

# Community Health Needs Assessment

Mountrail County Medical Center – Service Area  
**Stanley, North Dakota**

# 2025

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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 2025, the previous CHNA having been conducted in 2022. The Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences 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 four MCMC service area residents completed the survey. Additional information was collected through three 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 2020 to 2023 decreased by 4.2 percent. The average number of residents younger than age 18 (29.1%) for Mountrail County is 5.6 percentage points higher than the North Dakota average (23.5%). The percentage of residents ages 65 and older is almost 2.6 percent lower for Mountrail County (14.1%) than the North Dakota average (16.7%), and the rate of education is lower for Mountrail County (88.9%) than the North Dakota average (93.5%). The median household income in Mountrail County (\$81,292) is much higher than the state average for North Dakota (\$75,949).

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

Mountrail County, according to County Health Rankings data, is performing poorly relative to the rest of the state in 21 outcome/factor categories.

**Of 106 potential community and health needs set forth in the survey, the 104 MCMC service area residents who completed the survey indicated the following ten needs as the most important:**

- Youth smoking and tobacco use (second-hand smoke)
- Alcohol use and abuse – youth and adult
- Attracting and retaining young families
- Availability of resources to help the elderly stay in their homes
- Cancer
- Cost of long-term/nursing home care
- Depression/anxiety – youth and adult
- Drug use and abuse – youth and adult
- Having enough child daycare services
- Not enough affordable housing

The survey also revealed the biggest barriers to receiving healthcare (as perceived by community members). They included not enough evening or weekend hours (N=19), not able to get an appointment/limited hours (N=17), and no insurance or limited insurance (N=12).

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

- Safe place to live, little/no crime
- Healthcare
- Family-friendly, good place to raise kids
- People who live here are involved in their community
- People are friendly, helpful, and supportive
- Active faith community

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

- Availability of resources to help the elderly stay in their homes
- Alcohol use and abuse
- Availability of transportation for seniors
- Depression/ anxiety
- Having enough child daycare services
- Not enough affordable housing
- Not enough health care staff in general

## Overview and Community Resources

With assistance from the Center for Rural Health (CRH) at the University of North Dakota School of Medicine & Health Sciences, 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.



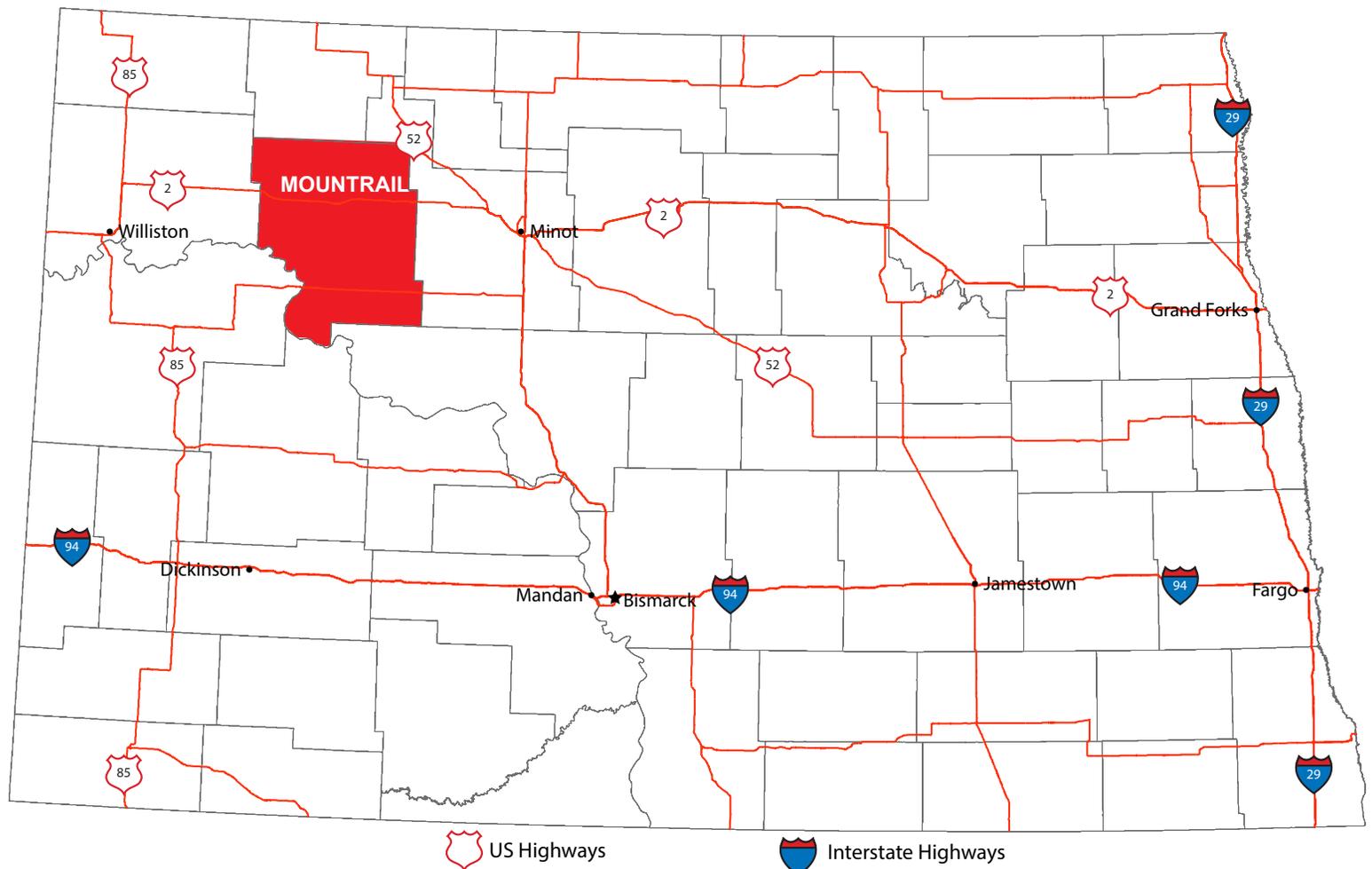
MCMC is located in Stanley, which is in northwest North Dakota, approximately 60 miles west of Minot. Stanley is the county seat of Mountrail County. The city is mainly dependent on agriculture and oil as sources of economic stability. It offers a diverse business community with services to fill all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

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-5) and one junior high to senior high school (6-12). 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, MCMC

The Stanley Community Hospital opened for business in June of 1952. In 1996, the Stanley Community Hospital started to explore options to combine the Mountrail Bethel Home (MBH) and the hospital under one roof. Their efforts resulted in the formation of the Mountrail County Medical Center (MCMC) and its governance structure, where the Mountrail Bethel Home, Inc., 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, fifty 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, three Doctorate of Nursing Practitioners, and two family nurse practitioners, three physical therapists, and 20 nurses. The CAH Profile for MCMC includes a summary of hospital-specific information and is available in Appendix A..



**Mission:** The mission of MCMC is: “At Mountrail County Health Center, we strive to create an environment which encourages all individuals to attain their highest level of physical, emotional, and spiritual health. We will achieve this environment by adhering to the words of our core values, which are: Honesty, Excellence, Accountability, Respect, Teamwork.”

## **Services offered locally by MCMC include:**

### **General and Acute Services**

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

### **Therapy and Other Services**

- Chronic disease management
- Diet instruction
- Occupational therapy
- Pediatric services
- Physical therapy
- Sleep studies
- Social services
- Mental health counseling and evaluation/assessment, which may include referrals, medication, and/or counseling

### **Lab and Radiology Services**

- CT scan
- EKGs
- General X-ray
- 2-D and 3-D mammography
- General labs with doctor's order
- Ultrasound/Echos (mobile unit)

## Upper Missouri District Health Unit

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

### Specific services UMDHU provides:

- Blood pressure checks
- 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 and blood pressure checks for senior citizens
- Immunizations
- Nutrition education – through WIC
- School health – health education and resource to the schools (immunizations/flu shots at the schools, puberty and STD talks/presentations at the schools)
- Tobacco prevention and control
- Tuberculosis testing and management
- West Nile program – surveillance and education
- WIC (Women, Infants, and Children) 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.
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.

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 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. Eight 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/Mountrail County Health Foundation
Heath Hetzel	Market President, Bravera Wealth
Becky Fladeland	Public Health Nurse, UMDHU
Ryan Gjellstad	Board President, MCMC
Elda Titus	Past Church Parish Nurse, Past MCMC Nurse
Lynn Patten	Credentialing Specialist, MCMC
Brittany Haugtvedt	Hospital/ER Director of Nursing, MCMC
Janel Borud	Clinic Director, Director of Nursing, 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 Health and Human Services’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
- 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, 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 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 eight community members, was convened and first met on December 5, 2024. During this first community group meeting, group members were introduced to the needs assessment process, reviewed basic demographic information about the community, and served as a focus group. Focus group topics included community assets and challenges, the general health needs of the community, community concerns, and suggestions for improving the community's health.

The community group met again on February 21, 2025, with nine community members in attendance. At this second meeting, the community group was presented with survey results, findings from key informant interviews and the focus group, and a wide range of secondary data, relating to the general health of the population in Mountrail County. The group was then tasked with identifying and prioritizing the community's health needs.

Members of the community group represented the broad interests of the community served by MCMC and UMDHU. They included representatives of the health community and business community. Not all members of the group were present at both meetings.

## Interviews

A one-on-one interview with one key informant was conducted in person in Stanley on December 5, 2024. Two additional key informant interviews were conducted over the phone in December of 2024. 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 B and a full listing of direct responses provided for the questions that included "Other" as an option are included in Appendix F.

**The community member survey was distributed to various residents of Mountrail County. The survey tool was designed to:**

- Learn of the good things in the community and the community's concerns.
- Understand perceptions and attitudes about the health of the community and hear suggestions for improvement.
- 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 help ensure anonymity, included with each paper 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 December 2 to December 16, 2024. No completed paper surveys were returned.

Area residents were also given the option of completing an online version of the survey, which was publicized just like the paper surveys above. In total, counting both paper and online surveys, 104 community member surveys were completed, equating to a 7% response rate.

## Secondary Data

Secondary data were collected and analyzed to provide descriptions of: (1) population demographics, (2) general health issues (including any population groups with particular health issues), and (3) contributing causes of community health issues. Data were collected from a variety of sources, including the U.S. Census Bureau; Robert Wood Johnson Foundation's County Health Rankings, which pulls data from 20 primary data sources; the National Survey of Children's Health, which touches on multiple intersecting aspects of children's lives; 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; and Youth Risk Behavior Surveillance System (YRBSS) data, which is published by the Centers for Disease Control and Prevention.

## Social Determinants of Health

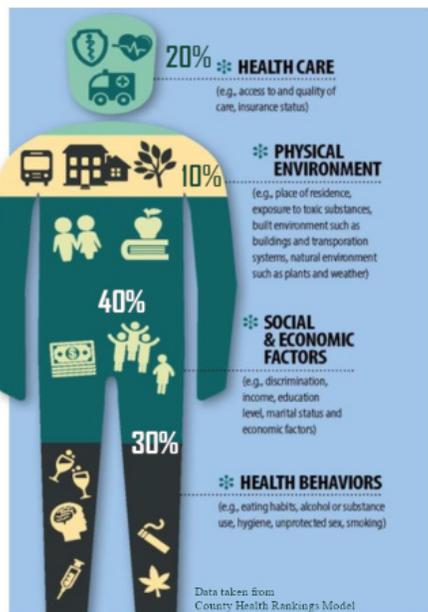
Social determinants of health are, according to the World Health Organization, *"The circumstances in which people are born, grow up, live, work, and age and the systems put in place to deal with illness. These circumstances are in turn shaped by wider set of forces: economics, social policies, and politics."*

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

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

For Figure 3, data have 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 CHNA 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**



In Figure 4, the 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, at <https://www.ruralhealthinfo.org/topics/social-determinants-of-health>.

**Figure 4: Social Determinants of Health**

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

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



## Demographic Information

**TABLE 1: Summarizes general demographic and geographic data about Mountrail County.**

(From 2020 Census/2020 American Community Survey; more recent estimates used where available)

	Mountrail County	North Dakota
Population (2023)	9,383	783,926
Population change (2020-2023)	-4.2%	0.6%
People per square mile (2020)	5.4	11.3
Persons 65 years or older (2023)	14.1%	16.7%
Persons under 18 years (2023)	29.1%	23.5%
Median age (2022)	34.7	36.2
White persons (2023)	62.9%	86.6%
High school graduates (2018-2022)	88.9%	93.5%
Bachelor’s degree or higher (2018-2022)	22.7%	31.4%
Live below poverty line (2022)	10.1%	11.5%
Persons without health insurance, under age 65 years (2022)	11.8%	7.5%
Households with a broadband Internet subscription (2022)	81.8%	93.2%

Source: <https://www.census.gov/quickfacts/fact/table/ND,US/INC910216#viewtop>

Source: <https://data.census.gov/cedsci/profile?q=0400000US38&q=North%20Dakota>

While the population of North Dakota has grown in recent years, Mountrail County has seen a decrease in population since 2020. The U.S. Census Bureau estimates show that Mountrail County’s population decreased from 9,794 (2020) to 9,383 (2023).

## County Health Rankings

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

The data used in the 2024 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. In 2024, County Health Rankings moved away from having ranks, such as 1 or 2, which would be considered the “healthiest.” Their focus now is allowing users to find counties who are experiencing similar conditions, whether it is across state lines or across the county, to collaborate and create solutions.

A model of the 2024 County Health Rankings – a flow chart of how a county’s rank is determined – may be found in Appendix C. For further information, visit the County Health Rankings website. [www.countyhealthrankings.org](http://www.countyhealthrankings.org).

Health Outcomes	Health Factors (continued)
<ul style="list-style-type: none"> <li>• Length of life</li> <li>• Quality of life</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical care               <ul style="list-style-type: none"> <li>- Access to care</li> <li>- Quality of care</li> </ul> </li> <li>• Social and Economic Factors               <ul style="list-style-type: none"> <li>- Education</li> <li>- Employment</li> <li>- Income</li> <li>- Family and social support</li> <li>- Community safety</li> </ul> </li> <li>• Physical Environment               <ul style="list-style-type: none"> <li>- Air and water quality</li> <li>- Housing and transit</li> </ul> </li> </ul>
Health Factors	
<ul style="list-style-type: none"> <li>• Health behavior               <ul style="list-style-type: none"> <li>- Smoking</li> <li>- Diet and exercise</li> <li>- Alcohol and drug use</li> <li>- Sexual activity</li> </ul> </li> </ul>	

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 Upper Missouri District Health Unit (UMDHU) and Mountrail County Medical Center (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 2022. 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 is included in the summary following. 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 one area of health outcomes compared to the rest of the state, which is the rate of low birth weight. Mountrail County, like 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 does 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:**

- Low birth weight
- Food environment index (10=best)
- Excessive drinking
- Preventable hospital stays
- Unemployment rate
- Income inequality
- Air pollution – particular matter
- Drinking water violations
- Severe housing problems

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

- Premature deaths
- Poor or fair health
- Poor physical health days (in past 30 days)
- Adult smoking
- Adult obesity
- Physical inactivity
- Access to exercise opportunities
- Alcohol-impaired driving deaths
- Sexually transmitted infections
- Teen birth rate
- Primary care physicians per capita
- Dentists per capita
- Mental health providers per capita
- Mammography screenings
- Flu vaccinations
- Children in poverty
- Children in single-parent households
- Social associations
- Injury deaths
- Uninsured

**Table 2: SELECTED MEASURES FROM COUNTY HEALTH RANKINGS 2024 – MOUNTRAIL COUNTY**

**COUNTY** ● = Not meeting North Dakota Average, ■ = Not meeting U.S. Top 10 % Performers + = Meeting or exceeding U.S. Top 10% performers.

	Mountrail County	U.S. Top 10%	ND
<b>Ranking: Outcomes</b>			
Premature death	17,100 ●■	8,000	7,600
Poor or fair health	17% ●■	14%	13%
Poor physical health days (in past 30 days)	3.5 ●■	3.3	3.1
Poor mental health days (in past 30 days)	4.3 +●	4.8	4.0
Low birth weight	6%+	8%	7%
<b>Ranking: Factors</b>			
<i>Health Behaviors</i>			
Adult smoking	21% ●■	15%	16%
Adult obesity	45% ●■	34%	36%
Food environment index (10=best)	9.1+	7.7	9.1
Physical inactivity	29% ●■	23%	25%
Access to exercise opportunities	75% ●■	84%	76%
Excessive drinking	22% ■	18%	23%
Alcohol-impaired driving deaths	46% ●■	26%	39%
Sexually transmitted infections	710	495.5	511.5
Teen birth rate	40 ●■	17	15
<i>Clinical Care</i>			
Uninsured	16% ●■	10%	9%
Primary care physicians	1,920:1 ●■	1,330:1	1,290:1
Dentists	1,550:1 ●■	1,360:1	1,420:1
Mental health providers	1,550:1 ●■	320:1	450:1
Preventable hospital stays	2,903 ■	2,681	2,945
Mammography screening (% of Medicare enrollees aged 65-74 receiving screening)	37% ●■	43%	53%
Flu vaccinations (% of fee-for-service Medicare enrollees receiving vaccination)	41% ●■	46%	49%
<i>Social and Economic Factors</i>			
Unemployment	1.5% +	3.7%	2.1%
Children in poverty	16% +●	16%	12%
Income inequality	4.2 +	4.9	4.4
Children in single-parent households	28% ●■	25%	18%
Social associations	13.6 +●	15.5	9.1
Injury deaths	155 ●■	80	75
<i>Physical Environment</i>			
Air pollution – particulate matter	4.6 +	7.4	5.0
Drinking water violations	No		
Severe housing problems	9% +	17%	12%

# Children’s Health

The National Survey of Children’s Health touches on multiple intersecting aspects of children’s lives. Data are not available at the county level; listed below is information about children’s health in North Dakota. The full survey includes physical and mental health status, access to quality healthcare, and information on the child’s family, neighborhood, and social context. Data are from 2022-23. More information about the survey may be found at [www.childhealthdata.org/learn/NSCH](http://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), 2021 / 2022

Health Status	North Dakota	National
Children born premature (three or more weeks early)	11.8%	11.3%
Children aged 6-17 who were overweight or obese	28%	32.2%
Children aged 0-5 who were ever breastfed	80.7%	82%
Children aged 6-17 who missed 11 or more days of school	6.2%	6.8%
<b>Healthcare</b>		
Children currently insured	94.6%	93.4%
Children who spent less than 10 minutes with the provider at a preventive medical visit	13.6%	19.1%
Children (1-17 years) who had preventive a dental visit in the past year	79.7%	79.2%
Children (3-17 years) received mental healthcare	14.2%	12.2%
Children (3-17 years) with problems requiring treatment did not receive mental healthcare	2.7%	3.0%
Young children (9-35 mos.) receiving standardized screening for developmental problems	45%	35.6 %
<b>Family Life</b>		
Children whose families eat meals together four or more times per week	74.8%	72.9%
Children who live in households where someone smokes	13.7%	11.5%
<b>Neighborhood</b>		
Children who live in neighborhoods with parks, recreation centers, sidewalks, and a library	90.8%	89.6%
Children living in neighborhoods with poorly kept or rundown housing	18%	23.9%
Children living in neighborhood that’s usually or always safe	97.3%	95%

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 born premature (three or more weeks early)
- Children aged 0-5 who were ever breastfed
- 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](http://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 on three of the examined measures. Areas where Mountrail County is performing more poorly than North Dakota include child food insecurity, the percentage of the population who are Medicaid recipients (ages 0-20), and the children in poverty rate (ages 0-17).

