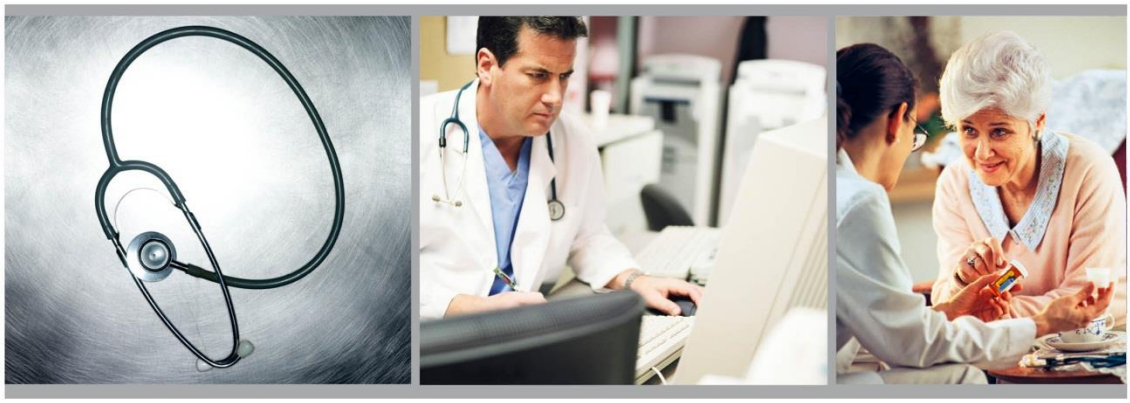
Community Health Needs Assessment



Mountrail County Health Center
Stanley, North Dakota

2012 - 2013

Completed by

The North Dakota Medicare Rural Hospital Flexibility (Flex) Program
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Introduction

To help inform future decisions and strategic planning, Mountrail County Health Center (MCHC) in Stanley, North Dakota conducted a community health needs assessment. Through a joint effort, Mountrail County Health Center and the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences analyzed community health-related data and solicited input from community members and local health care professionals. The Center for Rural Health's involvement was funded through its Medicare Rural Hospital Flexibility (Flex) Program. The Flex Program is federally funded by the Office of Rural Health Policy and as such associated costs of the assessment were covered by a federal grant.

The purpose of conducting a community health needs assessment is to describe the health of local people, identify use of local health care services, identify and prioritize community needs, and lay the groundwork for identifying action needed to address health needs. A health needs assessment benefits the community by: 1) collecting timely input from the local community, providers, and staff; 2) providing an analysis of secondary data related to health 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 health care delivery; and 5) allowing the charitable hospital to meet federal regulation requirements of the Patient Protection and Affordable Care Act, which requires not-for-profit hospitals to complete a community health needs assessment at least every three years.

To gather feedback from the community, residents of the health care service area and staff of Mountrail County Health Center were given the chance to participate in a widely distributed survey. Additional information was collected through a Community Group comprised of community residents as well as through one-on-one key informant interviews with community leaders.

Mountrail County Health Center

Mountrail County Health Center (MCHC) is an 11-bed critical access hospital providing quality health care to Mountrail County and the surrounding area by offering long-term health care, primary medical care, emergency medical care and clinic services. As part of Stanley's recently integrated health care system, MCHC offers many facilities for patients and residents on its campus. Under the MCHC umbrella is the hospital, a rural health clinic which is open on weekdays, a nursing home, an independent unit living facility and an aquatic center.

MCHC was dedicated on June 12, 1952, coinciding with the 50th anniversary of the city of Stanley. The hospital was operated by Lutheran Homes Society until 1955. A few years later an addition was built, completing the Stanley Medical Clinic building. In the early 1990s Mountrail County Health Foundation was formed to assist in supporting the hospital and it helped guide the newly formed MCHC to buy the Stanley Community Hospital in 1997. A smaller hospital was then built and it merged with the nursing home.

Mountrail Bethel Home is a nursing home with 57 beds. It provides skilled nursing care to chronically ill individuals including I.V. care, specialized diets and 24-hour care. It boasts a high staff-to-resident ratio. The nursing home is rated as one of the top nursing home facilities in the state and maintains an above average level of occupancy. Centennial Court is a 12-unit independent living facility that offers security, independence and companionship to its residents.

MCHC has benefitted from community fundraising efforts; the construction of the Ina Mae Rude Aquatic Center is one example of a generous donation from a community member.

Two physicians, two nurse practitioners, one physician assistant, 18 registered nurses and 14 licensed practical nurses are among the 128 employees of MCHC.

Mountrail County Health Center has had substantial economic impact on its community. Its primary impact to the county is $5 million. Its secondary impact is $1.29 which includes the relationship of MCHC and its employees with other sectors in the county. The total economic impact is $6.29 million annually. (Financial impacts were estimated using the Minnesota IMPLAN economic impact modeling software).

Overview of Services

Services offered locally by Mountrail County Health Center include:

General and Clinical Services

- Acne treatment
- Allergy, flu & pneumonia shots
- Blood pressure checks
- Clinic
- Long-term care
- Mole/wart/skin lesion removal
- Patient education & teaching
- Physicals: annual, D.O.T., sports & insurance
- Prenatal care up to 32 weeks
- Referrals and follow-up care
- Sports medicine
- Swing bed services

Acute services

- Cardiac rehab
- 24-hour emergency room
- General surgeon—visiting specialist
- Hospital (acute care)
- Senior housing
- Surgical services—biopsies
- Surgical services—outpatient
- Surgical services—podiatry procedures

Screening/therapy services

- Diet instruction
- Health screenings
- Laboratory services
- Occupational therapy
- Physical therapy
- Speech therapy
- Social services

Radiology services

- EKG
- CT scan
- Echocardiograms
- General x-ray
- Mammograms
- MRI
- Ultrasound

Health Care Facilities and Other Resources

Mountrail County is located in the northwest corner of North Dakota, lying above Lake Sakakawea. Stanley is situated in the middle of Mountrail County, and is about an hour west from the city of Minot.

The leading industries in Mountrail County are primarily agricultural and oil. Lake Sakakawea, one of North Dakota's largest recreational areas, offers excellent hunting and fishing. Other area recreational opportunities include a 9-hole golf course, parks, tennis courts, swimming pool, athletic fields, movie theatre and bowling alley.

Dental, chiropractic, massage and optometric services are available in the community.

Indian Health Services

Fort Berthold Reservation is located in New Town, about 30 miles from Stanley, and is home to The Three Affiliated Tribes (Mandan, Arikara and Hidatsa). The reservation spans about one million acres in west-central North Dakota and has a tribal enrollment of 8,500. The Minne-Tohe Health Center is operated by Indian Health Services and has a family practitioner and an internist on staff.

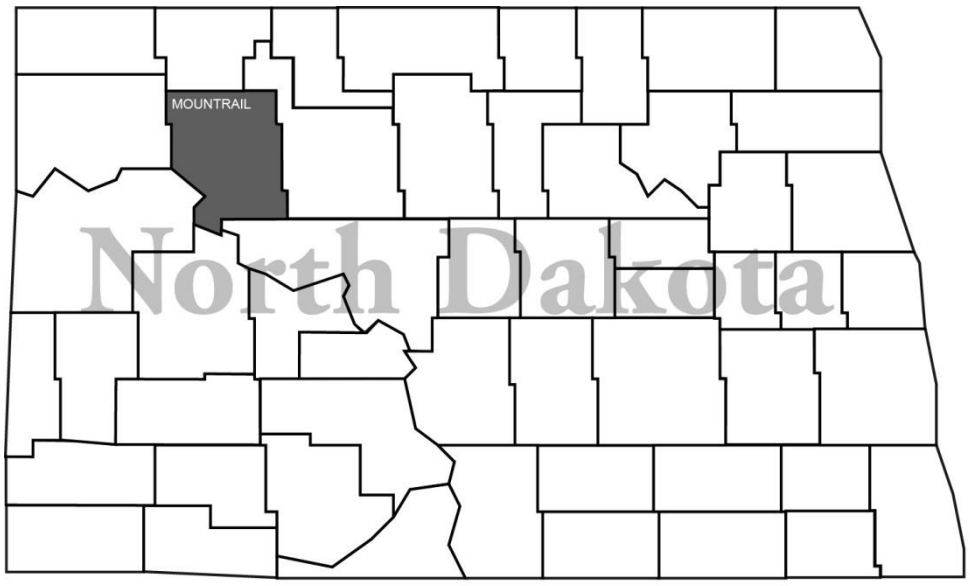
Stanley Ambulance EMS

Stanley Ambulance Service is a private company employing 11 to15 staff. Other ambulance companies available in Mountrail County service the communities of Parshall and New Town.

Assessment Methodology

Mountrail County Health Center's service area is residents of Mountrail County. This service area is defined based on the location of the medical facilities, the geographic distance to other hospitals, and the history of usage by consumers. Located in the hospital's service are the communities of Belden, Blaisdell, Coulee, Lostwood, New Town, Palermo, Parshall, Plaza, Ross, Sanish and White Earth.

FIGURE 1: SERVICE AREA OF MOUNTRAIL COUNTY HEALTH CENTER



The Center for Rural Health provided substantial support to MCHC in conducting this needs assessment. Center for Rural Health representatives collected data for the assessment in a variety of ways: (1) a survey solicited feedback from area residents; (2) another version of the survey gathered input from health care professionals who work at MCHC; (3) community leaders representing the broad interests of the community took part in one-on-one key informant interviews; (4) a Community Group comprised of community leaders and area residents was convened to discuss area health needs; and (5) a wide range of secondary sources of data was examined, providing information on a multitude of measures including demographics; health conditions, indicators, and outcomes; rates of preventive measures; rates of disease; and at-risk activities.

The Center for Rural Health is one of the nation's most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. The Center serves as a resource to health care providers, health organizations, citizens, researchers, educators, and policymakers across the state

of North Dakota and the nation. Activities are targeted toward identifying and researching rural health issues, analyzing health policy, strengthening local capabilities, developing community-based alternatives, and advocating for rural concerns.

As the federally designated State Office of Rural Health (SORH) for the state and the home to the North Dakota Medicare Rural Hospital Flexibility (Flex) Program, the Center connects the School of Medicine and Health Sciences and the university to rural communities and their health institutions to facilitate developing and maintaining rural health delivery systems. In this capacity the Center works both at a national level and at state and community levels. Detailed below are the methods undertaken to gather data for this assessment by convening a Community Group that served as a focus group, conducting key informant interviews, soliciting feedback about health needs via a survey, and researching secondary data.

Community Group

A community group consisting of nine members was convened and met on January 14, 2013 for approximately 90 minutes. During this first Community Group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the MCHC service area, and served as a focus group. Focus group topics included the general health needs of the community, general community concerns, community health concerns, delivery of health care by local providers, awareness of health services offered locally, barriers to using local services, suggestions for improving collaboration within the community, reasons community members use MCHC and reasons community members use other facilities for health care.

The Community Group met again on April 8, 2013 for approximately 90 minutes. 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 and behaviors of the population in the MCHC service area. 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 MCHC. They included representatives of the health community, public schools, business community, faith community, city personnel, business leaders and elected officials. To add varying perspectives, various age brackets were represented including senior citizens as well parents with young children. Members of the Community Group are listed in Appendix B. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with key informants were conducted in person in Stanley on January 14, 2013. Telephone interviews were held on January 28, 2013. A representative of the Center for Rural Health conducted the interviews. Interviews were held with key informants who could provide insights into the community's health needs. These interviewees represented the broad interests of the community served by MCHC. They included representatives of the medical community, business community and local government. Included among the informants was a public health nurse with special knowledge in public health acquired through several years of direct care experience in the community, including working with medically underserved, low income and Native populations, as well as with populations with chronic diseases. A resident of New Town where Fort Berthold Indian Reservation is located and who has interaction with low income and minority populations was also interviewed. Those taking part in interviews are listed in Appendix B.

Topics covered during the interviews included the general health needs of the community, local health care delivery concerns, general community concerns, awareness of health services offered locally, barriers to using local services, suggestions for improving collaboration within the community, reasons community members use local health care services, and reasons community members use non-local health facilities.

Survey

A survey was distributed to gather feedback from the community. The survey was not intended to be a scientific or statistically valid sampling of the population. Rather, 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.

Two versions of a survey tool were distributed to two different audiences: (1) community members and (2) health care professionals. Copies of both survey instruments are included in Appendix A.

Community Member Survey

The community member survey was distributed to residents of the service area of Mountrail County Health Center. The survey tool was designed to:

- Understand community awareness about services provided by the local health system and whether consumers are using local services;
- Understand the community's views and attitudes about potential health concerns in the area;
- Learn about broad areas of community concerns;
- Determine preferences for using local health care versus traveling to other facilities; and

- Solicit suggestions and help identify any gaps in services.

Specifically, the survey covered the following topics: community assets, awareness and utilization of local health services, barriers to using local services, suggestions for improving collaboration within the community, local health care delivery concerns, reasons consumers use local health care providers and reasons they seek care elsewhere, travel time to the nearest local provider clinic and to the nearest clinic not operated by a local provider, demographics (gender, age, marital status, employment status, income, and insurance status), and any health conditions or diseases respondents currently have.

Approximately 500 community member surveys were available for distribution in the service area. The surveys were distributed by Community Group members and were made available at banks, oil companies, area businesses, the aquatic center, and the hospital and clinic. To help ensure anonymity, included with each survey was a postage-paid return envelope to the Center for Rural Health. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling MCHC. The survey period ran from January 14, 2013 until February 8, 2013. Approximately 64 completed surveys were returned.

Area residents were given the option of completing an online version of the survey, which was publicized in area newspapers. Twenty-one online surveys were completed. Between the hard-copy surveys and the online version of the survey, a total of 85 community member surveys were completed.

Health Care Professional Survey

Employees of MCHC were encouraged to complete an online version of the survey geared to health care professionals. Fifty-seven of these surveys were completed online. The version of the survey for health care professionals covered the same topics as the consumer survey, although it sought less demographic information and did not ask whether health care professionals were aware of the services offered by MCHC.

Combining the print and online community member surveys with the health care professional surveys makes for a total survey sample of 142 responses.

Secondary Research

Secondary data were collected and analyzed to provide a snapshot of the area's overall health conditions, behaviors, and outcomes. Information was collected from a variety of sources including the U.S. Census Bureau; the North Dakota Department of Health; the Robert Wood Johnson Foundation's County Health Rankings (which pulls data from 14 primary data sources); North Dakota Health Care Review, Inc. (NDHCRI); the National Survey of Children's Health Data Resource Center; the Centers for Disease Control and Prevention; the North Dakota Behavioral Risk Factor Surveillance System; and the National Center for Health Statistics.

Demographic Information

Table 1 summarizes general demographic and geographic data about Mountrail County.

TABLE 1: COUNTY INFORMATION AND DEMOGRAPHICS (From 2010 Census where available; some figures from earlier Census data)		
	Mountrail County	**North Dakota**
Population (2011)	13,937	683,932
Population change, 2000-2010	15.7%	4.7%
Square miles	1,825	69,001
People per square mile	4.2	9.8
Caucasian	67.5%	90.0%
American Indian	29.1%	5.4%
High school graduates	88.5%	89.4%
Bachelor's degree or higher	19.9%	26.3%
Live below poverty level	16.5%	12.3%
Children in poverty	21%	14%
65 years or older	12.8%	14.5%
Median age	39.6	37.0

The data indicate that Mountrail County has a slightly smaller percentage of individuals over the age of 65 than the North Dakota average. The County also has a slightly higher median age, by more than two years, than the state median age. In 2000 the median age was 40 indicating the median age has remained stable over the past decade. A population with fewer senior citizens and an older median age may signify unique medical needs.

The data show that the robust population growth occurring in Mountrail County Health Center's service area may create an increasing number of residents most likely to use MCHC's services. If this trend continues, adults requiring care, especially those aged 65 years and older, will increase. State level data also greatly support this trend as the U.S. Census Bureau, Interim State Population

Projections (2005) predict the state population of residents 65 and older to increase 61.3% between 2000 and 2030.

Mountrail County has a slightly lower percentage of individuals with a high school diploma but a considerably lower rate of residents holding a bachelor's degree than the state averages. Approximately one out of five residents living in the County holds a bachelor's degree or higher, compared to one out of four for the state average. The reduced number of individuals with formal education could have implications for recruiting educated health care professionals to work with Mountrail County Health Center.

Mountrail County has concerning poverty rates, as both the rates for adults and children living below poverty level are higher than state averages. Of particular note is the rate of children aged eighteen years and younger who are living below the poverty line; this rate is one and a half times the state average signifying that children's access to and affordability of health care is an issue in this county.

Mountrail County is considered a frontier County, with an average of 4.2 people per square mile compared to the state average of 9.8 people per square mile. This rural area has implications for the delivery of services and residents' access to care. Transportation can be an issue for rural residents as can isolation, which can have many effects on health status.

Health Conditions, Behaviors, and Outcomes

As noted above, several sources were reviewed to inform this assessment. This data is presented below in four categories: (1) County Health Rankings, (2) public health community profiles, (3) preventive care data, and (4) children's health. One other source of information, the Gallup-Healthways Well-Being Index, shows that North Dakota ranked second nationally in well-being during 2011. The index is an average of six sub-indexes, which individually examine life evaluation, emotional health, work environment, physical health, healthy behaviors, and access to basic necessities.

Table 2: Variables Influencing a County's Health Rankings	

Health Outcomes
• Mortality (length of life)
• Morbidity (quality of life)
 	
Health Factors
• Health Behavior
  ○ Tobacco use
  ○ Diet and exercise
  ○ Alcohol use
  ○ Unsafe sex
• Clinical Care
  ○ Access to care
  ○ Quality of care
	Health Factors (continued)
	• Social and Economic Factors
	  ○ Education
	  ○ Employment
	  ○ Income
	  ○ Family and social support
	  ○ Community safety
	• Physical Environment
	  ○ Air quality
	  ○ Built environment

Table 2 summarizes pertinent information taken from County Health Rankings as it relates to Mountrail County Health Center's service area in Mountrail County. It is important to note that these statistics describe the population of each 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 patients of MCHC. Moreover, other health facilities are located in other counties that are adjacent to Mountrail County. For example, two other critical access hospital are located in adjacent Williams County, one in Tioga and one in Williston and there is an acute care, level 2 trauma center in Minot in Ward County. Additionally, in Mountrail County there is an Indian Health Services hospital located in New Town.

For some of the measures included in the rankings, the County Health Rankings' authors have calculated a national benchmark for 2012. As the authors explain, "The national benchmark is 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 (e.g., high school graduation) or negatively (e.g., adult smoking)."

Mountrail County's rankings are listed in Table 3. Mountrail County comes in 43rd place for both health outcomes and factors. The variables marked by a diamond (❖) are areas where the county is not measuring up to the national benchmark. The variables marked by a red checkmark (✓) are areas where the county is not measuring up to state averages. Appendix D sets forth definitions for each of the variables.

TABLE 3: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS			
	Mountrail County	**National Benchmark** ❖	**North Dakota** ✓
Ranking: Outcomes	**43rd**		**(of 46)**
Poor or fair health	❖✓ 17%	10%	12%
Poor physical health days (in past 30 days)	❖✓ 2.9	2.6	2.7
Poor mental health days (in past 30 days)	❖✓ 2.8	2.3	2.5
% Diabetic	✓ 10%	-	8%
Ranking: Factors	**43rd**		**(of 46)**
Health Behaviors			
Adult smoking	❖✓ 28%	14%	19%
Adult obesity	❖✓ 35%	25%	30%
Physical inactivity	❖✓ 34%	21%	26%
Excessive drinking	❖✓ 24%	8%	22%
Motor vehicle crash death rate	❖✓ 53	12	19
Sexually transmitted infections	❖✓ 1,075	84	305
Teen birth rate	❖✓ 63	22	28
Clinical Care			
Uninsured	❖✓ 15%	11%	12%
Primary care provider ratio	❖✓ 821:1	631:1	665:1
Mental health provider ratio	✓ 6,569:0	-	2,555:1
Preventable hospital stays	❖✓ 85	49	64
Diabetic screening	❖✓ 68%	89%	85%
Mammography screening	❖✓ 52%	74%	72%
Physical Environment			
Limited access to healthy foods	❖ 8%	0%	11%
Access to recreational facilities	❖✓ 0	16	13

Mountrail County

Mountrail County is ranked in the bottom tenth for overall health outcomes, coming in at 43 out of 46 ranked counties. County residents self-report a higher number of days of poor health, physical health and mental health as compared to national benchmarks and state averages. The percentage of diabetics in Mountrail County is also slightly elevated, at 10% compared to the state average of 8%.

In terms of health factors, including health behaviors, clinical care measures, and physical environment, Mountrail County maintains its low performing rank of 43 out of 46 counties. Mountrail County has higher rates in *all behavioral categories than both national benchmarks and state averages.*

Of particular concern as they show markedly worse rates than the national benchmark and state average are:

- Adult smoking rate (2x national benchmark)
- Physical inactivity rate (1 ½ x national benchmark)
- Excessive drinking rate (3x national benchmark)
- Motor vehicle crash death rate (4x national benchmark)
- Sexually transmitted infections (12x national benchmark)
- Teen birth rate (nearly 3x national benchmark)

In terms of clinical care, Mountrail County has some concerning results. The number of residents without insurance is higher than both the national benchmark and state average. The ratios of residents to primary care doctors and mental health providers are higher as is the rate of preventable hospital stays. Diabetic and mammography screening rates are lower. While Mountrail County has better rates of access to healthy foods than state averages, it lacks access to recreational facilities.

Public Health Community Profiles

Included as Appendix E is the North Dakota Department of Health's community health profile for the Upper Missouri District which includes the counties of Williams, Mountrail, Divide and McKenzie. While the appendix includes information on all counties served by MCHC, this report focuses on Mountrail County. Some of the demographic information presented in these community health profiles is based on earlier census data. Data concerning causes of death is from 2004 to 2008.

For Mountrail County, anomalies are the leading cause of death for infants. No information is reported for those aged 5-14. Unintentional injury is the leading cause of death for those aged 15-24, followed by suicide. Heart disease and suicide share the top causes of death for the 25-34 age bracket and information is unavailable for secondary causes. For those aged 35-44, unintentional injury is the leading cause of death, followed by heart disease. For those aged 45-65 heart disease is the leading cause, and unintentional injury and cancer come in second. Cancer is the number one cause of death for those aged 65-74, followed by heart disease. This pattern is flipped for those aged 75 and older where heart disease is the leading cause of death, followed by cancer.

This data on causes of death suggest that in Mountrail County, reductions in mortality may be achieved by focusing on prevention of accidents and suicides as well as early detection and prevention of cancer and heart disease.

In Mountrail County, there is a pointedly higher rate of residents who are overweight or obese, eat less than five fruits and vegetables per day and have a higher diabetes diagnosis rate as compared to the state average. Oral health is poor as the number of residents needing dental attention and having tooth loss is large. The drunk driving rate is over three times the state average. Additionally, there was a high percentage of respondents who lacked any health insurance as well as those who reported that they did not have one person whom they consider to be their health care provider. However, asthma rates and incidences of high blood pressure are lower than state averages.

In assessing the region's health needs, attention also should be paid to other information provided in the public health profiles about quality of life issues and conditions such as arthritis, asthma, cardiovascular disease, cholesterol, crime, drinking habits, fruit and vegetable consumption, health insurance, health screening, high blood pressure, mental health, obesity, physical activity, smoking, stroke, tooth loss, vaccination and crime.

Preventive Care Data

North Dakota Health Care Review, Inc., the state's quality improvement organization, reports rates related to preventive care.[1] They are summarized in Table 4 for Mountrail County. For a comparison with other counties in the state, see the respective maps for each variable found in Appendix F.

Those rates highlighted below marked with a red checkmark (✓) signify that the Mountrail County is underperforming – meaning the majority of other counties in North Dakota are performing better on that measure. Those rates marked with a happy face (☺) are performing better as compared to other counties in the state.

[1] The rates were measured using Medicare claims data from 2009 to 2010 for colorectal screenings, and using all claims through 2010 for pneumococcal pneumonia vaccinations, A1C screenings, lipid test screenings, and eye exams. The influenza vaccination rates are based on Medicare claims data between March 2009 and March 2010 while the potentially inappropriate medication rates and the percent of drug-drug interactions are determined through analysis of Medicare part D data between January and June of 2010.

TABLE 4: SELECTED PREVENTIVE MEASURES		
	Mountrail County	**North Dakota**
Colorectal cancer screening rates	✓ 49.0%	55.5%
Pneumococcal pneumonia vaccination rates	✓40.0%	51.3%
Influenza vaccination rates	✓33.2%	50.4%
Annual hemoglobin A1C screening rates for patients with diabetes	✓80.9%	92.2%
Annual lipid testing screening rates for patients with diabetes	✓ 65.8%	81%
Annual eye examination screening rates for patients with diabetes	✓ 64.3%	72.5%
PIM (potentially inappropriate medication) rates	✓11.7%	11.1%
DDI (drug-drug interaction) rates	✓ 9.9%	9.8%

The data indicate Mountrail County has some room for improvement as it is underperforming on all accounts compared to state averages. On a positive note, the potential drug to drug interaction rates is fairing only slightly worse than the state average.

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 in Table 5 is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality health care, and information on the child's family, neighborhood, and social context. Data is from 2007. More information about the survey may be found at: http://www.childhealthdata.org/learn/NSCH.

Key measures of the statewide data are summarized below. The rates highlighted with a **red** ✓ signify that North Dakota is faring worse on that measure than the national average.

TABLE 5: SELECTED MEASURES REGARDING CHILDREN'S HEALTH (For children aged 0-17 unless noted otherwise)		
Measure	**North Dakota**	**National**
Children who had preventive medical visit in past year	✓ 78.9%	88.5%
Children who had preventive dental visit in past year	✓ 77.2%	78.4%
Children aged 10-17 whose weight status is at or above the 85th percentile for Body Mass Index	25.7%	31.6%
Children aged 6-17 who engage in daily physical activity	✓ 27.1%	29.9%
Children who live in households where someone smokes	✓ 26.9%	26.2%
Children aged 6-17 who exhibit two or more positive social skills	95.6%	93.6%
Children aged 6-17 who missed 11 or more days of school in the past year	3.9%	5.8%
Young children (10 mos.-5 yrs.) receiving standardized screening for developmental or behavioral problems	✓ 17.6%	19.5%
Children aged 2-17 years having one or more emotional, behavioral, or developmental condition	✓ 11.4%	11.3%
Children aged 2-17 with problems requiring counseling who received mental health care	72.4%	60.0%

The data on children's health and conditions reveal that while North Dakota is doing better than the national average on several measures, it is not measuring up to the national average in annual preventive medical and dental visits and in terms of daily physical activity, households with smokers, developmental screening, and rates of emotional, behavioral or developmental conditions.

Approximately 20% or more of the state's children are not receiving an annual preventive medical visit or a preventive dental visit. Lack of preventive care now affects these children's future health status. Access to behavioral health is an issue throughout the state, especially in frontier and rural areas. Anecdotal evidence from the Center for Rural Health indicates that children living in rural areas may be going without care due to the lack of mental health providers in those areas.

Table 6 includes selected county-level measures regarding children's health in Mountrail County. 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 focus on main components of children's well-being; more information about KIDS COUNT is available at www.ndkidscount.org. The measures highlighted with a red checkmark (✓) indicate those measures in which the county is doing worse than the state average.

The data show that Mountrail County is faring substantially worse than the state averages in terms of uninsured children as well as total teen birth rates. The

County has more teenagers not enrolled in high school, are not high school graduates and not in the labor force compared to the state averages.

The percentage of births to mothers who are receiving inadequate prenatal care is markedly high in Mountrail County -- nearly five times the state average. A significant number of children living in Mountrail County receive free or reduced lunches and Medicaid. While the County reports lower percentages for domestic violence than state averages, anecdotal evidence from the Center of Rural Health indicates that cramped quarters symptomatic of oilfield employees living in temporary housing may heighten violence. Although the data show fewer children are impacted directly by domestic violence, the data is from 2011 and anecdotal reports from Mountrail County residents indicate that domestic violence is a rising concern since the oil boom.

On the positive side fewer teenagers in Mountrail County are dropping out of high school.

TABLE 6: SELECTED MEASURES OF CHILDREN'S HEALTH

(For children aged 0-17 unless noted otherwise)

Measure	Mountrail County	North Dakota
Children Receiving Free/Reduced Price Lunch	✓ 43.3%	33.2%
High School Dropouts, Grades 9-12	1.9%	2.2%
Children Ages 16-19 Not Enrolled in High School, Not High School Graduates, and Not in the Labor Force, (% of population 16-19)	✓ 5.3%	2.1%
Uninsured Children Ages 0-18,	✓ 15.6%	8.1%
Births to Mothers Receiving Inadequate Prenatal Care	✓ 20.4%	4.3%
Total Births to All Teens Ages 12-19	✓ 16.8%	7.4%
Low Weight Births	✓ 8.8%	6.4%
Medicaid Recipients Ages 0-20	✓ 38.6%	27.1%
Children Directly Impacted by Domestic Violence	2.4%	2.9%

Survey Results

Survey Demographics

Two versions of the survey were administered: one for community members and one for health care professionals. With respect to demographics, both versions asked participants about their gender, age, and education level. Community members were asked about marital status, employment status, household income, and travel time to the nearest non-MCHC health facility and to Mountrail County Health Center. Figures 2 through 14 illustrate the demographics of health care professionals and community members.

Throughout this report, numbers (N) instead of percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required to answer all survey questions; they were free to skip any questions they wished.

Community Members and Health Care Professionals

The demographic results from both the community member version and the health care professional version of the survey revealed similar findings about several measures. In both response groups, as illustrated in Figures 2 and 3, the number of females responding was considerably higher than the number of males responding. In the case of health care professionals, the number of female respondents outnumbered male respondents eight to one.

Figure 2: Gender - Community Members

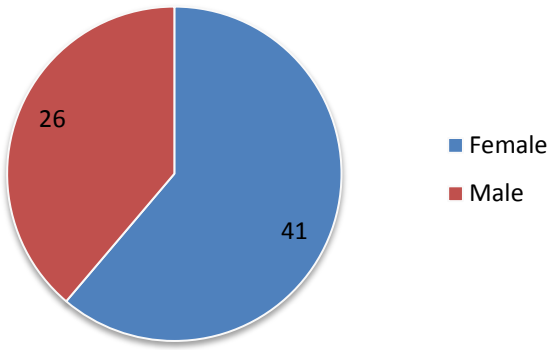
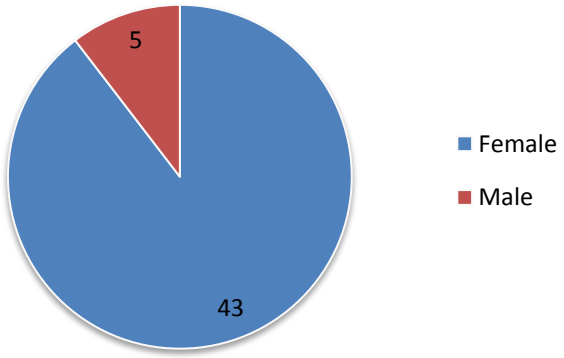


Figure 3: Gender – Health Care Professionals



A plurality of community members completing the survey were between the ages of 55 and 64 (N=26). The next most represented groups were those aged 45 to 54 (N=12) and those aged 65 to 74 (N=10). No one under the age of 25 completed the survey, which could suggest an older community population. Only six people under the age of 34 completed the survey. With respect to health care professionals, the largest age bracket was those aged 45 to 54 (N=15) followed by the younger age bracket of those aged 25 to 34 (N=14). In contrast to the community members, only eight health care providers over the age of 55 completed the survey, indicating a younger cohort of those staff members taking the survey. Figures 4 and 5 illustrate respondents' ages.

