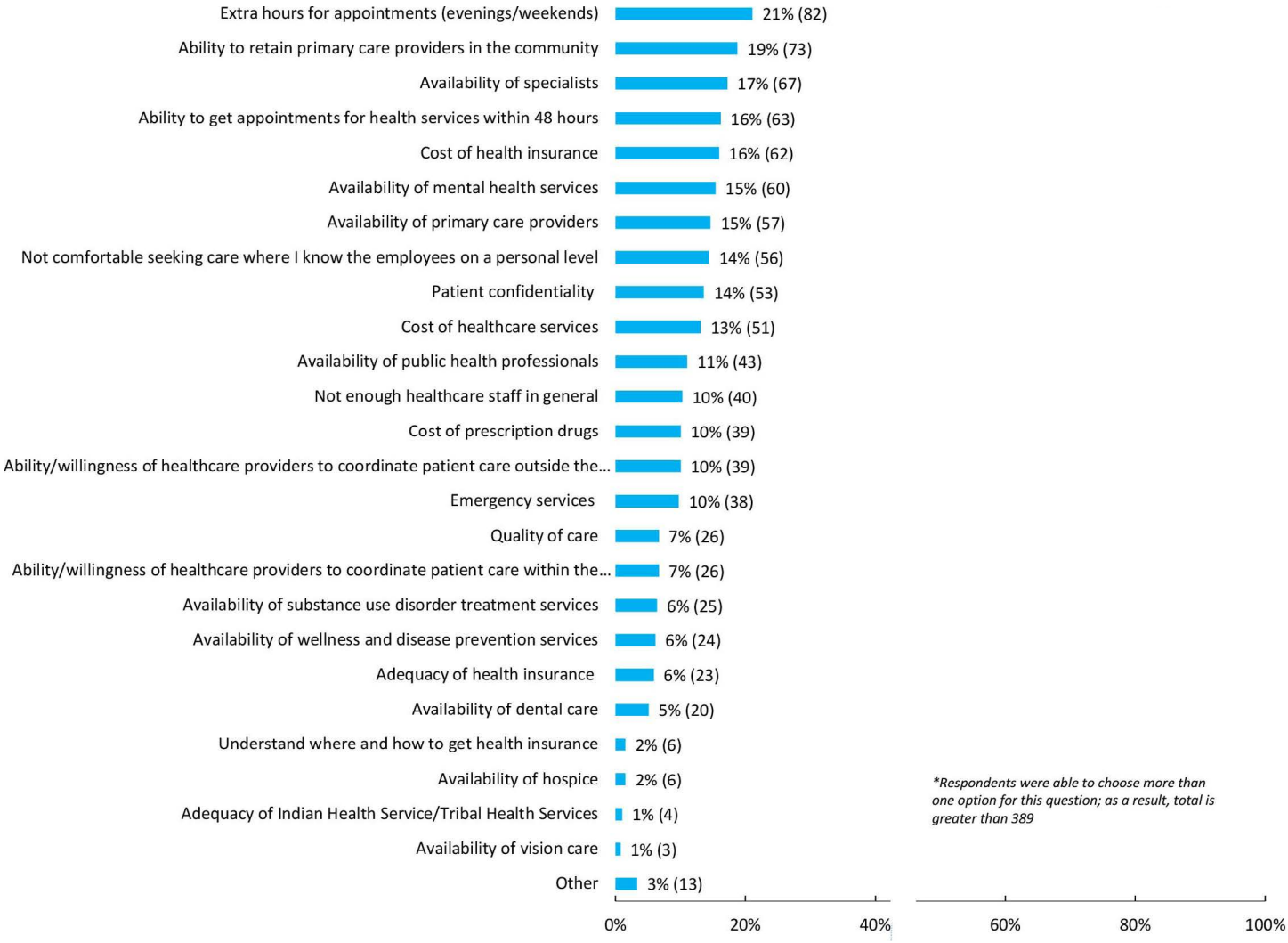
Figures 17 through 21 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 400*



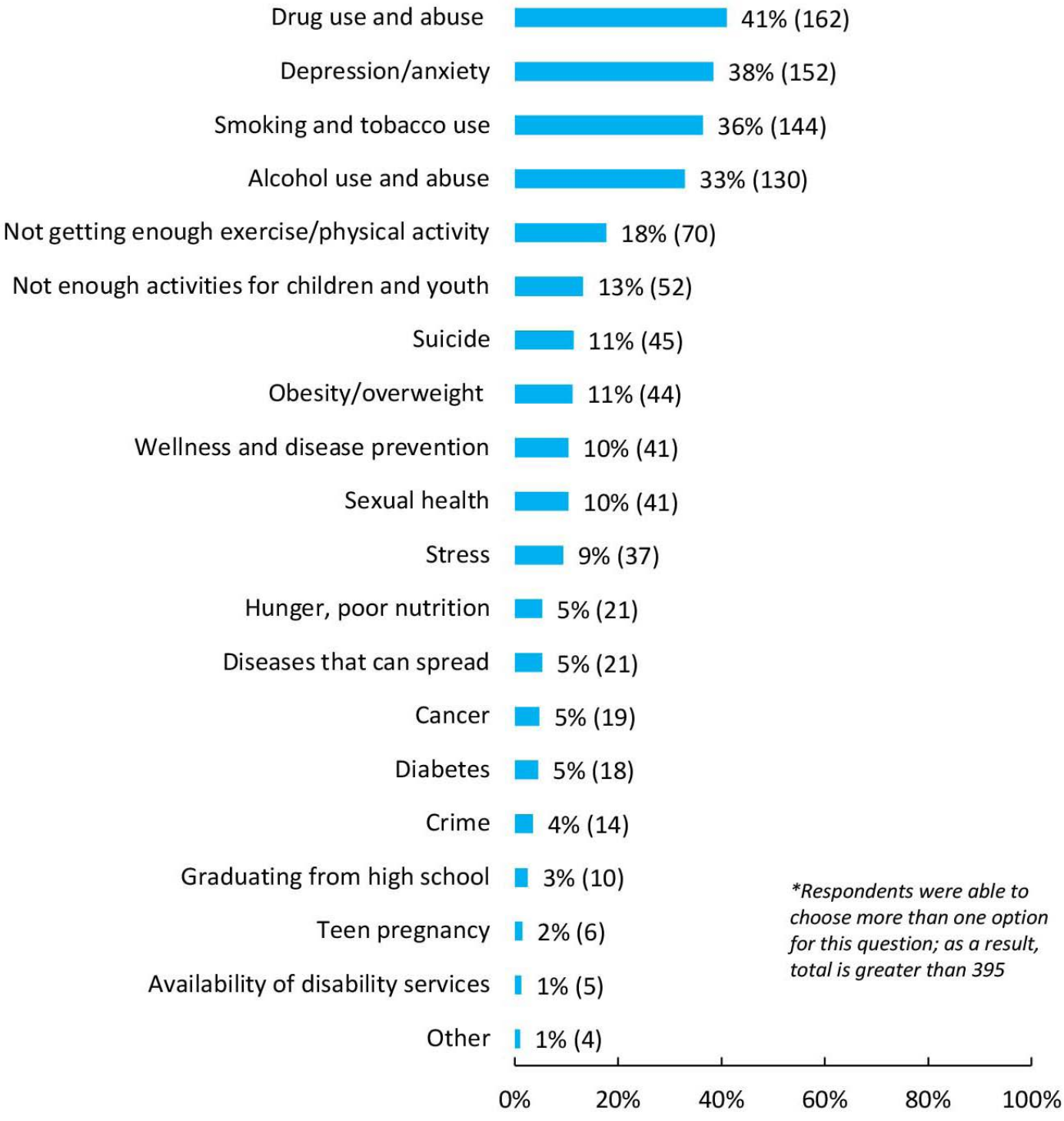
In the "Other" category for community and environmental health concerns, the following were listed: is local economy stable (coal, moving toward unreliable "renewable" energy when we have sustainable coal and jobs already in place), younger generation not giving of time to the greater good, lack of organic food options, streets/roads in need of repair, not enough outdoor spaces conducive to activity (walking paths or sidewalks) drug use, not having a grocery store, retaining retirees, retaining adults in community of 50s and older, not enough teen activities if not in sports, not enough housing, lack of options to purchase clothing for youth boys, poor COVID-19 knowledge/ compliance, and rising number of drug users.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 389*



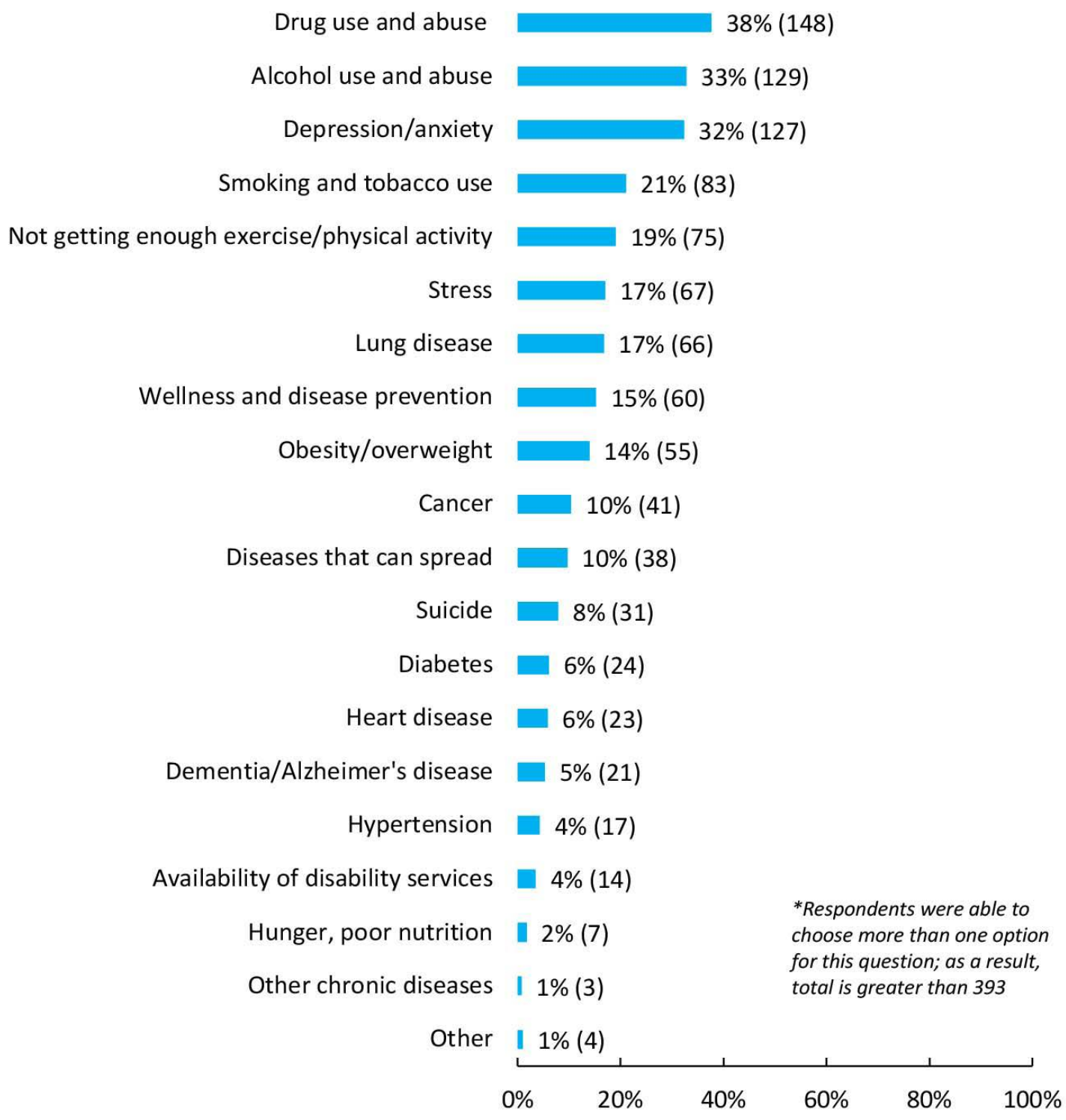
Respondents who selected "Other" identified concerns in experience and professionalism of doctors and nurses, mental health care, difficulty of getting an appointment with a doctor versus mid-level (FNP), lack of staff for the ambulance and rescue crews, surgeon is a concern, physical therapist knowledgeability, lack of actual physicians, availability of natural healthcare/wellness (osteopathic, integrative healthcare).