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

	<b>Mountrail County</b>	<b>North Dakota</b>
Child food insecurity, 2022	<b>14.2%</b>	13.5%
Medicaid recipient (% of population age 0-20), 2023	<b>36.7%</b>	29.4%
Children enrolled in Healthy Steps (CHIP) (% of population age 0-18), 2023	3.4%	2.4%
Supplemental Nutrition Assistance Program (SNAP) recipients (% of population age 0-18), 2023	10.4%	15.6%
Licensed childcare capacity (# of children), 2024	126	35,367
Four-year high school cohort graduation rate, 2022/2023	<b>&gt;=90%</b>	82.7%
Victims of child abuse and neglect requiring services (rate per 1,000 children ages 0-17), 2023	<b>16.3%</b>	10.1%

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

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

Table 5 depicts some of the YRBS data that have been collected in 2017, 2019, and 2021. 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 2019 to 2021, and “↓” for a decreased trend in the data changes from 2019 to 2021. The final column shows the 2021 national average percentage. For a more complete listing of the YRBS data, see Appendix D.

## 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 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
<b>Injury and Violence</b>							
% of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.1	5.9	49.6	↑	9.2	5.5	5.9
% of students who rode in a vehicle with a driver who had been drinking alcohol (one or more times during the 30 prior to the survey)	16.5	14.2	13.1	=	18.2	13.7	14.1
% of students who talked on a cell phone while driving (on at least one day during the 30 days before the survey)	56.2	59.6	64.4	↑	64.9	64.2	NA
% of students who texted or emailed while driving a car or other vehicle (on at least one day during the 30 days before the survey)	52.6	53.0	55.4	=	59.9	55.9	36.1
% of students who were in a physical fight on school property (one or more times during the 12 months before the survey)~2017/2019~ *in 2021 replaced by* % of students who carried a weapon on school property (such as a gun, knife, or club, on at least 1 day during the 30 days before the survey)	7.2	7.1	5.0	↓	6.2	4.4	3.0
% 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)	8.7	9.2	9.4	=	9.7	11.6	11
% of students who were bullied on school property (during the 12 months before the survey)	24.3	19.9	15.8	↓	19.8	15.0	15.0
% of students who were electronically bullied (includes texting, Instagram, Facebook, or other social media ever during the 12 months before the survey)	18.8	14.7	13.6	↓	16.2	14.5	15.9
% of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	14.5	15.3	14.8	=	15.1	17.2	17.6
<b>Tobacco, Alcohol, and Other Drug Use</b>							
% 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)	20.6	33.1	21.2	↓	24.2	23.6	18.0
% of students who currently used cigarettes, cigars, or smokeless tobacco (on at least one day during the 30 days before the survey)	18.1	12.2	5.9	↓	8.0	6.1	3.8

% 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)	16.4	15.6	14.0	=	17.8	14.6	10.5
% of students who currently used marijuana (one or more times during the 30 days before the survey)	15.5	12.5	10.7	=	10.2	12.9	15.8
% 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)	14.4	14.5	10.2	↓	9.7	11.0	12.2
<b>Weight Management, Dietary Behaviors, and Physical Activity</b>							
% of students who were overweight (>= 85th percentile but <95th percentile for body mass index)	16.1	16.5	15.6	=	15.5	14.2	16.0
% of students who had obesity (>= 95th percentile for body mass index)	14.9	14.0	16.3	=	17.4	15.0	16.3
% of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	4.9	6.1	5.0	=	5.7	4.6	7.7
% 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)	5.1	6.6	5.9	=	5.3	6.2	9.3
% 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)	16.3	15.9	16.6	=	17.5	13.8	14.7
% of students who did not drink milk (during the seven days before the survey)	14.9	20.5	26.2	↑	21.2	29.4	35.7
% of students who did not eat breakfast (during the seven days before the survey)	13.5	14.4	15.1	=	14.5	17.3	22.0
% 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)	2.7	2.8	2.1	=	2.2	2.1	NA
% of students who were physically active at least 60 minutes per day on five 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)	51.5	49.0	56.5	↑	58.0	55.3	NA
% of students who watched television three or more hours per day (on an average school day) *In 2021 replaced by*Percentage of students who spent three or more hours per day on screen time (in front of a TV, computer, smart phone, or other electronic device watching shows or videos, playing games, accessing the Internet, or using social media, not counting time spent doing schoolwork, on an average school day)	18.8	18.8	75.7	↑	75.8	78.6	75.7

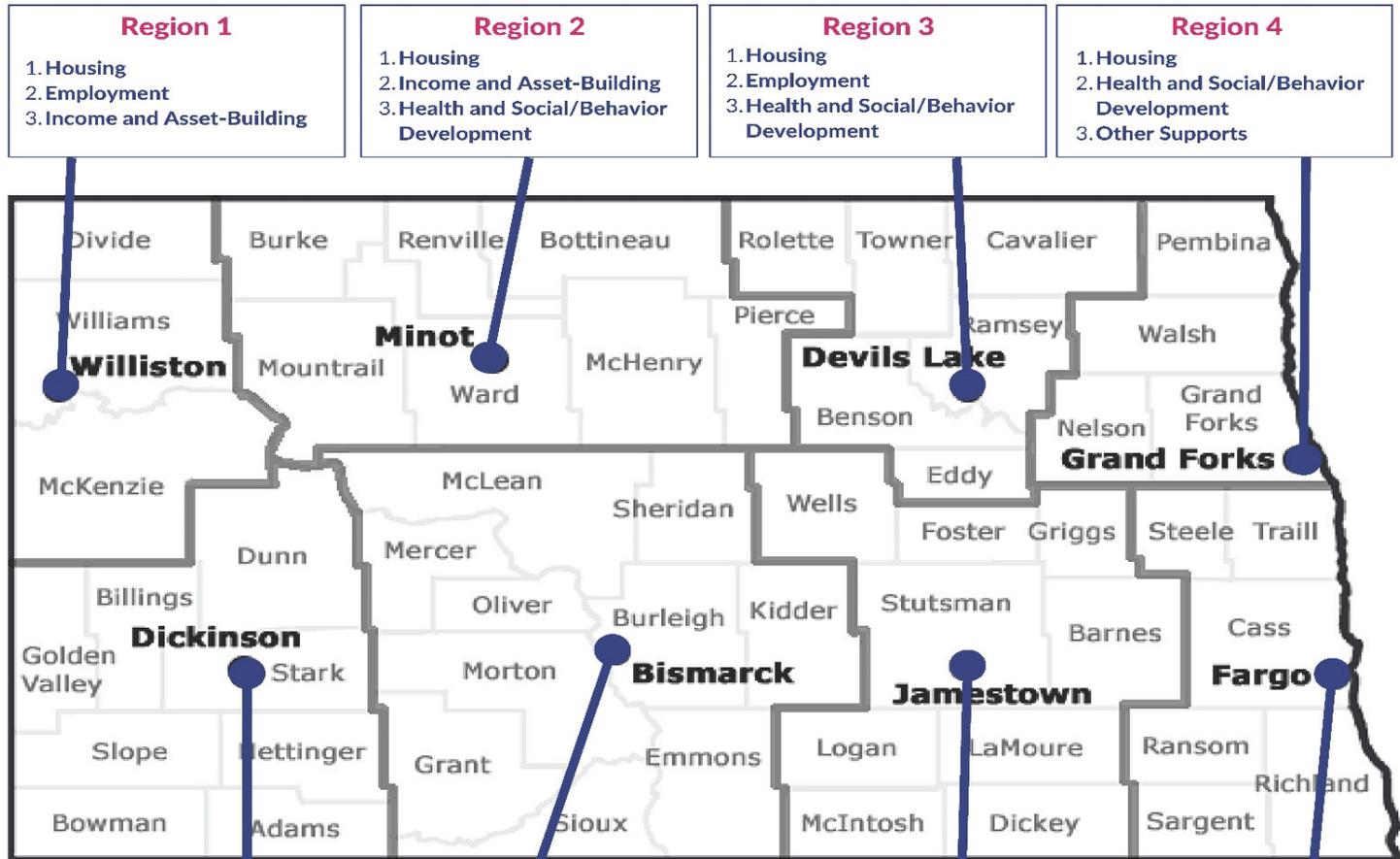
% of students who played video or computer games or used a computer three or more hours per day (for something that was not schoolwork on an average school day) *In 2021, % of students who played video or computer games was combined with % of students who watch television three or more hours per day.	43.9	45.3	NA	NA	NA	NA	NA
<b>Other</b>							
% of students who ever had sexual intercourse	36.6	38.3	36.6	=	36.5	37.0	30
% of students who had eight or more hours of sleep (on an average school night)	31.8	29.5	24.5	↓	28.3	23.2	22.7
% of students who brushed their teeth on seven days (during the seven days before the survey)	69.1	66.8	67.9	=	64.5	69.9	NA

Sources: <https://www.cdc.gov/healthyouth/data/yrbs/results.htm>; <https://www.nd.gov/dpi/districtschools/safety-health/youth-risk-behavior-survey>

### Low Income Needs

The North Dakota Community Action Agencies (CAAs), as nonprofit organizations, were originally established under the Economic Opportunity Act of 1964 to fight America’s war on poverty. CAAs are required to conduct statewide needs assessments of people experiencing poverty. The more recent statewide needs assessment study of low-income people in North Dakota, sponsored by the CAAs, was performed in 2023. The needs assessment study was accomplished through the collaboration of the CAAs and North Dakota State University 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 of which categories these needs belong to through the longitudinal comparison.

## Top Regional Needs for Households Experiencing Poverty



**Total Number of Survey Responses by Population Type**

- 1,701 Households Experiencing Poverty
- 1,015 Households Not Experiencing Poverty
- 511 Other (Roles cannot be identified)

**3227** Total Survey Responses

This 2023 Statewide Community Needs Assessment was conducted by the Community Action Partnership of North Dakota in conjunction with the North Dakota State University (NDSU) and the North Dakota Department of Commerce, Division of Community Service.

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# 2023 Statewide Community Needs Assessment

The Community Needs Assessment is a systematic process used to gather and analyze information about the needs and challenges of communities. These assessments are used in various fields, including public health, social services, urban planning, education, and economic development. They play a crucial role in ensuring that community resources are directed toward the most pressing issues and that community members' voices are heard in the decision-making process, ultimately leading to improved quality of life for the community as a whole.

Community Action Agencies conduct needs assessments every three years as a requirement for the Community Services Block Grant (CSBG) which supports community-based anti-poverty programs. The primary purpose of the study is to better understand the current conditions and priorities of a community so that local action plans can be developed and community resources/services can be allocated effectively to address those needs.



## Statewide Specific Needs By Population Type

### Households Experiencing Poverty

1. Rental Assistance
2. Food
3. Dental Insurance/Affordable Dental Care

### Households Not Experiencing Poverty

1. Mental Health Services
2. Recreational Activities
3. Safe Neighborhoods, Sidewalks, Parks

### Overall Combined Community Needs

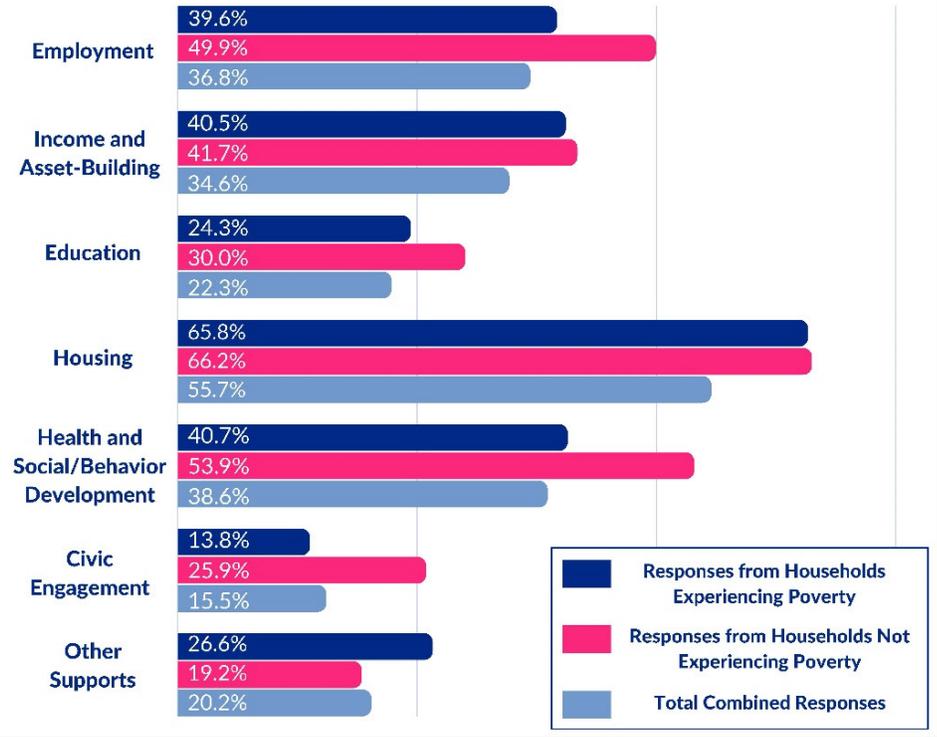
1. Rental Assistance
2. Food
3. Dental Insurance/Affordable Dental Care

**"Rental Assistance"** remains the first priority for respondents experiencing poverty across the state.

**"Mental Health Services"** was the first priority need for respondents not experiencing poverty.



## Statewide Overall Needs By Population Type



The comprehensive needs assessment was accomplished through surveys and focus groups in order to collect both quantitative and qualitative data. The surveys consist of both multiple-choice and open-ended questions with the intention of capturing both quantitative and qualitative data, and the focus groups are used to better understand the depth and breadth of the issue focusing on the collection of qualitative data.

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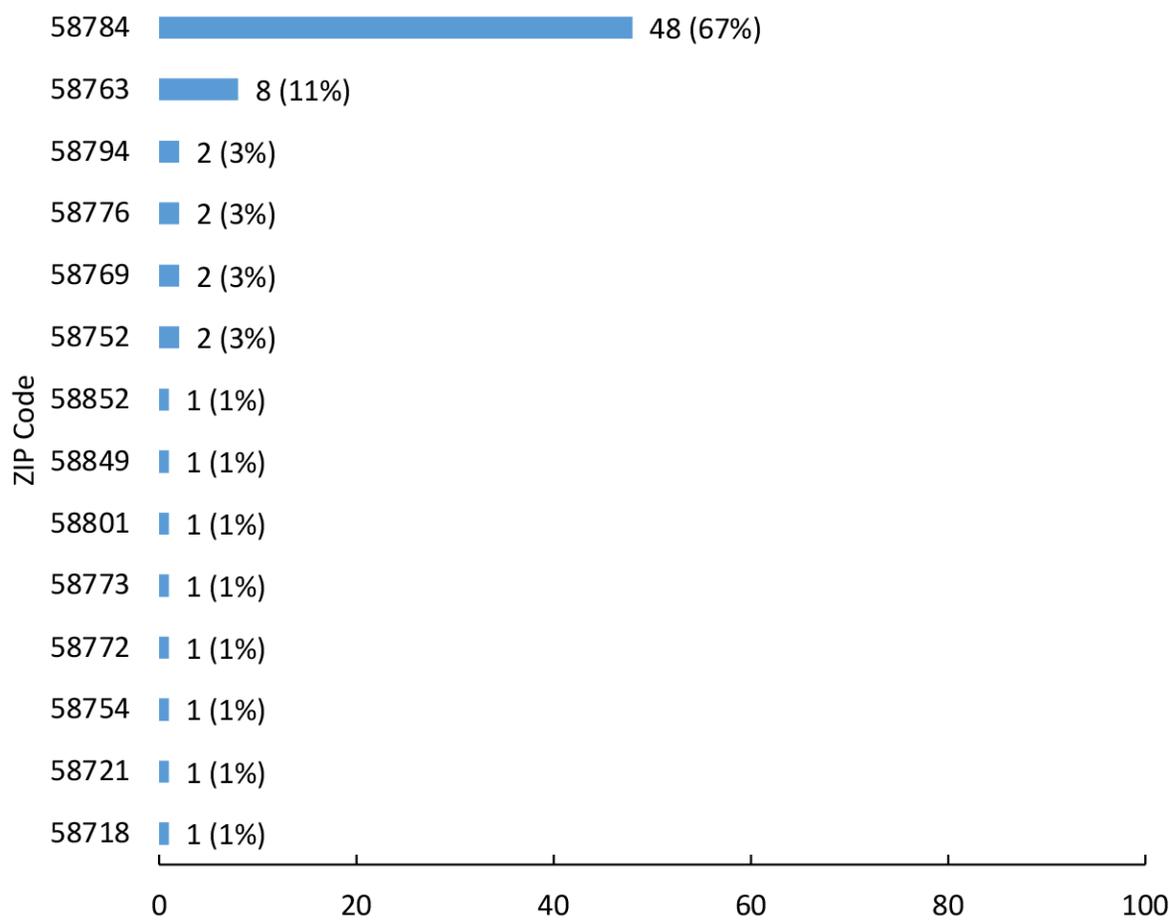
# Survey Results

As noted previously, 104 community members completed the survey in communities throughout the counties in 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, 72 did, revealing that a large majority of respondents (67%, N=48) lived in Stanley. These results are shown in Figure 5.

