Community Health Needs Assessment

Mountrail County Health Center

Stanley, North Dakota

2022

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Executive Summary

To help inform future decisions and strategic planning, Mountrail County Medical Center (MCMC) conducted a Community Health Needs Assessment (CHNA) in 2022, the previous CHNA having been conducted in 2019. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS) facilitated the assessment process, which solicited input from area community members and healthcare professionals as well as analysis of community health-related data.

To gather feedback from the community, residents of the area were given the opportunity to participate in a survey. One hundred twenty-three MCMC service area residents completed the survey. Additional information was collected through five 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.

With regard to demographics, Mountrail County's population from 2010 to 2019 increased by 27.8%. The average number of residents, younger than age 18 (27.6%) for Mountrail County, comes in 4.1 percentage points higher than the North Dakota average (23.5%). The percentage of residents, ages 65 and older, is almost 4% lower for Mountrail County (11.6%) than the North Dakota average (15.3%), and the rate of education is slightly lower for Mountrail County (92.4%) than the North Dakota average (92.5%). The median household income in Mountrail County ($72,147) is much higher than the state average for North Dakota ($63,473).

Data, compiled by County Health Rankings, show Mountrail County is doing better than North Dakota in health outcomes/factors for seven categories.

Mountrail County, according to County Health Rankings data, is performing poorly, relative to the rest of the state in 18 outcome/factor categories.

Of 106 potential community and health needs set forth in the survey, the 123 MCMC service area residents who completed the survey indicated the following 10 needs as the most important:

- Availability of mental health services
- Alcohol use and abuse – all ages
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Cost of long-term/nursing home care
- Depression/anxiety – all ages
- Drug use and abuse – youth and adult
- Having enough child daycare services
- Not enough affordable housing
- Bullying/cyberbullying

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not enough evening or weekend hours (N=27), concerns about confidentiality (N=22), and no insurance or limited insurance (N=21).

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

- Safe place to live, family-friendly
- Quality school system, active faith community
- Healthcare
- People who live here are involved in their community
- People are friendly, helpful, and supportive
- Local events and festivals, activities for families and youth

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:

- Having enough child daycare services
- Not enough affordable housing
- Attracting and retaining young families
- Alcohol use and abuse – all ages
- Depression/anxiety – all ages
- Availability of mental health services

Overview and Community Resources

With assistance from the Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences (UNDSMHS), the Mountrail County Medical Center (MCMC) completed a Community Health Needs Assessment (CHNA) of the MCMC service area. The hospital identifies its service area as Mountrail County. Many community members and stakeholders worked together on the assessment.

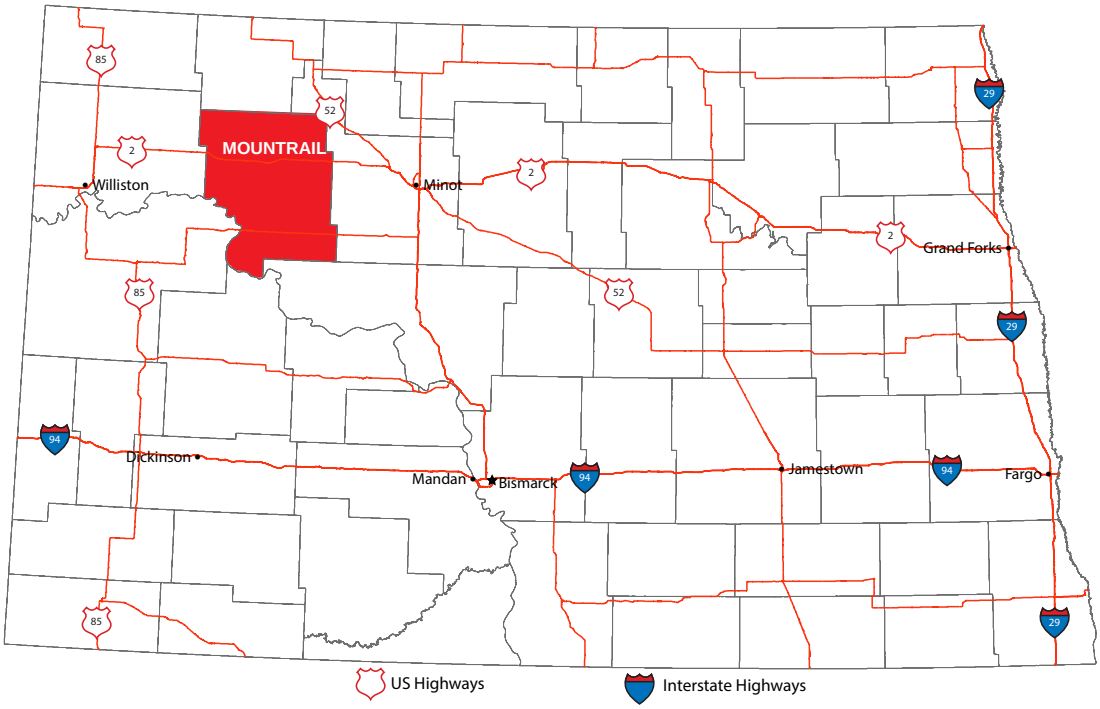
MCMC is located in Stanley, which is in northwest North Dakota, approximately 60 miles west of Minot. Stanley is the county seat of Mountrail County. The city is mainly dependent on agriculture and oil as sources of economic stability. It offers a diverse business community with services to fill all the community's 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 (K-5th) and one junior high to senior high school (6th-12th). The school boasts more than 80 qualified staff members for its 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.

Figure 1: Mountrail County



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 and the hospital under one roof. Their efforts resulted in the formation of the Mountrail County Medical Center (MCMC) and its governance structure, where the Mountrail Bethel Home, Inc. (MBH), and Trinity Medical Center shall be the sole members of the 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 (CAH), 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, two physician assistants, two doctorate of nursing practitioners and two family nurse practitioners, four physical therapists, two certified nursing assistants, and 26 nurses for a combined total of 28 health care providers. The Critical Access Hospital profile for MCMC, which includes a summary of hospital-specific information, is available in Appendix A.

Mission
MCMC will provide quality healthcare services to Mountrail County and the surrounding area, including primary medical care, emergency care, swing bed, and clinic services.

Services offered locally by MCMC include:

General and Acute Services

- Clinic
- Emergency room
- End of life care
- Hospital (acute care)
- Assisted senior living
- Pharmacy
- OB/GYN (visiting specialist)
- Podiatry (visiting specialist)
- Audiology (visiting specialist)
- Swing bed and respite care services
- Telemedicine via Avel eEmergency

Screening/Therapy Services

- Diet instruction
- Health screening
- Laboratory services
- Physical therapy
- Occupational therapy
- Social services

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)

Upper Missouri District Health Unit

Upper Missouri District Health Unit (UMDHU) provides public health services that encompass all residents ed birth to end of life, in Divide, McKenzie, Mountrail, and Williams counties. Services include environmental health, emergency preparedness, nursing services, WIC (women, infants, and children) program, prevention, 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 this community is a healthy place to live, and each person has an equal opportunity for optimal health.

UMDHU was founded and began offering sanitation and nursing services in Divide, McKenzie, and Williams counties in 1947. It was the third public health unit formed in the state. Mountrail County joined the health unit in 1949. The central office is located in Williston; satellite offices are maintained in Crosby, Stanley, and Watford City (all are county seats).

Funding for public health services comes from a variety of funding sources. Programs and services are covered by county mill dollars, state funding, federal funding, donations, and fees for services. UMDHU applies for other funding that supports the mission. Services are available to all eligible UMDHU residents, including all age groups and economic status. UMDHU uses a sliding fee scale for some services, based on financial income.

Mission
UMDHU, serving northwestern North Dakota, promotes healthy lifestyles through health education, prevention and control of disease, and the protection and enhancement of the environment.

UMDHU works to prevent illness and injury, promote healthy communities, and offer protection of the environment, keeping it clean, healthy, and safe. Quality of life is improved, and money is saved when illness and injury are prevented. Health promotion goals are to develop public policy and programs to support healthy lifestyles and to encourage the public to practice healthy lifestyles. A clean and safe environment doesn't just happen. Assisting people to identify and prevent public health risks in their community is an important public health responsibility.

Specific services that UMDHU provides are:

- Blood pressure check
- Breastfeeding resources
- Car seat program
- Emergency preparedness services – work with community partners as part of local emergency response team
- Environmental health services (water, sewer, health hazard abatement)
- Family planning
- Flu shots
- Health maintenance – foot care program
- IMMUNIZATIONS
- Nutrition education through WIC
- Office visits and consults
- School health – health education and resource to the schools (immunizations/flu shots at schools, puberty, and STD talks/presentations at schools
- Tobacco prevention and control
- Tuberculosis testing and management
- West Nile program – surveillance and education
- Women, Infants and Children (WIC) Program
- Worksite wellness

Assessment Process

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

A CHNA benefits the community by:

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

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

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

4) Engaging community members about the future of healthcare; 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 Center for Rural Health (CRH), in partnership with Mountrail County Medical Center (MCMC) and Upper Missouri District Health Unit (UMDHU), 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 CRH and MCMC. A small steering committee (see Figure 2) was formed that was responsible for planning and implementing the process locally. Representatives from CRH met and corresponded regularly by videoconference 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. Twelve people, representing a cross section demographically, attended the focus group meeting. The meeting was highly interactive with good participation. MCMC staff and board members were in attendance as well but largely played a role of listening and learning.

Figure 2: Steering Committee

Steph Everett	CEO/Foundation Director, MCMC/MCHF
Heath Hetzel	Market President, American Bank Center
Becky Fladeland	Public Health Nurse, UMDHU
Jessica Charon	Family Nurse Practitioner, MCMC
Elda Titus	Past Parish Nurse, Holy Cross/Bethel Church
Lynn Patten	Credentialing Specialist, MCMC

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

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

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

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

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

Community Group

A community group, consisting of 12 community members, was convened and first met via Zoom on November 1, 2021. During this first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again virtually on December 15, 2021, with 14 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, as well as UMDHU. They included representatives of the health community, business community, political bodies, law enforcement, education, and the faith community. Not all members of the group were present at both meetings.

Interviews

One-on-one interviews with four key informants were conducted virtually via Zoom on November 1, 2021. A representative from CRH conducted the interviews. Interviews were held with selected members of the community who could provide insights into the community's health needs. Included among the informants were public health professionals with special knowledge in public health, acquired through several years of direct experience in the community, including working with medically underserved, low income, and minority populations, as well as with populations with chronic diseases.

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

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

Survey

A survey was distributed to solicit feedback from the community and was not intended to be a scientific or statistically valid sampling of the population. It was designed to be an additional tool for collecting qualitative data from the community at large – specifically, information related to community-perceived health needs. A copy of the survey instrument is included in Appendix C, and a full listing of direct responses, provided for the questions that included "Other" as an option, are included in Appendix G.

The community member survey was distributed to various residents of Mountrail County, which is in the MCMC service area. The survey tool was designed to:

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

Specifically, the survey covered the following topics:

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

To promote awareness of the assessment process, press releases led to published articles in the local newspaper of Mountrail County. 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. The surveys were distributed by Community Group members and the following businesses: 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, the 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 gift card to Prairie Home Furnishings in Stanley for one lucky person who filled out the pop up after a person completed the online survey. UND drew the name for MCMC to ensure the anonymity.

To help ensure anonymity, included with each survey was a postage-paid return envelope to CRH. In addition, to help make the survey as widely available as possible, residents also could request a survey by calling MCMC or UMDHU. The survey period ran from November 1, 2021, to November 19, 2021. Six completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized the same as the paper surveys above. One hundred and seventeen online surveys were completed. Zero of those online respondents used the QR code to complete the survey. In total, counting both paper and online surveys, 123 community member surveys were completed, equating to a 13% response rate. 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 United States Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources (www.countyhealthrankings.org); the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives (www.childhealthdata.org/learn/NSCH); North Dakota KIDS COUNT, which is a national and state-by-state effort to track the status of children, sponsored by the Annie E. Casey Foundation (www.ndkidscount.org); and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention (https://www.cdc.gov/healthyyouth/data/yrbs/index.htm).

Social Determinants of Health

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 are also impacted by the social factors listed previously. The barriers already present in rural areas, such as limited public transportation options and fewer choices to acquire healthy food, can compound the impact of these challenges.

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

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

Figure 3: Social Determinants of Health

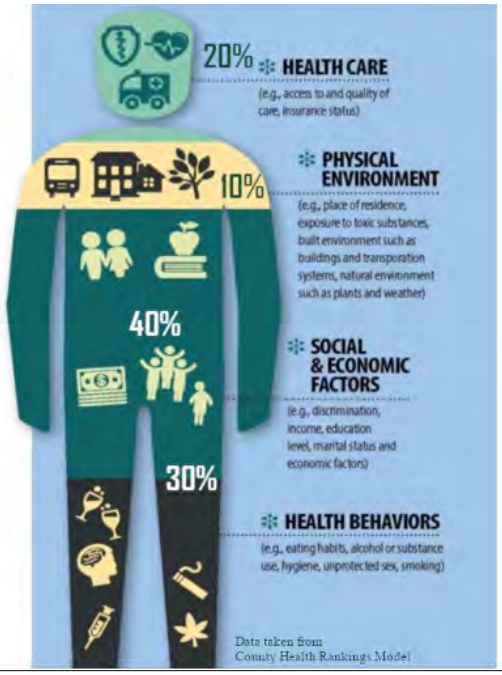
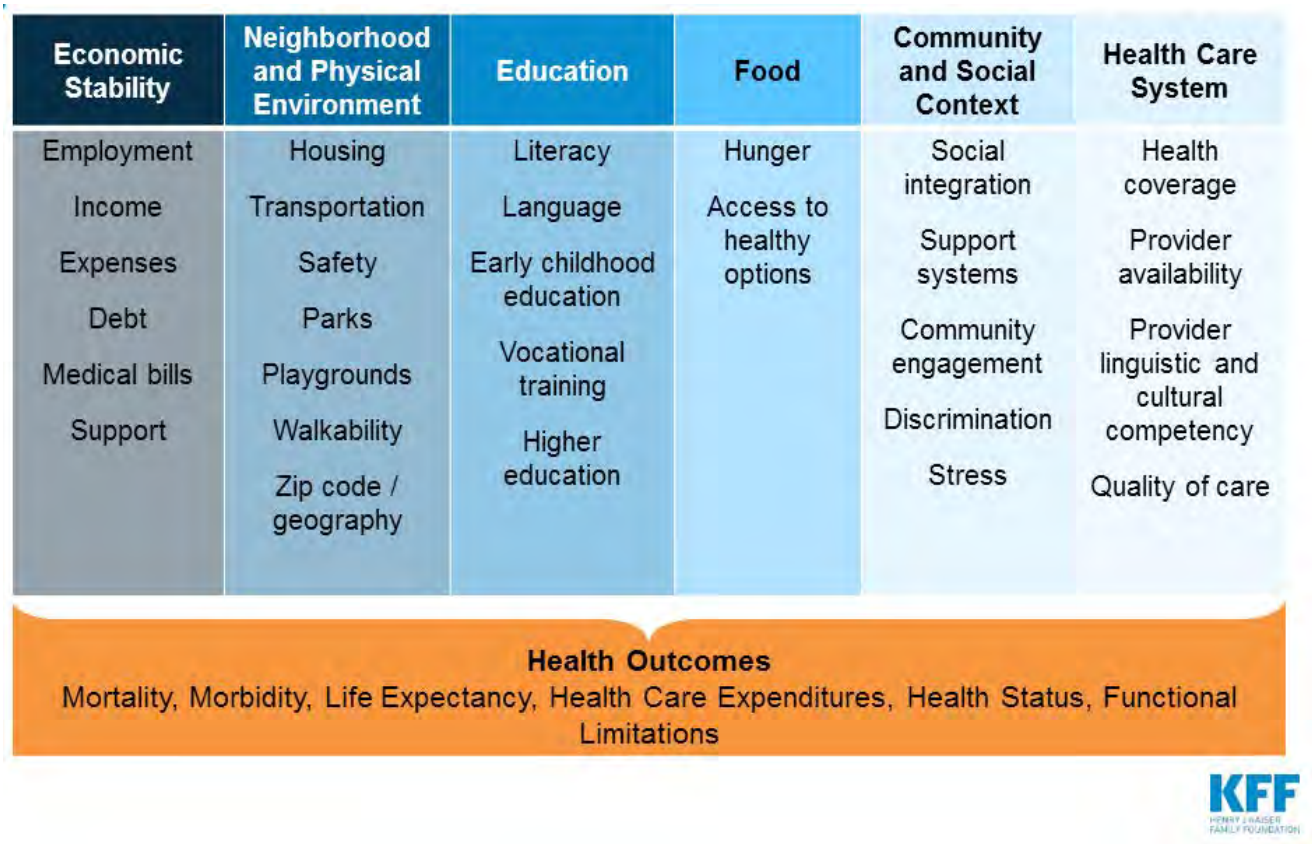


Figure 4 (Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/), provides examples of factors that are included in each of the social determinants of health categories that lead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

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

Figure 4: Social Determinants of Health



Demographic Information

Table 1: Summarizes general demographic and geographic data about Mountrail County

(From 2010 Census/2019 American Community Survey; more recent estimates used where available)

	Mountrail County	North Dakota
Population (2019)	10,545	762,062
Population change (2010-2019)	37.6%	13.3%
People per square mile (2010)	4.2	9.7
Persons 65 years or older (2019)	11.6%	15.7%
Persons under 18 years (2019)	27.6%	23.6%
Median age (2019 est.)	34.0	35.1
White persons (2019)	64.5%	86.9%
High school graduates (2019)	92.4%	92.6%
Bachelor's degree or higher (2019)	20.4%	30.0%
Live below poverty line (2019)	9.5%	10.6%
Persons without health insurance, under age 65 years (2019)	14.4%	8.1%
Households with a broadband Internet subscription (2019)	72.3%	80.7%

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

While the population of North Dakota has grown in recent years, Mountrail County has also seen an increase in population since 2010. The U.S. Census Bureau estimates show that Mountrail County's population increased from 7,673 (2010) to 10,545 (2019).

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, Stark 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 2021 County Health Rankings, are pulled from more than 20 data sources and then are compiled to create county rankings. Counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those counties, having high ranks, such as 1 or 2, are considered to be the "healthiest." Counties are ranked on both health outcomes and health factors. The following is a breakdown of the variables that influence a county's rank.