Figure 19: Youth Population Health Concerns
Total responses = 395*



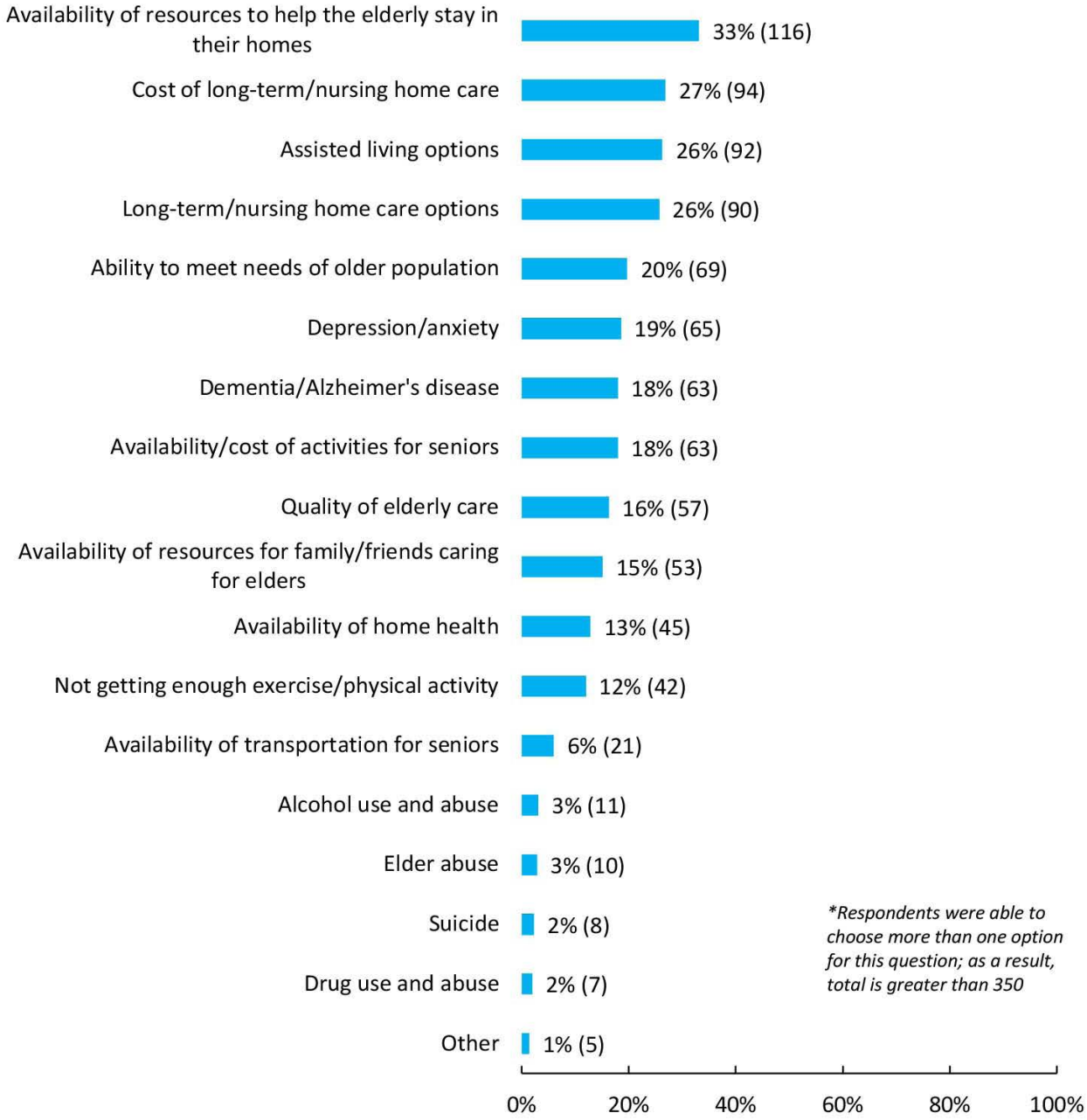
Listed in the "Other" category for youth population concerns were disrespect for others, places to go after school until parents are off work, and passive parenting/lack of involvement by parents.

Figure 20: Adult Population Concerns
Total responses = 393*



Availability of vulnerable adult/adult protective services, not enough vaccinated against COVID-19, women's healthcare and certainly awareness-based methods, and elder services were indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total responses = 350*



In the "Other" category, concerns listed were medical procedures, availability of affordable help to assist elderly staying in their own homes, not getting enough company and interaction with humans, activities, and not enough employees at elder care.

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. Concerns about the stability of the local job industry
2. Improving local healthcare and healthy living options

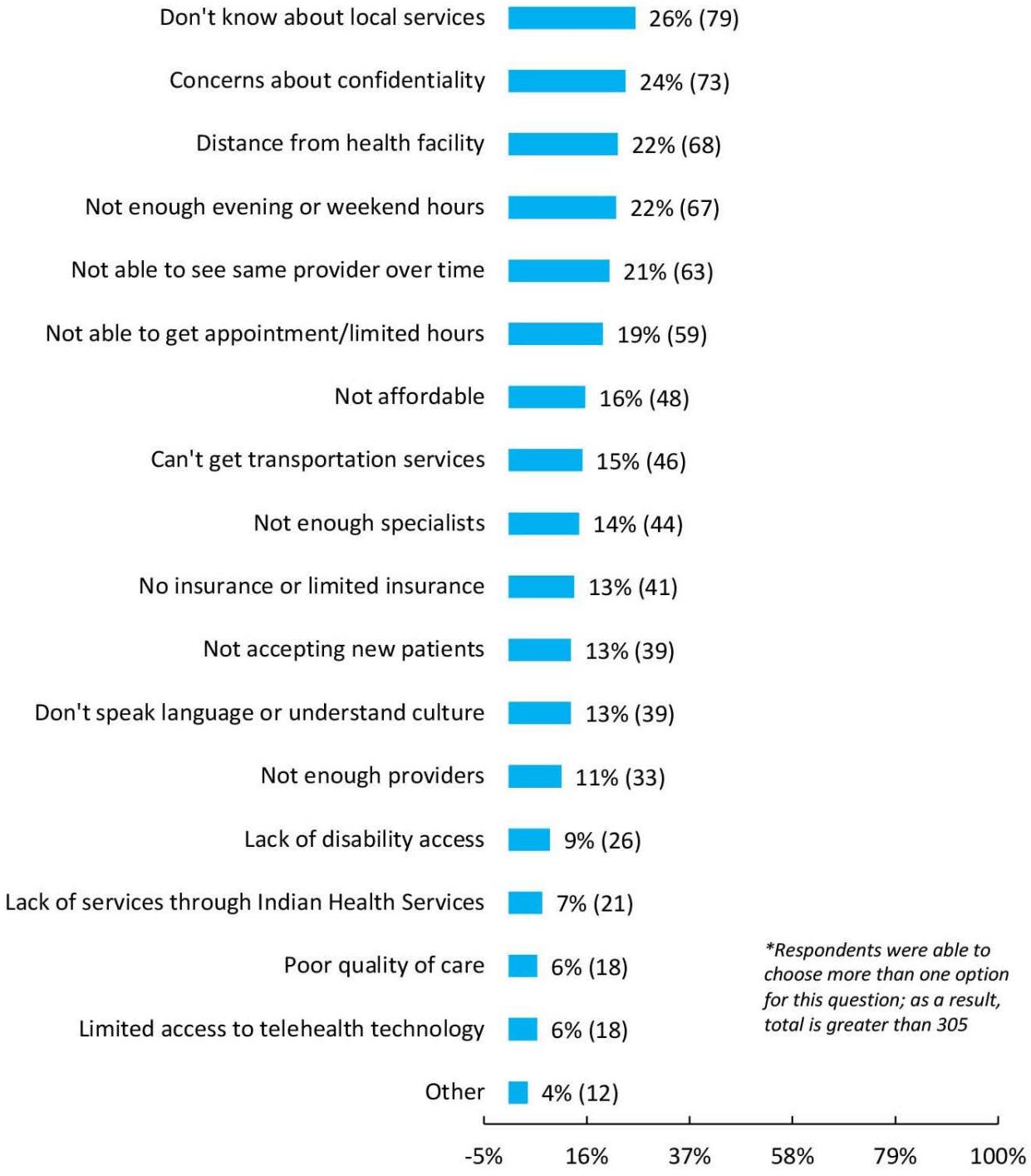
Other biggest challenges that were identified were the inability to attract families to live in the community, quality childcare options, aging population, staffing shortages, need for more collaboration between businesses and local resources, activities that are family-friendly, depression/suicide, and cost of healthcare/insurance.

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 as follows: don't know about local services (N=79), with the next highest being concerns about confidentiality (N=73). After these items, the next most commonly identified barriers were distance from health facility (N=68) and not enough evening or weekend hours (N=67). The majority of concerns indicated in the "Other" category were as follows: Difficult to get appointments to see a doctor, don't offer natural health services, unwilling to seek care, and only general services are provided at the clinic.

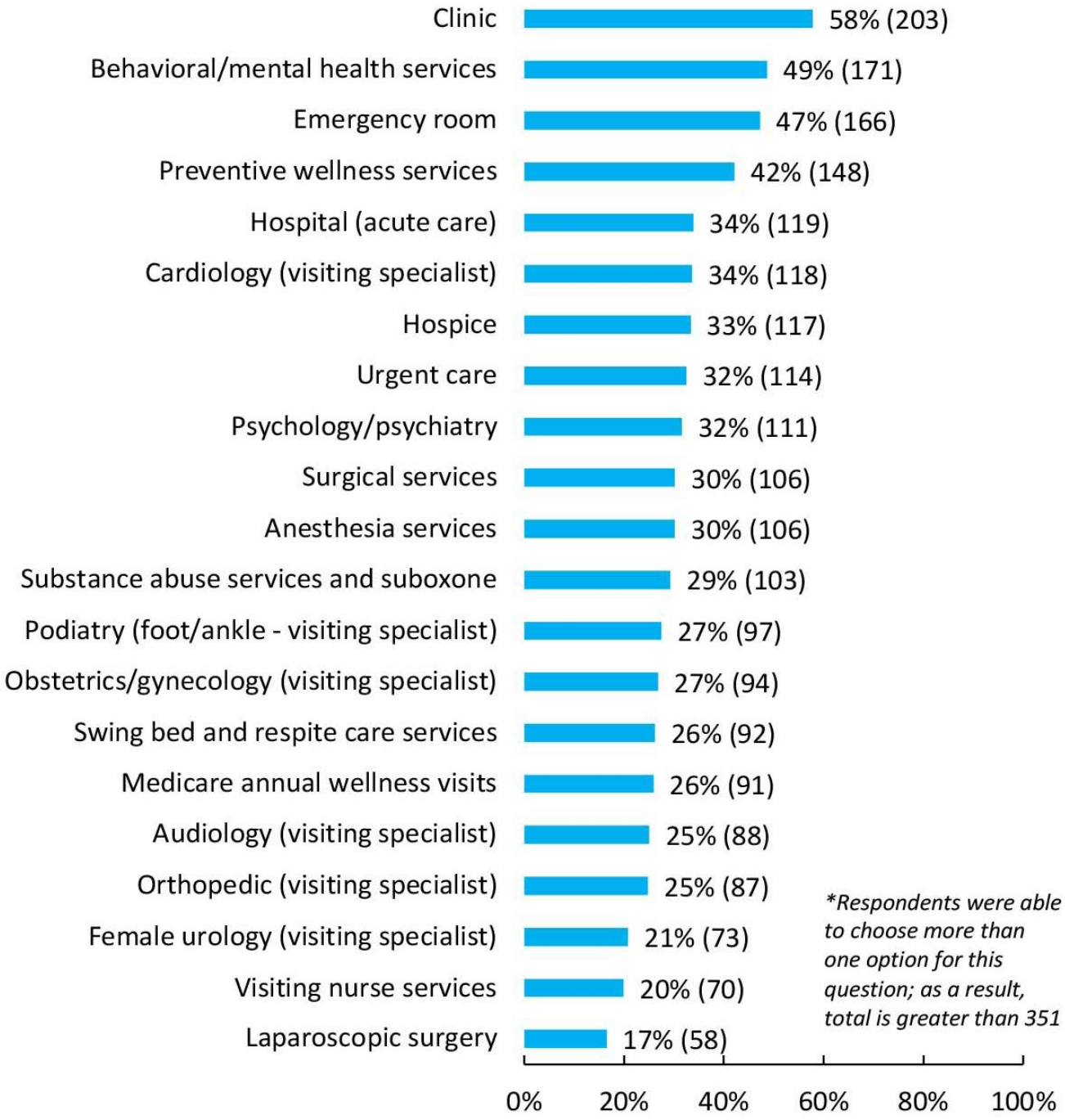
Figure 22 illustrates these results.

Figure 22: Perceptions about Barriers to Care
Total responses = 305



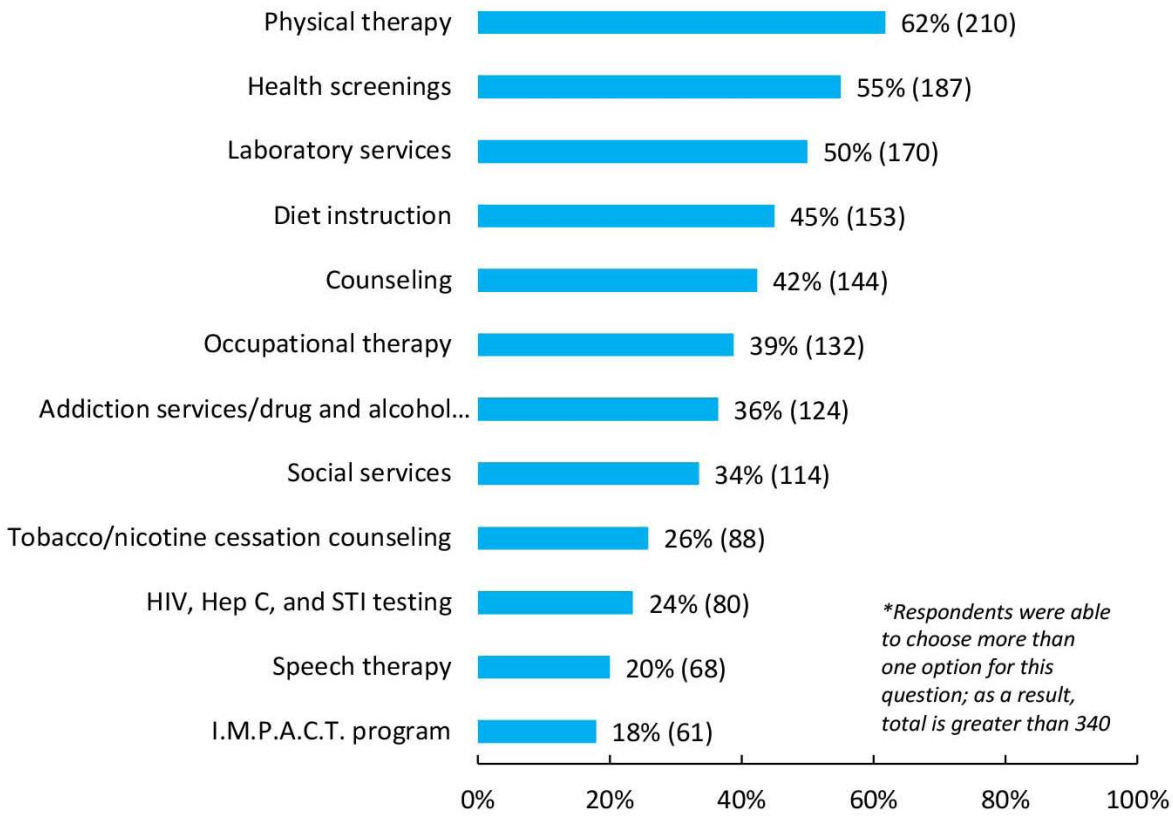
Considering a variety of healthcare services offered by SMC and CCCHC, respondents were asked to indicate if they were aware of or have utilized that healthcare service through SMC and CCCHC (See Figure 23).