Figure 4: Age – Community Members

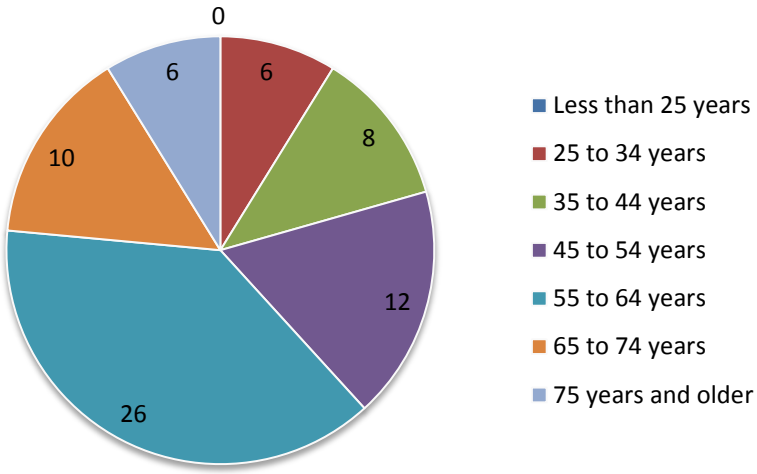
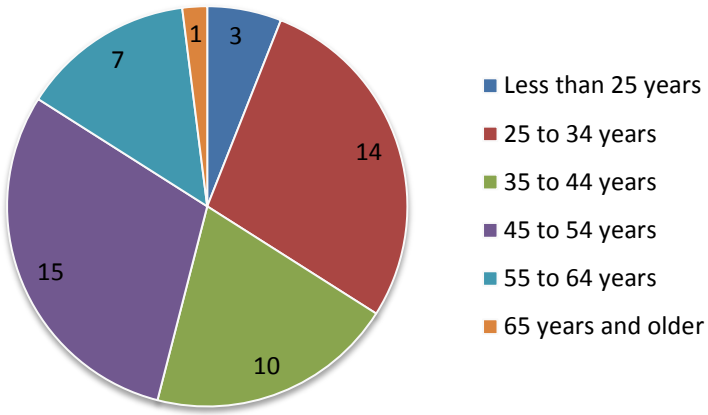


Figure 5: Age – Health Care Professionals



The next set of questions differed slightly for the two populations. Community members were asked how long they had lived in the community and the majority of respondents represent long-time residents with more than half of them indicating they lived in the area more than 20 years (N=41). Only three respondents (N=3) are classified as newcomers, living in the area for less than three years.

Health care professionals were asked how long they had worked for MCHC and their results differed significantly from those of community members. Health care professionals represent a newer workforce as the large majority (N=32) indicated they had only worked for the hospital for less than five years. Nine (N=9) staff reported working at MCHC for more than 10 years. These results are shown in Figures 6 and 7.

Figure 6: Years Lived in the Community – Community Members

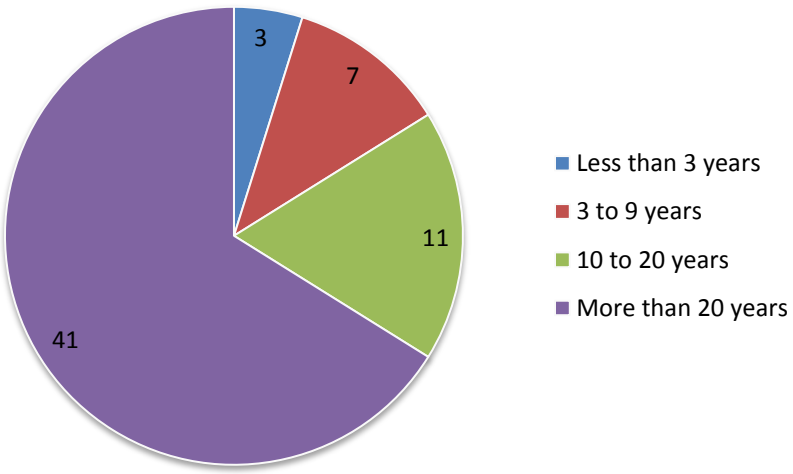
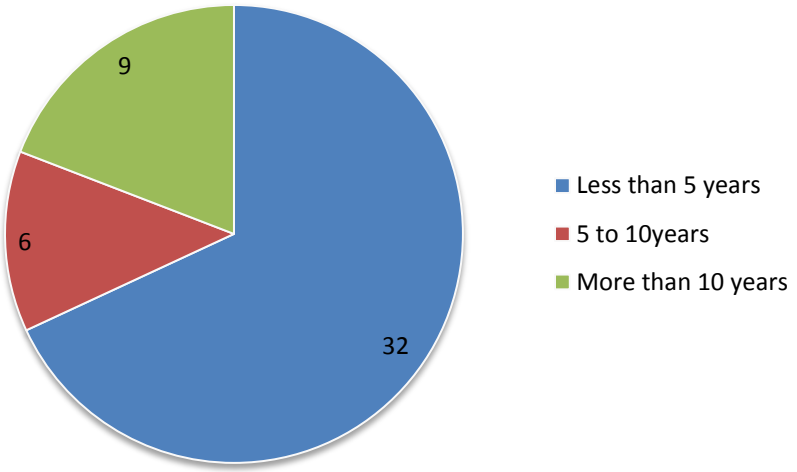


Figure 7: Years Employed by MCHC – Health Care Professionals



Community members and health care professionals represented a wide range of educational backgrounds, with similar distributions for each population. The largest group or respondents, (N=20) for community members and (N=17) for health care professionals, had a bachelor's degree. There was a tie among community members for the next largest group with 15 (N=15) respondents reporting they held a high school diploma or GED and 15 (N=15) respondents indicating they had a technical degree or some college. For health care professionals the next largest group consisted of those completihg some college or technical degree (N=14). Figures 8 and 9 illustrate the diverse background of respondents and demonstrate that the assessment took into account input from parties with a wide range of educational experiences.

Figure 8: Education Level – Community Members

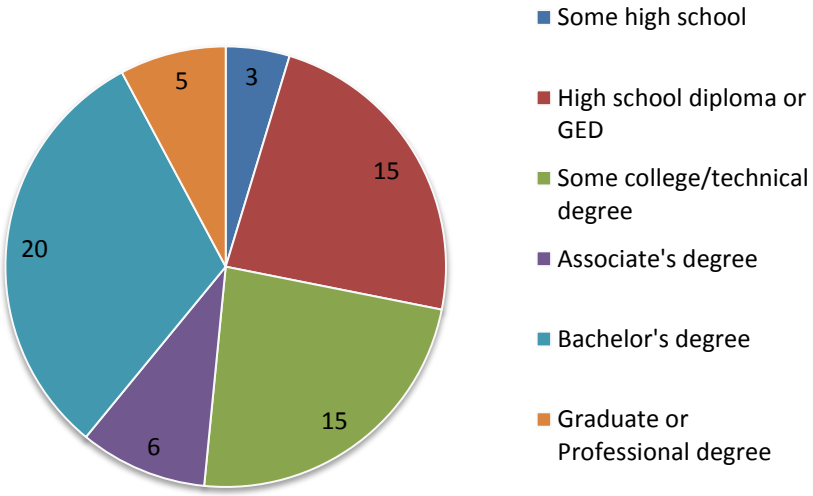
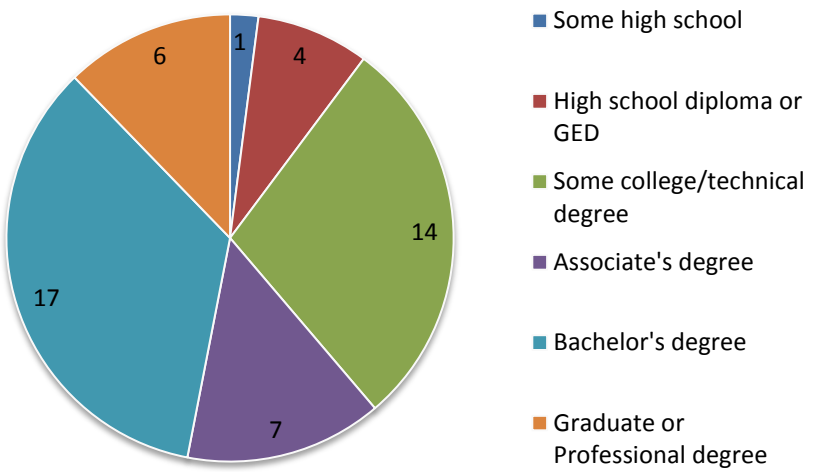


Figure 9: Education Level – Health Care Professionals

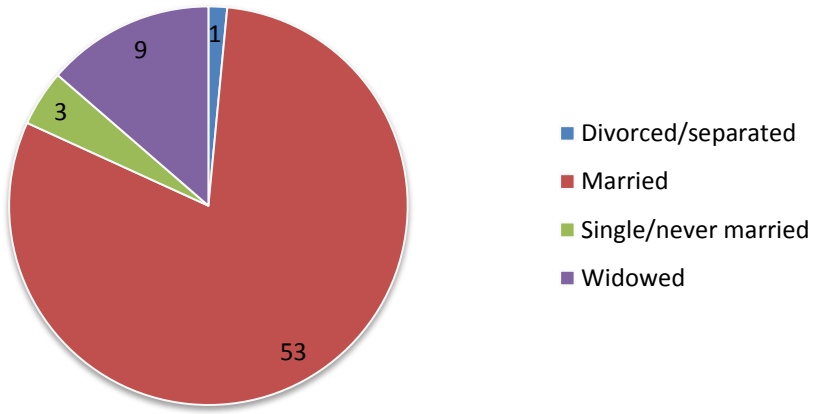


Community Members

Community members were asked additional demographic information not asked of health care professionals. This additional information included marital status, employment status, household income, and their proximity to the nearest clinic and to the Mountrail County Health Center in Stanley.

The majority of community members (N=53) identified themselves as married, as exhibited in Figure 10.

Figure 10: Marital Status – Community Members



As illustrated by Figure 11, a plurality of community members reported being employed full time (N=39), followed by retired (N=15).

Figure 11: Employment Status – Community Members

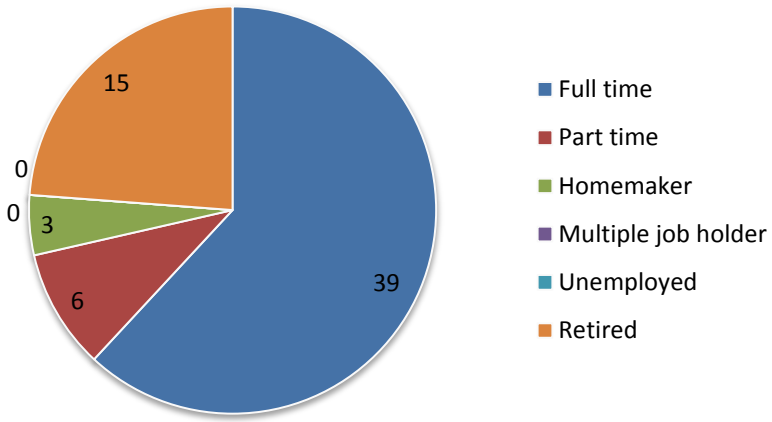
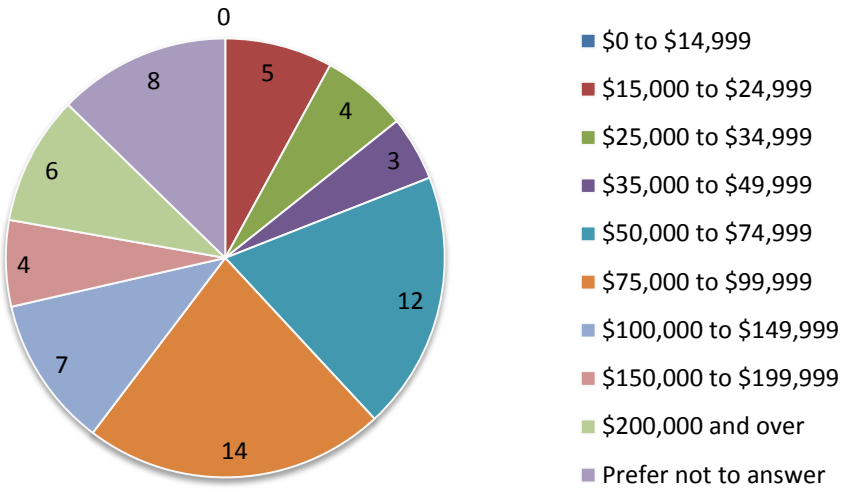


Figure 12 illustrates the wide range of community members' household income and again indicates how this assessment took into account input from parties who represent the broad interests of the community served, including lower-income community members. Of those that answered this question, the most commonly reported annual household income was $75,000 to $99,999 (N=14), followed by the $50,000 to $74,999 income bracket (N=12). Both ends of the socioeconomic spectrum were represented as five community members reported a household income of less than $25,000 and six community members reported a household income of more than $200,000. Eight respondents preferred not to answer this question.

Figure 12: Annual Household Income – Community Members



Community members responding to the survey represented a fairly large geographic area. As shown in Figure 13, a majority of the community members responding (N=51) live between 31 to 60 minutes to the nearest clinic outside of MCHC, followed by those living more than an hour away from the nearest clinic outside of the MCHC health care system (N=11).

Survey results about the travel time to the Mountrail County Health Center in Stanley were the direct opposite of the results pertaining to clinic proximity, with a majority (N=47) living less than ten minutes from the health care facility, followed by those living 10 to 30 minutes away (N=21) as illustrated in Figure 14. This data shows the importance of MCHC in providing health services within a close proximity to its rural residents.

Figure 13: Respondent Travel Time to Nearest Clinic Outside Mountrail County Health Center

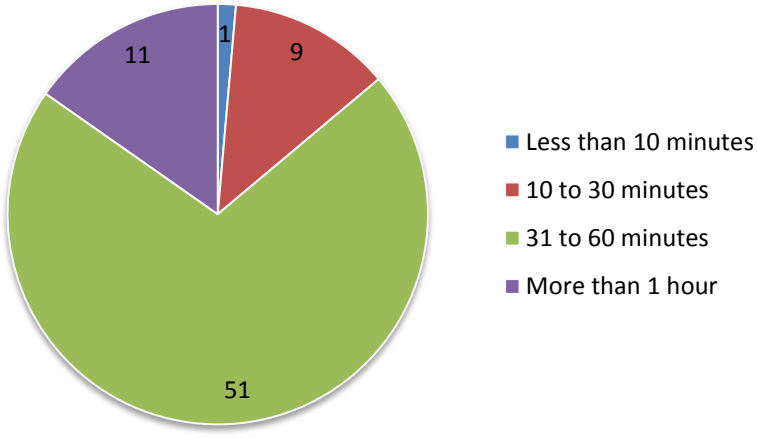
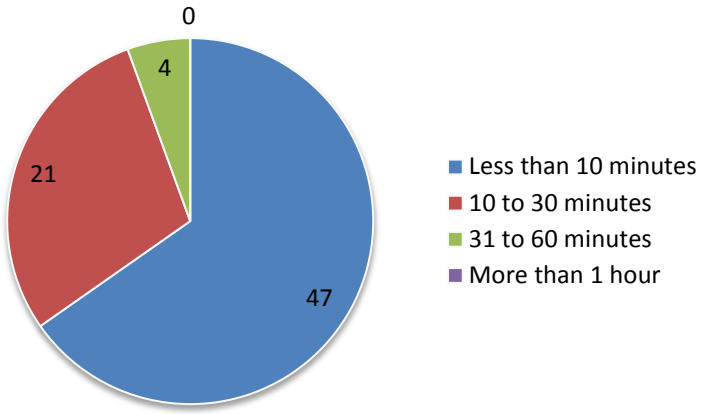


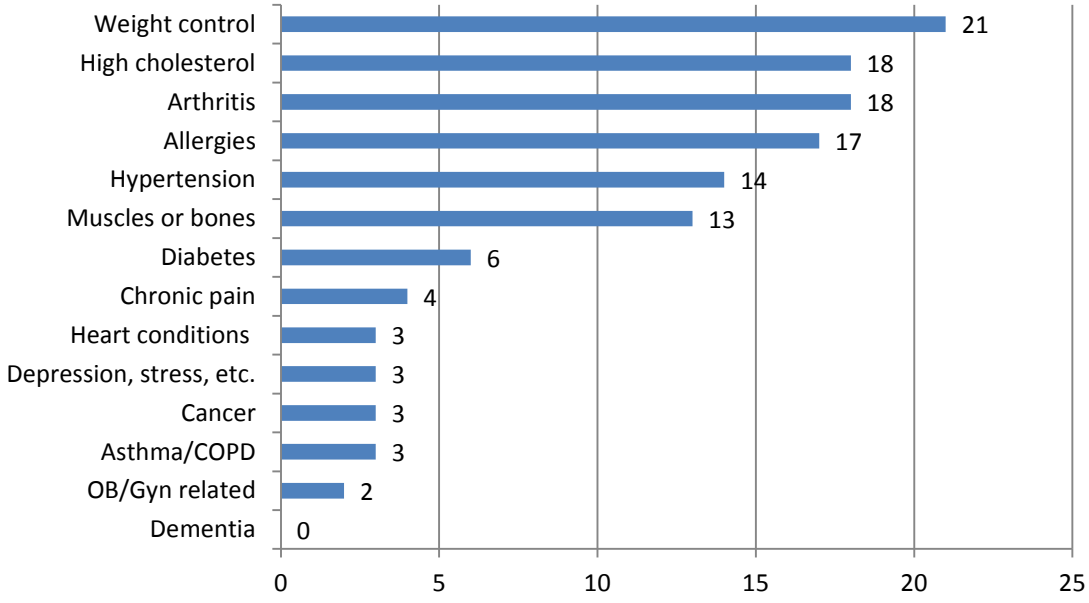
Figure 14: Respondent Travel Time to Mountrail County Health Center



Health Status and Access

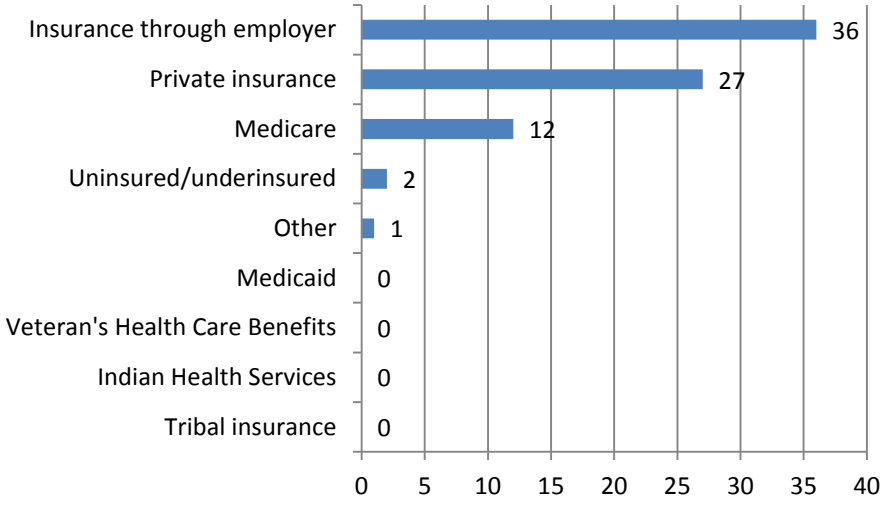
Community members were asked to identify general health conditions and/or diseases that they have. As illustrated in Figure 15, the results demonstrate that the assessment took into account input from those with chronic diseases and conditions. The health conditions reported most often were weight control (N=21), high cholesterol (N=18), arthritis (N=18) and allergies (N=17).

Figure 15: Health Status - Community Members



Community members also were asked what, if any, health insurance they have. Health insurance status often is associated with whether people have access to health care. Two community members reported having no insurance or being underinsured. As demonstrated in Figure 16, the most common insurance types were insurance through one's employer (N=36) and private insurance (N=27).

Figure 16: Insurance Status – Community Members



Awareness of Services

The survey asked community members whether they were aware of the services offered locally by Mountrail County Health Center. The survey given to health care professionals did not include this inquiry as it was assumed they were aware of local services due to their direct work in the health care system.

In the paper version of the survey, respondents were given the option to check a "Yes" or "No" box for each listed service to indicate whether they were familiar with the service. The online version included only a choice for "Yes, aware this service is offered locally." The limitation with this reporting method is that it is implied that the gap between how many answered "Yes" and the total response count reflects those that are not aware. However, it is unknown if the difference reflects unawareness or respondents skipping that particular listed service.

Overall, community members were cognizant of MCHC's service offerings, indicating successful advertising strategies by the hospital. Community members were most aware of:

- Ambulance (N=69)
- Emergency room (N=67)
- General x-ray (N=67)
- Clinic (N=66)
- Blood pressure checks (N=66)
- Allergy, flu and pneumonia shots (N=66)
- Physicals (annual, D.O.T., sports & insurance) (N=65)
- Health screenings (N=64)
- Laboratory services (N=64)

Community members were least aware of the following services:

- Acne treatment (N=29)
- MRI (N=31)
- CT scan (N=34)
- Speech therapy (N=34)
- Prenatal care up to 32 weeks (N=35)

The services with lower levels of awareness may present opportunities for further marketing, greater utilization, and increased revenue. Figures 17-21 illustrate community members' awareness of services.

Figure 17: Community Members' Awareness of Locally Available General Services

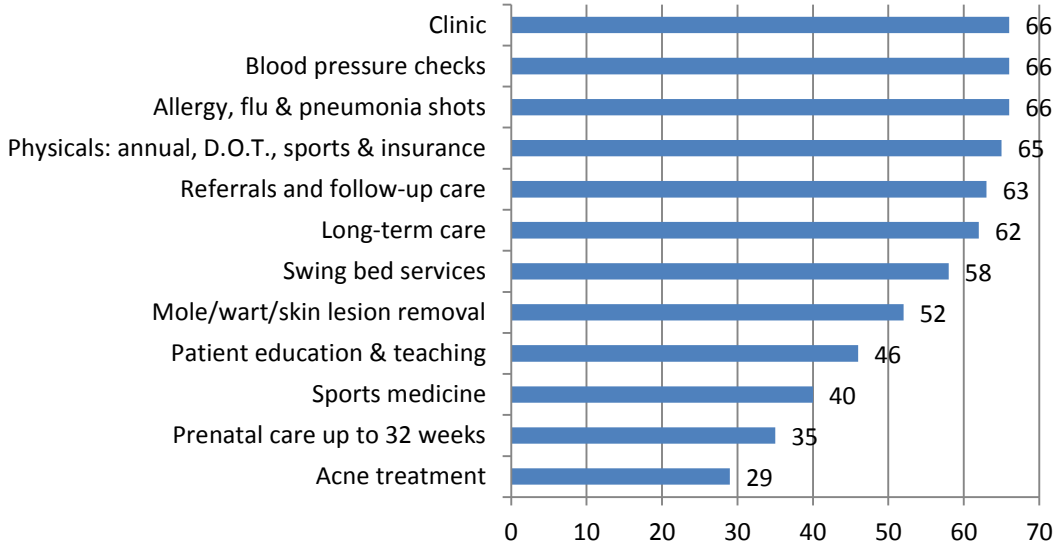


Figure 18: Community Members' Awareness of Locally Available Acute Services

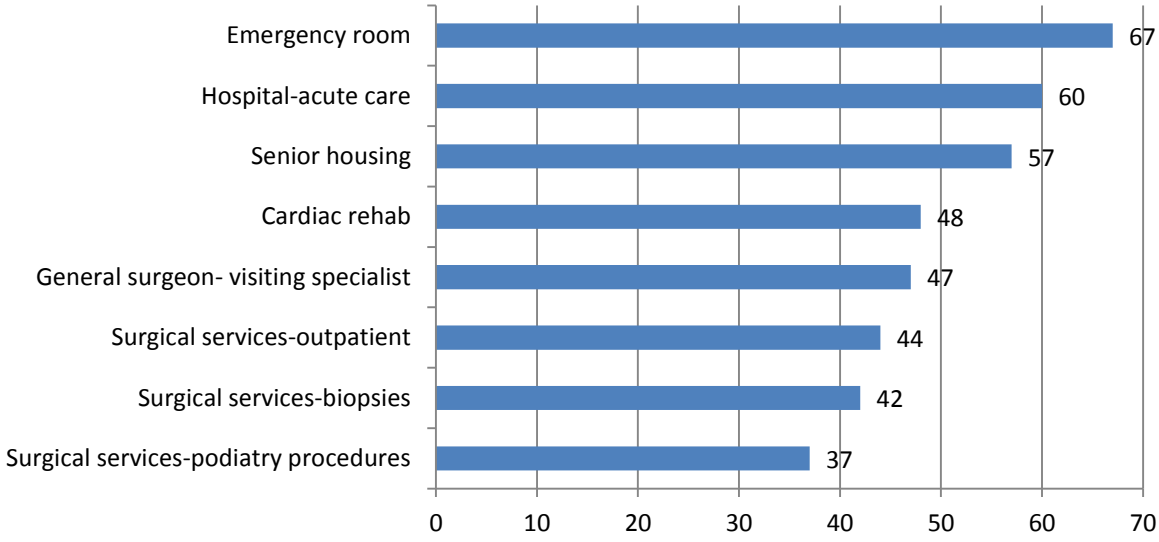


Figure 19: Community Members' Awareness of Locally Available Screening/Therapy Services

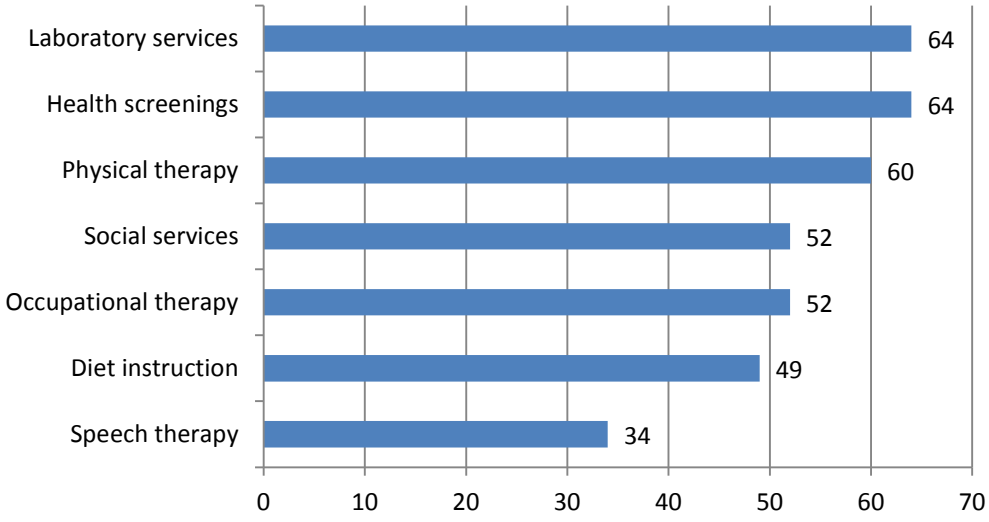


Figure 20: Community Members' Awareness of Locally Available Radiology Services

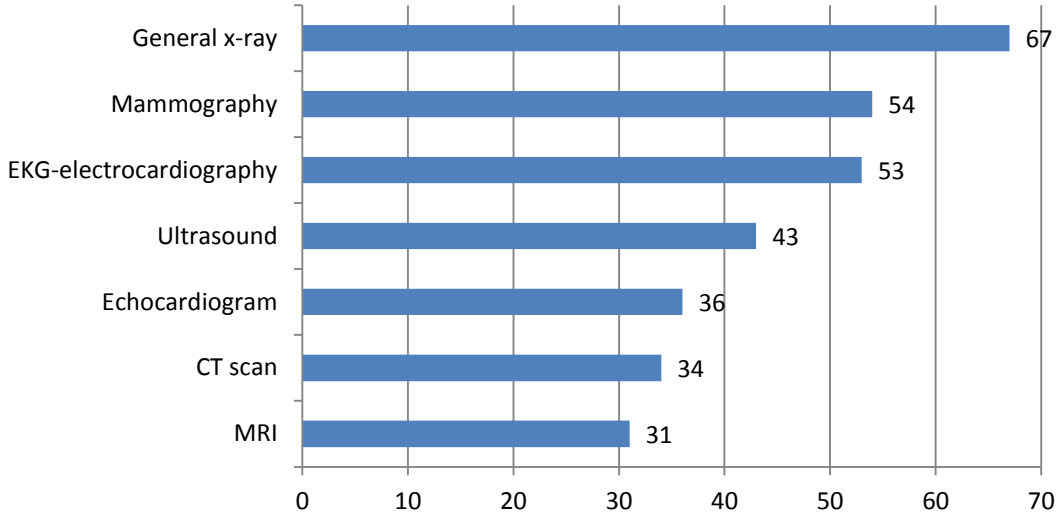
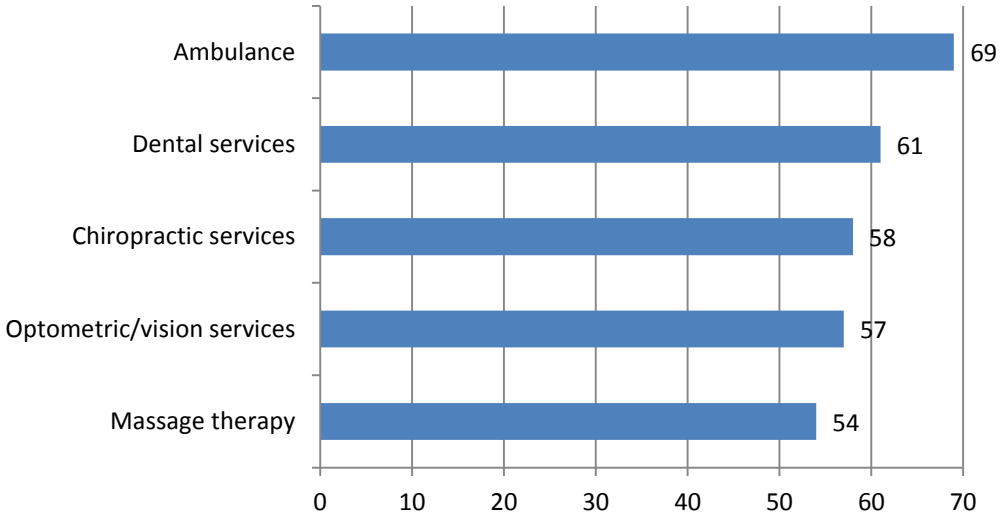


Figure 21: Community Members' Awareness of Other Community Services



Information about how community members learn of local services emerged during the interviews and focus group session. Participants said the majority learned of services through word of mouth communication and newspaper ads. Others said they were long-standing services and their kids had used them.

There was an overwhelming concern that the current communication efforts were not enough to convey all of the services offered, nor the schedule of specialists. Community members were worried newcomers may not know of all the service offerings and they are unlikely to read the local newspaper or watch

the local news station. To target the new labor force, community members suggested updating the MCHC website with more specifics. For example, they wanted to know what kind of occupational and physical therapy was available. What kinds of health screenings are offered? They were concerned that if the newcomers don't know of services offered, the default assumption is that a small hospital lacks options and the newcomer may seek care elsewhere.

Health Service Use

Community members were asked to review a list of services provided locally by Mountrail County Health Center and indicate whether they had used those services locally, out of the area, or both. Figures 22-26 illustrate these results.

Respondents identified clinic (N=57), laboratory services (N=42), emergency room (N=40) and physicals (annual, occupational, sports & insurance) (N=40) as the services most commonly used locally. There were a few services that respondents traveled outside of the area to receive, even though they are available locally at MCHC. The services they most commonly sought out of the area were:

- MRI (N=20)
- Surgical services—outpatient (N=13)
- CT scan (N=12)
- Acne treatment (N=6)
- Speech therapy (N=3)

As with low-awareness services, these services – for which community members are going elsewhere – may provide opportunities for additional education and advertising about their availability from the local health system and potential greater utilization of local services.

