Community Health Needs Assessment

2019

Stanley Service Area, North Dakota

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Executive Summary

To help inform future decisions and strategic planning, Mountrail County Medical Center (MCMC) and the Upper Missouri District Health Unit (UMDHU) conducted a community health needs assessment (CHNA) in 2018/2019, the previous CHNA having been conducted in 2016. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. There were 172 (electronic-161, paper-11) MCMC service area residents who completed the survey between September 14, and October 19, 2018. Additional information was collected through 11 key informant interviews with community members. The input from the residents, who primarily reside in Mountrail County represented the broad interests of the communities in the service area. Together with secondary data gathered from a wide range of sources, the survey presents a snapshot of the health needs and concerns in the community.

Mountrail County's population from 2010 to 2017 increased 33.8% compared to the state average 0f 12.3%. The average number of residents under the age of 18 is 26.9% for Mountrail County. That is higher than the state average of 23.3%. The percentage of residents ages 65 and older is about 4% lower for Mountrail County (11.3%) than the North Dakota average (15.0%), and the rates of education are lower for Mountrail County (91.9%) than the North Dakota average (92.0%) for high school graduates, and significantly lower for bachelor's degree or higher (23.6% compared to 28.2% respectively). Mountrail County has less individuals below the poverty line (9.5%) compared to the state average (0.7%); however, the county has a significantly higher level of individuals without health insurance under age 65 years (13% compared to 8.1% respectively).

Data compiled by County Health Rankings show Mountrail County is doing better than North Dakota in three health outcomes and tied or better than the national levels in four factors

Mountrail County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 20 factors and is not meeting the United Stated Top 10% performers in 25 factors.

Of the potential community and health needs set forth in the survey, the 172 MCMC service area residents who completed the survey indicated the following 10 needs as the most important:

- Having enough child daycare services
- Not having enough affordable housing
- Ability to retain primary care providers(MD,DO,NP, PA s) and nurses
- Extra hours for appointments such as evenings and weekends
- Drug use and abuse by adults including prescription drugs
- Alcohol use and abuse by adults
- Drug use and abuse by youth including prescription drugs
- Alcohol use and abuse by youth
- Availability of resources to help the elderly stay in their homes
- Cost of long-term nursing home care

The survey responses revealed the biggest barriers to receiving healthcare, as perceived by community members are the need for extra hours for appointments, such as evenings and weekends (29%), the ability to retain primary care providers (MD,DO, NP, PA) and nurses (27%), the availability of mental health services (26%), the availability of specialists (23%), and the ability to get appointments for health services within 48 hours (20%).

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

- Active faith community
- Community groups and organizations
- Quality school system
- Programs for youth
- Healthcare
- Access to healthy foods

Input from community leaders, provided via key informant interviews, and the community focus group echoed many of the concerns raised by survey respondents.

Concerns emerging from these sessions were:

- Not enough affordable housing
- Physical violence, domestic violence, sexual abuse
- Availability of mental health services
- Ability to retain primary care providers (MD, DO, NP, PAs) and nurses
- Drug use and abuse among adults (including prescription drug use)
- Depression/anxiety among adults
- Drug use and abuse among youth (including prescription drug abuse)
- Suicide among youth
- Cost of long-term/nursing home care
- Assisted living options

Overview and Community Resources

With assistance from the CRH at the UNDSMHS, MCMC completed a CHNA of the Stanley service area. The hospital identifies its service area as the towns of Stanley, Lostwood, White Earth, Ross, Palermo, Blaisdell, Belden, New Town, Parshall, Plaza and Wabek. Many community members and stakeholders worked together on the assessment.

Stanley Community

MCMC is located in Stanley, which is in northwest North Dakota, approximately 60 miles west of Minot. Stanley is the county seat of Mountrail County. The city is mainly dependent on agriculture and oil as sources of economic stability. It offers a diverse business community with services to fill all your needs. As of 2017 the population of Stanley was 2,645, with the county population being 10,265.

The area provides excellent hunting and fishing. Stanley is located 30 miles from Lake Sakakawea, one of North Dakota's largest recreational areas. Golf, parks, tennis courts, indoor and outdoor swimming pools, athletic fields, a movie theater, bowling alley and of course the world-famous Whirl-A-Whip are in the community.

Stanley has one elementary school (Kindergarten through grade 5) and one junior high to senior high school (grade 6 through 12). The school boasts more than 80 qualified staff members for more than 757 students, with a student/classroom teacher ratio of 1 to 20. The schools offer a variety of athletics and organizations for students to join.

Other healthcare facilities and services in the area include a pharmacy, optometrist, dentist, chiropractors, massage therapy, community ambulance service, and a volunteer fire department.

Upper Missouri District Health Unit

Upper Missouri District Health Unit (UMDHU) provides public health services that include environmental health, nursing services, the WIC (women, infants, and children) program, health screenings and education services. Each of these programs provides a wide variety of services in order to accomplish the mission of public health, which is to assure that North Dakota is a healthy place to live and each person has an equal opportunity to enjoy good health. To accomplish this mission, UMDHU is committed to the promotion of healthy lifestyles, protection and enhancement of the environment, and provision of quality healthcare services for the people of North Dakota.

Specific services provided by Upper Missouri District Health Unit are:

- Blood pressure checks
- Breastfeeding resources
- Car seat program
- Emergency response & preparedness services
- Environmental health services (water, sewer, health hazard abatement)
- Family planning (STD and HIV testing)
- Flu shots
- Foot care
- Foreign travel immunizations
- Immunizations
- Member of Child Protection Team
- Newborn home visits/clinic
- Nutrition education
- School health (education/resources in the schools)
- Tobacco prevention and control
- Tuberculosis testing and management
- WIC (women, infants & children) program
- Tribal services

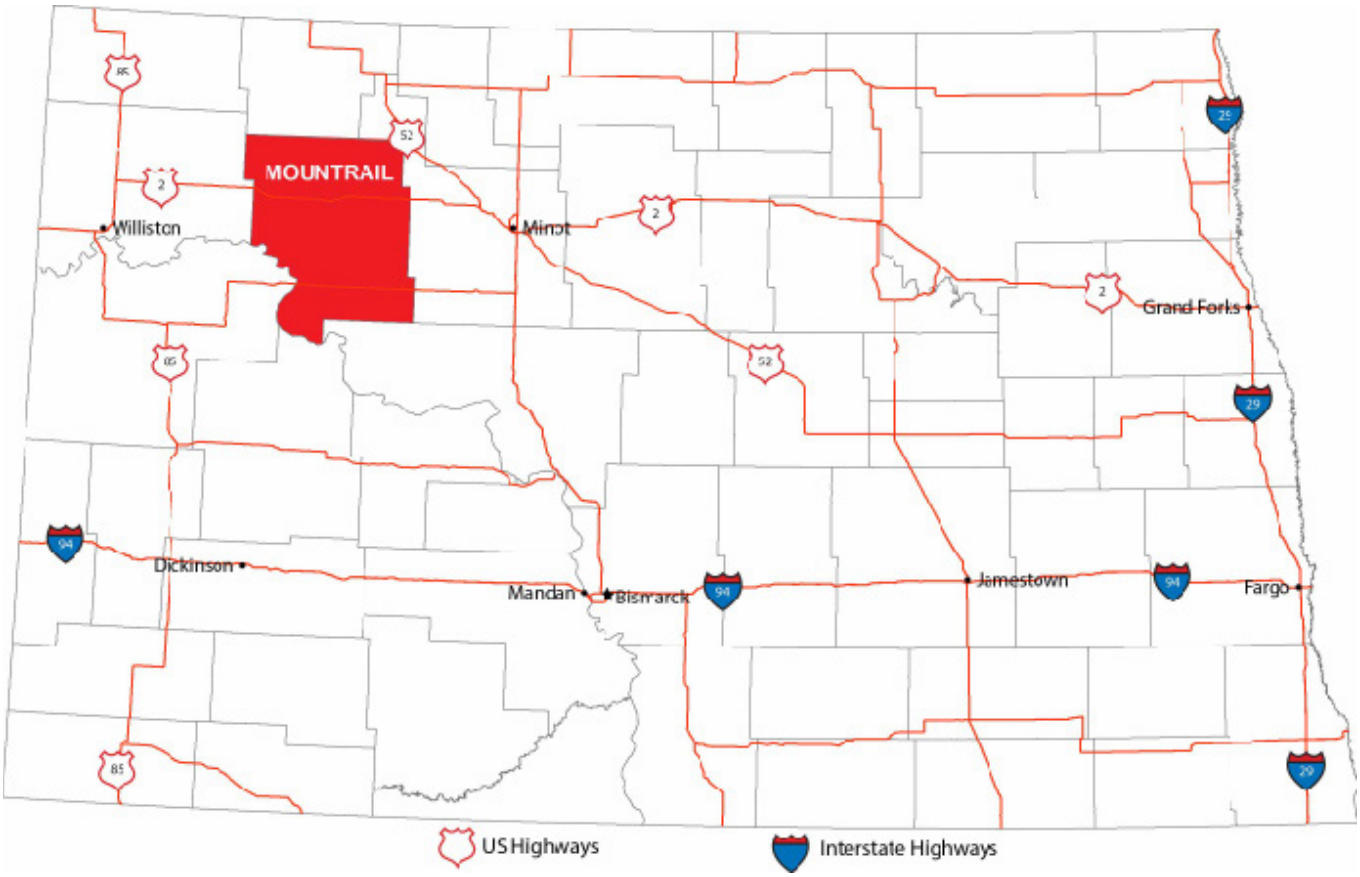
Mountrail County Medical Center

The Stanley Community Hospital opened for business in June of 1952. In 1996, the Stanley Community hospital started to explore options to combine the Mountrail Bethel Home (MBH) and the Hospital under one roof. Their efforts resulted in the formation of MCMC and its governance structure where the Mountrail Bethel Home, Inc. and Trinity Medical Center shall be the sole members of this corporation. On November 1, 1997 MCMC was formed and purchased the assets of the Stanley Community Hospital. In June of 2002, 50 years after the original Stanley Community Hospital opened for business, the newly formed MCMC opened as an 11 bed hospital, emergency room and clinic adjacent to the Bethel Home. As a Critical Access Hospital, MCMC provides comprehensive medical care with physician and mid-level medical providers and consulting/visiting medical providers. With nearly 140 employees,

MCMC/MBH is one of the largest employers in the region. MCMC has one full-time physician, one physician assistant, one doctorate of nursing practitioner and one family nurse practitioner, 2 certified nursing assistants, and 26 nurses for a combined total of 28 healthcare providers.

The mission of MCMC is to: "Mountrail County Medical Center will provide quality healthcare services to Mountrail County and the surrounding area including; primary medical care, emergency care, swing bed and clinic services."

Figure 1: Mountrail County



Services that MCMC offers locally include:

General and Acute Services

- Clinic
- Emergency room
- End of life care
- Hospital (acute care)
- Independent senior housing
- Pharmacy
- OB/GYN (visiting specialist)
- Podiatry (visiting specialist)
- Swing bed and respite care services
- Telemedicine via eEmergency
- Othopedic Services (visiting specialists)

Screening/Therapy Services

- Diet Instruction
- Health screenings
- Laboratory services
- Occupational therapy
- Physical therapy
- Social service

Radiology Services

- In-house CT scan
- In-house 2-D and 3-D mammography unit
- In-house general X-ray
- EKG – electrocardiography
- Echocardiogram
- MRI (mobile unit)
- Ultrasound (mobile unit)

Assessment Process

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

A CHNA benefits the community by:

1) Collecting timely input from the local community members, providers, and staff;

2) Providing an analysis of secondary data related to health-related behaviors, conditions, risks, and outcomes;

3) Compiling and organizing information to guide decision making, education, and marketing efforts, and to facilitate the development of a strategic plan;

4) Engaging community members about the future of healthcare; and

5) Allowing the community hospital to meet the federal regulatory requirements of the Affordable Care Act, which requires not-for-profit hospitals to complete a CHNA at least every three years, as well as helping the local public health unit meet accreditation requirements.

This assessment examines health needs and concerns in Mountrail County. In addition to Stanley, located in the county are the communities of Lostwood, White Earth, Ross, Palermo, Blaisdell, Belden, New Town, Parshall, Plaza, and Wabek.

The CRH, in partnership with MCMC, facilitated the CHNA process. Community representatives met regularly in-person, by telephone conference, and email. A CHNA liaison was selected locally, who served as the main point of contact between the CRH and the Stanley area communities. A small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from the CRH met and corresponded regularly by teleconference and/or via the eToolkit with the CHNA liaison. The community group (described in more detail below) provided in-depth information and informed the assessment process in terms of community perceptions, community resources, community needs, and ideas for improving the health of the population and healthcare services. There were 17 people, representing a cross section demographically, who attended the focus group meeting. The meeting was highly interactive with good participation. Some of the medical facility staff and board members attended as well, but largely played a role of listening and learning.

Figure 2: Steering Committee

Steph Everett	Foundation Director
Belinda Moen	MCMH employee member
Health Hetzel	Community member
Michelle Svangstu	UMDHU public health nurse

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

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

- A survey solicited feedback from area residents;
- Community leaders representing the broad interests of the community took part in one-on-one key informant interviews;
- The Community Group, comprised of community leaders and area residents, convened to discuss area health needs and inform the assessment process; and
- A wide range of secondary sources of data were examined, providing information on a multitude of measures, including demographics, health conditions, indicators, outcomes, rates of preventive measures; rates of disease; and at-risk behavior.
- The CRH is one of the nation's most experienced organizations committed to providing leadership in rural health. Its mission is to connect resources and knowledge to strengthen the health of people in rural communities. The CRH is the designated State Office of Rural Health and administers the Medicare Rural Hospital Flexibility (Flex) program, funded by the Federal Office of Rural Health Policy, Health Resources Services Administration, and Department of Health and Human Services. The CRH connects the UNDSMHS and other necessary resources, to rural communities and their healthcare organizations in order to maintain access to quality care for rural residents. In this capacity, the CRH works at a national, state, and community level.

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

Community Group

A Community Group consisting of ten community key members met on October 17, 2018. During this first Community Group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The Community Group met again on January 16, 2019 with 18 community members in attendance. At this second meeting the Community Group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data relating to the general health of the population in Mountrail County. 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 MCMC and UMDHU. They included representatives of the health community, business community, political bodies, law enforcement, education, faith community, and social service agencies. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with six key informants were conducted in person in Stanley on October 17, 2018. A representative from the CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. The informant interviews included public health professionals with several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

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

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

Survey

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

The community member survey was distributed to various residents of its service area which is defined as Mountrail County.

The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases led to published articles in local newspapers in Mountrail County including in the communities of Stanley, Powers Lake, New Town, and Parshall. Additionally, information was published on the Mountrail County Health Foundation's Facebook page. Approximately 100 community member surveys were available for distribution in Mountrail County. Community Group members and the following businesses distributed the surveys: T.H. Reiarson Rural Health Clinic and the Upper Missouri District Health. Email blasts with the online link were sent to board members and employees of MCMC, Stanley Public School, City of Stanley and Mountrail County and they were asked to share this email to their contacts. The link and pickup locations were also advertised on the local cable channel. As an incentive to complete the survey, the Mountrail County Health Foundation donated a Traeger Tailgater Grill for one lucky person who filled out the pop up after a person completed the online survey. The CRH drew the name for MCMC to ensure the anonymity.

To help ensure anonymity, included with each survey was a postage-paid return envelope to the CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling MCMC. The survey period ran from September 15, to October 19, 2018. A total of 172 surveys were completed, 161 of them electronic and 11 of them paper. This response rate is on par for this type of unsolicited survey methodology and indicates an engaged community.

Secondary Data

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

Social Determinants of Health

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

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

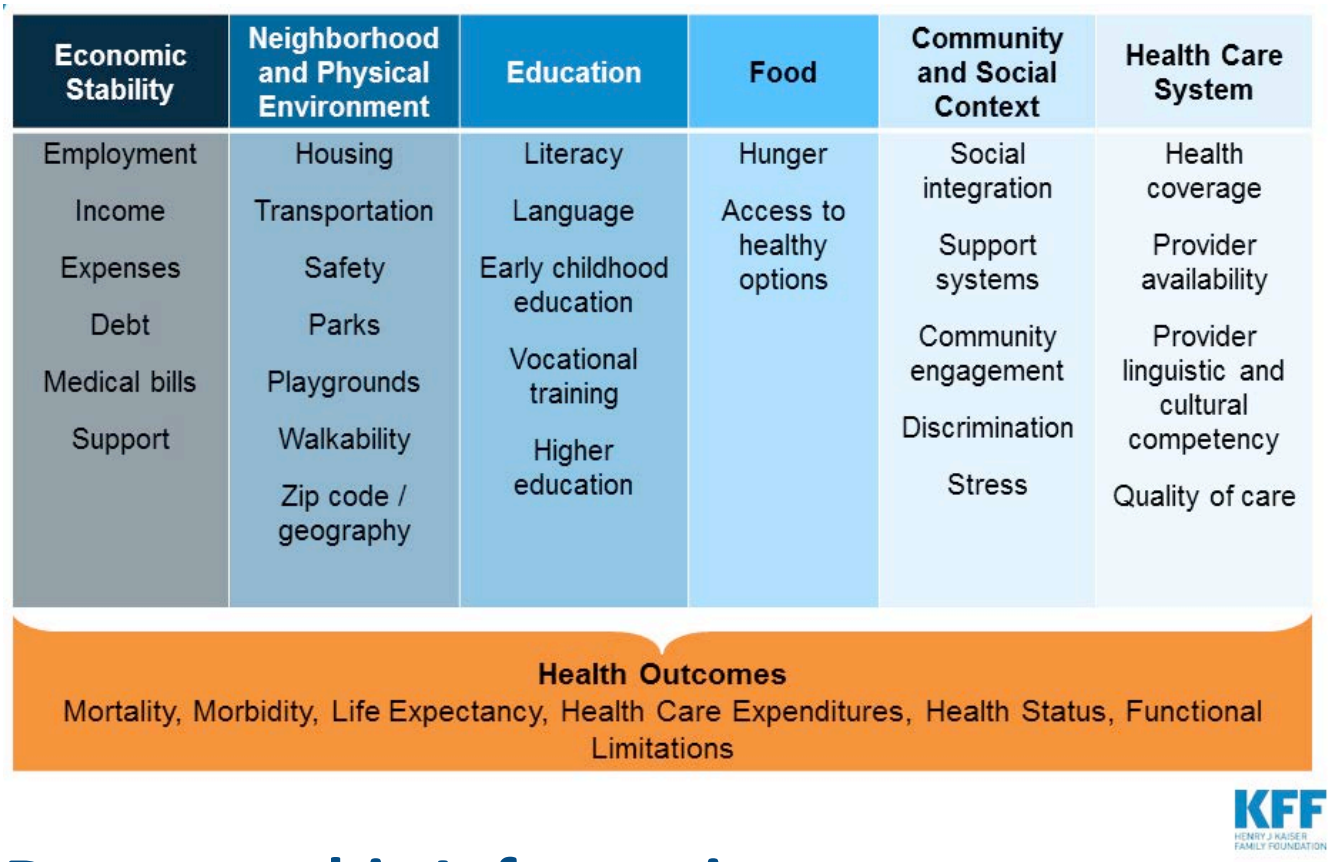
Healthy People 2020, (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health) illustrates that health and healthcare, while vitally important, play only one small role (approximately 20%) in the overall health of individuals and ultimately of a community. Social and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

Figure 3: Social Determinants of Health

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

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

Figure 4: Social Determinants of Health



Demographic Information

Table 1 summarizes general demographic and geographic data about Mountrail County.
(From 2010 Census/2017 American Community Survey; more recent estimates used where available)

	Mountrail	North Dakota
Population (2017)	10,265	755,393
Population change (2010-2017)	33.8	12.3%
People per square mile (2010)	4.2	9.7
Persons 65 years or older (2016)	11.3%	15.0%
Persons under 18 years (2016)	26.9%	23.3%
Median age (2016 est.)	35.2	35.2
White persons (2016)	66.3%	87.5%
Non-English speaking (2016)	6.4%	5.6%
High school graduates (2016)	91.9%	92.0%
Bachelor's degree or higher (2016)	23.6%	28.2%
Live below poverty line (2016)	9.5%	10.7%
Persons without health insurance, under age 65 years (2016)	13.0%	8.1%

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

While the population of North Dakota has grown in recent years, more of a population change in Mountrail County (33.8%) compared to the state average (12.3%). It can also be noted the number of persons 65 or older in 2017 (11.3%) is less than the North Dakota average which is only 15%. Less individuals in the county live below the poverty level (9.5%) compared to the state average (10.7%), but Mountrail County has a significantly higher average (13%) without health insurance under age 65 compared to the state average (8.1%)

County Health Rankings

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

The data used in the 2017 County Health Rankings are from more than 20 data sources and then compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. Following is a breakdown of the variables that influence a county's rank.