A model of the 2021 County Health Rankings – a flow chart of how a county's rank is determined – may be found in Appendix D. For further information, visit the 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. It is important to note that these statistics describe the population of a county, regardless of where county residents choose to receive their medical care. In other words, all of the following statistics are based on the health behaviors and conditions of the county's residents, not necessarily the patients and clients of UMDHU and MCMC or of any particular medical facility.

For most of the measures included in the rankings, the County Health Rankings' authors have calculated the "Top U.S. Performers" for 2021. The Top Performer number marks the point at which only 10% of counties in the nation do better, i.e., the 90th percentile or 10th percentile, depending on whether the measure is framed positively (such as high school graduation) or negatively (such as adult smoking).

Mountrail County rankings within the state are included in the summary following. For example, Mountrail County ranks 43 out of 48 ranked counties in North Dakota on health outcomes and 41st 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 square (■) indicates that the county is not meeting the U.S. Top 10% rate on that measure. Measures that are not marked with a colored shape but are marked with a plus sign (+) indicate that the county is doing better than the U.S. Top 10%.

The data from County Health Rankings show that Mountrail County is doing better in some areas, compared to the rest of the state on all but eight of the outcomes, landing at or below rates for other North Dakota counties. Mountrail County, such as many North Dakota counties, is doing poorly in many areas, when it comes to the U.S. Top 10% ratings. One particular outcome, where Mountrail County do not meet the U.S. Top 10% ratings, is the number of premature deaths.

On health factors, Mountrail County performs below the North Dakota average for counties in several areas as well.

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

- Poor mental health days
- Low birthweight
- Food environment index
- Unemployment rate

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

- Premature death
- Poor or fair health
- Poor physical health days
- Adult smoking
- Adult obesity
- Physical inactivity
- Access to exercise opportunities
- Uninsured
- Primary care physicians
- Dentists
- Excessive drinking
- Alcohol-impaired driving deaths
- Sexually transmitted diseases
- Teen birth rate
- Mammography screenings
- Flu vaccinations
- Children in poverty
- Children in single-parent households
- Social associations
- Injury deaths

TABLE 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2021 – MOUNTRAIL COUNTY

● = Not meeting North Dakota average

■ = Not meeting U.S. Top 10% Performers

+ = Meeting or exceeding U.S. Top 10% Performers

Blank values reflect unreliable or missing data

TABLE 2: SELECTED MEASURES FROM *COUNTY HEALTH RANKINGS* 2021 – MOUNTRAIL COUNTY			
	Mountrail County	**U.S. Top 10%**	**North Dakota**
Ranking: Outcomes	**43rd**		**(of 46)**
Premature death	14,100 ●■	5,400	6,600
Poor or fair health	17% ●■	14%	14%
Poor physical health days (in past 30 days)	3.6●■	3.4	3.2
Poor mental health days (in past 30 days)	3.6 +	3.8	3.8
Low birth weight	6%	6%	6%
Ranking: Factors	**41st**		**(of 46)**
Health Behaviors			
Adult smoking	22% ●■	16%	20%
Adult obesity	39% ●■	26%	34%
Food environment index (10=best)	9.6 +	8.7	8.9
Physical inactivity	30% ●■	19%	23%
Access to exercise opportunities	45% ●■	91%	74%
Excessive drinking	25% ●■	15%	24%
Alcohol-impaired driving deaths	58% ●■	11%	42%
Sexually transmitted infections	750.1 ●■	161.2	466.6
Teen birth rate	47●■	12	20
Clinical Care			
Uninsured	15% ●■	6%	8%
Primary care physicians	2,550:1●■	1,030:1	1,300:1
Dentists	2,110:1 ●■	1,210:1	1,510:1
Mental health providers		270:1	510:1
Preventable hospital stays	3,211 ■	2,565	4,037
Mammography screening (% of Medicare enrollees ages 65-74 receiving screening)	38% ●■	51%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	35% ●■	55%	50%
Social and Economic Factors			
Unemployment	1.4% +	2.6%	2.4%
Children in poverty	13% ●■	10%	11%
Income inequality	4.0 ■	3.7	4.4
Children in single-parent households	26% ●■	14%	20%
Social associations	11.7●■	18.2	16.0
Violent crime	165 ■	63	258
Injury deaths	143 ●■	59	71
Physical Environment			
Air pollution – particulate matter	4.1 +	5.2	4.7
Drinking water violations	No +		
Severe housing problems	10% ■	9%	12%

Source: http://www.countyhealthrankings.org/app/north-dakota/2021/rankings/outcomes/overall

Children's Health

The National Survey of Children's Health touches on multiple intersecting aspects of children's lives. Data are not available at the county level; listed below is information about children's health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child's family, neighborhood, and social context. Data is from 2018-19. More information about the survey may be found at www.childhealthdata.org/learn/NSCH.

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

TABLE 3: SELECTED MEASURES REGARDING CHILDREN'S HEALTH (For children ages 0-17 unless noted otherwise), 2019

Health Status	North Dakota	National
Children born premature (3 or more weeks early)	9.6%	11.2%
Children 10-17 overweight or obese	24.8%	31.4%
Children 0-5 who were ever breastfed	84.6%	80.6%
Children 6-17 who missed 11 or more days of school	3.9%	4.5%
Healthcare		
Children currently insured	93.4%	93.4%
Children who spent less than 10 minutes with the provider at a preventive medical visit	18.4%	19.0%
Children (1-17 years) who had preventive a dental visit in the past year	75.4%	79.6%
Children (3-17 years) received mental health care	12.0%	10.4%
Children (3-17 years) with problems requiring treatment did not receive mental health care	1.2%	2.3%
Young children (9-35 mos.) receiving standardized screening for developmental problems	32.6%	36.4 %
Family Life		
Children whose families eat meals together 4 or more times per week	75.5%	73.6%
Children who live in households where someone smokes	15.3%	14.4%
Neighborhood		
Children who live in neighborhoods with parks or playgrounds	81.1%	75.4%
Children living in neighborhoods with poorly kept or rundown housing	9.1%	13.3%
Children living in neighborhood that's usually or always safe	97.4%	95.0%

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

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

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

Table 4 includes selected county-level measures, regarding children's health in North Dakota. The data come from North Dakota KIDS COUNT, a national and state-by-state effort to track the status of children, sponsored

by the Annie E. Casey Foundation. KIDS COUNT data focus on the main components of children's well-being; more information about KIDS COUNT is available at www.ndkidscount.org. The measures, highlighted in blue in the table, are those in which the counties are doing worse than the state average. The year of the most recent data is noted.

The data show Mountrail County is performing more poorly than the North Dakota average in the following examined measures: percent of child food insecurity, percent of Medicaid recipients ages 0-20, and the four-year high school cohort graduation rate. The most marked difference was on the measure of Medicaid recipients (almost 3% higher rate in Mountrail County).

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

	Mountrail County	North Dakota
Child food insecurity, 2019	**10.1%**	9.6%
Medicaid recipient (% of population age 0-20), 2020	**28.9%**	26.6%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2020	1.8%	1.6%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2020	11.3%	16.9%
Licensed childcare capacity (# of children), 2020	329	36,701
4-year high school cohort graduation rate, 2019/2020	**83.6%**	89.0%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2019	8.89	9.98

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

Another means for obtaining data on the youth population is through the Youth Risk Behavior Survey (YRBS). The YRBS was developed in 1990 by the Centers for Disease Control and Prevention (CDC) to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability and social problems among youth and adults in the United States. The YRBS was designed to monitor trends, compare state health risk behaviors to national health risk behaviors and intended for use to plan and evaluate as well as improve school and community programs. North Dakota began participating in the YRBS survey in 1995. Students in grades 7-8 and 9-12 are surveyed in the spring of odd years. The survey is voluntary and completely anonymous.

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

Table 5 depicts some of the YRBS data that has been collected in 2015, 2017, and 2019. They are further broken down by rural and urban percentages. The trend column shows a "=" for statistically insignificant change (no change), "↑" for an increased trend in the data changes from 2017 to 2019, and "↓" for a decreased trend in the data changes from 2017 to 2019. The final column shows the 2019 national average percentage. For a more complete listing of the YRBS data, see Appendix E.

TABLE 5: Youth Risk Behavior Survey Results

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

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

% of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
% of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
% of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
% of students who did not eat breakfast (during the seven days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.7
% of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
% of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the seven days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9
% of students who watched television 3 or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
% of students who played video or computer games or used a computer 3 or more hours per day (for something that was not schoolwork on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
% of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
% of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
% of students who brushed their teeth on seven days (during the seven days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA

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

Low Income Needs

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

Top Needs Identified by People Experiencing Poverty Across North Dakota

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

2020 North Dakota LOW INCOME COMMUNITY NEEDS

Helping People. Changing Lives. community Action PARTNERSHIP
AMERICA'S POVERTY FIGHTING NETWORK

NDSU NORTH DAKOTA STATE UNIVERSITY

Assessed by CAPND and NDSU, November 2020

KEY FINDINGS

1st Priority Need

Rental Assistance

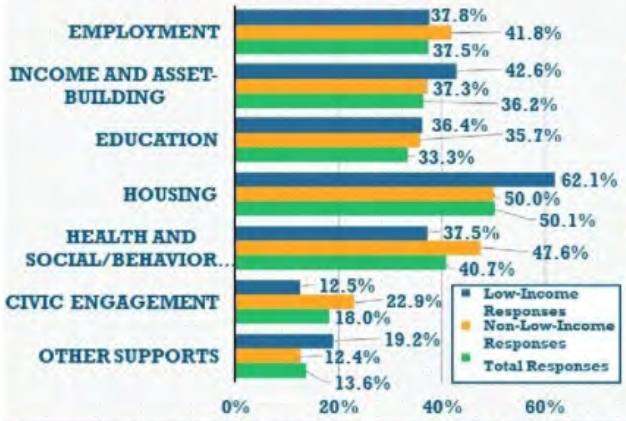
3,458 Total Survey Responses

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

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

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

STATEWIDE OVERALL NEEDS



TOP STATEWIDE SPECIFIC NEEDS

Low-Incomes

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

Non-Low-Incomes

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

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

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

TOP REGIONAL OVERALL NEEDS FOR LOW-INCOMES

1. Housing
2. Health and Social/Behavior Development
3. Income and Asset - Building

1. Housing
2. Income and Asset - Building
3. Employment

1. Housing
2. Employment
3. Health and Social/Behavior Development

1. Health and Social/Behavior Development
2. Income and Asset - Building
3. Housing

1. Housing
2. Income and Asset - Building
3. Education

1. Housing
2. Education
3. Income and Asset - Building

1. Housing
2. Health and Social/Behavior Development
3. Income and Asset - Building

1. Housing
2. Employment
3. Income and Asset - Building

ACKNOWLEDGMENTS

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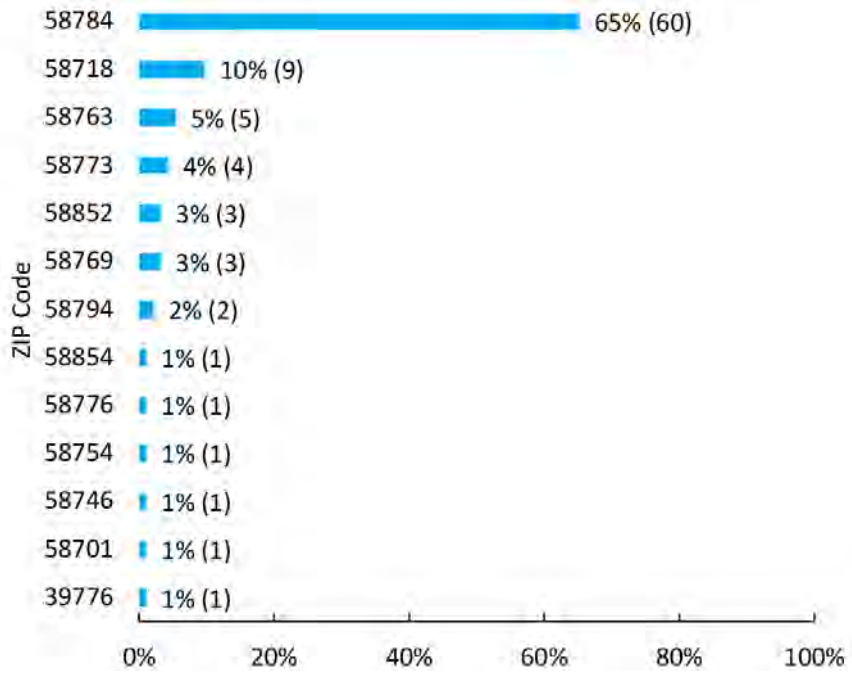
Survey Results

As noted previously, 123 community members completed the survey in communities throughout the Mountrail County Medical Center (MCMC) service area. For all questions that contained an "Other" response, all of those direct responses may be found in Appendix G. In some cases, a summary of those comments is additionally included in the report narrative. The "Total respondents" number under each heading indicates the number of people who responded to that particular question, and the "Total responses" number under the heading depicts the number of responses selected for that question (some questions allow for selection of more than one response).

The survey requested that respondents list their home zip code. While not all respondents provided a zip code, 92 did, revealing that a large majority of respondents (65%, N=60) lived in Stanley. These results are shown in Figure 5.

Figure 5: Survey Respondents' Home Zip Code
Total respondents: 92



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

Survey Demographics

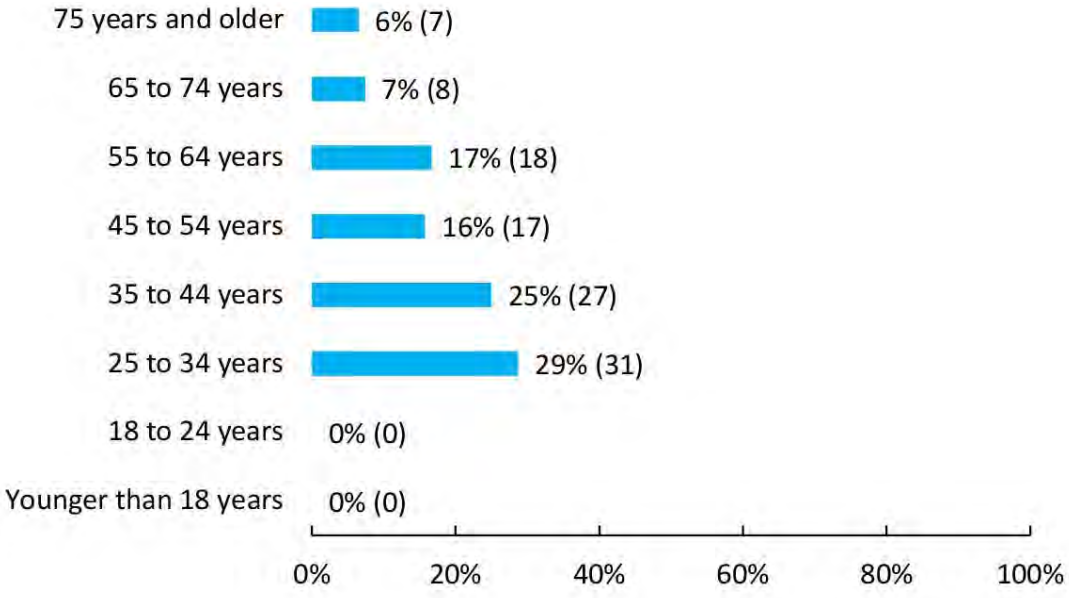
To better understand the perspectives being offered by survey respondents, survey-takers were asked a few demographic questions. Throughout this report, numbers (N) instead of just percentages (%) are reported because percentages can be misleading with smaller numbers. Survey respondents were not required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

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

- 29% (N=31) were ages 25-34
- The majority (87%, N=107) were female
- Slightly more than half of the respondents (55%, N=60) had bachelor's degrees or higher
- The number of those working full time (79%, N=85) was more than eight times higher than those who were retired (9%, N=10)
- 98% (N=105) of those who reported their ethnicity/race were White/Caucasian
- 11% of the population (N=11) had household incomes of less than $50,000

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

Figure 6: Age Demographics of Survey Respondents
Total respondents = 108



For the CHNA, people younger than age 18 are not questioned using this survey method.