Figure 22: Community Member Use of Locally Available General Services

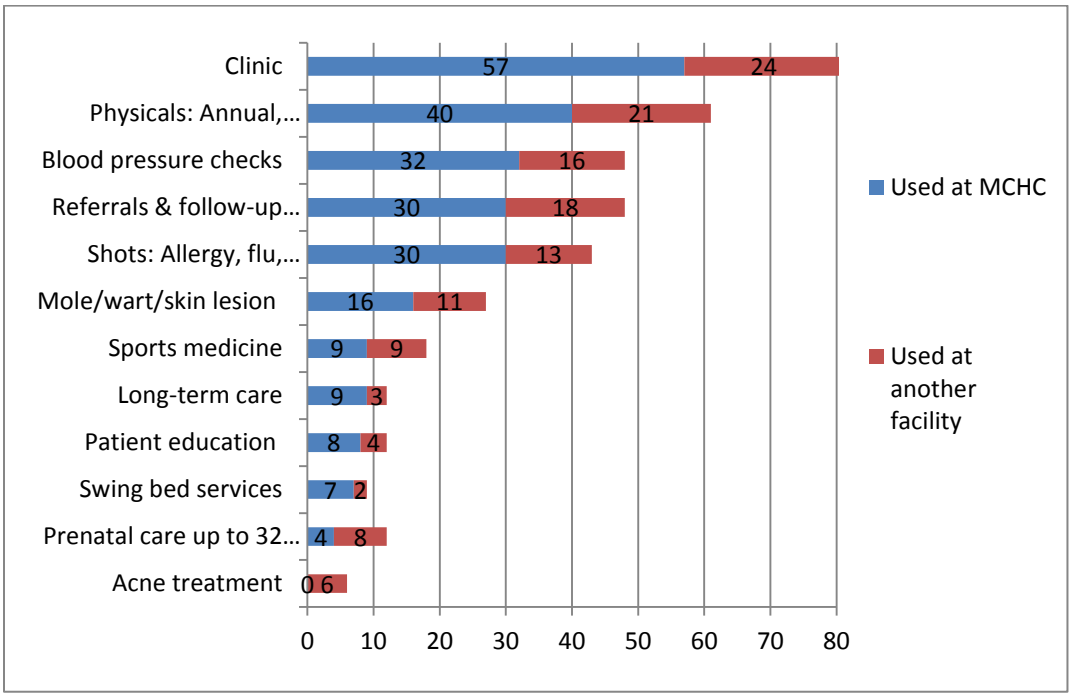


Figure 23: Community Member Use of Locally Available Acute Services

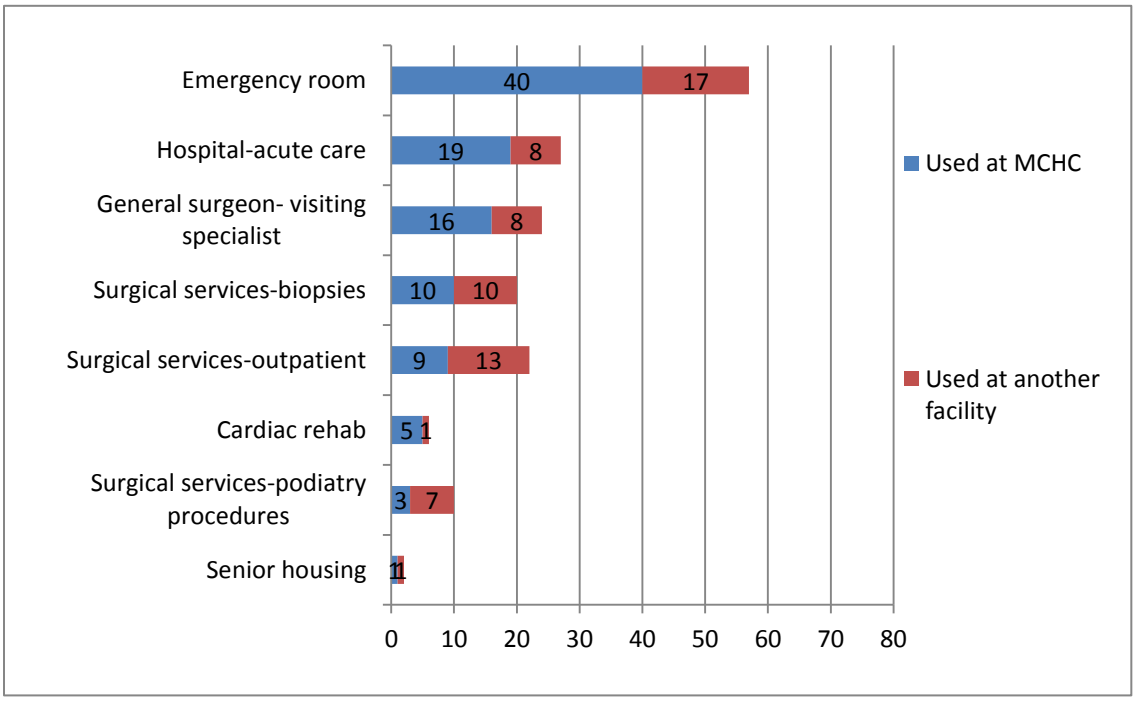


Figure 24: Community Member Use of Locally Available Screening/Therapy Services

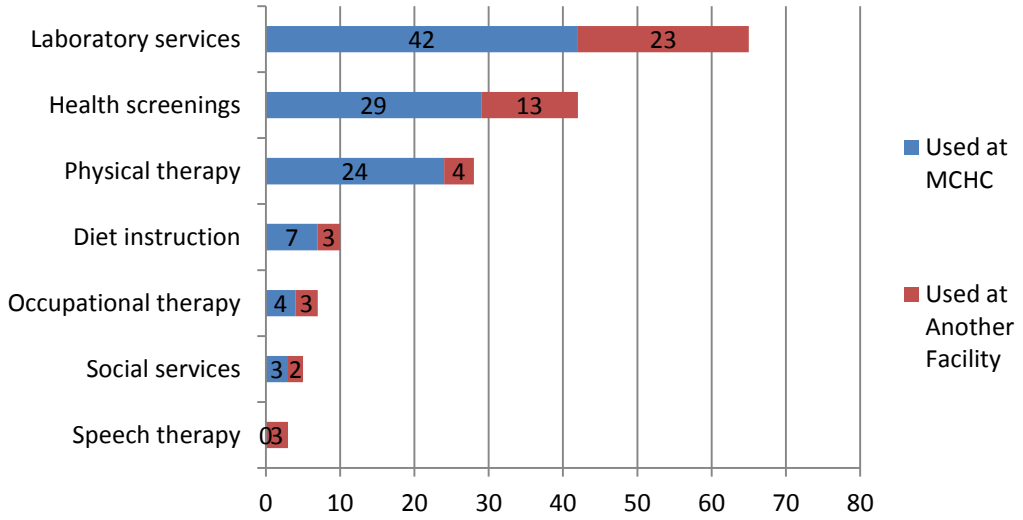


Figure 25: Community Member Use of Locally Available Radiology Services

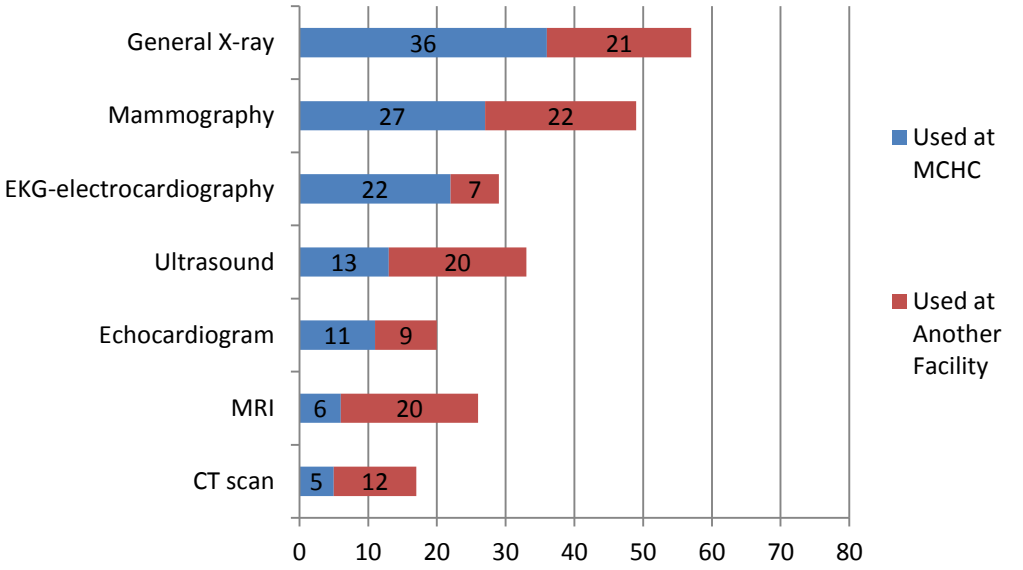
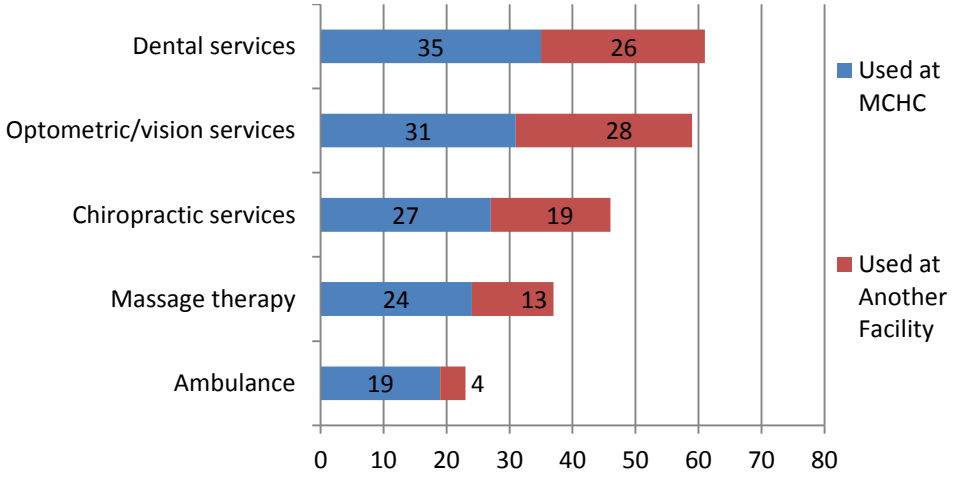


Figure 26: Community Member Use of Services Offered by Providers Other than Mountrail County Health Center



Additional Services

In another open-ended question, both community members and health care professionals were asked to identify services they think Mountrail County Health Center needs to add. Seventeen community members provided responses to this question, with four of those requesting that MCHC get their CT scanner up and running. Two suggested adding a mental health /addiction counselor. Other responses included offering more surgical procedures, MRI, rape examinations, acupuncture and providing more specialty physicians.

Of the four health care professionals who gave responses, one recommended adding more providers, saying "we usually end up turning people away on a daily basis due to the fact that we do not have any open appointments. There are some days there is only one provider and that provider also has to cover the Emergency Room." The other suggestions varied from adding a billing specialist, paying higher wages to keep up with the competitive economy and offering pediatrics, including providing a facility daycare.

Reasons for Using Local Health Care Services and Non-Local Health Care Services

The survey asked community members why they seek health care services at Mountrail County Health Center and why they seek services at another health care facility. Health care professionals were asked why they think patients use services at MCHC and why they think patients use services at another facility. Respondents were allowed to choose multiple reasons.

Community members and health care professionals were in alignment across the board concerning why people choose care at MCHC. The top five reasons among both groups are: convenience (N=62 and N=46), familiarity with providers (N=47 and N=37) proximity (N=43 and N=40), loyalty to local service providers (N=42 and N=30) and high quality of care (N=35 and N=29). The similarities among the results from the two groups indicate a shared set of health care values from community members and health care professionals. The parallel results could also indicate an accurate assessment of the hospital's strengths and weaknesses.

Figures 27 and 28 illustrate these responses.

Figure 27: Reasons Community Members Seek Services at Mountrail County Health Center

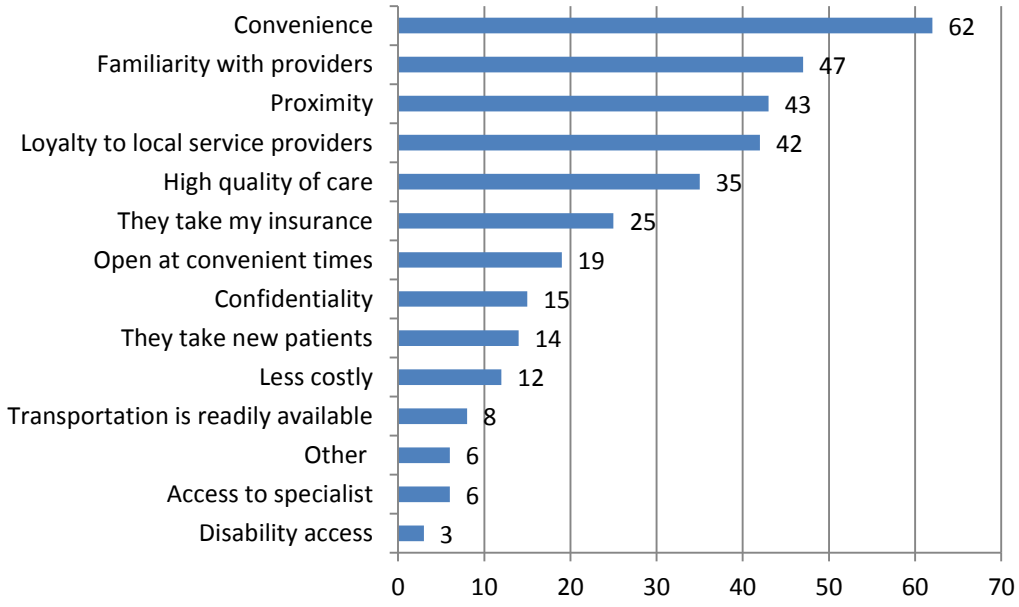
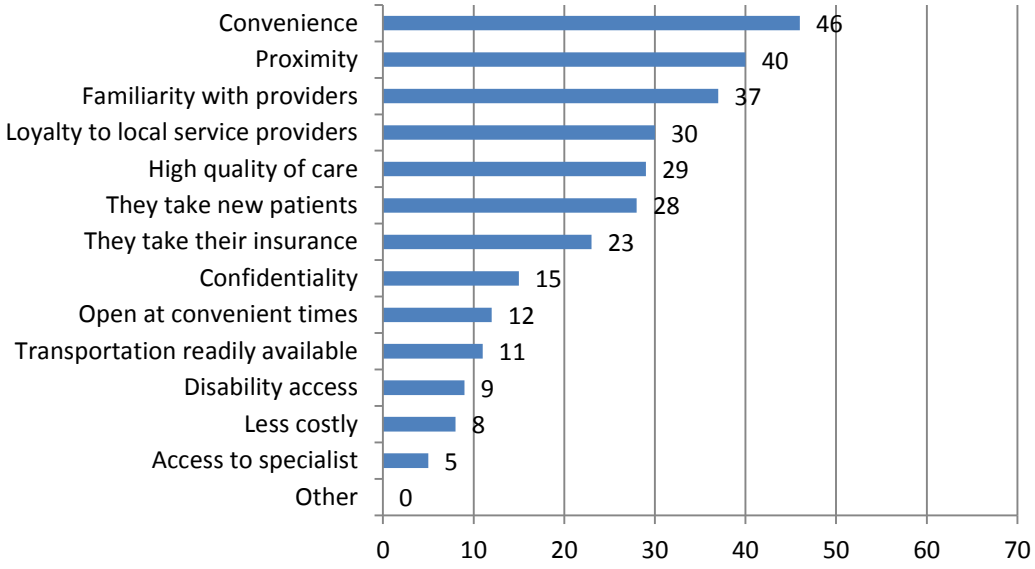


Figure 28: Reasons Health Care Professionals Believe Community Members Seek Services at Mountrail County Health Center



The similarities continued in results from community members and health care professionals with respect to seeking health care services at other facilities. Both groups indicated that the primary motivator for seeking care elsewhere was, by a large margin, that another facility has a needed specialist (N=59 and N=44). Another oft-cited reason for seeking care elsewhere was high quality care (N=20 and N=15). Being open at convenient times and confidentiality were rated in the top four reasons among both groups.

Differences emerged in that health care professionals perceived readily available transportation as a motivator to go elsewhere whereas community members reported that was their least important factor when deciding to go elsewhere. These results are illustrated in Figures 29 and 30.

Figure 29: Reasons Community Members Seek Services at Other Health Care Facilities

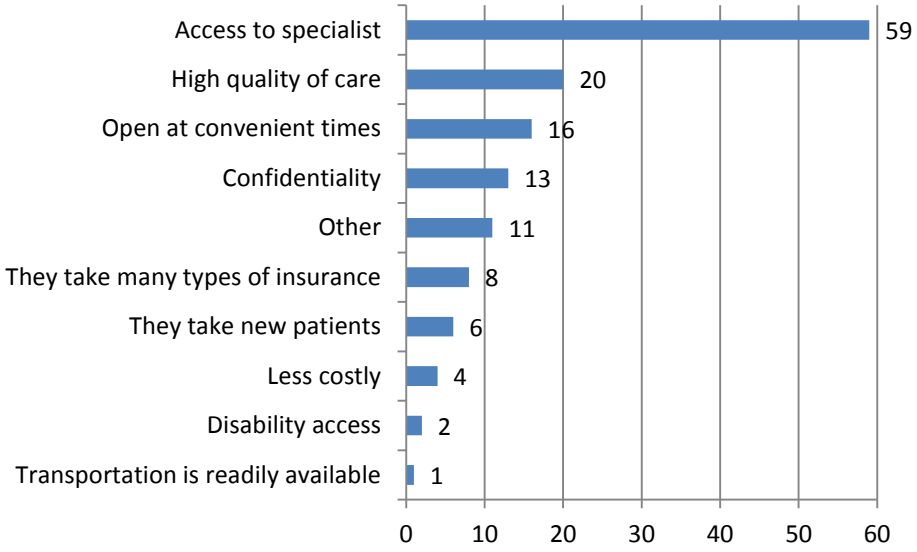
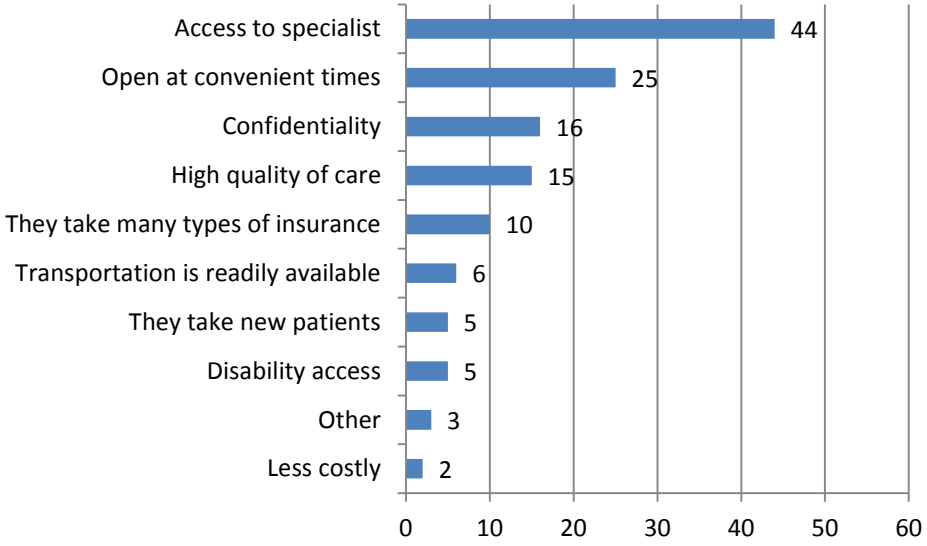


Figure 30: Reasons Health Care Professionals Believe Community Members Seek Services at Other Health Care Facilities



The survey provided both community members and health care professionals the opportunity to suggest "other" reasons that patients seek health care services in the local area as well as other reasons they seek services outside of the area. In terms of using local services, six community members wrote in "other" comments with two explaining they would like to use MCHC more but it is either not within their insurance network or not in proximity to their work. One praised the staff of MCHC, commenting "the staff we do have go out of their way to take good care of you." No health care professionals provided "other" comments.

In terms of using other health care facilities, 11 community members chose the open-ended "other" answer, most often citing loyalty to another doctor or clinic (N=4), being referred to another provider (N=3) and access to specialists (N=2). One commented that the ease of getting an appointment on short notice was better elsewhere and one noted the need for testing and imaging equipment.

Three health care professionals offered "other" responses, with two noting the need for additional diagnostic equipment and better machines (Xray, MRI, EKG, mammograms) and one indicating convenience as the main reasons to seek care at another facility.

Barriers to Accessing Health Care

Both community members and health care professionals were asked what barriers exist that prevent people from receiving health care in the Stanley area. Community members and health care professionals agreed in their top recommendations that having greater access to specialists (N=24 for community members; N=31 for health care professionals) and offering more evening and weekend clinic hours (N=23 and N=31) would help remove barriers to using local care. The next most common barriers identified from community members were lack of doctors (N=23) and lack of continuity of care (N=21). Two community members provided comments in the "other" field attesting to the lack of doctors. "Sometimes they are so busy that they can't squeeze you in until you have already begun to feel better which is great if you don't have a serious condition but if you do and don't feel like traveling, you are out of luck." Another said "lack of good doctors—if they are good, they don't stay."

Health care professionals perceived different barriers with their next most common responses being lack of affordability and inability to get an appointment (N=17 for both).

See Figures 31 and 32 for additional barriers to local health care use.

Figure 31: Community Members' Barriers to Using Local Care

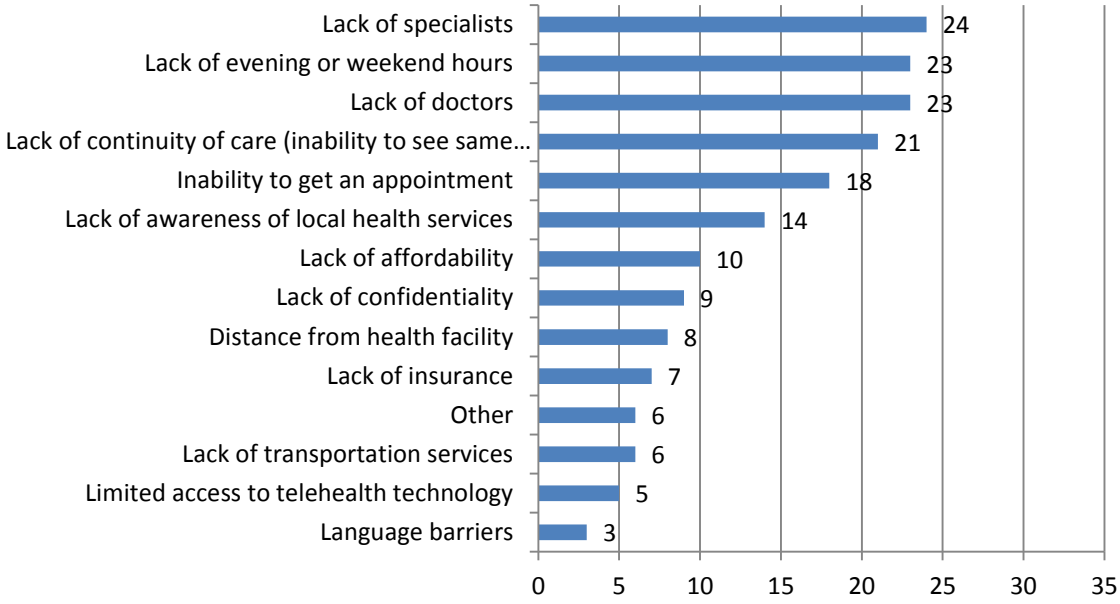
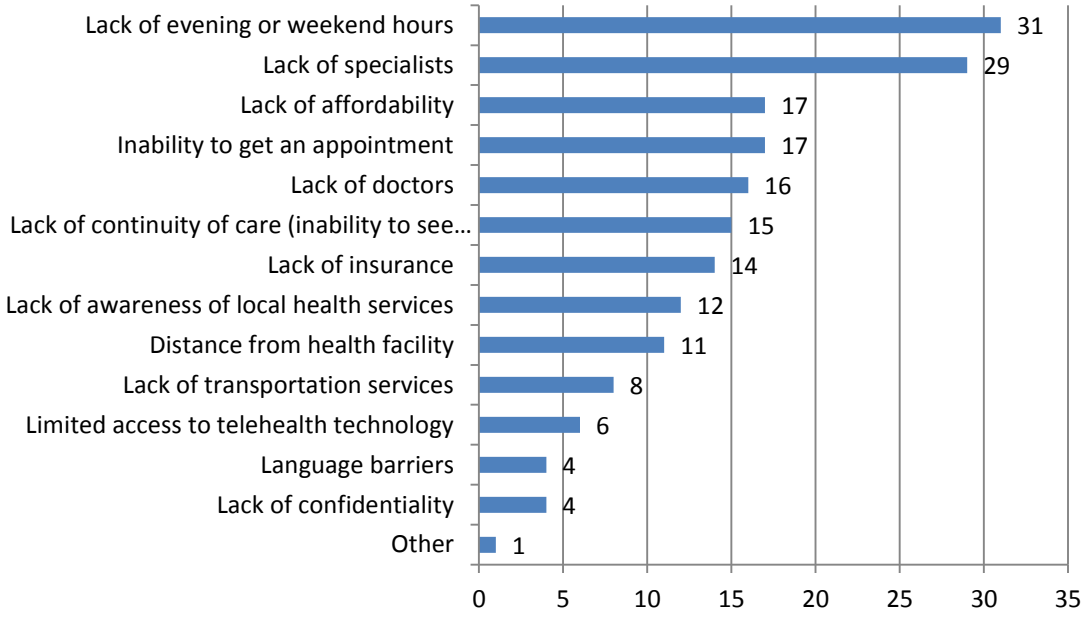


Figure 32: Health Care Professionals' Barriers to Using Local Care



Health Concerns

Respondents were asked to review a list of potential health concerns or conditions and rank them on a scale of 1 to 6 based on the importance of each potential concern to the community, with 6 being more of a concern and 1 being less of a concern.

Not enough health care staff in general was a top concern for both community members and health care professionals (average rating of 4.74 and 4.69 respectively). In a similar vein, having an adequate number of health care providers and specialists was tied for first place among community members (N=4.74) while health care professionals ranked this concern in third place (N=4.39). Similarly, the financial viability of MCHC was a top concern among both groups, with community members placing it in fourth place (N=4.43) and health care professionals ranking it their second most pressing concern (N=4.55).

Both groups of respondents also rated higher costs of health care for consumers among their top concerns (N=4.55, second highest concern for community members and N=4.16, fourth highest concern among health care professionals).

Heart disease (N=4.06) was among the top five most pressing health concerns among community members whereas health care professionals ranked access to needed technology/equipment (N=3.96) as their fifth highest health concern.

On the opposite end of the spectrum, accident and injury prevention and a focus on wellness and prevention were perceived to be the lowest concerns for community members with average rankings of 3.15 and 3.43 respectively. For health care professionals, emergency services (3.14) and suicide prevention (3.16) were their least important concerns. However, it is important to point out that even though these concerns were on the bottom of the lists, their averages are still in the low 3s, on the scale of 1 to 6, indicating that these concerns still position themselves as "more of a concern" on the continuum.

Figures 33 and 34 illustrate these results.

Figure 33: Health Concerns of Community Members

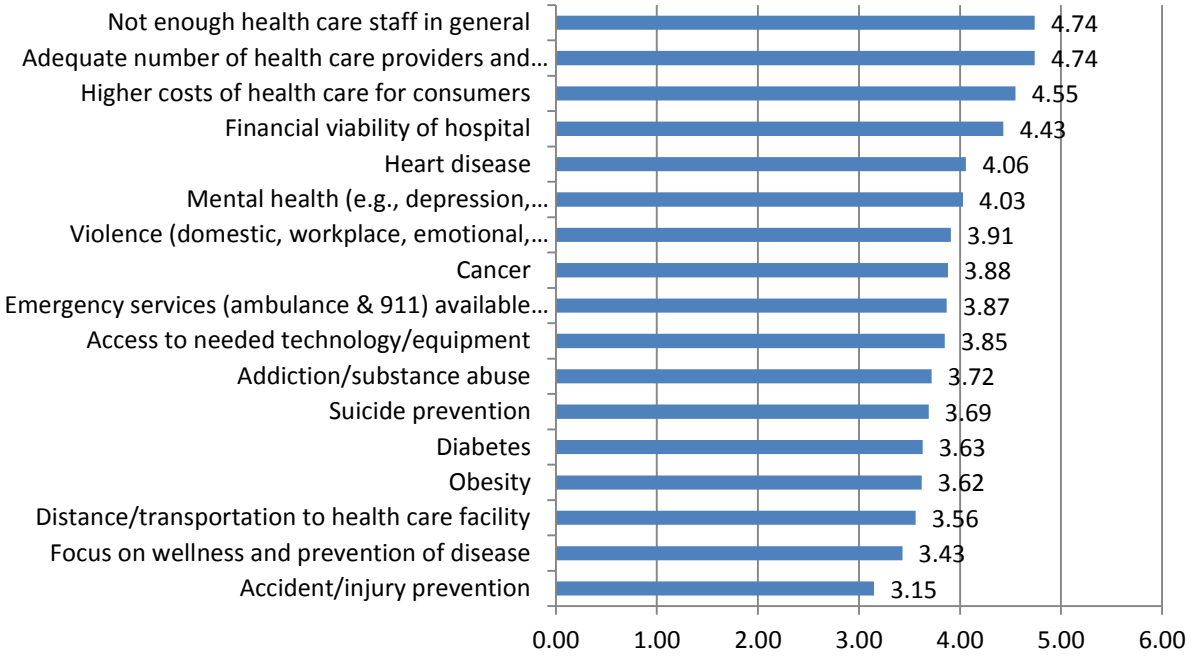
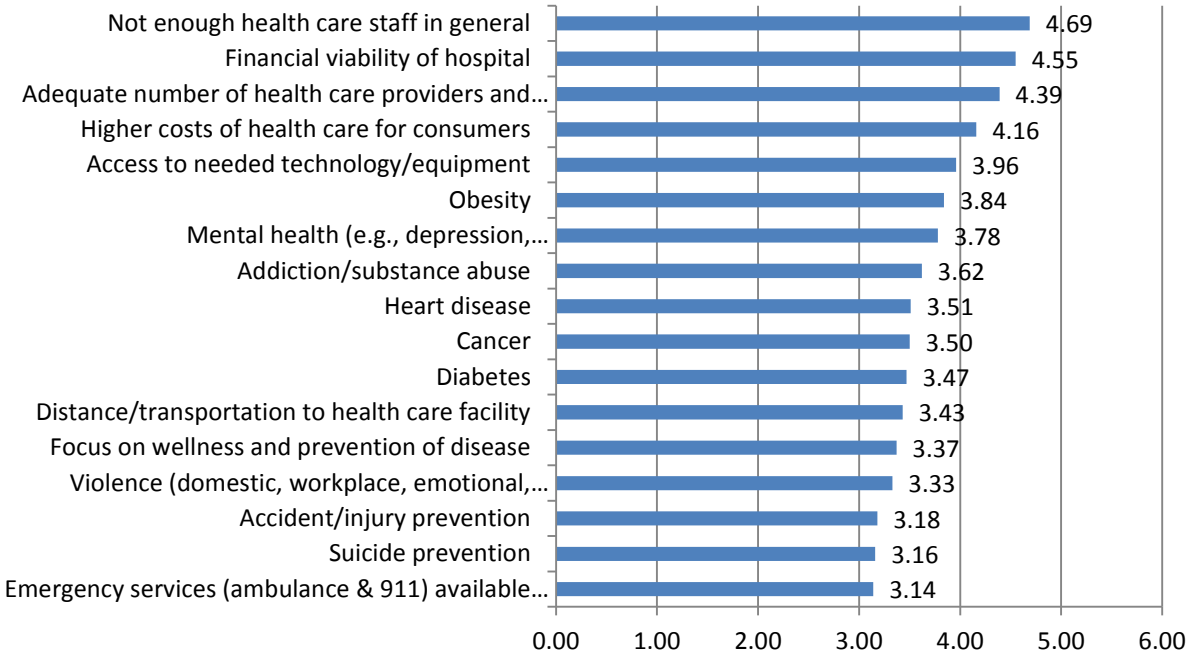


Figure 34: Health Concerns of Health Care Professionals



Respondents also were asked, in an open-ended question, how do these concerns impact their community. Nineteen community members answered this question.