**Figure 5: Survey Respondents’ Home ZIP Code**

**Total respondents: 72**



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:**

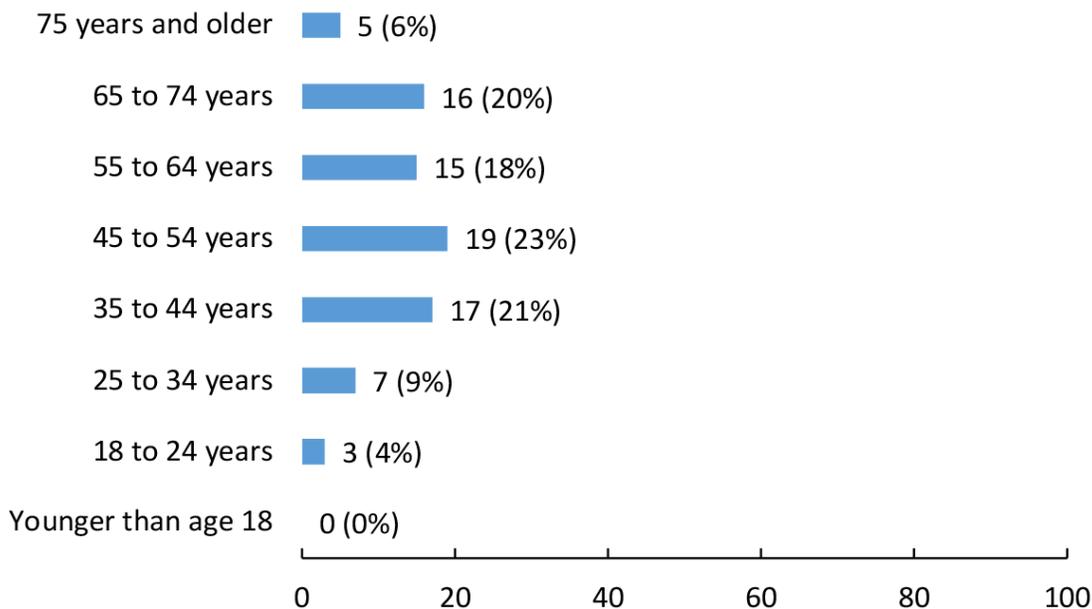
- Forty-four percent (N=36) were age 55 or older.
- The majority (75%, N=61) were female.
- Less than half of the respondents (43%, N=35) had bachelor’s degrees or higher.

- The number of those working full time (52%, N=43) was almost two times higher than those who were retired (28%, N=23).
- Ninety-eight percent (N=79) of those who reported their ethnicity / race were White / Caucasian.
- Thirteen percent of the population (N=10) 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

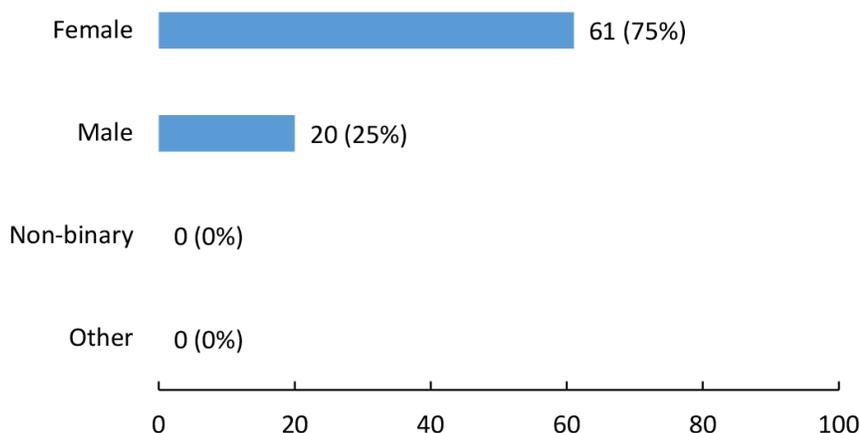
Total respondents = 82



People younger than age 18 are not questioned using this survey method..

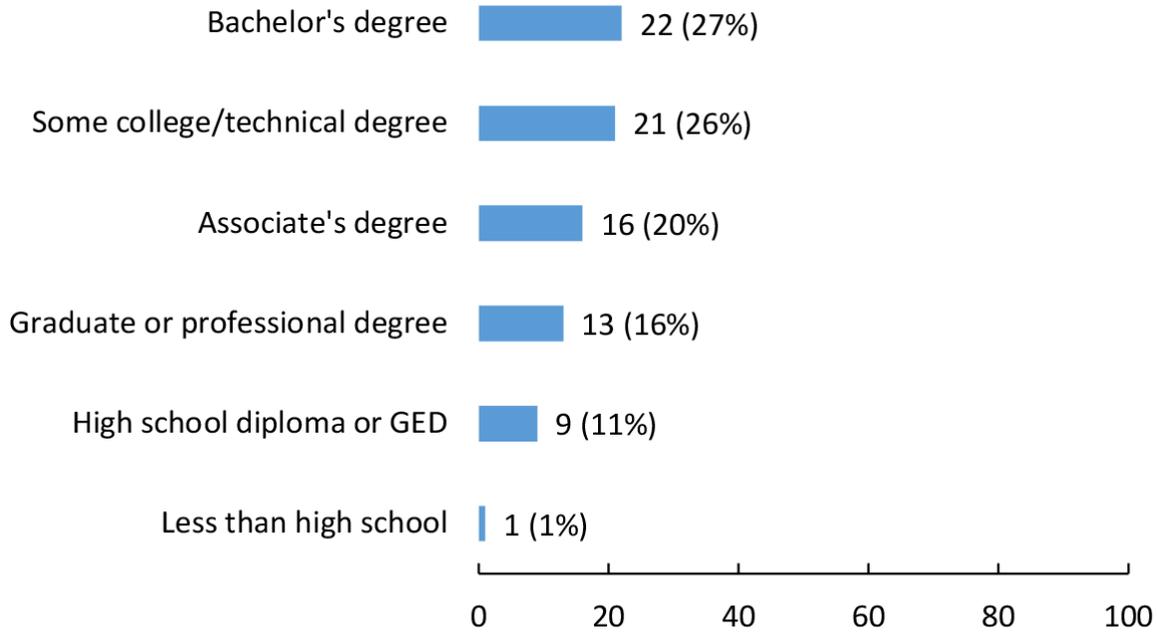
### Figure 7: Gender Demographics of Survey Respondents

Total respondents = 81



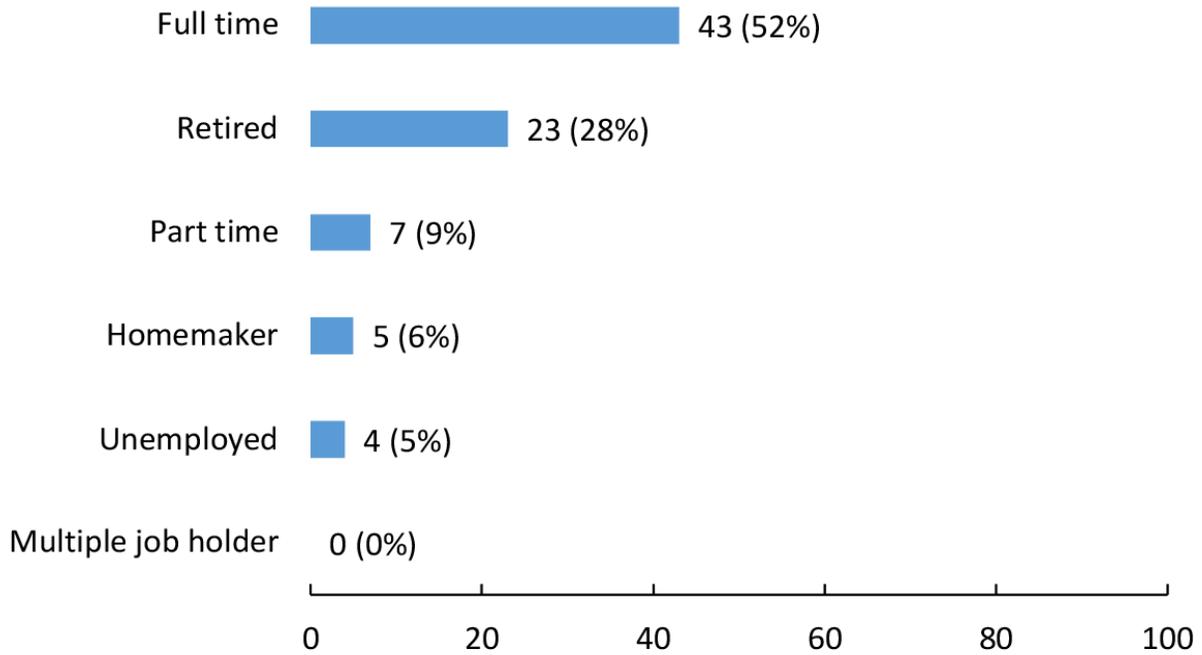
**Figure 8: Educational Level Demographics of Survey Respondents**

**Total respondents = 82**



**Figure 9: Employment Status Demographics of Survey Respondents**

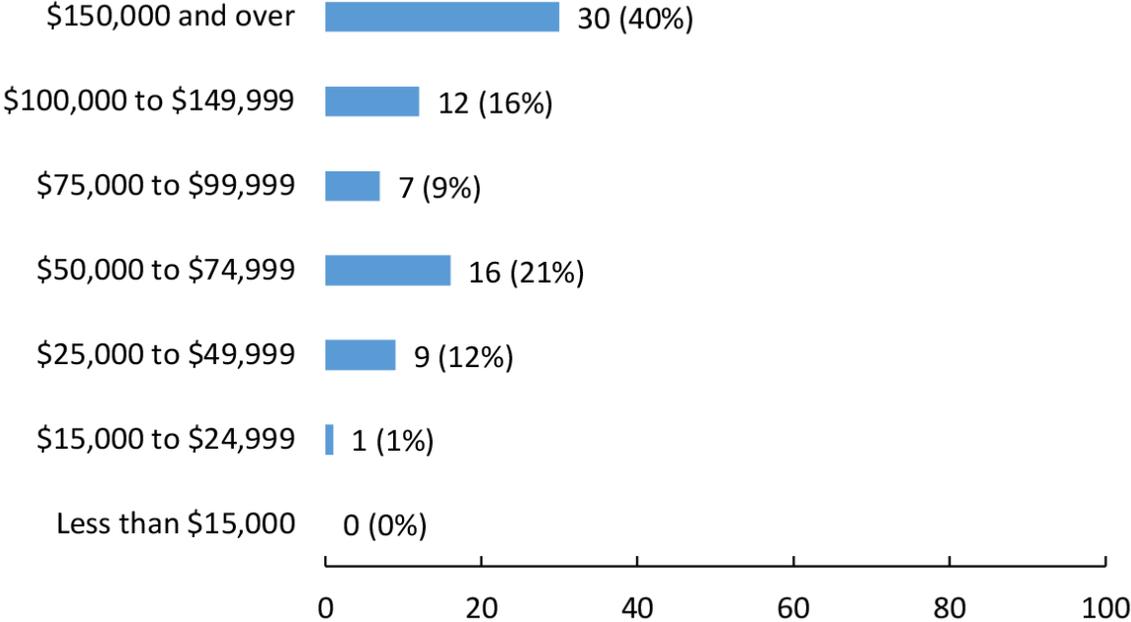
**Total respondents = 82**



Of those who provided a household income, one percent (N=1) of community members reported a household income of less than \$25,000. Fifty-six percent (N=42) indicated a household income of \$100,000 or more. This information is shown in Figure 10.

**Figure 10: Household Income Demographics of Survey Respondents**

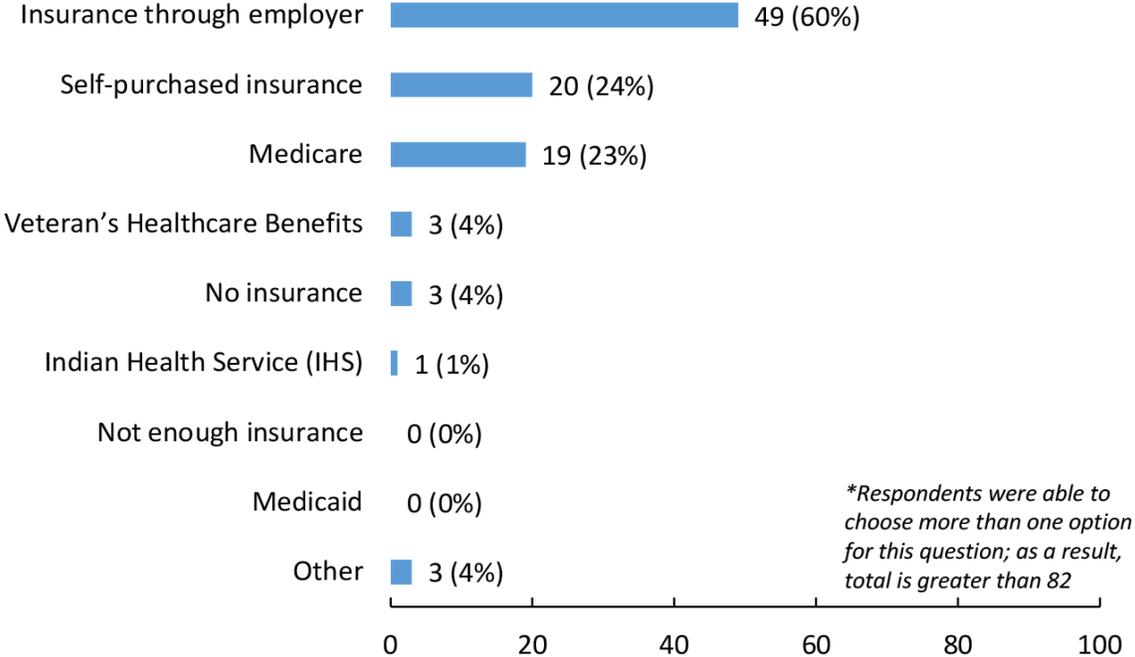
**Total respondents = 75**



Community members were asked about their health insurance status, which is often associated with whether people have access to healthcare. Three percent (N=4) of the respondents reported having no health insurance or being under-insured. The most common insurance types were insurance through one’s employer (N=49), followed by self-purchased (N=20) and Medicare (N=19).

**Figure 11: Health Insurance Coverage Status of Survey Respondents**

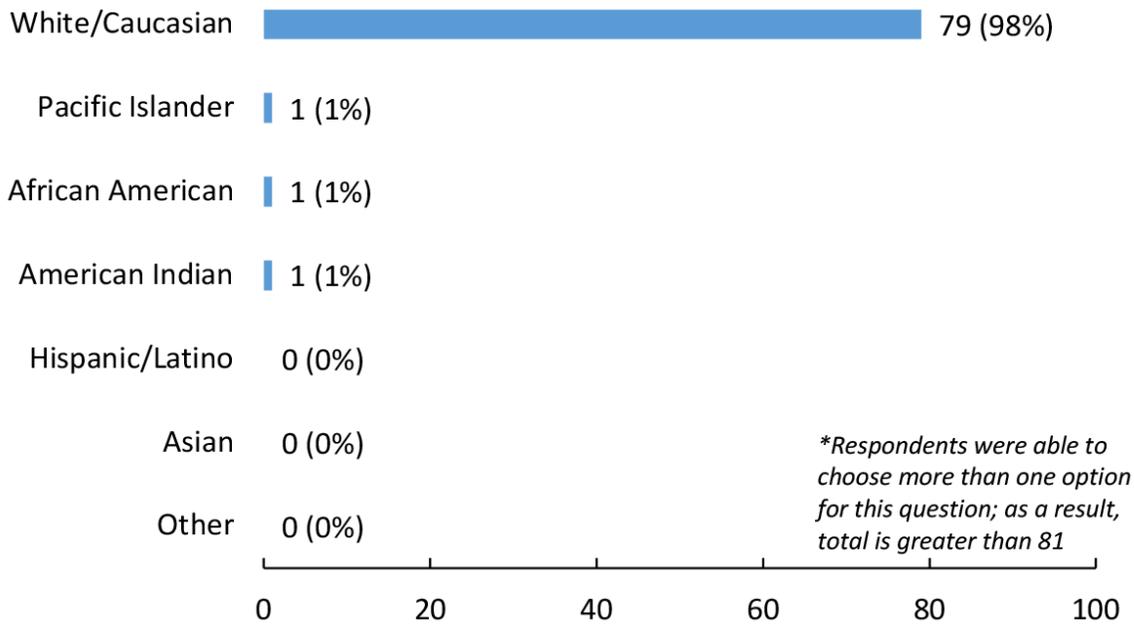
**Total responses = 82\***



As shown in Figure 12, nearly all of the respondents were White/Caucasian (98%). This was not in line with the race/ethnicity of the overall population of Mountrail County; the U.S. Census indicates that 62.9% of the population is White in Mountrail County.