Figure 7: Gender Demographics of Survey Respondents
Total respondents = 107

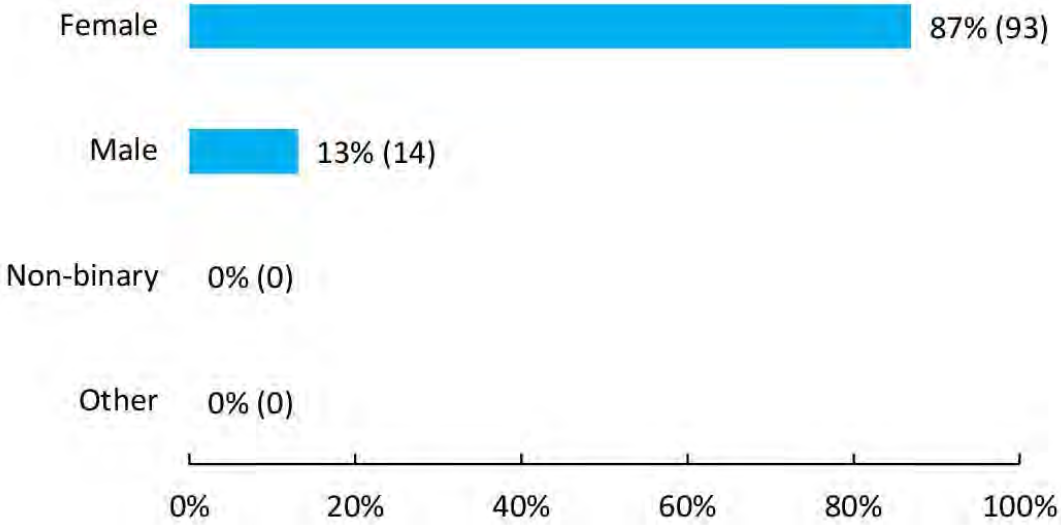


Figure 8: Educational Level Demographics of Survey Respondents
Total respondents = 108

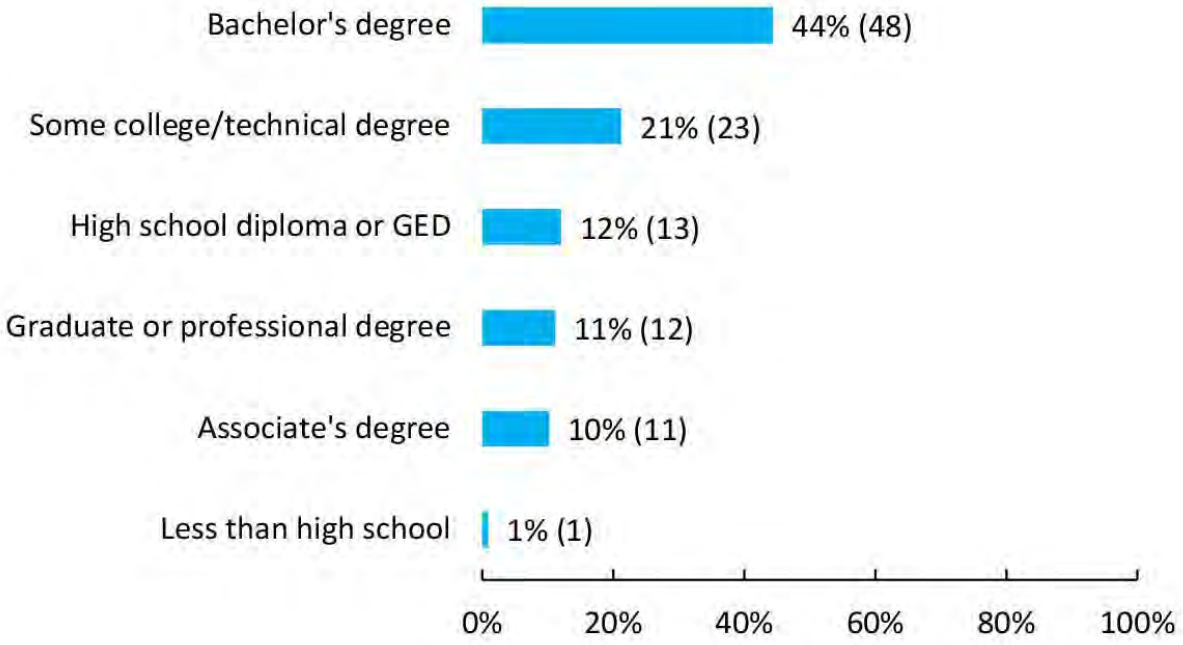
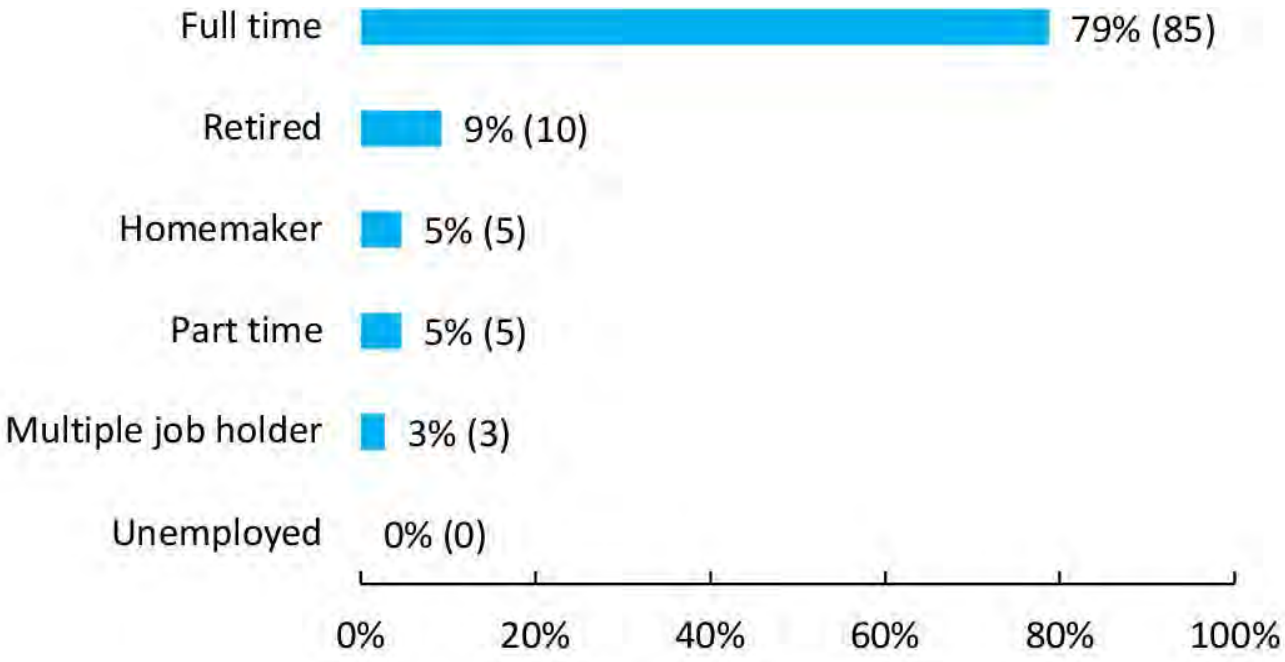
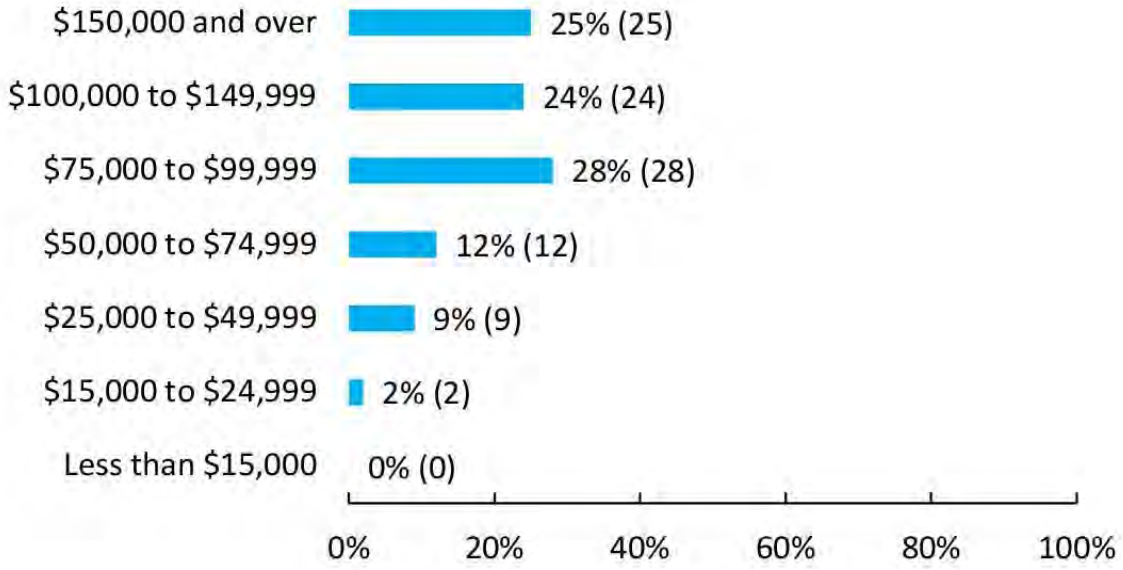


Figure 9: Employment Status Demographics of Survey Respondents
Total respondents = 108



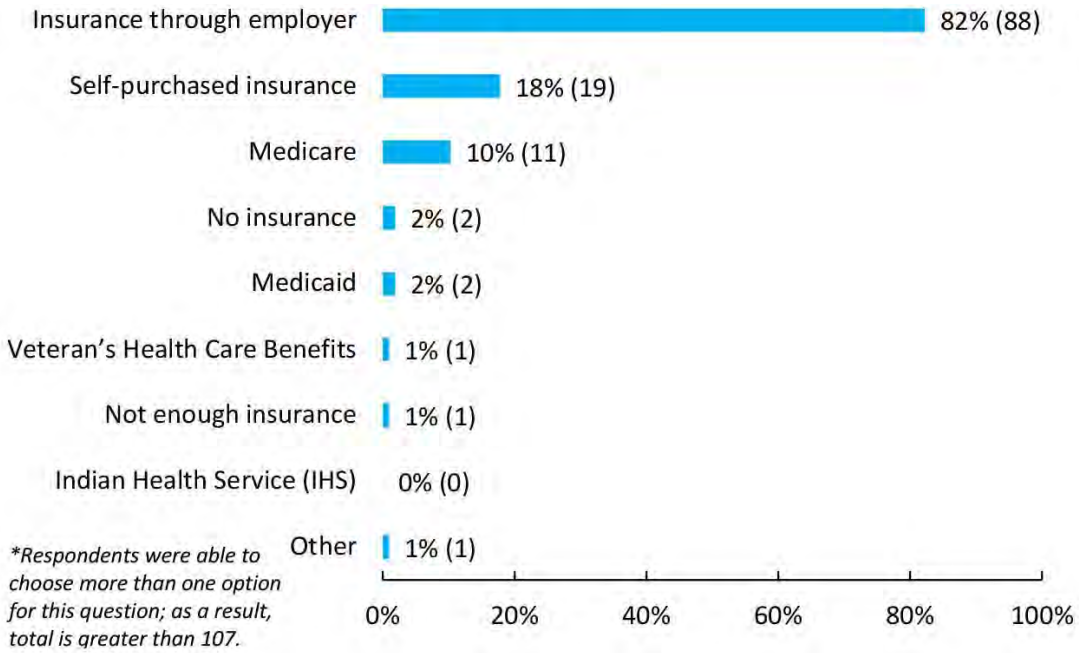
Of those who provided a household income, 2% (N=2) community members reported a household income of less than $25,000. Forty-nine percent (N=49) indicated a household income of $100,000 or more. This information is shown in Figure 10.

Figure 10: Household Income Demographics of Survey Respondents
Total respondents = 100



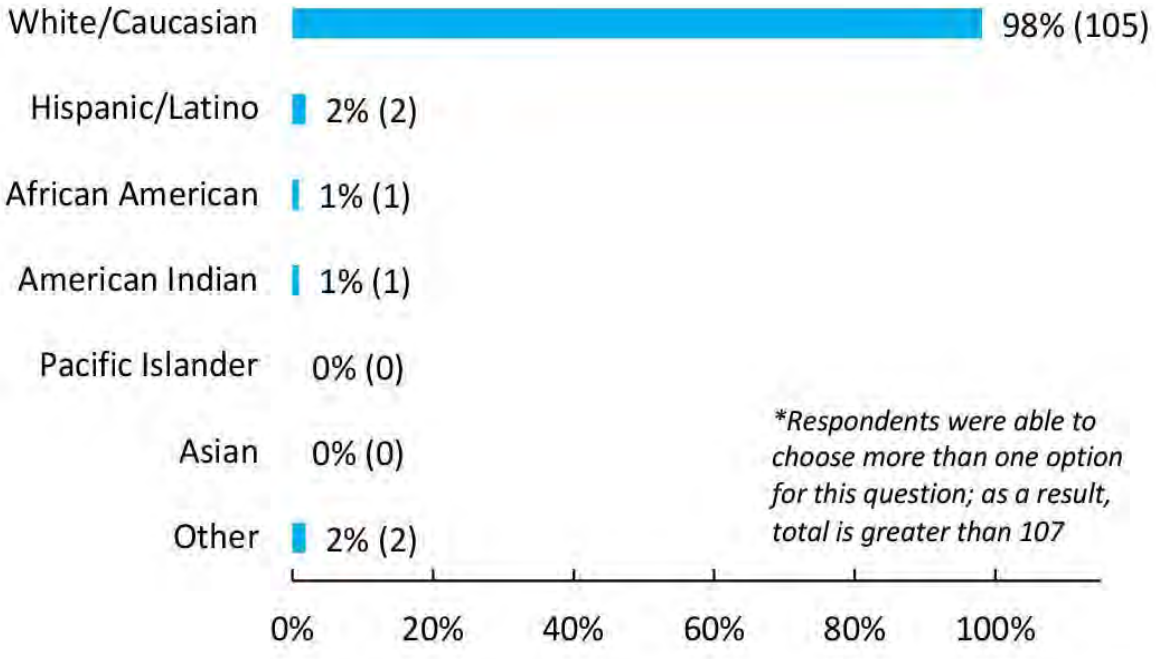
Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Three percent (N=3) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one's employer (N=88), followed by self-purchased (N=19), and Medicare (N=11).

Figure 11: Health Insurance Coverage Status of Survey Respondents
Total respondents = 107*



As shown in Figure 12, nearly all of the respondents were White/Caucasian (98%). This statistic was not in-line with the race/ethnicity of the overall population of Mountrail County; the U.S. Census indicates that 64.5% of the population is White in Mountrail County, with American Indians making up 30.1% of the population.

Figure 12: Race/Ethnicity Demographics of Survey Respondents
Total respondents = 107*



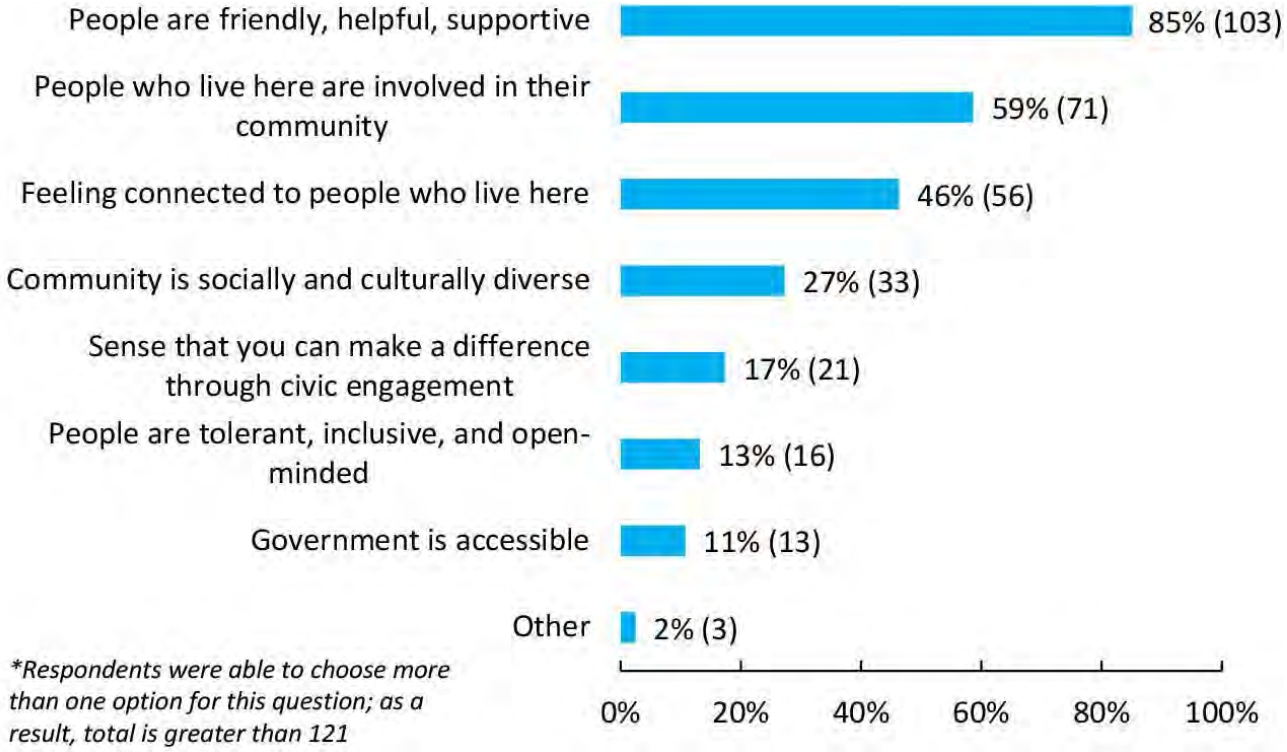
Community Assets and Challenges

Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally chose less than three or more than three choices within each category. If more than three choices were selected, their responses were not included. The results indicate there is consensus (with at least 71 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=103)
- Family-friendly (N=95)
- Healthcare (N=82)
- Safe place to live (N=81)
- Local events and festivals (N=75)
- Activities for families and youth (N=73)
- People who live here are involved in their community (N=71)

Figures 13 to 16 illustrate the results of these questions.

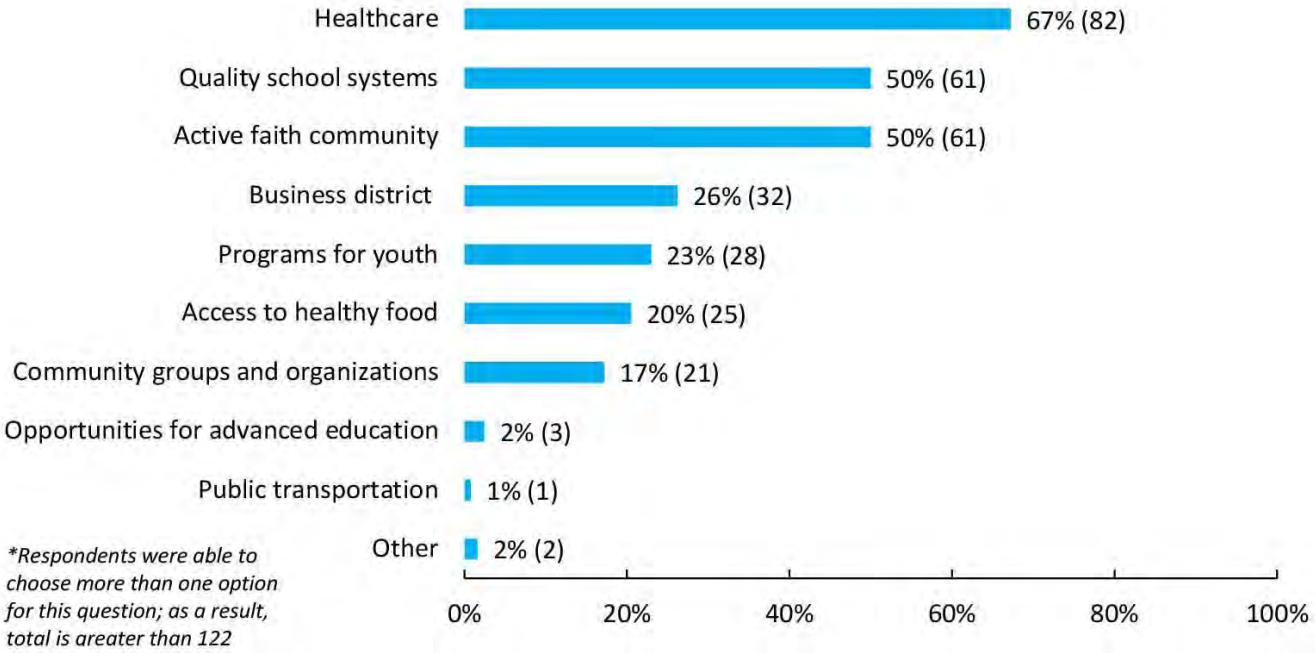
Figure 13: Best Things About the PEOPLE in Your Community
Total responses = 121*



Respondents were able to choose more than one option for this question; as a result, total is greater than 121

Included in the "Other" category of the best things about the people was the government leaves you alone, none of these apply, and close-minded.