Figure 23: Use and Awareness of General and Acute Services
Total responses = 351*



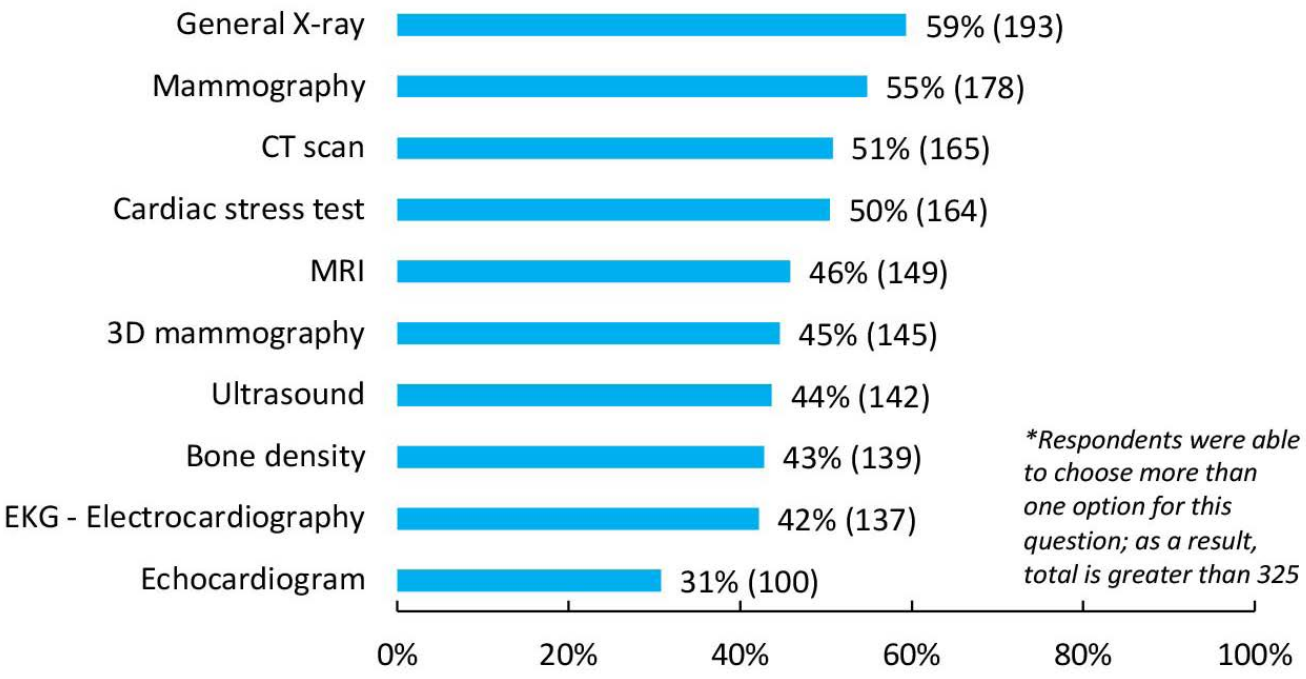
Considering the screening and therapy services offered by SMC, respondents were asked to indicate if they were aware of or have utilized that healthcare service through SMC (See Figure 24).

Figure 24: Use and Awareness of Screening and Therapy Services
Total responses = 340*



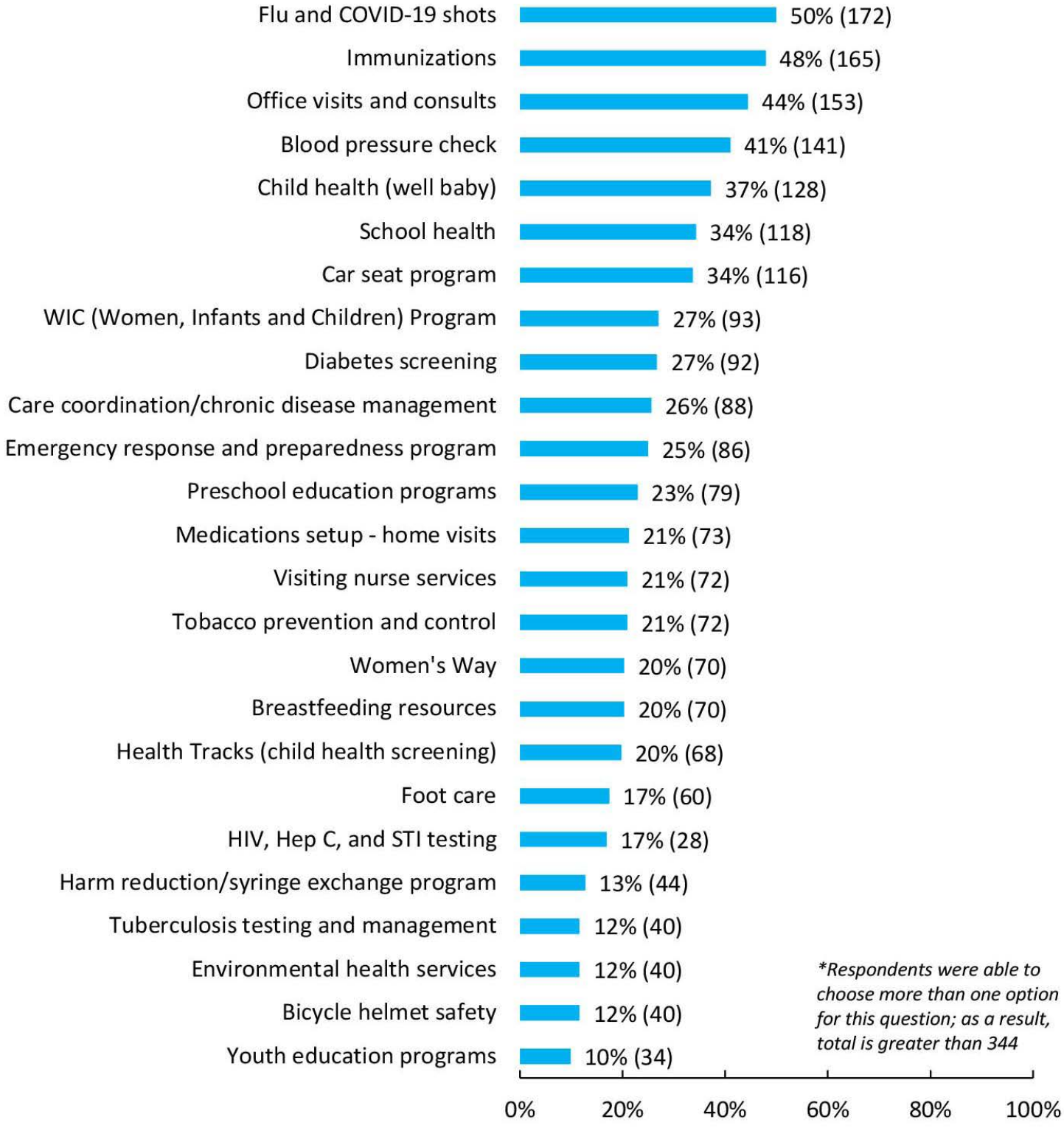
Considering the radiology services offered by SMC, respondents were asked to indicate if they were aware of or have utilized that healthcare service through SMC (See Figure 25).

Figure 25: Use and Awareness of Radiology Services
Total responses = 325*



Considering the screening and therapy services offered by SMC and CCCHC, respondents were asked to indicate if they were aware of or have utilized that healthcare service through SMC (See Figure 26)."

Figure 26: Awareness and Utilization of Community and Public Health Services

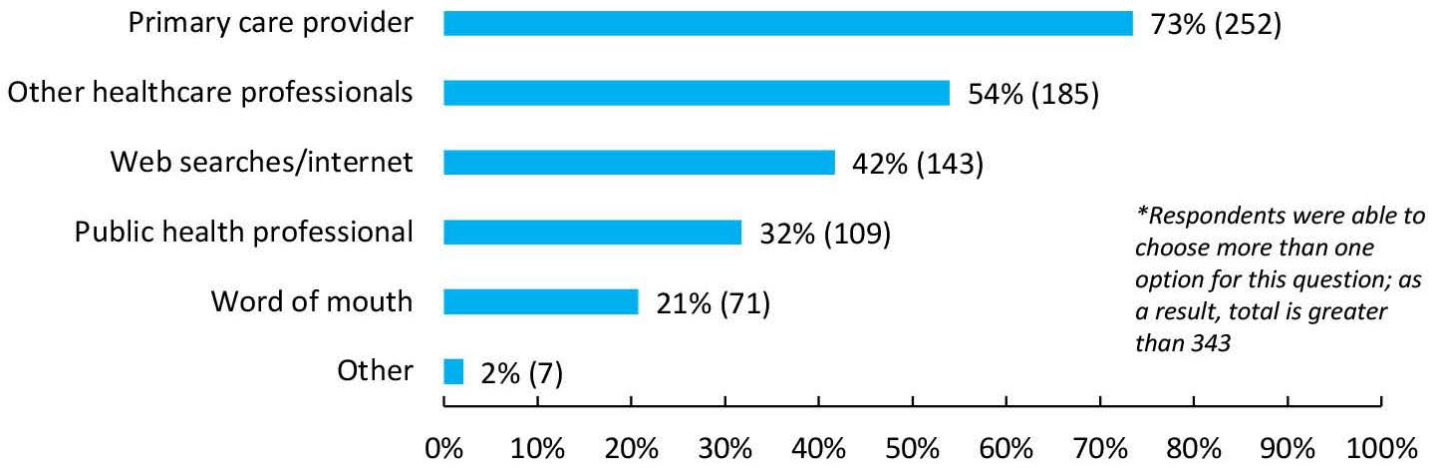


In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was more availability of specialty services. Other requested services included:

- After hours clinic 5:00 pm – 8:00 pm
- Better access to all medical services
- Community paramedic program
- Visiting specialists: dermatology, rheumatology, nephrology, neurology, GI specialist, and neuropsychic assessments
- Dialysis
- Homeopathic, holistic medicinal services/providers, naturopathic doctors and services
- In-home mental health care
- OBGYN (not just visiting ones)
- Option to deliver babies at SMC like in the past
- Pediatric therapy services (PT, OT, speech)
- Regular health lectures or classes (preschool health education, teen's health/growing up, relaxation/meditation, yoga)
- Supplementary nutrition assistance program (SNAP)
- Van transport to hospital for tests or surgery
- Need an assisted living facility attached to the nursing home

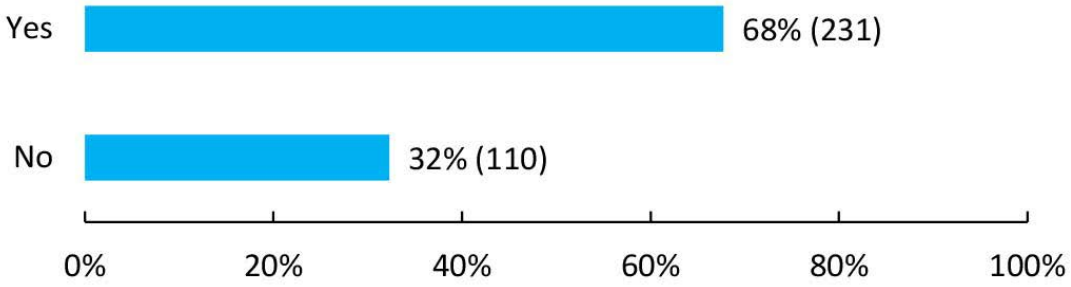
The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a number of services where they felt the hospital should increase marketing efforts; these included all the services in general, physician outreach, advertise farther out, every home needs this list of services (mailer), and suggested they should put flyers for sexual health in bar/restaurants bathrooms.

Figure 27: Sources of Trusted Health Information
Total responses = 343



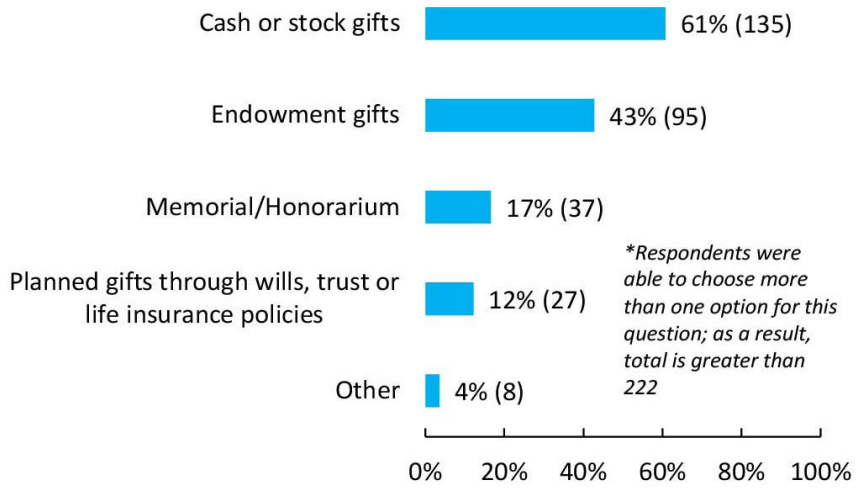
In the "Other" category, books, publications, family is medical, holistic medicine resources, counselor, and journals/research articles are needed.