A plurality of community members (N=5) selected that addiction/violence impacted the community the most. The second most impactful concern was lack of enough health care staff (N=3) which went along with the concern of not enough health care services offered. (N=2). Others were concerned with the amount of travel to receive specialized health care (N=3).

Fourteen health care professionals responded and their most important concerns that impacted the community were lack of health care staff (N=6) and access to equipment (N=2) and financial viability of hospital (N=2).

Comments from both community members and health care professionals about what they view as the most impactful concerns in their own words include:

Community members' comments relating to the concern of addiction/violence

- Addictions/drunk driver = DANGER TO ALL
- People are dying from a low intensity focus on drug and alcohol treatment.
- Too many addictions in families lead to many problems.
- Fear for families with children and older residents.

Community members' comments relating to not enough health care staff and services offered.

- If we had more of these services available we could keep our medical dollars in our community. Also, we could provide more jobs for medical staff and eliminate the need to go elsewhere when we are sick.
- High turnover for health care workers, especially doctors.
- The concerns of the highest importance are due mostly to lack of enough professional staff to meet needs. Thus, people need to travel for more specialized treatment/care.
- General healthy community is threatened by these concerns. We need to be able to address them. Hospital could be of help with qualified staff.

Health care professionals' comments relating to lack of health care staff

- If we had more staff and specialists more people would come to our health center.
- If there is not enough staff it is hard to operate a facility and produce the best care. Very hard to get providers to want to come to Stanley.
- Without the staff resources how can we serve the community?

- People need to feel that they have the best care they can possibly get in their own neighborhood. It brings a sense of fear if they do not feel that way.

Health care professionals' comments relating to financial viability

- The financial viability of the facility is very concerning due to us being the only hospital in the area. If we cannot keep the doors open the community will completely suffer. All other concerns I have stem from the financial part of the facility.
- We risk losing our hospital if financial stability cannot be maintained.

Community Concerns

In addition to the local health concerns, the survey asked respondents to rank larger health and wellness problems that may be affecting the community. Some of these concerns may not typically be addressed by hospitals, but given the changing dynamics of Stanley due to the oil patch activity and increasing population, it is important to assess greater community concerns. Moreover, monitoring community conditions can help to address mental health issues that accompany a stretched and stressed community.

Lack of affordable housing was the number one community condition stated by both community members (N=5.48) and health care professionals (N=5.54). The fact that both groups' average response is so close to a ranking of 6.00 shows the severity of this concern.

Both community members and health care professionals ranked similarly their next three most pressing community concerns, indicating congruent perceptions about community problems. Both groups ranked traffic safety, including speeding, road safety and drunk driving (N=4.92 for community members and N=4.83 for health care professionals), maintaining enough health workers (N=4.80 and 5.08) and lack of employees to fill positions (N=4.77 and N=5.21) as among their most pressing concerns, though not in the same order.

The fifth most pressing community concern among community members was alcohol and drug use and abuse (N=4.64) whereas health care professionals placed impact of increased oil/energy development (N=4.46) in their fifth position.

On the other end of the spectrum both groups were in agreement that the least pressing community concerns were lack of employment opportunities (N=2.14 and 2.12) and environmentally unsound (or unfriendly) place to live (N=2.65 and 2.63 respectively). The fact that the averages differ between the two groups by only .02 indicates close alignment in community observations.

"Other" was the eighth most selected category for health care professionals (N=4.83) so a detailed description of the responses is worth mentioning. Two respondents wrote in their own concerns which were daycare and better truck inspections.

Although the aforementioned results were the most frequently ranked concerns it is also important to acknowledge the open-ended responses this survey question asked:
a) Which concern is the most important and
b) How do these concerns impact your community?

Even though the open ended questions mirror the ranked list of concerns it is important to hear from the community members in their own words and phrasings as their responses were long and addressed many concerns at once, indicating a domino effect of the impacts. Due to the overlapping nature of these two questions, respondents tended to respond to both questions, the concern and the impact, at once. Therefore, what follows is a list of combined responses from both community members and health care professionals.

Sixty community members and 33 health care professionals completed the questions. This large response rate to a write-in question indicates that the community has a lot to say and may welcome more outlets to express these community concerns.

The majority of responses fall into the following thematic concerns:

- Lack of affordable housing (N=34)
- Lack of employees to fill positions (N=18)
- Crime and community violence (N=13)
- Road and traffic safety (N=12)
- Alcohol and drugs (N=8)
- Impact of inflation and low wages (N=4)

Specific comments referring to the *lack of affordable housing* include (direct quotes):

- People are living in vehicles.
- Workers/families living in campers year round.
- Without affordable housing people moving to the area are forced to live in undesirable conditions in campers, etc. The problem also affects our businesses and the difficulty they have hiring or keeping help.
- Too many living in campers.
- Lack of affordable housing causes a lack of health workers and also a shortage of workers for stores and restaurants.
- If more affordable housing we could fill jobs.
- It is causing some people to be homeless and this is a social problem.
- Some people have to move because they can't afford to live here.
- No young families are moving in.

- People leave as they can't afford high rent/house prices.
- It is very hard to find people in the healthcare field to work at our wages as they won't be able to afford housing. Therefore, that person has no choice but to work at a job they truly don't enjoy.
- Our youth need a place that is affordable to stay in the area and work.

Specific comments referring to the *lack of employees to fill positions* include (direct quotes):

- Lack of available workers results in cutting back of available health care services.
- Travel to other communities for services, no consistent care, and change of our workers means lack of trust in system.
- May lose hospitals and doctors if we don't have enough health workers.
- It's important to keep hospital and Bethel home going.
- Not enough health workers puts health and well-being of our community at risk.
- Businesses can't find employees so customers are waiting.
- Need more employees in medical, dental, wellness and service—convenience stores, food stores, restaurants.
- We continue to lose money from having to contract health staff from other towns.

Specific comments referring to *crime and community violence* include (direct quotes):

- We are kept in the dark about crime. We have no idea what we need to be on the lookout for. Too many people come into the community without our knowledge of their criminal history or activity, i.e., sex offenders.
- Do not feel enough history/research has been done to determine long-term consequences of possible accidents/spills.
- As population goes up so do incidents of crime and violence usually. We would like to be able to keep our community safe and continue as a great place to raise children.
- Safety of the area is decreasing due to incoming people. My community members do not feel as safe as they used to. A large number of people I know carry loaded weapons at all times.
- The safety of all the people living here. When people worry about their well-being and safety the atmosphere is agitated, nervous, making life more stressful and hard to live here.
- So much violence that gets unresolved. Jails are exploding with people. Unsafe to take a walk by self.

Specific comments referring to *road and traffic safety* include (direct quotes):

- Do not feel safe.
- Safety issues with all the new people—not everyone knows everyone anymore. I would not feel safe letting my kids walk around the grocery store by themselves.

- Some roads are a safety hazard themselves not to mention some drivers are safety hazards to everyone.
- Safety both personal and road safety.
- Police do not ensure that people in the city are following the laws, i.e., parking in yellow area on streets, double-parking, new smoking laws are not enforced. It can create more accidents, make it a less desirable place to live.
- Safety—this impacts everything!

Specific comments referring to *alcohol and drug use* include (direct quotes):

- Drunk driving is a concern because it is "socially" accepted here.
- Drugs—becoming an unsafe environment.
- There has been an increase in drinking and driving which increases accidents. Families are forever impacted by deaths and serious injuries. I'm afraid for my children as well as others.
- I have children on the roads and the increase in use of alcohol and drugs is scary. I would like to see stiffer penalties for these offenses.

Specific comments referring to *inflation and low wages* include (direct quotes):

- Cost of living is high. If you don't have oil revenue yourself it could put some people into a poverty level that will cause them to lose everything they have worked for. They will have to leave the area and start over. Some jobs in the community don't even pay well, cost of living is not going to go down, but keep raising.
- Grocery prices just seem to keep getting higher; we don't get that increase in our wages.

Figures 35 and 36 illustrate the complete results.

Figure 35: Community Concerns of Community Members

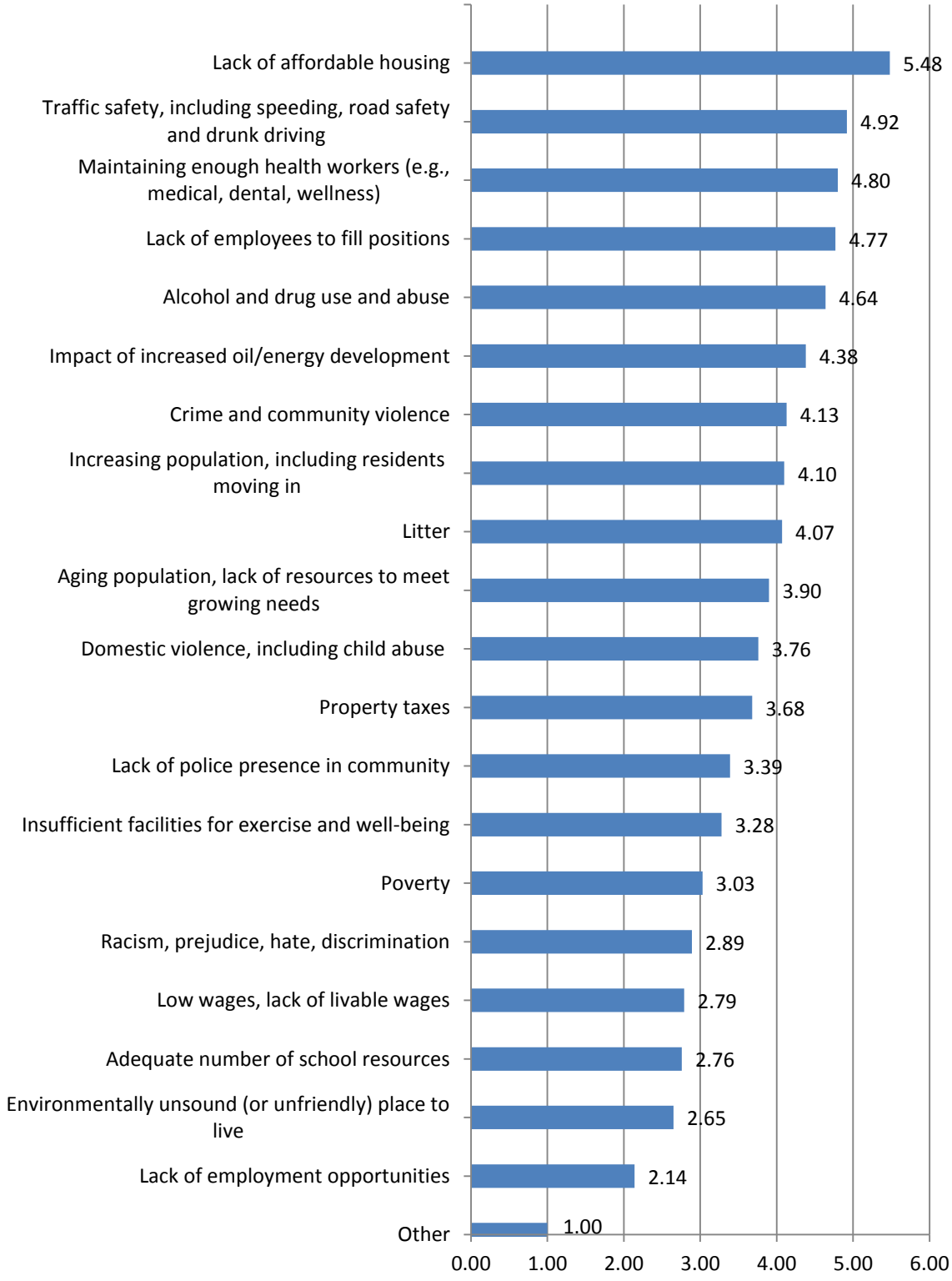
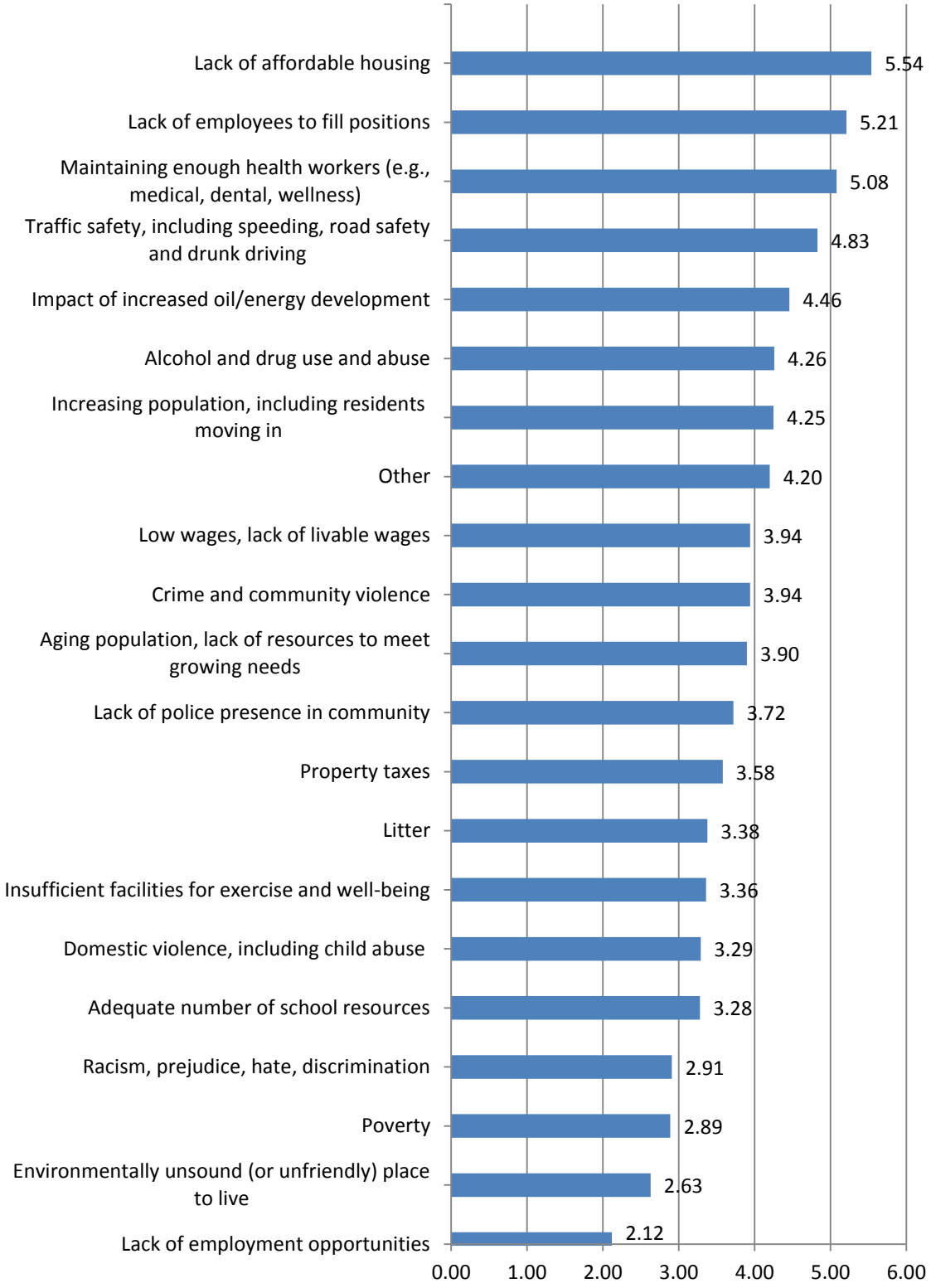


Figure 36: Community Concerns of Health Care Professionals



Foundational Awareness and Support

Community members were polled regarding their awareness of MCHC's foundation and whether or not they had supported it. The majority of community members were aware of MCHC's foundation (N=54). Of those that support the foundation, cash or stock gifts are the most common option (N=18), followed by giving a memorial or honorarium (N=15). The "other" ways community members support the foundation include buying tickets for event sponsored by the foundation, general donations and taxes and fundraising.

Figures 37 and 38 illustrate these results.

Figure 37: Aware of MCHC's Foundation

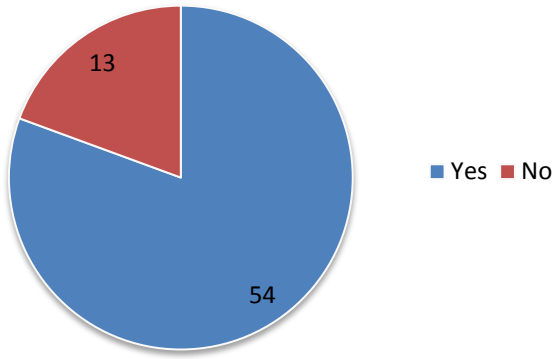
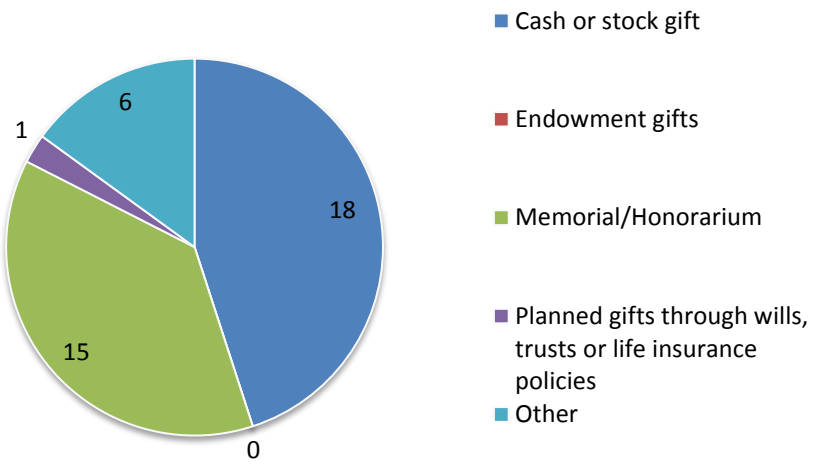


Figure 38: Support for MCHC's Foundation



Collaboration

Respondents were asked whether Mountrail County Health Center could improve its levels of collaboration with other local entities, such as schools, economic development organizations, local businesses, schools and other providers.

Of the three answer choices, ("yes," "no, it's fine as is," "don't know"), community members were mixed, indicating "Yes," collaboration could be improved with business and oil industry and hospitals and clinics in other cities; "No, it's fine as it is" with public health and schools; and "don't know" for local job/economic development and other local health providers.

Health care professionals responded more decisively with a "Yes" response, meaning collaboration could be improved, to five out of the six entities. The category of "other local health providers" was the only entity that health care providers deemed collaboration was "fine as it is." In the area of local job/economic development, health care professionals responded assertively that more collaboration is sought, with twice as many votes for "Yes" (N=29) than "No, it's fine as it is" (N=14).

Figures 39 and 40 illustrate these results.

Figure 39: Community Members – Could MCHC Improve Collaboration?

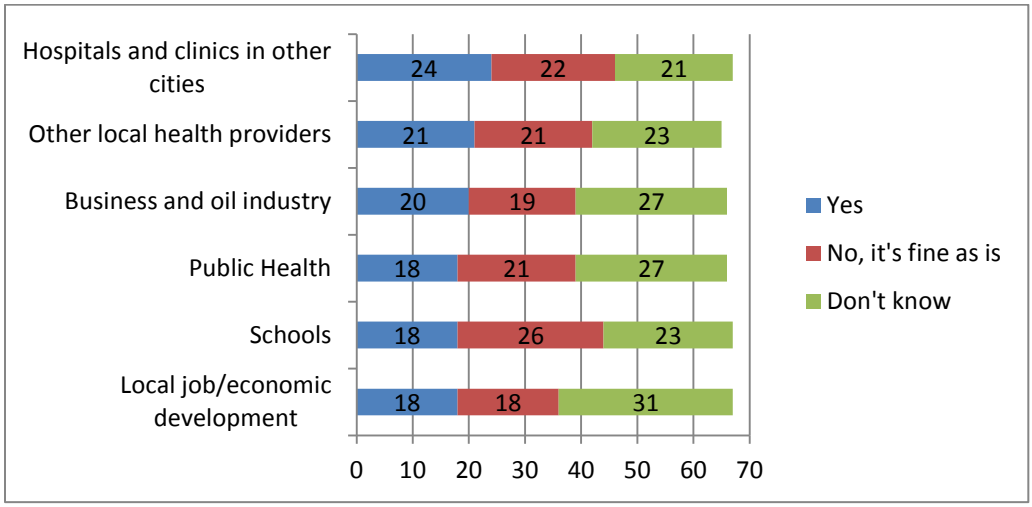
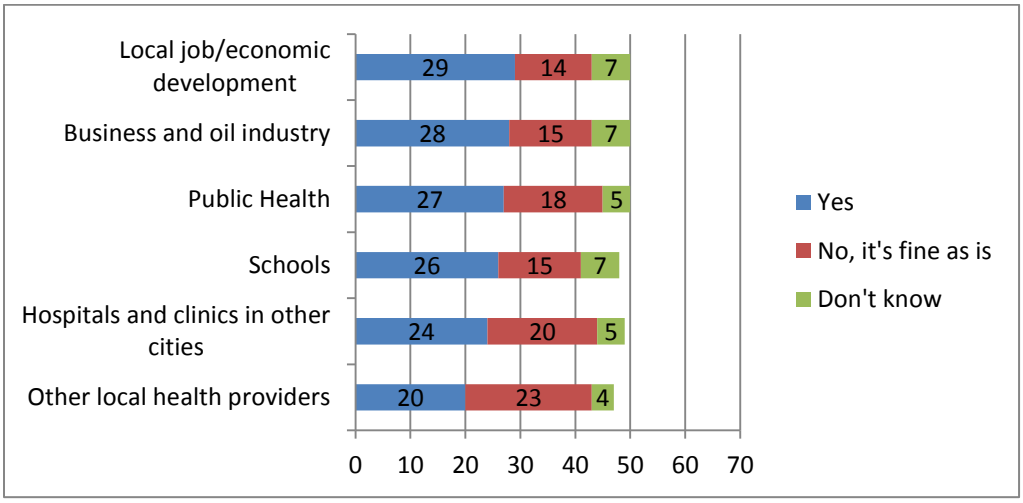


Figure 40: Health Care Professionals – Could MCHC Improve Collaboration?



Concerns and Suggestions for Improvement

Each version of the survey concluded with an open-ended question that asked, "Overall, please share concerns and suggestions to improve the delivery of local health care." Responses were supplied by 21 community members and seven health care professionals. Responses varied widely, but an appreciation for and contentment with the services offered by MCHC was often expressed. Examples include "It's nice to know that effort is made to provide the best care and refer and make arrangements when needed." Another community member wrote, "Great health care facility." This sentiment was echoed by a health care provider who wrote "We have a very good health care facility that is willing to work day and night for the well-being of the people in our community as well as surrounding locations. Our health care providers are experts at what they do and friendly to everyone. They are always willing to help."

Below are some of the specific comments relating to overall concerns and suggestions from *community members*. Unless otherwise indicated, each response was given once.

- Recruitment/retention of doctors (N=4)
- Great health care facility.
- Could use another doctor on weekends to help with emergency room.

- Do everything possible to hang on to doctors by providing adequate relief for E.R. or clinic hours so doctors do not get burned out so quickly. It has been a long time since we have had a M.D. stay more than three years, contract or not.
- Communities need to know what MCHC can provide to them.
- I travel to another health care facility because I have been told over and over again that the clinic will send you somewhere else if it is serious and there are not trained enough staff in town.
- Complete all medical equipment.
- Need to have more services available through the E.R.
- Rural clinics and hospitals need financial support, staffing support and support in obtaining equipment. The oil-patch areas are especially in need. They need help to just be open and they are definitely of great importance to the area they serve.

Below are some of the specific comments relating to overall concerns and suggestions from *health care professionals*:

- Leave a few open spots at the clinic each day so you can take drop-ins. If you have a kid with an earache, you shouldn't have to wait a day or two or have to drive to Minot.
- The Board of Directors, Administrator, and CFO need to have a good relationship with the providers. These key people need to communicate with the providers on a regular basis to ensure the best possible care is being given and always striving for what can be done to improve. I think lack of communication within the facility is a huge problem and has been for quite some time.
- More convenient hours for the clinic to be open.
- More staff to assist with people, phone calls, billing, training and record keeping.
- Continuity of care is huge. Improve diagnostics so do not need to transfer to Minot for diagnostic treatment.
- More extended clinic hours/ weekend clinic.
- Need for more providers. I feel that the providers and nurses in this facility are required to give up a lot to work here. I think that they work a lot of hours and give extra time to take care of things. I think if there were additional providers maybe there wouldn't be as much "burn out and "turn over".

Community Assets

Although a profound amount of community disruption has been reported by community members and health care professionals due to the oil boom, it is important to take into consideration the resources that people value and appreciate while choosing to live in Mountrail County.

Both community members and health care professionals were asked what they perceived as the best things about their community in five categories: people, services and resources, quality of life, geographic setting, and activities. In each category, respondents were given a list of choices and asked to pick the top three. Respondents occasionally chose less than three or more than three choices within each category. The results indicate that residents view the helpfulness of people and sense of community as the top community assets.

Other assets include things such as quality of schools and health care facility; family-friendly environment; economic opportunities, relatively small size of town and proximity to work. Health care professionals added the benefit of the natural setting and outdoors and nature. Figures 41 to 45 illustrate the results of these questions.

Figure 41: Best Things about the PEOPLE in Your Community

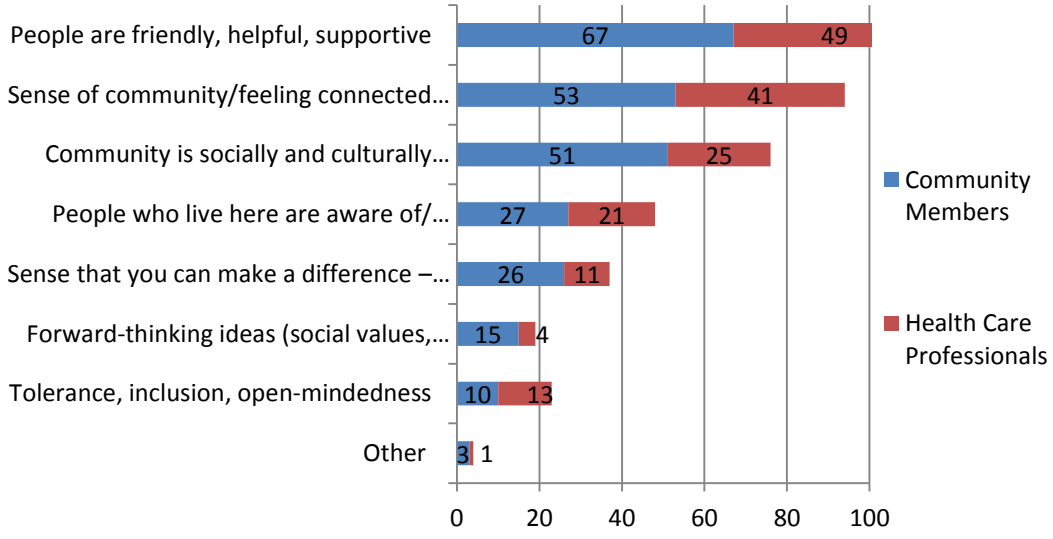


Figure 42: Best Things about the SERVICES AND RESOURCES in Your Community

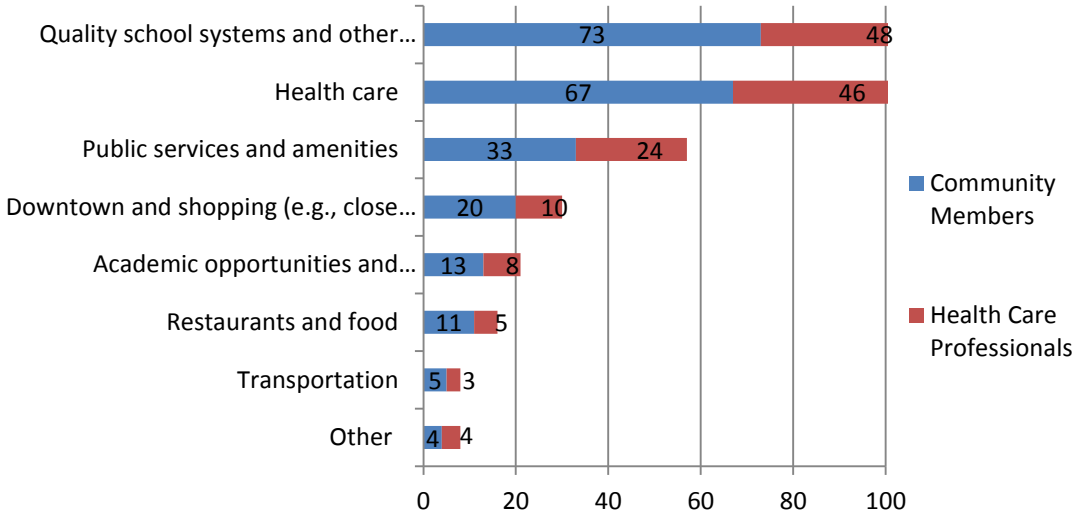


Figure 43: Best Things about the QUALITY OF LIFE in Your Community

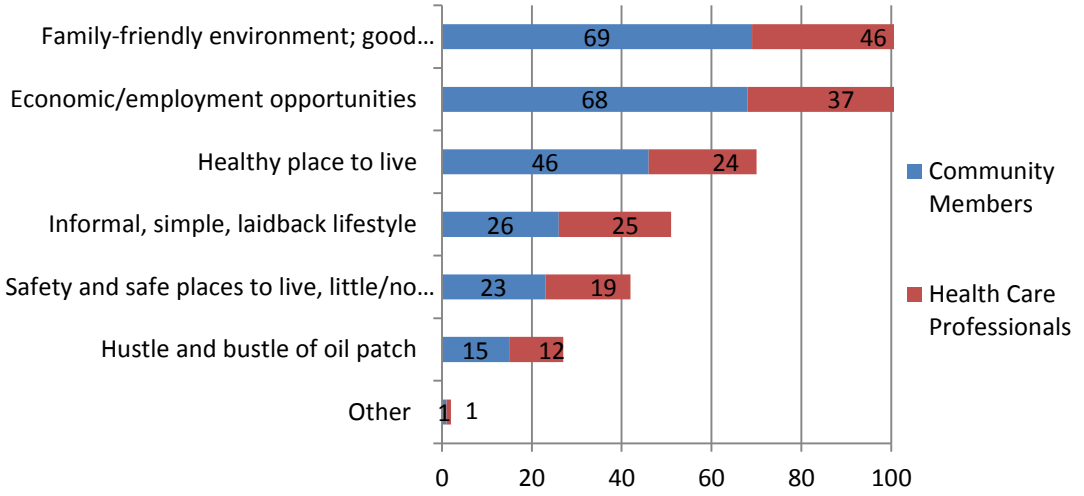


Figure 44: Best Things about the GEOGRAPHIC SETTING of Your Community

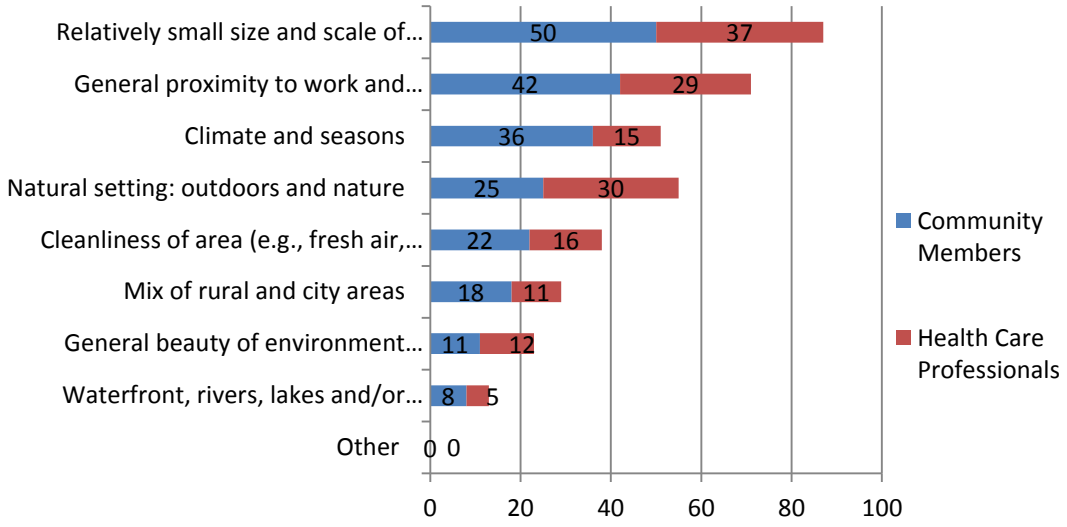
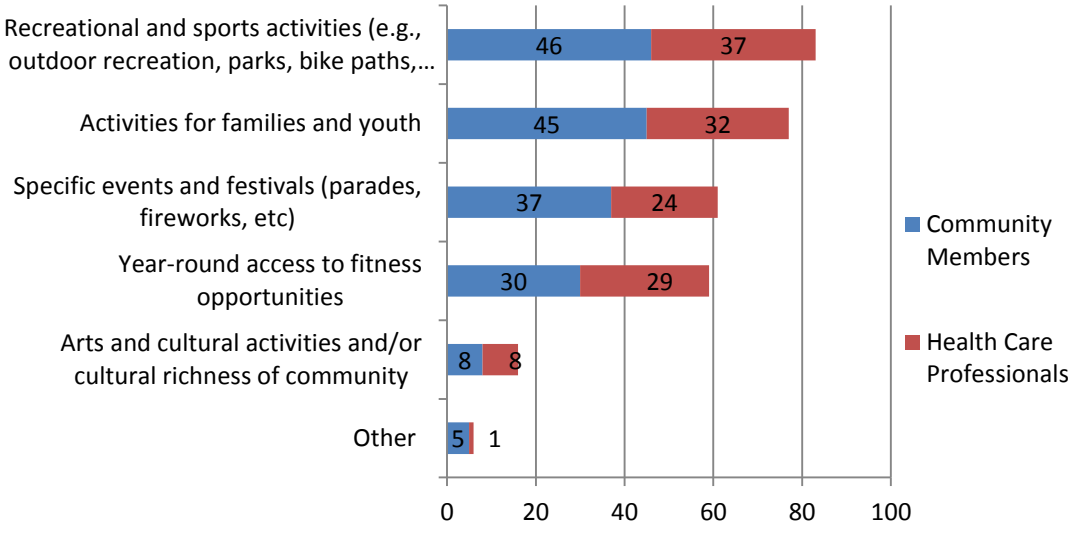


Figure 45: Best Thing about the ACTIVITIES in Your Community



Findings from Key Informant Interviews and Focus Group

The questions posed in the survey also were explored during a focus group session with the Community Group as well as during key informant interviews with community leaders and public health professionals. As an initial matter, interviewees and focus group participants generally were very complimentary toward hospital staff and their overall presence in the community. As one key informant summarized, "We have good quality of staff. Familiarity with them helps healing." The community's loyalty to MCHC was proven by the unanimous support in favor increasing the sales tax a half of percent to help the hospital expand.