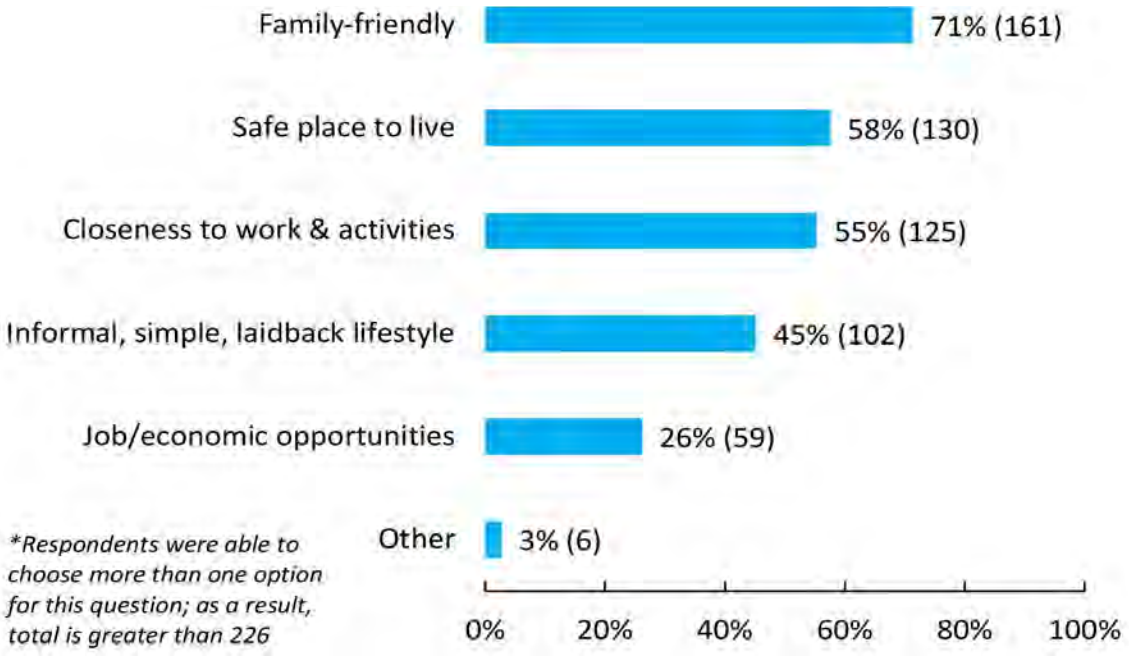
Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community
Total responses = 122*



Respondents were able to choose more than one option for this question; as a result, total is greater than 122

Respondents who selected "Other" specified that the best things about services and resources included it is only 55 miles from Minot, and the government leaves you alone.

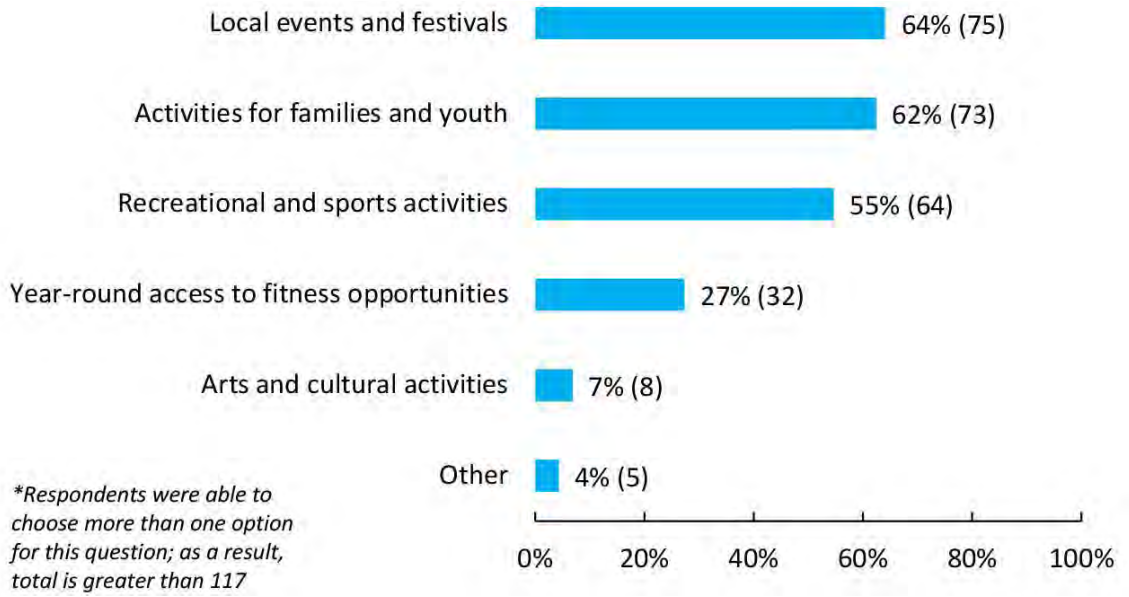
Figure 15: Best Things About the QUALITY OF LIFE in Your Community
Total responses = 226*



Respondents were able to choose more than one option for this question; as a result, total is greater than 226

The "Other" responses, regarding the best things about the quality of life in the community, included no traffic/congestion, recreational opportunities, and providing for the learning challenged.

Figure 16: Best Thing About the ACTIVITIES in Your Community
Total responses = 117*



Respondents were able to choose more than one option for this question; as a result, total is greater than 117

Respondents who selected "Other" specified that the best things about the activities in the community included community gym, play area for kids, walking space, somewhere for families to meet in winter and stay active.

Community Concerns

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

- Community/environmental health
- Availability/delivery of health services
- Youth population
- Adult population
- Senior population
- Violence

With regard to responses about community challenges, the most highly voiced concerns (those having at least 50 respondents) were:

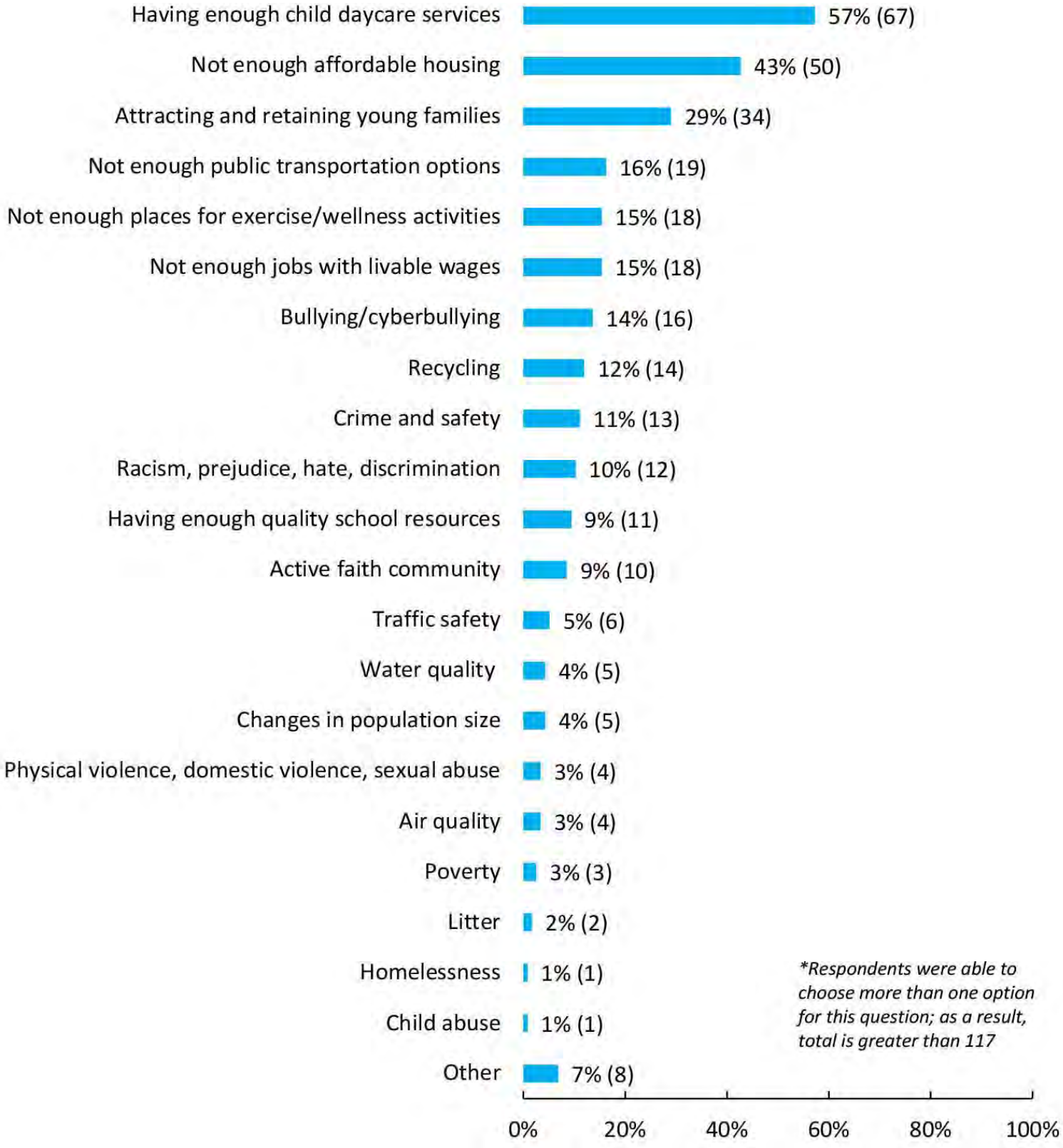
- Having enough child daycare services (N=67)
- Drug use and abuse – youth (N=66)
- Cyberbullying/social media bullying (N=61)
- Alcohol use and abuse – adults (N=60)
- Cost of long-term/nursing home care (N=53)
- Smoking and tobacco use – youth (N= 51)
- Not enough affordable housing (N=50)
- Bullying (N=50)

The other issues that had at least 30 votes included:

- Alcohol use and abuse – youth (N=49)
- Depression/anxiety – youth (N=49)
- Depression/anxiety – adult (N=48)
- Child abuse/neglect (N=46)
- Drug use and abuse – adult (N=42)
- Availability of mental health services (N=41)
- Stress – Adult (N=35)
- Attracting and retaining young families (N=34)
- Availability of resources to help the elderly (N=30)

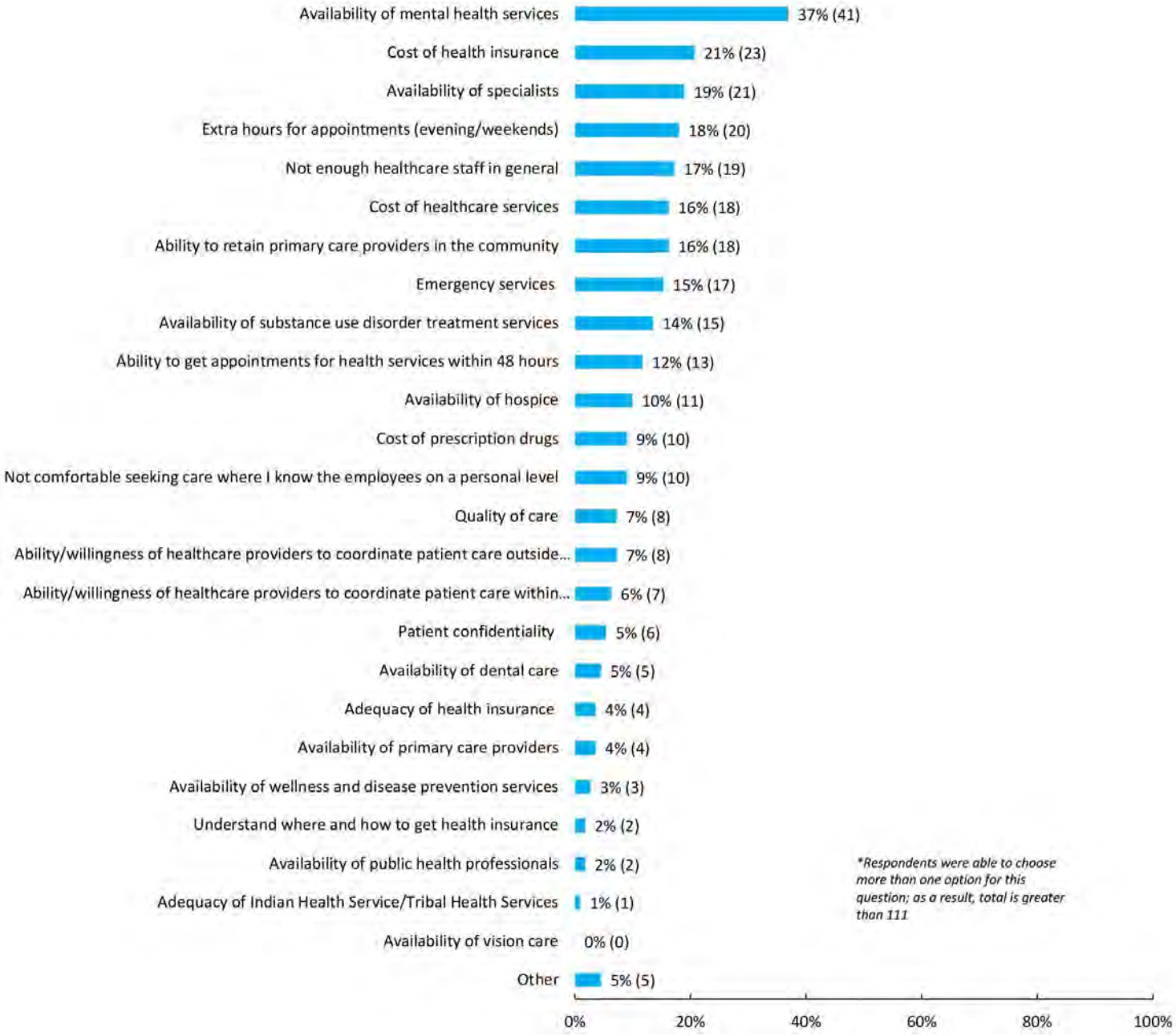
Figures 17 through 22 illustrate these results.

Figure 17: Community/Environmental Health Concerns
Total responses = 117*



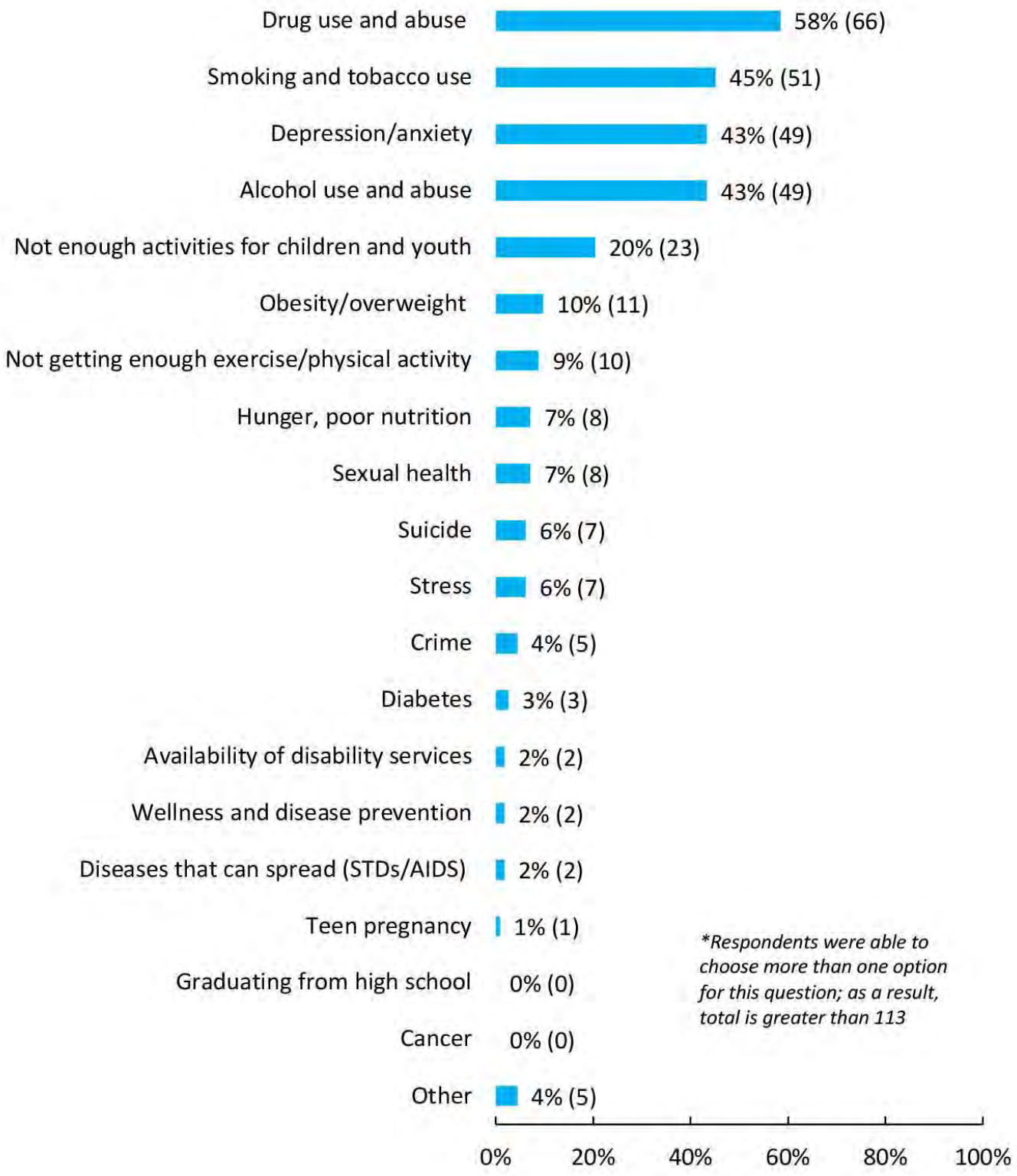
In the "Other" category for community and environmental health concerns, the following were listed: property tax too high, people who want to work, options/activities for adults other than bars, juvenile misbehavior in community, drugs aren't a concern to local law enforcement, drug dealers, and crime derived from low end people moving in.