Figure 28: Awareness of Local Healthcare Foundations
Total responses = 341



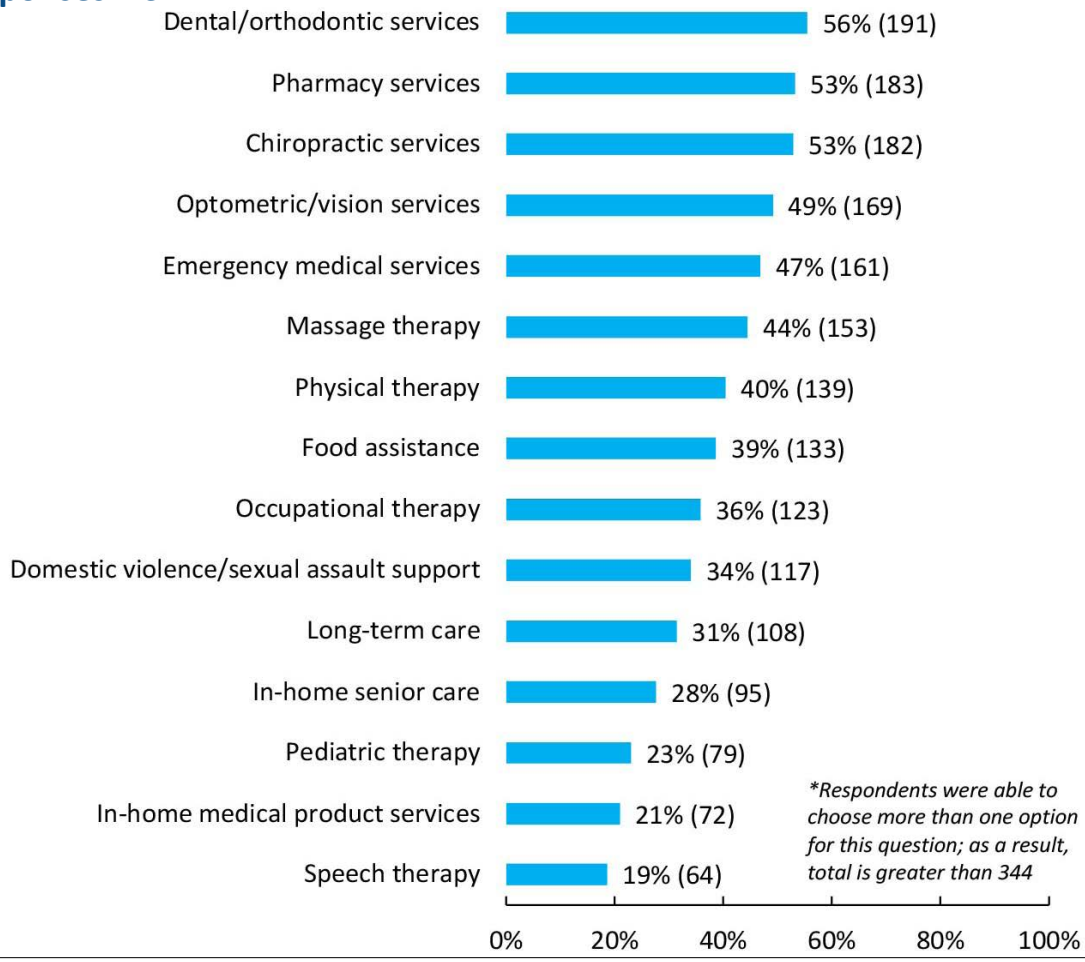
In an effort to gauge ways that community members would be most likely to financially support facility improvements/new equipment, a question was included, asking them to select ways they are most likely to support facility improvements/new equipment at SMC (see Figure 30). In the "Other" category were ways community members supported the foundation or hospital. Answers included serviced local ambulance, bought raffle tickets, and other fundraisers in the community.

Figure 29: Forms of Support for Local Healthcare Foundations
Total responses = 222*



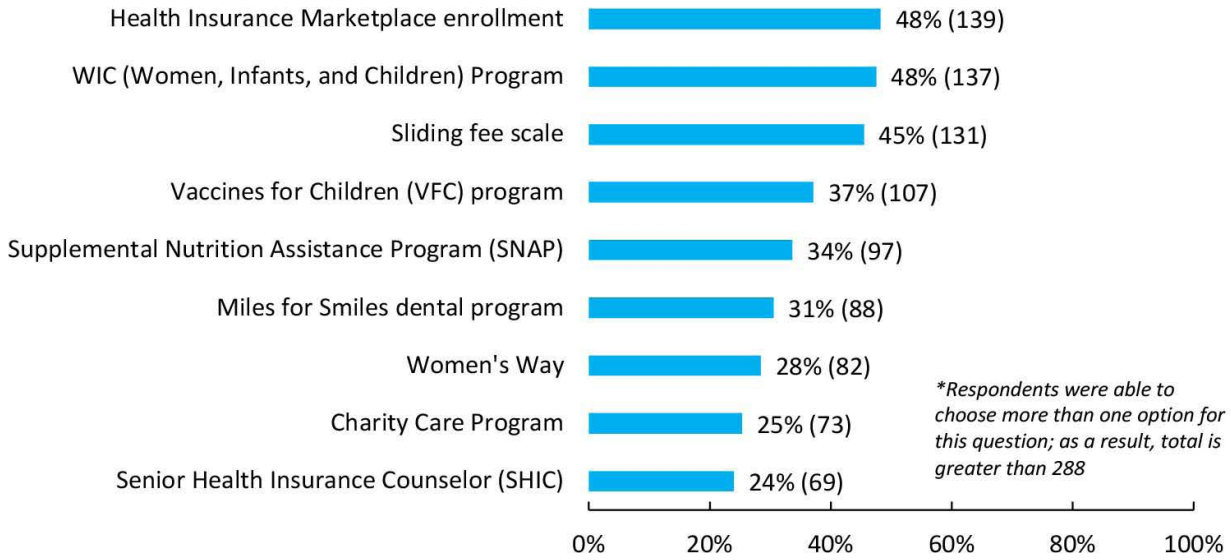
Respondents were asked if they use or were aware of other services in the community. The majority of respondents use or are aware of dental services, pharmacy services, and chiropractic services (Figure 30).

Figure 30: Use/Awareness of Other Services in the Community
Total responses = 344*



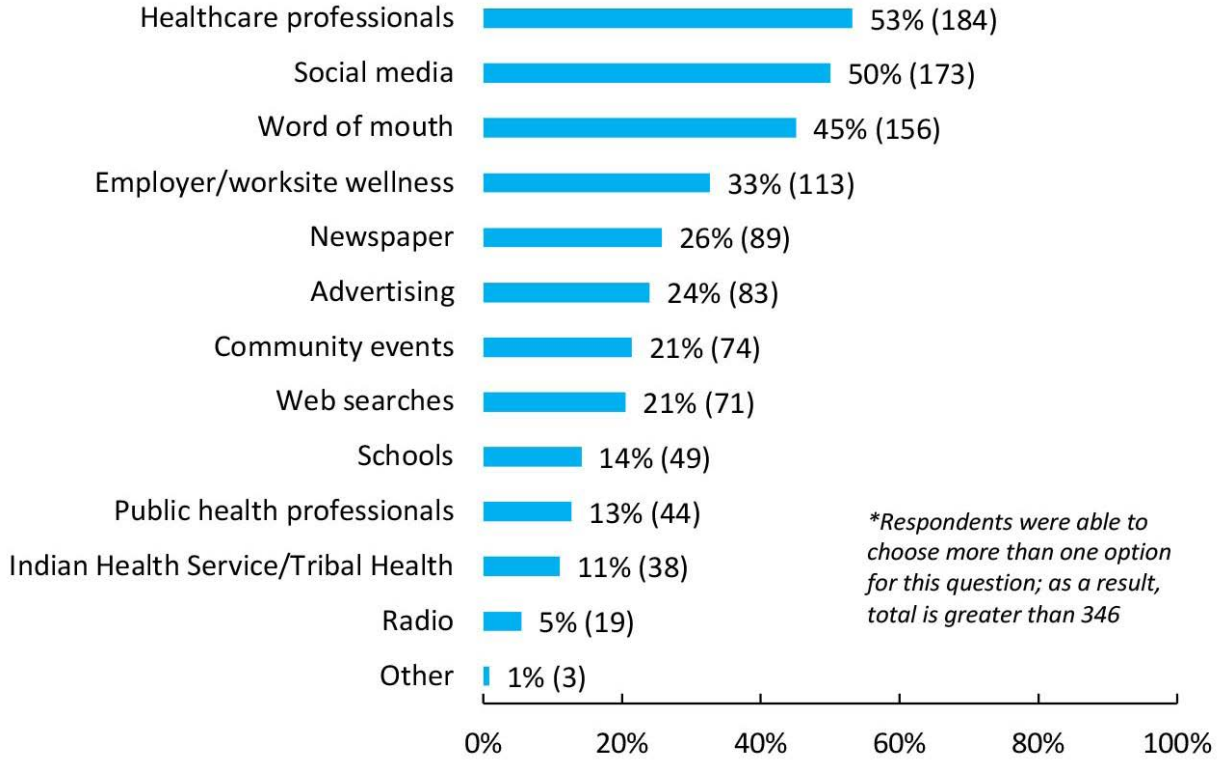
When asked about use or awareness of the eligibility resources in the community, respondents chose health insurance and WIC (Women, Infants, and Children) program as most used or are aware of their services.

Figure 31: Use/Awareness of Eligibility Resources in the Community
Total responses = 288*



Respondents were asked where they go to for sources of information about local health services. Healthcare professionals (N=184) received the highest response rate, followed by social media (N=173), and then word of mouth (N=156). Results are shown in Figure 33.

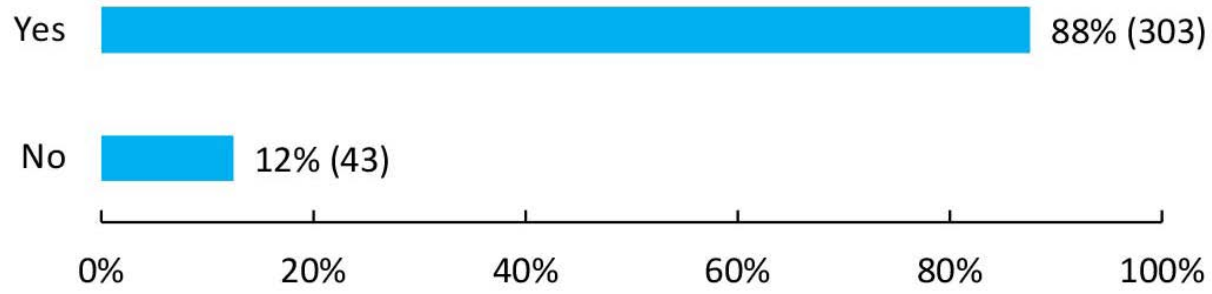
Figure 32: Sources of Information about Local Health Services
Total responses = 346*



In the "Other" category, family members who work at the hospital were listed as a source of trusted information.

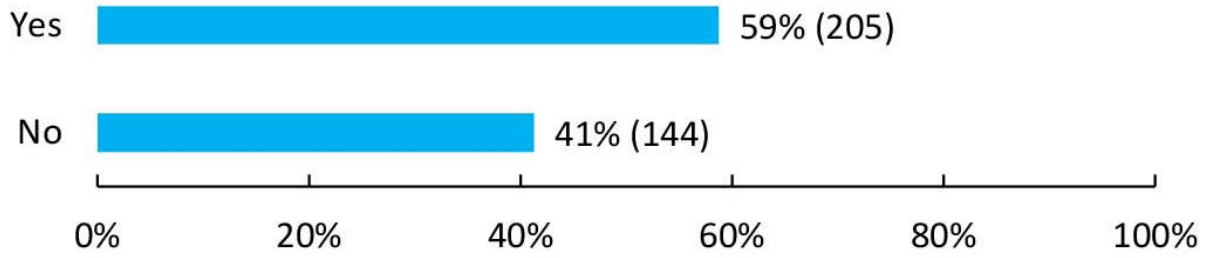
Respondents were asked if they had an established Primary Care Provider (PCP) in the community. A majority of the respondents selected Yes (N=303), and 12% selected No (N= 43). Results are shown in Figure 33.

Figure 33: Respondents with an Established PCP in the Community
Total responses = 346



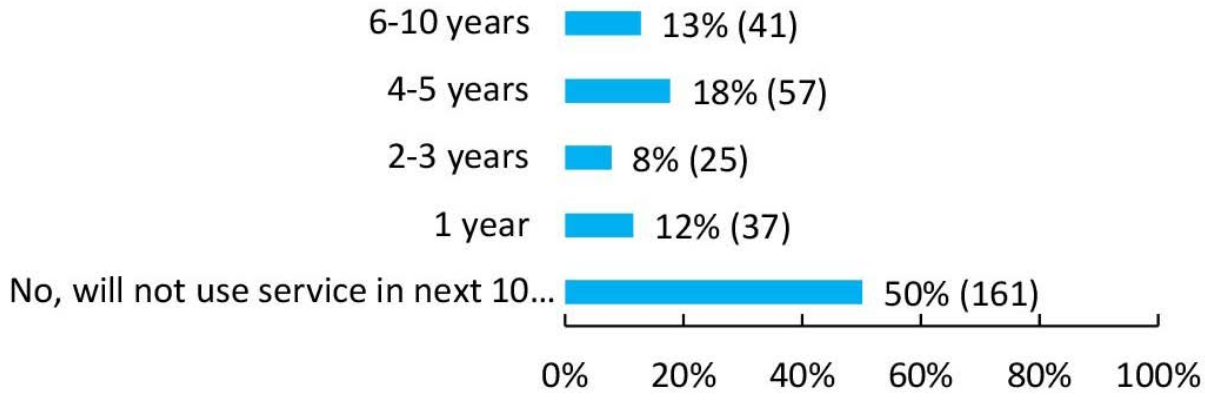
Respondents were asked if they were aware of the patient-centered medical neighborhood. A majority of the respondents selected Yes (N=205), and 41% selected No (N= 144). Results are shown in Figure 34.

Figure 34: Awareness of Patient Centered Medical Neighborhood
Total responses = 349



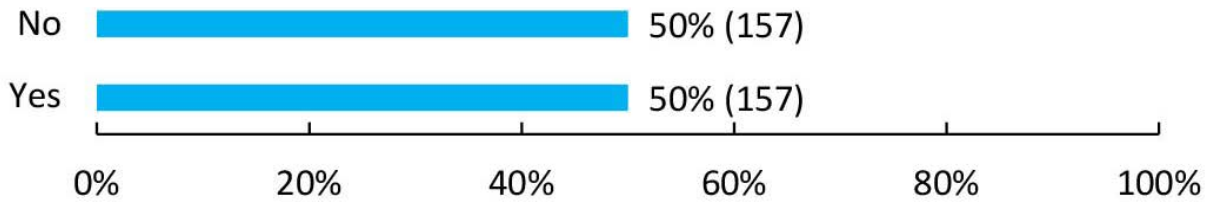
In addition to the questions, regarding SMC and CCCHC, the following questions were also asked about Hill Top Home of Comfort services and Knife River Care Center services.