A model of the 2017 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix B. For further information, visit the County Health Rankings website at www.countyhealthrankings.org.

Health Outcomes

- Length of life
- Quality of life

Health Factors

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

Health Factors (continued)

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

Table 2 summarizes the pertinent information gathered by County Health Rankings as it relates to Mountrail County. All of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of MCMC or UMDHU or of any particular medical facility.

It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care.

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

Mountrail County rankings within the state are included in the summary following. For example, Mountrail County ranks 44th out of 49 ranked counties in North Dakota on health outcomes and 46th on health factors. The measures marked with a bullet point (•) are those where a county is not measuring up to the state rate/percentage; a asterisk (*) indicates that the county is faring better than the North Dakota average but is not

meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a bullet or asterisk but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings shows that Mountrail County is doing equal to or better than other counties in North Dakota on all but two of the outcomes, (premature deaths and the percentage of people with diabetes) landing at or above rates for other North Dakota counties. The only health outcome above the state average is the reported poor mental health days.

Mountrail County rates equal to or higher than the national top 10% outcomes in reporting less poor physical health days, less poor mental health days, less low birth weights, a high food environment index, lower unemployment and no drinking water violations.

Data compiled by County Health Rankings show Mountrail County is doing better than North Dakota in health factors in the following areas:

- Poor mental health days
- High food environmental index
- Diabetic monitoring
- Mammography screening
- Unemployment rate
- Air pollution
- Poor mental health data

Of the identified factors, the behavioral factors in which Mountrail County is performing poorly relative to the rest of the state include:

- Adult smoking
- Adult obesity
- Physical inactivity
- Access to exercise
- Excessive drinking
- Alcohol-impaired driving deaths
- Sexually transmitted diseases
- Teen birth rate

Mountrail County ties with the state in excessive drinking rates, which are 26% compared to the national average of 13%. Mountrail County is performing poorly relative to the rest of the state in all of the clinical factors.

Social and economic factors in which Mountrail County is performing poorly relative to the rest of the state include:

- Children in poverty
- Income inequality
- Violent crime
- Injury deaths

Mountrail County ties with the state rate for severe housing shortage, which is 11% compared to the national rate of 9%

Table 2: Selected Measures from County Health Rakings 2018 - Mountrail County

+ Meeting or exceeding U.S. top 10% performers

***** Not meeting U.S. top 10% performers

• Not meeting North Dakota average

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2018 – MOUNTRAIL COUNTY			
	Mountrail County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**44th**		**(of 49)**
Premature death	11,700 •*	5,300	6,600
Poor or fair health	14% *	12%	14%
Poor physical health days (in past 30 days)	3.0 +	3.0	3.0
Poor mental health days (in past 30 days)	2.9 +	3.1	3.1
Low birth weight	6% +	6%	6%
% Diabetic	12% •*	8%	8%
Ranking: Factors	**46th**		**(of 49)**
Health Behaviors			
Adult smoking	21% •*	14%	20%
Adult obesity	37% •*	26%	32%
Food environment index (10=best)	9.4 +	8.6	9.1
Physical inactivity	30% •*	20%	24%
Access to exercise opportunities	45% •*	91%	75%
Excessive drinking	26% *	13%	26%
Alcohol-impaired driving deaths	53% •*	13%	48%
Sexually transmitted infections	582.7 •*	145.1	427.2
Teen birth rate	65 •*	15	25
Clinical Care			
Uninsured	14% •*	6%	9%
Primary care physicians	2,580:1 •*	1,030:1	1,330:1
Dentists	2,050:1 •*	1,280:1	1,550:1
Mental health providers	2,050:1 •*	330:1	610:1
Preventable hospital stays	54 •*	35	49
Diabetic monitoring (% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring)	80% •*	91%	87%
Mammography screening (% of Medicare enrollees ages 67-69 receiving screening)	53% •*	71%	69%
Social and Economic Factors			
Unemployment	3.1% +	3.2%	3.2%
Children in poverty	14% •*	12%	12%
Income inequality	4.8 •*	3.7	4.3
Children in single-parent households	40% •*	20%	28%
Violent crime	256 *	62	26
Injury deaths	103 •*	55	68
Physical Environment			
Air pollution – particulate matter	7.3 *	6.7	7.5
Drinking water violations	No +	No	
Severe housing problems	11% *	9%	11%

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

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2011-12. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

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

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

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

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

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

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

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

The data shows Mountrail County is performing more poorly than the North Dakota average on four factors:

- Uninsured children at 5.1% higher than state average
- Medicaid recipient population is 4.8% higher than state average
- Licensed child care capacity is only 17% compared to the North Dakota state average of 41.9%. A difference of almost 25%.
- The 4-year high school cohort graduation rate in 2017 was 5.9% less than the state average.

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

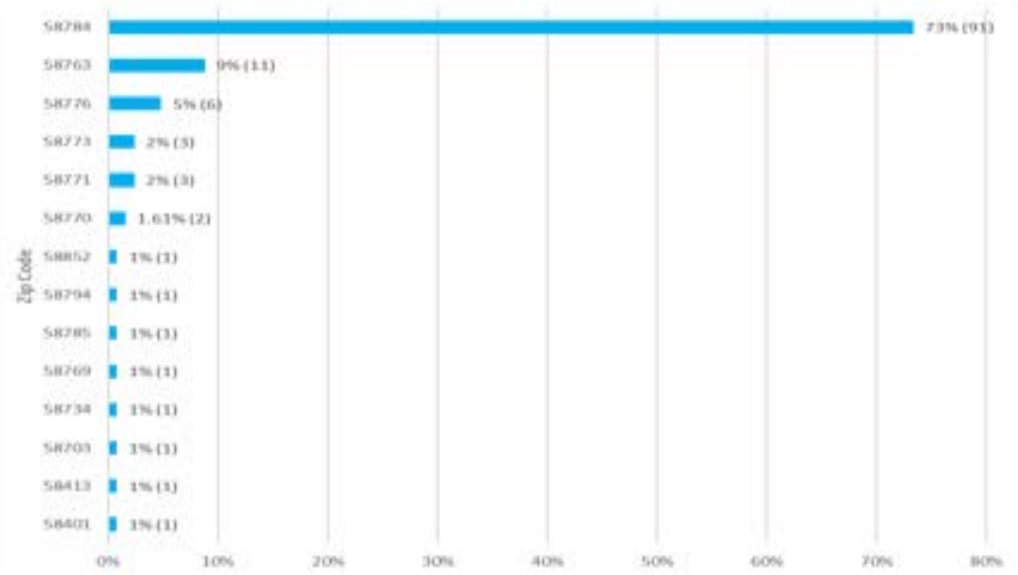
	Mountrail County	North Dakota
Uninsured children (% of population age 0-18), 2016	**14.1%**	9.0%
Uninsured children below 200% of poverty (% of population), 2016	31.8%	41.9%
Medicaid recipient (% of population age 0-20), 2017	33.1%	28.3%
Children enrolled in Healthy Steps (% of population age 0-18), 2013	**1.8%**	2.5%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2017	14.5%	20.1%
Licensed childcare capacity (% of population age 0-13), 2018	**17.0%**	41.9%
4-Year High School Cohort Graduation Rate, 2017	81.1%	87.0%

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

Survey Results

As noted previously, 172 community members completed the survey in communities throughout the counties in the MCMC service area. The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 124 did, revealing that the large majority of respondents (73%, N=91) lived in Stanley. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 124



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

Survey Demographics

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

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

- 35% (N=47) were age 55 or older
- The majority (73%, N=98) were female.
- Respondents (45%, N=61) had bachelor's degrees or higher.
- The number of those working full time (78%, N=104)
- Only 3% of those who reported their ethnicity/race were non-white/Caucasian.
- 7% of the population (N=9) had household incomes of less than $50,000. 34% reported incomes over $100,000 (N=44)

Figures 6 through 12 show these demographic characteristics. It illustrates the range of community members' household incomes and indicates how this assessment considered input from parties who represent the varied interests of the community served, including a balance of age ranges, those in diverse work situations, and community members with lower incomes.

Figure 6: Age Demographics of Survey Respondents
Total respondents = 135

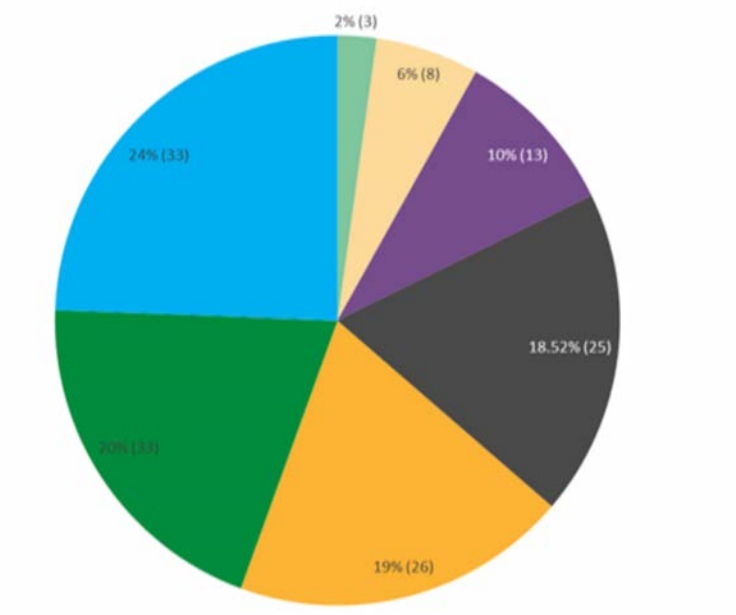


Figure 7: Gender Demographics of Survey Respondents
Total respondents = 135

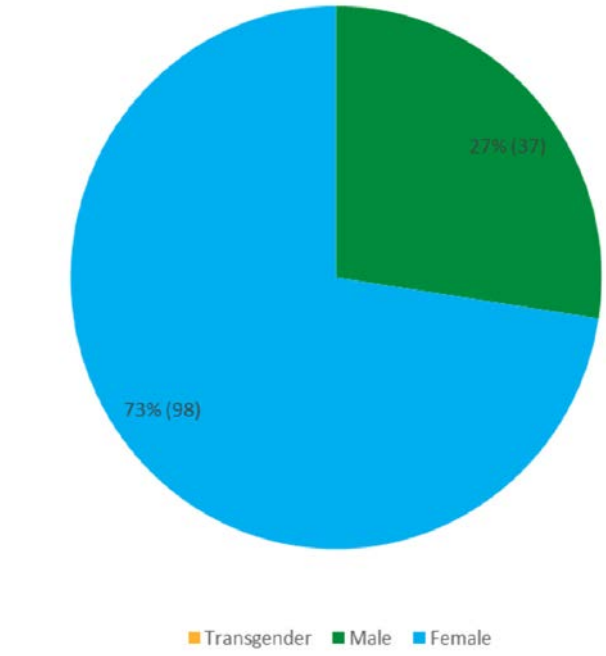


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 136

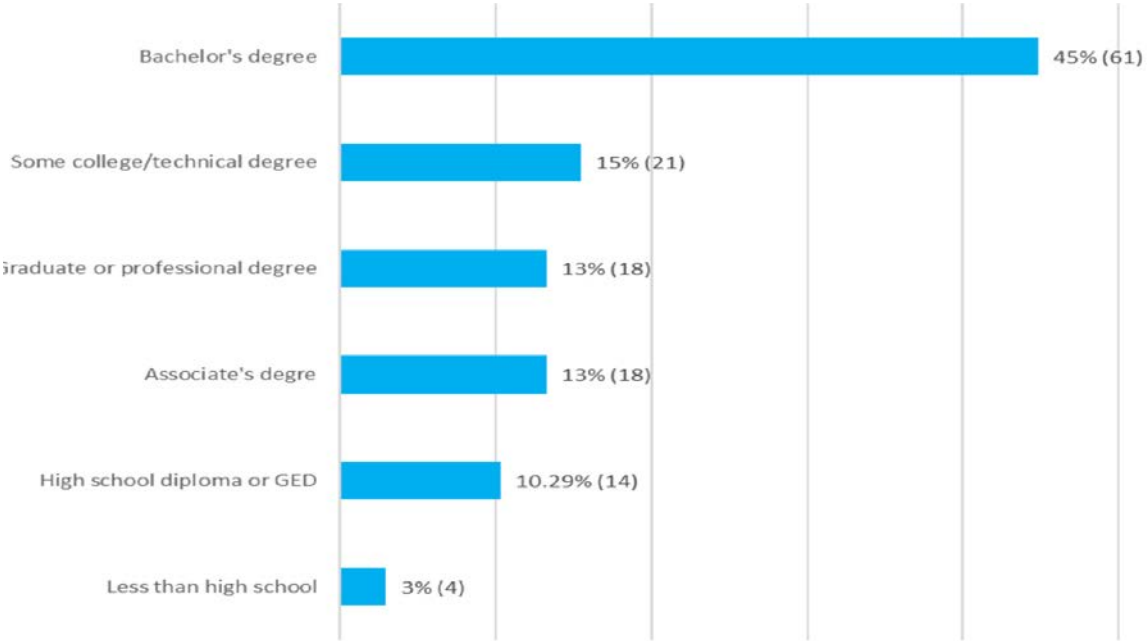
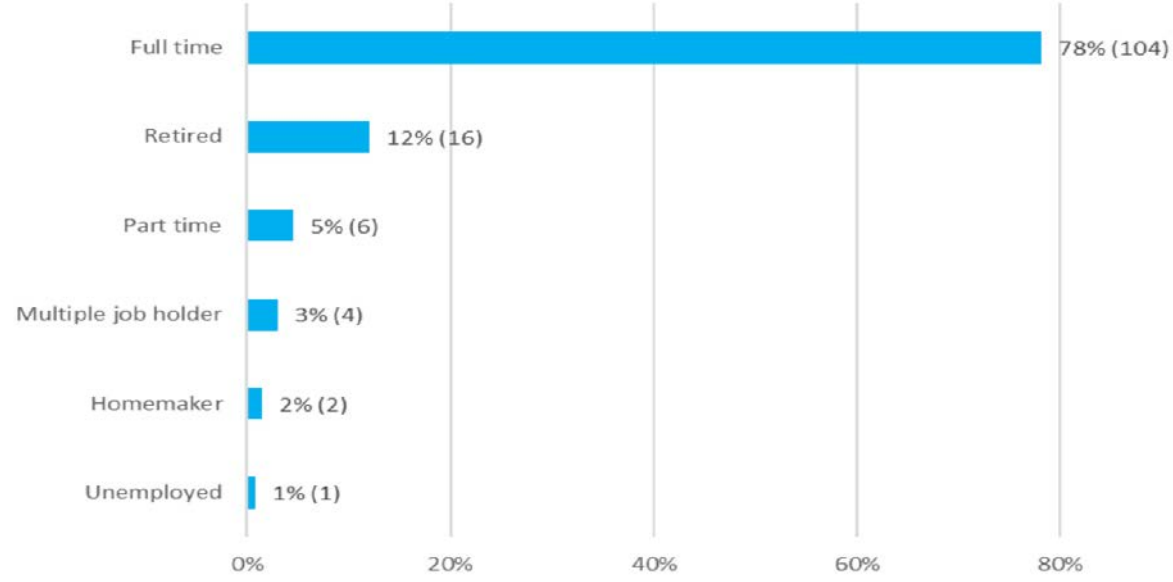
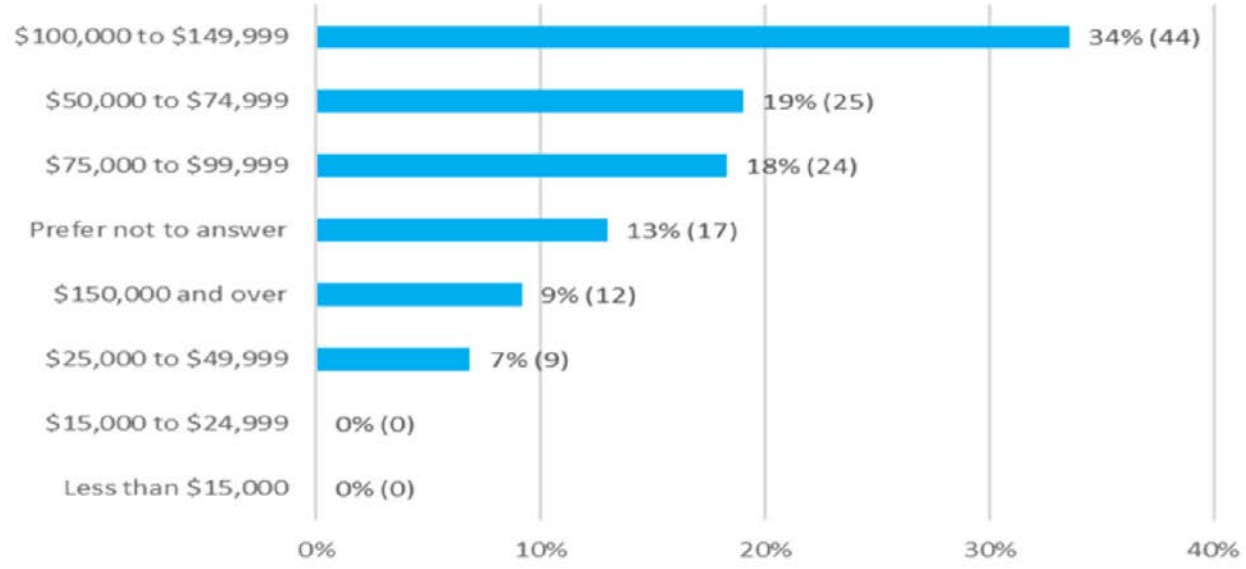


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 133



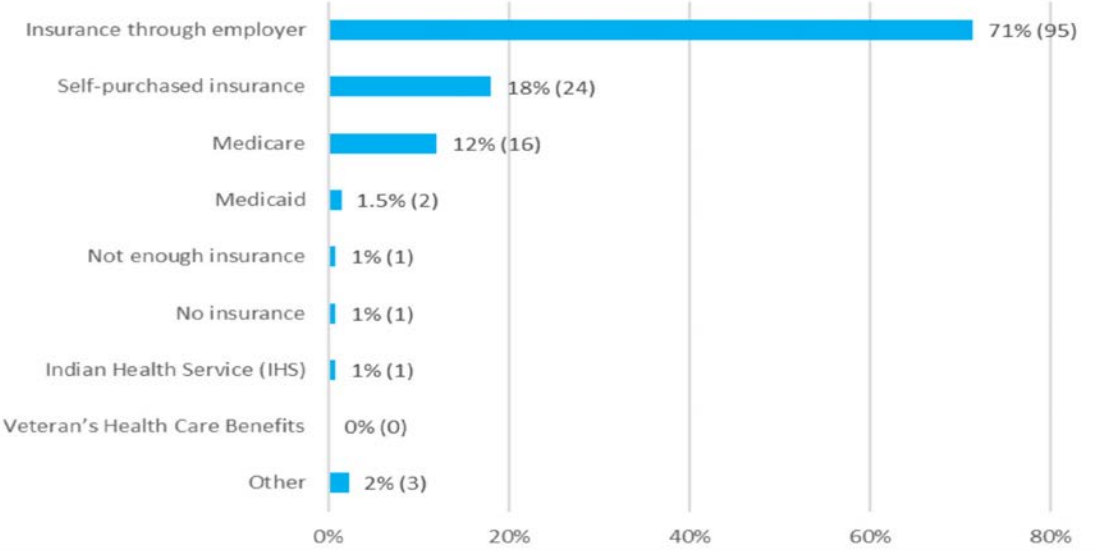
Of those who provided a household income, 7% (N=9) community members reported a household income of less than $25,000, 34% (N=44) indicated a household income of $100,000 or more. This information is show in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 131