Several themes emerged from these sessions. Many of the same issues that were prevalent in the survey results emerged during the key informant interviews as well (and were further explored during the discussions), but additional issues also appeared. Generally, overarching issues that developed during the interviews can be grouped into five recommendations (listed in no particular order):

1. Increase marketing campaign
2. Hire addiction/ substance abuse counselor
3. Hire social services liaison
4. Make CT scanner available
5. Hire more health care staff

A more detailed discussion about these noteworthy issues follows:

1. Increase marketing campaign

Awareness of services is limited to word of mouth referrals. Many key informant interviewees and community group members were not aware of the surgical services offered at MCHC. Specifically, the ability to perform biopsies, outpatient surgical and podiatry procedures was news to many. "It's not loudly advertised, "one member commented regarding the list of services.

Others commented on the rotating schedule of visiting specialists and the frequency of schedule changes, making it hard for residents to know which services are available when. Some commented on the high turnover of staff which necessitates a need to remind locals of services offered. To increase

awareness of locally available health care services, participants recommended that advertising needs to be increased in both paper and digital mediums, especially in areas outside of Stanley. The community of Parshall was one town identified as needing more advertising in the form of full page newspaper ads.

Additionally, residents suggested that the MCHC advertise in the newspaper. Included in this advertising is a need for the hospital to convey its financial needs. Residents want to know more about the hospital's financial feasibility. They want to be aware of needs and efforts at fundraising. Other ideas for newspaper spreads include more community education. A weekly hospital column could tackle the myths, advantages and disadvantages of the Affordable Care Act, e-records and other health initiatives. For a modest budget, some said to the tune of one penny and up depending on the spread, MCHC could enlarge its advertising reach.

Updating the MCHC webpage was also encouraged as it is a viable advertising network targeting newcomers. It has been observed that new residents are unlikely to subscribe to the local paper or watch local news programming but they are apt to surf the internet for local services. Increasing hospital signage is another marketing area participants would like to see more of. Some claimed it is easy to find the ER but difficult to find the Clinic. At night, it is particularly hard to navigate.

Furthermore, participants would like to see more aggressive marketing efforts extended to oil companies. Not only was this framed as a way to increase hospitality, but also a financial opportunity. Participants encouraged MCHC to promote its ability to offer physicals and other employment screenings by supplying oil companies a schedule of dates and times when employees can schedule their screenings. Along this line, launching an overall publicity and marketing campaign was mentioned. Promoting preventative care and occupational medicine available at MCHC to oil company employees was endorsed as a way of promoting wellness, increasing public relations and being business savvy. The hospital could offer incentives, for example, one participant suggested partnering with local businesses to offer those that schedule physicals or get immunized a gift card for 20% off local dining or services. Partnering with the faith community and other community leaders could build collaborative relationships and help to spread responsibilities and tasks.

Finally, participants would like MCHC to brag more about their services. Specifically, the hospital needs to tout its aquatic center. It was claimed that this is a state of the art facility that is both under-utilized and under-advertised. It was also flaunted as the best aquatic facility from the West Coast to Minneapolis. "It's a shame no one uses it as it is a balm for treating depression and arthritis."

Promoting this feature could promote a focus on health and wellness. Participants commented on how it is readily available and appropriate for those aged six months to 90 years. One participant suggested that health care professionals would be "wise to prescribe the pool instead of the anti-depressants." Promoting the aquatic center to the community as a recreational outlet could extend MCHC's commitment to prevention and wellness.

2. Hire addiction/ substance abuse counselor

Many participants expressed concern over the increase in use and abuse of substances. Anecdotal reporting conveyed to Center of Rural Health staff revealed that older people are more likely to use and abuse, with alcohol being the drug of choice. A surge in the abuse of bath salts, cocaine and meth has also been seen. In the community of New Town, there is a brisk demand for prescription drug sales. It was reported that kids are breaking in to houses to get their hands on oxycodone and other prescription drugs on the reservation.

Moreover, the oil boom has ushered in a market for the selling of illegal drugs. As a result, the crime rate is higher, with the biggest changes seen in the past two years. Others attested to the proliferation of substance abuse as the cause of so many expensive problems, including child abuse, as people are not in their right minds.

Participants expressed the need for an addiction counselor to start the treatment process. They also commented that more collaboration is needed with addiction. Access to prescription medicine is too easy. More education and awareness on prescription history and use is needed. An addiction counselor could help facilitate educational workshops and increase awareness of addiction abuse in the community.

Specific comments in participants' own words follow:

- Addiction/substance abuse is picking up rapidly.
- Major spike in domestic and sexual violence.
- Lots of nightlife fighting in the four bars. Newcomers think they own the place.
- Addiction and substance abuse has gone up since the oil boom.
- People are dying from untreated addictions.
- Addiction and substance abuse is major problem on reservation and oil fields. We need an addiction counselor.

3. Hire social services liaison

Many participants identified unmet social needs. A need for a social worker to serve as a screener to identify needs and resources was mentioned. There is an

urgent need for housing and food. There is also a record number of kids in foster care. It was reported that 27 kids need placement for only two foster homes; this rate is higher than ever seen before. The colder temperatures in winter have caused frozen pipes. All of these pressures on daily living, combined with cramped living quarters for those living in trailers, causes an increase in domestic violence. Some phrased the physical and domestic violence as a numbers game. A large number of people that are squeezed into tight living conditions is a formula for violence. Camper trailers that house families and are only positioned six feet away from the next camper were said to breed violence. It was reported that 200 school age kids are living in RVs. They are over-crowded and cold. When a six-pack of beer is added into the mix the result is a major health problem.

A compounding problem is that many oil field employees do not have health insurance but they make too much money to qualify for Medicare. As a result, they don't go to the doctor but seek out public health when their illness has escalated to an emergency. Furthermore, due to the high cost of living, a focus on wellness and prevention has been placed on the back burner. People are consumed with meeting immediate living needs like buying groceries and securing heat that overarching mental health needs are "pushed under the rug." A social worker is needed to serve as a clearinghouse of information. This position would act as an umbrella of resources and referrals.

4. Make CT scanner available

Numerous participants expressed disappointment with the unavailability of a CT scanner. Confusion surrounded if MCHC has the capability to offer CT scans. Some were surprised to see it listed on the services offered by the hospital; others said it was here, but not available for use. An overall feeling of dissatisfaction was expressed relating to the availability of the CT scanner. It was mentioned that it needs to be available 24/7, not one day a week

The majority saw a need for diagnostically testing locally, both in terms of better treating patients as well as retaining patients. There was a perception that many patients are sent elsewhere due to not having diagnostical testing on hand. Concerned with the hospital's financial viability, participants thought that the MCHC was losing money by having to transfer patients to get a CT scan. Performing CT scans locally would be one way the hospital could generate revenue and care for patients in-house.

5. Hire more health care professional staff

In addition to hearing requests for a general surgeon and more ER staff, the majority of requests identified more nursing staff, specifically more registered

nurses and licensed practical nurses. Praises for having lots of experience and offering a high quality of care were expressed for the current staff, but participants articulated a need for more help. "The girls work long hours." A need for more nursing was articulated as the one piece of advice most often given to improve the delivery of local health care. "Secure good nursing staff," one participant offered. "Get stable and local staff," echoed another.

To offset the nursing shortage, the hospital has had to rely on a temporary locum tenens workforce which has been the cause for resentment among employees. The travel nurses are paid more which breeds resentment among local staff and upsets employee morale. Some said the traveling nurses are paid as much as double the local pay, which undermines the staff who work there. Nursing home residents and hospital patients do not know who is going to take care of them on a daily basis. The lack of continuity of care tires patients who may have to explain their needs and history on a regular basis to new health care employees.

On a related field to workforce, participants expressed security concerns for the staff. It was noted that due to the oil boom, there is an off-balance ratio of men to women in the community. Often, female staff is alone at night leaving them feeling vulnerable.

Additionally, participants identified a need for a second doctor to relieve the on-call burden resting on the sole doctor as well as providing a network of support. It was noted that the one doctor has to shoulder a lot of responsibility and the physician can feel alienated, especially living in a small, rural town without having a support network. High stress levels and feelings of burn out would be ameliorated with an additional physician as well as adding professional support for the doctor and nurses.

Additional Issues

When talking about overall community health concerns, some participants are wary of the things they don't know about. For example, they are concerned about the environmental impact of the oil boom and the methods being used that have not been documented as problematic, though research has not been conclusive. Participants expressed apprehension about the use of methane flares and the impact they have on pollution and inhalation. Some attested to increased rates of asthma. Elevated levels of dust particles produced from the increase in trucks driving on dirt roads has warranted health concerns for animals and humans and has long term implications for respiratory health.

The hydraulic fraction oil extraction method termed "fracking" has some nervous about ground water contamination. Oil spills are a viable environmental

threat. The overall "cost of oil" weighs heavily on locals who are nervous about the unrealized and undocumented effects of the oil boom. One strategy to offset this is to increase the education of environmental health and hazards for EMS staff.

The influx of people to these small towns has many concerned about the threat of disease and illness. Specifically, a need for a school health nurse has been articulated. Currently, the secretaries are accountable for ensuring student immunizations are up to date, which places a high amount of responsibility on them. A more global student population ushers in new public health problems. Additionally, a workforce shortage has brought international workers to fill in local positions. There is a large pool of employees coming from South Africa to help on farms and a high Hispanic population to work in agricultural areas and grocery stores. Oil field jobs have hailed people from all over the world to join the labor force. All of this immigration has increased the risk of and exposure to communicable diseases. There has been a tuberculosis outbreak that has not been seen in the past twenty years plus pertussis, chicken pox and head lice outbreaks recently in the community. The need for a school nurse to keep a systematic watch on immunizations is great. There is a perception that "no one is checking immunizations."

Other issues that did not emerge as themes, but were mentioned, may license additional consideration.

- There is a need for cancer treatment, both radiation and chemotherapy, to be offered locally.
- There is a demand for Hospice care.
- There is a need for a farmer's market.
- More families moving into town warrant an obstetrician. Similarly, lots of kids use the E.R. There is a perception that the doctors are not comfortable with treating kids. Families are doctoring in Minot but would like to see pediatrics offered locally.
- Confidentiality is not what it should be. Native Americans get treated poorly. They perceive the hospital staff looking down upon them, judging there occurrence or emergency could have waited until the next day.
- A community space is needed to exercise and practice yoga. Roads and fields are no longer safe to run in due to increases in traffic pollution and dust. Could the hospital provide space for fitness programs?

On a positive note, many participants applauded the hiring of two full-time paramedics. It was reported that emergency room nurses and community

members love it. They have witnessed a lot better and early care given, which is a boon for the patient as well as the community.

Priority of Health Needs

The Community Group held its second meeting on the evening of April 8, 2013. Eleven members of the group attended the meeting. A representative from the Center for Rural Health presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the results of the survey (including perceived community health concerns, awareness of local services, why patients seek care at MCHC, community collaboration, and barriers to care), and findings from the focus group and key informant interviews.

Following the presentation of the assessment findings, and after careful consideration of and discussion about the findings, each member of the group was asked to identify on a ballot what they perceived as the top five community needs. There was a tie (eight votes each) between limited number of health care providers, access to needed technology, including making CT scanner available, and elevated rate of uninsured adults. After a discussion, the community group decided to prioritize the limited number of health care as the number one concern as the group determined that staffing resources affects so many of the other concerns. Additionally, although the group members were concerned with the high number of uninsured adults, they concluded that there was not much they could do about that issue so they de-prioritized, moving it into the fifth position. The group wanted to focus on the concerns where they perceived the ability to instigate change.

The results were totaled and categorized into three tiers: those receiving five or more votes, those receiving three or four votes and those receiving one or two votes. After ranking the concerns, the Community Group was asked if they thought the list adequately reflected the healthy needs of their community. The Community Group thought the ranked list did reflect the health needs of the community and would serve as a guiding light for the hospital's strategic planning. Concerns comprising the top three tiers were:

Tier 1

- Limited number of health care providers/ not enough health care staff in general (8 votes)
- Access to needed technology/equipment including making CT scanner available (8 votes)
- Elevated rate of uninsured adults (8 votes)
- Financial viability of hospital (7 votes)
- Increase marketing efforts (6 votes)

Tier 2

- Elevated rate of excessive drinking (4 votes)
- Elevated motor vehicle crash death rate (3 votes)

Tier 3

- Elevated level of preventable hospital stays (2 votes)
- Hire addiction/substance abuse counselor (2 votes)
- Elevated rate of adult smoking (1 vote)
- Elevated rate of adult obesity (1 vote)
- Limited number of mental health care providers (1 vote)
- Decreased rate of diabetic screening (1 vote)
- Decreased rate of colorectal cancer screening (1 vote)
- Decreased rate of annual hemoglobin A1C screening rates for patients with diabetes (1 vote)
- Higher cost of health care for consumers (1 vote)
- Heart disease (1 vote)

Mountrail County Health Center may use this prioritization for informational purposes – and as one form of community feedback – as it develops its implementation strategy, which is a plan for addressing community health needs. These identified needs satisfy the terms of the community health needs assessment, as mandated by the ACA, and they can help MCHC's strategic planning and programming implementation. A summary of this priority of needs may be found in Appendix G.

Summary

This study took into account input from approximately 142 community members and health care professionals from Mountrail County including a public health professional. This input represented the broad interests of the community served by Mountrail County Health Center. Together with secondary data gathered from a wide range of sources, the information presents a snapshot of health needs and concerns in the community.

An analysis of secondary data reveals that a large portion of MCHC's service area has a higher percentage of people who live below the poverty level and children living in poverty than the state averages indicating an increased need for medical services to low income residents. Additionally, the data compiled by County Health Rankings shows that Mountrail County is performing below the state average on all of the measures. Particular concern is warranted on the levels of residents without insurance. The ratios for primary care doctors and mental health providers are higher as is the rate of preventable hospital stays. Diabetic and mammography screening rates are lower

Mountrail County is not meeting the national benchmark with respect to sexually transmitted infections, with a rate that is 12 times the national benchmark. The rate of excessive drinking is three times the national benchmark. Additionally, the county's motor vehicle crash death rate is four times the national benchmark, while the adult smoking rate and teen birth rate is more than twice the national benchmark.

Results from the survey revealed that among community members the top five community health concerns were: (1) not enough health care staff in general (2) adequate number of health care providers and specialists, (3) higher costs of health care for consumers (4) financial viability of hospital and (5) heart disease.

Health care professionals also focused on medical and health conditions, collectively ranking as the top five concerns (1) not enough health care staff in general, (2)) financial viability of hospital, (3) adequate number of health care providers and specialists, (4) higher costs of health care for consumers and (5) access to needed technology/equipment. The amount of overlap between these two survey results indicates strong alignment in the perception of community health care needs from community members and health care professionals.

There is similar alignment in thought regarding the perception of overall community concerns, especially as a result of the rapid amount of change due to the oil boom. Both community members and health care professionals ranked

lack of affordable housing, traffic safety, maintaining enough health care workers and lack of employees to fill the positions as the top four community concerns.

Input from Community Group members and community leaders echoed many of the concerns raised by survey respondents, and also highlighted concerns about needing a more aggressive marketing campaign, hiring addiction/substance abuse counselor, a social services liaison as well as more health care staff in general and making CT scanner available.

Following careful consideration of the results and findings of this assessment, Community Group members determined that the top health needs or issues in the community are limited number of health care providers, access to needed technology/equipment including making CT scanner available, elevated rate of uninsured adults, financial viability of hospital and increasing marketing efforts.

Appendix A1 – Community Member Survey Instrument

Center for Rural Health Community Health Needs Assessment
(Community Member survey)

Mountrail County Health Center is interested in hearing from you about area health needs. The Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences is administering this survey on behalf of Mountrail County Health Center. This initiative is funded by the N.D. Medicare Rural Hospital Flexibility Program. The focus of the assessment is to:

- Learn about the community's assets and concerns, and hear suggestions for improvement
- Learn of the community's awareness of local health care services being provided
- Determine preferences for using local health care services versus traveling to other facilities

Please take a few moments to complete the survey. If you prefer, this survey may be completed online by visiting: **http://tinyurl.com/mountrailcommunitysurvey.** 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 in aggregate form. If you have questions about the survey, you may contact Karin Becker at the Center for Rural Health, 701.777.4499 or Karin.becker@email.und.edu

Surveys will be accepted through February 1, 2013. Your opinion matters – thank you in advance!

Community Assets/Best Things about Your Community

Please tell us about your community by choosing up to three options you most agree with in each category (i.e., people, services and resources, quality of life, geographic setting, and activities).

Q1a. Considering the PEOPLE in your community, the best things are (choose the top THREE):

☐	Community is socially and culturally diverse and/or becoming more diverse	☐	Sense of community/feeling connected to people who live here
☐	Forward-thinking ideas (e.g. social values, government)	☐	Sense that you can make a difference – government is accessible
☐	People who live here are aware of/ engaged in social, civic, or political issues	☐	Tolerance, inclusion, open-mindedness
☐	People are friendly, helpful, supportive	☐	Other (please specify)_____

Q1b. Considering the SERVICES AND RESOURCES in your community, the best things are (choose the top THREE):

☐	Academic opportunities and institutions (benefits that come from the proximity to colleges and universities)	☐	Public services and amenities
☐	Downtown and shopping (e.g., close by, good variety, availability of goods)	☐	Restaurants and food
☐	Health care	☐	Transportation
☐	Quality school systems and other educational institutions and programs for youth	☐	Other (please specify)_____

Q1c. Considering the QUALITY OF LIFE in your community, the best things are (choose the top THREE):

☐	Economic/employment opportunities	☐	Informal, simple, "laidback" lifestyle
☐	Family-friendly environment; good place to raise kids	☐	Safety and safe places to live, little/no crime
☐	Healthy place to live	☐	Other (please specify)_____
☐	Hustle and bustle of oil patch		

Q1d. Considering the GEOGRAPHIC SETTING in your community, the best things are (choose the top THREE):

☐	Cleanliness of area (e.g., fresh air, lack of pollution and litter)	☐	Natural setting: outdoors and nature
☐	Climate and seasons	☐	Relatively small size and scale of community
☐	General beauty of environment and/or scenery	☐	Waterfront, rivers, lakes, and/or beaches
☐	General proximity to work and activities (e.g., short commute, convenient access)	☐	Other (please specify)_____
☐	Mix of rural and city areas		

Q1e. Considering the ACTIVITIES in your community, the best things are (choose the top THREE):

☐	Activities for families and youth	☐	Specific events and festivals (e.g., parades, fireworks, etc.)
☐	Arts and cultural activities and/or cultural richness of community	☐	Year-round access to fitness opportunities (indoor activities, winter sports, etc.)
☐	Recreational and sports activities (e.g., outdoor recreation, parks, bike paths, and other activities)	☐	Other (please specify)_____

Q1f. What are other "best things" about your community that are not reflected in the questions above?

_____
_____
_____
_____

Community Concerns

Q2. Regarding the conditions in your community, please rank each of the potential concerns on a scale of 1 to 6, with 1 being less of a concern and 6 being more of a concern:

Community Concerns	Less of a concern					More of a concern
	1	2	3	4	5	6
Adequate number of school resources						
Aging population, lack of resources to meet growing needs						
Alcohol and drug use and abuse						
Crime and community violence						
Domestic violence, including child abuse						
Environmentally unsound (or unfriendly) place to live						
Impact of increased oil/energy development						
Increasing population, including residents moving in						
Insufficient facilities for exercise and well-being						
Lack of affordable housing						
Lack of employees to fill positions						
Lack of employment opportunities						
Lack of police presence in community						
Litter						
Low wages, lack of livable wages						
Maintaining enough health workers (e.g., medical, dental, wellness)						
Poverty						
Property taxes						
Racism, prejudice, hate, discrimination						
Traffic safety, including speeding, road safety and drunk driving						
Other. Please specify:						

b) Which concern above is the most important? _____

c) How do these concerns impact your community?_____

_____

_____

Health Care Services

Regarding each of the following health care services, please tell us:

a) Whether you are aware that the health care service is offered at Mountrail County Health Center (MCHC).
b) Whether you have used the health care service at Mountrail County Health Center (MCHC), at another facility, or both.

Q3a. General services

a) Aware of services at MCHC?		Type of service offered	b) Used services, either at MCHC or another facility? (Check both if applicable)	
Yes	No		Used Services at MCHC	Used Services at another facility
		Acne treatment		
		Allergy, flu & pneumonia shots		
		Blood pressure checks		
		Clinic		
		Long-term care		
		Mole/wart/skin lesion removal		
		Patient education & teaching		
		Physicals: annual, D.O.T., sports & insurance		
		Prenatal care up to 32 weeks		
		Referrals and follow-up care		
		Sports medicine		
		Swing bed services		

Q3b. Acute services

a) Aware of services at MCHC?		Type of service offered	b) Used services, either at MCHC or another facility? (Check both if applicable)	
Yes	No		Used Services at MCHC	Used Services at Another Facility
		Cardiac rehab		
		Emergency room		
		General surgeon—visiting specialist		
		Hospital (acute care)		
		Senior housing		
		Surgical services – biopsies		
		Surgical services – outpatient		
		Surgical services – podiatry procedures		

Q3c. Screening/therapy services

a) Aware of services at MCHC?		Type of service offered	b) Used services, either at MCHC or another facility? (Check both if applicable)	
Yes	No		Used Services at MCHC	Used Services at Another Facility
		Diet instruction		
		Health screenings		
		Laboratory services		
		Occupational therapy		
		Physical therapy		
		Social services		
		Speech therapy		

Q3d. Radiology services

a) Aware of services at MCHC?		Type of service offered	b) Used services, either at MCHC or another facility? (Check both if applicable)	
Yes	No		Used Services at MCHC	Used Services at Another Facility
		EKG--Electrocardiography		
		CT scan		
		Echocardiogram		
		General x-ray		
		Mammography		
		MRI		
		Ultrasound		

Q3e. Services offered **locally by other providers/organizations**

a) Aware of services offered locally?		Type of service offered	b) Used services, either locally or non-locally? (Check both if applicable)	
Yes	No		Used Services Locally	Used Services Non-Locally
		Ambulance		
		Chiropractic services		
		Dental services		
		Massage Therapy		
		Optometric/vision services		

Q3f. What specific services, if any, do you think Mountrail County Health Center needs to add, and why?

_____

Delivery of Health Care

Q4. Regarding the delivery of health care in your community, please rank each of the potential health concerns listed below on a scale of 1 to 6, with 1 being less of a concern and 6 being more of a concern:

Health Concerns	Less of a concern					More of a concern
	1	2	3	4	5	6
Access to needed technology/equipment						
Accident/injury prevention						
Addiction/substance abuse						
Adequate number of health care providers and specialists						
Cancer						
Diabetes						
Distance/transportation to health care facility						
Emergency services (ambulance & 911) available 24/7						
Financial viability of hospital						
Focus on wellness and prevention of disease						
Heart disease (e.g., congestive heart failure, heart attack, stroke, coronary artery disease)						
Higher costs of health care for consumers						
Mental health (e.g., depression, dementia/Alzheimer's)						
Not enough health care staff in general						
Obesity						
Suicide prevention						
Violence (domestic, workplace, emotional, physical, sexual)						

b) How do these concerns impact your community? _____
_____
_____
_____

Q5. Please tell us why you seek health care services at Mountrail County Health Center. (Choose ALL that apply.)

- ☐ Access to specialist
- ☐ Confidentiality
- ☐ Convenience
- ☐ Disability access
- ☐ Familiarity with providers
- ☐ High quality of care
- ☐ Less costly
- ☐ Loyalty to local service providers
- ☐ Open at convenient times
- ☐ Proximity
- ☐ They take my insurance
- ☐ They take new patients
- ☐ Transportation is readily available
- ☐ Other (please specify)_____
_____

Q6. Please tell us why you seek health care services at another health care facility. (Choose ALL that apply.)

- ☐ Access to specialist
- ☐ Confidentiality
- ☐ Disability access
- ☐ High quality of care
- ☐ Less costly
- ☐ Open at convenient times
- ☐ They take many types of insurance
- ☐ They take new patients
- ☐ Transportation is readily available
- ☐ Other (please specify)_____
  _____

Q7. What barriers prevent you or other community members from receiving health care? (Choose ALL that apply.)

- ☐ Distance from health facility
- ☐ Inability to get an appointment
- ☐ Lack of affordability
- ☐ Lack of awareness of local health services
- ☐ Lack of confidentiality
- ☐ Lack of continuity of care (inability to see same provider over time)
- ☐ Lack of doctors
- ☐ Lack of evening or weekend hours
- ☐ Lack of insurance
- ☐ Lack of specialists
- ☐ Lack of transportation services
- ☐ Language barriers
- ☐ Limited access to telehealth technology (patients seen by providers at another facility through a monitor/TV screen)
- ☐ Other (please specify)_____
  _____

Q8. How long does it take you to reach the nearest clinic outside Mountrail County Health Center?

- ☐ Less than 10 minutes
- ☐ 10 to 30 minutes
- ☐ 31 to 60 minutes
- ☐ More than 1 hour

Q9. How long does it take you to reach Mountrail County Health Center?

- ☐ Less than 10 minutes
- ☐ 10 to 30 minutes
- ☐ 31 to 60 minutes
- ☐ More than 1 hour

Q10. Do you believe that Mountrail County Health Center could improve its collaboration with:

	Yes	No. It's fine as it is.	Don't know
a) Business and oil industry	☐	☐	☐
b) Hospitals and clinics in other cities	☐	☐	☐
c) Local job/economic development	☐	☐	☐
d) Other local health providers	☐	☐	☐
e) Public Health	☐	☐	☐
f) Schools	☐	☐	☐

Q11. Are you aware of Mountrail County Health Foundation, which exists to support MCHC?

- ☐ Yes
- ☐ No

Q12. Have you supported the Mountrail County Health 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)

_____

Demographic Information

Please tell us about yourself.

Q13. Listed below are some general health conditions/diseases. Please select all that apply to you.

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma/COPD
- ☐ Cancer
- ☐ Chronic pain
- ☐ Dementia
- ☐ Depression, stress, etc.
- ☐ Diabetes
- ☐ Heart conditions (e.g., congestive heart failure)
- ☐ High cholesterol
- ☐ Hypertension
- ☐ OB/Gyn related
- ☐ Weight control
- ☐ Muscles or bones (e.g. back problems, broken bones)

Q14. Health insurance status. (Choose all that apply.)

- ☐ Indian Health Services
- ☐ Insurance through employer
- ☐ Medicaid
- ☐ Medicare
- ☐ Private insurance
- ☐ Tribal insurance
- ☐ Uninsured/underinsured
- ☐ Veteran's Health Care Benefits
- ☐ Other

Q15. Age:

- ☐ Less than 25 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

Q16. Highest level of education:

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

Q17. Gender:

- ☐ Female
- ☐ Male

Q. 18. How long have you lived in your community?

- ☐ Less than 3 years
- ☐ 3 to 9 years
- ☐ 10 to 20 years
- ☐ More than 20 year

Q19. Your zip code: _____

Q20. Marital status:

- ☐ Divorced/separated
- ☐ Married
- ☐ Single/never married
- ☐ Widowed

Q21. Employment status:

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

Q22. Annual household income before taxes:

- ☐ $0 to $14,999
- ☐ $15,000 to $24,999
- ☐ $25,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,999
- ☐ $150,000 to $199,999
- ☐ $200,000 and over
- ☐ Prefer not to answer

Q23. Overall, please share concerns and suggestions to improve the delivery of local health care.

Thank you for assisting us with this important survey!