Figure 35: When Hill Top Home of Comfort Services Will be Needed
Total responses = 321



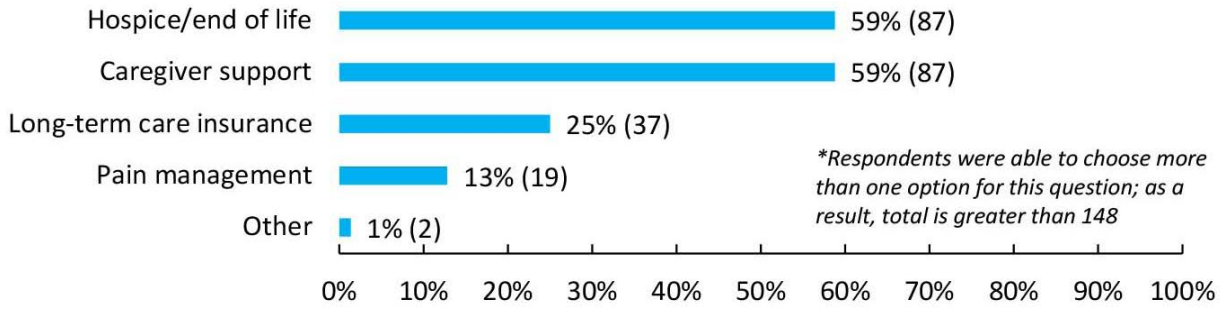
Respondents were asked when Hill Top Home of Comfort services will be needed. The majority of the respondents selected not in the next 10 years (N=161), followed by 4-5 years (N= 57). Results are shown in Figure 37.

Figure 36: Anticipated Use of Hill Top Home of Comfort Community Health Education
Total responses = 314



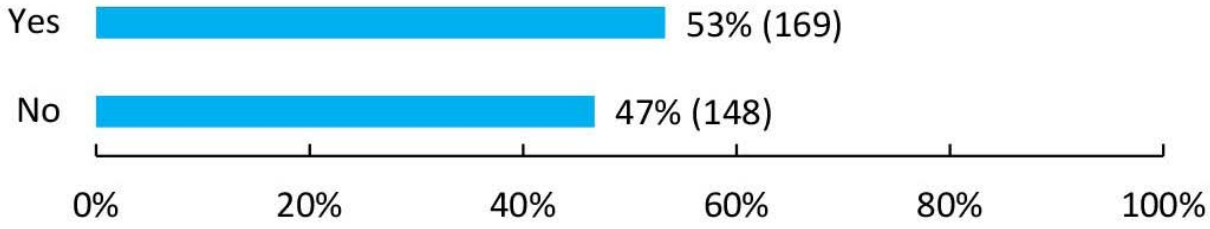
When asked about anticipated use of Hill Top Home of Comfort community health education, respondents were split 50/50.

Figure 37: Beneficial Types of Health Education from Hill Top Home of Comfort
Total responses = 148*



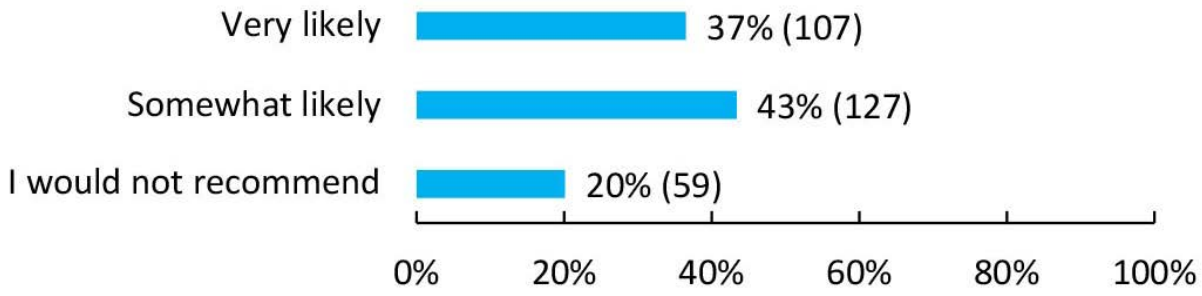
When asked about beneficial types of health education from Hill Top Home of Comfort, hospice/end of life and caregiver support tied for top choice.

Figure 38: Awareness of Outpatient Services from Therapy Solutions at Hill Top Home of Comfort



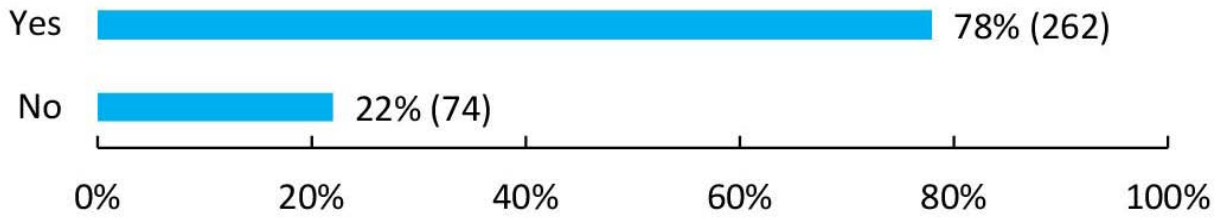
Respondents were asked about the awareness of outpatient services from Therapy Solutions at Hill Top Home of Comfort. Fifty-three percent of respondents were aware, while 47% were not aware of these services.

Figure 39: Likelihood of Recommending Therapy Services at Hill Top Home of Comfort
Total responses = 293



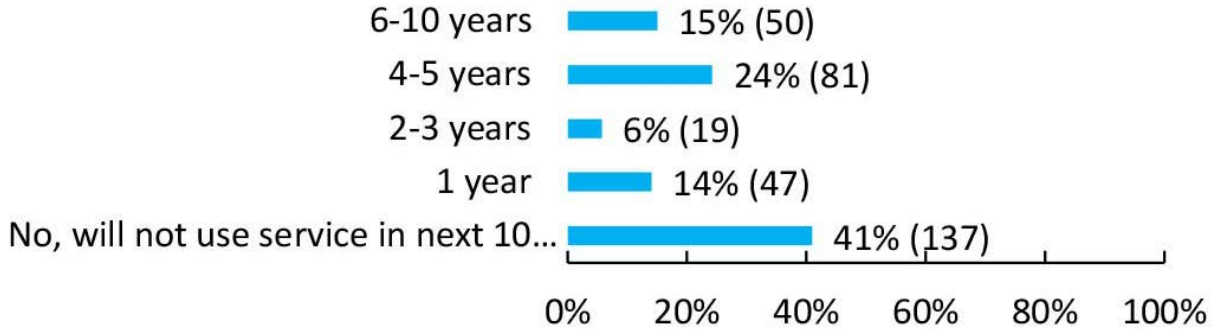
When respondents were asked how likely they would recommend therapy services at Hill Top Home of Comfort community, 80% of the respondents (N= 234) were at least somewhat likely to recommend it.

Figure 40: Awareness of Therapy Services at Knife River Care Center
Total responses = 336



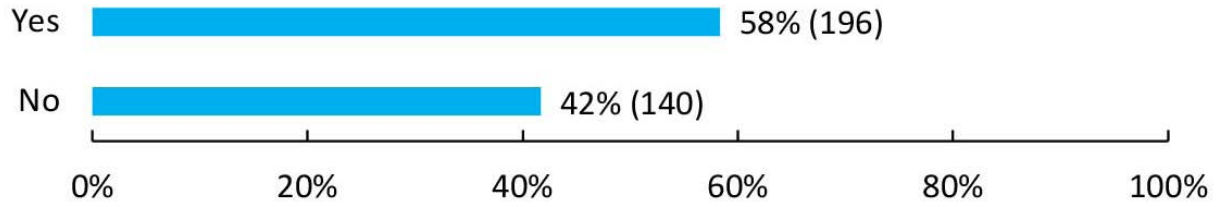
Respondents were asked about the awareness of therapy services at Knife River Care Center. Seventy-eight percent of respondents were aware (N= 262), while 22% were not aware of these services (N= 74).

Figure 41: When Knife River Care Center Services Will be Needed
Total responses = 321



Respondents were asked when Knife River Care Center services will be needed. The majority of the respondents selected not in the next 10 years (N=137), followed by 4-5 years (N= 81). Results are shown in Figure 37.

Figure 42: Anticipated Use of Fall Prevention and Management Classes at Knife River Care Center
Total responses = 336



When asked about anticipated use of fall prevention and management classes at Knife River Care Center, 58% of respondents do anticipate using the classes (N= 196), while 42% do not plan on using the classes (N= 140).

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 concern with the lack of primary care providers and quality and level of care patients receive when being seen. Local providers are healthcare drivers in the community. The community needs to do all that they can to retain existing providers and continue to recruit new ones.

The health facilities should utilize marketing tools to bring awareness to the community of all the services SMC and CCCHC offers. Community residents would also like more clinic options, such as walk-in, evening, and weekend hours. They want more access to visiting specialists. Respondents suggested classes for chronic disease education, such as diabetes.

The hospital needs to take care of their clinic and hospital staff in order to keep them financially secure. If SMC takes the healthcare workers for granted and if the community does not support them, they risk losing them.

The cost of healthcare services is also a concern for the community. One respondent mentioned being billed over $300 for vitals taken, and simple advice was given. Respondents would like more medical assistance and diversified medical insurance services.

Others believe that SMC and CCCHC does a great job of identifying and delivering healthcare within its means and offers a wide variety of healthcare 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 also 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
- Cost of long-term/nursing home care
- Depression/anxiety (adults)
- Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling (youth)

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

- The community has the energy industry, but now spouses have to work as well to have a comfortable life.

Availability of mental health services

- Not aware of any services available
- Many concerns stem from mental health, drugs/alcohol, etc.
- Mainly for youth and adults. There has been a handful of suicides in the last few years. Need to let go of the stigma that seeking help is weak

Cost of long-term/nursing home care

- Cost of care definitely weighs heavy on families' minds

Depression/anxiety

- Depression and anxiety lead to stress and suicide
- Due to pandemic, isolation has caused and increased depression/anxiety
- Teens and young adults have increased depression/anxiety

Smoking and tobacco use, exposure to second-hand smoke, or vaping/juuling

- Juuling has become a very popular thing
- Kids are not educated in this area

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 question was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to score. 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 scores (with 5 being "excellent" engagement or collaboration) were:

- Schools (4.5)
- Business and industry (4.25)
- Emergency services, including ambulance and fire (4.25)
- Hospital (healthcare system) (4.25)
- Economic development organizations (4.0)
- Law enforcement (4.0)
- Long-term care, including nursing homes and assisted living (4.0)
- Public health (4.0)
- Clinics not affiliated with the main health system (3.5)
- Faith-based (3.5)
- Pharmacy (3.5)
- Other local health providers, such as dentists and chiropractors (3.25)
- Human/Social services agencies (2.75)
- Tribal Health/Indian Health Services (2.5)

Priority of Health Needs

A community group met on January 18, 2022, via Zoom. Twenty-three community members attended the meeting. Representatives from the Center for Rural Health (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 in a Qualtrics survey, and each member was able to vote for their top four needs they considered the most significant.

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

- Depression/anxiety - all ages (18 votes)

- Attracting and retaining young families (13 votes)
- Availability of mental health services (9 votes)
- Having enough child daycare services (8 votes)

From those top four priorities, each person was able to vote once more in a Qualtrics survey on the item they felt was the most important. The rankings were:

1. Depression/anxiety (7 votes)
2. Attracting and retaining young families (4 votes)
3. Availability of mental health services (4 votes)
4. Having enough child daycare services (3 votes)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was depression and anxiety for all ages. A summary of this prioritization may be found in Appendix E.

Comparison of Needs Identified Previously

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2022 CHNA Process
Availability of behavioral health services	Depression/anxiety (all ages)
Availability of resources to help the elderly stay in their homes	Attracting and retaining young families
Youth alcohol use and abuse (including prescription drugs)	Availability of mental health services
Youth depression/anxiety	Having enough child daycare services
Attracting and retaining young families	

The current process identified similar common needs from 2019. Depression/anxiety and attracting and retaining young families were identified as a need during the last community health needs assessment. Having enough child daycare services is a new top need that was identified during the current process.

Local health care providers invited written comments invited written comments on the most recent CHNA report and implementation strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

CCCHC's CHNA must also be approved and adopted by the CCCHC board as this is a Compliance requirement set forth by HRSA. Written comments on this report can be submitted to SMC.

Hospital and Community Projects and Programs Implemented to Address Needs Identified in 2019

In response to the needs identified in the 2019 CHNA process, the following actions were taken:

Availability of behavioral health services (mental health and substance abuse/treatment):

Coal Country Community Health Center (CCCHC) continues to innovatively lead, organize, and implement behavioral health services through various collaborating community partnerships and resources. With the increase in demand for youth and adolescent behavioral health services, a full-time Licensed Master Social Worker (LMSW) was hired in April 2021, as a direct result of the challenges encompassed by the global SARS-CoV-2 pandemic. The IMPACT (Integrating Mental Health, Physical Health, and Continuity of Care Together) Program is currently available at all four school districts in Beulah, Hazen, Center, and Killdeer, ND. The mission of the IMPACT program is to enhance and improve the overall wellness of our children through collaboration of CCCHC, local school districts, and the community. Goals of the IMPACT program are to destigmatize mental health and substance use; advocate for students mental and physical health, emphasizing that academic performance is directly affected by the student's health; and to remove the barriers students face by providing services on-site for mental and physical health. CCCHC is projected to begin offering medical (physical health) visits at the Beulah High School on January 19, 2022, for all students K-12, including school staff as an expansion to the IMPACT program in response to limited access appointments in the afternoons. Furthermore, CCCHC's Substance Use Disorder team continues to innovatively address the needs of the community through expansion of services and programs.

a. CCCHC has increased availability and access to all four school districts (Beulah, Center, Killdeer, and Hazen schools) from one day per week per school in 2019 to two days per week per school district in 2021-2022 school year, providing increased access and counseling/support services to the youth and adolescent populations in our communities.

b. CCCHC will offer medical visits Monday, Wednesday, and Friday from 8:00 am – 12:00 pm at the Beulah High School for K-12th grade, facilitating depression, anxiety, and substance misuse screenings with appropriate referrals and follow-up as identified.

c. Beulah Elementary school was unable to hire a school counselor for the 2021-2022 school year. CCCHC has provided a counseling intern two days/week via contract to the Beulah School District for the provision of school counseling services in September 2021. Services were increased to three days/week, beginning January 2022 due to increased demand for services.

d. CCCHC has expanded psychotherapy treatment options locally for patients who have experienced trauma through EMDR (Eye Movement Desensitization and Reprocessing) therapy. Two behavioral health clinicians received training and certification as EMDR specialists.

e. CCCHC has expanded substance use disorder services locally by offering drug and alcohol evaluations via telehealth for all patients including incarcerated inmates at Mercer County Jail. Intensive Outpatient Programming (IOP) was implemented in August 2019 and continues today to support patients who require SUD treatment but do not require 24-hour services. IOP also supports patients in their recovery steps to maintain employment with late afternoon/evening hour programming. DUI seminars continue to be offered frequently throughout the year as well as various levels of services and programming as identified through completion of drug and alcohol evaluations locally. CCCHC also continues to provide a comprehensive Medication Assisted Treatment (MAT) program locally in Beulah and Killdeer for patients with opioid use disorder.

f. CCCHC continues to expand and offer innovative tobacco and nicotine cessation services for all clinic and hospital patients as well the promotion of prevention programming to youth and adolescents at the local school districts through financial resources, training, and education as provided by the NDQuits Cessation grant, funded by the ND Department of Health. CCCHC and SMC have increased the availability of Trained Tobacco Specialists (TTS) for cessation counseling and follow-up from four TTS in

2019 to 12 TTS staff in 2022. TTS team members are available at all CCCHC clinic locations and at SMC. The Catch My Breath curriculum has been delivered to local school districts as well as further expansion of the N-O-T (Not on Tobacco) and InDepth (Alternative to Suspension) programs in 2022.

i. % of patients screened for tobacco/nicotine use and if a tobacco/nicotine user, received cessation education services and/or referral.