Figure 18: Availability/Delivery of Health Services Concerns
Total responses = 111*



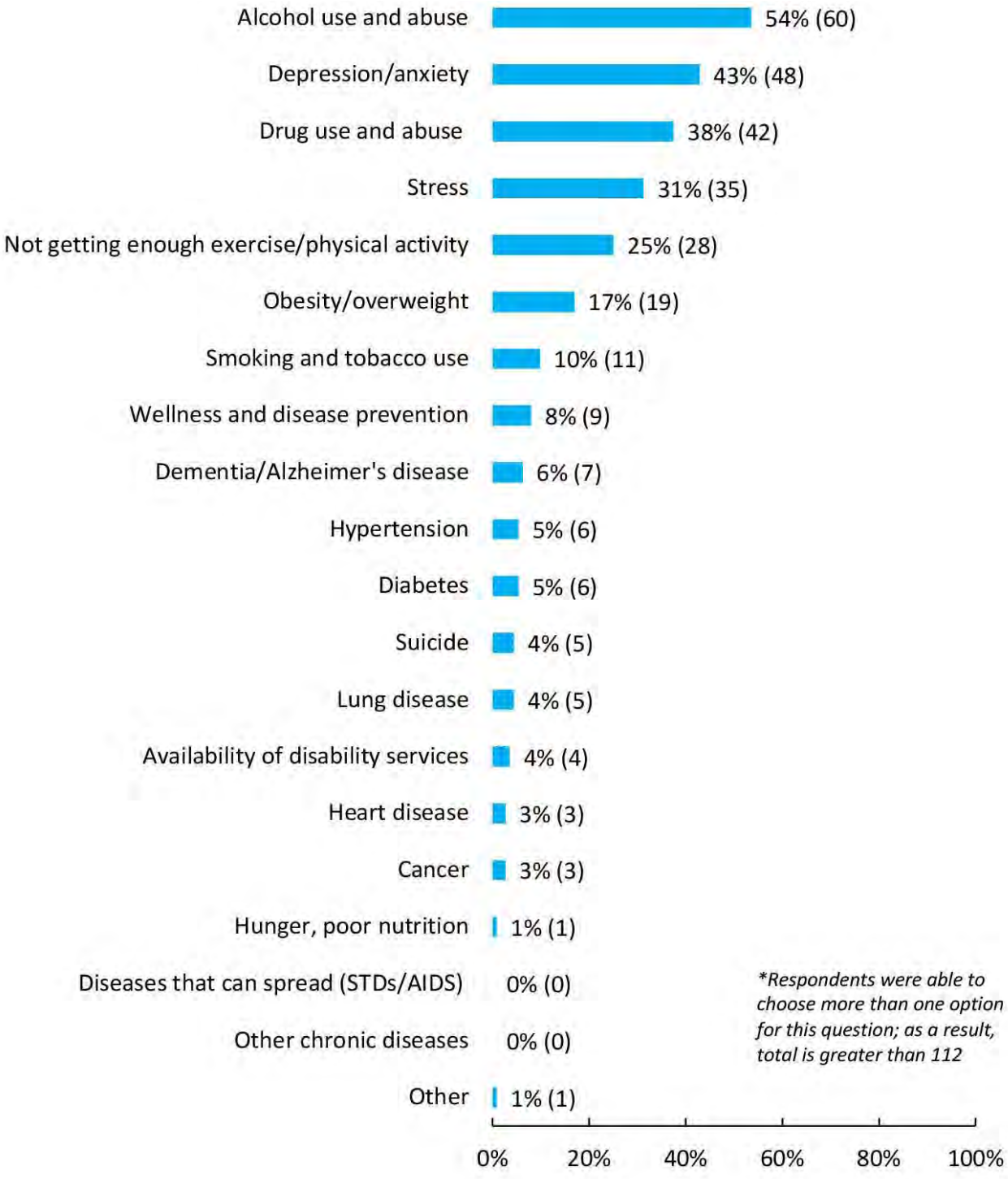
Respondents who selected "Other" identified concerns in the availability/delivery of health services as quality of service and providers: only one doctor and he is always in too much of a hurry so he can visit with other providers in the hallway, need travelers COVID-19 testing, healthcare professionals who oppose scientific fact (antivax nurses), and feel the medical staff in general is way below par/national standards.

Figure 19: Youth Population Health Concerns
Total responses = 113*



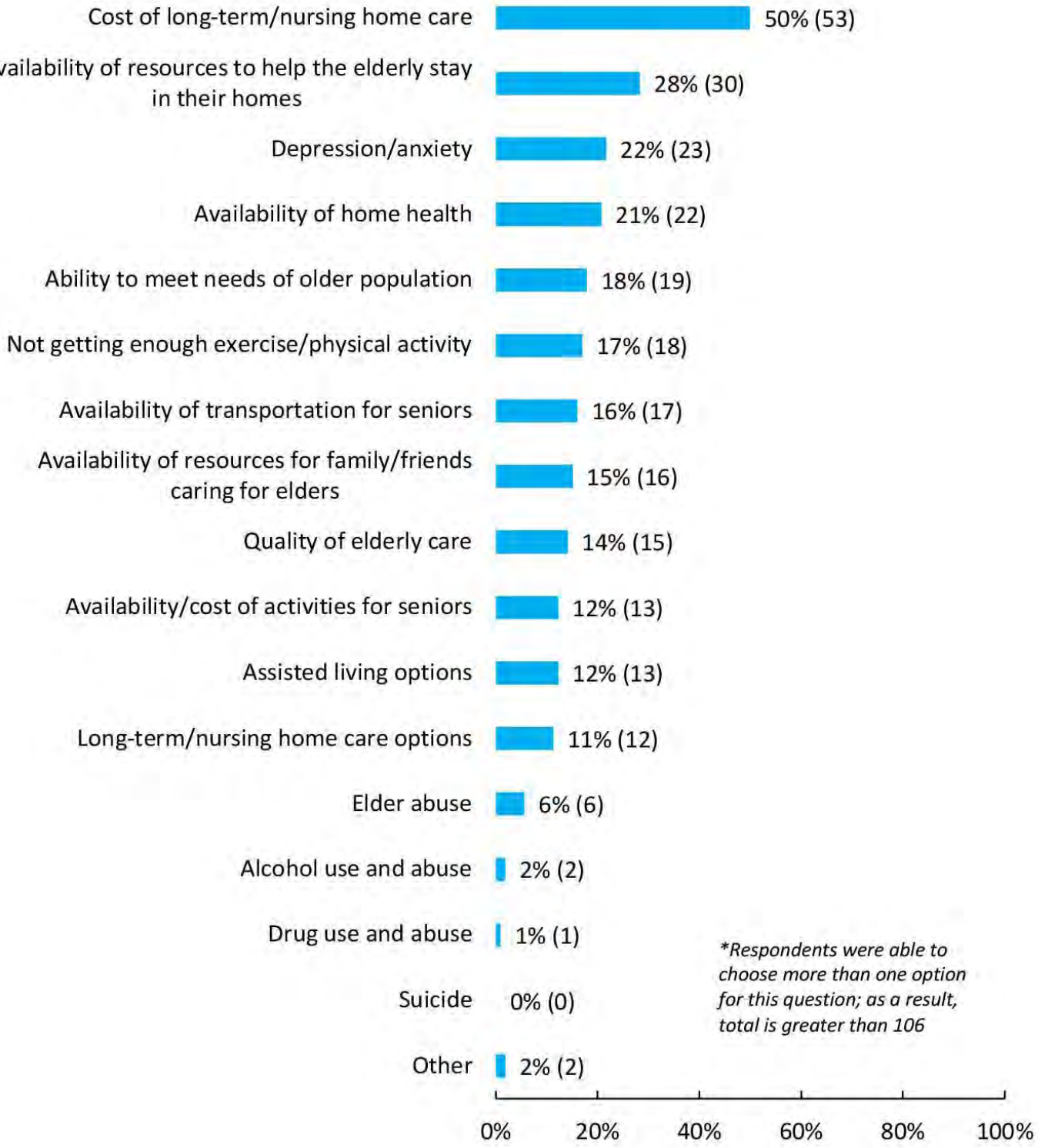
Listed in the "Other" category for youth population concerns were values are degrading, noisy vehicles cruising town, need to go after drug suppliers, children in homes where they maybe shouldn't be, and bullying.

Figure 20: Adult Population Concerns
Total responses = 112*



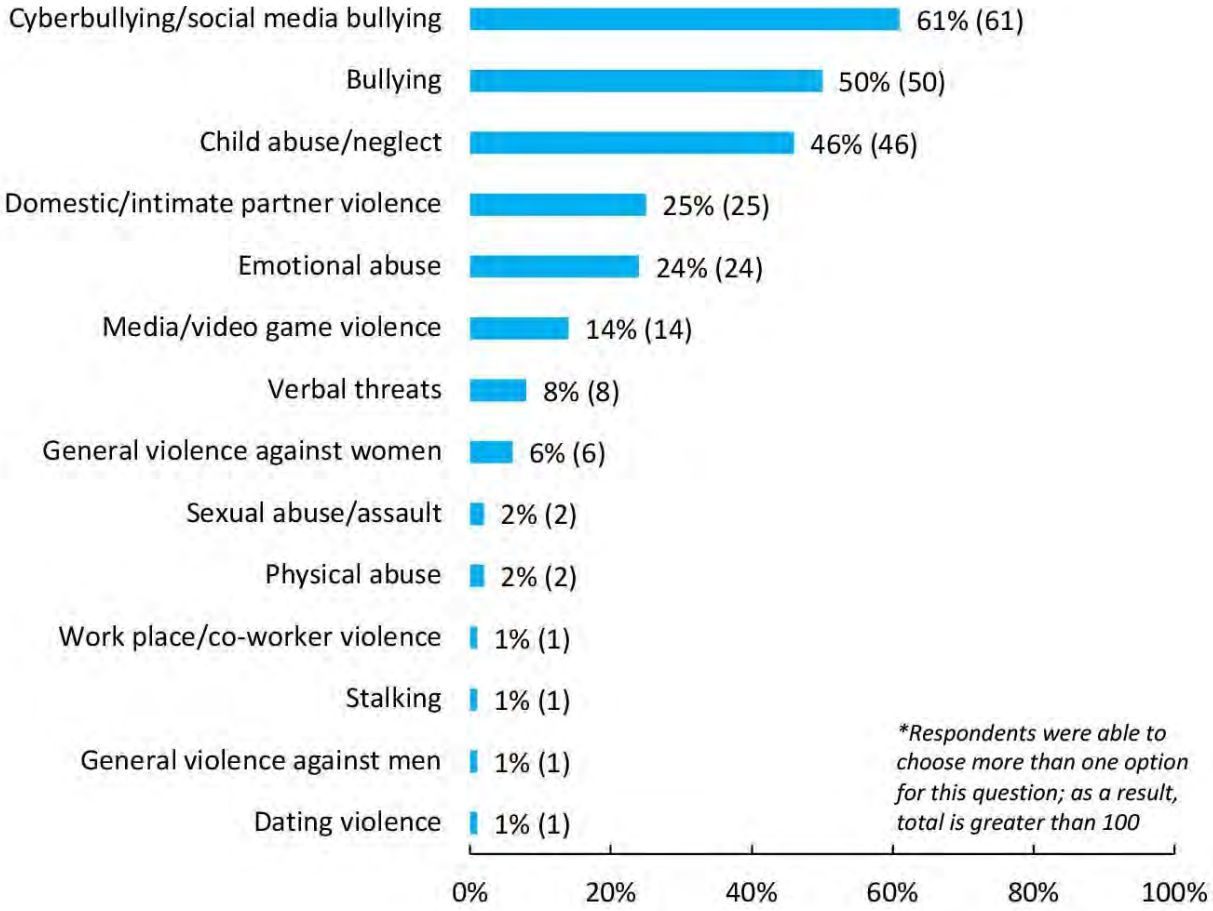
Adults can sort themselves out was the one response indicated in the "Other" category for adult population concerns.

Figure 21: Senior Population Concerns
Total responses = 106*



In the "Other" category, the two reasons specified were unsafe driving and distance and location of grocery store.

Figure 22: Violence Concerns
Total responses = 100*



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

1. Alcohol/drug/substance abuse
2. Depression/anxiety – all ages

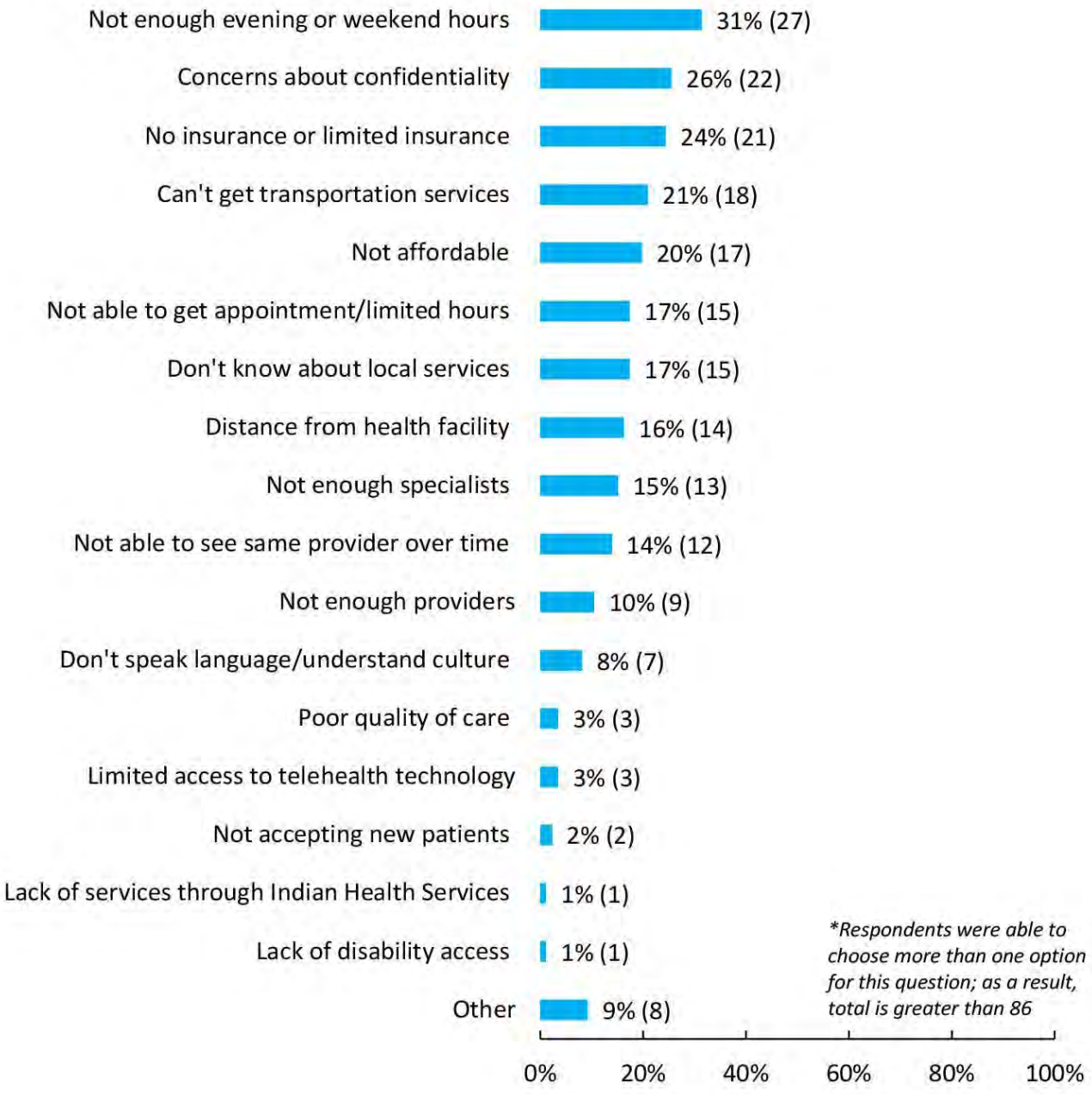
Other biggest challenges identified were having enough daycare services, not enough affordable housing, attracting and retaining families, availability of mental health services, cost of healthcare services, smoking, and tobacco use/vaping.

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 evening or weekend hours (N=27), with the next highest being concerns about confidentiality (N=22). After these items, the next most commonly identified barriers were no insurance or limited insurance (N=21), can't get transportation services (N=18), and not affordable (N=17). The majority of concerns indicated in the "Other" category were that walk-in clinics are more convenient, partnership with Trinity, no weekend hours so we have to drive to Minot, no pediatrician, needing endocrinology specialist, and cost.