Appendix A1 – Health Care Professional Survey Instrument

Mountrail County Health Center - Health Care Professional

Mountrail County Health Center is interested in hearing from you about area health needs. The Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences is administering this survey on behalf of Mountrail County Health Center. This initiative is funded by the N.D. Medicare Rural Hospital Flexibility Program. The focus of the assessment is to:

- Learn about the community's assets and concerns, and hear suggestions for improvement
- Learn of the community's awareness of local health care services being provided
- Determine preferences for using local health care services versus traveling to other facilities

Please take a few moments to complete the survey. 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 in aggregate form. If you have questions about the survey, you may contact Karin Becker at the Center for Rural Health, 701.777.4499 or Karin.becker@email.und.edu

Surveys will be accepted through February 1, 2013. Your opinion matters – thank you in advance!

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

Q1 Considering the PEOPLE in your community, the best things are (choose the top THREE):

- ❑ Community is socially and culturally diverse and/or becoming more diverse
- ❑ Forward-thinking ideas (e.g. social values, government)
- ❑ People who live here are aware of/ engaged in social, civic, or political issues
- ❑ People are friendly, helpful, supportive
- ❑ Sense of community/feeling connected to people who live here
- ❑ Sense that you can make a difference - government is accessible
- ❑ Tolerance, inclusion, open-mindedness
- ❑ Other (please specify) _____

Q2. Considering the SERVICES AND RESOURCES in your community, the best things are (choose the top THREE):

- ❑ Academic opportunities and institutions (benefits that come from the proximity to colleges and universities)
- ❑ Downtown and shopping (e.g., close by, good variety, availability of goods)
- ❑ Health care
- ❑ Quality school systems and other educational institutions and programs for youth
- ❑ Public services and amenities
- ❑ Restaurants and food
- ❑ Transportation
- ❑ Other (please specify) _____

Q3. Considering the QUALITY OF LIFE in your community, the best things are (choose the top THREE):

- ❑ Economic/employment opportunities
- ❑ Family-friendly environment; good place to raise kids
- ❑ Healthy place to live
- ❑ Hustle and bustle of oil patch
- ❑ Informal, simple, "laid back" lifestyle
- ❑ Safety and safe places to live, little/no crime
- ❑ Other (please specify) _____

Q4 Considering the GEOGRAPHIC SETTING in your community, the best things are (choose the top THREE):

- ❑ Cleanliness of area (e.g., fresh air, lack of pollution and litter)
- ❑ Climate and seasons
- ❑ General beauty of environment and/or scenery
- ❑ General proximity to work and activities (e.g., short commute, convenient access)
- ❑ Mix of rural and city areas
- ❑ Natural setting: outdoors and nature
- ❑ Relatively small size and scale of community
- ❑ Waterfront, rivers, lakes, and/or beaches
- ❑ Other (please specify) _____

Q5 Considering the ACTIVITIES in your community, the best things are (choose the top THREE):

- ❑ Activities for families and youth
- ❑ Arts and cultural activities and/or cultural richness of community
- ❑ Recreational and sports activities (e.g., outdoor recreation, parks, bike paths, and other activities)
- ❑ Specific events and festivals (e.g., parades, fireworks, etc.)
- ❑ Year-round access to fitness opportunities (indoor activities, winter sports, etc.)
- ❑ Other (please specify) _____

Q6 What are other "best things" about your community that are not reflected in the questions above?

_____

Q7 Community Concerns Regarding the conditions in your community, please rank each of the potential concerns on a scale of 1 to 6, with 1 being less of a concern and 6 being more of a concern:

	1 = less of a concern	2	3	4	5	6 = more of a concern
Adequate number of school resources	❍	❍	❍	❍	❍	❍
Aging population, lack of resources to meet growing needs	❍	❍	❍	❍	❍	❍
Alcohol and drug use and abuse	❍	❍	❍	❍	❍	❍
Crime and community violence	❍	❍	❍	❍	❍	❍
Domestic violence, including child abuse	❍	❍	❍	❍	❍	❍
Environmentally unsound (or unfriendly) place to live	❍	❍	❍	❍	❍	❍
Impact of increased oil/energy development	❍	❍	❍	❍	❍	❍
Increasing population,	❍	❍	❍	❍	❍	❍

including residents moving in						
Insufficient facilities for exercise and well-being	❍	❍	❍	❍	❍	❍
Lack of affordable housing	❍	❍	❍	❍	❍	❍
Lack of employees to fill positions	❍	❍	❍	❍	❍	❍
Lack of employment opportunities	❍	❍	❍	❍	❍	❍
Lack of police presence in community	❍	❍	❍	❍	❍	❍
Litter	❍	❍	❍	❍	❍	❍
Low wages, lack of livable wages	❍	❍	❍	❍	❍	❍
Maintaining enough health workers (e.g., medical, dental, wellness)	❍	❍	❍	❍	❍	❍
Poverty	❍	❍	❍	❍	❍	❍
Property taxes	❍	❍	❍	❍	❍	❍
Racism, prejudice, hate, discrimination	❍	❍	❍	❍	❍	❍
Traffic safety, including speeding, road safety and drunk driving	❍	❍	❍	❍	❍	❍
Other. Please specify:	❍	❍	❍	❍	❍	❍

Q8 a) Which concern above is the most important? _____

b) How do these concerns impact your community?_____

Q9 What specific services, if any, do you think Mountrail County Health Center needs to add, and why?

Q10 Delivery of Health Care Regarding the delivery of health care in your community, please rank each of the potential health concerns listed below on a scale of 1 to 6, with 1 being less of a concern and 6 being more of a concern:

	1 = less of a concern	2	3	4	5	6 = more of a concern
Access to needed technology/equipment	❍	❍	❍	❍	❍	❍
Accident/injury prevention	❍	❍	❍	❍	❍	❍
Addiction/substance abuse	❍	❍	❍	❍	❍	❍
Adequate number of health care providers and specialists	❍	❍	❍	❍	❍	❍
Cancer	❍	❍	❍	❍	❍	❍
Diabetes	❍	❍	❍	❍	❍	❍
Distance/transportation to health care facility	❍	❍	❍	❍	❍	❍
Emergency services (ambulance & 911) available 24/7	❍	❍	❍	❍	❍	❍
Financial viability of hospital	❍	❍	❍	❍	❍	❍
Focus on wellness and prevention of disease	❍	❍	❍	❍	❍	❍
Heart disease (e.g., congestive heart failure, heart attack, stroke, coronary artery disease)	❍	❍	❍	❍	❍	❍
Higher costs of health care for consumers	❍	❍	❍	❍	❍	❍
Mental health (e.g., depression, dementia/Alzheimer's)	❍	❍	❍	❍	❍	❍
Not enough health care staff in general	❍	❍	❍	❍	❍	❍
Obesity	❍	❍	❍	❍	❍	❍
Suicide prevention	❍	❍	❍	❍	❍	❍
Violence (domestic, workplace, emotional, physical, sexual)	❍	❍	❍	❍	❍	❍

Q11 How do these concerns impact your community?

_____

Q12 Please tell us why you think patients seek health care services at Mountrail County Health Center. (Choose ALL that apply.)

- ❑ Access to specialist
- ❑ Confidentiality
- ❑ Convenience
- ❑ Disability access
- ❑ Familiarity with providers
- ❑ High quality of care
- ❑ Less costly
- ❑ Loyalty to local service providers
- ❑ Open at convenient times
- ❑ Proximity
- ❑ They take my insurance
- ❑ They take new patients
- ❑ Transportation is readily available
- ❑ Other (please specify) _____

Q13 Please tell us why you think patients seek health care services at another health care facility. (Choose ALL that apply.)

- ❑ Access to specialist
- ❑ Confidentiality
- ❑ Disability access
- ❑ High quality of care
- ❑ Less costly
- ❑ Open at convenient times
- ❑ They take many types of insurance
- ❑ They take new patients
- ❑ Transportation is readily available
- ❑ Other (please specify) _____

Q14 What barriers prevent you or other community members from receiving health care? (Choose ALL that apply:

- ❑ Distance from health facility
- ❑ Inability to get an appointment
- ❑ Lack of affordability
- ❑ Lack of awareness of local health services
- ❑ Lack of confidentiality
- ❑ Lack of doctors
- ❑ Lack of continuity of care (inability to see same provider over time)
- ❑ Lack of evening or weekend hours
- ❑ Lack of insurance
- ❑ Lack of specialists
- ❑ Lack of transportation services
- ❑ Language barriers
- ❑ Limited access to telehealth technology (patients seen by providers at another facility through a monitor/TV screen)
- ❑ Other (please specify) _____

Q15 Do you believe that Mountrail County Health Center could improve its collaboration with:

	Yes	No. It's fine as it is.	Don't Know
Business and oil industry	❍	❍	❍
Hospitals and clinics in other cities	❍	❍	❍
Local job/economic development	❍	❍	❍
Other local health providers	❍	❍	❍
Public Health	❍	❍	❍
Schools	❍	❍	❍

Demographic Information: Please tell us about yourself.

Q16 Age:

- ❍ Less than 25 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

Q17 Highest level of education:

- ❍ Some high school
- ❍ High school diploma or GED
- ❍ Some college/technical degree
- ❍ Associates degree
- ❍ Bachelor's degree
- ❍ Graduate or professional degree

Q18 How long have you been employed by Mountrail County Health Center?

- ❍ Less than five years
- ❍ 5 to 10 years
- ❍ More than 10 years

Q19 Gender:

- ❍ Female
- ❍ Male

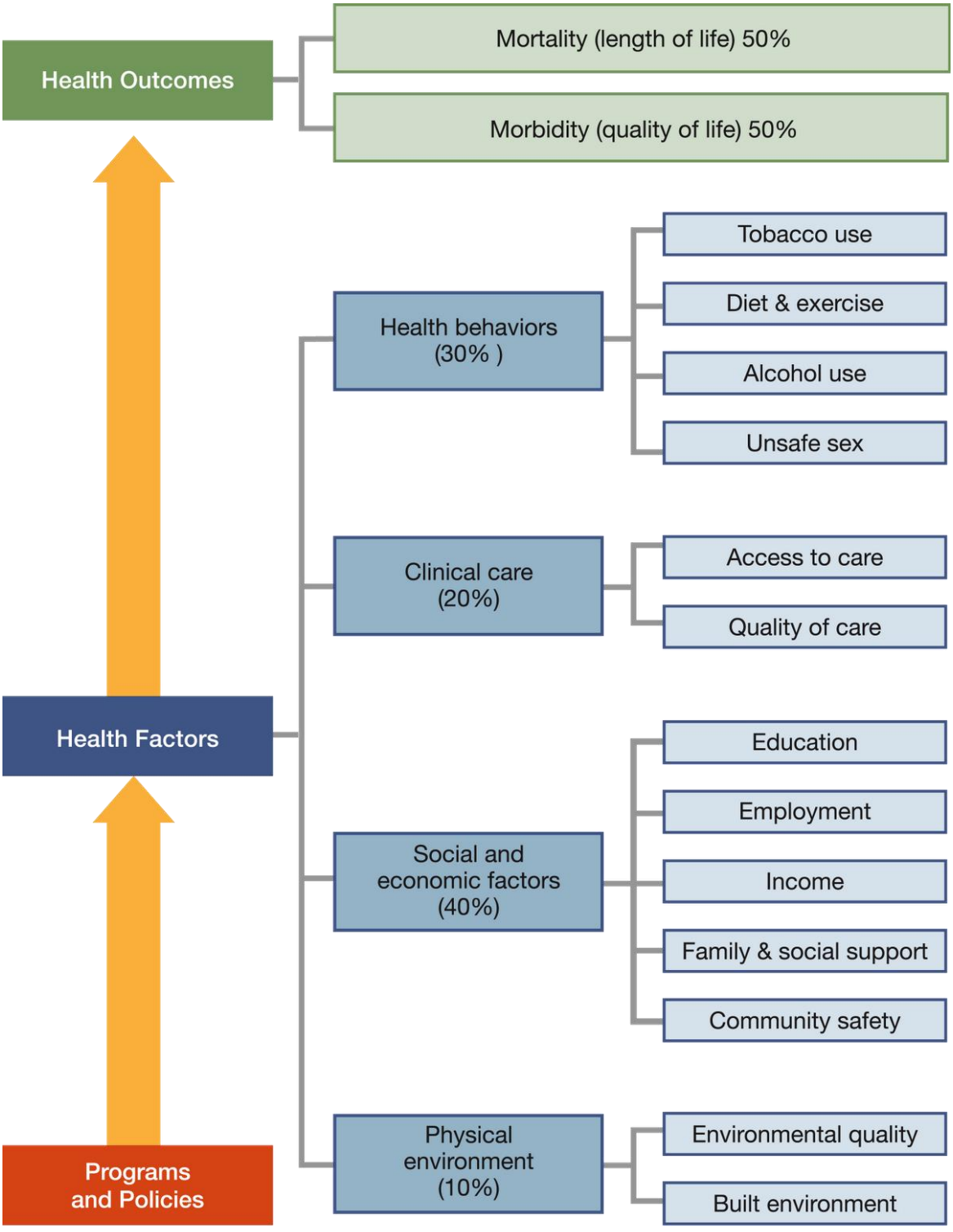
Q20 Overall please share concerns and suggestions to improve the delivery of local health care.

_____

Appendix B – Community Group Members and Key Informants Participating in Interviews

Name	Organization	Title
Marilyn Everson	MCHC	Retired nurse
Ryan Gjellstad	Agriculture	Business owner
Debbie Lund	Mountrail County Public Health	Nurse
Ken Weathers	Stanley Ambulance	Paramedic
Mike Hynek	Mountrail County	Mayor
Terry Wilbur	Construction Owner	President
Brian Quigley	Social services	Director
Donald Longmuir	Mountrail County	City planner
Kari Enget	Powers Lake Ambulance	Co Squad leader
Cherlyn Beiver	Mountrail County	Legal assistant
Steve Springan	Retail/ EDC	Member
Doug Kinnoin	Agriculture	Farmer
Carolyn Philstrom	Prairie Lutheran Parish	Pastor
Kevin Hoherz	Mountrail County Schools	High school principal
Greg Boschee	Mountrail County	Commissioner
Blair Hynek	American Bank Center	Loan officer
Bob Grant	MCMC	Chairman of Board
Doris Brown	MCMC	CEO
Christopher Beehler	MCMC	IT Coordinator
Susan Weston	MCMC	CFO
Belinda Moen	MCMC	Quality/risk/Infection Director
Janel Borud	MCMC	RN-Clinic Manager
Ruth Hysjulien	Retail Clothing	Owner

Appendix C – County Health Rankings Model



County Health Rankings model ©2010 UWPHI

Appendix D – Definitions of Health Variables

Definitions of Health Variables from the *County Health Rankings 2011 Report*

Variable	Definition
Poor or Fair Health	Self-reported health status based on survey responses to the question: "In general, would you say that your health is excellent, very good, good, fair, or poor?"
Poor Physical Health Days (in past 30 days)	Estimate based on 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?"
Poor Mental Health Days (in past 30 days)	Estimate based on 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?"
Adult Smoking	Percent of adults that report smoking equal to, or greater than, 100 cigarettes and are currently a smoker
Adult Obesity	Percent of adults that report a BMI greater than, or equal to, 30
Excessive Drinking	Percent of as individuals that report binge drinking in the past 30 days (more than 4 drinks on one occasion for women, more than 5 for men) or heavy drinking (defined as more than 1 (women) or 2 (men) drinks per day on average
Sexually Transmitted Infections	Chlamydia rate per 100,000 population
Teen Birth Rate	Birth rate per 1,000 female population, ages 15-19
Uninsured Adults	Percent of population under age 65 without health insurance
Preventable Hospital Stays	Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees
Mammography Screening	Percent of female Medicare enrollees that receive mammography screening
Access to Healthy Foods	Healthy food outlets include grocery stores and produce stands/farmers' markets
Access to Recreational Facilities	Rate of recreational facilities per 100,000 population
Diabetics	Percent of adults aged 20 and above with diagnosed diabetes
Physical Inactivity	Percent of adults aged 20 and over that report no leisure time physical activity
Primary Care Provider Ratio	Ratio of population to primary care providers
Mental Health Care Provider Ratio	Ratio of population to mental health care providers
Diabetic Screening	Percent of diabetic Medicare enrollees that receive HbA1c screening.
Binge Drinking	Percent of adults that report binge drinking in the last 30 days. Binge drinking is consuming more than 4 (women) or 5 (men) alcoholic drinks on one occasion.

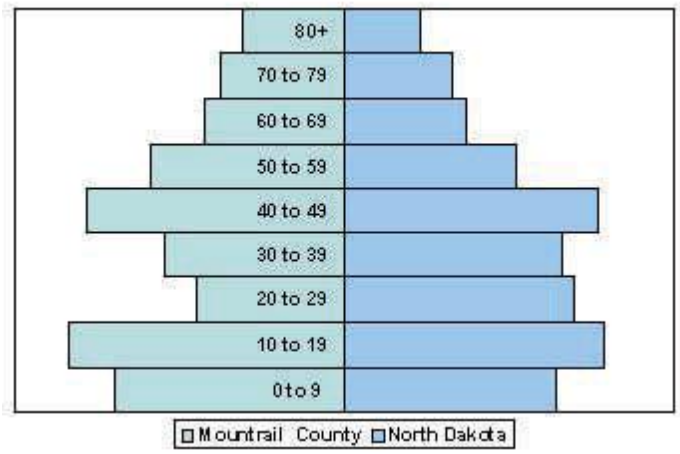
Appendix E – Upper Missouri Community Health Profile

Population by Age Group, 2000 Census						
Age Group	Williams County		UMDHU		North Dakota	
	Number	Percent	Number	Percent	Number	Percent
0-9	2469	12.5	4,391	12.8	82,382	12.8%
10-19	3329	16.8	5,839	17.0	101,082	15.7%
20-29	1805	9.1	2,860	8.3	89,295	13.9%
30-39	2355	11.9	3,969	11.5	85,086	13.2%
40-49	3480	17.6	5,799	16.9	98,449	15.3%
50-59	2192	11.1	3,996	11.6	66,921	10.4%
60-69	1639	8.3	2,947	8.6	47,649	7.4%
70-79	1448	7.3	2,592	7.5	41,844	6.5%
80+	1044	5.3	2,019	5.9	29,492	4.6%
Total	19761	100.0	34,412	100.0	642,200	100.0%
0-17	5,172	26.2%	9,250	26.9%	160,849	25.0%
65+	3,261	16.5%	6,009	17.5%	94,478	14.7%

Population by Age Group, 2000 Census						
Age Group	Divide County		McKenzie County		Mountrail County	
	Number	Percent	Number	Percent	Number	Percent
0-9	189	8.3	810	14.1	923	13.9
10-19	314	13.8	1,088	19.0	1,108	16.7
20-29	99	4.3	362	6.3	594	9.0
30-39	237	10.4	655	11.4	722	10.9
40-49	320	14.0	967	16.9	1,032	15.6
50-59	311	13.6	711	12.4	782	11.8
60-69	270	11.8	475	8.3	563	8.5
70-79	287	12.6	358	6.2	499	7.5
80+	256	11.2	311	5.4	408	6.2
Total	2,283	100.0	5,737	100.0	6,631	100.0
0-17	462	20.2%	1,756	30.6%	1,860	28.1%
65+	674	29.5%	900	15.7%	1,174	17.7%

Mountrail County Community Health Profile

POPULATION



Upper Missouri Community Health Profile

Female Population and Percentage Female by Age, 2000 Census						
Age Group	Divide County		McKenzie County		Mountrail County	
	Number	Percent	Number	Percent	Number	Percent
0-9	79	41.8%	390	48.1%	440	47.7%
10-19	150	47.8%	528	48.5%	564	50.9%
20-29	43	43.4%	177	48.9%	298	50.2%
30-39	116	48.9%	344	52.5%	365	50.6%
40-49	145	45.3%	470	48.6%	511	49.5%
50-59	153	49.2%	350	49.2%	369	47.2%
60-69	138	51.1%	222	46.7%	302	53.6%
70-79	148	51.6%	207	57.8%	262	52.5%
80+	165	64.5%	171	55.0%	258	63.2%
Total	1,137	49.8%	2859	49.8%	3,369	50.8%

Female Population and Percentage Female by Age, 2000 Census						
Age Group	Williams County		UMDHU		North Dakota	
	Number	Percent	Number	Percent	Number	Percent
0-9	1222	49.5%	2,131	48.5%	40,200	48.8%
10-19	1637	49.2%	2,879	49.3%	48,823	48.3%
20-29	909	50.4%	1,427	49.9%	42,196	47.3%
30-39	1212	51.5%	2,037	51.3%	41,884	49.2%
40-49	1676	48.2%	2,802	48.3%	48,521	49.3%
50-59	1078	49.2%	1,950	48.8%	32,799	49.0%
60-69	846	51.6%	1,508	51.2%	24,937	52.3%
70-79	827	57.1%	1,444	55.7%	23,106	55.2%
80+	667	63.9%	1,261	62.5%	19,210	65.1%
Total	10074	51.0%	17,439	50.7%	321,676	50.1%

Population Change 1990 to 2000 Census						
Census	Divide County	McKenzie County	Mountrail County	Williams County	UMDHU	North Dakota
1990	2,899	6,383	7,021	21,129	37,432	638,800
2000	2,283	5,737	6,631	19,761	34,412	642,200
Change	-21.2%	-10.1%	-5.6%	-6.5%	-8.1%	0.5%

Race, 2000 Census	Divide County		McKenzie County		Mountrail County	
Race	Number	Percentage	Number	Percentage	Number	Percentage
Total	2,283	100.0%	5,737	100.0%	6,631	100.0%
White	2,260	99.0%	4,438	77.4%	4,376	66.0%
Black	0	0.0%	4	0.1%	6	0.1%
Am.Indian	3	0.1%	1,215	21.2%	1,988	30.0%
Asian	12	0.5%	3	0.1%	14	0.2%
Pac. Islander	0	0.0%	1	0.0%	3	0.0%
Other	4	0.2%	8	0.1%	17	0.3%
Multirace	4	0.2%	68	1.2%	227	3.4%

Race, 2000 Census	Williams County		UMDHU		North Dakota	
Race	Number	Percentage	Number	Percentage	Number	Percentage
Total	19,761	100.0%	34,412	100.0%	642,200	100.0%
White	18,367	92.9%	29,441	85.6%	593,181	92.4%
Black	24	0.1%	34	0.1%	3,916	0.6%
Am.Indian	869	4.4%	4,075	11.8%	31,329	4.9%
Asian	36	0.2%	65	0.2%	3,606	0.6%
Pac. Islander	2	0.0%	6	0.0%	230	0.0%
Other	27	0.1%	56	0.2%	2,540	0.4%
Multirace	436	2.2%	735	2.1%	7,398	1.2%

Household Populations, 2000 Census	Divide County		McKenzie County		Mountrail County	
	Number	Percent	Number	Percent	Number	Percent
Total	2,283	100.0%	5,737	100.0%	6,631	100.0%
In Family Households	1,815	79.5%	5,017	87.4%	5,571	84.0%
In Non-Family Households	378	16.6%	659	11.5%	89	1.3%
Total In Households	2,193	96.1%	5,676	98.9%	6,467	97.5%
Institutionalized	90	3.9%	151	2.6%	151	2.3%
Non-Institutionalized	0	0.0%	13	0.2%	13	0.2%
Total in Group Quarters	90	3.9%	164	2.9%	164	2.5%

Household Populations, 2000 Census	Williams County		UMDHU		North Dakota	
	Number	Percent	Number	Percent	Number	Percent
Total	19,761	100.0%	34,412	100.0%	642,000	100.0%
In Family Households	16,030	81.1%	28,433	82.6%	507,581	79.1%
In Non-Family Households	3,252	16.5%	4,378	12.7%	110,988	17.3%
Total In Households	19,282	97.6%	33,618	97.7%	618,569	96.4%
Institutionalized	164	0.8%	556	1.6%	9,688	1.5%
Non-Institutionalized	315	1.6%	341	1.0%	13,943	2.2%
Total in Group Quarters	479	2.4%	897	2.6%	23,631	3.7%

Marital Status of Persons Age 15 and Older, 2000 Census						
	Divide County		McKenzie County		Mountrail County	
Marital Status	Number	Percent	Number	Percent	Number	Percent
Total Age 15+	1,934	100.0%	4,338	100.0%	5,130	100.0%
Never Married	328	17.0%	1,007	23.2%	1,269	24.7%
Now Married	1,214	62.8%	2,600	59.9%	2,922	57.0%
Separated	12	0.6%	43	1.0%	46	0.9%
Widowed	228	11.8%	369	8.5%	486	9.5%
Female	200	10.3%	289	6.7%	420	8.2%
Divorced	152	7.9%	319	7.4%	407	7.9%
Female	65	3.4%	163	3.8%	178	3.5%

Marital Status of Persons Age 15 and Older, 2000 Census						
	Williams County		UMDHU		North Dakota	
Marital Status	Number	Percent	Number	Percent	Number	Percent
Total Age 15+	15,744	100.0%	27,146	100.0%	512,281	100.0%
Never Married	3,839	24.4%	6,443	23.7%	141,300	27.6%
Now Married	9010	57.2%	15,746	58.0%	290,833	56.8%
Separated	104	0.7%	205	0.8%	3,610	0.7%
Widowed	1290	8.2%	2,373	8.7%	36,702	7.2%
Female	1025	6.5%	1,934	7.1%	30,346	5.9%
Divorced	1501	9.5%	2,379	8.8%	39,836	7.8%
Female	740	4.7%	1,146	4.2%	21,235	4.1%

Educational Attainment Among Persons 25+, 2000 Census						
	Divide County		McKenzie County		Mountrail County	
Education	Number	Percent	Number	Percent	Number	Percent
No schooling completed	9	0.5%	12	0.3%	14	0.3%
No High School	159	9.1%	341	9.4%	417	9.7%
Some High School	173	9.9%	410	11.3%	523	12.1%
High school or GRE	608	34.9%	1185	32.5%	1274	29.6%
Some College	561	32.2%	1123	30.8%	1408	32.7%
Bachelor's degree	196	11.3%	458	12.6%	515	12.0%
Post Graduate Degree	35	2.0%	115	3.2%	158	3.7%

Educational Attainment Among Persons 25+, 2000 Census						
	Williams County		UMDHU		North Dakota	
Education	Number	Percent	Number	Percent	Number	Percent
No schooling completed	60	0.5%	95	0.4%	1,605	0.4%
No High School	1038	8.0%	1,955	8.6%	34,053	8.3%
Some High School	1181	9.1%	2,287	10.1%	30,326	7.4%
High school or GRE	4143	31.8%	7,210	31.7%	113,931	27.9%
Some College	4471	34.3%	7,563	33.3%	138,855	34.0%
Bachelor's degree	1622	12.4%	2,791	12.3%	67,551	16.5%
Post Graduate Degree	533	4.1%	841	3.7%	22,292	5.5%

Persons Age 5 and Older with Disabilty, 2000 Census						
	Divide County		McKenzie County		Mountrail County	
Group	Number	Percent	Number	Percent	Number	Percent
Total	2,123	100.0%	5,332	100.0%	6,038	100.0%
No Disability	1804	85.0%	4,489	84.2%	4,955	82.1%
Any Disability	319	15.0%	843	15.8%	1,083	17.9%
Self Care Disability	35	1.6%	95	1.8%	123	2.0%
5-15 with any disability	18	5.8%	23	2.0%	41	3.4%
16-64 with any disabilty	107	8.7%	455	13.7%	588	15.4%
65+ with any disability	194	33.0%	365	43.0%	454	44.6%

Persons Age 5 and Older with Disabilty, 2000 Census						
	Williams County		UMDHU		North Dakota	
Group	Number	Percent	Number	Percent	Number	Percent
Total	18,456	100.0%	31,949	100.0%	586,289	100.0%
No Disability	15,124	81.9%	26,372	82.5%	488,472	83.3%
Any Disability	3,332	18.1%	5,577	17.5%	97,817	16.7%
Self Care Disability	461	2.5%	714	2.2%	11,011	1.9%
5-15 with any disability	118	3.6%	200	3.4%	5,586	5.6%
16-64 with any disabilty	1990	16.5%	3,140	15.4%	58,630	14.7%
65+ with any disability	1224	39.2%	2,237	40.1%	33,601	38.5%

Income and Poverty Status by Age Group, 2000 Census						
	Divide County		McKenzie County		Mountrail County	
Median Household Income	$30,089		$29,342		$27,098	
Per Capita Income	$16,225		$14,732		$13,422	
	Number	Percent	Number	Percent	Number	Percent
Below Poverty Level	319	14.6%	968	17.2%	1,243	19.3%
Under 5 years	10	14.9%	78	23.3%	137	32.1%
5 to 11 years	39	22.0%	162	24.3%	178	25.3%
12 to 17 years	40	18.8%	150	20.8%	120	16.8%
18 to 64 years	144	12.6%	470	15.3%	622	17.3%
65 to 74 years	39	14.8%	51	11.9%	87	18.4%
75 years and over	47	14.6%	57	13.6%	99	18.2%

Income and Poverty Status by Age Group, 2000 Census						
	Williams County		UMDHU		North Dakota	
Median Household Income	$31,491		NA		$34,604	
Per Capita Income	$16,763		NA		$16,227	
	Number	Percent	Number	Percent	Number	Percent
Below Poverty Level	2,314	11.9%	4,844	14.4%	73,457	11.9%
Under 5 years	196	17.5%	421	21.6%	6,784	17.6%
5 to 11 years	341	17.9%	720	20.9%	8,666	14.3%
12 to 17 years	331	16.1%	641	17.3%	6,713	11.3%
18 to 64 years	1194	10.6%	2430	12.8%	41,568	11.1%
65 to 74 years	94	6.0%	271	9.9%	3,797	8.4%
75 years and over	158	10.2%	361	12.7%	5,929	14.1%

Family Poverty and Childhood and Elderly Poverty, 2000 Census	Divide County		McKenzie County	
	Number	Percent	Number	Percent
Total Families	651		1544	
Families in Poverty	62	9.5%	212	13.7%
Families with Own Children	230		793	
Families with Own Children in Poverty	37	5.7%	150	9.7%
Families with Own Children and Female Parent Only	23		146	
Families with Own Children and Female Parent Only in Poverty	12	1.8%	62	4.0%
Total Known Children in Poverty	89	19.5%	390	22.6%
Total Known Age 65+ in Poverty	86	14.7%	108	12.4%

Family Poverty and Childhood and Elderly Poverty, 2000 Census	Mountrail County		Williams County	
	Number	Percent	Number	Percent
Total Families	1768		5244	
Families in Poverty	247	14.0%	502	9.6%
Families with Own Children	887		2619	
Families with Own Children in Poverty	179	10.1%	418	8.0%
Families with Own Children and Female Parent Only	190		538	
Families with Own Children and Female Parent Only in Poverty	83	4.7%	277	5.3%
Total Known Children in Poverty	435	23.6%	868	17.1%
Total Known Age 65+ in Poverty	186	18.3%	252	8.1%

Family Poverty and Childhood and Elderly Poverty, 2000 Census	UMDHU		North Dakota	
	Number	Percent	Number	Percent
Total Families	9207		166963	
Families in Poverty	1023	11.1%	13890	8.3%
Families with Own Children	4529		83678	
Families with Own Children in Poverty	784	8.5%	10043	12.0%
Families with Own Children and Female Parent Only	897		13971	
Families with Own Children and Female Parent Only in Poverty	434	4.7%	5402	38.7%
Total Known Children in Poverty	1782	19.6%	22,163	13.8%
Total Known Age 65+ in Poverty	632	11.3%	9,726	10.2%

	Divide County		McKenzie County		Mountrail County	
	Number	Percent	Number	Percent	Number	Percent
Housing units: Total	1,469	100.0%	2,719	100.0%	3,438	100.0%
1980 and Later	180	12.3%	717	26.4%	724	21.1%
1970 to 1979	298	20.3%	635	23.4%	681	19.8%
Prior to 1970	991	67.5%	1,367	50.3%	2,033	59.1%