**Figure 12: Race/Ethnicity Demographics of Survey Respondents**

**Total responses = 81\***



## Community Assets and Challenges

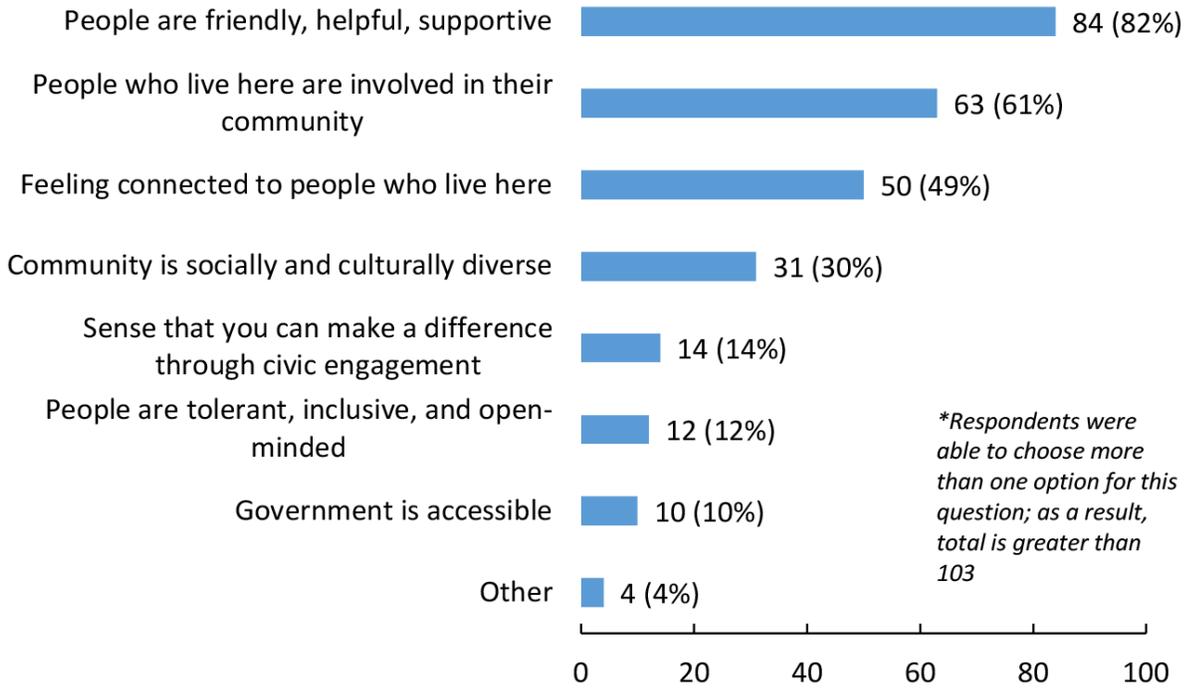
Survey-respondents were asked what they perceived as the best things about their community in four categories: people, services and resources, quality of life, and activities. In each category, respondents were given a list of choices and asked to pick the three best things. Respondents occasionally 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 65 respondents agreeing) that community assets include:

- People are friendly, helpful, supportive (N=84)
- Family-friendly (N=74)
- Healthcare (N=73)
- Safe place to live, little/no crime (N=70)
- Active faith community (N=66)

Figures 13 to 16 illustrate the results of these questions.

### Figure 13: Best Things About the PEOPLE in Your Community

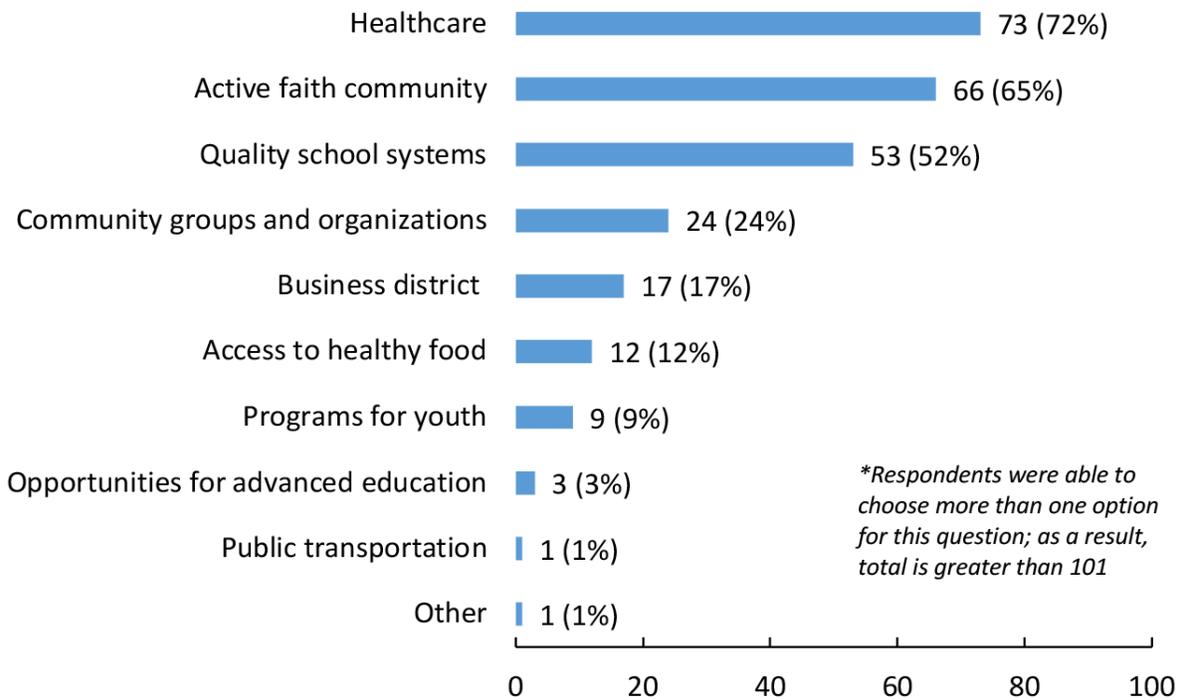
Total responses = 103\*



Included in the “Other” category of the best things about the people was many have a strong faith life and people care about traditional family values.

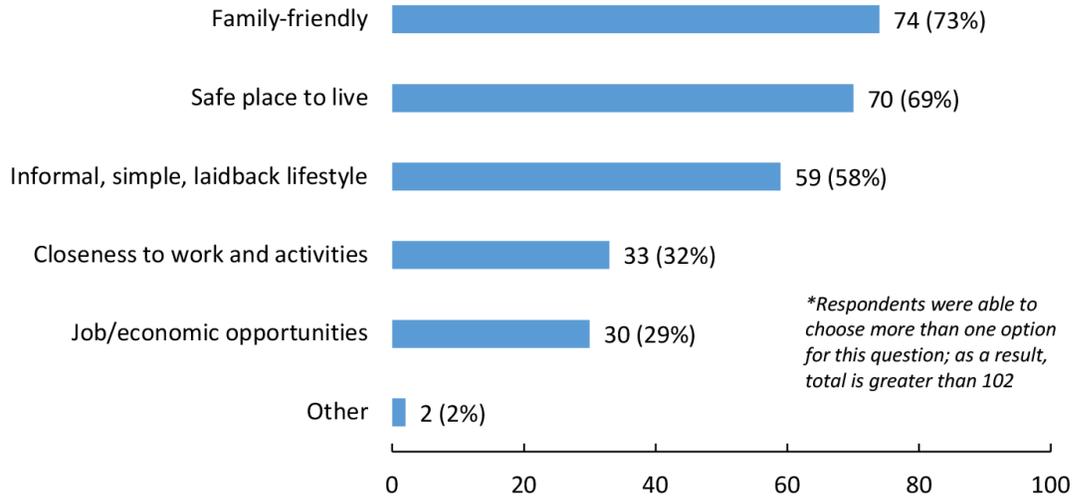
### Figure 14: Best Things About the SERVICES AND RESOURCES in Your Community

Total responses = 101\*



### Figure 15: Best Things About the QUALITY OF LIFE in Your Community

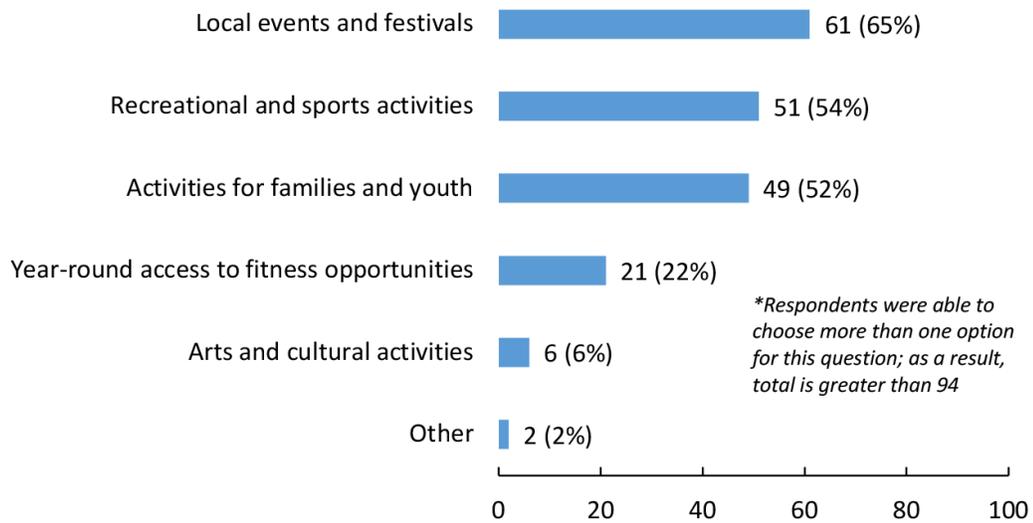
Total responses = 102\*



The one “Other” response regarding the best things about the quality of life in the community was it’s clean and there is not a lot of litter and trash.

### Figure 16: Best Thing About the ACTIVITIES in Your Community

Total responses = 94\*



## Community Concerns

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

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

**With regard to responses about community challenges, the most highly voiced concerns (those having at least 60 respondents) were:**

- Having enough child daycare services (N=49)
- Drug use and abuse – youth (N=42)
- Alcohol use and abuse – adults (N=41)
- Depression / anxiety – youth (N=40)
- Not enough affordable housing (N=37)
- Availability of resources to help the elderly stay in their homes (N=35)
- Cost of long-term / nursing home care (N=35)

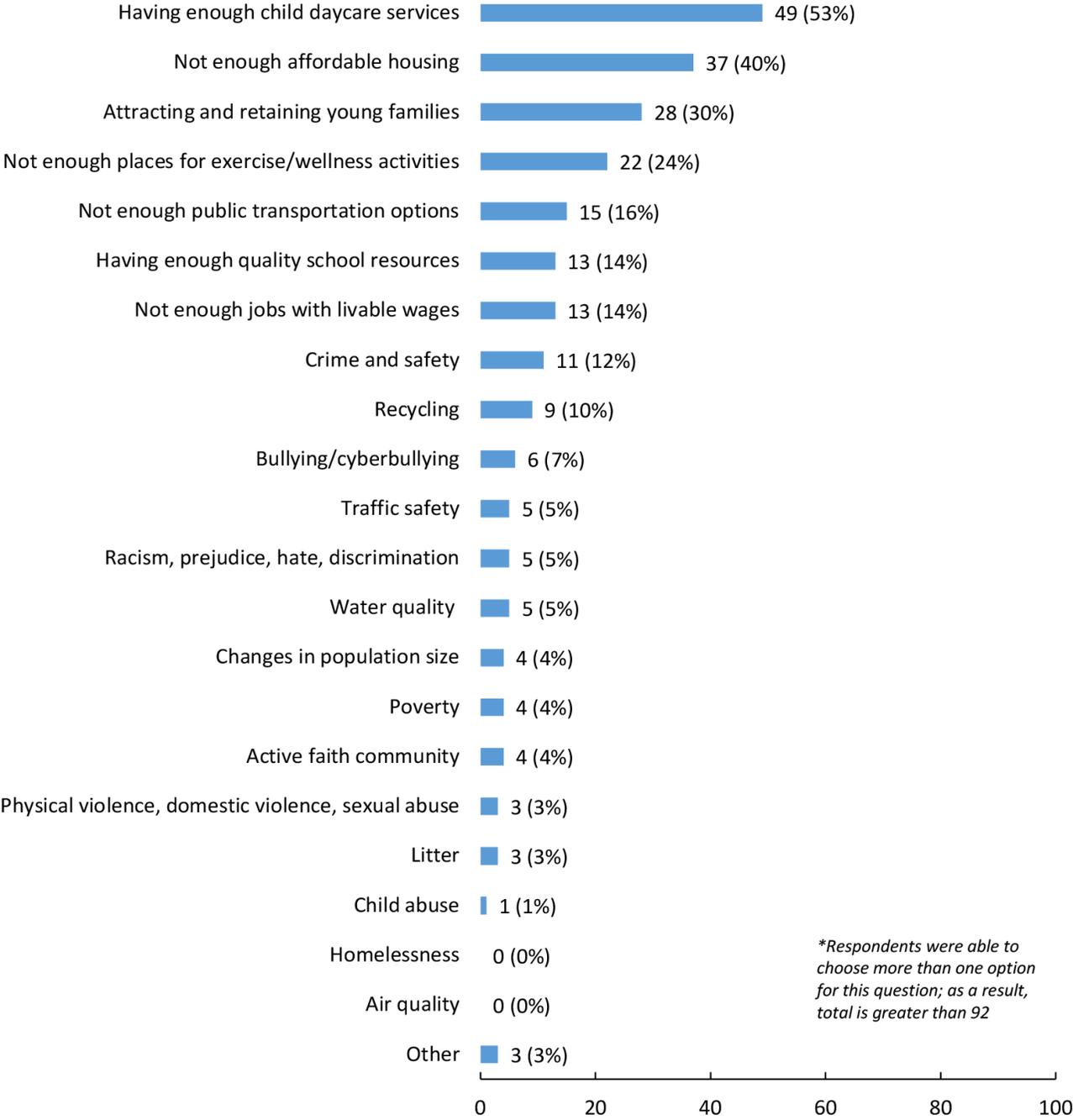
**The other issues that had at least 25 votes included:**

- Smoking and tobacco use (second-hand smoke) – youth (N= 35)
- Drug use and abuse – adult (N=34)
- Depression / anxiety – adult (N=29)
- Alcohol use and abuse – youth (N=28)
- Attracting and retaining young families (N=28)
- Cancer – adult (N=27)
- Lack of employees to fill positions (N=27)
- Cost of health insurance (N=26)

Figures 17 through 22 illustrate these results.

**Figure 17: Community/Environmental Health Concerns**

**Total responses = 92\***

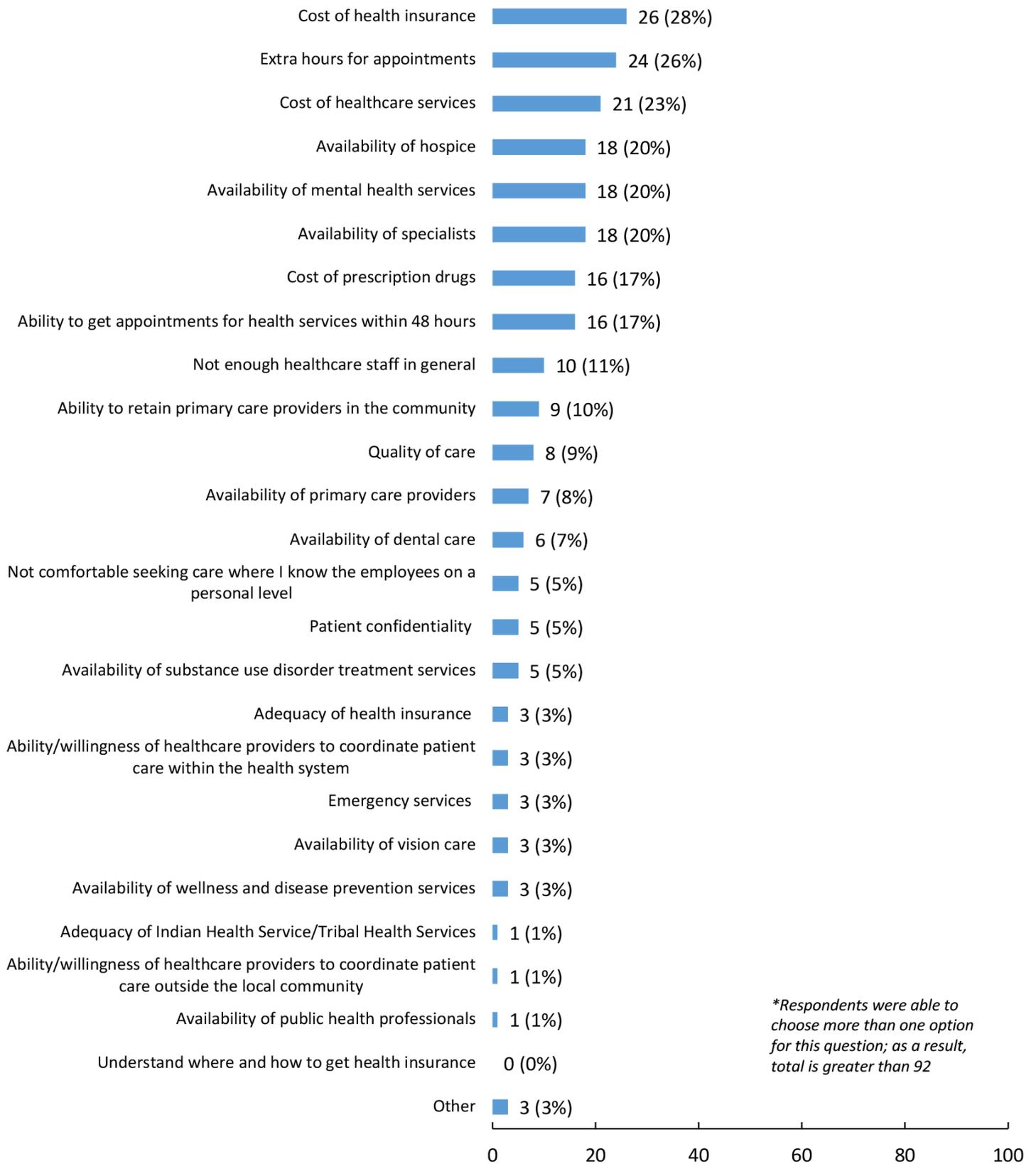


*\*Respondents were able to choose more than one option for this question; as a result, total is greater than 92*

In the “Other” category for community and environmental health concerns, the following were listed: need recreational center for young people and empty buildings.