1. 2017-2019 average = 78.01% of all patients seen at CCCHC clinics

2. 2020 = 84.74% of all patients seen at CCCHC clinics

3. 2021 = 82.75% of all patients seen at CCCHC clinics

g. CCCHC and SMC facilitated a suicide crisis response plan to address and appropriately coordinate care for patients in acute suicide crisis. Training was completed for all providers and nursing staff on use of the C-SSRS (Columbia Suicide Severity Rating Scale) to assess suicide risk with additional response plans implemented at SMC through the local emergency department.

h. CCCHC hired a part-time psychiatrist in 2019 with only 51 visits provided in 2019 to now more than 225 visits completed in 2021. Furthermore, Knife River Care Center (KRCC) is now provided with psychiatric visits by CCCHC's psychiatrist for residents via telehealth services to identified individuals further expanding a medical neighborhood of care model to the residents of KRCC.

i. Custer Health with the support of CCCHC has facilitated a local harm reduction syringe service program in Beulah; however, zero patients have utilized services locally and are still seeking services at the Mandan location in Morton County.

j. CCCHC continues to expand and enhance its comprehensive care coordination model with additional team members added to include the following:

i. BH Integration Care Coordinator – provides follow-up phone calls to all patients seen at SMC with a mental health or SUD diagnosis for primary care integration and follow-up.

ii. BH Support Specialist – provides support to all BH providers, including scheduling and case management services to parents, guardians, and youth patients.

Availability of resources to help the elderly stay in their homes:

The local healthcare community continues to innovatively provide services through outreach, collaboration, and comprehensive care coordination to keep older adults living in their home longer. The collective goal is to decrease potentially preventable admissions and emergency room visits all while addressing the triple aim of reducing overall costs of care, improving health outcomes, and improving overall patient satisfaction. Fouded on the principles of a Patient-Centered Medical Home, local healthcare providers focus efforts on the patient-provider care team relationship, including patient/family involvement. Further commitment has been strengthened by the board of directors at SMC, CCCHC, KRCC, Custer Health, and Mercer County Ambulance to collaboratively deliver a Patient-Centered Medical Neighborhood model of care, further strengthened by primary care provider led, comprehensive care coordination for all patients.

a. A comprehensive care coordination committee with representatives from the healthcare community meets monthly to review repeat admissions and repeat emergency department visits with a goal of implementing care coordination interventions from team members at Custer Health, SMC, KRCC, or CCCHC, including community care coordination, visiting nurse services, or palliative care team members. Furthermore, the local healthcare community has welcomed a private sector, Home Instead, for the provision of personalized in-home private pay senior care services, which may include but not limited to, personal care, Alzheimer's & Dementia care, Hospice support, home helper, and transportation services. The following services are provided through collaborative partnerships between SMC and CCCHC:

i. Community Care Coordination team has provided 1,573 phone or home visits to 174 at-risk patients, 65 years of age and older in 2021. Total Chronic Care Management (CCM) rate for all traditional Medicare beneficiaries was less than 8% in 2020 with an overall increase to 8.7% in quarter 3 of 2021. Average national CCM rate is 4.9%.

ii. Visiting Nurse Services (VNS) provides skilled nursing care to patients in their home as an alternative to in-clinic visits to those patients who are "home bound." VNS provided 225 home visits in 2020 with a significant increase to 560 total visits in 2021.

iii. Palliative Care Services are provided in the home for patients as an alternative to in-clinic visits. Palliative care is specialized medical care, focused on relief of symptoms and stress, related to a serious illness with a goal of improving quality of life for the patient and family. Most Palliative care visits are now provided through a two-way virtual platform called Tytocare that provides visual and audio diagnostic capabilities for the provider-patient visit from the patient's home with the provider in the clinic.

b. CCCHC provides transportation to clinic visits for all established patients of CCCHC. In 2021 CCCHC also secured an agreement with Hazen Busing to establish additional transportation options for patients who need transportation assistance to other healthcare organizations within the Medical Neighborhood.

c. KRCC is in the process of developing and offering the Stepping On program as a primary falls prevention strategy for patients who are assessed to be at risk for falls.

d. CCCHC, SMC, and KRCC along with two private chiropractors in Beulah and Hazen continue to participate in an Accountable Care Organization (ACO) for Medicare beneficiaries. The goal of our ACO is to provide better care to patients at a lower cost. ACO models focus on value-based care with a goal of screening, education, and recommending care to patients to remain healthy rather than responding to problems as they arise. CCCHC offers and performs Annual Wellness Visits (AWV) for all Medicare beneficiaries. The AWV is a prevention-focused visits with recommendations provided at the time of visit for follow-up screenings or prevention programs, following evidence-based clinical guidelines. CCCHC has continued to focus efforts on keeping the aging population healthy throughout the global pandemic with additional phone outreach and offering of virtual or home visits as appropriate. CCCHC and SMC continue to partner in the provision of Transitional Care Management (TCM) visits for all Medicare beneficiaries, discharged from the hospital. The TCM visit is geared towards care coordination efforts to prevent repeat admissions and/or unnecessary emergency room visits.

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 simply 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, 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 – Critical Access Hospital Profile

Critical Access Hospital Profile
Spotlight on: Hazen, North Dakota

Sakakawea Medical Center

Quick Facts

Administrator:
Darrold Bertsch

Chief of Medical Staff:
Jacinta Klindworth, M.D.

Board Chair:
Christie Obenauer

City Population:
2,450 (2014 Estimate)[1]

County Population:
8,746 (2014 Estimate)[1]

County Median Household 2009 Income:
66,712 (2014 Estimate)[1]

County Median Age:
46.3 (2014 Estimate)[1]

Owned by: Nonprofit

Hospital Beds: 13

Trauma Level: V

Critical Access Hospital Designation: 2001

Economic Impact on the County*

Jobs:
Primary – 130
Secondary – 65
Total – 195

Financial Impact:
Primary – $6.5 Million
Secondary – $3.25 Million
Total – $9.75 Million

** The impact of jobs and expenditures generated by the hospital within the community was estimated using payroll information and an economic multiplier of 1.5.*

County: Mercer
Address: 510 8th Avenue NE
Hazen, ND 58545-4637
Phone: 701.748.2225
Fax: 701.748.5757
Web: smcnd.org

Present

Caring for our community is a long-standing tradition at Sakakawea Medical Center (SMC). Ever since our founding more than 70 years ago, we have strived to care for all who need us and to bring health, healing and a better quality of life to our neighbors. SMC consists of a critical access hospital (licensed for 13 beds) and 34-bed licensed basic care facility. The medical center is a community-owned, not-for-profit organization with a charitable purpose; governed by a volunteer board of directors. Any money remaining after expenses have been paid is reinvested back into healthcare and stays in the community to purchase needed medical equipment and support health education and other community needs.

SMC serves the communities, residents and visitors of Beulah, Dodge, Dunn, Center, Golden Valley, Halliday, Hazen, Killdeer, Pick City, Stanton, and Zap, and is located in the heart of rural Mercer County and housed in the City of Hazen.

Vision

SMC strives to be a complete healthcare system dedicated to providing the best comprehensive care possible to the area that we serve. Our vision is "To be the preeminent providers of innovative and collaborative healthcare services."

Sakakawea Medical Center provides the following services directly through the hospital:

- Acute Care
- Anesthesia
- Cardio-Pulmonary Services
- Cardiac Stress testing
- Convenience Clinic
- Emergency Services (Level V Trauma)
- Hospice Care
- Laboratory
- Observation Care
- Physician Services
- Rehabilitation Services (Physical and Occupational therapy)
- Radiology Services: CT, ultrasound, 3D mammography, bone densitometry, general x-ray
- Senior Suites (basic care facility)
- General Surgery
- Swing Bed program
- Social Services
- Volunteer Services
- Respiratory Therapy
- Peripheral Arterial Disease (PAD) Testing
- Sleep Studies
- Worksite Wellness Screenings and Educational Programs

Staffing

Physicians: 2
Nurse Practitioners: 1
PAs: 1
CRNAs: 1
RNs: 29
LPNs: 2
CNAs: 21
Support Staff: 50
Ancillary Personnel: 23
Total Employees: 130

Local Sponsors and Grant Funding Sources

- Center for Rural Health
  - SHIP Grant (Small Hospital Improvement Program)
  - Flex Grant (Medicare Rural Hospital Flexibility Grant Program)
- Blue Cross Blue Shield
- Workforce Safety Insurance

Sources

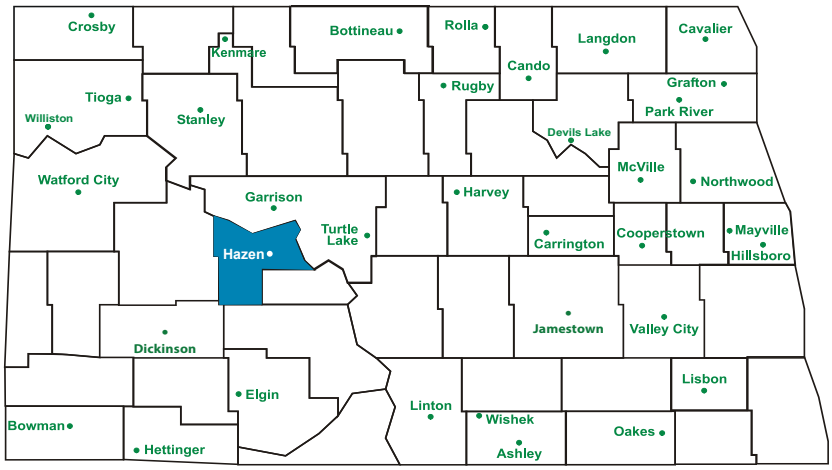
[1] US Census Bureau; American Factfinder; Community Facts

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

This project is supported by the Medicare Rural Hospital Flexibility Grant Program at the Center for Rural Health, University of North Dakota School of Medicine & Health Sciences located in Grand Forks, North Dakota.

ruralhealth.und.edu

North Dakota Critical Access Hospitals



History

Sakakawea Medical Center 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 2012, Local Health Providers completed a comprehensive Community Health Needs Assessment (CHNA) which took into account input from more than 640 community members and health care professionals from the three counties, as well as 22 community leaders. Additional information was also collected through key informant interviews and a focus group involving locally identified community leaders.

The top priority of services identified during this process included:
- Additional providers
- Additional mental health services
- More accessible clinic(s), more locations, longer hours
- Increased access to specialists
- Additional equipment/technology

In addition, upon completion of the CHNA, Local Health Providers convened again to work on a strategic plan that would best serve the interests of all agencies involved and the community. Information obtained from the planning emphasized the need to address the physical environment in which we provide care to include space for additional services; need to expand and deliver efficient outpatient care; and the need to address the most efficient use of staff in a community where adequate staffing is an issue.

In the fall of 2015, directly south of the old 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 in April 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 and centralized nurse's station; and a myriad of other needed changes and technology updates. The new facility was 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.

07/2018

Appendix B – Economic Impact Analysis

December 2020

Sakakawea Medical Center

Healthcare, especially a hospital, plays a vital role in local economies.

Economic Impact

Sakakawea Medical Center is composed of a Critical Access Hospital (CAH), a basic care facility, and hospice in Hazen, North Dakota.

Sakakawea Medical Center **directly** employs **106.5 FTE employees** with an annual payroll of more than **$7.3 million** (including benefits).

- After application of the employment multiplier of 1.38, these employees created an additional **40** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.16 is applied to create over **$1.17 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 147 jobs and nearly $8.5 million in income.**

Healthcare and Your Local Economy

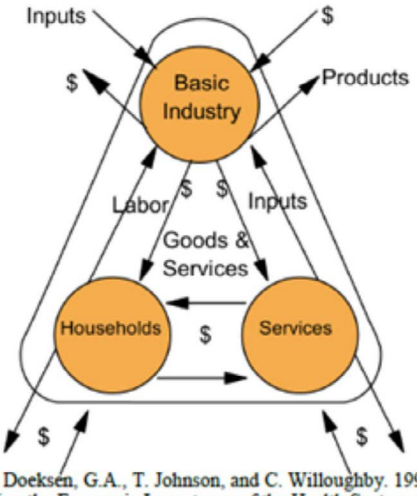
The health sector in a rural community, anchored by a CAH, is responsible for a number of full- and part-time jobs and the resulting wages, salaries, and benefits. Research findings from the National Center for Rural Health Works indicate that rural hospitals typically are one of the top employers in the rural community. The employment and the resulting wages, salaries, and benefits from a CAH are critical to the rural community economy. Figure 1 depicts the interaction between an industry like a healthcare institution and the community, containing other industries and households.

Key contributions of the health system include

- Attracts retirees and families
- Appeals to businesses looking to establish and/or relocate
- High quality healthcare services and infrastructure foster community development
- Positive impact on retail sales of local economy
- Provides higher-skilled and higher-wage employment
- Increases the local tax base used by local government

Data analysis was completed by the Center for Rural Health at the Oklahoma State University Center for Health Sciences utilizing IMPLAN data.