Age of Housing, 2000 Census	Williams County		UMDHU		North Dakota	
	Number	Percent	Number	Percent	Number	Percent
Housing units: Total	9,680	100.0%	17,306	100.0%	289,677	100.0%
1980 and Later	2,240	23.1%	3,861	22.3%	76,239	26.3%
1970 to 1979	2,283	23.6%	3,897	22.5%	68,376	23.6%
Prior to 1970	5,157	53.3%	9,548	55.2%	145,062	50.1%

Vital Statistics Data

BIRTHS AND DEATHS

Births, 2004 - 2008	Divide County		McKenzie County		Mountrail County	
	Number	Rate or Ratio	Number	Rate or Ratio	Number	Rate or Ratio
Live Births and Rate	78	7	333	12	555	17
Pregnancies and Rate	84	7	368	13	608	18
Fertility Rate		53		65		93
Teen Births and Rate	0	0	37	16	86	36
Teen Pregnancies and Rate	NA	NA	42	18	88	36
Out of Wedlock Births and Ratio	17	218	147	441	316	569
Out of Wedlock Pregnancies and Ratio	20	238	170	462	357	587
Low Birth Weight Birth and Ratio	0	0	12	36	41	74

Births, 2004 - 2008	Williams County		UMDHU		North Dakota	
	Number	Rate or Ratio	Number	Rate or Ratio	Number	Rate or Ratio
Live Births and Rate	1,296	13	2,262	13	42925	13
Pregnancies and Rate	1,380	14	2,440	14	47350	15
Fertility Rate		66		70		63
Teen Births and Rate	126	19	249	21	3306	17
Teen Pregnancies and Rate	144	21	274	23	4097	21
Out of Wedlock Births and Ratio	503	388	983	435	13743	320
Out of Wedlock Pregnancies and	557	404	1,104	452	16862	356
Low Birth Weight Birth and Ratio	78	60	131	58	2823	66

Child Deaths, 2004-2008	Divide County		McKenzie County		Mountrail County	
	Number	Rate or Ratio	Number	Rate or Ratio	Number	Rate or Ratio
Infant Deaths and Ratio	0	0	0	0	0	0
Child and Adolescent Deaths and Rate	0	0	0	0	0	0
Total Deaths and Crude Rate	163	1428	268	934	386	1164

Child Deaths, 2004-2008	Williams County		UMDHU		North Dakota	
	Number	Rate or Ratio	Number	Rate or Ratio	Number	Rate or Ratio
Infant Deaths and Ratio	0	0	0	0	261	6.1
Child and Adolescent Deaths	0	0	0	0	290	33
Total Deaths and Crude Rate	977	989	1794	1043	28,494	887

Deaths and Age Adjusted Death Rate by Cause, 2004-2008	Divide County	McKenzie County	Mountrail County
	Number (Adj. Rate)	Number (Adj. Rate)	Number (Adj. Rate)
All Causes	163 (563)	268 (764)	386 (838)
Heart Disease	28 (79)	71 (184)	116 (238)
Cancer	25 (95)	69 (194)	67 (147)
Stroke	17 (53)	13 (34)	22 (42)
Alzheimers Disease	26 (69)	*	7 (11)
COPD	8 (30)	12 (31)	19 (38)
Unintentional Injury	*	22 (84)	29 (82)
Diabetes Mellitus	*	10 (28)	37 (82)
Pneumonia and Influenza	7 (24)	10 (25)	5 (12)
Cirrhosis	0 (0)	*	9 (27)
Suicide	*	*	5 (17)

Deaths and Age Adjusted Death Rate by Cause, 2004-2008	Williams County	UMDHU	North Dakota
	Number (Adj. Rate)	Number (Adj. Rate)	Number (Adj. Rate)
All Causes	977 (747)	1794 (746)	28,494 (739)
Heart Disease	228 (168)	443 (174)	7,327 (183)
Cancer	243 (191)	404 (172)	6,573 (180)
Stroke	57 (41)	109 (42)	1,872 (45)
Alzheimers Disease	43 (29)	79 (27)	1,679 (38)
COPD	52 (39)	91 (37)	1,449 (37)
Unintentional Injury	59 (55)	114 (62)	1,477 (42)
Diabetes Mellitus	38 (29)	89 (38)	1,059 (28)
Pneumonia and Influenza	26 (19)	48 (18)	760 (18)
Cirrhosis	*	16 (9)	295 (9)
Suicide	12 (12)	21 (13)	433 (13)

Adj. Rate = Age Adjusted Rate; * Fewer than five deaths

Mountrail County: Leading Causes of Death by Age Group, 2004-2008			
Age	1	2	3
0-4	Anomally		
5-14			
15-24	Unintentional Injury	Suicide	
25-34	Suicide Heart		
35-44	Unintentional Injury 6	Heart	Cirrhosis
45-54	Heart 13	Unintentional Injury 6	Diabetes Cirrhosis
55-64	Heart 12	Cancer 11	Diabetes 7
65-74	Cancer 15	Heart 10	Diabetes 7
75-84	Heart 24	Cancer 22	Stroke 7
85+	Heart 52	Cancer 15	Diabetes 13

ADULT BEHAVIORAL RISK FACTORS, 2000-2008

	ASTHMA	Divide County	McKenzie County	Mountrail County
Ever Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma.	7.7 (2.7-12.6)	10.1 (4.8-15.4)	7.0 (3.0-10.9)
Current Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma and who still have asthma.	6.5 (1.8-11.2)	5.4 (2.1- 8.6)	5.5 (2.2- 8.9)

	ASTHMA	Williams County	UMDHU	North Dakota
Ever Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma.	11.1 (8.2-13.9)	9.8 (7.8-11.9)	11.6 (10.4-12.8)
Current Asthma	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had asthma and who still have asthma.	8.5 (5.9-11.1)	7.2 (5.5- 8.9)	7.9 (6.9- 9.0)

	BODY WEIGHT	Divide County	McKenzie County	Mountrail County
Overweight But Not Obese	Respondents with a body mass index greater than or equal to 25 but less than 30 (overweight)	43.7 (33.7-53.7)	35.0 (28.3-41.8)	42.0 (35.1-48.9)
Obese	Respondents with a body mass index greater than or equal to 30 (obese)	24.1 (15.6-32.5)	34.9 (27.4-42.4)	32.9 (26.8-39.1)
Overweight or Obese	Respondents with a body mass index greater than or equal to 25 (overweight or obese)	67.8 (58.1-77.5)	69.9 (63.1-76.8)	74.9 (69.0-80.9)

	BODY WEIGHT	Williams County	UMDHU	North Dakota
Overweight But Not Obese	Respondents with a body mass index greater than or equal to 25 but less than 30 (overweight)	38.8 (35.0-42.7)	39.0 (36.1-42.0)	39.6 (37.7-41.5)
Obese	Respondents with a body mass index greater than or equal to 30 (obese)	25.1 (21.5-28.6)	28.4 (25.6-31.2)	27.8 (26.1-29.5)
Overweight or Obese	Respondents with a body mass index greater than or equal to 25 (overweight or obese)	63.9 (60.0-67.9)	67.5 (64.6-70.3)	67.4 (65.5-69.3)

	CARDIOVASCULAR	Divide County	McKenzie County	Mountrail County
Heart Attack	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a heart attack.	6.8 (2.2-11.4)	4.4 (1.6- 7.2)	4.8 (2.1- 7.6)
Angina	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had angina.	7.1 (2.1-12.1)	5.1 (2.0- 8.2)	4.1 (1.1- 7.0)
Stroke	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a stroke.	NA	3.9 (0.0- 7.7)	2.1 (0.3- 3.8)
Any Cardiovascular Disease	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had any of the following: heart attack, angina or stroke.	11.1 (5.1-17.1)	9.3 (4.6-14.0)	7.7 (4.0-11.4)

	CARDIOVASCULAR	Williams County	UMDHU	North Dakota
Heart Attack	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a heart attack.	4.5 (2.8- 6.1)	4.7 (3.5- 5.9)	3.9 (3.4- 4.5)
Angina	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had angina.	5.3 (3.6- 7.0)	5.2 (3.9- 6.5)	4.1 (3.5- 4.6)
Stroke	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had a stroke.	1.9 (0.9- 3.0)	2.2 (1.2- 3.1)	2.3 (1.9- 2.7)
Any Cardiovascular Disease	Respondents who reported ever having been told by a doctor, nurse or other health care professional that they had any of the following: heart attack, angina or stroke.	8.1 (6.0-10.2)	8.5 (6.8-10.1)	7.5 (6.8- 8.3)

	CHOLESTEROL	Divide County	McKenzie County	Mountrail County
Never Cholesterol Test	Respondents who reported never having a cholesterol test	NA	20.9 (13.8-28.1)	26.9 (18.2-35.5)
No Cholesterol Test in Past 5 Years	Respondents who reported never having a cholesterol test in the past five years	NA	27.1 (19.3-34.9)	31.9 (23.1-40.7)
High Cholesterol	Respondents who reported that they had ever been told by a doctor, nurse or other health professional that they had high cholesterol.	NA	28.8 (19.9-37.7)	34.3 (25.3-43.3)

	CHOLESTEROL	Williams County	UMDHU	North Dakota
Never Cholesterol Test	Respondents who reported never having a cholesterol test	21.8 (16.9-26.8)	23.3 (19.7-27.0)	22.5 (20.6-24.5)
No Cholesterol Test in Past 5 Years	Respondents who reported never having a cholesterol test in the past five years	26.3 (21.2-31.3)	28.0 (24.3-31.8)	27.3 (25.3-29.3)
High Cholesterol	Respondents who reported that they had ever been told by a doctor, nurse or other health professional that they had high cholesterol.	31.1 (26.3-35.8)	31.2 (27.6-34.9)	37.1 (35.3-38.9)

	COLORECTAL CANCER	Divide County	McKenzie County	Mountrail County
Fecal Occult Blood	Respondents age 50 and older who reported not having a fecal occult blood test in the past two years.	NA	NA	85.0 (76.2-93.8)
Never Sigmoidoscopy	Respondents age 50 and older who reported never having had a sigmoidoscopy or colonoscopy	NA	NA	NA
No Sigmoidoscopy in Past 5 Years	Respondents age 50 and older who reported not having a sigmoidoscopy or colonoscopy in the past five years.	NA	NA	NA

	COLORECTAL CANCER	Williams County	UMDHU	North Dakota
Fecal Occult Blood	Respondents age 50 and older who reported not having a fecal occult blood test in the past two years.	77.8 (69.9-85.7)	76.1 (70.5-81.8)	77.8 (76.1-79.4)
Never Sigmoidoscopy	Respondents age 50 and older who reported never having had a sigmoidoscopy or colonoscopy	54.2 (46.6-61.8)	54.4 (48.7-60.0)	42.1 (40.2-44.0)
No Sigmoidoscopy in Past 5 Years	Respondents age 50 and older who reported not having a sigmoidoscopy or colonoscopy in the past five years.	66.2 (59.7-72.7)	66.2 (61.4-71.0)	62.1 (60.2-64.0)

	DIABETES	Divide County	McKenzie County	Mountrail County
Diabetes Diagnosis	Respondents who reported ever having been told by a doctor that they had diabetes.	6.5 (1.1-11.9)	5.3 (2.2- 8.4)	9.4 (5.0-13.9)

	DIABETES	Williams County	UMDHU	North Dakota
Diabetes Diagnosis	Respondents who reported ever having been told by a doctor that they had diabetes.	5.9 (4.2- 7.6)	6.5 (5.1- 8.0)	7.6 (6.8- 8.4)

	FRUITS AND VEGETABLES	Divide County	McKenzie County	Mountrail County
Five Fruits and Vegetables	Respondents who reported that they do not usually eat 5 fruits and vegetables per day	79.9 (69.6-90.2)	75.1 (67.3-83.0)	74.0 (66.2-81.8)

	FRUITS AND VEGETABLES	Williams County	UMDHU	North Dakota
Five Fruits and Vegetables	Respondents who reported that they do not usually eat 5 fruits and vegetables per day	79.7 (75.8-83.6)	77.9 (74.8-81.0)	78.1 (76.5-79.6)

	GENERAL HEALTH	Divide County	McKenzie County	Mountrail County
Fair or Poor Health	Respondents who reported that their general health was fair or poor	10.2 (4.8-15.5)	17.6 (12.2-23.0)	14.6 (10.6-18.7)
Poor physical Health	Respondents who reported they had 8 or more days in the last 30 when their physical health was not good	14.0 (6.6-21.4)	11.0 (6.0-15.9)	12.0 (7.6-16.4)
Poor Mental Health	Respondents who reported they had 8 or more days in the last 30 when their mental health was not good	10.4 (3.4-17.4)	10.1 (4.9-15.3)	11.8 (7.5-16.2)
Activity Limitation Due to Poor Health	Respondents who reported they had 8 or more days in the last 30 when poor physical or mental health kept them from doing their usual activities.	5.1 (0.8- 9.3)	5.1 (1.9- 8.2)	6.1 (2.9- 9.4)
Any Activity Limitation	Respondents who reported being limited in any way due to physical, mental or emotional problem.	16.1 (9.0-23.2)	14.0 (9.1-19.0)	17.7 (13.0-22.3)

	GENERAL HEALTH	Williams County	UMDHU	North Dakota
Fair or Poor Health	Respondents who reported that their general health was fair or poor	13.1 (10.7-15.5)	14.1 (12.2-16.0)	13.4 (12.2-14.6)
Poor physical Health	Respondents who reported they had 8 or more days in the last 30 when their physical health was not good	11.5 (9.0-14.0)	11.7 (9.7-13.6)	10.6 (9.6-11.6)
Poor Mental Health	Respondents who reported they had 8 or more days in the last 30 when their mental health was not good	7.5 (5.6- 9.4)	9.1 (7.3-10.8)	8.9 (7.8-10.0)
Activity Limitation Due to Poor Health	Respondents who reported they had 8 or more days in the last 30 when poor physical or mental health kept them from doing their usual activities.	5.0 (3.6- 6.5)	5.3 (4.0- 6.5)	5.4 (4.7- 6.2)
Any Activity Limitation	Respondents who reported being limited in any way due to physical, mental or emotional problem.	16.7 (14.1-19.4)	16.3 (14.3-18.4)	17.0 (15.8-18.3)

	HEALTH CARE ACCESS	Divide County	McKenzie County	Mountrail County
Health Insurance	Respondents who reported not having any form or health care coverage	5.2 (1.7- 8.7)	15.1 (9.9-20.3)	17.8 (11.6-24.0)
Access Limited by Cost	Respondents who reported needing to see a doctor during the past 12 months but could not due to cost.	11.3 (3.7-18.9)	6.9 (2.2-11.5)	6.0 (2.9- 9.2)
No Personal Provider	Respondents who reported that they did not have one person they consider to be their personal doctor or health care provider.	19.2 (11.0-27.4)	24.5 (17.4-31.5)	39.0 (31.7-46.3)

	HEALTH CARE ACCESS	Williams County	UMDHU	North Dakota
Health Insurance	Respondents who reported not having any form or health care coverage	12.7 (9.8-15.7)	13.6 (11.4-15.9)	11.6 (10.1-13.2)
Access Limited by Cost	Respondents who reported needing to see a doctor during the past 12 months but could not due to cost.	7.4 (5.3- 9.5)	7.3 (5.6- 9.0)	6.2 (5.3- 7.1)
No Personal Provider	Respondents who reported that they did not have one person they consider to be their personal doctor or health care provider.	19.0 (15.7-22.4)	23.9 (21.1-26.7)	23.8 (22.0-25.6)

	HYPERTENSION	Divide County	McKenzie County	Mountrail County
High Blood Pressure	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had high blood pressure.	45.6 (30.9-60.2)	26.8 (18.5-35.1)	24.6 (17.1-32.1)

	HYPERTENSION	Williams County	UMDHU	North Dakota
High Blood Pressure	Respondents who reported ever having been told by a doctor, nurse or other health professional that they had high blood pressure.	25.0 (20.6-29.4)	26.7 (23.3-30.1)	26.0 (24.5-27.4)

	IMMUNIZATION	Divide County	McKenzie County	Mountrail County
Influenza Vaccine	Respondents age 65 and older who reported that they did not have a flu shot in the past year	NA	NA	NA
Pneumococcal Vaccine	Respondents age 65 or older who reported never having had a pneumonia shot.	NA	NA	NA

	IMMUNIZATION	Williams County	UMDHU	North Dakota
Influenza Vaccine	Respondents age 65 and older who reported that they did not have a flu shot in the past year	29.5 (22.9-36.2)	30.7 (25.6-35.7)	26.5 (24.1-28.8)
Pneumococcal Vaccine	Respondents age 65 or older who reported never having had a pneumonia shot.	32.4 (25.6-39.3)	36.7 (31.5-42.0)	31.6 (29.0-34.2)

	INJURY	Divide County	McKenzie County	Mountrail County
Fall	Respondents 45 years and older who reported that they had fallen in the past 3 months	NA	14.7 (5.2-24.2)	11.9 (3.8-20.0)
Seat Belt	Respondents who reported not always wearing their seatbelt	NA	NA	NA

	INJURY	Williams County	UMDHU	North Dakota
Fall	Respondents 45 years and older who reported that they had fallen in the past 3 months	15.7 (10.5-20.8)	15.7 (11.8-19.6)	13.9 (12.7-15.2)
Seat Belt	Respondents who reported not always wearing their seatbelt	50.5 (44.7-56.4)	52.8 (48.2-57.5)	40.8 (38.8-42.7)

	ORAL HEALTH	Divide County	McKenzie County	Mountrail County
Dental Visit	Respondents who reported that they have not had a dental visit in the past year	NA	41.1 (31.3-50.9)	39.6 (31.0-48.1)
Tooth Loss	Respondents who reported they had lost 6 or more permanent teeth due to gum disease or decay.	NA	13.3 (8.0-18.6)	25.4 (18.4-32.4)

	ORAL HEALTH	Williams County	UMDHU	North Dakota
Dental Visit	Respondents who reported that they have not had a dental visit in the past year	31.5 (26.9-36.0)	35.1 (31.4-38.8)	25.9 (24.3-27.6)
Tooth Loss	Respondents who reported they had lost 6 or more permanent teeth due to gum disease or decay.	23.0 (18.9-27.1)	21.7 (18.7-24.6)	14.9 (13.8-15.9)

	PHYSICAL ACTIVITY	Divide County	McKenzie County	Mountrail County
Recommend Physical Activity	Respondents who reported that they did not get the recommended amount of physical activity	NA	28.9 (20.2-37.6)	39.8 (30.6-48.9)
No Leisure Physical Activity	Respondents who reported that they participated in no leisure time physical activity	2.5 (0.0- 5.4)	6.9 (1.9-11.9)	8.9 (2.4-15.3)

	PHYSICAL ACTIVITY	Williams County	UMDHU	North Dakota
Recommend Physical Activity	Respondents who reported that they did not get the recommended amount of physical activity	38.4 (33.3-43.5)	36.5 (32.7-40.3)	37.4 (35.5-39.3)
No Leisure Physical Activity	Respondents who reported that they participated in no leisure time physical activity	6.0 (3.5- 8.4)	6.4 (4.4- 8.5)	6.0 (5.2- 6.9)

	TOBACCO	Divide County	McKenzie County	Mountrail County
Current Smoking	Respondents who reported that they smoked every day or some days	14.9 (8.2-21.7)	29.2 (22.0-36.4)	29.4 (23.0-35.9)

	TOBACCO	Williams County	UMDHU	North Dakota
Current Smoking	Respondents who reported that they smoked every day or some days	26.0 (22.4-29.6)	26.5 (23.8-29.3)	18.1 (16.5-19.7)

	PROSTATE CANCER	Divide County	McKenzie County	Mountrail County
PSA Testing	Men age 40 and older who reported that they have not had a PSA test in the past two years	NA	NA	NA

	PROSTATE CANCER	Williams County	UMDHU	North Dakota
PSA Testing	Men age 40 and older who reported that they have not had a PSA test in the past two years	54.5 (44.9-64.1)	52.9 (46.1-59.7)	45.4 (42.7-48.2)

	WOMEN'S HEALTH	Divide County	McKenzie County	Mountrail County
Pap Smear	Women 18 and older who reported that they have not had a pap smear in the past three years	NA	NA	13.6 (6.7-20.5)
Mammogram Age 40+	Women 40 and older who reported that they have not had a mammogram in the past two years	NA	NA	NA

	WOMEN'S HEALTH	Williams County	UMDHU	North Dakota
Pap Smear	Women 18 and older who reported that they have not had a pap smear in the past three years	10.3 (5.8-14.7)	12.3 (8.8-15.7)	17.2 (14.7-19.8)
Mammogram Age 40+	Women 40 and older who reported that they have not had a mammogram in the past two years	22.1 (15.8-28.3)	25.1 (20.3-30.0)	23.1 (21.2-25.1)

CRIME

Divide County

	2004	2005	2006	2007	2008	5 year	5-Year Rate
Murder	NA	NA	NA	NA	NA		
Rape	NA	NA	NA	NA	NA		
Robbery	NA	NA	NA	NA	NA		
Assualt	NA	NA	NA	NA	NA		
Violent crime							
	NA	NA	NA	NA	NA		
Burglary	NA	NA	NA	NA	NA		
Larceny	NA	NA	NA	NA	NA		
Motor vehicle theft	NA	NA	NA	NA	NA		
Property crime							
Total	NA	NA	NA	NA	NA		

McKenzie County

	2004	2005	2006	2007	2008	5 year	5-Year Rate
Murder	0	0	0	0	0	0	0.0
Rape	0	1	0	0	0	1	3.6
Robbery	0	0	0	0	0	0	0.0
Assualt	3	4	3	1	1	12	43.0
Violent crime	3	5	3	1	1	13	46.5
Burglary	4	16	8	7	4	39	139.6
Larceny	40	34	37	33	29	173	619.3
Motor vehicle theft	0	3	9	4	3	19	68.0
Property crime	44	53	54	44	36	231	826.9
Total	47	58	57	45	37	244	873.5

Mountrail County

	2004	2005	2006	2007	2008	5 year	5-Year Rate
Murder	0	0	0	0	0	0	0.0
Rape	1	0	0	0	0	1	3.1
Robbery	0	0	0	0	0	0	0.0
Assualt	0	1	0	0	3	4	12.3
Violent crime	1	1	0	0	3	5	15.4
Burglary	3	18	8	8	10	47	144.5
Larceny	28	26	26	17	50	147	452.0
Motor vehicle theft	3	9	8	1	5	26	79.9
Property crime	34	53	42	26	65	220	676.4
Total	35	54	42	26	68	225	691.8

Williams County

	2004	2005	2006	2007	2008	5 year	5-Year Rate
Murder	0	0	1	0	0	1	1.0
Rape	3	5	7	4	16	35	36.4
Robbery	0	1	1	2	2	6	6.2
Assualt	16	11	9	16	23	75	77.9
Violent crime	19	17	18	22	41	117	121.5
Burglary	38	49	38	33	58	216	224.3
Larceny	228	163	179	202	209	981	1018.9
Motor vehicle theft	34	50	41	38	39	202	209.8
Property crime	300	262	258	273	306	1,399	1453.0
Total	319	279	276	295	347	1,516	1574.5

North Dakota

	2004	2005	2006	2007	2008	5 year	5-Year Rate
Murder	10	13	8	16	4	51	1.6
Rape	157	146	184	202	222	911	28.4
Robbery	42	45	69	68	71	295	9.2
Assualt	319	396	525	599	738	2,577	80.3
Violent crime	528	600	786	885	1,035	3,834	119.5
Burglary	1,855	1,884	2,364	2,096	2,035	10,234	319.1
Larceny	8,832	9,081	8,884	8,672	8,926	44,395	1384.1
Motor vehicle theft	858	998	966	878	854	4,554	142.0
Property crime	11,545	11,963	12,214	11,646	11,815	59,183	1845.1
Total	12,073	12,563	13,000	12,531	12,850	63,017	1964.7

CHILD HEALTH INDICATORS

Child Indicators: Education 2008	Divide County	McKenzie County	Mountrail County
Children Ages 3 and 4 Enrolled in Head Start (Percent of all children Head Start eligible)	0	36 (74)	110 (66)
Enrolled in Special Education Ages 3-21 (Number and percent of total school enrollment)	24 (11)	68 (8.3)	222 (16)
Speech or Language Impaired Children in Special Education (Percent of all special education children)	9 (38)	20 (29)	92 (41)
Mentally Handicapped Children in Special Education (Percentage of total special education children)	2 (8.3)	2 (2.9)	16 (7.2)
Children with Specific Learning Disability in Special Education (Percentage of total special education children)	3 (13)	26 (38)	60 (27)
High School Dropouts (Dropouts per 1000 persons Grades 9-12)	1 (0.9)	9 (3.4)	11 (2.5)
Average ACT Composite Score	21.3	21.7	19.4
Average Expenditure per Student in Public School	$10,312	$14,062	$8,440

Child Indicators: Education 2008	Williams County	North Dakota
Children Ages 3 and 4 Enrolled in Head Start (Percent of all children Head Start eligible)	115 (91)	2,607(65)
Enrolled in Special Education Ages 3-21 (Number and percent of total school enrollment)	536 (17)	13,278(14)
Speech or Language Impaired Children in Special Education (Percent of all special education children)	150 (28)	3,644 (27)
Mentally Handicapped Children in Special Education (Percentage of total special education children)	27 (5.0)	860 (6.5)
Children with Specific Learning Disability in Special Education (Percentage of total special education children)	197 (37)	4,224 (32)
High School Dropouts (Dropouts per 1000 persons Grades 9-12)	62 (5.9)	791 (2.4)
Average ACT Composite Score	21.6	21.5
Average Expenditure per Student in Public School	$8,583	$8,096

Child Indicators: Economic Health 2008	Divide County	McKenzie County	Mountrail County
TANF Recipients Ages 0-19 (Percent of persons ages 0-19)	0	99 (6.7)	169 (9.3)
Food Stamp Recipients Ages 0-19 (Percent of all children ages 0-19)	55 (15)	439 (30)	516 (30)
Children Receiving Free and Reduced Price Lunches (Percent of total school enrollment	65 (29)	259 (32)	708 (51)
Medicaid Recipients Ages 0-20 (Percent of all persons ages 0-20)	73 (18)	577 (34)	770 (39)
Median Income for Families with Children Ages 0-17 (Percent of all women with children ages 0-17)*	$37,292	$35,856	$31,901
Children Ages 0-17 Living in Extreme Poverty (Percent of children 0-17 for whom poverty is determined)*	31 (6.8)	97 (5.6)	207 (11)
* Year 2000 data			

Child Indicators: Economic Health 2008	Williams County	North Dakota
TANF Recipients Ages 0-19 (Percent of persons ages 0-19)	95 (2.0)	7,532 (4.5)
Food Stamp Recipients Ages 0-19 (Percent of all children ages 0-19)	810 (18)	31,380 (20)
Children Receiving Free and Reduced Price Lunches (Percent of total school enrollment	940 (29)	32,445 (32)
Medicaid Recipients Ages 0-20 (Percent of all persons ages 0-20)	1,237 (24)	41,376 (23)
Median Income for Families with Children Ages 0-17 (Percent of all women with children ages 0-17)*	$37,479	$44,640
Children Ages 0-17 Living in Extreme Poverty (Percent of children 0-17 for whom poverty is determined)*	414 (8.2)	11,000 (8)
* Year 2000 data		

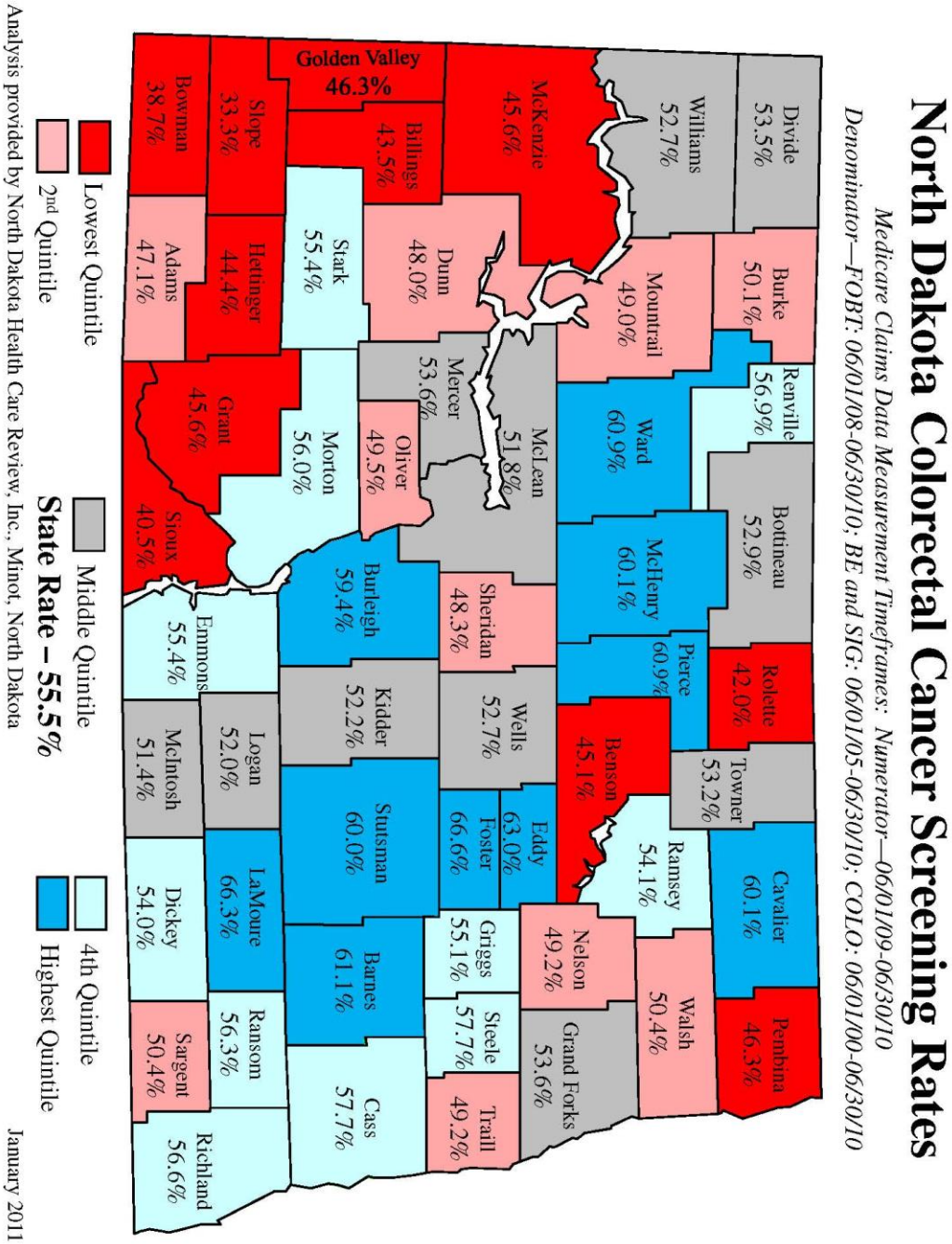
Child Indicators: Families and Child Care 2008	Divide County	McKenzie County	Mountrail County
Child Care Providers - All Approved Categories†	11	18	66
Child Care Capacity†	94	159	332
Mothers in Labor Force with a Child Ages 0-17 (Percent of all mothers with a child ages 0-17)*	188 (86)	498 (75.6)	597 (75)
Children Ages 0-17 Living in a Single Parent Family (Percent of all children ages 0-17)*	59 (13)	394 (22)	498 (27)
Children in Foster Care (Percent of children ages 0-18)	4 (1.2)	18 (1.3)	35 (2)
Children Ages 0-17 with Suspected Child Abuse or Neglect (Cases per 100 children 0-17)	10 (3.2)	27 (2.0)	43 (2.6)
Children Ages 0-17 Impact by Domestic Violence (Percent of all children ages 0-17)	4 (0.9)	94 (5.4)	218 (12)
Births to Mothers with Inadequate Prenatal Care**	NA	10 (17)	26 (24)
†2009 ** 2007 data ***2002 data			