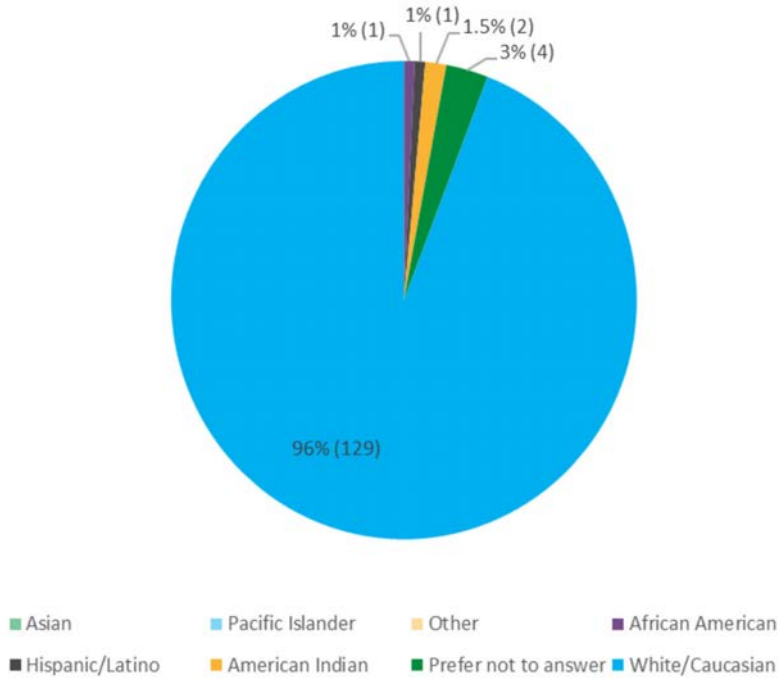
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Less than 1% (N=1) of the respondents reported having no health insurance or being under-insured. The survey results do align with the state data for the county uninsured rate of those under the age of 65 (13%). The most common insurance types were insurance reported by the respondents was through one's employer (N=95), followed by self-purchased (N=24) and Medicare (N=16).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 143



As shown in Figure 12, nearly all of the respondents were white/Caucasian (96%) (N=129). This response is significantly higher than the Mountrail County data (2016) of 63.3% white/Caucasian.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 137

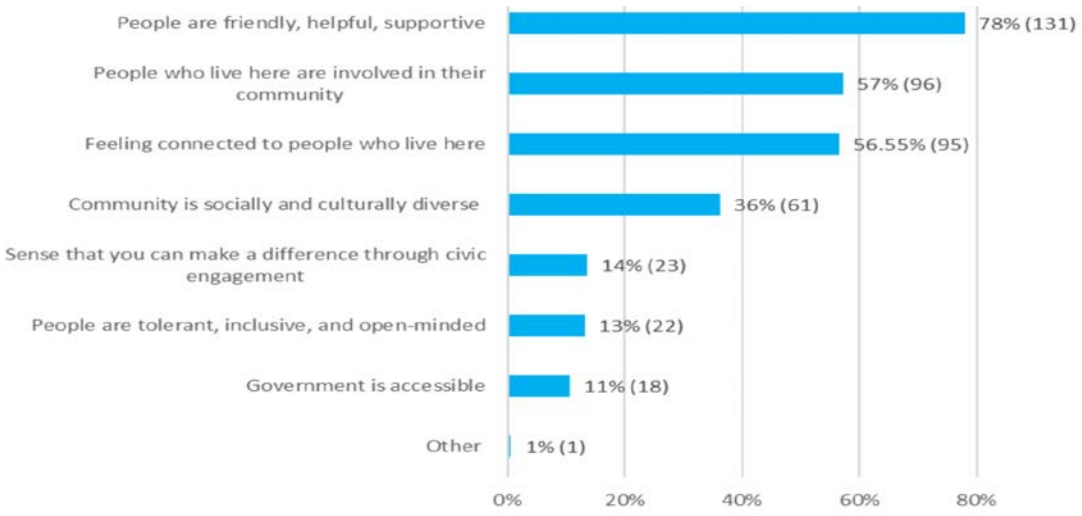


Community Assets and Challenges

Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. If more than three choices were selected, their responses were not included.

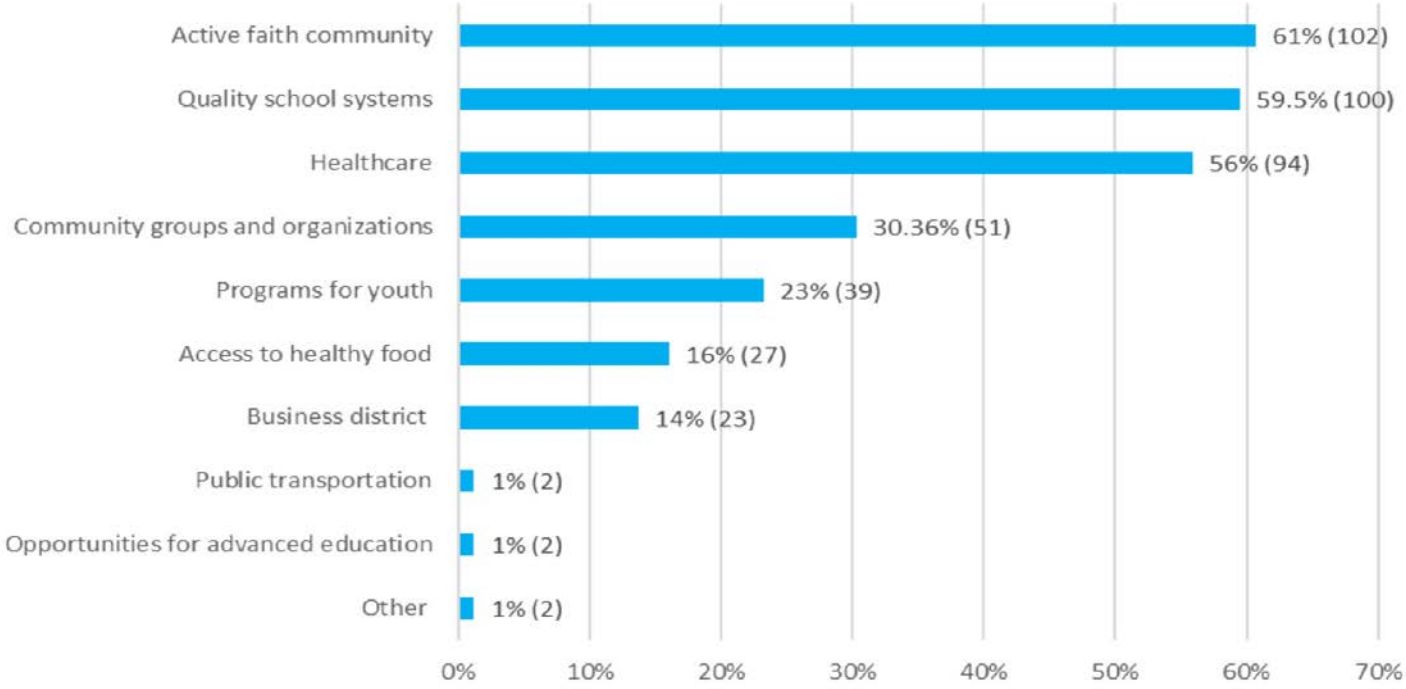
Figures 13 to 16 illustrate the results of these questions.

Figure 13: Best Things about the PEOPLE in Your Community
Total responses = 447



More than 130 individuals stated the community was friendly, helpful, supportive, and had feelings of being connected to the people living in the community, people who live here are involved in the community and they feel connected to the people who live in the community. However, one of the comments under "other' stated some native community members are very rude to newcomers.

Figure 14: Best Things about the SERVICES AND RESOURCES in Your Community
Total responses = 442



Other comments from the respondents were very expensive transportation and the jobs/economy.

Figure 15: Best Things about the QUALITY OF LIFE in Your Community
Total responses = 444

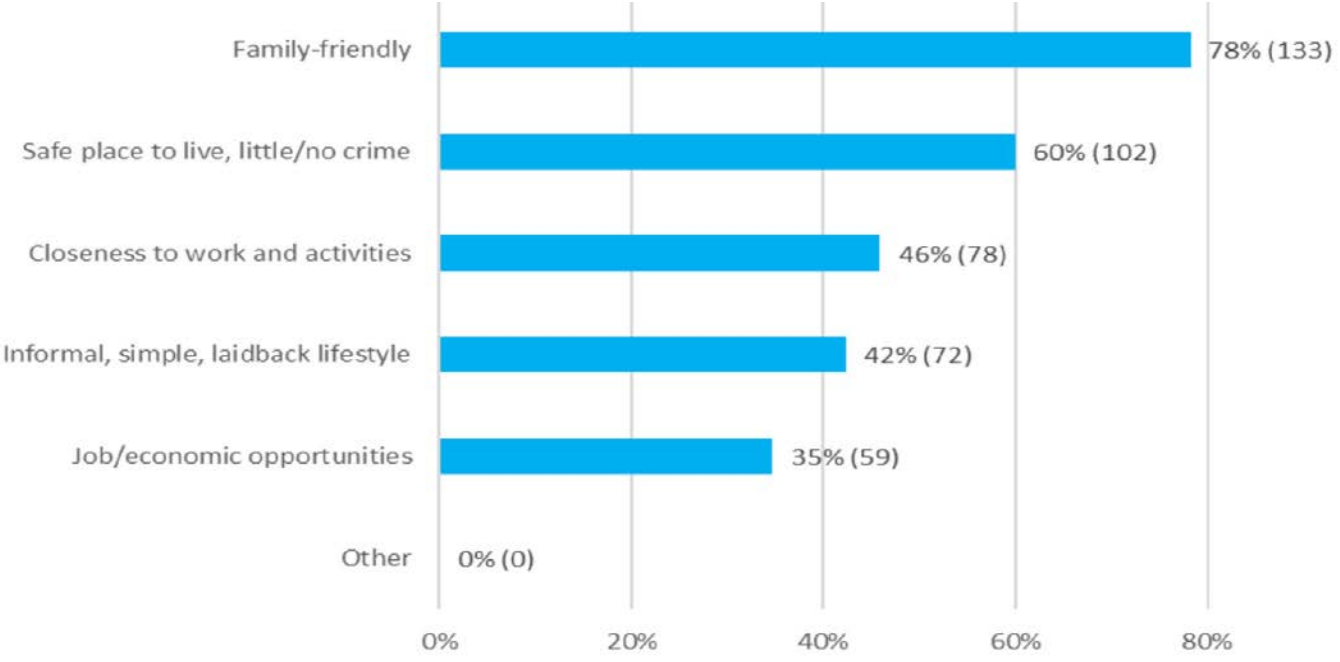
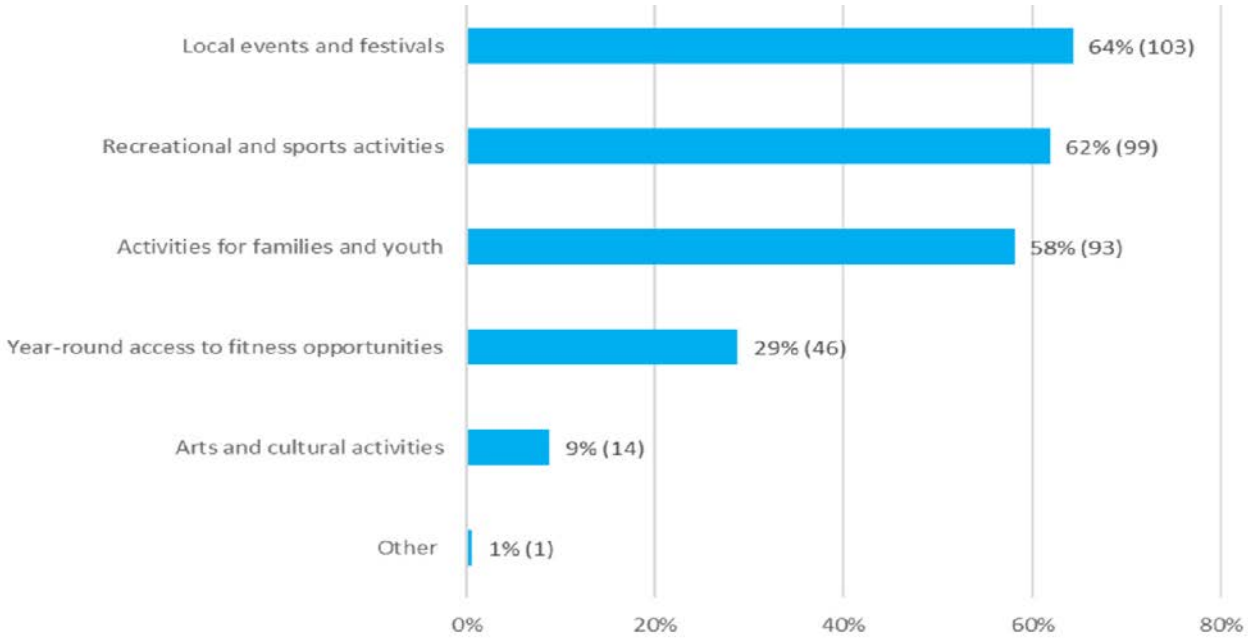


Figure 16: Best Thing about the ACTIVITIES in Your Community
Total responses = 356



One individual who selected "Other" specified that the best things about the activities in the community also noted various school activities.

Community Concerns

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

- Community and environmental health
- Availability/Delivery of health services
- Adult population concerns
- Youth population concerns
- Senior population concerns
- Violence concerns

With regard to responses about community challenges, the most highly voiced concerns were:

- Alcohol and drug use
- Affordable housing
- Lack of quality family activities
- Attracting and retaining young families
- Mental health services

Figures 17 through 36 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 392

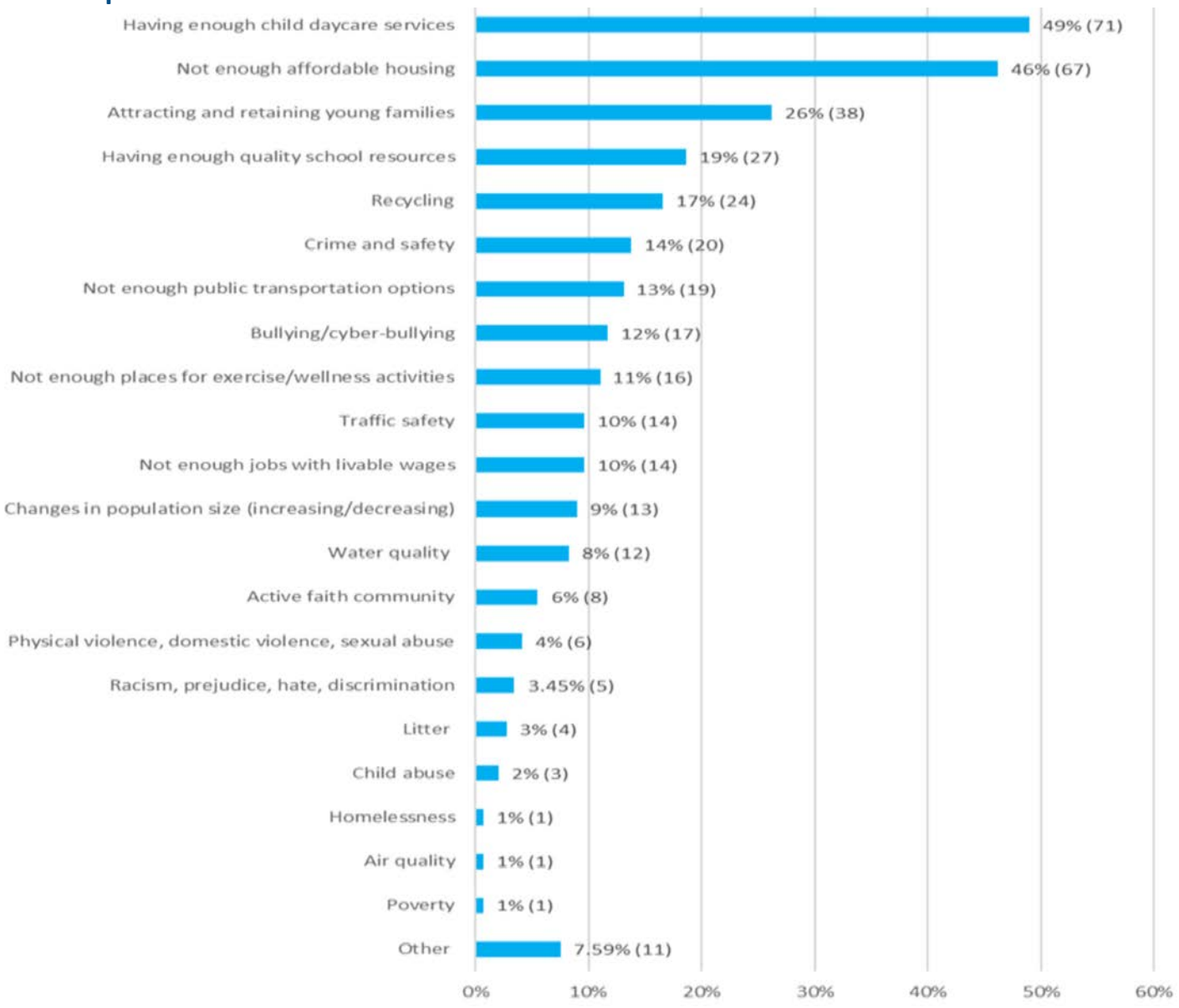
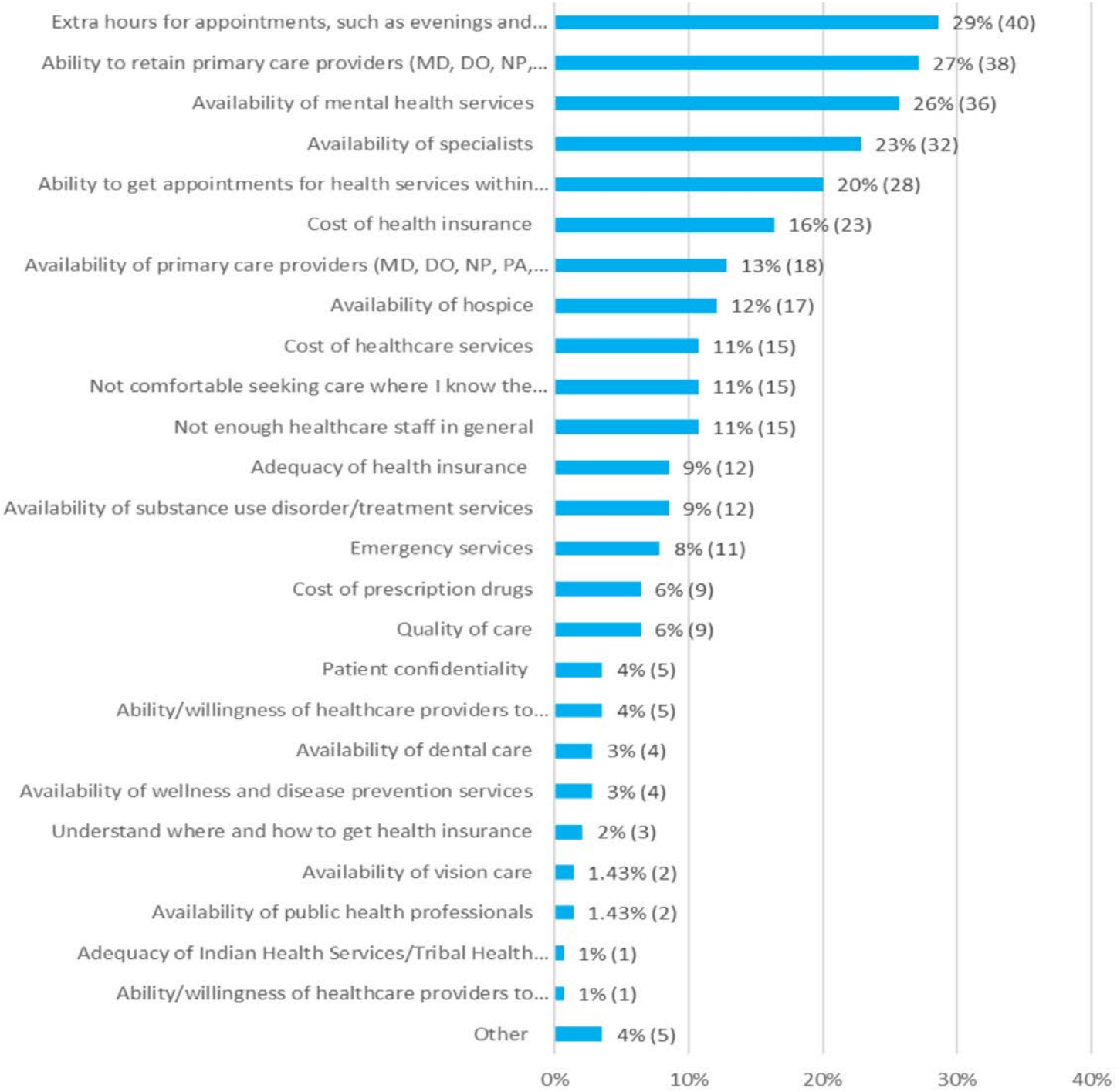
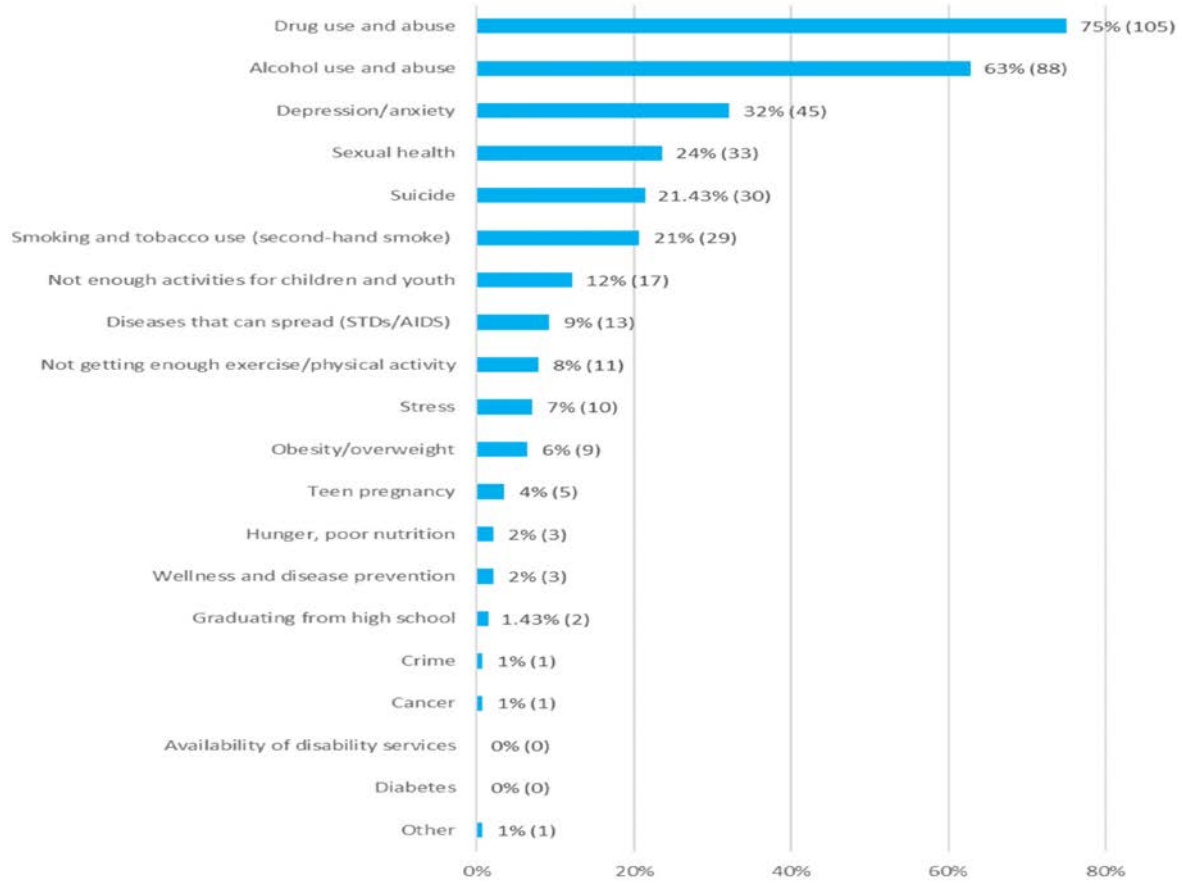


Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 362



Respondents who selected "Other" identified concern was a comment about poor billing from clinic and hospital in town.

Figure 19: Youth Population Health Concerns - Total responses = 406



Listed in the "Other" category for youth population concerns was unplanned pregnancy.

Figure 20: The Skittle school event of 2018 covered numerous topics, which topics covered concern you the most for our Youth and should be looked into further? Total responses = 399

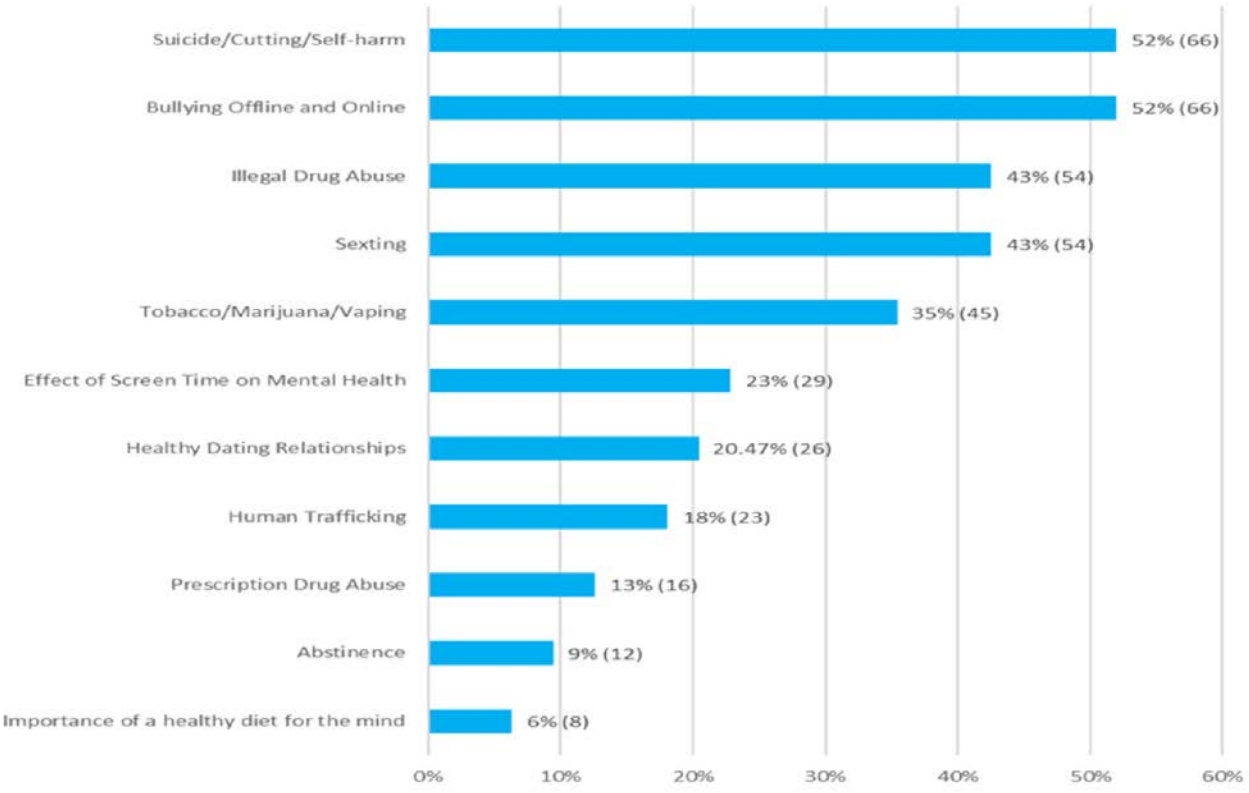
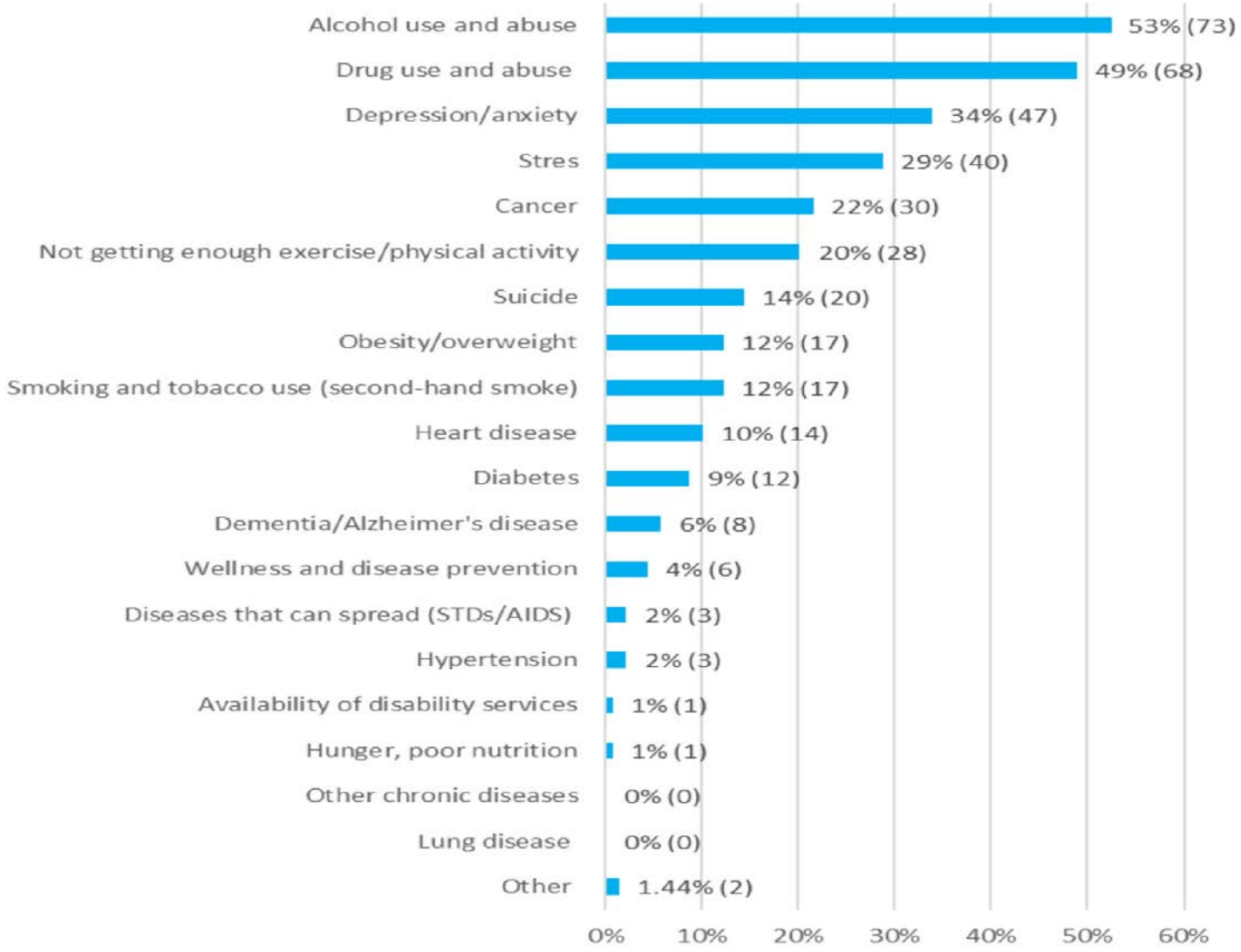
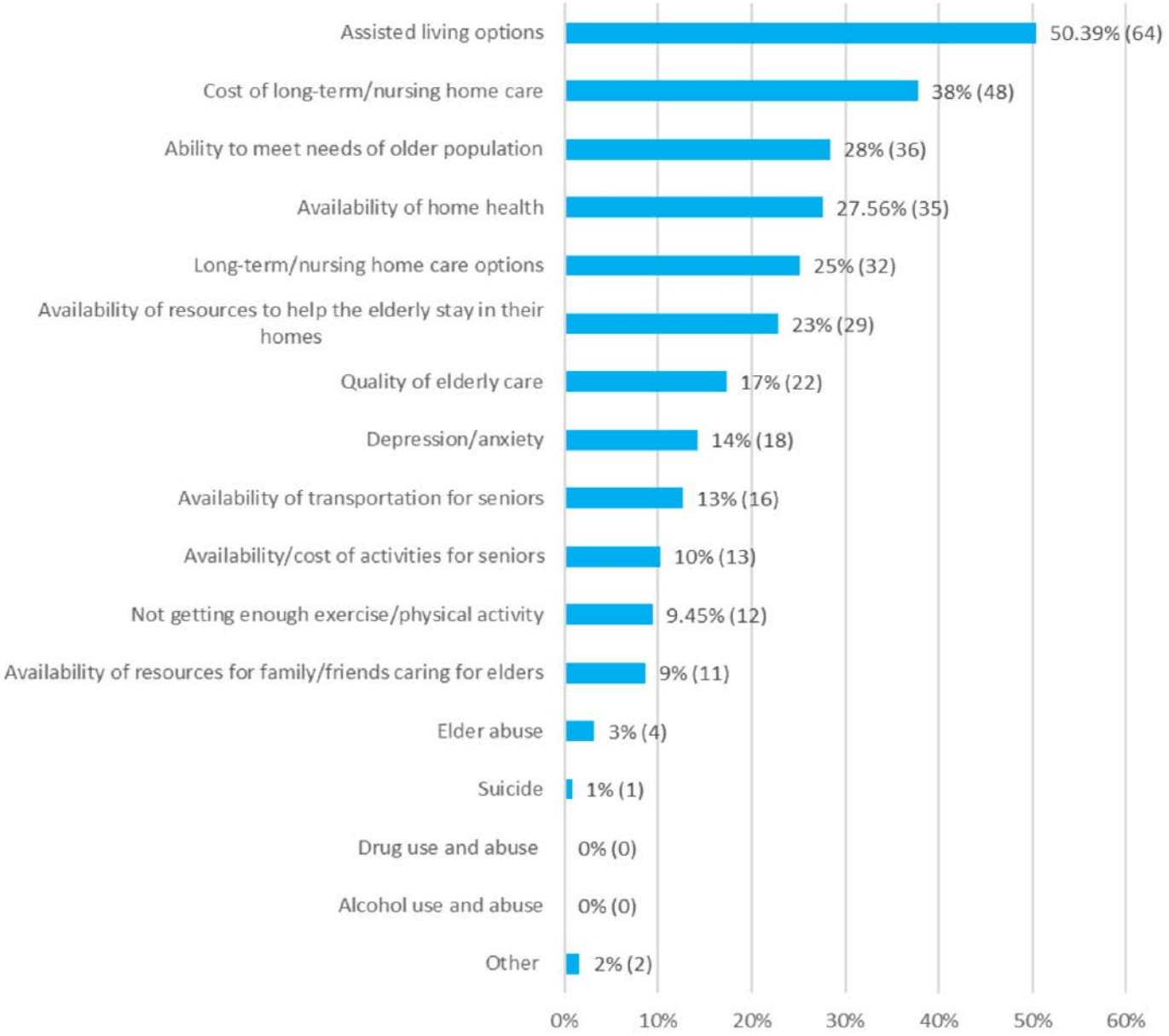


Figure 21: Adult Population Concerns
Total responses = 390



Listed in the "Other" category for adult population concerns was the isolation of elderly people and mental health support.

Figure 22: Violence Concerns
Total responses = 343



In the "Other" category, is concern listed was the high cost of services for elderly to remain in their home with assistance from health aides.

Figure 23: Survey-what are the impacts from the Oil Development in the community N=362

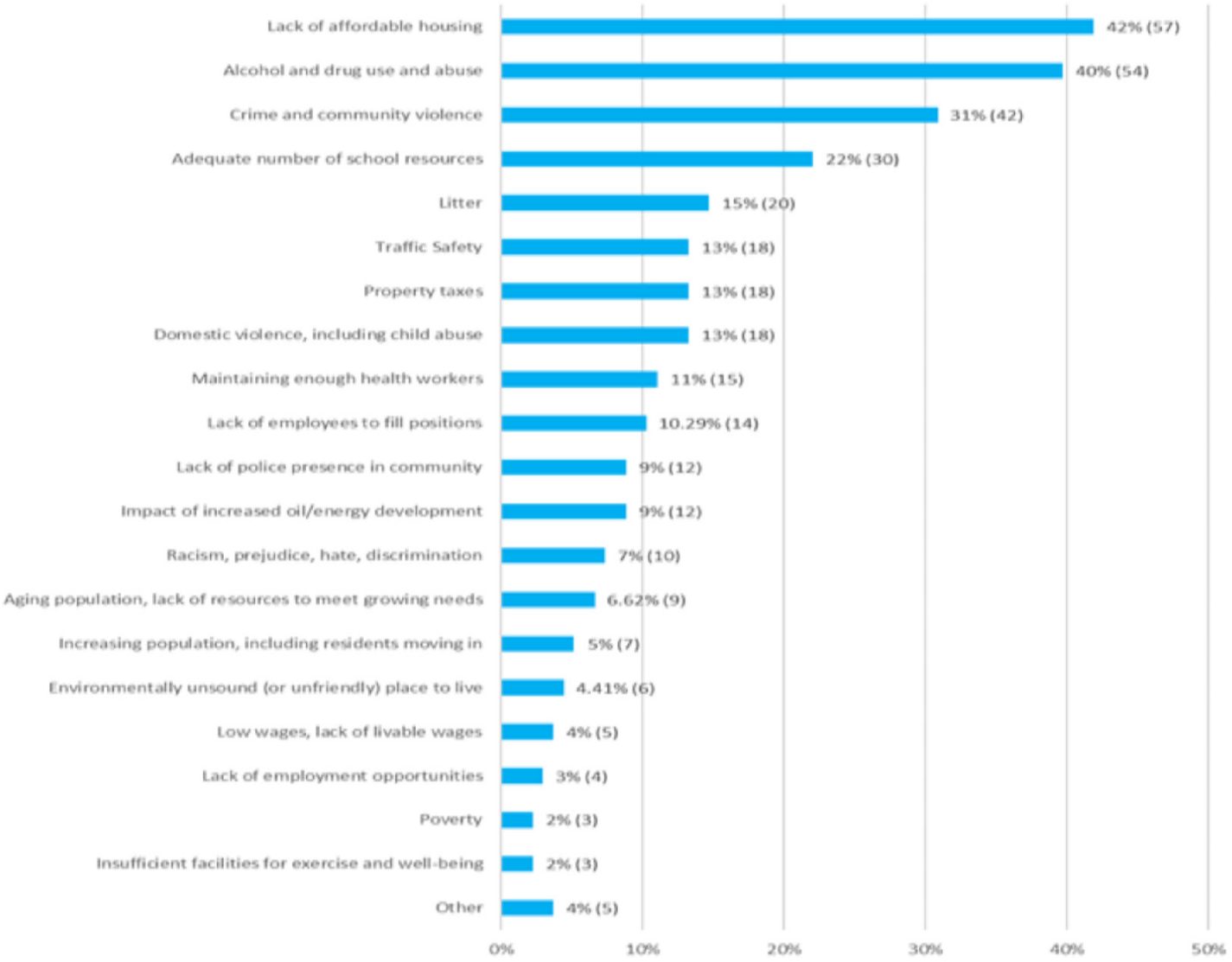
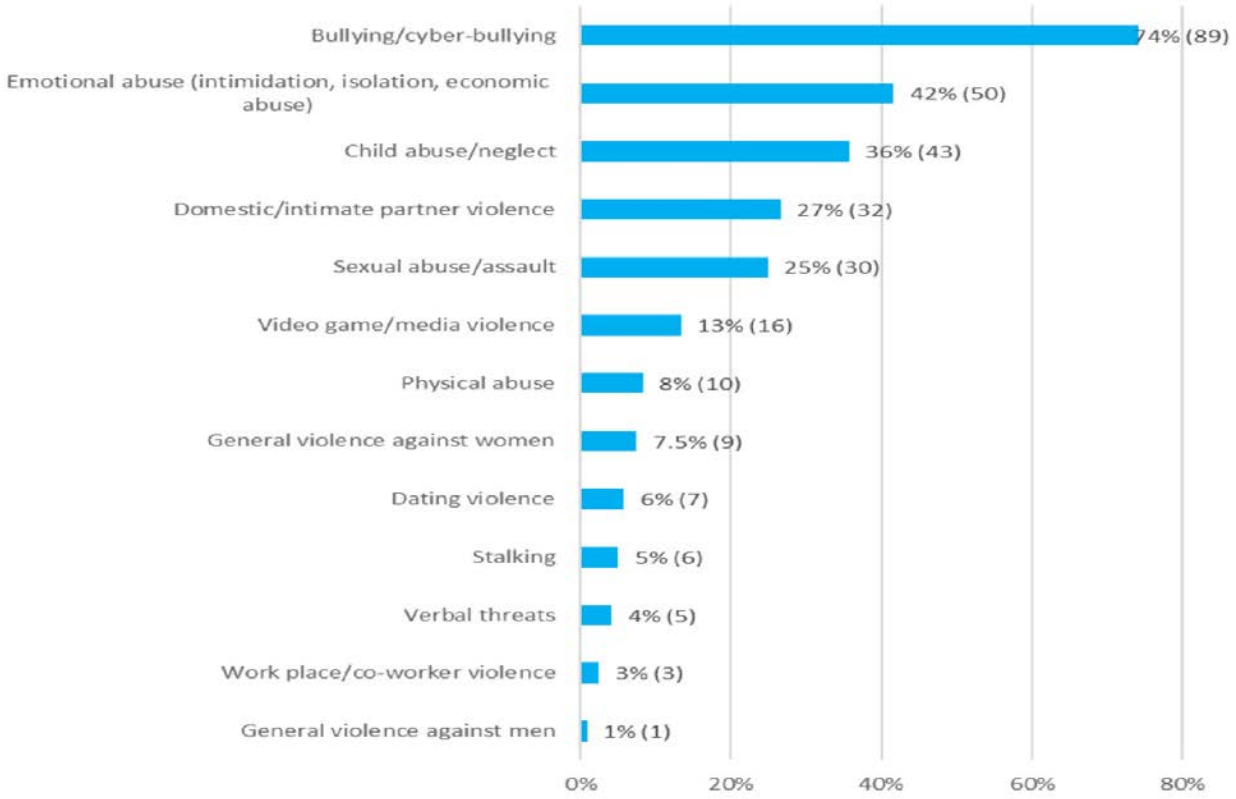