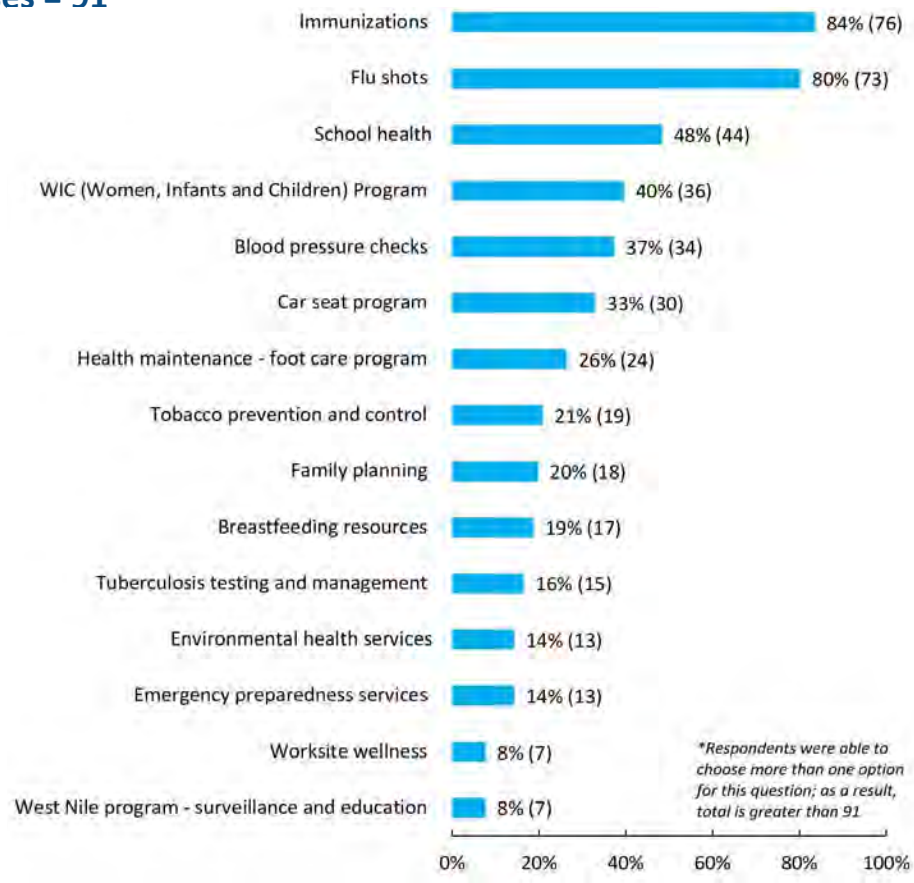
Figure 23 illustrates these results.

Figure 23: Perceptions about Barriers to Care
Total responses = 86*



Considering a variety of healthcare services offered by UMDHU, respondents were asked to indicate if they were aware that the healthcare service is offered though MCMC and to also indicate what, if any, services they or a family member have used at MCMC, at another public health unit, or both (See Figure 24).

Figure 24: Awareness and Utilization of Public Health Services
Total responses = 91*



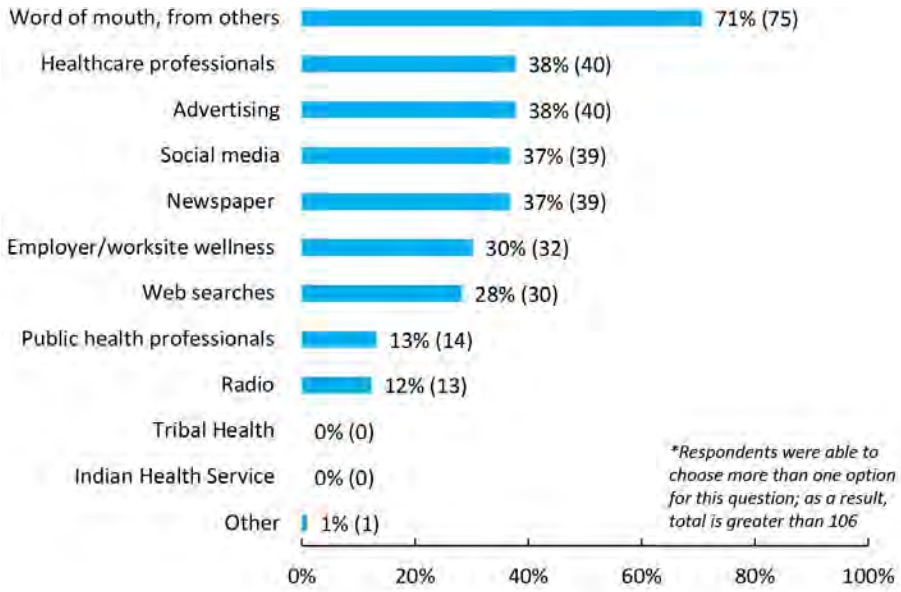
In an open-ended question, respondents were asked what specific healthcare services, if any, they think should be added locally. The number one desired service to add locally was mental health services. Other requested services included:

- Physical and occupational therapy
- Immunizations
- Cardiac rehab
- Lactation consulting
- Holistic methods
- Diabetes educator
- Dietician
- Dermatology
- Hospice
- Transportation for medical appointments for elderly/disabled populations
- Cancer care/treatment
- Mental health services for children
- Drug reinforcement, especially for youth
- Orthopedic
- Pediatrician
- Travelers inoculations and COVID-19 testing for airline travel
- Women's health
- After hours/Saturday walk-in availability

While not a service, many respondents indicated that they would like physicians added. One person indicated they repeatedly hear there is a lack of mental health services. People must go to Minot to seek counseling. Emergency responders do not have any outlets to give people who are seeking help.

The key informant and focus group members felt that the community members were aware of the majority of the health system and public health services. There were a number of services, where they felt the hospital should increase marketing efforts; these included sports medicine, physical and occupational therapy, diabetes monitoring, and hearing services.

Figure 25: Sources of Information about Local Health Services
Total responses = 106*



In the "Other" category, phone calls to or talking to employees at the facility was specified.

Figure 26: Awareness/Use of Mountrail County Medical Center Services
Total responses = 106*

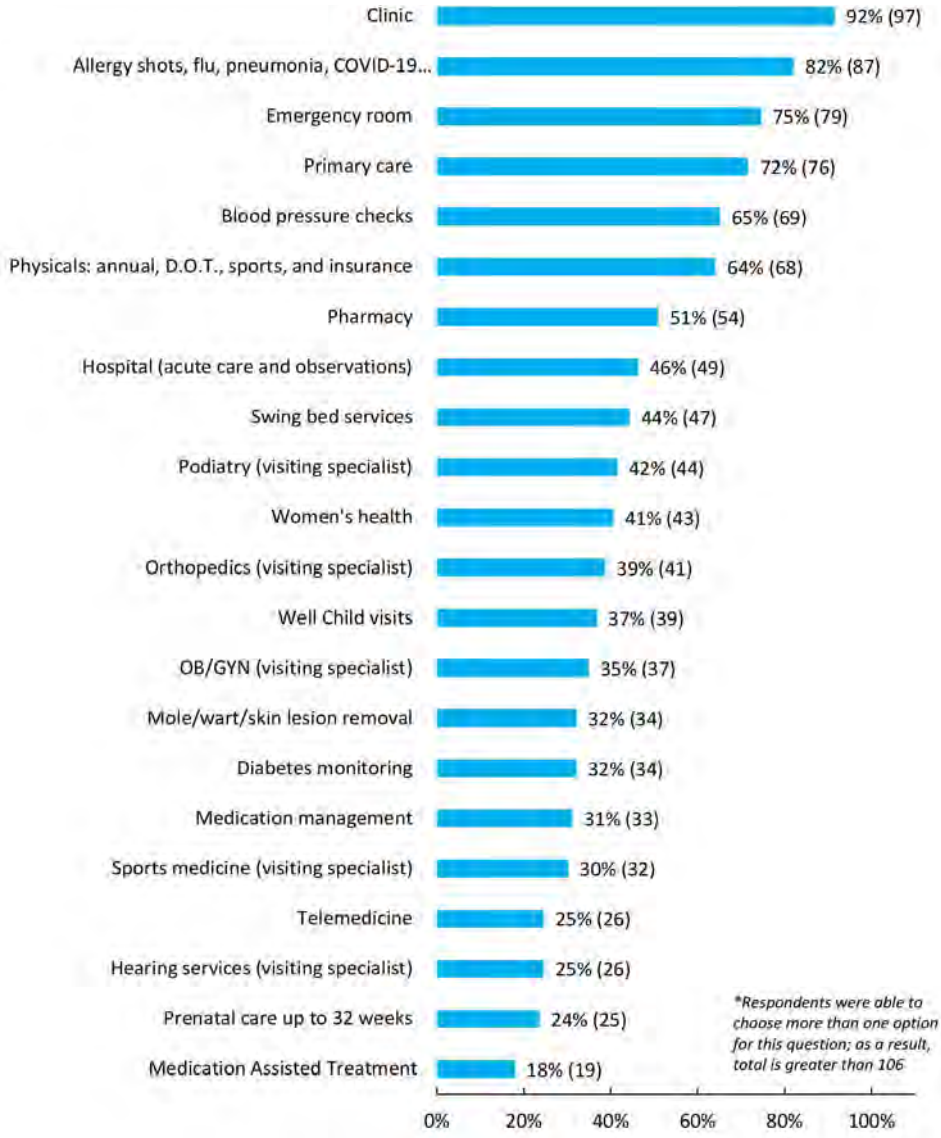


Figure 27: Awareness/Use of Therapy and Other Services at Mountrail County Medical Center Total responses = 89*

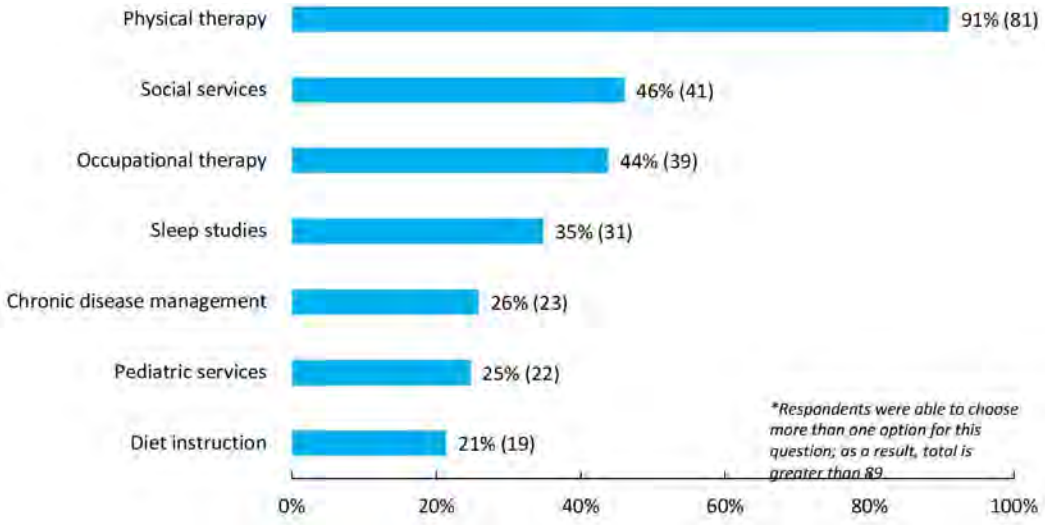
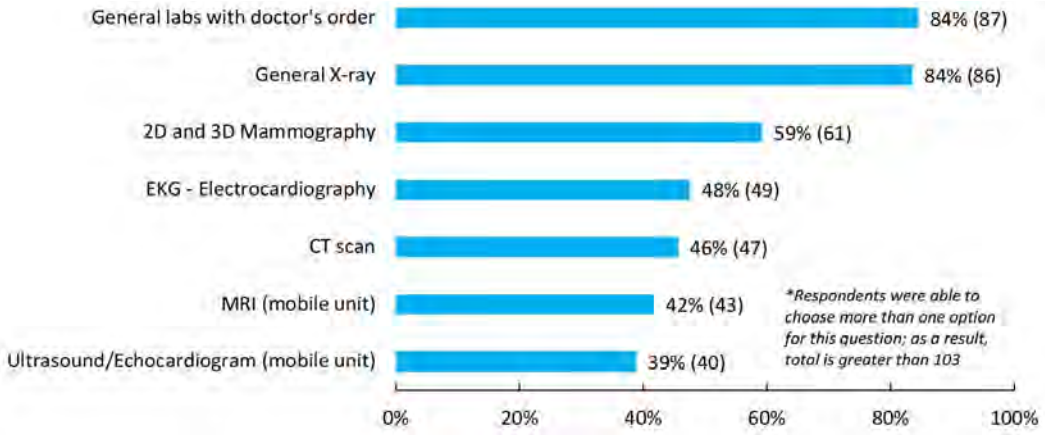
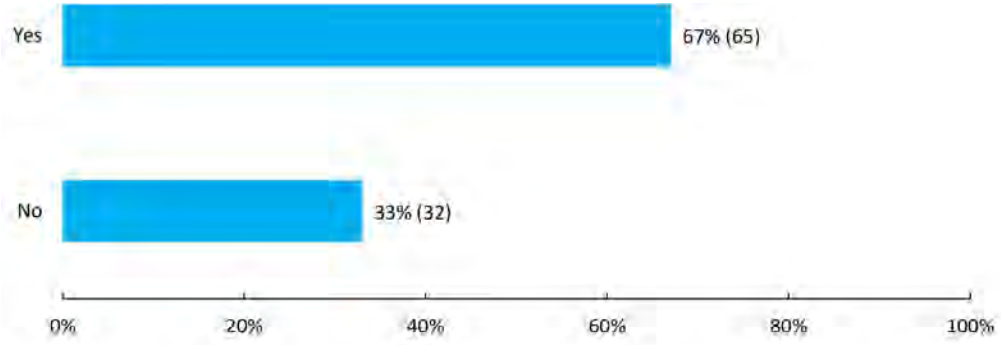


Figure 28: Awareness/Use of Lab and Radiology Services at Mountrail County Medical Center Total responses = 103*



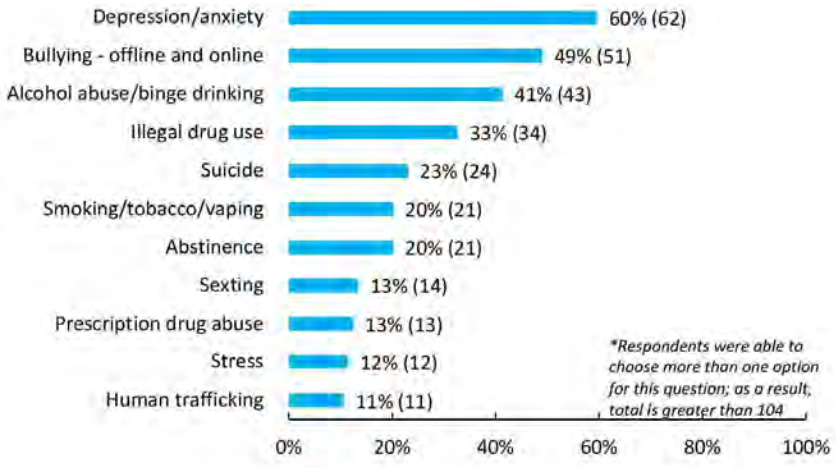
Respondents were asked if they support phase three Mountrail Bethel Home building project (Figure 29).

Figure 29: Support for Phase Three Mountrail Bethel Home Building Project Total responses = 97



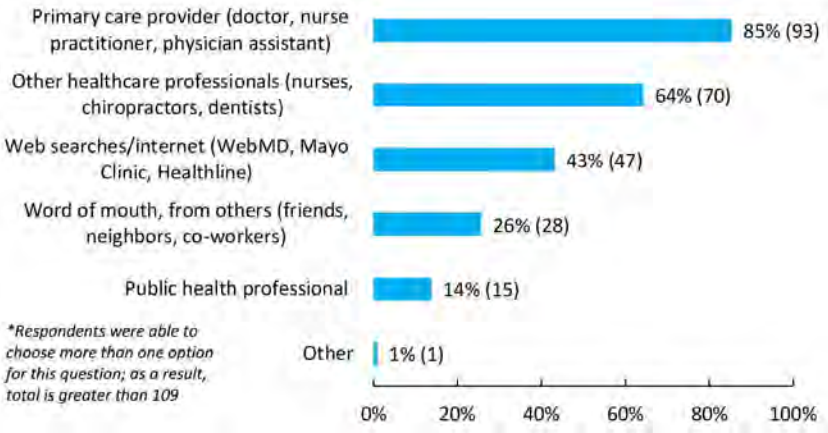
Respondents were also asked if what were the most important topics to cover in Skittle Skool (Figure 30).

Figure 30: Most Important Topics to Cover in Skittle Skool
Total responses = 104*



Respondents were asked where they go to for trusted health information. Primary care providers (N=93) received the highest response rate, followed by other healthcare professionals (N=70), and then web/Internet searches (N=47).

Figure 31: Sources of Trusted Health Information
Total responses = 109*



In the "Other" category, particular on-line providers' websites were listed as a source of trusted information.

The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. The majority of responses focused on concern with the lack of quality physicians and improvements that can be made in the hospital. The respondents stated the ambulance issue needs to be addressed immediately; leaders at the hospital need to lead in this issue and work together.

There is a lack of trust and confidence in the current MCMC staff. While gathering data, it was mentioned numerous times that confidentiality is not kept, and HIPAA violations are common. One respondent suggested training courses, regarding HIPAA and the laws surrounding it. This issue needs to be addressed; if the patients do not feel comfortable seeking care at MCMC due to confidentiality issues, they will go elsewhere.

Also suggested for the hospital is to have social media training for all staff. Each employee is viewed as an ambassador for MCMC. When medical professionals and staff share radical political posts and medical misinformation, that misinformation spreads further than they think. One respondent stated it is disappointing to see medical professionals ignoring science and getting caught up in political drama.

Respondents went onto suggest better outreach. MCMC works with the Stanley school to provide presentations to the students; however, residents in the surrounding areas do not get that same benefit. They would like MCMC to work with surrounding area schools as well. Respondents shared they would like more services

options, offered at MCMC and on the reservation. Other's suggested weekend hours, simplify billing, comprehensive sex education, and a recreational center for residents to enjoy all year long.

Others believe that MCMC does a great job of identifying and delivering healthcare within its means and offers a wide variety of healthcare services.

Findings from Key Informant Interviews & the Community Meeting

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

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

- Alcohol use and abuse
- Availability of mental health services
- Depression/anxiety
- Having enough child daycare services

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

Alcohol use and abuse

- Top concern is addressing alcohol abuse in both adults and youth
- Major concern in the youth population
- Huge problem in the area

Availability of mental health services

- Mental health services are needed – very limited options, even to get an appointment in Minot or Williston; it takes three to four months
- Mental health, telehealth has been helpful but needs more. Need to work with younger and older generation, not enough workers in the field/area
- Mental health overall. All issues can be tied into this, substance abuse, anxiety/depression, and lack of exercise. Child/teenage mental health is very important. Substance abuse is the main reason for violence in the community
- Availability of mental health providers. Can spend hours looking for a bed for someone in the state. The need is escalating, and we are not catching up

Depression/anxiety

- Depression and anxiety - people feel a loss of identify, hopelessness, confused

- Less relational, person to person. People become more lonely, isolated. They need someone to listen and be there. No one has time to sit with others. People feel they need to go to therapist/specialist instead of going to family/friends. The church does but not anywhere else

Having enough child daycare services

- Only a few daycare options available
- People can't find anyone to care for their children

Community Engagement and Collaboration

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

- Business and industry (4.25)
- Schools (4.25)
- Faith-based (4.0)
- Hospital (healthcare system) (3.75)
- Emergency services, including ambulance and fire (3.75)
- Economic development organizations (3.75)
- Long-term care, including nursing homes and assisted living (3.5)
- Pharmacy (3.5)
- Law enforcement (3.5)
- Public health (3.25)
- Human/social services (3.25)
- Tribal health/Indian health services (3.25)
- Other local health providers, such as dentists and chiropractors (2.75)
- Clinics not affiliated with the main health system (2.75)

Priority of Health Needs

A community group met on December 15, 2021. Fourteen community members attended the meeting. Representatives from the Center for Rural Health (CRH) presented the group with a summary of this report's findings, including background and explanation about the secondary data, highlights from the survey results (including perceived community assets and concerns, and barriers to care), and findings from the key informant interviews.