Figure 1. An overview of the community economic system.



Source: Doeksen, G.A., T. Johnson, and C. Willoughby. 1997. Measuring the Economic Importance of the Health Sector on a Local Economy: A Brief Literature Review and Procedures to Measure Local Impacts

Fact Sheet Author: Kylie Nissen, BBA

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CENTER FOR RURAL HEALTH
OSU Center for Health Sciences

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

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) through the Medicare Rural Hospital Flexibility Grant Program and the State Office of Rural Health Grant.

Appendix C – CHNA Survey Instrument

Mercer, Oliver, and Dunn County Area 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

If you prefer, you may take the survey online at http://tinyurl.com/Hazen21 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 December 15, 2021. 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):

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

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

- ☐ Access to healthy food
- ☐ Active faith community
- ☐ Business district (restaurants, availability of goods)
- ☐ Community groups and organizations
- ☐ Healthcare
- ☐ Opportunities for advanced education
- ☐ Public transportation
- ☐ Programs for youth
- ☐ Quality school systems
- ☐ Other (please specify): _____

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

- ☐ Closeness to work and activities
- ☐ Family-friendly; good place to raise kids
- ☐ Informal, simple, laidback lifestyle
- ☐ Job opportunities or economic opportunities
- ☐ Safe place to live, little/no crime
- ☐ Other (please specify): _____

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

- ☐ Activities for families and youth
- ☐ Arts and cultural activities
- ☐ Local events and festivals
- ☐ Recreational and sports activities
- ☐ Year-round access to fitness opportunities
- ☐ 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):

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

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

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

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

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

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

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

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

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

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

_____

_____

Delivery of Healthcare

11. 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.)

- ☐ Anesthesia services
- ☐ Audiology (visiting specialist)
- ☐ Behavioral/mental health services
- ☐ Cardiology (visiting specialist)
- ☐ Clinic
- ☐ Emergency room
- ☐ Female urology (visiting specialist)
- ☐ Hospice
- ☐ Hospital (acute care)
- ☐ Laparoscopic surgery
- ☐ Medicare annual wellness visits
- ☐ Obstetrics/gynecology (visiting specialist)
- ☐ Orthopedic (visiting specialist)
- ☐ Podiatry (foot/ankle – visiting specialist)
- ☐ Preventative wellness services
- ☐ Psychology/psychiatry
- ☐ Substance abuse services and suboxone
- ☐ Surgical services
- ☐ Swing bed and respite care services
- ☐ Urgent care
- ☐ Visiting nurse services

12. 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.)

- ☐ Addiction services/drug & alcohol evaluations
- ☐ Counseling
- ☐ Diet instruction
- ☐ Health screenings
- ☐ HIV, Hep. C. & sexually transmitted infection (STI) testing
- ☐ I.M.P.A.C.T. program
- ☐ Laboratory services
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Social services
- ☐ Speech therapy
- ☐ Tobacco/nicotine cessation counseling

13. 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.)

- ☐ 3D mammography
- ☐ Bone density
- ☐ Cardiac stress tests
- ☐ CT scan
- ☐ Echocardiogram
- ☐ EKG-electrocardiography
- ☐ General x-ray
- ☐ Mammography
- ☐ MRI
- ☐ Ultrasound

14. 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.)

- ☐ Bicycle helmet safety
- ☐ Blood pressure check
- ☐ Breastfeeding resources
- ☐ Car seat program
- ☐ Care coordination/chronic disease management
- ☐ Child health (well-baby)
- ☐ Diabetes screening
- ☐ Emergency response & preparedness program
- ☐ Environmental health services (water, sewer, health hazard abatement)
- ☐ Flu & COVID-19 shots
- ☐ Foot care
- ☐ Harm reduction/syringe exchange program
- ☐ Health Tracks (child health screening)
- ☐ HIV, Hep. C. & sexually transmitted infection (STI) testing
- ☐ Immunizations
- ☐ Medication setup-home visits
- ☐ Office visits and consults
- ☐ Preschool education programs
- ☐ School health (vision screening, puberty talks, school immunizations)
- ☐ Tobacco prevention and control
- ☐ Tuberculosis testing and management
- ☐ Visiting nurse services
- ☐ WIC (Women, Infants & Children) Program
- ☐ Women's Way
- ☐ Youth education programs (First Aid, bike safety)

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

- ☐ Chiropractic services
- ☐ Dental/orthodontic services
- ☐ Domestic violence/sexual assault support
- ☐ Emergency medical services
- ☐ Food assistance
- ☐ In-home medical product services
- ☐ In-home senior care
- ☐ Long-term care
- ☐ Massage therapy
- ☐ Occupational therapy
- ☐ Optometric/vision services
- ☐ Pediatric therapy
- ☐ Pharmacy services
- ☐ Physical therapy
- ☐ Speech therapy

16. Considering **ELIGIBILITY RESOURCES** available locally, which services are you aware of (or have you used in the past year)? (Choose ALL that apply.)

- ☐ Charity Care Program
- ☐ Health Insurance Marketplace enrollment
- ☐ Miles for Smiles dental program
- ☐ Senior Health Insurance Counselors (SHIC)
- ☐ Sliding fee scale
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Vaccines for Children (VFC) program
- ☐ WIC (Women, Infants & Children) Program
- ☐ Women's Way

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

_____

_____

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

- ☐ Advertising
- ☐ Community events
- ☐ Employer/worksite wellness
- ☐ Health care professionals
- ☐ Indian Health Services/Tribal Health
- ☐ Newspaper
- ☐ Public health professionals
- ☐ Radio
- ☐ Schools
- ☐ Social media (Facebook, Instagram, etc.)
- ☐ Web searches
- ☐ Word of mouth, from others (friends, neighbors co-workers, etc.)
- ☐ Other (Please specify) _____

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

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

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

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

21. 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? _____

22. 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

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

- ☐ Yes
- ☐ No

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

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

25. 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
- ☐ 2-3 years
- ☐ 4-5 years
- ☐ 6-10 years
- ☐ No, will not use service in next 10 years

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

- ☐ Yes
- ☐ No

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

- ☐ Caregiver support
- ☐ Hospice/end of life
- ☐ Long term care insurance
- ☐ Pain management
- ☐ Other: _____

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

28. 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

29. In Mercer County, are you aware that Knife River Care Center offers therapy services in a comfortable, homelike environment?

- ☐ Yes
- ☐ No

30. In Mercer County, Knife River Care Center offers skilled nursing and therapy services for short stay and long stay residents. 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
- ☐ 2-3 years
- ☐ 4-5 years
- ☐ 6-10 years
- ☐ No, will not use service in next 10 years

31. If Knife River Care Center offered classes related to fall prevention and management for community members would you or one of your immediate family members (parents, grandparents, etc.) utilize these services?

- ☐ Yes
- ☐ No

Demographic Information: Please tell us about yourself.

32. Do you work for the hospital, clinic, or public health unit?

- ☐ Yes
- ☐ No

33. How did you acquire the survey (or survey link) that you are completing?

- ☐ Hospital or public health website
- ☐ Hospital or public health social media page
- ☐ Hospital or public health employee
- ☐ Hospital or public health facility
- ☐ Economic development website or social media
- ☐ Other website or social media page (please specify): _____
- ☐ Newspaper advertisement
- ☐ Newsletter (if so, what one):_____
- ☐ Church bulletin
- ☐ Flyer sent home from school
- ☐ Flyer at local business
- ☐ Flyer in the mail
- ☐ Word of mouth
- ☐ Direct email (if so, from what organization):_____
- ☐ Other (please specify): _____

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

- ☐ Indian Health Service (IHS)
- ☐ Insurance through employer (self, spouse, or parent)
- ☐ Self-purchased insurance
- ☐ Medicaid
- ☐ Medicare
- ☐ No insurance
- ☐ Veteran's Healthcare Benefits
- ☐ Other (please specify): _____

35. Age:

- ☐ Less than 18 years
- ☐ 18 to 24 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 to 74 years
- ☐ 75 years and older

36. Highest level of education:

- ☐ Less than high school
- ☐ High school diploma or GED
- ☐ Some college/technical degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Graduate or professional degree

37. Gender:

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Other (please specify): _____

38. Employment status:

- ☐ Full time
- ☐ Part time
- ☐ Homemaker
- ☐ Multiple job holder
- ☐ Unemployed
- ☐ Retired

39. Your zip code: _____

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

- ☐ American Indian
- ☐ African American
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Pacific Islander
- ☐ White/Caucasian
- ☐ Other: _____

41. Annual household income before taxes:

- ☐ Less than $15,000
- ☐ $15,000 to $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 and over

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

_____

_____

Thank you for assisting us with this important survey!

Appendix D – County Health Rankings Explained

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

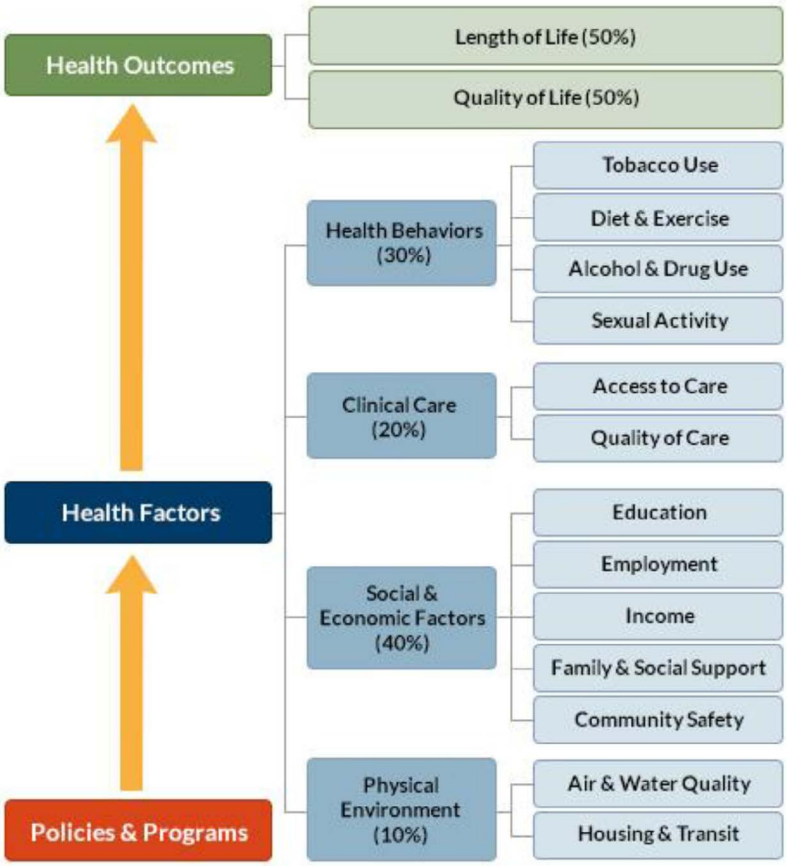
Methods

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 U.S. 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 U.S. 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 U.S. 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 U.S., 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 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.

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.

Flu Vaccinations

Flu vaccinations are Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination.

Reason for Ranking

Influenza is a potentially serious disease that can lead to hospitalization and even death. Every year there are millions of influenza infections, hundreds of thousands of flu-related hospitalizations, and thousands of flu-related deaths. An annual flu vaccine is the best way to help protect against influenza and may reduce the risk of flu illness, flu-related hospitalizations, and even flu-related death. It is recommended that everyone 6 months and older get a seasonal flu vaccine each year, and those over 65 are especially encouraged because they are at higher risk of developing serious complications from the flu.

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 U.S. 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 U.S. 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 E – Youth Risk Behavior Survey

Youth Behavioral Risk Survey Results
North Dakota High School Survey
Rate Increase "↑" rate decrease "↓", or no statistical change = in rate from 2017-2019

	ND 2015	ND 2017	ND 2019	Trend ↑, ↓, =	Town Average	ND Town Average	Average 2019
Injury and Violence							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.5	8.1	5.9	=	8.8	5.4	6.5
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)	17.7	16.5	14.2	=	17.7	12.7	16.7
Percentage of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey, among students who drove a car or other vehicle)	NA	56.2	59.6	=	60.7	60.7	NA
Percentage of students who texted or e-mailed while driving a car or other vehicle (on at least one 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)	57.6	52.6	53.0	=	56.5	51.8	39.0
Percentage of students who never or rarely wore a helmet (during the 12 months before the survey, among students who rode a motorcycle)	NA	20.6	NA	**NA**	NA	NA	NA
Percentage of students who carried a weapon on school property (such as a gun, knife, or club on at least one day during the 30 days before the survey)	5.2	5.9	4.9	=	6.2	4.2	2.8
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	5.4	7.2	7.1	=	7.4	6.4	8.0
Percentage of students who experienced sexual violence (being forced by anyone to do sexual things [counting such things as kissing, touching, or being physically forced to have sexual intercourse] that they did not want to, one or more times during the 12 months before the survey)	NA	8.7	9.2	=	7.1	8.0	10.8
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)	7.6	NA	NA	**NA**	NA	NA	8.2
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)	NA	11.4	11.6	=	12.6	11.4	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.0	24.3	19.9	↓	24.6	19.1	19.5
Percentage of students who were electronically bullied (including being bullied through texting, Instagram, Facebook, or other social media during the 12 months before the survey)	15.9	18.8	14.7	↓	16.0	15.3	15.7
Percentage of students who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities during the 12 months before the survey)	27.2	28.9	30.5	=	31.8	33.1	36.7
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.2	16.7	18.8	=	18.6	19.7	18.8

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	9.4	13.5	13.0	=	12.5	11.7	8.9
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
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)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	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 one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	NA	18.1	12.2	NA	15.1	10.9	10.5
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7

	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	18.2	12.1	NA	NA	NA	NA	21.8
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)	NA	NA	NA	NA	NA	NA	NA
Sexual Behaviors							
Percentage of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
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 seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
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 seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
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 seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the 7 days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.7
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)	NA	2.7	2.8	=	2.1	2.9	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)	NA	51.5	49.0	=	55.0	22.6	55.9

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	NA	69.1	66.8	=	63.0	68.2	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)	NA	12.8	NA	NA	NA	NA	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)	NA	8.3	7.0	=	6.0	5.9	4.5

Sources: https://www.cdc.gov/healthyyouth/data/yrbs/results.htm; https://www.nd.gov/dpi/districtsschools/safety-health/youth-risk-behavior-survey

Appendix F – Prioritization of Community's Health Needs

Hazen/Beulah/Center/Killdeer, North Dakota
Ranking of Concerns

The top concerns for each of the five-topic area, based on the community survey results, were listed a Qualtrics survey. The numbers below indicate the total number of votes by the people in attendance at the virtual second community meeting. The "Priorities" column lists the number of concerns indicating which areas are felt to be priorities. Each person was told to choose four items they felt were priorities on Williston survey part 1. After tallying the first round of votes, a second survey was given with the top four concerns from the first survey. The "Most Important" column shows the results of the second survey, with depression/anxiety for all ages receiving the highest votes, followed by attracting & retaining young families and availability of mental health services.