Figure 24: Violence Concerns
Total responses = 301



In an open-ended question, respondents were asked what single issue they feel is the biggest challenge facing their community. The comments primarily focused on one essential challenge or need. There was a large response. The following are the comments;

- There exists a lack of quality family activity and a lack of people going to church of any denomination. Youth are hurting and I feel it's a lack of these things that are causing it.
- Lack of AFFORDABLE housing for non-oil families. (4)
- Activities for older teens and young adults that don't involve drinking or other things like that.
- Affordable housing and keeping quality people in the area. (2)
- Alcohol and drug abuse (2)
- Alcohol and drug abuse have increased crime in our community and more abuse and neglect. This affects the community as a whole, as these people tend to need more community social service needs which strains the economy and community well-being.
- Alcohol, drug, crime has increased, and all go hand-in-hand. These three things lead to many of the other concerns such as depression/anxiety, abuse, poverty, children in poverty/lack of food & resources, traffic safety, violence, and therefore lack of fun.
- Childcare/ daycare opportunities or lack of (3)
- Diet and clean water
- Drug use and abuse
- Drug/alcohol use in youth.

- Drugs in school systems
- Education on resources that are available for every individual in the community.
- Enough workers to fill the positions that are open particularly in retail and service industries
- Excessive alcohol use by adults and sometimes teens is considered normal, the only way to 'have fun', and viewed as funny or playfully promoted on social media.
- Getting students at the high school college ready.
- Giving all the free healthcare to the Indians that come up here for free treatment. That is wrong and it is making our hospital look bad.
- Having law enforcement take seriously concerns such as drugs, meth houses.....and DOING something about it.
- Housing is unaffordable for the average income
- I cannot understand the way the ministers in this community act toward one another and how some of them even preach that other denominations are bound for hell. We cannot even have a community worship service (like National Day of Prayer) because of some ministers.
- I think the biggest challenge is proportionally sizing our infrastructure and services to match the changes in the population, including school, housing, law enforcement and public services, while still maintaining the friendly attitude of a small town.
- Illegal drug use. Huge increase in the percentage of children in foster care due to drug use by parents and other caregivers (parents' intimate partners or stepparents).
- Keeping MCMC strong and growing
- Keeping healthcare professionals and senior care
- Keeping our most knowledgeable and skilled young people living in the community.
- Keeping the doors open at our healthcare facility
- Lack of mental health providers. Many people do not receive the help that they need because they cannot afford to take time off of work to drive to Minot or Williston to see a counselor.
- Lack of acceptance/ empathy/ openness.
- Lack of mental health services and support (2)
- Money to live a fulfilling life
- Native American Indians have their own government rules, yet they are able to vote in elections
- Oil money coming into families in this area makes it hard for young people to learn that it's not like this everywhere. Federal minimum wage is $7.25 but even students who are working part-time jobs are making at least $15.00/hour.
- Open and follow through communication between the various entities involved in planning development in our town, between those entities and other organizations, and between those two and the people
- People not passing drug test to keep employment and being dependable.
- SCHOOL SIZE AND HOW TO PAY FOR IT.
- Substance abuse

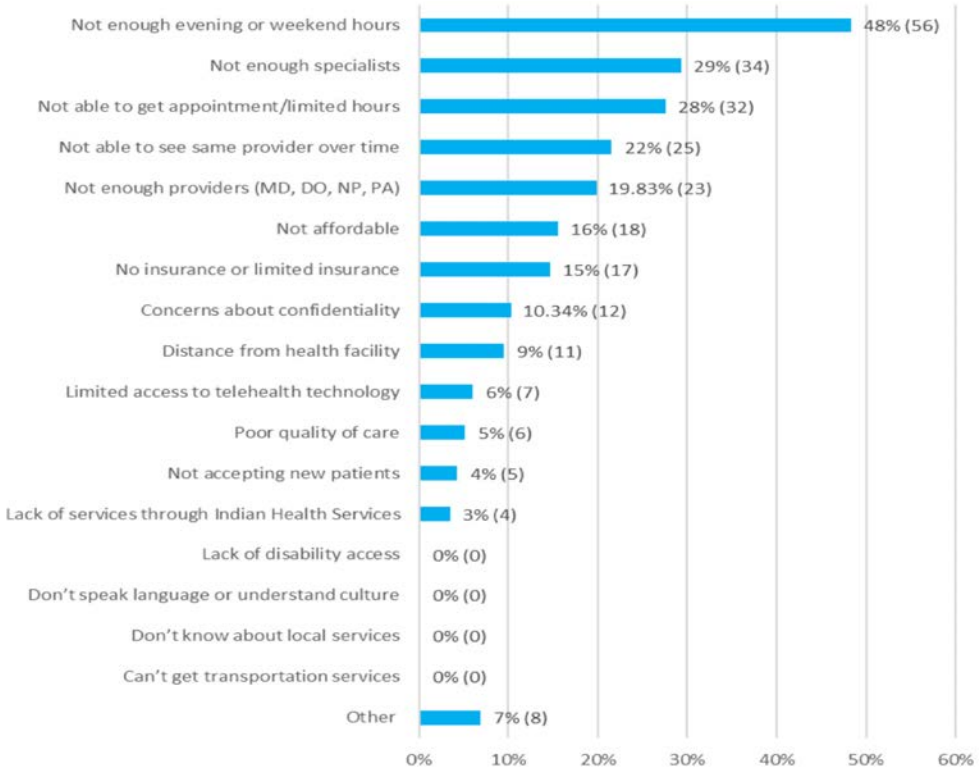
- The need for Hospice. Stanley is too far from Minot or Williston to have such services.
- Too many projects needing money raising right now
- Underage drinking culture that is seen as acceptable by many adults in the community.
- We as a community provide a lot of opportunities for the youth to be active but our numbers are NOT where they should be. We need to promote this activity as a community much better. We should have too many kids out for sports.
- Wellness of local youth
- Abuse of all
- Access to home health services to those living far away from healthcare facilities
- Locals not willing to expand and change, trying to keep the town in the 1950's.
- The high prices the oil has brought in for food, services, housing, gas, etc. jobs do not pay enough for those starting out to afford to live.
- Traffic safety- semi trucks increased traffic, construction road signs bad, need painted

Delivery of Healthcare

The survey asked residents what they see as barriers that prevent them, or other community residents, from receiving healthcare. The most prevalent barrier perceived by residents was not enough weekend and evening hours (N=56), with the next highest being not enough specialists (N=34). After these, the next most commonly identified barriers were not being able to get appointments due to limited hours (N=32), not able to see the same provider over time (N=25), not enough providers (MD, DO, NP, PA) and nurses (N=23), not affordable (N=18).

The majority of concerns indicated in the "Other" category were in regard to billing issues.

Figure 25: Perceptions about Barriers to Care-what prevents individuals from receiving healthcare Total responses = 258



Considering a variety of healthcare services offered by Mountrail County, respondents were asked to indicate if they were aware that the healthcare service is offered and to also indicate what, if any, services they or a family member have used in Mountrail County, at another public health unit, or both (See Figure 26).