## Figure 18: Availability/Delivery of Health Services Concerns

Total responses = 92\*

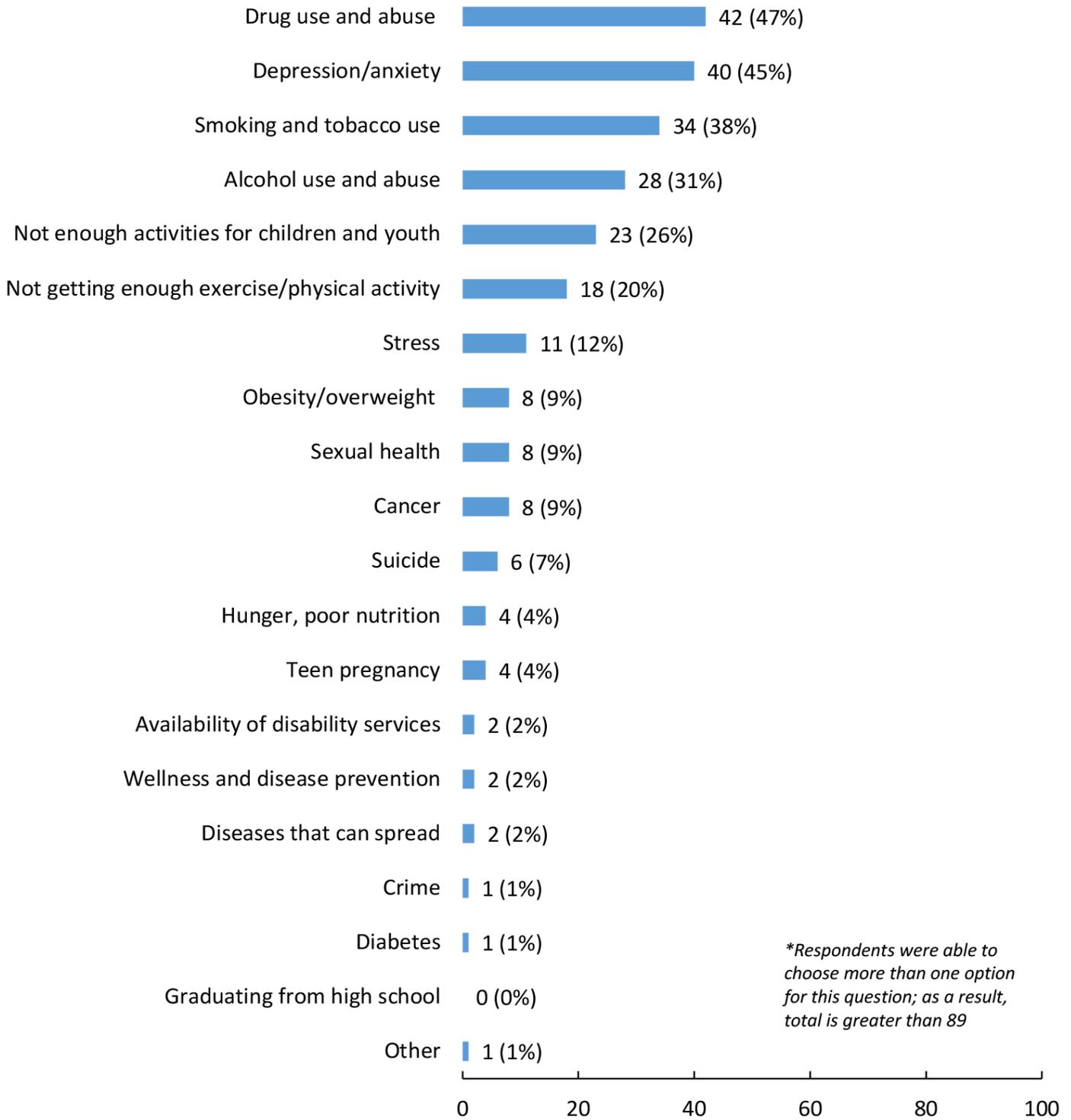


\*Respondents were able to choose more than one option for this question; as a result, total is greater than 92

Respondents who selected “Other” identified concerns in the availability/delivery of health services as a dialysis unit is needed and healthcare providers need to listen to their patients.

## Figure 19: Youth Population Health Concerns

Total responses = 89\*

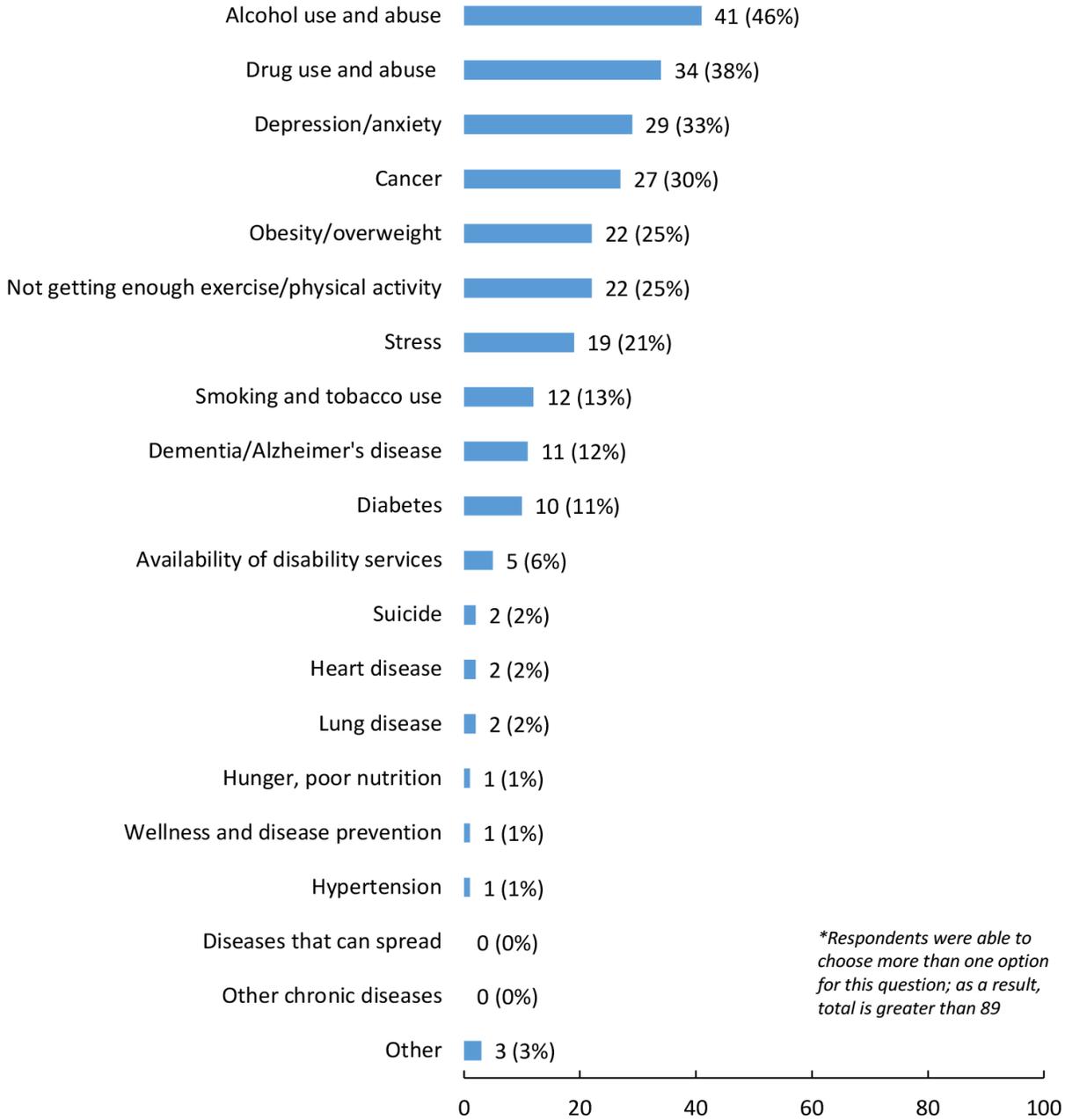


\*Respondents were able to choose more than one option for this question; as a result, total is greater than 89

Listed in the "Other" category for youth population concern was acknowledgement of non-athletes.

**Figure 20: Adult Population Concerns**

**Total responses = 89\***

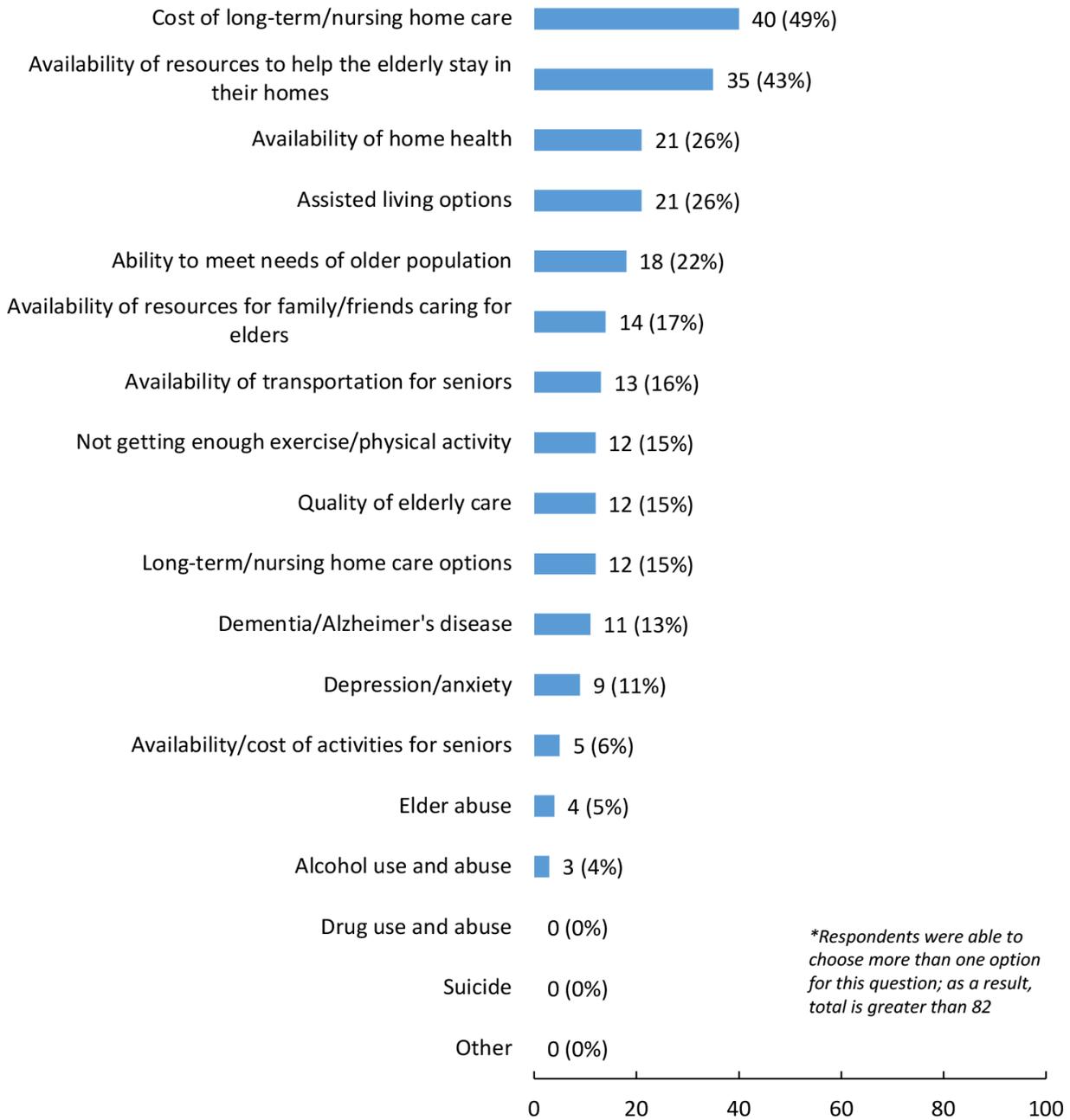


*\*Respondents were able to choose more than one option for this question; as a result, total is greater than 89*

Safe environments to live in and not enough activities outside of bar life were indicated in the “Other” category for adult population concerns.

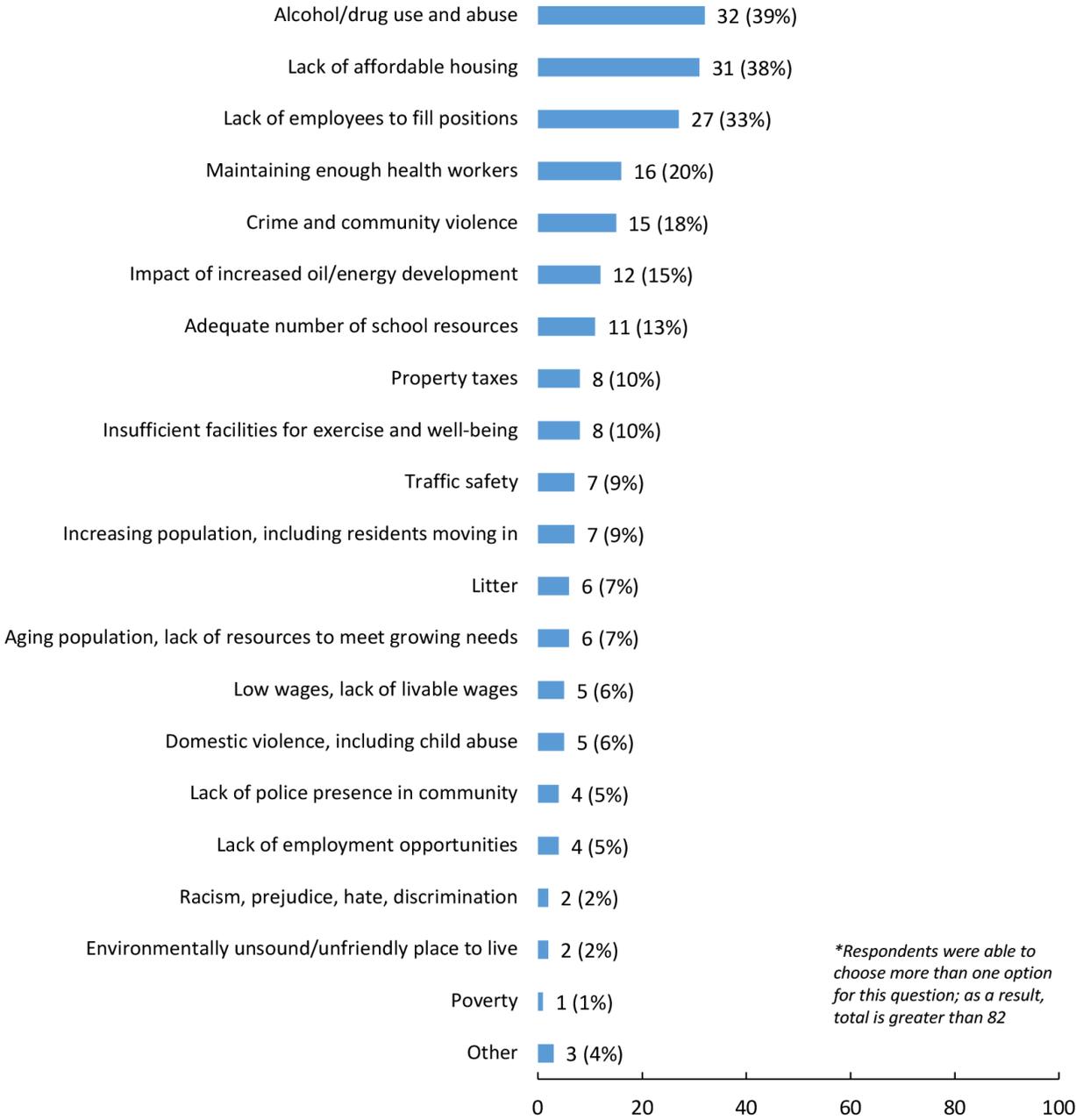
## Figure 21: Senior Population Concerns

Total responses = 82\*



**Figure 22: Concerns About Impacts of Oil Development on the Community**

**Total responses = 82\***



Respondents who selected “Other” identified concerns in the impact from oil development as too many pets left behind, no activity center, and tax relief for boom in oil.

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. Not enough affordable child daycare options
2. Availability and affordability of housing

Other biggest challenges that were identified were lack of activities, drug use and abuse, quality school resources, low wages, cost of living, discrimination, lack of workforce, lack of resources for the elderly, and availability of providers and specialists.