Following the presentation of the assessment findings, and after considering and discussing the findings, all members of the group were asked to identify what they perceived as the top four community health needs. All of the potential needs were listed in a Qualtrics survey, and each member was able to vote for their top four needs they considered the most significant.

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

- Alcohol use and abuse for all ages (10 votes)
- Having enough child daycare services (8 votes)
- Depression/anxiety (4 votes)
- Attracting and retaining young families (4 votes)

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

1. Alcohol use and abuse for all ages (6 votes)
2. Depression/anxiety (4 votes)
3. Attracting and retaining young families (2 votes)
4. Having enough child daycare services (2 votes)

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

Comparison of Needs Identified Previously

Top Needs Identified 2019 CHNA Process	Top Needs Identified 2021 CHNA Process
Availability of mental health services	Alcohol use and abuse for all ages
Adult alcohol use and abuse	Depression/anxiety
Youth drug use and abuse	Attracting and retaining young families
Having enough daycare services	Having enough child daycare services

The current process identified similar common needs from 2019. Two of the top needs identified were also identified in the 2019 CHNA process. The two new needs identified are attracting and retaining young families as well as depression/anxiety.

Mountrail County Medical Center (MCMC) invited written comments on the most recent CHNA report and implementation strategy, both in the documents and on the website, where they are widely available to the public. No written comments have been received.

Upon adoption of this CHNA Report by the MCMC Board vote, a notation will be documented in the board minutes, reflecting the approval. Then the report will be widely available to the public on the hospital's website, and a paper copy will be available for inspection upon request at the hospital. Written comments on this report can be submitted to MCMC.

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

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

Need 1: Availability of Mental Health Services – The objective was to bring in a much-needed service to the county. They addressed it within the Medical Center for the county as a whole and also with the youth at the schools. The Dare to Define YOU youth leadership program was started in New Town and Stanley for the school year 2019/2020, 2020/2021 and now into 2021/2022. This program addresses the mental health issue with the children and their parents by helping them with skill building leadership and having a developed sense of who you are, what you can do, where you are going, and the ability to influence communication, emotions, and behavior on the way to getting there. They have found that when they become leaders, together – lives are transformed. They continue to work with the Stanley High School Administration to identify at-risk children, and the Mountrail County Health Foundation helps fund ways for these children to receive help. Skittle Skool III was held on December 2, 2021.

Need 2: Adult Alcohol Use and Abuse – The objective was to work closely with local agencies, such as the UMDHU and the local social services along with the MCMC emergency room (ER), to see how the hospital could help patients who come in repeatedly for alcohol issues. They compiled a brochure that shows all the services that can help these patients once they leave the ER, worked closely with UMDHU and their addiction counselor, worked closely with Stanley's local AA group, and even offered them a space in the clinic to meet. Skittle Skool III was held again on December 2, 2021, with speakers, addressing Alcohol Use and Abuse.

Need 3: Youth Drug Use and Abuse – The objective was to work closely with the schools that fall under their area of impact and see what their biggest concerns that they are seeing on their campus with their children and drugs. They started a Dare to Define YOU youth leadership program to build up the resiliency and critical coping skills to deal with the ups and downs in everyday life. There is now committee representation on the Stanley Drug Task Force that the City Council created to address the local drug issue. They held Skittle Skool III on December 2, 2021, addressing issues pertaining to drug abuse to vaping.

The above implementation plan for MCMC is posted on the MCMC website at https://www.stanleyhealth.org/wp-content/uploads/2020/12/2020-CHNA-Implentation-Plan.pdf.

Next Steps – Strategic Implementation Plan

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

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

Community Benefit Report

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

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

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

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

What Are Community Benefits?

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

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

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

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

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

Appendix A – Critical Access Hospital Profile

Critical Access Hospital Profile

Spotlight on: Stanley, North Dakota

Mountrail County Medical Center

Quick Facts

Administrator: Steph Everett

Chief of Medical Staff:
Mark Longmuir, MD

Board Chair: Heath Hetzel

City Population:
$2,655 (2019 estimate)[1]

County Population:
$10,321 (2019 estimate)[1]

County Median Household Income:
$72,147 (2019 estimate)[1]

County Median Age:
33.2 years (2019 estimate)[1]

Service Area Population:
8,000 (35 mile radius)

Owned by: Not for profit

Hospital Beds: 11

Skilled Nursing Facility Beds:
41

Trauma Level: V

Critical Access Hospital Designation: 1999

Economic Impact on the Community[2]
Primary – $8.4 million
Secondary – $1.4 million
Total – $9.8 million

Mission:

Mountrail County Medical Center will provide quality health care services to Mountrail County and the surrounding area including; primary medical care, emergency care, swing bed and clinic services.

The Mountrail Bethel Home is an ELCA Social Ministry Organization, which will provide skilled nursing care to chronically ill individuals, of all religions. In doing so, the Home realizes it has a mandate from our Lord Jesus, Himself to minister to his people by providing a 24 hour a day, seven day a week skilled nursing facility.

County: Mountrail
Address: 615 6th Street SE, P.O. Box 399
Stanley, ND 58784
Phone: 701.628.2424
Fax: 701.628.3990
Email: severett@stanleyhealth.org
Web: www.stanleyhealth.org

Mountrail County Medical Center (MCMC) is proud to be a part of Stanley's integrated health care system. Located on the campus along with the hospital is a rural health clinic, nursing home, assisted living facility, and an aquatic center.

Mountrail County Medical Center and Mountrail Bethel Home together work to provide the area's residents with high quality care for their healthcare needs. Along with our focus on quality of care, we focus on being an employer of choice. We work hard to make our facility a great place to work.

Together by focusing on quality of care and our employees, we are able to create an environment that is a positive place for our residents to live, our patients to get the care they deserve, and offer our staff a fulfilling career caring for others.

Services:

MCMC provides the following services directly:

- Acute care and observation services
- 24-hour emergency room services
- Swing bed
- Diet instruction
- Therapy - occupational, physical, aquatic, and speech
- Social services
- Lab, X-Ray, CT, EKGs
- Dermatology screening
- Mammograms

MCMC provides the following services through contract or agreement:

- Podiatry
- OB/GYN
- Orthopedics
- Hearing assessment
- MRI
- Ultrasound
- Sleep studies

Staffing

Physicians: 1
Nurse Practitioners:..... 4
Physician Assistants:..... 2
RNs: 21
LPNs: 5
Total Employees: 135

Local Sponsors and Grant Funding Sources

- Center for Rural Health
  - SHIP Grant (Small Hospital Improvement Program)
  - Flex Grant (Medicare Rural Hospital Flexibility Grant Program)
- Local Division of Emergency Services

Sources

[1] US Census Bureau; 2019 American Community Survey; Mountrail County, ND

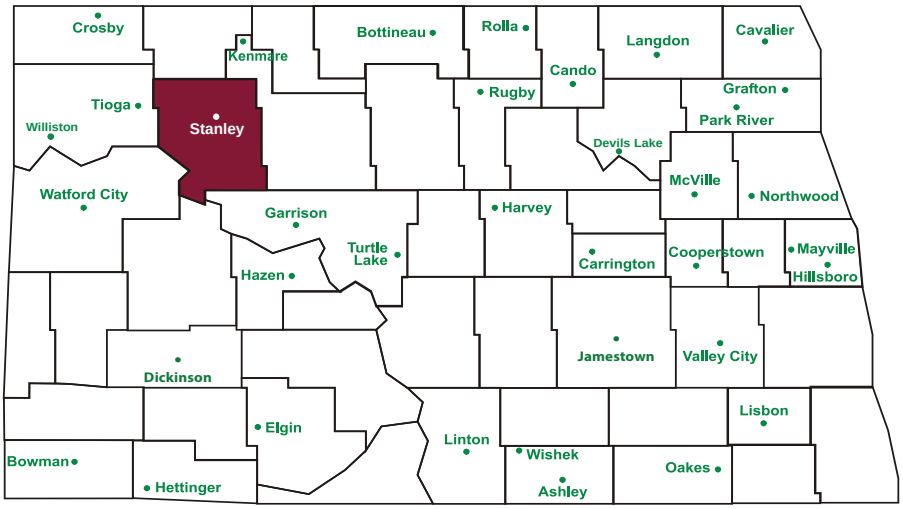
[2] Economic Impact 2020 Center for Rural Health Oklahoma State University and Center for Rural Health University of North Dakota

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

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

ruralhealth.und.edu

North Dakota Critical Access Hospitals



History

The dedication of the hospital was held June 12, 1952 coinciding with the 50th Anniversary of the city of Stanley. The hospital was operated by Lutheran Homes Society until July 1, 1955. In 1958 an addition was built on the south end of the hospital. The Stanley Medical Clinic Building was completed in 1959.

With a gift of $100,000 from Mr. A. H. Nelson, the decision was made to build intensive care units, additional rooms, a conference room, and an enlarged lobby. Construction of this addition was complete in December 1971.

In the early 1990's Mountrail County Health Foundation was formed to assist in supporting the hospital. In 1997 the newly formed corporation, Mountrail County Medical Center, bought Stanley Community Hospital.

In 1998 a new program for rural hospitals emerged and created Critical Access Hospitals. This program changed the way the Mountrail County Medical Center was reimbursed by the Medicare program.

The decision was made to build a new downsized hospital facility and merge the operations for Mountrail County Medical Center and Mountrail Bethel Home. Operation of the new 11-bed hospital and clinic began on June 2, 2002.

The outcome of the fundraising efforts ultimately was very successful due to the support of the community, especially Mr. Raymond Rude, inventor of the Duraflex diving board, who donated a major portion of the cost of the project.

Also in 2002 through the generous donations of Mr. Rude, the addition of the Ina Mae Rude Aquatic Center was added to the campus that housed Mountrail Bethel Home and Mountrail County Medical Center. In 2014-2015, a CT room and additional ER space was added, the ambulance bay was enclosed, and the Clinic was remodeled and expanded to include more exam rooms and offices, a new conference room, and a larger lobby area.

Recreation

Located in northwest North Dakota, Stanley is mainly dependent on agriculture and oil as sources of economic stability. The city is an hour's drive from Minot, population 47,370, home to Minot Air Force Base and Minot State University. The Stanley school system offers instruction in both vocational and pre-college studies in addition to a regular curriculum. The area provides excellent hunting and fishing and includes Lake Sakakawea, one of North Dakota's largest recreational areas. Golf, parks, tennis courts, swimming pools, athletic fields, a movie theatre, and a bowling alley are also in the community.

With oil and gas exploration across the Bakken formation beginning in 2006, the community and county experienced significant growth in population and business.

Appendix B – Economic Impact Analysis

March 2020

Mountrail County Medical Center

Mountrail County Medical Center
Many Avenues - One Goal…Your Health

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

Economic Impact

The campus of Mountrail County Medical Center includes a Critical Access Hospital (CAH), a Rural Health Clinic, a nursing home, and an assisted living facility.

Mountrail County Medical Center, along with Mountrail Bethel Home, make up Mountrail County Health Center. Mountrail County Health Center directly employs 83.3 FTE employees with an annual payroll of $8.4 million (including benefits).

- After application of the employment multiplier of 1.27, these employees created an additional **22** jobs.
- The same methodology is applied to derive the income impact. The income multiplier of 1.17 is applied to create over **$1.4 million** in income as they interact with other sectors of the local economy.
- **Total impacts = 105 jobs and more than $9.8 million in income.**

Healthcare and Your Local Economy

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

Key contributions of the health system include

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

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

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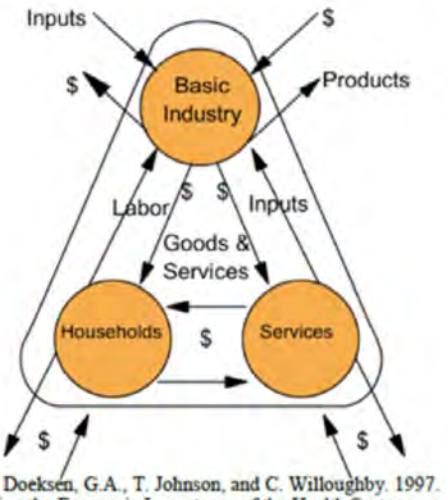
University of North Dakota
School of Medicine & Health Sciences

Figure 1. An overview of the community economic system.



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

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Appendix C – CHNA Survey Instrument

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Center for Rural Health

Mountrail County Medical Center
Many Avenues - One Goal...Your Health

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/Stanley21 or by scanning on the QR Code at the right.

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

Surveys will be accepted through November 15, 2021. Your opinion matters – thank you in advance!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Regarding various forms of **VIOLENCE** in your community, concerns are (choose up to THREE):

- ☐ Bullying
- ☐ Cyber-bullying/social media bullying
- ☐ Child abuse or neglect
- ☐ Dating violence
- ☐ Domestic/intimate partner violence
- ☐ Emotional abuse (ex. intimidation, isolation, verbal threats, withholding of funds)
- ☐ General violence against women
- ☐ General violence against men
- ☐ Media/video game violence
- ☐ Physical abuse
- ☐ Stalking
- ☐ Sexual abuse/assault
- ☐ Verbal threats
- ☐ Workplace/co-worker violence

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

_____

_____

Delivery of Healthcare

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

- ☐ Allergy shots, flu, pneumonia, COVID-19 vaccinations
- ☐ Blood pressure checks
- ☐ Clinic
- ☐ Diabetes monitoring
- ☐ Emergency room
- ☐ Hearing services (visiting specialist)
- ☐ Hospital (acute care & observation)
- ☐ Medication Assisted Treatment – certified Buprenorphine providers
- ☐ Medication management
- ☐ Mole/wart/skin lesion removal
- ☐ OB/GYN (visiting specialist)
- ☐ Orthopedics (visiting specialist)
- ☐ Pharmacy
- ☐ Physicals: annual, D.O.T., sports, & insurance
- ☐ Podiatry (visiting specialist)
- ☐ Prenatal care up to 32 weeks
- ☐ Primary care
- ☐ Sports medicine (visiting specialist)
- ☐ Swing bed services
- ☐ Telemedicine
- ☐ Well Child visits
- ☐ Women's health

13. Considering **THERAPY AND OTHER SERVICES** at Mountrail County Medical Center, which services are you aware of (or have you or a family member used in the past year)? (Choose ALL that apply)

- ☐ Chronic disease management
- ☐ Diet instruction
- ☐ Occupational therapy
- ☐ Pediatric services
- ☐ Physical therapy
- ☐ Sleep studies
- ☐ Social services

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

- ☐ 2D and 3D mammography
- ☐ CT scan
- ☐ EKG—Electrocardiography
- ☐ General labs with doctor's order
- ☐ General x-ray
- ☐ MRI (mobile unit)
- ☐ Ultrasound/Echocardiogram (mobile unit)

15. Which of the following **SERVICES** provided by your local **PUBLIC HEALTH** unit (Upper Missouri District Health Unit) are you aware of (or have you or a family member used in the past year)? (Choose ALL that apply)

- ☐ Blood pressure checks
- ☐ Breastfeeding resources
- ☐ Car seat program
- ☐ Emergency preparedness services
- ☐ Environmental health services (water, sewer, health hazard abatement)
- ☐ Family planning
- ☐ Flu shots
- ☐ Health maintenance – foot care program
- ☐ Immunizations
- ☐ School health (health education, puberty talks, school immunizations)
- ☐ Tobacco prevention and control
- ☐ Tuberculosis testing and management
- ☐ West Nile program – surveillance and education
- ☐ WIC (Women, Infants, & Children) Program
- ☐ Worksite wellness

16. 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): _____

17. 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): _____

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

_____

_____

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

- ☐ Advertising
- ☐ Employer/worksite wellness
- ☐ Healthcare 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): _____

20. Would you feel led to support fundraising efforts for the Phase Three Mountrail Bethel Home building project for the new 46-bed nursing home?

☐ Yes ☐ No

21. What topics are the most important to cover in school programs such as Skittle Skool? (Choose up to THREE)

- ☐ Abstinence
- ☐ Alcohol abuse/binge drinking
- ☐ Bullying - offline and online
- ☐ Depression/anxiety
- ☐ Human trafficking
- ☐ Illegal drug use
- ☐ Prescription drug abuse
- ☐ Sexting
- ☐ Smoking/tobacco/vaping
- ☐ Stress
- ☐ Suicide

Demographic Information: Please tell us about yourself.

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

☐ Yes ☐ No

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

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

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

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

25. 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

26. 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

27. Gender:

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

28. Employment status:

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

29. Your zip code: _____

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

☐ American Indian
☐ African American
☐ Asian
☐ Hispanic/Latino
☐ Pacific Islander
☐ White/Caucasian

☐ Other: _____

31. 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

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

_____

_____

Thank you for assisting us with this important survey!