Figure 26: General and Acute Services N=525

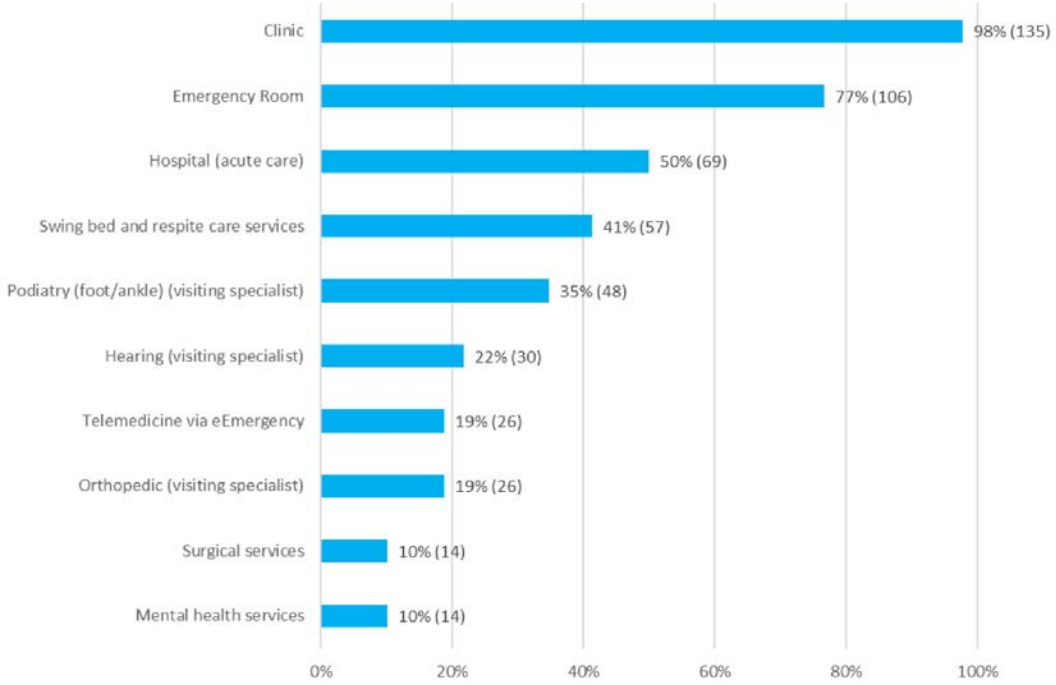


Figure 27: Screening/Therapy Services N=414

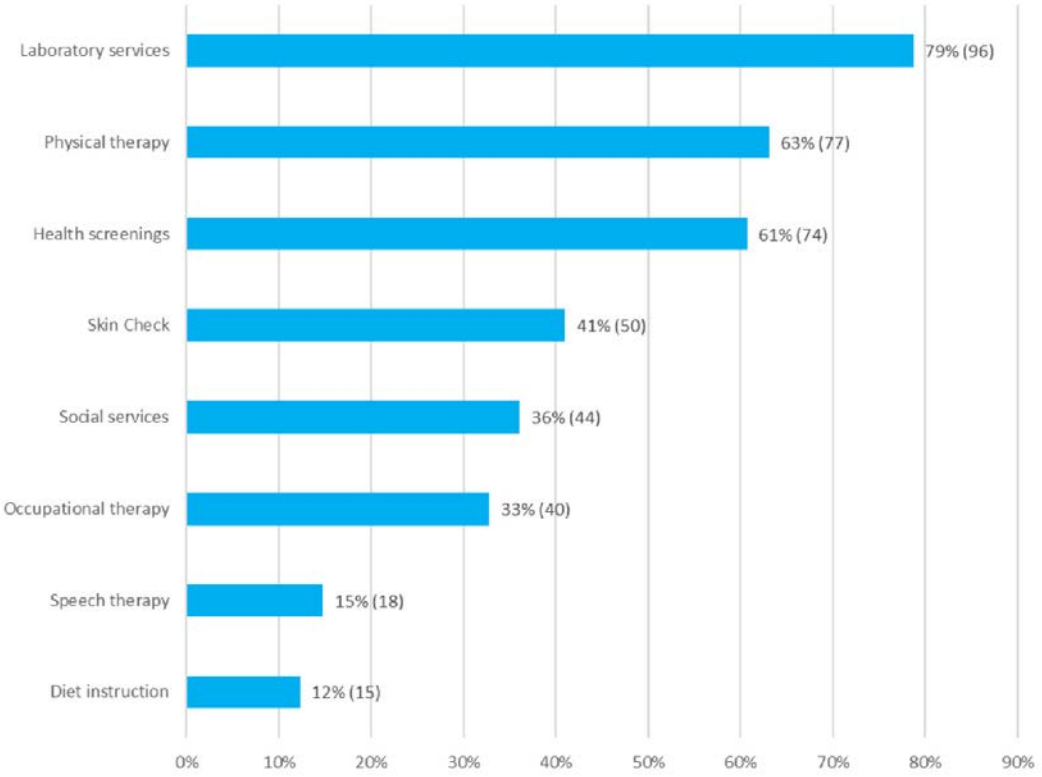


Figure 28: Radiology Services N=396

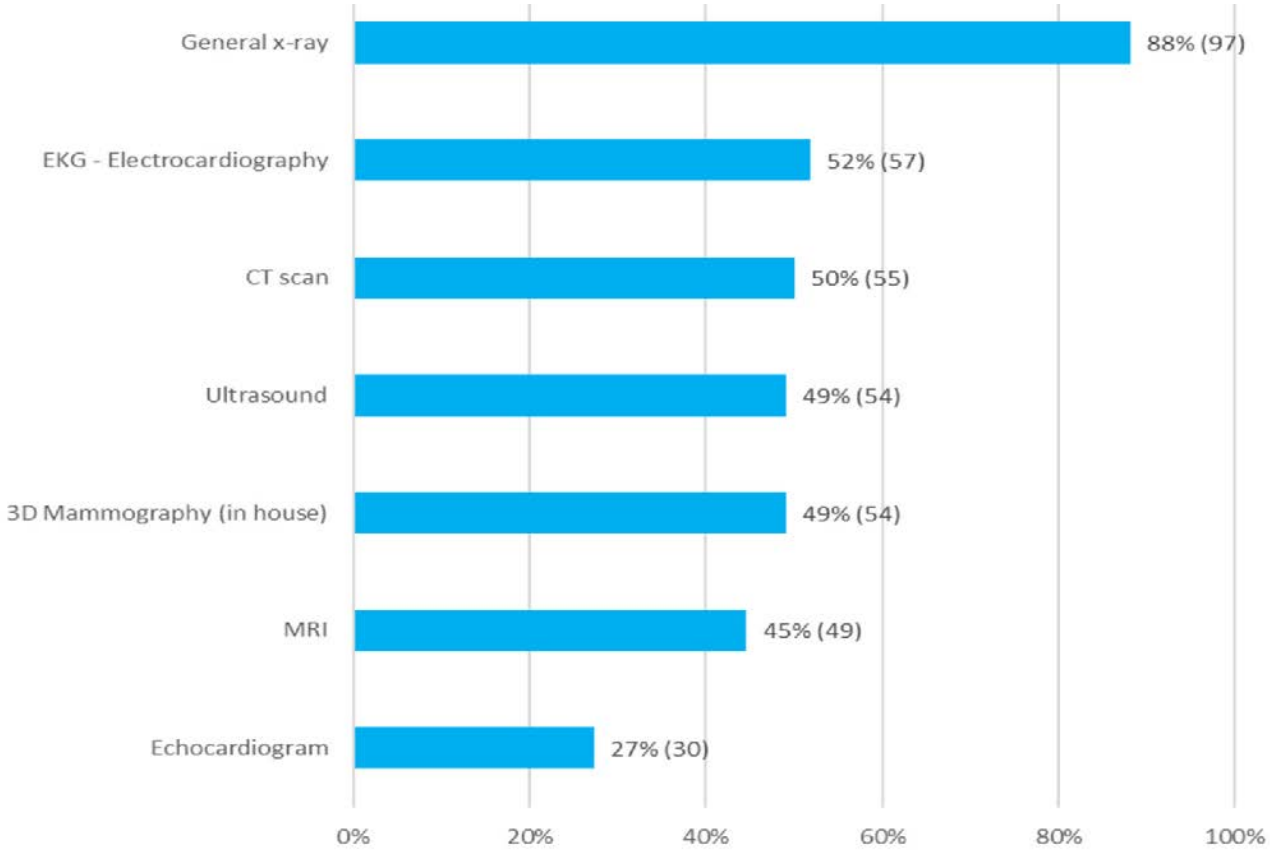


Figure 29: Awareness and Utilization of Public Health Services N=277

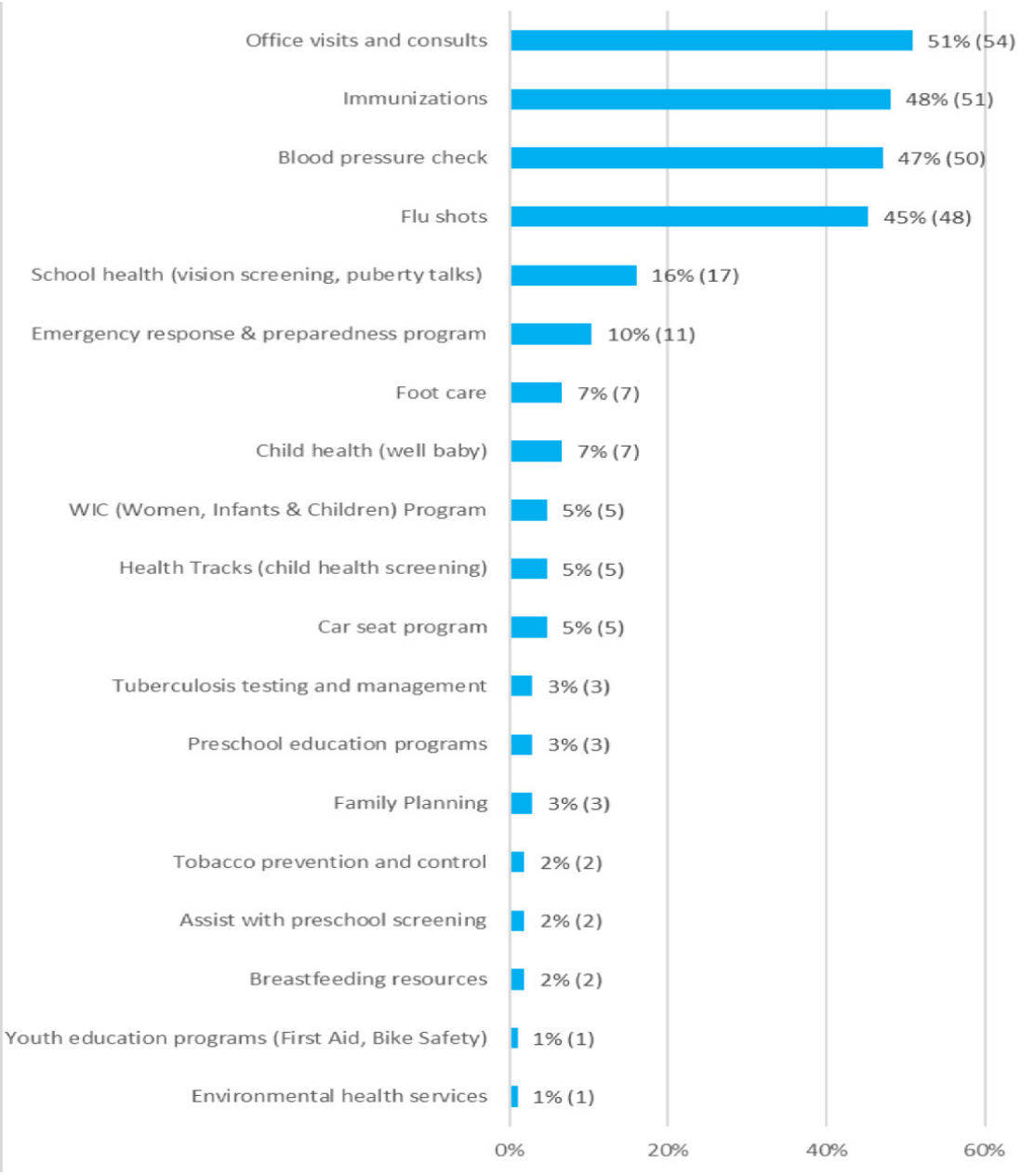
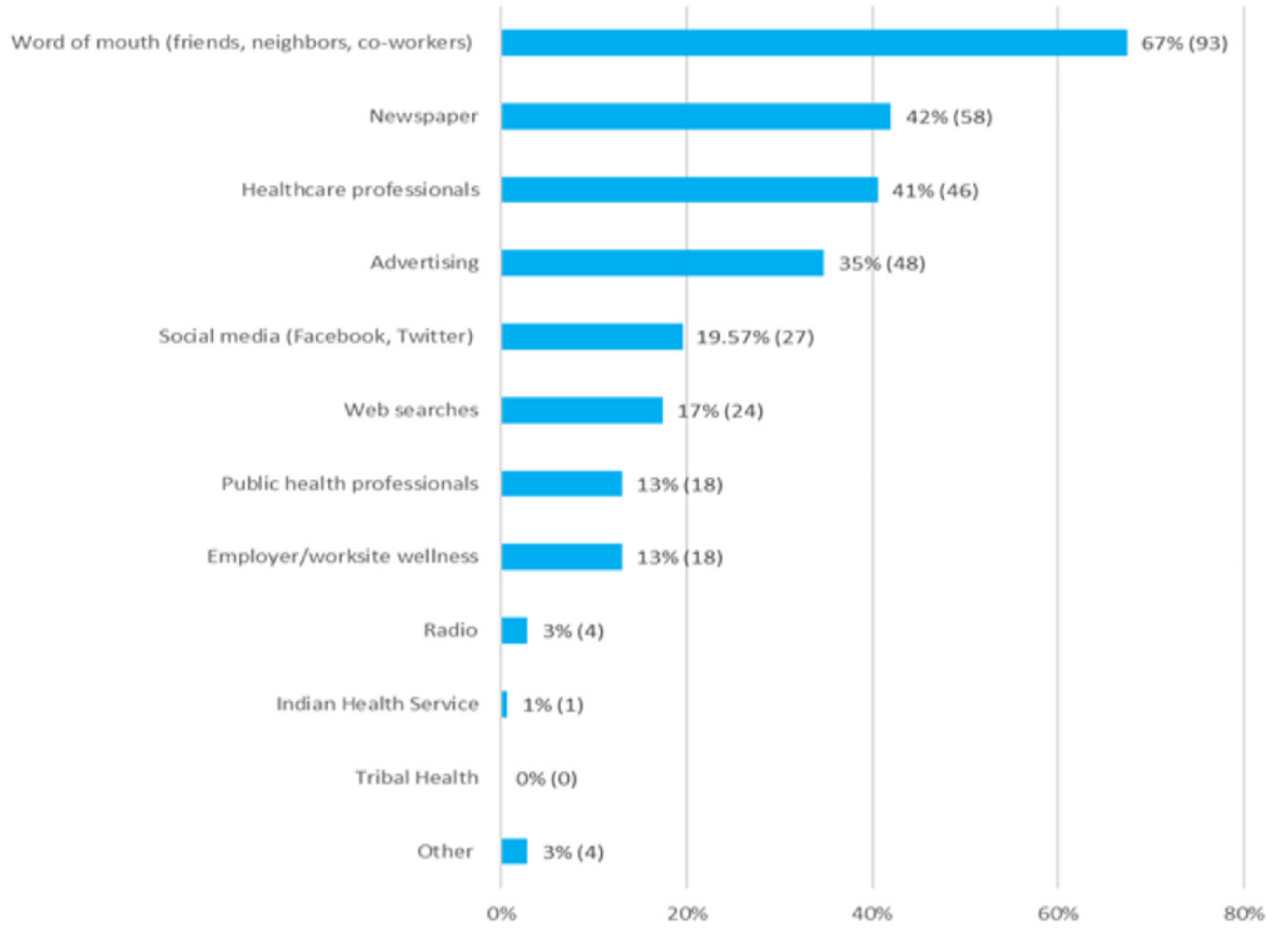


Figure 30: Where Do You Find Out About Local Health Services in Your Area? Total responses = 351



In the "Other" category, several respondents commented, from co-workers or they have lived in the area their entire life.

Figure 31: Do You Work for the Hospital, Clinic or Public Health Unit? Total responses = 135

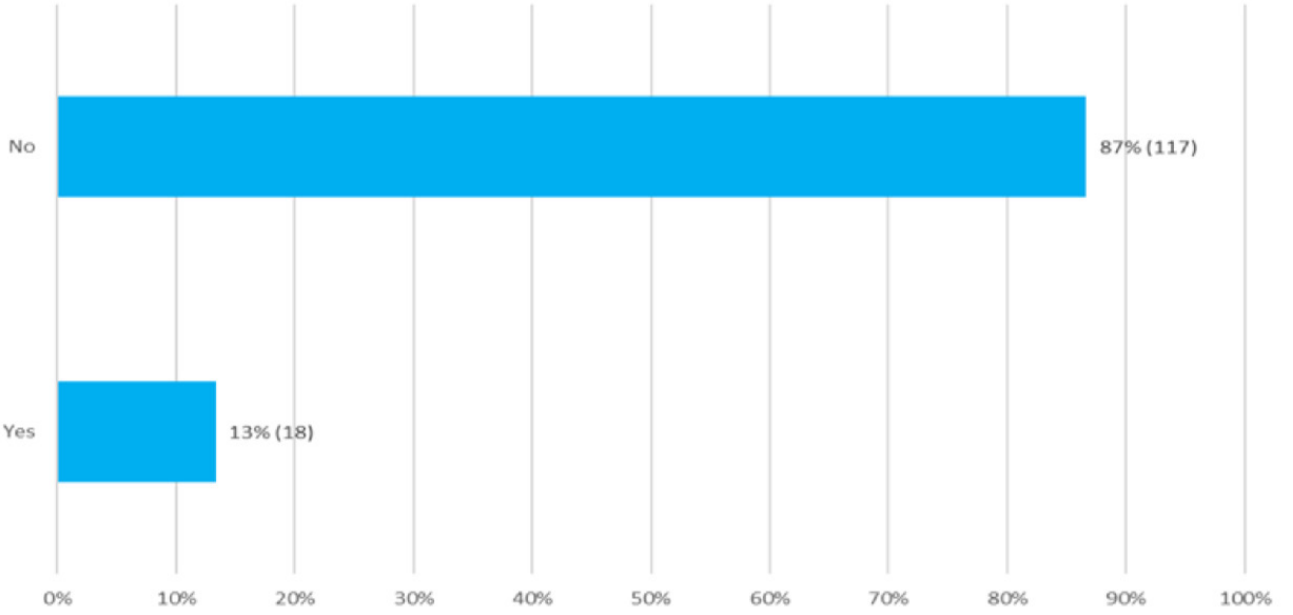


Figure 32. When asked what they would like to see included in the new Mountrail Bethel Home during the Phase Three building project. Total responses = 144

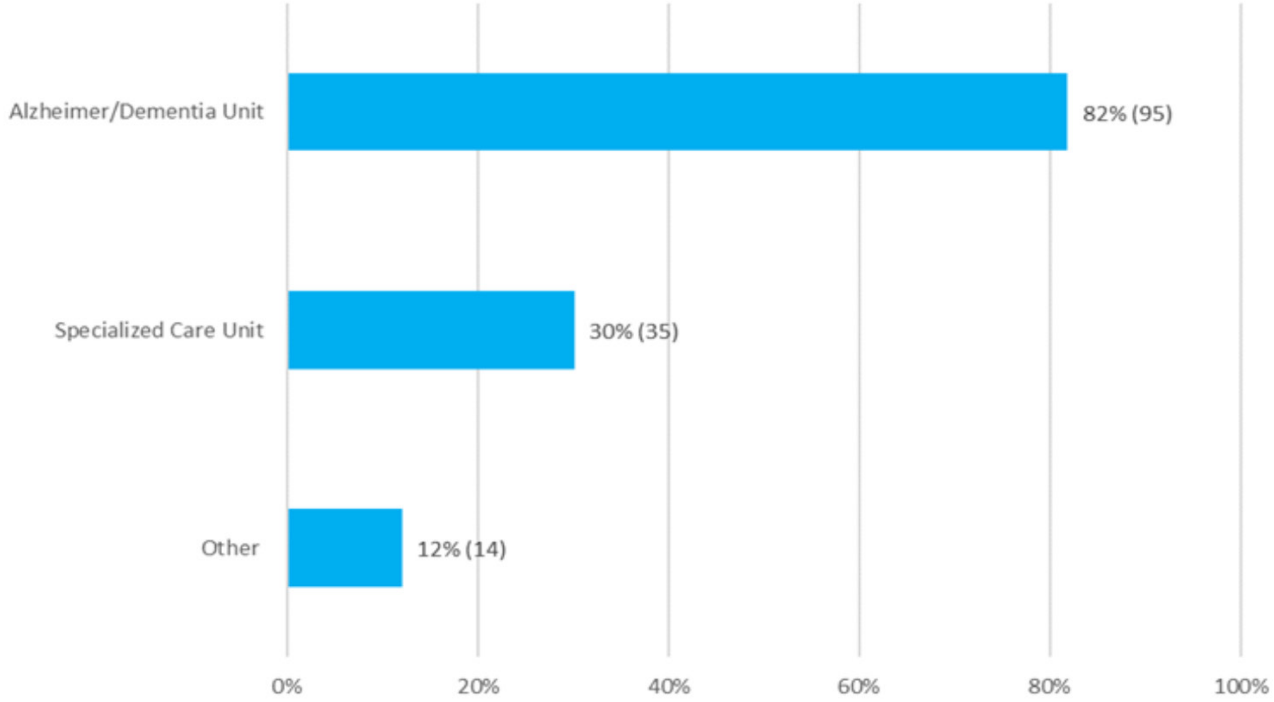


Figure 33. When asked if the respondent would be willing to support the MCH Foundation efforts to raise funds for the Mountrail Bethel Home portion of Phase Three? Total responses = 116

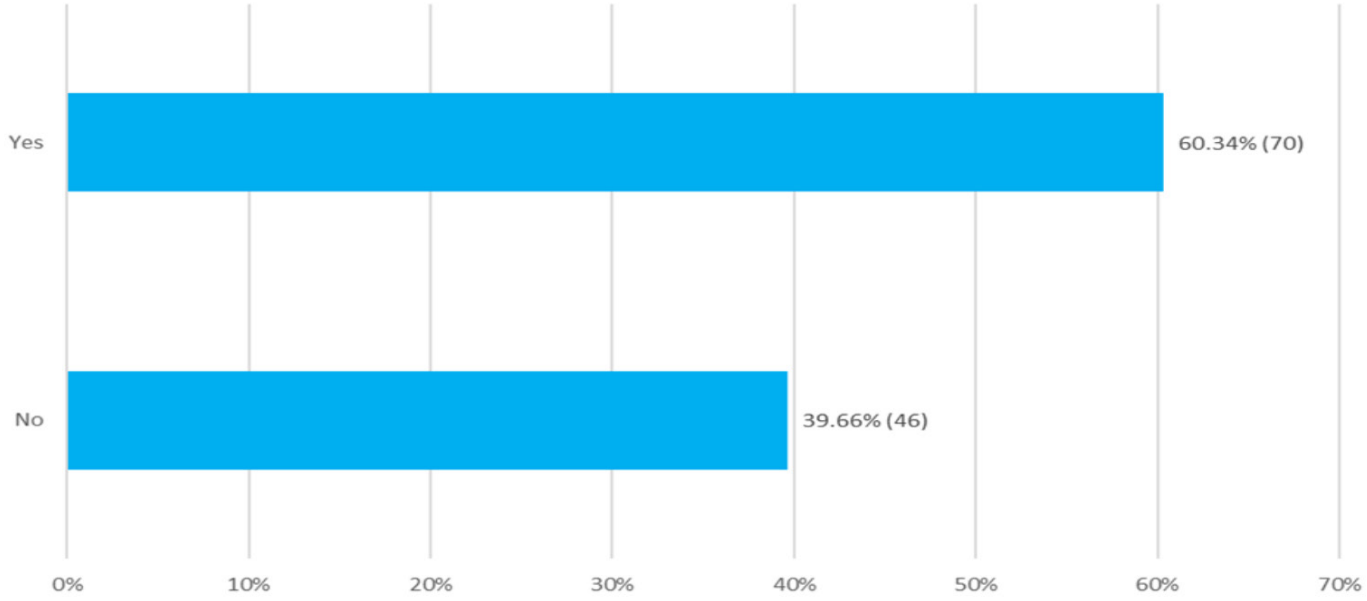


Figure 34: Survey-Awareness of the Mountrail County Health Foundation which exists to financially support Mountrail County Medical Center N=141

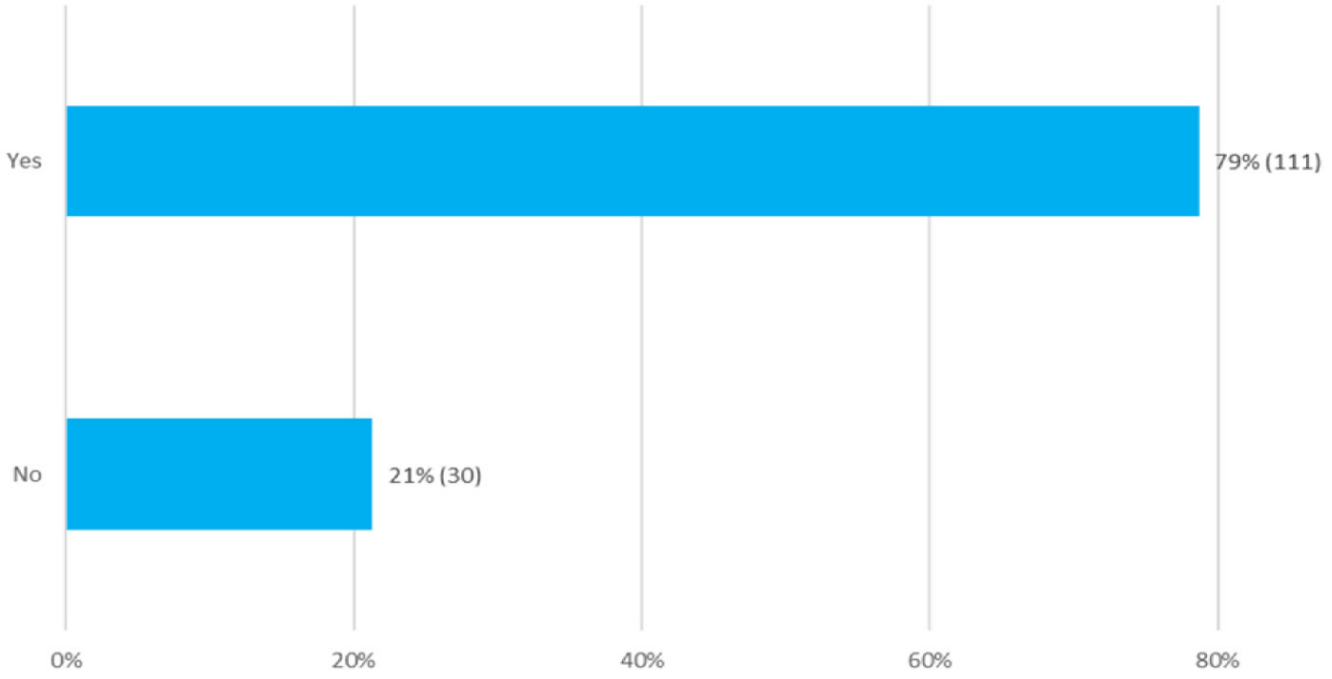
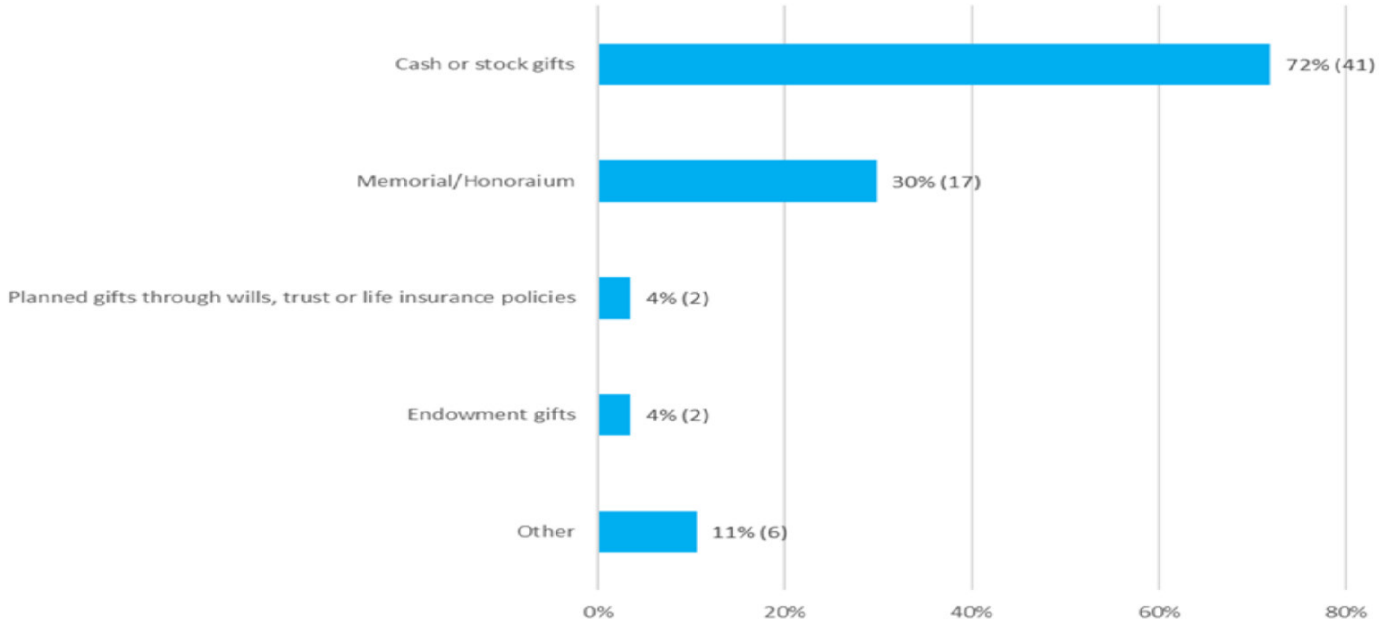