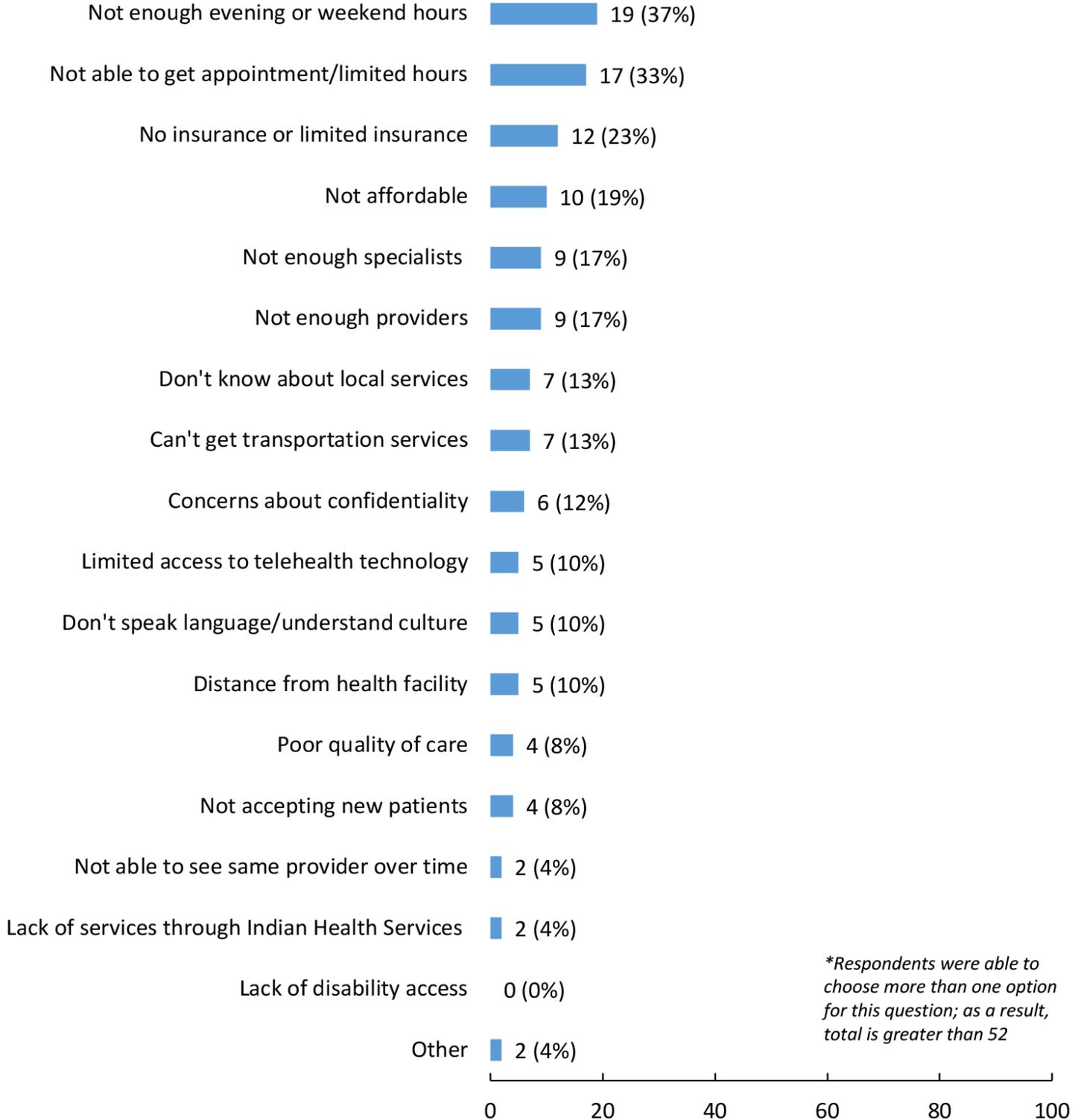
## Delivery of Healthcare

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=19), with the next highest not being able to get an appointment/limited hours (N=17). After these, the next most commonly identified barriers were no insurance or limited insurance (N=12), not affordable (N=10), and not enough providers or specialists (N=9). The concerns indicated in the "Other" category was not enough mental health services.

Figure 22 illustrates these results.

### Figure 23: Perceptions About Barriers to Care

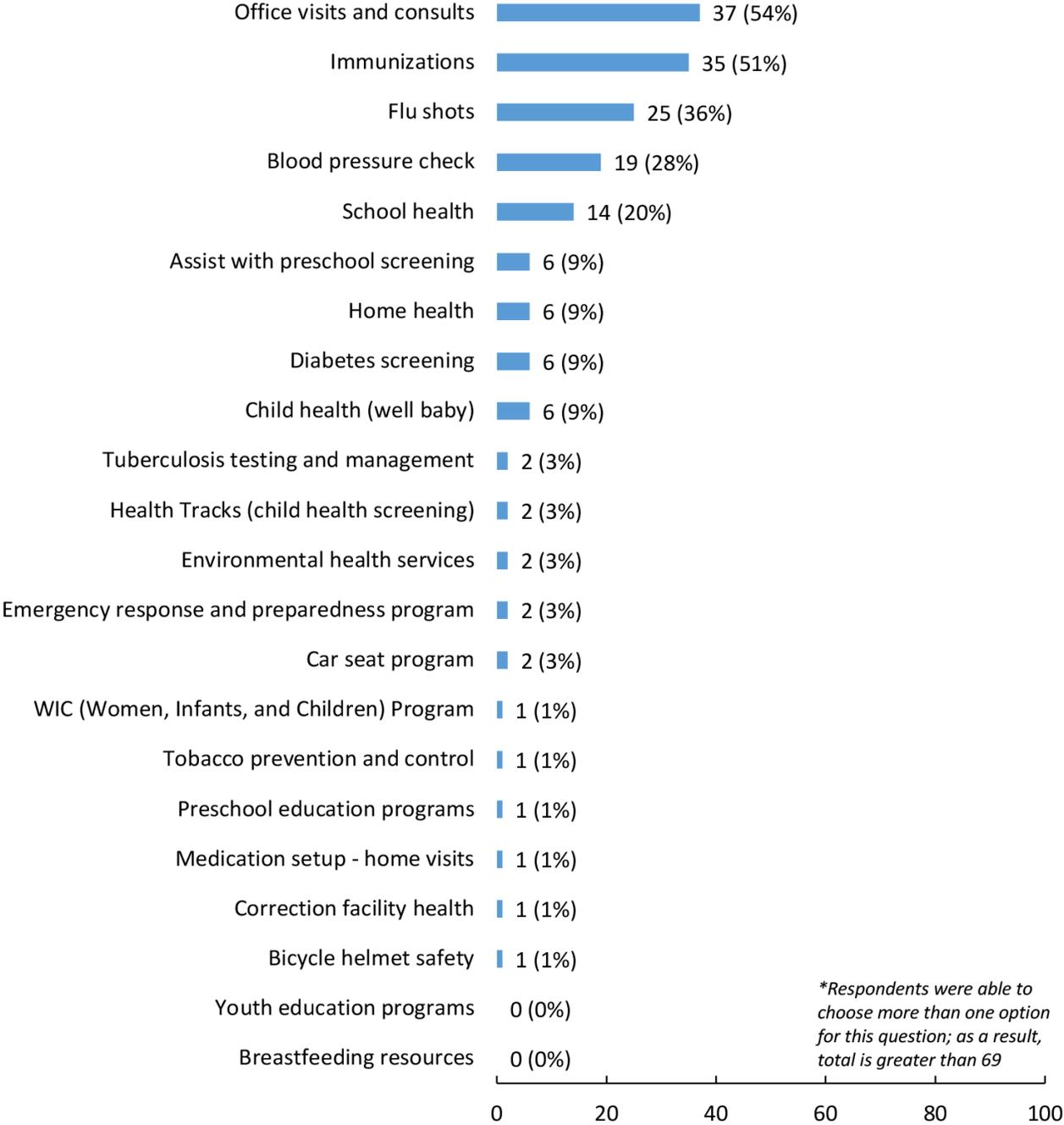
Total responses = 52\*



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

**Figure 24: Awareness and Utilization of Public Health Services**

**Total responses = 69\***



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:

- Therapist
- Surgical suite
- Smoking cessation classes
- Colonoscopy

- Hospice
- Cancer care
- Allergy
- Pain management
- Walk-in clinic
- Vision
- Dermatology
- Pediatrician
- Endocrinology
- ENT
- Ophthalmology
- Cardiology
- Hearing orthopedics
- Neurologist

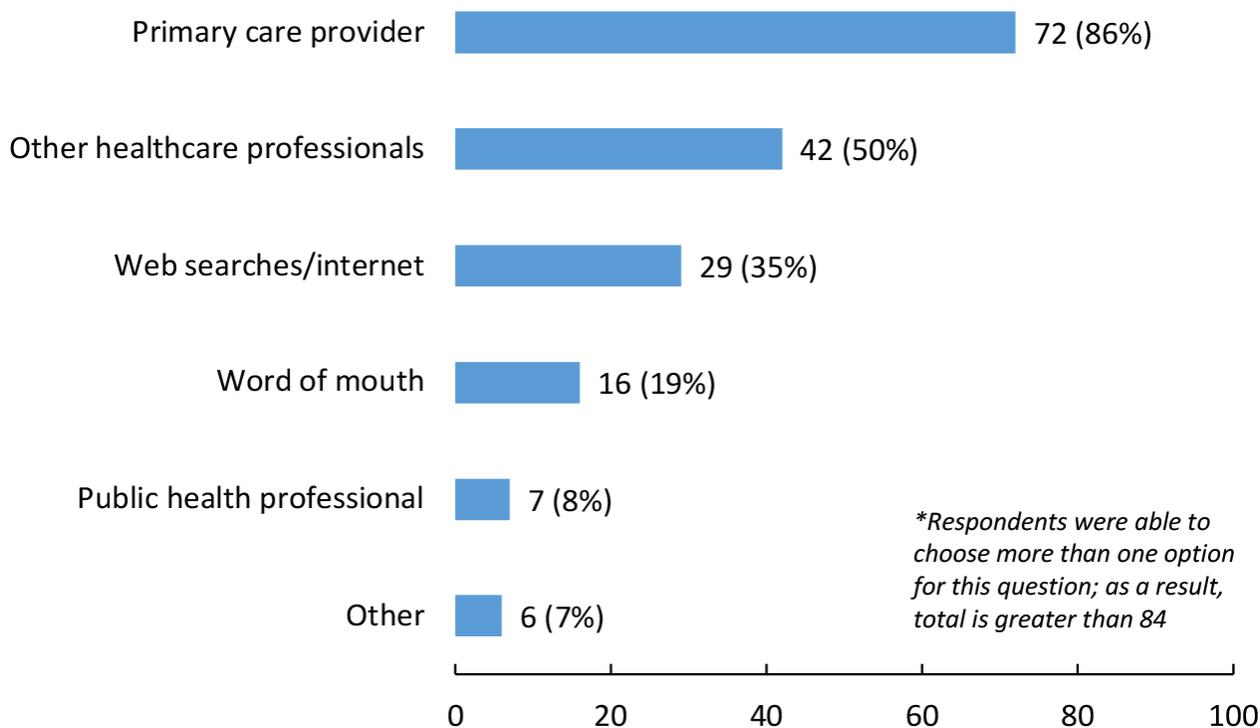
The key informant and focus group members felt that the community members were aware of the majority of the health system services. There were a number of services where they felt UMDHU should increase marketing efforts. One participant stated that they are not out in the public very much. Another person said they're mainly in Williston and other towns do not see them as much and are not aware of most of the services that are offered.

Respondents were asked where they go to for trusted health information. Primary care providers (N=72) received the highest response rate, followed by other healthcare professionals (N=42), and then web/internet searches (N=29).

Results are shown in Figure 25

**Figure 25: Sources of Trusted Health Information**

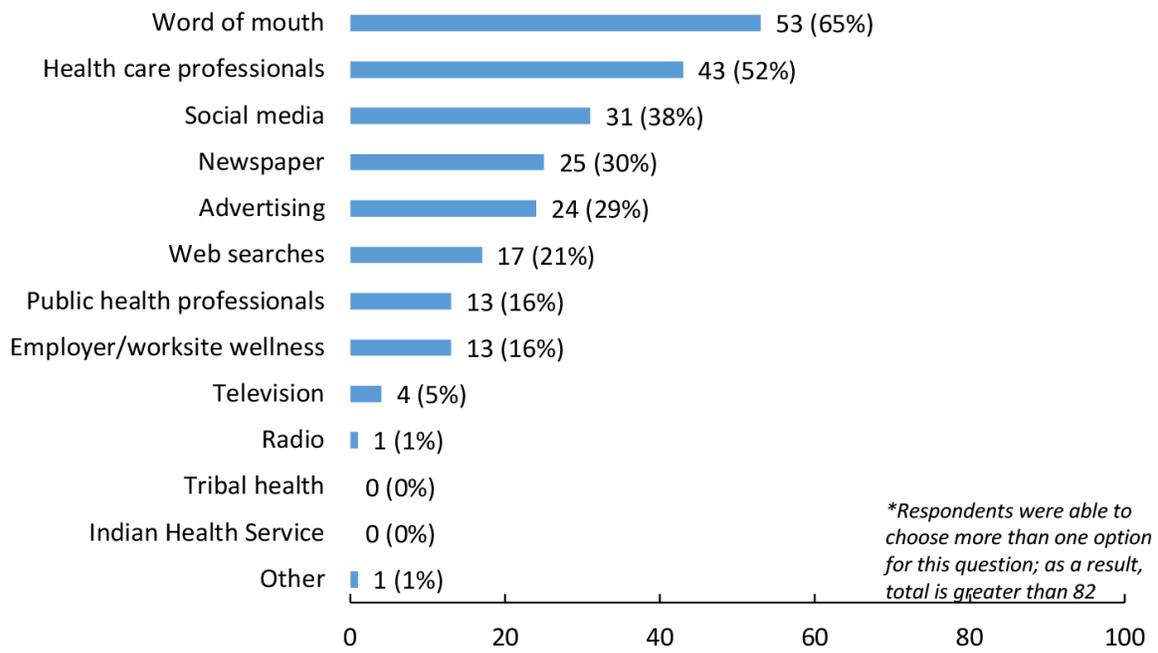
**Total responses = 84\***



In the "Other" category, several respondents stated their own research.

**Figure 26: Sources of Information About Local Health Services**

**Total responses = 82\***

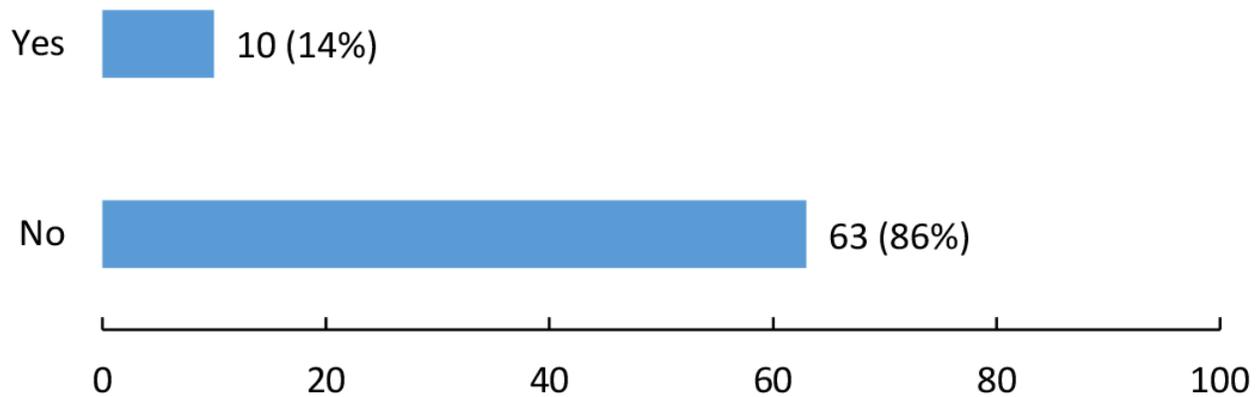


In the “Other” category, my own research was listed as a source of information about local health services.

In the survey, participants were asked if they have a new community concern. Majority of respondents selected no (N=63). If a respondent selected yes, they were asked to specify their concern, which included: people cleaning their yards, unleashed dogs, domestic violence, drug use, lead pipes, and bullying.

**Figure 27: Have a New Community Concern**

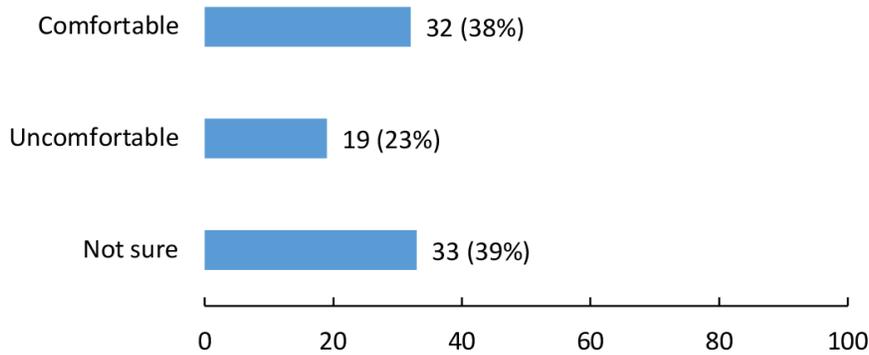
**Total responses = 73**



Participants were asked how they felt about traveling to nearby areas for specialists and surgeries. The results were split between comfortable (N=32) and not sure (N=33). See Figure 28.