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Attracting & retaining young families	13	4
Having enough child daycare services	8	3
Change in population size (increasing & decreasing)	5	
Not enough jobs with livable wages	0	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health services	9	4
Extra hours for appointments, such as evenings and weekends	6	
Ability to retain primary care providers (MD, DO, NP, PA)	5	
Availability of specialists	0	
YOUTH POPULATION HEALTH CONCERNS		
Alcohol use and abuse	4	
Drug use and abuse (including prescription drugs)	6	
Depression/anxiety (all ages)	11	7
Smoking and tobacco use, exposure to second-hand smoke, juuling/vaping	3	
ADULT POPULATION HEALTH CONCERNS		
Alcohol use and abuse	2	
Drug use and abuse (including prescription drugs)	2	
Depression/anxiety	7	
Stress	5	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	1	
Availability of resources to help elderly stay in their homes	3	
Assisted living options	1	
Long-term/nursing home options	1	

Appendix G – Survey "Other" Responses

The number in parenthesis () indicates the number of people who indicated that EXACT same answer. All comments below are directly taken from the survey results and have not been summarized.

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:
    - Close minded and cliques!
    - People are hard working
    - Selective cliques
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
    - People
    - Community is a joke! School system… you better believe in sports!
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
    - None
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
    - Fishing and boating near by
    - Not many activities
    - County fair
    - Not a lot available

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:
    - Is local economy stable - coal
    - Moving toward unreliable "renewable" energy when we have sustainable coal and jobs already in place
    - Younger generation not giving of time to the greater good
    - Lack of organic food options
    - Streets/roads in need of repair
    - Not enough outdoor spaces conducive to activity (walking paths or sidewalks)
    - Drug use
    - Not having a grocery store - people don't want to live in a town without one
    - Retaining retirees
    - Retaining adults in community - 50's and older
    - Not enough teen activities if not in sports
    - Not enough housing
    - Lack of options to purchase clothing for youth boys.
    - Drugs
    - Poor Covid knowledge/ compliance

- Having a police force and states attorney that will do their job!
- Rising numbers of drug use

6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: "Other" responses:

- Concerns of experience and professionalism of doctors and nurses
- Mental health care
- I don't have concerns-- love that we have a health food store that provides great quality vitamins!!!
- It's difficult to get an appointment with a doctor vs an NP
- I use our healthcare system several times a week. My wife is disabled. The healthcare system in Mercer, Dunn, and Oliver county is fantastic. I can't check any of the above.
- None of the above
- Enough people to staff the ambulance and rescue crews
- Trustworthy pharmacy
- Having Michael Schmidt as a surgeon is a concern

8. Considering the YOUTH POPULATION in your community, concerns are: "Other" responses:

- Disrespect for others
- Places to go after school until parents are off work
- Passive parenting/lack of involvement by parents
- Disrespect for others
- Places to go after school until parents are off work

9. Considering the ADULT POPULATION in your community, concerns are: "Other" responses:

- Availability of vulnerable adult/adult protective services
- Not enough vaccinated against COVID
- Women's health care and certainly awareness-based methods

10. Considering the SENIOR POPULATION in your community, concerns are: "Other" responses:

- Medical procedures
- Availability of affordable help to assist elderly staying in their own homes
- Not getting enough company and interaction with humans
- Activities
- Not enough employees at elder care facilities

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

- A more diverse economy
- I believe the biggest challenge in Stanton (Mercer County) is the lack of commerce here -- restaurant, coffee stand, quilt store, etc.
- Access to adequate healthcare related to the shortage of healthcare providers.
- Access to good health care
- Alcohol/drugs in the community
- Assisted living facilities to fit the "in between" stage of in home and nursing home. Having a place that enhances the quality of life for that time in their life.
- Attracting and retaining new families to the communities.
- "Availability of AFFORDABLE options for helping elderly stay in their homes.
- In Dunn County, availability of resources for the elderly. "
- Availability of resources to individuals for all-around health, youth, adults, and seniors. And the lack of collaboration of the few resources and companies that are available.
- Bringing in young families and having jobs for them making the economy more diverse at not everyone

can work at a power plant not promoting work at home people to the community to bring in more people. Not enough teen activities especially for those not involved in sports. The festivals and stuff are great but they never had any teen activities is all for younger kids.

- "Care for Dementia and support group and porn addiction. There are none.
- Child care-hard to find dependable, quality care.
- Cost of Long-term/nursing home care
- Covid
- Delays in medical assistance
- COVID
- Democrat control of our country. Killing industry. Handing out money and causing massive inflation.
- Depression/anxiety
- Depression/Anxiety
- Drug use and abuse
- Drugs
- Elderly care
- Elderly population usually pack up and move out to a bigger city closer to hospitals or they go into nursing homes.
- Endowment quality
- General knowledge about well-being such as healthy habits, good nutrition, need for exercise
- Getting community members active in our communities....information about where to volunteer. Healthy activities for families and elderly population.
- Great ? A lack of quality parenting.
- Having social activities for youth outside of school activities. Also, for adults' social activities outside of going to bars.
- Health insurance costs
- Heavy reliance on one industry for jobs and tax base
- Help for out of pocket cost when people don't have insurance
- High personnel mobility
- How much does the community protect my health and whether my economic ability is equal to that of health insurance
- Industry and whether or not the plants are going to close.
- It is a competition for college students to enter the community.
- Keeping people here
- Keeping the coal mines viable
- Keeping the younger families here and decent earning potential.
- Keeping the younger population in our communities instead of them moving to Bismarck
- Lack of affordable housing
- Lack of daycare center
- Lack of open-minded residence to allow new opportunities and businesses to come in. Some change is good, but then other change is restricted. Be more welcoming to new comers.
- "Lack of parental participation in education. Family engagement in educational directives, goals and learning outcomes is critically absent. Additionally, alcohol use among teenagers and lack of parental concern about the issue.
- Lack of places to exercise
- Lack of pride in community and lack of willing to improve/volunteer/support local.
- Long term stability of jobs in natural resources. The people of this area are mostly involved in non-renewable energy.
- Long-term care costs
- Many elderly people in our community are very resistant to receiving help in their home or living in

assisted living or nursing home when obviously needed by them.

- medical care
- More gym space for kids' activities
- no
- NO
- No one works together. Horrible states attorney, no laws enforced, different rules for different residents.
- not enough activities for the specific groups (example) widows and widowers / divorced people/ single people-who don't want to go to the bars
- Not enough basic care, assisted living for elderly
- Not enough involvement for the elderly
- Not enough of a workforce/ This is the number one cause for less business expansion.
- Not enough things to do, especially families with children as a lot of activities (especially evening ones) are not child friendly or do not allow kids
- Not much housing and not affordable
- Now is very good
- Nursing home care with enough care professionals. Shortages of workers at these facilities.
- Old people have no good medical equipment for sudden illness
- Police not enforcing the laws with young people especially the drug and alcohol. Too many kids get away with it and they know they won't get in trouble if caught.
- Potential loss of jobs due to changes in industry

Delivery of Healthcare

13. Where do you find out about LOCAL HEALTH SERVICES available in your area? "Other" responses:

- I work at CCCHC
- family members employers

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

- After hours clinic 5-8 pm, ER not proper use for most issues after the clinic closes
- Better access to all medical services. Not just a few.
- Community Paramedic program
- Dermatology
- Dermatology; visiting nephrology; visiting neurology (neuropsych assessments)
- Dialysis
- Girl talk. Teach teens about health growing up
- Holistic health services
- Homeopathic medicinal services/providers with this in mind
- In home mental health care
- More relaxation like different types of yoga and a store that offers very healthy food choices where the food is already prepared for you!
- Naturopathic Doctors and Services
- NO
- no
- no
- no idea
- OB
- OBGYN (not just visiting ones)
- Option to deliver babies at SMC like we had in the past.

- Pediatric therapy services PT OT Speech
- Preschool health education. I am a preschool teacher and I feel someone could reach out to me
- Regular health lectures are offered
- Supplementary nutrition assistance program (SNAP)
- There is a need for daycare
- There is no
- Too many to add here
- Van transport to hospital for test or surgery, Dermatology, breast specialist, urology, nephrology, rheumatology, GI specialist
- Visiting dermatologist
- We need an assisted living facility attached to the nursing home.
- Where people live closer to home
- After hours clinic 5-8 pm, ER not proper use for most issues after the clinic closes
- Better access to all medical services. Not just a few.
- Community Paramedic program
- Dermatology
- dermatology; visiting nephrology; visiting neurology (neuropsych assessments)
- Dialysis
- Girl talk. Teach teens about health growing up
- Holistic health services

16. What PREVENTS community residents from receiving healthcare? "Other" responses:

- Nothing-- I stay healthy
- I don't have a concern here.
- Difficult to get appointments to see a doctor. Often have to wait a day or 2 to make appointments for injections
- Nothing
- NONE
- Only used when needed
- None of the above
- I don't see a prevention
- I don't know of anything that prevents one from getting health care.
- Unwilling to seek care.

17. Where do you turn for trusted health information? "Other" responses:

- Books, publications,
- Sister is Dr
- Holistic medicine resources
- my own counselor
- Research
- journals/research articles
- Personal research (not WebMD)

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

- board member
- NONE
- Fundraising events
- No

- no
- Local ambulance serviced
- Donated bought raffle tickets
- fundraisers in the community
- board member
- NONE
- Fundraising events
- No
- no

30. Overall, please share concerns and suggestions to improve the delivery of local healthcare.
    - At this point, I am so over the top satisfied with the care received from Coal Country Community Health.
    - "At this time our primary health care providers are terrible. Nice clinic and they are afraid to refer or treat anything or ask for help
    - Or second opinion. They could be helping 4 times as many people but they are afraid to really do diagnostics or treat anything but tell you it's allergies…."
    - Diversified medical insurance services
    - Enhance medical assistance
    - I feel we are blessed to have excellent health care and providers in Mercer County. I've only had a problem once when SMC was supposed to send results of tests to a provider in Sanford, when I showed up a couple of days later for my appointment in Bismarck I found no test results had been sent to them. In general, though I am happy with the health care I get here. We would like to see a dermatologist in Mercer County
    - I suspect that this survey is subject to selection bias. Those individuals who are in most need of services most likely can't or will not access this survey. thus, this is most likely a flawed survey. We will most likely select behavioral and substance abuse as primary issues. Yet poverty, lack of housing and opportunities for adequate employment probably drive a significant amount of behavioral and substance abuse. Please, recognize that this survey is skewed and limited.
    - I/We feel blessed to have the healthcare services here. We love it here!!
    - If we had more people willing to work in our community we could have so many more services (Restaurants, Clinics, recreation, etc) and not have to seek them in Bismarck.
    - Improve confidentiality at clinics, the hospital and care centers; retain care providers with adequate salaries, benefits and a good community environment
    - Making sure we also take care of all healthcare employees-financially. Some are terribly underpaid while others make more than needed.
    - More options for clinic: walk in, evening, weekend hours, etc
    - Need more after hour appointment times at the clinic. Maybe 2-3 days a week have a walk in from 5-8 pm
    - Need more doctors available. Seem to have plenty of mid-levels
    - Need to maintain adequate numbers of competent staff to care for our patients in clinics and hospital.
    - NO
    - Not suggest
    - Offer more visiting specialists in healthcare. Offer regular scheduled appointments on Saturdays. Urgent care is only open on Saturdays in the morning and if you need to be seen on Sunday for any reason you have to go to the ER and then they have to call a provider in as they aren't staffed usually.
    - ok
    - Only have general care - it seems that if you have a cold, earache, bladder infection. Seems like none of the staff is receiving any training - some cannot draw blood without giving you a huge black and blue mark. X-rays are painful or you are told to go to Bismarck. No availability for in depth mental health care. Lack of caring staff. I do not drive and need physical therapy and pain management. I quit going to physical therapy in Center's Coal Country due to non-exercises; expect to do exercises at home.
    - People need to be made aware that many services are available here but it is important that people with

certain chronic diseases like diabetes be referred to a specialist if they cannot be treated in a satisfactory manner here.

- "prefer not to answer income
- Making people more aware of the services offered in the area would be the best way to increase utilization.
- There is concern about receiving care from people in a small community - some services I would not utilize since medical information may not stay confidential. "
- Promote the knowledge of disease prevention
- Reduce medical expenses
- Services for seniors to assist families with caring for elderly parents so can stay in home.
- Shorten appointment times and open more hospitals and clinics in the community.
- that short 10-minute services where advice and vitals are taken is $300+ after insurance.
- There may be great healthcare for residents around Beulah - Hazen but coal country has very little available in killdeer. One provider is adequate but has few appointments available. The other provider is rude and not anyone I'd take my family to see. SMC is a great hospital but it and its specialists and programs are over an hour away. Might as well drive to Dickinson or Bismarck and see the same provider consistently.
- We are blessed to have the providers and facilities that we do have.
- We have great health care facilities here. Daycare is a need; however, I'd prefer if it wasn't a daycare that tried to eliminate the need for private preschool as is what happened in Hazen with ECCC
- We have much to be proud of in terms of the availability of local quality healthcare in Mercer County
- We need to pay our local employees the same as the incoming traveling staff. It's basic supply and demand. If you need employees, pay them more and they will work. If you continue to pay the incoming travel nurses, CNA's more than the local staff they will continue to be short staffed.
- We need well educated people who continue to learn. Too many mistakes are made
- Would prefer to have healthcare that looks at the root cause of issues and treat that as naturally as possible before simply getting a prescription for every ailment. Integrative and overall health is not something I'm aware of that exists at the clinic where I live, so I tend to avoid the clinic. If it does exist, then I'm unaware of it and would appreciate it being advertised.