Figure 35.Have you supported the MCH Foundation in any of the following ways? (checked all applicable) N=68



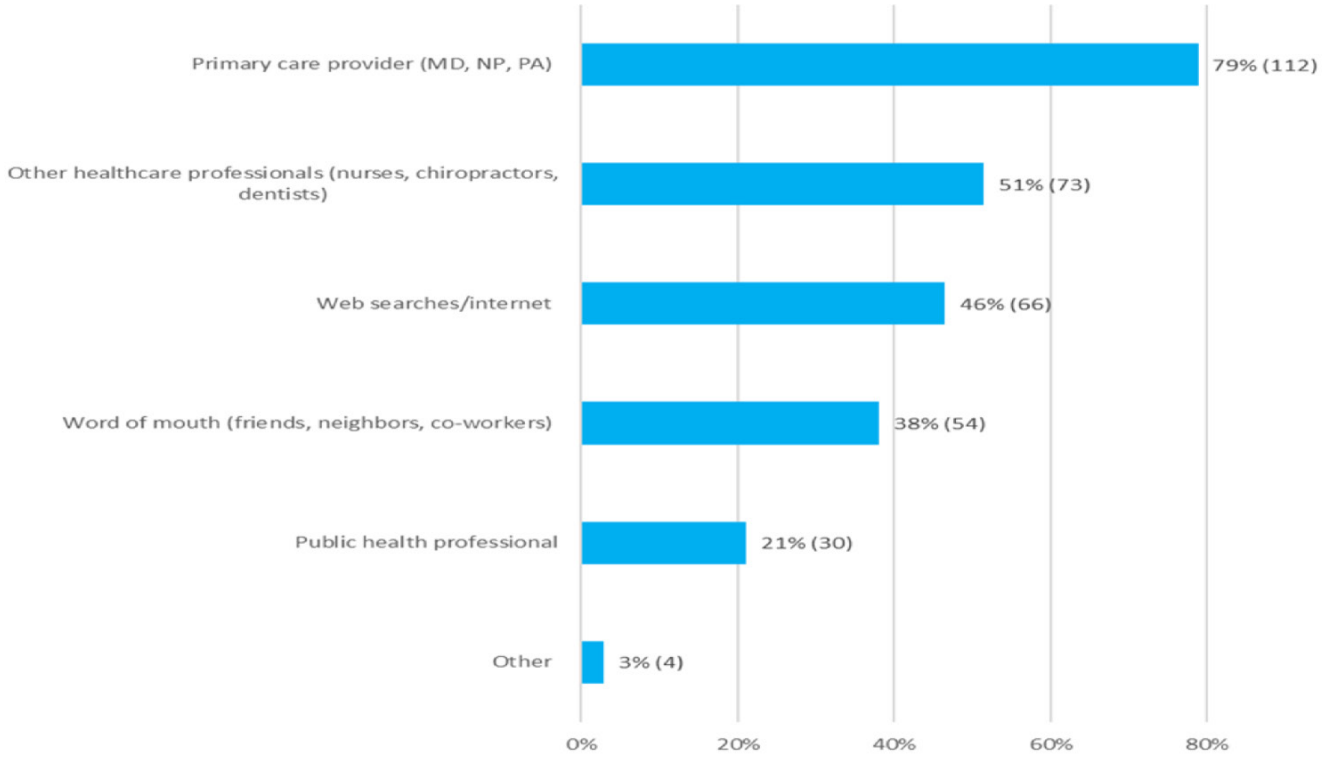
Other comments were;

- Donations
- Health fair
- No, don't have the extra money to donate. Where does all the money locally go from oil and gas development.
- Did not know
- Fundraising donations

Respondents were asked where they go to for trusted health information. Primary care providers (N=72) received the highest response rate, followed by other healthcare professionals (N=57), and then word of mouth (N=37).

Results are shown in Figure 36.

Figure 36: Sources of Trusted Health Information
Total responses = 339



In the "Other" category were;

- Mayo - direct
- We do all of our healthcare in Minot due to lack of confidentiality issues in Stanley.
- Non-traditional health specialists such as nutritionists, naturopaths, etc.
- Wife

Findings from Key Informant Interviews & the Community Meeting

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

The key informant identified the following items as the highest concerns:

Community/Environmental Health Concerns=

- Not enough affordable housing
- Physical violence, domestic violence, sexual abuse
- Having enough child daycare services
- Bullying/cyber-bullying

Availability/Delivery of Health Services Concerns

- Availability of mental health services
- Ability to retain primary care providers (MD, DO, NP, PAs) and nurses
- Cost of prescription drugs Availability of substance use disorder/treatment services
- Cost of health insurance

Adult Population Health Concerns

- Drug use and abuse (including prescription drug abuse)
- Depression/anxiety
- Suicide
- Alcohol use and abuse

Youth Population Health Concerns

- Drug use and abuse (including prescription drug abuse)
- Suicide
- Depression/anxiety
- Smoking and tobacco use, exposure to second-hand smoke

Senior Population Health Concerns

- Cost of long-term/nursing home care
- Assisted living options
- Availability of resources to help the elderly stay in their homes
- Availability of home health

When asked the most important concern, key informants answered mental health and behavioral health the most often. The following are specific comments;

- Retaining providers
- Mental health - adolescent psychiatric
- Help people be able to stay here -especially elderly (55-75 yrs.) because of higher cost of living - they are/were more community-involved as volunteers
- Community has blinders or turn a blind eye to family dynamics - kids in need - mental health services
- Hospice - people could stay home more
- Alcohol use ties into mental health, sexual, suicide
- Preventive healthcare - the earlier the problem is addressed to more successful the outcome
- Viability of rural healthcare in general.
- abuse/domestic violence
- Suicide and opioid/drug crisis - affecting all generations and more of them.
- Bullying/cyber-bullying - leads to depression, anxiety, suicide, etc. Affects all age categories.
- Mental health - we are seeing such issues at the school level - we need to figure out a solution for these poor kids and their parents - we need to help them cope
- I have a real burden for those who are addicted, mentally ill or just going through a "suicidal" phase! Need to help.
- My biggest concern is keeping the doors open at our facility we need to have an administrator who is dedicated and lives closer to the community.
- Mental and behavioral health
- Assisted Living. Resources for family and friends caring for elderly. Cost of LTC.
- Active faith community.

Generally, overarching issues that developed during the interviews and community meeting can be grouped into five categories, not listed in any particular order, to provide context for the identified needs, the following are some of the comments made by those interviewed about these issues:

Community/Environmental concerns

- The faith community could do more.
- We've taken God out of too many areas.
- Housing is over priced
- The county and city local law enforcement need to work together.
- Seems like there is an increase in crime causing an overload on the system.
- Regarding water quality there needs to be more control in the oil field.
- Air quality is caused by flaring.
- Recycling would help with litter.
- We need daycare within the school and healthcare facility
- It is difficult to find childcare.
- There is poor quality education (in south of county only)
- There is no taxi or public transportation on a daily basis
- There is an increase in incidents of physical violence/domestic violence and sexual abuse. There are families with repeated abuse issues.
- Those living in travel trailers are considered homeless.

Healthcare concerns

- We need behavioral health

- Teachers and others working hours make it hard to seek an appointment.
- We want to retain and have longevity with healthcare providers (3)
- Better communication would help retention.
- We need to be consistently recruiting and not just when someone puts in their notice.
- The nursing home is particularly short of healthcare staff.
- Mental health is non-existent. We need it for both the schools and community (city).
- There is no home hospice available in Mountrail County. People move elsewhere or die unattended.
- Healthcare costs are a major concern nationwide.
- Some people that would qualify for child healthcare insurance programs are unaware they exist.
- There are many tribal health services available, but many tribal members choose not to utilize them or follow-though with self-care.

Adult population concerns

- Alcohol use and abuse is part of the community culture.
- Alcohol use by adults in this county is off the charts. Most have DUI's, ties into domestic and physical and domestic violence. The community even does benefits for an alcohol-related death that involves alcohol.
- Drug use and abuse is an increasing problem due to the opioid epidemic.
- Drug use and abuse is a very large problem in this area.
- There needs to be coordination between providers, hospital, clinic and the county to curb the drug use and abuse.
- Second-hand smoke is tough to get away from in front of a building.
- Depression and anxiety are grossly under-served. We need better social welfare/behavior health.
- Dementia/Alzheimer's disease do not mix well in a nursing home. We need a memory care unit in the county. Most of them are cared for at home until they go to Minot or another center.
- I think the adult suicide rate has increased as a result of bullying. There is a mental health need.

Youth population concerns

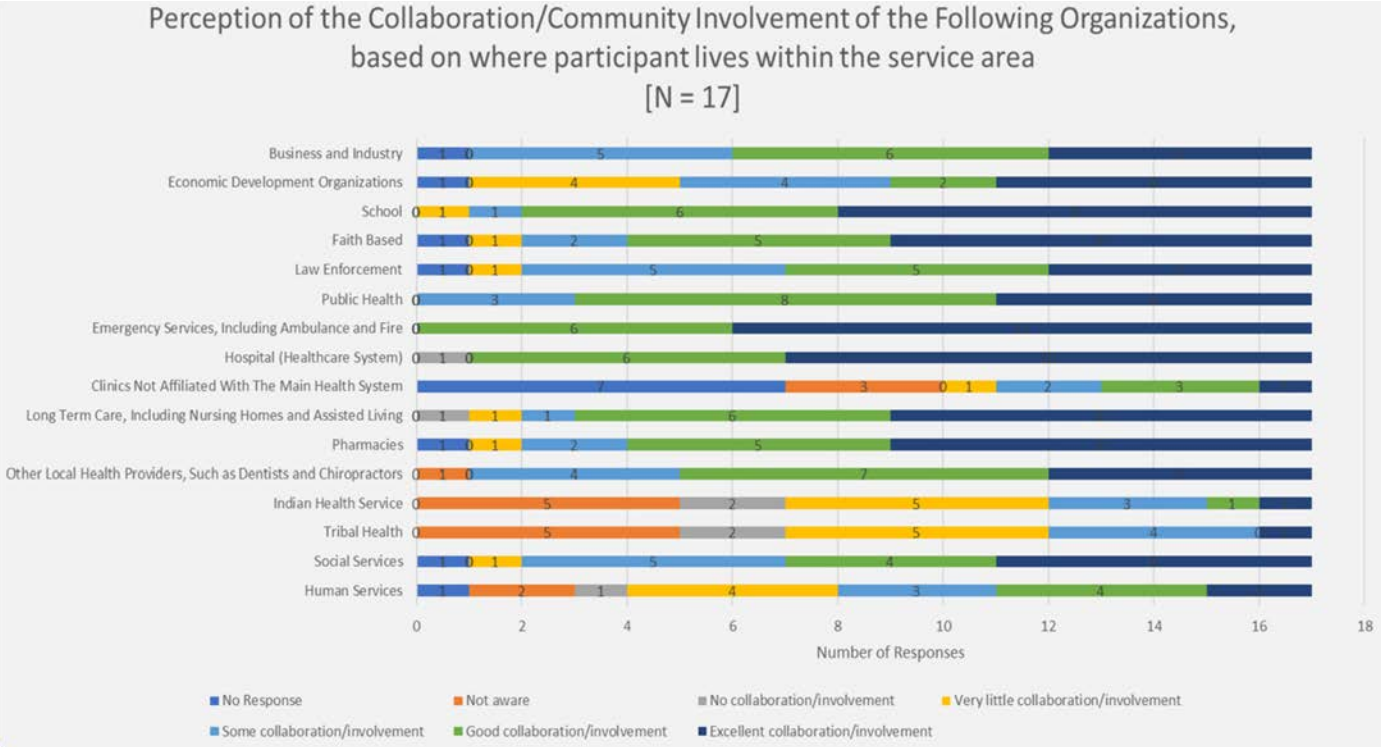
- Kids see adults using alcohol and follow suit.
- Alcohol is way too easy to get. The family backs minors using alcohol.
- Vaping is huge. (4)
- Social media can cause stress.
- A lot of kids are thinking about suicide or are showing potential issue/concern
- Concern about sexual health is that it goes hand in hand with alcohol use. Kids are starting younger and dress inappropriately-no respect, "advertising".
- More education is needed for STDs and sexual health in general.
- Lots of kids are not sure where their next meal will come from.
- There is absenteeism in school. Kids need to have a habit of responsibility of showing up-it is the same issue with adults and their jobs.
- Kids think marijuana is a natural medicine and has no side effects including depression and suicide. I know kids are hungry and there is money in the family.

Availability of resources for the elderly

- Until the assisting living complex is built, we have no options here.
- There is no respite care available.
- We have a swimming pool for arthritis.
- We need to find more activities for seniors to do.

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

Figure 37. Perception Collaboration/Community Involvement Scale of 1-5 (5 excellent)



The emergency services, including ambulance and fire scored the highest followed closely by the hospital, and the school and faith-based communities. The lowest scoring were Indian Health Services and Tribal health, which are a very small minority in the region, however it should also be mentioned these two groups also scored high in people not being aware of their presence along with human services and other local providers not affiliated with the main health system.

Priority of Health Needs

A Community Group met on November 5, 2018. Ten community members attended the meeting. Representatives from the CRH presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results, including perceived community assets and concerns, and barriers to care, and findings from the key informant interviews.

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

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

- Availability of mental health services (14 votes)
- Youth drug use and abuse (12 votes)
- Alcohol use and abuse (9 votes)
- Having enough child day care services (7 votes)

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

1. Availability of mental health services (11 votes)
2. Alcohol use and abuse in the adult population (4 votes)
3. Drug use and abuse among the youth population (1 vote)

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

Comparison of Needs Identified Previously

Top Needs Identified 2016 CHNA Process	Top Needs Identified 2019 CHNA Process
Ability to recruit and retain primary care providers (MD, DO, PA, NP)	Availability of mental health services
Adult alcohol use and abuse	Adult alcohol use and abuse
Cost of health insurance	Youth drug use and abuse (including prescription drugs)
Adequate childcare services	
Obesity/overweight	

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

A Community Health Needs Assessment (CHNA) was performed in Winter 2015/2016 in collaboration with public health to determine the most pressing health needs of western Mountrail County. In an effort to gauge overall health needs and identify health concerns of the community, a survey was distributed throughout the county between February 15, 2016 and March 7, 2016. MCMC had released the results and findings of the study about community health needs in the Stanley area.

The assessment process used a variety of methods to gather information and data about the health status and needs of the local population. The community members collectively ranked the top five health-related needs facing the community as:

1. Ability to recruit and retain primary care providers
2. Cost of health insurance
3. Adult alcohol use and abuse
4. Adequate childcare services
5. Obesity/overweight

For each of these needs, MCMC had outlined in an Implementation Plan its objectives and strategies to address the issues pertaining to the needs. The report and the Implementation Plan were approved and accepted by the MCMC Board of directors in 2016. Over the next several years, staff and community members implemented, evaluated and adjusted its strategies to obtain the best outcomes for its community.

Ability to recruit and retain primary care providers:

Background:

- Data compiled by County Health Rankings show Mountrail County is not doing as well as North Dakota as a whole regarding health outcomes. There is also room for improvement on individual factors that influence health, such as health behaviors, clinical care, social economic factors, and the physical environment. Factors which Mountrail County was performing poorly relative to the rest of the state include primary care physicians.
- Input from community leaders provided by key informant interviews echoed many of the concerns raised by the survey respondents. Thematic concerns emerging from the sessions was the concern that MCMC is currently okay, but there had been a lot of turnover.

Objective:
Work closely with the present resources to help stay in contact with resident and medical students as they get ready to graduate. This was considered the best option for bringing in another qualified physician to MCMC.

Goal:
MCMC brought in an FNP in December 2015 to join the MCMC team. However, the facility is always in the recruiting process, as the need to recruit providers is ongoing.

Strategy:

- Always have the position posted on the MCMC website under the careers tab.
- Work closely with the CRH and participate in the recruiting programs they have available. For instance, MCMC went to all four of the Provider Showcases they offered in Minot, Grand Forks, Fargo and Bismarck.

- Review the monthly 3R Network list the CRH sends out.
- Look into the J1 program as an option.
- Host a Scrubs Camp with the local high school on National Rural Health Day on November 17, 2016.
- Work with the local high school to bring in students for job shadowing at MCMC.

Measurement of Effectiveness: Staff would work together to bring in the right fit for MCMC and the provider team to ensure consistent and qualified care for the residents of Mountrail County and the surrounding area.

Updates for 2017: MCMC completed all of the strategies listed above. They hosted a second Scrubs Camp on November 16, 2017 for the local high schoolers. The Mountrail County Health Foundation also sponsored six students from grades 6, 7, and 8 to attend a three-day Scrubs Academy that is put on by the CRH in June.

Updates for 2018: MCMC completed steps one, two, three and six this year. The Scrubs Camp cannot be held in 2018 due to construction at the high school. MCMC did send eight students in grades 7 and 8 to the Scrubs Academy again this past summer. MCMC actively recruited a PA who will start in early 2019 to the replace a current PA employee that is leaving.

Adult Alcohol Use and Abuse

Background:

- On health factors, Mountrail County performed below the majority of North Dakota counties.
- Input from community leaders provided by the key informant interviews echoed many of the concerns raised by 91 of the survey respondents.
- Generally, overarching thematic issues that developed during the interviews and community meetings were that many are using alcohol to cope with depression.

Objective: work closely with local agencies such as the UMDHU and the local social services along with the MCMC ER to see how these individuals that are repetitive for alcohol issues can be assisted.

Goal
As stated above, help patients that frequently visit the ER due to alcohol abuse over the next year.

Strategy

- Compile a brochure that shows all the services that can help these patients once they leave the ER.
- Work closely with UMDHU and their addiction counselor.
- Work closely with Stanley's local AA group and even offer them a space in the clinic to meet.
- Work with the local school during their Red Ribbon Week every year. Help promote the speaker that is coming in at the end of October.
- Measurement of Effectiveness: Staff will work together to reduce the frequency of alcohol abuse visits to our own ER.

Updates for 2017: MCMC completed all of the above strategies except for the brochure. The brochure will be worked on over the upcoming year. MCMC will again be helping the school with their Red Ribbon Week which is at the end of October. MCMC also held a Mini Health Fair at the local high school in March and had the local sheriff's department and Social Services department on hand to talk to children of alcohol and drugs. Future partnerships and events with the local school, police department and social services will be done over the upcoming year.

Updates for 2018: MCMC held a Skittle Skool for their grade seven and eight students. One of the topics covered was alcohol abuse. MCMC had the addiction counselor from Mountrail County provide a presentation to the students.

Cost of Health Insurance

The cost of health insurance cannot be addressed by the MCMC Implementation Plan

MCMC is always concerned with and recognizes the importance of all the healthcare needs identified in the community. However, MCMC is unable to address the issue of the cost of health insurance, as it is beyond their scope of control. This is a nationwide issue which is being addressed by the federal and state governments. MCMC and UMDHU have minimal control over the overall cost of the health insurance premiums that are put in place by the insurance marketplace. However, MCMC vows to do its share to contain their costs of healthcare. While MCMC could not address the need, it is in their plan to steer community members to appropriate resources available to possibly meet their needs.

Adequate Childcare Services

Background

- The population of North Dakota has grown in recent years, and Mountrail County had seen a substantial increase in population since 2010; the U.S. Census Bureau estimates the county's population increased from 7,672 (2010) to 10,331 (2015).
- Input from community leaders provided by key informant interviews echoed many of the concerns raised by 83 survey respondents.

Objective
After Phase Three expansion of the nursing home is complete, MCMC will evaluate their facility and see if there is an area to be remodeled into an on-site daycare for MCMC employees. This will not only fill a huge need in the community but be a recruiting tool.

Goal
MCMC aims to have this CHNA need addressed within the year of 2018.

Strategy

- Determine if there is space available for an on-site daycare.
- Write a plan on how this on-site daycare can be accessible to employees'' children as an employee benefit.
- Explore grant options and opportunities that could help fund the daycare.