**Figure 28: Attitude Towards Traveling to Nearby Areas for Specialists and Surgeries**

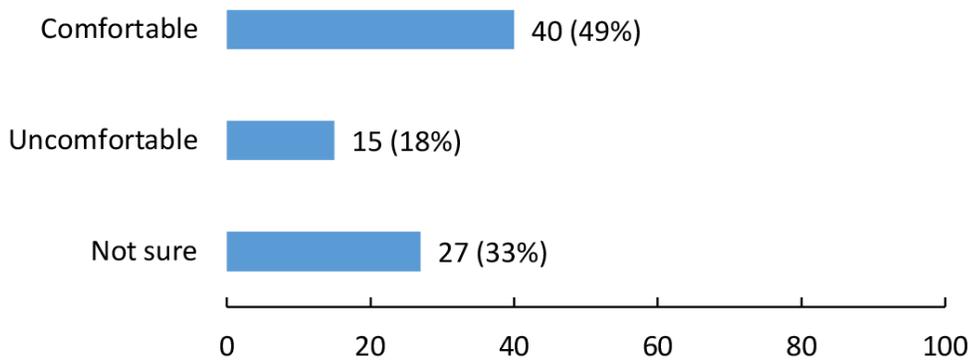
**Total responses = 84**



Participants were asked how they felt about using telehealth for appointments with specialists. Majority of respondents selected comfortable (N=40); not sure (N=27) was the next highest response. See Figure 29.

**Figure 29: Attitude Towards Utilizing Telehealth for Appointments with Specialists**

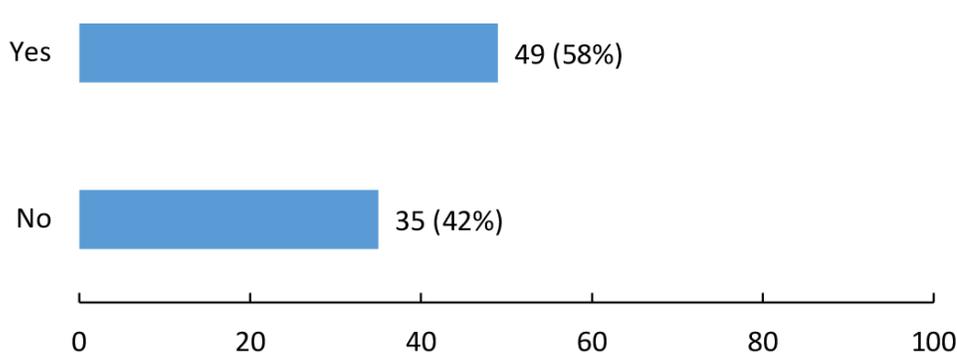
**Total responses = 82**



Respondents were asked if they were aware of psychiatric mental health appointments via telehealth. Majority of respondents are aware (N=49). See Figure 30.

**Figure 30: Aware that Psychiatric Mental Health Appointments are Available via Telehealth**

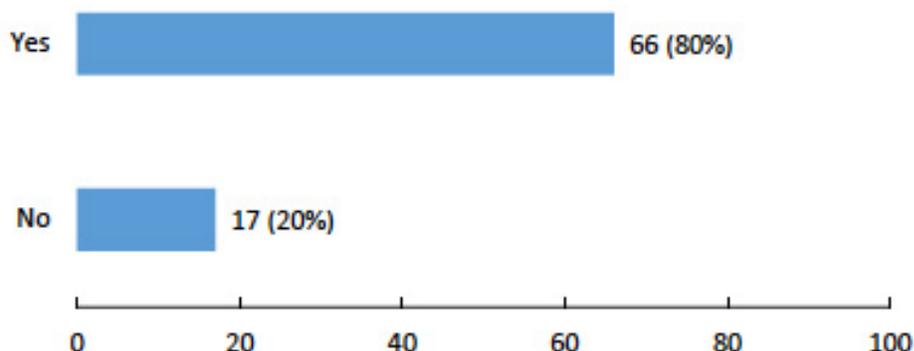
**Total responses = 84**



In an effort to gauge participants' knowledge about Mountrail County Medical Center's Foundation, they were asked of their awareness, with majority selecting yes 80% (N=66). They were asked how they'd be most likely to financially support the foundation, cash/stock gifts and memorial/honorarium received the most responses. In the "Other" category included donations. See figures below.

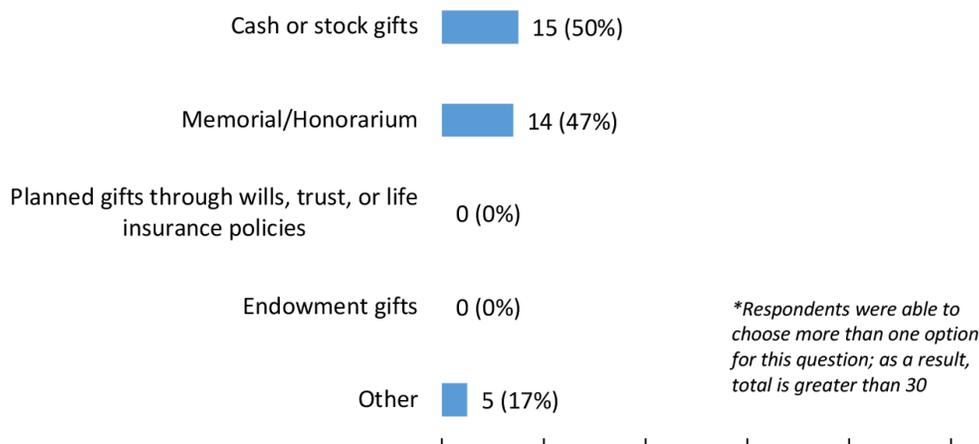
**Figure 31: Awareness of Mountrail County Medical Center's Foundation**

**Total responses = 83**



**Figure 32: Forms of Support for Mountrail County Medical Center**

**Total responses = 30\***



The final question on the survey asked respondents to share concerns and suggestions to improve the delivery of local healthcare. A number of responses stated they would like more appointment time options. It is hard for people who work during the day to leave work for an appointment for themselves or their children. One respondent said they wished there were acute care or urgent care options.

There is also a need for more mental health services. People would like to see a therapist in person. Having a therapist on-call for mental health crisis would help police share this burden. Right now, there is nothing in place for an individual who is suffering with mental health issues.

Respondents would like more resources for elderly to stay in the community longer. There is an aging population who do not have enough supports to keep them home. This is a dangerous problem for the elderly. If they stay home without home healthcare, they may fall, and no one is there to help them, or they might forget if they took important medication and take more, causing an overdose. Finding funding and budget friendly programs is essential for this population.

Another issue mentioned was domestic violence. There are not enough resources for people who are in an unsafe situation to leave and support themselves and their children. They said there needs to be a safe house in the area for victims to escape to refuge. There is also a lack of transportation in the area. People do not have a way to go to their medical appointments. They would like to have transportation options for non-emergency appointments.

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

# Findings from Key Informant Interviews and the Community Meeting

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

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

- Alcohol use and abuse
- Availability of transportation for seniors
- Depression/ anxiety
- Having enough child daycare services
- Not enough affordable housing

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

## **Alcohol use and abuse**

- There are no activities that do not include alcohol
- Top concern is addressing alcohol abuse in both adults and youth.
- This is the most important concern that we need to address, leads to other problems.

## **Availability of transportation for seniors**

- There are no transportation options for the elderly.
- Need more resources for seniors to be able to stay at home, this includes home healthcare and reliable transportation choices.

## **Depression/anxiety**

- Mental health services are needed for all ages but especially for the youth.
- Most people don't have insurance that will cover therapy or are able to pay for their portion.
- Bullying and cyberbullying is an issue; children and teenagers are not able to escape it

## **Having enough child daycare services**

- Young families have to leave the area for jobs because there are no daycare openings.
- Families have to rely on grandparents and retired family members to watch their children.
- The cost of childcare services is too much, parents have to work opposite shifts, or one parent has to stay home with the kids.

## **Not enough affordable housing**

- People are not able to find homes to live in the area that is in their budget.
- Homes are becoming multigenerational due to the cost of living.

## Community Engagement and Collaboration

Key informants and focus group participants were asked to weigh in on community engagement and collaboration of various organizations and stakeholders in the community. Specifically, participants were asked, “On a scale of 1 to 5, with 1 being no collaboration/community engagement and 5 being excellent collaboration/community engagement, how would you rate the collaboration/engagement in the community among these various organizations?” This was not intended to rank services provided. They were presented with a list of 13 organizations or community segments to 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:

- Faith-based (4.5)
- Emergency services, including ambulance and fire (4.25)
- Business and industry (4.0)
- Hospital (healthcare system) (4.0)
- Long-term care, including nursing homes and assisted living (4.0)
- Schools (4.0)
- Law enforcement (3.75)
- Economic development organizations (3.5)
- Pharmacy (3.5)
- Public health (3.5)
- Human/Social services (3.0)
- Other local health providers, such as dentists and chiropractors (3.0)
- Tribal Health/ Indian Health Service (3.0)



## Priority of Health Needs

A community group met on February 21, 2025. Nine 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 on large poster boards, and each member was given four stickers to place next to each of the four needs they considered the most significant.

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

- Having enough child daycare services (8 votes)
- Availability of resources to help the elderly stay in their homes (5 votes)
- Alcohol use and abuse for adults (5 votes)
- Extra hours for appointments, such as evenings and weekends (4 votes)
- Depression/anxiety for youth (4 votes)

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

1. Availability of resources to help the elderly stay in their homes (7 votes)
2. Having enough child daycare services (2 votes)
3. Alcohol use and abuse for adults (0 votes)
4. Depression/anxiety for youth (0 votes)
5. Extra hours for appointments, such as evenings and weekends (0 votes)

Following the prioritization process during the second meeting of the community group and key informants, the number one identified need was the availability of resources to help the elderly stay in their homes. A summary of this prioritization may be found in Appendix E.

## Comparison of Needs Identified Previously

Top Needs Identified 2022 CHNA Process	Top Needs Identified 2025 CHNA Process
Availability of mental health services	Adult alcohol use and abuse
Adult alcohol use and abuse	Availability of resources to help the elderly stay in their homes
Youth drug use and abuse	Extra appointment hours, such as evening and weekends
Having enough child daycare services	Having enough child daycare services
	Youth drug use and abuse

The current process did identify three identical common needs from 2022. Adult alcohol use and abuse, having enough child daycare services, and youth drug use and abuse were concerns from 2022 CHNA cycle. The new identified concerns are availability of resources to help the elderly stay in their homes and extra appointment hours.

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, and then the report will be widely available to the public on the hospital's website; 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 2022

In response to the needs identified in the 2022 CHNA process, the following actions were taken:

Need 1: Depression and Anxiety – The Dare to Define YOU youth leadership program was started in New Town and Stanley for the school year 2019/2020, 2020/2021, 2021/2022, 2022/2023 and again for 2023/2024. With this program, MCMC is addressing the mental health issue with the children and their parents by helping them with skill building. Leadership is 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 you become leaders, together – lives are transformed.

Continuing to work with the Stanley High School administration to identify at risk children and the Mountrail County Health Foundation helps funds needs for these children to receive help.

In 2023, MCMC brought in two mental health providers. Tara Schaefer-Nygaard, LCSW, sees patients every Wednesday in the clinic. Rosalyn Geier, DNP, PMHNP, sees patients on Mondays and Fridays via telehealth.

In 2024, MCMC continued to utilize Tara Schaefer-Nygaard and Rosalyn Geier. They also brought in Avel eCare Behavioral Health Services into their emergency room.

Need 2: Alcohol Use and Abuse for all Ages – The objective was to work closely with local agencies, such as the UMDHU and the local social services along with the MCMC emergency room 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.

Need 3: Attracting and Retaining Young Families – Cannot be addressed by this implementation plan

Need 4: Having Enough Child Daycare Services – After reviewing spaces for this in their building and offsite, they determined that this issue cannot be addressed by the MCMC. They do not have available space on site.

The above implementation plan for MCMC is posted on the Mountrail County Medical Center’s website at <https://www.stanleyhealth.org/resources>.

## 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.

### 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. 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 the health of the community
- Advance the medical or health knowledge
- Relieve or reduce the burden of government or other community efforts

**A program or activity should not be reported as a 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

**Administrator:**  
Steph Everett

**Chief of Medical Staff:**  
Mark Longmuir, MD

**Board Chair:**  
Ryan Gjellstad

**City Population:**  
2,655 (2019 estimate)<sup>1</sup>

**County Population:**  
10,321 (2019 estimate)<sup>1</sup>

**County Median Household  
Income:**  
\$72,147 (2019 estimate)<sup>1</sup>

**County Median Age:**  
33.2 years (2019 estimate)<sup>1</sup>

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

**Owned by:** Not for profit

**Hospital Beds:** 11

**Basic Care Beds:** 10

**Assisted Living:** 14 Units

**Skilled Nursing Facility  
Beds:** 36

**Trauma Level:** V

**Critical Access Hospital  
Designation:** 1999

### Mission

Mountrail County Medical Center (MCMC) will provide quality healthcare 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

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

MCMC 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

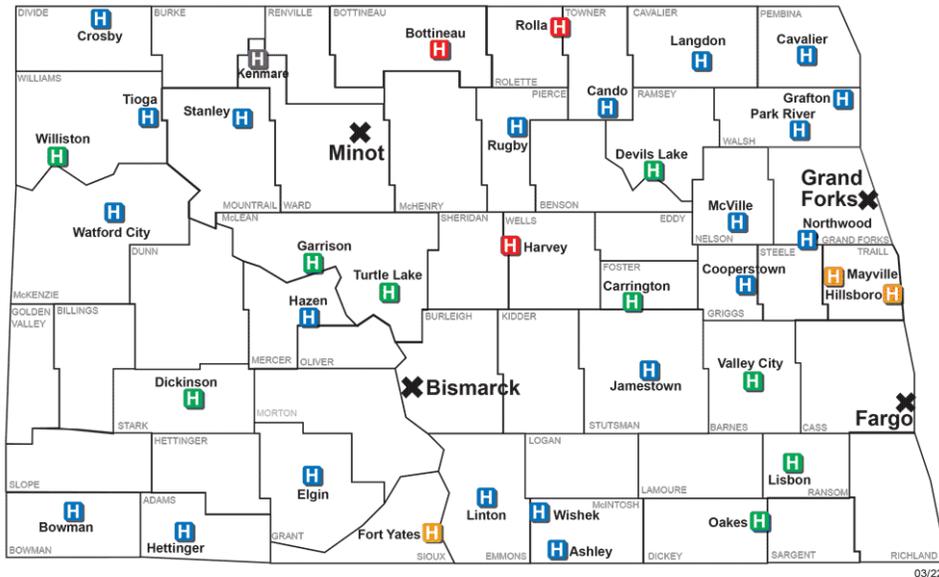
**MCMC provides the following services directly:**

- 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
- Sports medicine
- MRI
- Hearing assessment
- Ultrasound
- Sleep studies

# North Dakota Critical Access Hospitals



**Hospital Ownership**

- H Independently owned
- H CommonSpirit Health
- H Sanford Health
- H Sisters of Mary of the Presentation Health System
- H Trinity
- H Indian Health Services

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

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

The decision was made to build a new downsized hospital facility and merge the operations for MCMC 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 MCMC. 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.

## Staff

- Physicians: 1
- Nurse Practitioners: 5
- PAs: 2
- RNs: 21
- LPNs: 10
- Total Employees: 138

## Local Sponsors and Grant Funding Sources

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

## Sources

- <sup>1</sup> US Census Bureau; American Factfinder; Community Facts



[ruralhealth.und.edu](http://ruralhealth.und.edu)

Updated 4/2025

# Appendix B – CHNA Survey Instrument



## Stanley Area Health Survey

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

The focus of this effort is to:

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



If you prefer, you may take the survey online at <https://tinyurl.com/chnastanley24> 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 Holly Long at 701.777.3848.

***Surveys will be accepted through December 16, 2024. Your opinion matters – thank you in advance!***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Regarding impacts from **OIL DEVELOPMENT** in your community, concerns are (choose up to THREE):

- |  |  |
|--|--|
| <input type="checkbox"/> Adequate number of school resources                       | <input type="checkbox"/> Lack of employment opportunities                                    |
| <input type="checkbox"/> Aging population, lack of resources to meet growing needs | <input type="checkbox"/> Lack of police presence in community                                |
| <input type="checkbox"/> Alcohol and drug use and abuse                            | <input type="checkbox"/> Litter  |
| <input type="checkbox"/> Crime and community violence                              | <input type="checkbox"/> Low wages, lack of livable wages                                    |
| <input type="checkbox"/> Domestic violence, including child abuse                  | <input type="checkbox"/> Maintaining enough health workers (e.g., medical, dental, wellness) |
| <input type="checkbox"/> Environmentally unsound (or unfriendly) place to live     | <input type="checkbox"/> Poverty   |
| <input type="checkbox"/> Impact of increased oil/energy development                | <input type="checkbox"/> Property taxes  |
| <input type="checkbox"/> Increasing population, including residents moving in      | <input type="checkbox"/> Racism, prejudice, hate, discrimination                             |
| <input type="checkbox"/> Insufficient facilities for exercise and well-being       | <input type="checkbox"/> Traffic safety, including speeding, road safety and drunk driving   |
| <input type="checkbox"/> Lack of affordable housing                                | Other (please specify): _____  |
| <input type="checkbox"/> Lack of available housing (for purchase or rent)          |  |
| <input type="checkbox"/> Lack of employees to fill positions                       |  |

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

\_\_\_\_\_

\_\_\_\_\_

## Delivery of Healthcare

12. 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)

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

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

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

14. 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): \_\_\_\_\_

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

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

16. Are there any new Community Concerns in the area that is alarming to you?

- Yes
- No

17. If yes, what?

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18. How do you feel about using/traveling to facilities in nearby areas that are Critical Access Hospital's (Watford City, Rugby, Jamestown, Grafton, etc.) in order to meet your healthcare needs for specialists and surgeries?

- Comfortable
- Uncomfortable
- Not sure

19. Mountrail County Medical Center currently has the following specialists coming to our facility: Orthopedics, Podiatry, Hearing, Audiology, OB/GYN. Are there other specialists you would utilize like to see come to Stanley?

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---

20. How would you feel about utilizing appointments via telehealth with these other specialists you are suggesting?

- Comfortable
- Uncomfortable
- Not sure

21. Are you aware that Psychiatric Mental Health appointments, with a Psychiatric Nurse Practitioner, are currently available at our Clinic via Telehealth? Services provided include evaluation assessments and prescription medication management.