Child Indicators: Families and Child Care 2008	Williams County	North Dakota
Child Care Providers - All Approved Categories	91	3,353
Child Care Capacity	723	43,213
Mothers in Labor Force with a Child Ages 0-17 (Percent of all mothers with a child ages 0-17)*	2,067 (84)	63,085 (81)
Children Ages 0-17 Living in a Single Parent Family (Percent of all children ages 0-17)*	1,094 (21)	30,695 (18)
Children in Foster Care (Percent of children ages 0-18)	144 (3.2)	2,134 (1.4)
Children Ages 0-17 with Suspected Child Abuse or Neglect (Cases per 100 children 0-17)	281 (6.7)	6,982 (4.9)
Children Ages 0-17 Impact by Domestic Violence (Percent of all children ages 0-17)	248 (4.8)	4,862 (3.0)
Births to Mothers with Inadequate Prenatal Care**	16 (5.2)	478 (5.4)
** 2007 data ***2002 data		

Child Indicators: Juvenile Justice 2008	Divide County	McKenzie County	Mountrail County
Children Ages 10-17 Referred to Juvenile Court (Percent of all children ages 0-17)	5 (2.9)	27 (3.8)	16 (2.1)
Offense Against Person Juvenile Court Referral (Percent of total juvenile court referral)	1 (10)	5 (9.4)	1 (3)
Alcohol-Related Juvenile Court Referral (Percent of all juvenile court referrals)	0	11 (21)	13 (39)

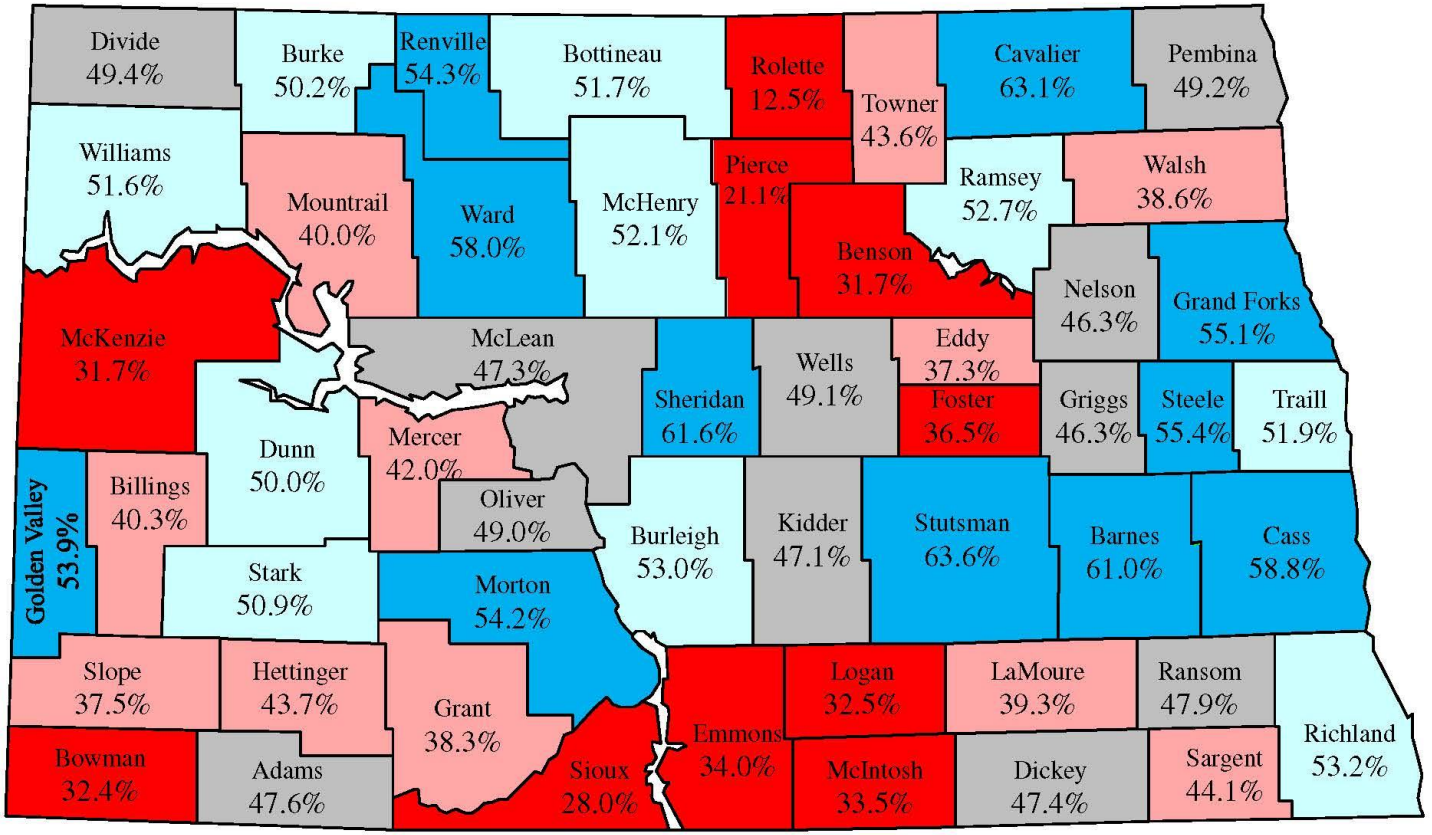
Child Indicators: Juvenile Justice 2008	Williams County	North Dakota
Children Ages 10-17 Referred to Juvenile Court (Percent of all children ages 0-17)	276 (14)	5,555 (8.4)
Offense Against Person Juvenile Court Referral (Percent of total juvenile court referral)	26 (5.0)	808 (7.8)
Alcohol-Related Juvenile Court Referral (Percent of all juvenile court referrals)	68 (13)	1,845 (18)

Appendix F – County Analysis by North Dakota Health Care Review, Inc.



North Dakota Pneumococcal Pneumonia Vaccination Rates

Medicare Claims Data – Claims through 06/30/10

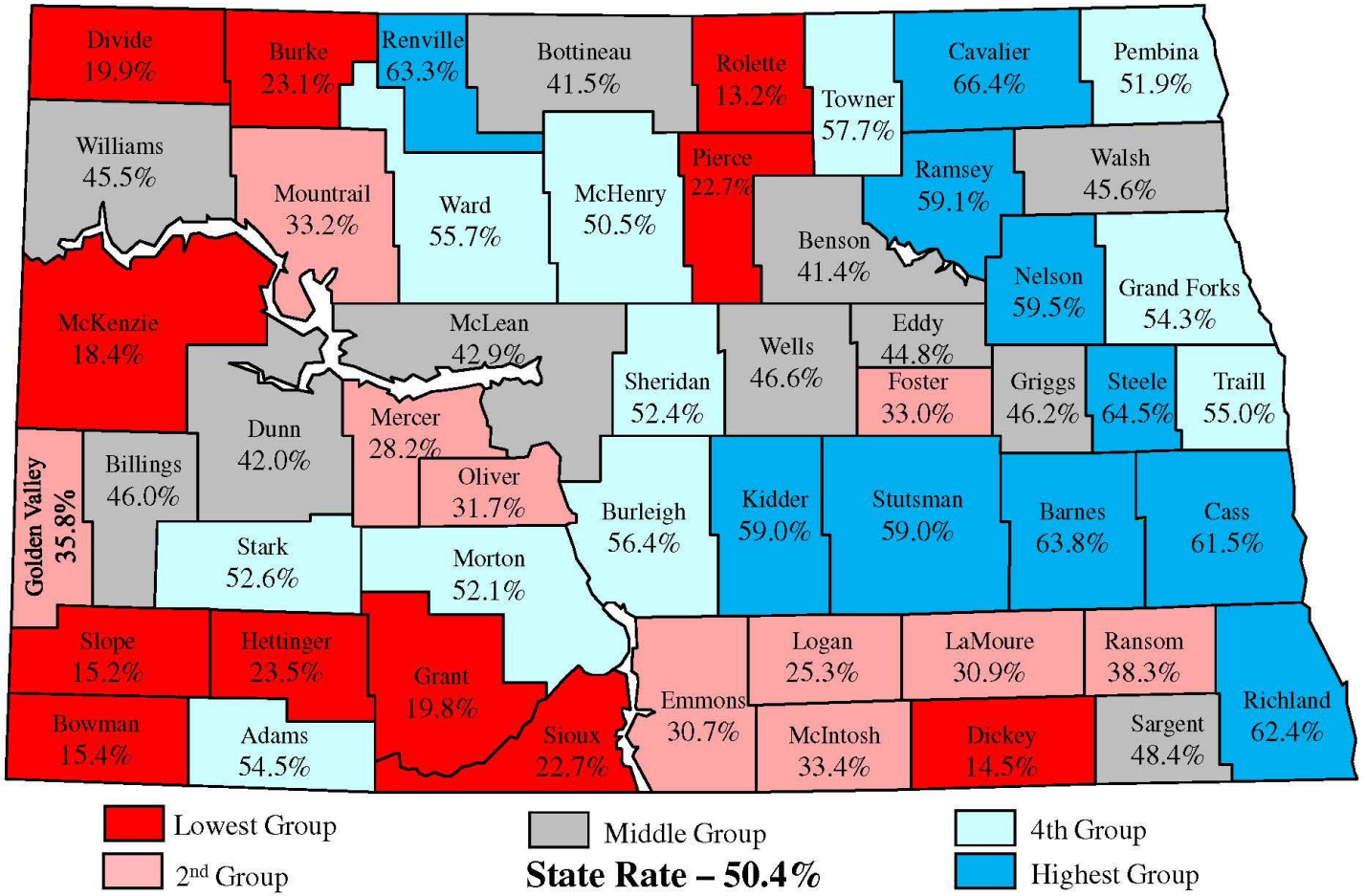


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

North Dakota Influenza Vaccination Rates

Medicare Claims Data – 03/01/09-03/31/10

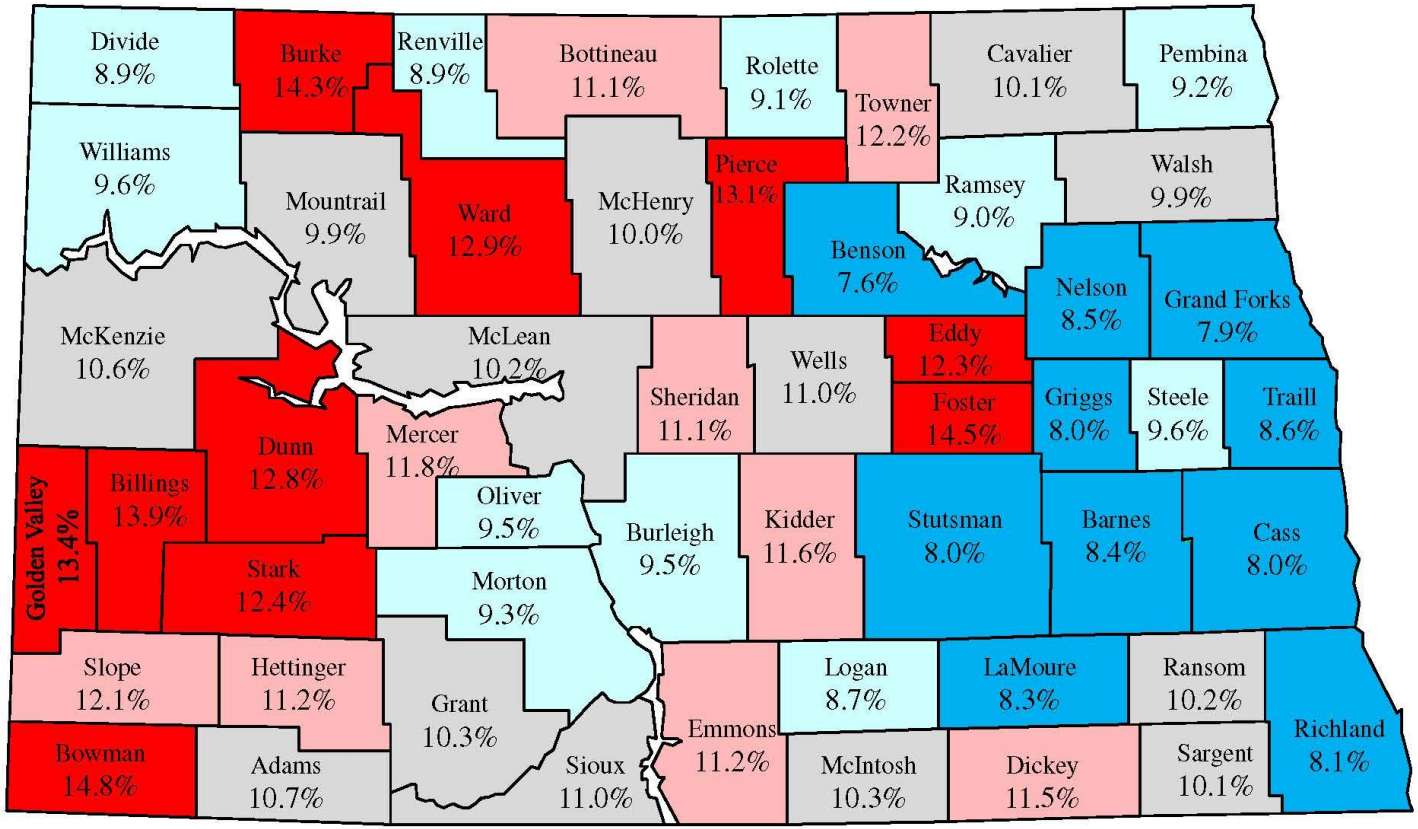


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

October 2010

North Dakota DDI Rates

Timeframe: 01/01/10-06/30/10; Data Source: Medicare Part D

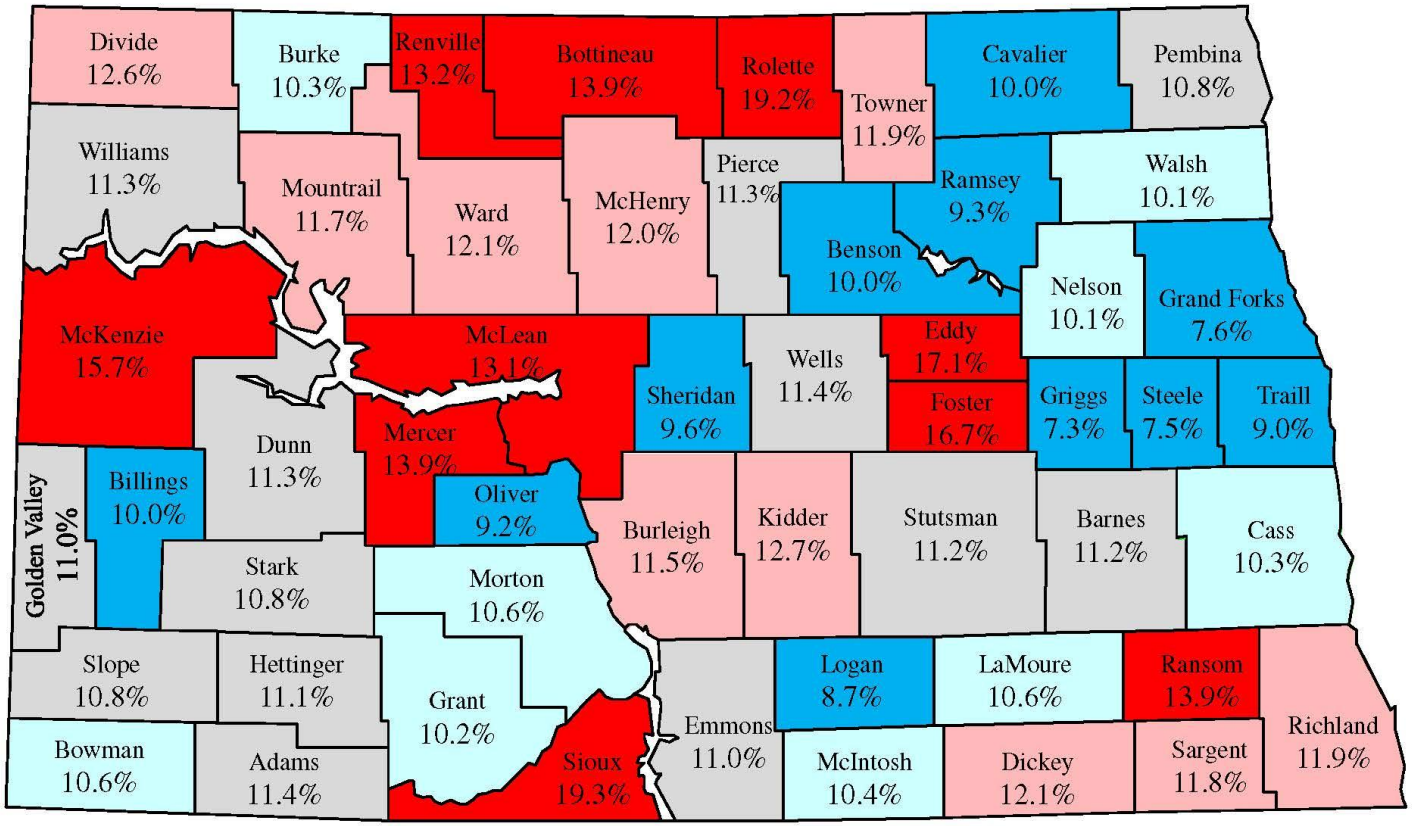


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

North Dakota PIM Rates

Timeframe: 01/01/10-06/30/10; Data Source: Medicare Part D

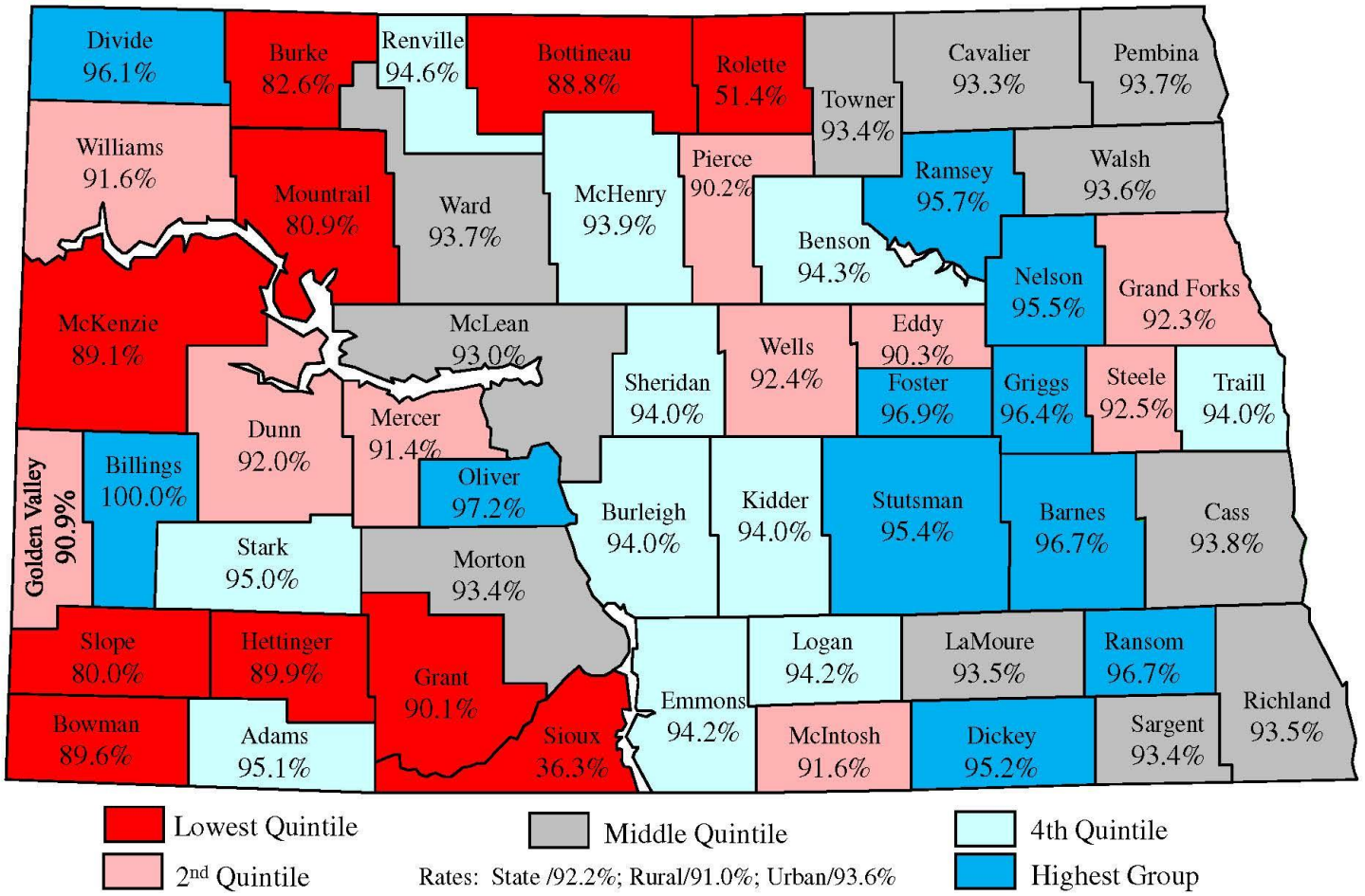


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

Annual Hemoglobin A1C Screening Rates for Patients with Diabetes

Medicare Claims Data Quarter 10 – End date 06/30/10

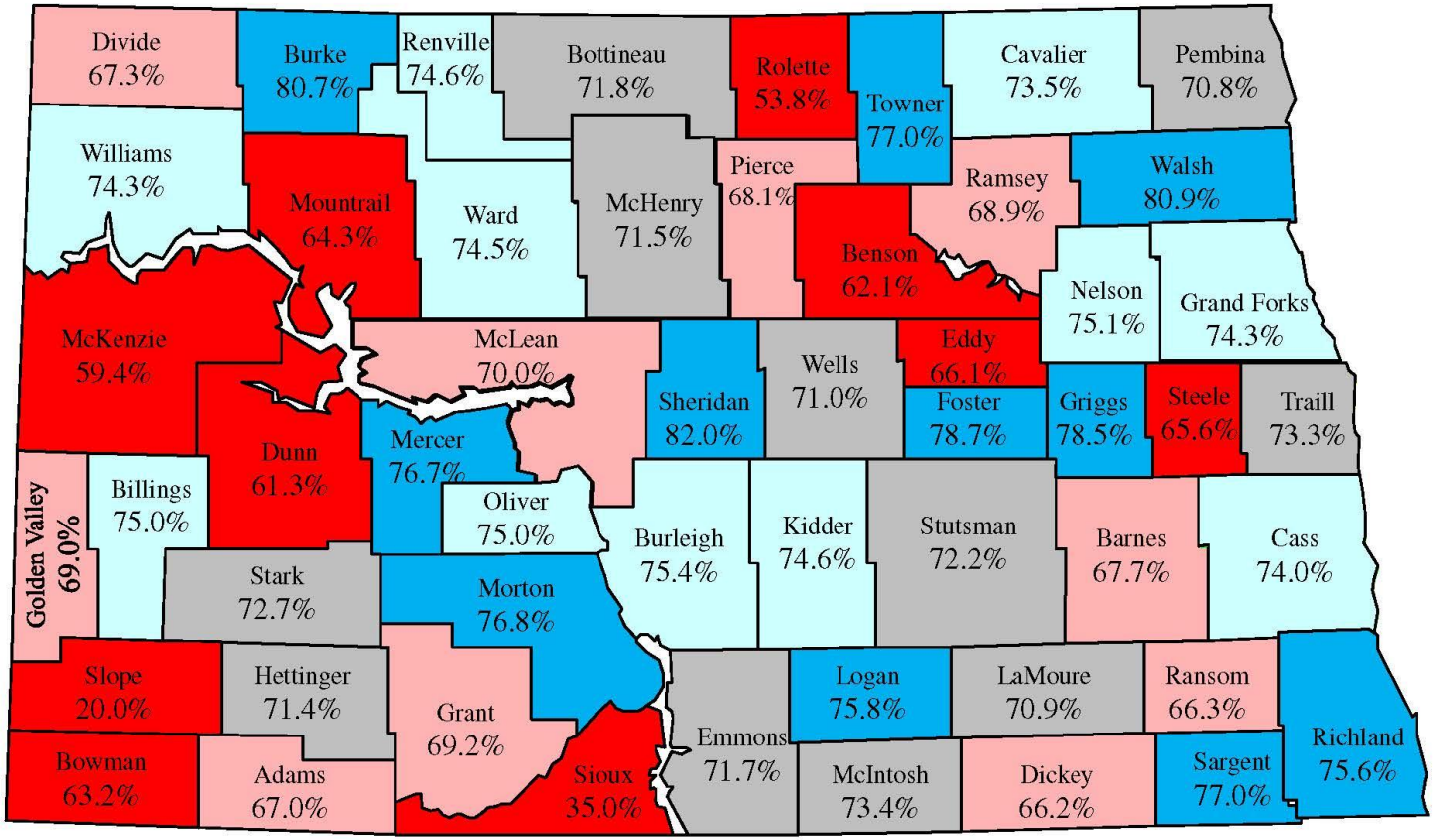


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

Annual Eye Examination Screening Rates for Patients with Diabetes

Medicare Claims Data Quarter 10 – End date 06/30/10

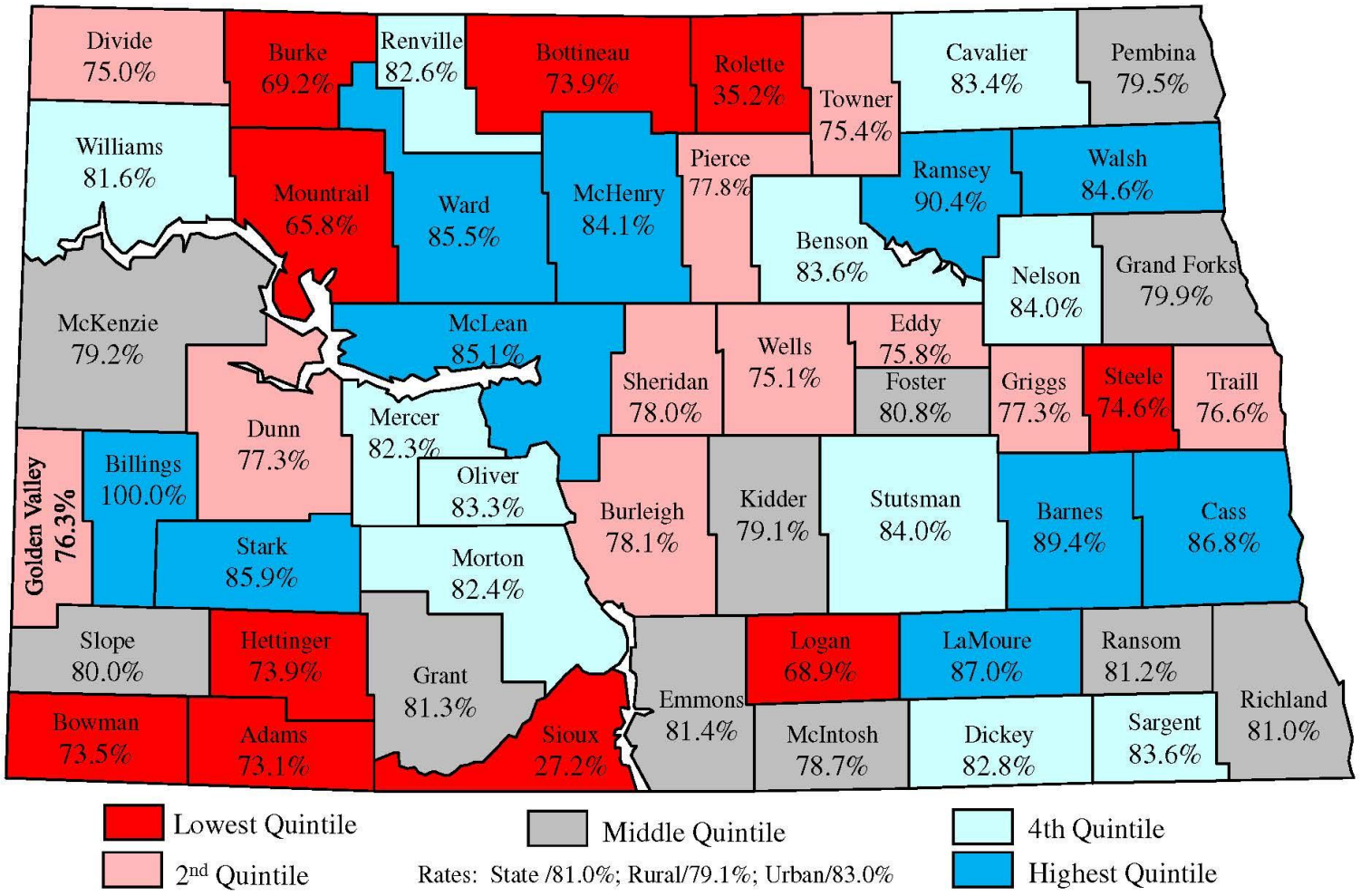


Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

Annual Lipid Testing Screening Rates for Patients with Diabetes

Medicare Claims Data Quarter 10 – End date 06/30/10



Analysis provided by North Dakota Health Care Review, Inc., Minot, North Dakota

January 2011

Appendix G – Prioritization of Community's Health Needs

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

POTENTIAL COMMUNITY HEALTH NEEDS – Stanley
(Listed in no particular order)

	IDENTIFIED NEED	VOTE
1.	Secondary data: Elevated rate of diabetics ✓	0
2.	Secondary data: Elevated rate of adult smoking ✓❖	1
3.	Secondary data: Elevated rate of adult obesity ✓❖	1
4.	Secondary data: Elevated rate of physical inactivity ✓❖	0
5.	Secondary data: Elevated rate of excessive drinking ✓❖	4
6.	Secondary data: Elevated level of sexually transmitted infections❖	0
7.	Secondary data: Elevated motor vehicle crash death rate ✓❖	3
8.	Secondary data: Elevated teen birth rate ✓❖	0
9.	Secondary data: Elevated rate of uninsured adults ✓❖	8
10.	Secondary data & Survey & Interview/Focus Group: Limited number of health care providers – not enough health care staff in general ✓❖	8
11.	Secondary data: Limited number of mental health care providers ✓❖	1
12.	Secondary data: Elevated level of preventable hospital stays ✓❖	2
13.	Secondary data: Decreased rate of diabetic screening ✓❖	1
14.	Secondary data: Decreased rate of mammography screening ✓❖	0
15.	Secondary data: Limited access to healthy foods ❖	0
16.	Secondary data: Decreased rate of colorectal cancer screening ✓	1
17.	Secondary data: Decreased rate of pneumococcal pneumonia vaccination ✓	0
18.	Secondary data: Decreased rate of influenza vaccination rates ✓	0
19.	Secondary data: Decreased rate of annual hemoglobin A1C screening rates for patients with diabetes ✓	1
20.	Secondary data: Decreased rate of annual lipid testing screening rates for patients with diabetes ✓	0
21.	Secondary data: Decreased rate of annual eye examination screening rates for patients with diabetes ✓	0
22.	Survey: Higher cost of health care for consumers	1
23.	Survey: Financial viability of hospital	7

24.	Survey: Heart disease	1
25.	Interview/Focus Group: Increase marketing efforts	6
26.	Interview/Focus Group: Hire addiction/substance abuse counselor	2
27.	Interviews/Focus Group: Hire social services liaison	0
28.	Survey & Interviews/Focus Group: Access to needed technology/equipment including making CT scanner available	8

✓ = Not meeting state average ❖ = Not meeting national benchmark