Measurement of Effectiveness
To be able to accommodate the growing need for affordable daycare for MCMC employees; one of the largest employers in the MCMC service area.

Updates for 2017: Nothing was able to be done with this in 2017.

Updates for 2018: Nothing was able to be done with this over the past year. MCMC is currently working on building the Assisted Living portion of the Phase Three and will how the expansion proceeds once completed.

Obesity and Overweight

Background

- Data compiled by the County Health Rankings show Mountrail County is doing as well as North Dakota as a whole in regard to health outcomes. There is also room for improvement on individual facts that influence health, such as health behaviors, clinical care, social economic factors, and the physical environment.
- Input from community leaders provided by key informant interviews echoed many of the concerns raised by 150 survey respondents. Some of their concerns regarding community health concerns were:

adequate school resources, adequate youth activities, physical inactivity, and access to exercise and wellness activities.

Objective
Work with area businesses, the schools and community services to provide ways for getting healthy meals, more activities and more informational resources to the community.

Goal
Work would begin immediately.

Strategy

- Meet with the school and the local grocery store to start a backpack buddies program in Stanley.
- Have staff and providers talk to the schoolchildren about how important healthy eating and activity are.
- Focus this year's Health Fair, which will be held in the fall of 2016, on fitness and eating well. The theme will be "Don't Just Sit, Get Fit" and a Fitbit Blaze will be given away to an attendee.
- Work with the local Social Services to see how to get information to families on how to eat healthy on a budget and physical activities in which they could take part.
- Work with the park board to start activities enabling children to follow our health fair motto.
- Create a brochure which tells the community about the activities being implemented and inform them of free apps they can put on their phone to track fitness such as; MyFitnessPal.

Measurements of Effectiveness
Seeing some of the above strategies get started which get children and adults alike moving and having fun doing it. MCMC intents to create lifelong habits of eating healthy and exercising regularly.

Updates for 2017: MCMC spent a lot of their energy focusing on this community health need. As stated in their strategy, the 2016 Health Fair focus was on fitness and healthy eating. MCMC also incorporated a food program for the elementary children, partnered with the school and park board for a summer challenge and held lunch and learns on healthy eating habits.

- MCMC held a Lunch and Learn in March on the topic of Healthy Eating in honor of National Nutrition Month.
- MCMC had a table at the Mini Health Fair that was held at the high school with the topic focusing on National Nutrition Month. Handouts were given to all students in grades seven through twelve on healthy eating habits and ideas on what to eat.
- MCMC partnered with the local churches, Cash Wise, the park board, and the schools on a program to help children who are not getting the nutritious food they need on a regular basis. The Stanley Area Cares for Kids (S.A.C.K.) offered a supply of nutritious meals and snacks for children over their weekends and extended breaks, free of charge during the school year.
- In the future, at the high school, there will be an actual space where the food will be stocked, and the students may come in and shop for the food they need at a time that works for them. Any child enrolled in the Stanley School District is eligible to receive these weekly sacks of food.
- In doing research on the MCMC CHNA needs, staff and community saw a new coined term "sitting is the new smoking". MCMC would like to help combat this by starting a pilot program to see if having the option of standing a few hours a day, while at work, improves your health. MCMC will partner with the Stanley Public Schools and the Mountrail County Courthouse staff and implement five Flexi spot Sit-Stand Desktop workstations at each location. MCMC received a Blue Cross Caring Foundation grant for the sitting/standing desks.

- MCMC promotions stated the below statement for the Summer Challenge:

One of the CHNA top five concerns for Mountrail County is overweight and obesity. To address this issue, the Mountrail County Health Foundation has teamed up with the Stanley Red-Stanley Park District and the Stanley Public Schools to issue a challenge to Mountrail County:

Get OFF the Couch and GO Summer Challenge!!!

- A punch card was created with 25 different events throughout the summer. All Stanley Public School system children received the punch card and rules during the last week of school. Additional punch cards and rules were available all summer at Town and Country Credit Union, BNC Bank, American Bank Center and the T.H. Reiarson Rural Health Clinic. The rules were for each event a child completes on the punch cared, they will receive a stamp. Whoever has the most stamps on their punch card wins a YETI 35 TUNDRA COOLER sponsored by the Mountrail County Health Foundation. In case of a tie, a drawing would be held for the cooler. Consolation prizes were Scheel's gift cards, sponsored by Scheel's.

Updates for 2018:

- The SACK program is now in both the elementary and high school and is being well received. MCMC is feeding 50 elementary school children and the pantry at the high school is being used more and more each week by the students.
- MCMC again did the Get OFF the Couch and GO Summer Challenge. The winner received a family weekend getaway in the North Dakota town of their choice.
- MCMC held a Skittle Skool for students in grades seven through twelve and one of the topics covered was healthy eating and effects of sugar on the brain. MCMC had a Naturopath from Bismarck as one of the presenters.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

- Free and discounted care to those unable to afford healthcare.

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – CHNA Survey Instrument

Stanley Area Health Survey

Mountrail County Medical Center, and Upper Missouri District Health Unit are interested in hearing from you about community health concerns.

The focus of this effort is to:

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

If you prefer, you may take the survey online at http://tinyurl.com/Stanley18 or by scanning on the QR Code at the right.

Scan here to take the survey!

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

Surveys will be accepted through October 19, 2018. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

- ☐ Activities for families and youth
- ☐ Arts and cultural activities
- ☐ Local events and festivals
- ☐ Recreational and sports activities
- ☐ Year-round access to fitness opportunities
- ☐ Other (please specify) _____

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

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

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

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

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

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

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

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

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

9. Considering **GENERAL and ACUTE SERVICES** at **Mountrail County Medical Center**, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ Clinic
- ☐ Emergency room
- ☐ Hospital (acute care)
- ☐ Mental health services
- ☐ Hearing (visiting specialist)
- ☐ Orthopedic (visiting specialist)
- ☐ Podiatry (foot/ankle) (visiting specialist)
- ☐ Surgical services (Scopes)
- ☐ Swing bed and respite care services
- ☐ Telemedicine via eEmergency

10. Considering **SCREENING/THERAPY SERVICES** at **Mountrail County Medical Center**, which services are you aware of (or have you used in the past year? (Choose ALL that apply)

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

11. Considering **RADIOLOGY SERVICES** at **Mountrail County Medical Center**, which services are you aware of (or have you used in the past year)? (Choose ALL that apply)

- ☐ EKG—Electrocardiography
- ☐ CT scan
- ☐ Echocardiogram
- ☐ General x-ray
- ☐ 3D Mammography (In House)
- ☐ MRI
- ☐ Ultrasound

12. Which of the following **SERVICES** provided by your local **PUBLIC HEALTH** unit have you or a family member used in the past year? (Choose ALL that apply)

- ☐ Blood pressure check
- ☐ Breastfeeding resources
- ☐ Car seat program
- ☐ Emergency response & preparedness program
- ☐ Family Planning
- ☐ Flu shots
- ☐ Foot Care
- ☐ Environmental health services (water, sewer, health hazard abatement)
- ☐ Immunizations
- ☐ Office visits and consults
- ☐ School health (puberty talks, school immunizations)
- ☐ Preschool education programs
- ☐ Tobacco prevention and control
- ☐ Tuberculosis testing and management
- ☐ WIC (Women, Infants & Children) Program
- ☐ Youth education programs (First Aid, Bike Safety)

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

- ☐ Advertising
- ☐ Employer/worksite wellness
- ☐ Health care professionals
- ☐ Indian Health Service
- ☐ Newspaper
- ☐ Public health professionals
- ☐ Radio
- ☐ Social media (Facebook, Twitter, etc.)
- ☐ Tribal Health Web searches
- ☐ Word of mouth, from others (friends, neighbors, co-workers, etc.)
- ☐ Other: (please specify) _____

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

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

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

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

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

_____

_____

17. Are you aware of the Mountrail County Health Foundation, which exists to financially support Mountrail County Medical Center?

- ☐ Yes
- ☐ No

18. In regards to the Phase Three building project occurring on the Mountrail County Health Center Campus, what would you like to see included in the new Mountrail Bethel Home:

- ☐ Alzheimer/Dementia Unit
- ☐ Specialized Care Unit
- ☐ Other (please specify):_____

19. 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): _____

25. Regarding various forms of **VIOLENCE** in the Stanley Area, concerns are (choose up to THREE):

- ☐ Bullying/cyber-bullying
- ☐ Violence against children
- ☐ Dating violence
- ☐ Domestic/intimate partner violence
- ☐ Intimidation
- ☐ Isolation
- ☐ Emotional abuse (ex. intimidation, isolation, verbal threats, withholding of funds)
- ☐ General violence against women
- ☐ General violence against men
- ☐ Physical abuse
- ☐ Stalking
- ☐ Sexual abuse/assault
- ☐ Verbal threats
- ☐ Video game/media violence
- ☐ Work place/co-worker violence

26. Regarding impacts from **OIL DEVELOPMENT** in the Stanley Area, concerns are (choose up to THREE):

- ☐ 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) _____

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

_____

_____

28. Are you aware of the Mountrail County Health Foundation, which exists to financially support Mountrail County Medical Center?

☐ Yes ☐ No

29. In regards to the Phase Three building project occurring on the Mountrail County Health Center Campus, what would you like to see included in the new Mountrail Bethel Home:

- ☐ Alzheimer/Dementia Unit
- ☐ Specialized Care Unit
- ☐ Other (Please specify:_____

30. 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) _____

31. Would you be willing to support the Mountrail County Health Foundation's effort for raising funds for Mountrail Bethel Home portion of Phase Three?

☐ Yes ☐ No

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

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

34. Age:

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

35. Highest level of education:

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

36. Gender:

☐ Female ☐ Male ☐ Transgender

37. Employment status:

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

38. Your zip code: _____

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

☐ American Indian
☐ African American
☐ Asian
☐ Hispanic/Latino
☐ Pacific Islander
☐ White/Caucasian
☐ Other: _____
☐ Prefer not to answer

40. Annual household income before taxes:

☐ Less than $15,000
☐ $15,000 to $24,999
☐ $25,000 to $49,999
☐ $50,000 to $74,999
☐ $75,000 to $99,999
☐ $100,000 to $149,999
☐ $150,000 and over
☐ Prefer not to answer

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

_____

_____

Thank you for assisting us with this important survey!

Appendix B – County Health Rankings Explained

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

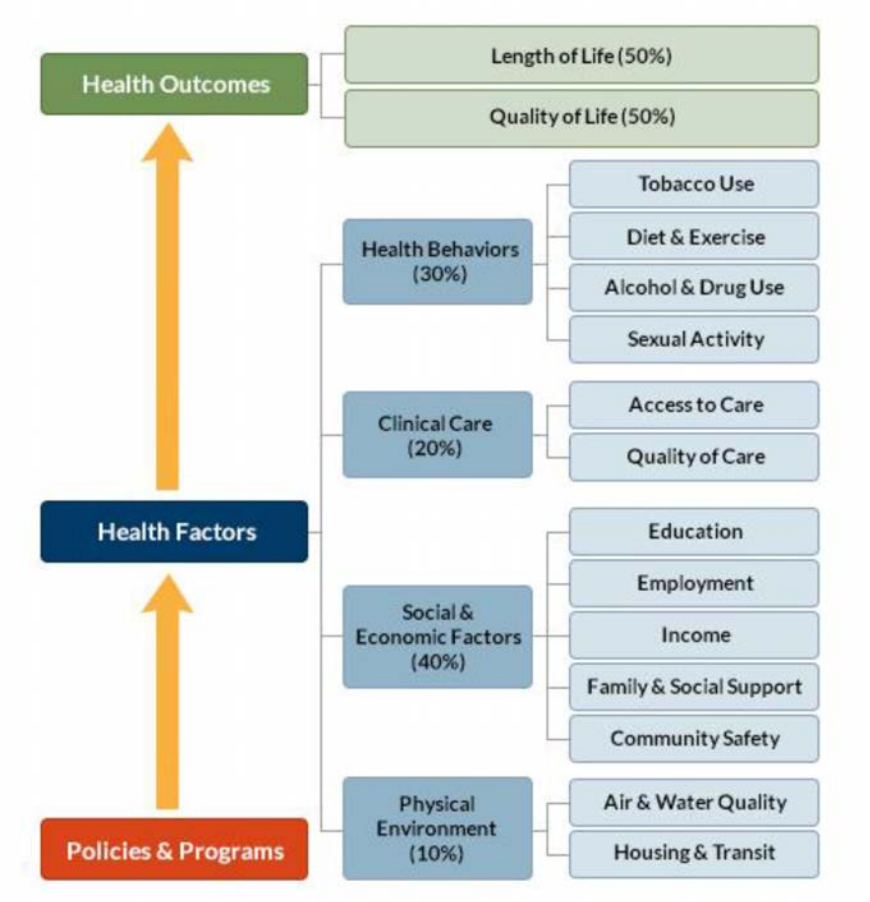
Methods

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

What is Ranked

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

Ranking System



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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

- household is severely cost burdened.

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

Reason for Ranking

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

Appendix C – Prioritization of Community's Health Needs

Community Health Needs Assessment

Stanley, North Dakota

Ranking of Concerns

The top four concerns for each of the six topic areas, based on the community survey results were listed on flipcharts. In the first round of ranking at the second community meeting, each person in attendance they were asked to place four small dots. The "Priorities column lists the number of small dots placed. In the second round of ranking, each person in attendance at the meeting was given one large dot to place on one of the four highest ranking concerns from the first round. The "Most important column lists the number of large dots placed on the flip chart which prioritized the final three concerns.

	Priorities	Most Important
Community/Environmental Health Concerns		
Having enough child daycare services	7	
Not enough affordable housing	2	
Attracting and retaining young families	2	
Not having enough quality resources for the schools		
	1	
Availability/Delivery of Health Services Concerns		
Extra hours for appointments i.e. evenings and weekends		
Ability to retain primary care providers (MN, Do, NP, PA) and nurses	5	
Availability of mental health services	14	11
Availability of specialists	1	
Adult Population Health Concerns		
Alcohol use and abuse	9	4
Drug use and abuse (including prescriptions)	3	
Depression/anxiety	1	
Stress		
Youth Population Health Concerns		
Drug use and abuse (including prescriptions	12	1
Alcohol use and abuse	4	
Depression/anxiety	4	
Sexual health	3	
Senior Population Health Concerns		
Assisted Living options		
Cost of long-term/nursing home care		
Availability of home health		
Long-term/nursing home options		
Violence Concerns		
Bullying/Cyber-bullying		
Emotional abuse (Isolation, verbal threats ,with-holding of funds)		
Child abuse/neglect		
Domestic/Intimate partner violence		

Appendix D – Survey "Other" Responses

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

1. Considering the COMMUNITY /ENVIRONMENTAL HEALTH in your community, concerns are: "Other" responses:

- Concern about our church leaders distrusting and disliking one another.
- Limited places to eat, nothing healthy to eat that's also quick
- Not enough restaurants
- Suicide awareness/help
- Doubled up isn't homeless
- Drugs
- Law enforcement that acts on problems in the area
- Resistance to diversity
- The same people volunteer for everything while so many sit back & don't get involved
- Very 'clicky' town- difficult to fit in a group and not inviting at events for new people

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

- The clinic doesn't do vaccinations and insurance covers the clinic but not the county health place that does the immunizations
- Billing department needs qualified individuals
- Billing, walk in clinic is convenience and not charged for ER
- Do not get results or bills timely from local clinic
- Lack of mental health
- Not knowledgeable
- Out of network

3. When asked what prevents them (including other community residents) from receiving healthcare "other" responses were:

- I'm a pretty healthy person so I don't need it.
- The clinic doesn't do vaccinations and insurance covers the clinic but not the county health place that does the immunizations
- Billing department needs qualified individuals
- Billing, walk in clinic is convenience and not charged for ER
- Do not get results or bills timely from local clinic
- Lack of mental health
- Not knowledgeable
- Out of network

4. When asked "What specific healthcare services, if any, do you think should be added locally?" responses were:

- A 24 CARE 7 days a week
- Addiction education and treatment, mental health
- Allow more people in the home to fill it (nursing home)
- Colonoscopies (2)

- Dentist (2)
- Dermatology
- Doctor home visits
- Hospice
- Immunizations at the clinic
- Mental Health Therapists/mental health/telehealth/mental health for young people (4)/mental health awareness
- Behavioral health
- Parenting classes, support groups
- Methadone clinic
- Nutrition type classes
- Not enough business locally to have specialists in Stanley.
- Outpatient therapy (infusions, dressing changes, etc.), memory care unit
- Pediatrician(2)
- Primary Care Doctors
- Vaccinations for students in the clinic (so its covered by insurance)
- Visiting general surgery providers
- Bone and joint doctor coming maybe once a week?
- Increase preventative medicine services
- Another /New doctors(2)

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

- Replace present Administrator with someone how cares about the local hospital & nursing home.
- Access to specialty healthcare needs more than once a month as it is hard to get appointments, so people go out of town. Diabetes specialist for both type 1 and type 2 for our community as these are not treated all the same way as some medical professionals.
- Additional MD would be great.
- Additional mental health services for teens are truly needed. Teens are turning to self-harm. They are suffering from suicidal thoughts. Mental health services or counseling services are often an hour away. For students who face economic hardship.
- Billing statements need to be more detailed and understandable to the public (less profession jargon). Please stick to one billing platform as it seems that many changes have been made over the past years. People have been billed for supposed services.
- Great facility! Great providers! Great nurses! The best thing to improve is the billing.
- Have a nurse or PA in the community.
- Honesty- No stealing and putting down the correct time spent for care.
- I do feel that we need to offer an evening clinic and also mental health services on our campus. We are missing a GREAT need for our community by not offering these services. Telehealth!!!!
- I have not had issues with the healthcare in the local area. I always received notice of mammogram scheduling two weeks after the day in Stanley, but this year had no problem with the new in-house technology.
- I really do not have any concerns. I think the quality of healthcare provided at the clinic is excellent.
- I think for our community size, we're doing a great job. I would like to see some more specialists come in one day a month that could eliminate having to drive to Minot or Bismarck for other options. A dermatologist would be a great addition.
- I would like to see providers connect a bit more deeply with their patients, and spend more time discussing patients' conditions, the patient's understanding of their treatment, and follow up with them via mailed letters or mailed forms to help keep patients.
- If I could be certain that I could receive medical care locally and know that it was held in highest confidentiality I would receive it locally.
- Lack of after-hours access to healthcare.

- Listen to our needs and keep a positive attitude towards everyone. We have to put other people before ourselves.
- MCMC doing a great job.
- Mountrail County Health Center should have started with the renovations/construction of our NURSING HOME first. It has become last on the priority list and the areas that need addressing aren't even included in the construction, and probably never will be.
- Our extreme climate, limited housing and limited social activities make it difficult to retain long term employees.
- Tough to get doctors here, with such a limited recreation and social interaction.
- We need more community Action... providing parenting support and mental health support to help grow stronger families and individuals.
- We've been very pleased with the healthcare we've received here. But it would be wonderful if the clinic could include immunizations with the well child checks, rather than referring patients to public health. Public health is not considered in network.
- Continued education knowing limits and willing to refer right away if you don't have a clue don't just guess or prescribe something get a second opinion.

6. When asked what they would like to see included in the new Mountrail Bethel Home during the Phase Three building project "other responses";

- Assisted Living
- Family Communication Center (for family far away - Skype or Facetime)
- Group clients by their impairment.
- Locked Unit
- More staff added, updated rooms for residents
- None - need to pay for and support current services
- Private rooms and showers
- What is most needed
- Additional apartments for the elderly that need limited assistance
- Assisted living
- Decent therapy room for the residents who live there- not feasible to go downstairs to the therapy room
- Dialysis center
- New Skilled Nursing Home facility
- Whatever floats your boat.

7. Regarding impacts from the Oil Development "other" responses were:

- Lack of tolerance from locals towards oil field families
- Money education for elderly people who now have oil money
- Need more police presence/enforcement during the day.
- Why are the impacts of oil development viewed only in a negative way? There is a big positive impact as well, and I wish the local community would accept the new residents and new students, rather than being so negative toward them.
- limited childcare options