Appendix D – County Health Rankings Explained

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

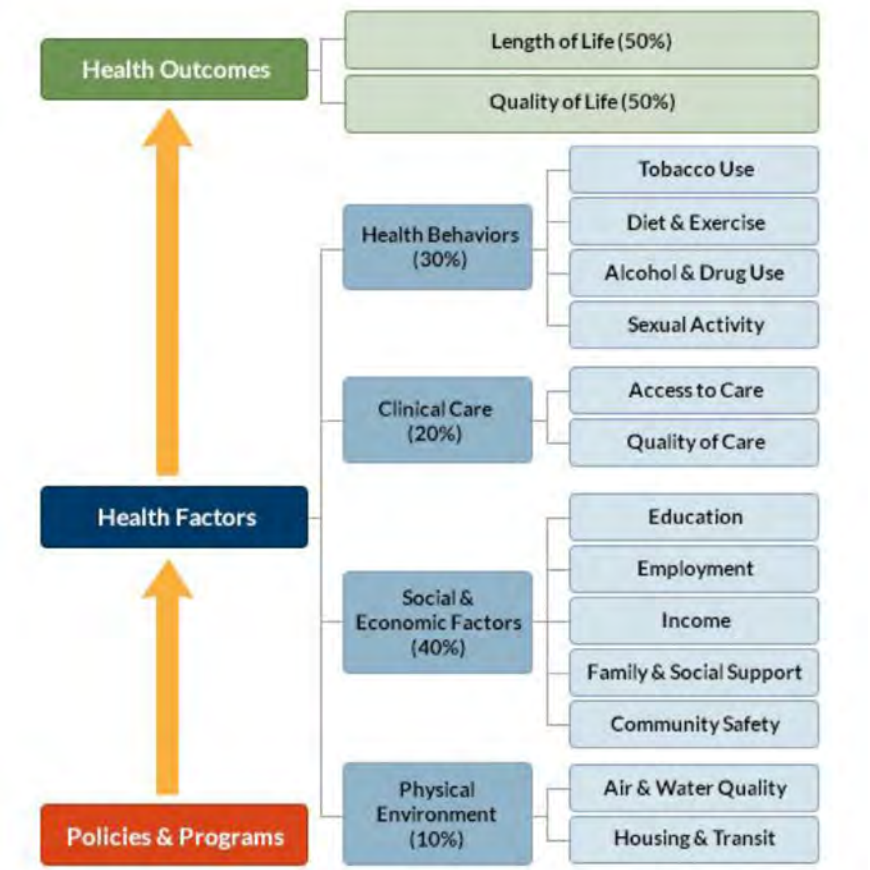
Methods

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

What is Ranked

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

Ranking System



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

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

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

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

Data Sources and Measures

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

Data Quality

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

Calculating Scores and Ranks

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

Health Outcomes and Factors

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

Health Outcomes

Premature Death (YPLL)

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

Reason for Ranking

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

Poor or Fair Health

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

Reason for Ranking

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

Poor Physical Health Days

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

Reason for Ranking

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

Poor Mental Health Days

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

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

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

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

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

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

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

Health Factors

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

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

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

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

Food Environment Index

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

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

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

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

Reason for Ranking

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

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

Physical Inactivity

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

Reason for Ranking

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

Access to Exercise Opportunities

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

Individuals who:

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

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

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

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

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

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

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

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

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

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

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

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

Uninsured

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

Reason for Ranking

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

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

Primary Care Physicians

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

Reason for Ranking

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

Dentists

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

Reason for Ranking

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

Mental Health Providers

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

Reason for Ranking

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

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

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

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

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

Flu Vaccinations

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

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

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

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

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

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

Reason for Ranking

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

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

Income Inequality

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

Reason for Ranking

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

Children in Single-Parent Households

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

Reason for Ranking

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

Violent Crime Rate

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

Reason for Ranking

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

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

Injury Deaths

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

Reason for Ranking

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

Air Pollution-Particulate matter

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

Reason for Ranking

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

Drinking Water Violations

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

Reason for Ranking

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

Severe Housing Problems

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

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

- household is severely cost burdened.

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

Reason for Ranking

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

Appendix E – Youth Risk Behavior Survey Results

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

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

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	13.5	14.5	15.3	=	16.3	16.0	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	9.4	13.5	13.0	=	12.5	11.7	8.9
Tobacco Use							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	35.1	30.5	29.3	=	32.4	23.8	24.1
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	NA	11.2	NA	**NA**	NA	NA	NA
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	11.7	12.6	8.3	↓	10.9	7.3	6.0
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	4.3	3.8	2.1	↓	2.3	1.7	1.3
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.2	3.0	1.4	↓	1.6	1.2	1.1
Percentage of students who usually obtained their own cigarettes by buying them in a store or gas station (during the 30 days before the survey among students who currently smoked cigarettes and who were aged <18 years)	NA	7.5	13.2	=	9.4	10.1	8.1
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	NA	50.3	54.0	=	52.8	51.4	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	22.3	20.6	33.1	↑	32.2	31.9	32.7
Percentage of students who currently used smokeless tobacco (chewing tobacco, snuff, or dip on at least one day during the 30 days before the survey)	NA	8.0	4.5	↓	5.7	3.8	3.8
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	9.2	8.2	5.2	↓	6.3	4.3	5.7
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	NA	18.1	12.2	NA	15.1	10.9	10.5
Alcohol and Other Drug Use							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	62.1	59.2	56.6	=	60.6	54.0	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	12.4	14.5	12.9	=	16.4	13.2	15.0
Percentage of students who currently drank alcohol (at least one drink of alcohol on at least one day during the 30 days before the survey)	30.8	29.1	27.6	=	29.4	25.4	29.2
Percentage of students who currently were binge drinking (four or more drinks of alcohol in a row for female students, five or more for male students within a couple of hours on at least one day during the 30 days before the survey)	NA	16.4	15.6	=	17.2	14.0	13.7
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	41.3	37.7	NA	**NA**	NA	NA	40.5
Percentage of students who tried marijuana before age 13 years (for the first time)	5.3	5.6	5.0	=	5.5	5.1	5.6
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.2	15.5	12.5	=	11.4	14.1	21.7

	ND 2013	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet, one or more times during their life)	NA	14.4	14.5	=	12.8	13.3	14.3
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	18.2	12.1	NA	NA	NA	NA	21.8
Percentage of students who attended school under the influence of alcohol or other drugs (on at least one day during the 30 days before the survey)	NA	NA	NA	NA	NA	NA	NA
Sexual Behaviors							
Percentage of students who ever had sexual intercourse	38.9	36.6	38.3	=	35.4	36.1	38.4
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.6	2.8	NA	NA	NA	NA	3.0
Weight Management and Dietary Behaviors							
Percentage of students who were overweight (>= 85th percentile but <95th percentile for body mass index, based on sex and age-specific reference data from the 2000 CDC growth chart)	14.7	16.1	16.5	=	16.6	15.6	16.1
Percentage of students who had obesity (>= 95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth chart)	13.9	14.9	14.0	=	17.4	14.0	15.5
Percentage of students who described themselves as slightly or very overweight	32.2	31.4	32.6	=	35.7	33.0	32.4
Percentage of students who were trying to lose weight	NA	44.5	44.7	=	46.8	45.5	NA
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	3.9	4.9	6.1	=	5.8	5.3	6.3
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	NA	61.2	54.1	↓	54.1	57.2	NA
Percentage of students who did not eat vegetables (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	4.7	5.1	6.6	=	5.3	6.6	7.9
Percentage of students who ate vegetables one or more times per day (green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables, during the seven days before the survey)	NA	60.9	57.1	↓	58.2	59.1	NA
Percentage of students who did not drink a can, bottle, or glass of soda or pop (such as Coke, Pepsi, or Sprite, not including diet soda or diet pop, during the seven days before the survey)	NA	28.8	28.1	=	26.4	30.5	NA
Percentage of students who drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or diet pop, during the seven days before the survey)	18.7	16.3	15.9	=	17.4	15.1	15.1
Percentage of students who did not drink milk (during the seven days before the survey)	13.9	14.9	20.5	↑	14.8	20.3	30.6
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	NA	33.9	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the 7 days before the survey)	11.9	13.5	14.4	=	13.3	14.1	16.7
Percentage of students who most of the time or always went hungry because there was not enough food in their home (during the 30 days before the survey)	NA	2.7	2.8	=	2.1	2.9	NA
Physical Activity							
Percentage of students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)	NA	51.5	49.0	=	55.0	22.6	55.9

	ND 2015	ND 2017	ND 2019	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2019
Percentage of students who watched television three or more hours per day (on an average school day)	18.9	18.8	18.8	=	18.3	18.2	19.8
Percentage of students who played video or computer games or used a computer three or more hours per day (counting time spent on things such as Xbox, PlayStation, an iPad or other tablet, a smartphone, texting, YouTube, Instagram, Facebook, or other social media, for something that was not school work on an average school day)	38.6	43.9	45.3	=	48.3	45.9	46.1
Other							
Percentage of students who had eight or more hours of sleep (on an average school night)	NA	31.8	29.5	=	31.8	33.1	NA
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	NA	69.1	66.8	=	63.0	68.2	NA
Percentage of students who most of the time or always wear sunscreen (with an SPF of 15 or higher when they are outside for more than one hour on a sunny day)	NA	12.8	NA	NA	NA	NA	NA
Percentage of students who used an indoor tanning device (such as a sunlamp, sunbed, or tanning booth [not including getting a spray-on tan] one or more times during the 12 months before the survey)	NA	8.3	7.0	=	6.0	5.9	4.5

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

Appendix F – Prioritization of Community's Health Needs

Community Health Needs Assessment
Stanley, North Dakota
Ranking of Concerns

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

	Priorities	Most Important
COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS		
Having enough child daycare services	8	2
Not enough affordable housing	4	
Attracting & retaining young families	4	2
Not enough public transportation options	1	
AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS		
Availability of mental health services	5	
Cost of healthcare services	2	
Availability of specialists	0	
Extra hours for appointments, such as evenings and weekends	1	
YOUTH POPULATION HEALTH CONCERNS		
Drug use and abuse (including prescription drugs)	1	
Smoking and tobacco use, exposure to second-hand smoke, juuling/vaping	2	
Alcohol use and abuse (All ages)	10	6
Depression/anxiety (All ages)	4	4
ADULT POPULATION HEALTH CONCERNS		
Drug use and abuse (including prescription drugs)	2	
Stress	1	
SENIOR POPULATION HEALTH CONCERNS		
Cost of long-term/nursing home care	1	
Availability of resources to help elderly stay in their homes	1	
Long-term/nursing home options	0	
VIOLENCE CONCERNS		
Cyber-bullying/social media bullying	0	
Bullying	1	
Child abuse/neglect	0	
Domestic/intimate partner violence	0	

Appendix G – Survey "Other" Responses

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

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

1. Considering the PEOPLE in your community, the best things are: "Other" responses:
   - None of these apply. Unfortunately, a very close-minded community that has exhibited racism
   - Government leaves you alone
   - Closed in self mind, stick knife in your back-type people who only want to hear from you if you are a "right" kind of person
2. Considering the SERVICES AND RESOURCES in your community, the best things are: "Other" responses:
   - That is only 55 miles to Minot so I can get medical care and food
   - Government leaves you alone
3. Considering the QUALITY OF LIFE in your community, the best things are: "Other" responses:
   - You can be as involved as you want in this community - there are a lot of avenues to go
   - Since no one talks to you, you know no one is in your business
   - Government leaves you alone
4. Considering the ACTIVITIES in your community, the best things are: "Other" responses:
   - There are none, unless you want to drink yourself to death
   - No matter what is available you still have to engage
   - Need more activities for the community
   - Government leaves you alone
   - Community gym/play area for kids/walking space/somewhere for families to meet in winter & stay active

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

5. Considering the COMMUNITY /ENVIRONMENTAL HEALTH in your community, concerns are: "Other" responses:
   - Property tax to high
   - People who want to work
   - Options/activities for adults (not bars)
   - Juvenile misbehavior in community
   - Government leaves you alone
   - Drugs aren't a concern to local law enforcement
   - Drug dealers
   - Crime derived from low end people moving in
6. Considering the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, concerns are: "Other" responses:
   - Quality of service and providers

- Only 1 doctor and he is always in too much of a hurry so he can visit with other providers in the hallway. Some of the other providers are pretty good
- Need travelers Covid testing
- Healthcare professionals who oppose scientific fact (antivax nurses)
- Feel the medical staff in general is way below par/national standards

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

- Values are degrading
- Noisy vehicles cruising town
- Need to go after drug suppliers: "Authorities no know they are"
- children in homes where they maybe shouldn't be
- Bullying

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

- Adults can sort themselves out

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

- Unsafe driving by a majority of them
- Distance and location of grocery store

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

- An aging population. The ability to retain young families is important to ensure stability of our community and its services.
- Cost of living vs wages
- Cost of long-term/nursing home care.
- Daycare availability
- Our hospital and ambulance service need to come to an understanding in order to provide services that are vital to our community. Those involved need to check their egos at the door and work for the good of our town, which is something they clearly are NOT doing. Seems more like a contest to see who wins, who's right or wrong, more than working out the disagreement as quickly as possible to get things back to how they should be.
- Access to exercise facility/community recreational center.
- No recreational center for all ages - no indoor walking track or gyms for Rec. leagues or other options for kids/adults to stay active in the winter.
- No recreational center to walk or have league sports
- addiction
- Drug abuse
- Drug and alcohol addiction
- Drugs
- Drugs
- Drugs and the dealers who are never arrested
- The single biggest issue in Mountrail County as a whole is the widespread use and availability of narcotics and abuse of prescription opioids.
- Alcohol abuse.
- Drug and alcohol addiction
- It's a tossup between the negative effects of social media and alcohol use.
- lack of quality law enforcement
- Law enforcement not doing their job, children and young adults are not given tickets, are not charged when they commit crimes; they are allowed to do as they please without consequences.
- Poor city police department that does not press any charges. We have young teenagers committing crimes in our community with no repercussions. The stories I hear of what happens at our city park is appalling. I would never send my children there alone.

- Lack of consistent consequences for behavior.
- Knowing the abuse is going on and nothing gets done about it.
- Accountability of actions (youth and adult)
- Close mindedness
- not enough things to do around here.
- Lack of social and community events
- Migrants, non-English speaking people, and other losers who have run down the school, and overwhelmed law enforcement, E.R., and Social Programs.
- Our youth drinking, doing drugs, vaping, and destroying property. I feel the community, as a whole, tends to sweep things under the rug or downplays the severity of situations to make the community seem like a "Mayberry".
- Undisciplined juveniles (middle school age) are affecting overall way of life for others in the community. We need law enforcement services to be more visible during the day at known "hotspots" like the park and pool. We need to enforce laws and policies to hold parents accountable. Right now, it appears there are no consequences for misbehavior. "Good kids" are staying away from places like the park and pool because their parents don't want them spending time around the unsupervised, poorly behaved kids.
- Youth drug use
- Youth problems
- LBGTQ resistance/ignorance.
- Not every family it treated fairly.
- "Stanley still seems to be pretty much controlled by people who have lived here for generations and there are some who seem to be Stanley's ""royalty"" and don't seem very approachable."
- Not having a reason for young adults to stay in Stanley or to move here.
- People on their cellphones while driving
- dealing with after effects of COVID, such as depression, stress, isolation, etc.
- The lack of kindness and the amount of if you don't agree with someone let's bully them.
- It's a tossup between the negative effects of social media and alcohol use.
- Protecting and teaching our children the harms of the cyber world/social media.
- Same thing happening all over - Social media is at fault for losing our respect/niceness to others.
- social media
- Social media has the biggest challenge with bullying everywhere!
- Insurance
- Mental Health

Delivery of Healthcare

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

- Phone calls to or talking to employees at the facility

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

- All of them, diabetic, cancer, immunizations, physical and occupational therapy,
- Cancer Care/Treatment
- Convenience clinic - walk-in clinic
- Dermatology -- many times 6+ month wait for appointments and a long drive.
- Dietician
- Holistic methods
- Lactation consulting, adolescent mental health provider (in house, not telehealth), cardiac rehab, hospice, diabetes educator
- Mental health

- Mental health counseling services need to be increased drastically in the world we live in today
- Mental health including children
- Mental health services
- Mental health services
- More mental health services, more drug reinforcement, especially for our youth.
- Orthopedic
- Pediatrician
- Transportation for medical appointments for elderly and disabled populations.
- Travelers inoculations and Covid testing for airline travel.
- Walk-in clinic convenience clinic after hours
- Women's health
- Would love to have Saturday walk in availability - but understand with the # of providers they are already spread to thin

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

- Walk in clinics are more convenient
- Partnership with Trinity.
- No weekend hours so we have to drive to Minot.
- No pediatrician
- Needing endocrinology specialist
- NA
- Doesn't apply to me
- Cost

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

- Particular on-line providers' websites

18. Race/ethnicity "Other" responses:

- European American
- American

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

- Ambulance service needs to improve.
- "Fix the ambulance issue IMMEDIATELY. Put egos and personal opinions aside for the wellbeing of your PATIENTS. This starts with the LEADERSHIP of the hospital, starting at the top.
- Consider a training course for your employees on confidentiality and the laws surrounding it. Hospital employees, especially those that work or have worked in the ER, are known to discuss patients among persons not employed there. As a community member, it doesn't promote confidence in our local healthcare facility when we hear about other people's issues from employees "out on the street." "
- Get another MD
- Have no faith in the medical doctors in the Stanley area, I believe they need additional training on modern standards and since they are part of the community "family" ie, returned home after med school, no one will give them the truth about their care.
- I really enjoy getting the flyers emailed letting me know what services are being offered/promoted during specific times of the year. Ex. Mole checks. Access to dermatology in our community would be fantastic.
- I wish we had more local options.
- "I would like to see not just Stanley school receive benefits of our MCMC providers for certain speakers or job fairs. North Shore Plaza school is also within Mountrail County as well as Parshall and New Town. I see in the paper how often MCMC providers are involved in the Stanley school and would be nice to see that outstretched to our entire community not just Stanley.

- Overall, I am pleased with care provided by the clinic and emergency center and appreciate the availability of it if my family needs emergency care. You are all appreciated for all the hours you put in and you all deserve the praise. It is also exciting to see the developments on the nursing home assisted living side of the health center and I know that there will be a need for my family in the future. "
- Please don't teach abstinence - if kids are going to do it, they're going to do it. It's so much more beneficial to teach safe sex practices as well as where they can safely go for affordable help (like Planned Parenthood).
- "Simplify billing. Consider cutting ties with Trinity.
- Social media training for employees -- they are all ambassadors of the Medical Center (whether they want to be or not) and when they share radical political posts and medical misinformation, the negative effect and the impression spreads further than just their family and friends. It's truly disappointing to see medical professionals ignoring science and getting caught up in political drama. "
- There needs to be a recreational center for seniors/adults/kids to stay active throughout the entire year.
- There needs to be a variety of quality options available, especially on or near the reservation.
- We have been very satisfied with our care at Mountrail Co . Clinic!
- Weekend Hours