- Yes
- No

22. Are you aware of Mountrail County Medical Center's Foundation, which exists to financially support Sakakawea Medical Center?

- Yes  No

23. Have you supported the Mountrail County Medical Center Foundation in any of the following ways? (Choose ALL that apply)

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

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

\_\_\_\_\_

\_\_\_\_\_

**Demographic Information:** Please tell us about yourself.

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

- Yes  No

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

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

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

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

28. Age:

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

29. Highest level of education:

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

30. Gender:

- |   |                               |                                     |
|---|-------------------------------|-------------------------------------|
| <input type="checkbox"/> Female                           | <input type="checkbox"/> Male | <input type="checkbox"/> Non-binary |
| <input type="checkbox"/> Other (please specify):<br>_____ |                               |                                     |

31. Employment status:

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

32. Your zip code: \_\_\_\_\_

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

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> American Indian  | <input type="checkbox"/> Hispanic/Latino  | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> African American | <input type="checkbox"/> Pacific Islander |                                       |
| <input type="checkbox"/> Asian            | <input type="checkbox"/> White/Caucasian  |                                       |

34. Annual household income before taxes:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Less than \$15,000   | <input type="checkbox"/> \$50,000 to \$74,999   | <input type="checkbox"/> \$150,000 and over |
| <input type="checkbox"/> \$15,000 to \$24,999 | <input type="checkbox"/> \$75,000 to \$99,999   |   |
| <input type="checkbox"/> \$25,000 to \$49,999 | <input type="checkbox"/> \$100,000 to \$149,999 |   |

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

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***Thank you for assisting us with this important survey!***

# Appendix C – County Health Rankings Explained

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

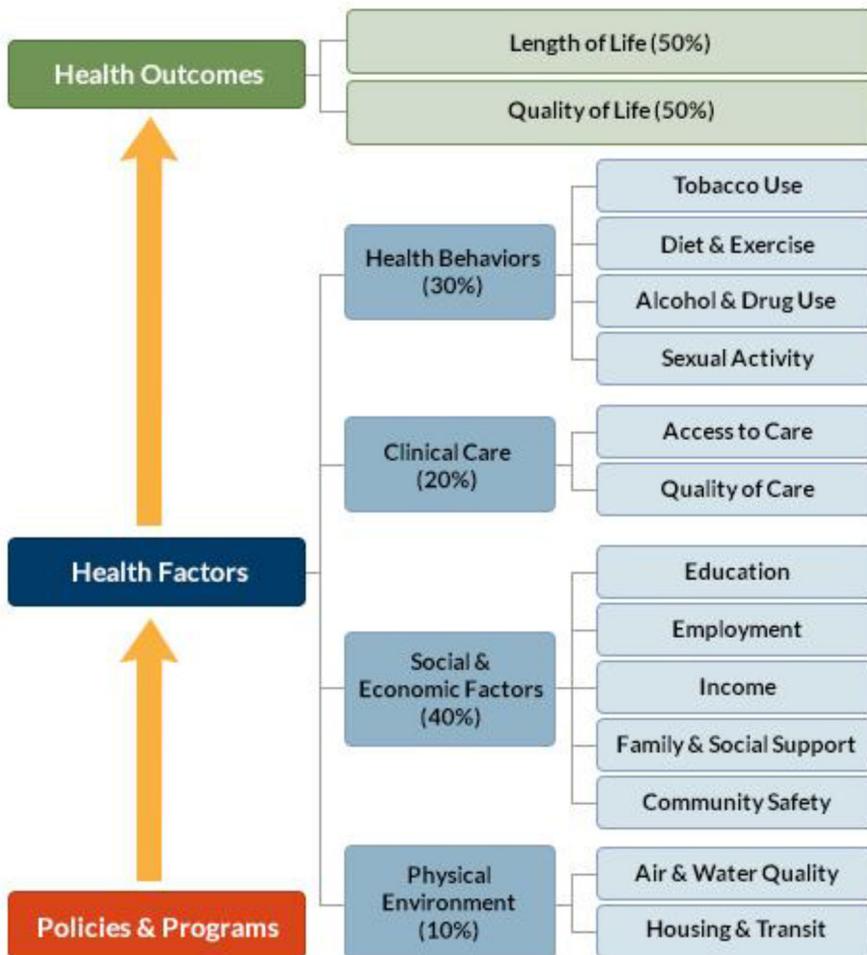
## Methods

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

## What is Ranked

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

## Ranking System



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

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

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

## Data Sources and Measures

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

## Data Quality

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

## Calculating Scores and Ranks

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

# Health Outcomes and Factors

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

## Health Outcomes

### Premature Death (YPLL)

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

#### *Reason for Ranking*

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

### Poor or Fair Health

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

#### *Reason for Ranking*

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

### Poor Physical Health Days

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

#### *Reason for Ranking*

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

### Poor Mental Health Days

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

#### *Reason for Ranking*

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

### Low Birth Weight

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

### *Reason for Ranking*

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

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

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

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

## **Health Factors**

### **Adult Smoking**

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

### *Reason for Ranking*

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

### **Adult Obesity**

Adult obesity is the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m<sup>2</sup>.

### *Reason for Ranking*

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

### **Food Environment Index**

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

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

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

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

### *Reason for Ranking*

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

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

### **Physical Inactivity**

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

### *Reason for Ranking*

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

### **Access to Exercise Opportunities**

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

Individuals who:

- reside in a census block within a half mile of a park or
- in urban census blocks: reside within one mile of a recreational facility or
- in rural census blocks: reside within three miles of a recreational facility
- are considered to have adequate access for opportunities for physical activity.

### *Reason for Ranking*

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

### **Excessive Drinking**

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

### *Reason for Ranking*

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

### **Alcohol-Impaired Driving Deaths**

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

### *Reason for Ranking*

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

### **Sexually Transmitted Infection Rate**

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

### *Reason for Ranking*

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

### **Teen Births**

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

### *Reason for Ranking*

Evidence suggests teen pregnancy significantly increases the risk of repeat pregnancy and of contracting a STI, both of which can result in adverse health outcomes for mothers, children, families, and communities. A systematic review of the sexual risk among pregnant and mothering teens concludes that pregnancy is a marker for current and future sexual risk behavior and adverse outcomes [1]. Pregnant teens are more likely than older women to receive late or no prenatal care, have eclampsia, puerperal endometritis, systemic infections, low birthweight, preterm delivery, and severe neonatal conditions [2, 3]. Pre-term delivery and low birthweight babies have increased risk of child developmental delay, illness, and mortality [4]. Additionally, there are strong ties between teen birth and poor socioeconomic, behavioral, and mental outcomes. Teenage women who bear a child are much less likely to achieve an education level at or beyond high school, much more likely to be overweight/obese in adulthood, and more likely to experience depression and psychological distress [5-7].

### **Uninsured**

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

### *Reason for Ranking*

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

The Kaiser Family Foundation released a report in December 2017 that outlines the effects insurance has on access to healthcare and financial independence. One key finding was that “Going without coverage can have serious health consequences for the uninsured because they receive less preventative care, and delayed care often results in serious

illness or other health problems. Being uninsured can also have serious financial consequences, with many unable to pay their medical bills, resulting in medical debt.”[1]

### **Primary Care Physicians**

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

#### *Reason for Ranking*

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

### **Dentists**

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

#### *Reason for Ranking*

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

### **Mental Health Providers**

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

#### *Reason for Ranking*

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

### **Preventable Hospital Stays**

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

#### *Reason for Ranking*

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

### **Diabetes Monitoring**

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

#### *Reason for Ranking*

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

## **Mammography Screening**

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

### *Reason for Ranking*

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

## **Unemployment**

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

### *Reason for Ranking*

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

## **Children in Poverty**

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

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

### *Reason for Ranking*

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

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

## **Income Inequality**

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

### *Reason for Ranking*

Income inequality within U.S. communities can have broad health impacts, including increased risk of mortality, poor

health, and increased cardiovascular disease risks. Inequalities in a community can accentuate differences in social class and status and serve as a social stressor. Communities with greater income inequality can experience a loss of social connectedness, as well as decreases in trust, social support, and a sense of community for all residents.

### **Children in Single-Parent Households**

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

#### *Reason for Ranking*

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

### **Violent Crime Rate**

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

#### *Reason for Ranking*

High levels of violent crime compromise physical safety and psychological well-being. High crime rates can also deter residents from pursuing healthy behaviors, such as exercising outdoors. Additionally, exposure to crime and violence has been shown to increase stress, which may exacerbate hypertension and other stress-related disorders and may contribute to obesity prevalence.[1] Exposure to chronic stress also contributes to the increased prevalence of certain illnesses, such as upper respiratory illness, and asthma in neighborhoods with high levels of violence.[2]

### **Injury Deaths**

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

#### *Reason for Ranking*

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

### **Air Pollution-Particulate matter**

Air pollution-particulate Matter is the average daily density of fine particulate matter in micrograms per cubic meter (PM<sub>2.5</sub>) 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 D – Youth Risk Behavior Survey

Youth Risk Behavior Survey Results. North Dakota High School Survey.

Rate Increase “↑” rate decrease “↓”, or no statistical change = in rate from 2017-2019

	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
<b>Injury and Violence</b>							
Percentage of students who rarely or never wore a seat belt (when riding in a car driven by someone else)	8.1	5.9	<b>49.6</b>	=	9.2	5.0	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)	16.5	14.2	<b>13.1</b>	=	18.2	13.7	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)	56.2	59.6	<b>64.4</b>	=	64.9	64.2	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)	52.6	53.0	<b>55.4</b>	=	59.9	55.9	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)	20.6	NA	<b>NA</b>	<b>NA</b>	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)	5.9	4.9	<b>5.0</b>	=	6.2	4.4	3.1
Percentage of students who were in a physical fight on school property (one or more times during the 12 months before the survey)	7.2	7.1	<b>NA</b>	<b>NA</b>	NA	NA	5.8
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)	8.7	9.2	<b>9.4</b>	=	9.7	11.6	9.7
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)	NA	NA	<b>NA</b>	<b>NA</b>	NA	NA	8.5
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)	11.4	11.6	<b>11.0</b>	=	11.2	11.1	NA
Percentage of students who were bullied on school property (during the 12 months before the survey)	24.3	19.9	<b>15.8</b>	↓	19.8	15.0	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)	18.8	14.7	<b>13.6</b>	↓	16.2	14.5	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)	28.9	30.5	<b>36.0</b>	↑	34.8	39.7	42.3
Percentage of students who seriously considered attempting suicide (during the 12 months before the survey)	16.7	18.8	<b>18.6</b>	=	18.5	20.6	22.2

	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
Percentage of students who made a plan about how they would attempt suicide (during the 12 months before the survey)	14.5	15.3	<b>14.8</b>	=	15.1	17.2	15.7
Percentage of students who attempted suicide (one or more times during the 12 months before the survey)	13.5	13.0	6.1	↓	7.9	7.5	10.2
<b>Tobacco Use</b>							
Percentage of students who ever tried cigarette smoking (even one or two puffs)	30.5	29.3	<b>22.3</b>	↓	26.8	21.1	17.8
Percentage of students who smoked a whole cigarette before age 13 years (even one or two puffs)	11.2	NA	<b>NA</b>	<b>NA</b>	NA	NA	6.3
Percentage of students who currently smoked cigarettes (on at least one day during the 30 days before the survey)	12.6	8.3	<b>5.9</b>	↓	8.0	6.1	3.8
Percentage of students who currently frequently smoked cigarettes (on 20 or more days during the 30 days before the survey)	3.8	2.1	<b>0.8</b>	↓	1.7	1.3	0.7
Percentage of students who currently smoked cigarettes daily (on all 30 days during the 30 days before the survey)	3.0	1.4	<b>0.7</b>	↓	1.3	1.1	0.41
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) ~2021~ Usually got their electronic vapor products by buying them themselves in a convenience store, supermarket, discount store, or gas station	7.5	13.2	<b>NA</b>	<b>NA</b>	NA	NA	6.8
Percentage of students who tried to quit smoking cigarettes (among students who currently smoked cigarettes during the 12 months before the survey)	50.3	54.0	<b>30.9</b>	↓	30.4	29.9	NA
Percentage of students who currently use an electronic vapor product (e-cigarettes, vape e-cigs, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens at least one day during the 30 days before the survey)	20.6	33.1	<b>21.2</b>	↓	24.2	23.6	18.0
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)	8.0	4.5	<b>4.3</b>	↓	5.2	3.7	2.5
Percentage of students who currently smoked cigars (cigars, cigarillos, or little cigars on at least one day during the 30 days before the survey)	8.2	5.2	<b>2.8</b>	↓	4.0	3.3	3.1
Percentage of students who currently used cigarettes, cigars, or smokeless tobacco (on at least 1 day during the 30 days before the survey)	18.1	12.2	8.9	↓	11.2	8.9	18.7
<b>Alcohol and Other Drug Use</b>							
Percentage of students who ever drank alcohol (at least one drink of alcohol on at least one day during their life)	59.2	56.6	<b>50.4</b>	↓	55.7	50.6	NA
Percentage of students who drank alcohol before age 13 years (for the first time other than a few sips)	14.5	12.9	<b>12.1</b>	=	13.7	10.9	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)	29.1	27.6	<b>23.7</b>	=	28.7	23.7	22.7
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)	16.4	15.6	<b>14.0</b>	=	17.8	14.6	10.5
Percentage of students who usually obtained the alcohol they drank by someone giving it to them (among students who currently drank alcohol)	37.7	NA	<b>NA</b>	<b>NA</b>	NA	NA	40.0
Percentage of students who tried marijuana before age 13 years (for the first time)	5.6	5.0	<b>4.1</b>	=	3.7	3.3	4.9
Percentage of students who currently used marijuana (one or more times during the 30 days before the survey)	15.5	12.5	<b>10.7</b>	=	10.2	12.9	15.8

	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
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)	14.4	14.5	10.2	↓	9.7	11.0	12.2
Percentage of students who were offered, sold, or given an illegal drug on school property (during the 12 months before the survey)	12.1	NA	NA	NA	NA	NA	13.3
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
<b>Sexual Behaviors</b>							
Percentage of students who ever had sexual intercourse	36.6	38.3	36.6	=	36.5	37.1	30.0
Percentage of students who had sexual intercourse before age 13 years (for the first time)	2.8	NA	NA	NA	NA	NA	3.2
<b>Weight Management and Dietary Behaviors</b>							
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)	16.1	16.5	15.6	=	15.5	14.2	16.0
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)	14.9	14.0	16.3	=	17.4	15.0	16.3
Percentage of students who described themselves as slightly or very overweight	31.4	32.6	31.7	=	35.3	32.5	32.3
Percentage of students who were trying to lose weight.	44.5	44.7	21.6	↓	20.8	23.2	54.3
Percentage of students who did not eat fruit or drink 100% fruit juices (during the seven days before the survey)	4.9	6.1	5.0	=	5.8	4.6	7.7
Percentage of students who ate fruit or drank 100% fruit juices one or more times per day (during the seven days before the survey)	61.2	54.1	25.4	↓	21.9	27.0	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)	5.1	6.6	5.9	=	5.3	6.2	9.3
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)	60.9	57.1	61.3	=	60.0	59.3	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)	28.8	28.1	27.7	=	27.1	31.6	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)	16.3	15.9	16.6	=	17.5	13.8	14.7
Percentage of students who did not drink milk (during the seven days before the survey)	14.9	20.5	26.2	↑	21.2	29.4	35.7
Percentage of students who drank two or more glasses per day of milk (during the seven days before the survey)	33.9	NA	NA	NA	NA	NA	NA
Percentage of students who did not eat breakfast (during the 7 days before the survey)	13.5	14.4	15.1	=	14.5	17.3	22.0
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)	2.7	2.8	2.1	=	2.2	2.1	NA
<b>Physical Activity</b>							
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	51.5	49.0	56.5	↑	58.0	55.3	55.9

increased their heart rate and made them breathe hard some of the time during the 7 days before the survey)							
	ND 2017	ND 2019	ND 2021	ND Trend ↑, ↓, =	Rural ND Town Average	Urban ND Town Average	National Average 2021
Percentage of students who watched television three or more hours per day (on an average school day) *In 2021, % of students who played video or computer games was combined with % of students who watch television 3 or more hours per day.	18.8	18.8	<b>75.7</b>	<b>NA</b>	75.8	78.6	75.9
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). ~2021~ questioned combined with previous question regarding television.	43.9	45.3	NA	NA	NA	NA	NA
<b>Other</b>							
Percentage of students who had eight or more hours of sleep (on an average school night)	31.8	29.5	<b>24.5</b>	=	28.3	23.2	22.7
Percentage of students who brushed their teeth on seven days (during the 7 days before the survey)	69.1	66.8	<b>67.9</b>	=	64.5	69.9	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)	12.8	NA	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)	8.3	7.0	7.4	=	8.6	6.8	64.4

# Appendix E – Prioritization of Community’s Health Needs

## Community Health Needs Assessment Stanley, North Dakota Ranking of Concerns

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

	Priorities	Most Important
<b>COMMUNITY/ENVIRONMENTAL HEALTH CONCERNS</b>		
Attracting & retaining young families		
Having enough child daycare services	8	2
Not enough affordable housing	2	
Not enough places for exercise and wellness activities		
<b>AVAILABILITY/DELIVERY OF HEALTH SERVICES CONCERNS</b>		
Availability of mental health services	1	
Cost of health insurance		
Cost of healthcare services		
Extra hours for appointments, such as evenings and weekends	4	0
<b>YOUTH POPULATION HEALTH CONCERNS</b>		
Alcohol use and abuse		
Depression/anxiety	4	0
Drug use and abuse (including prescription drugs)	1	
Smoking and tobacco use, exposure to second-hand smoke, juuling/vaping		
<b>ADULT POPULATION HEALTH CONCERNS</b>		
Alcohol use and abuse	5	0
Cancer		
Depression/anxiety	3	
Drug use and abuse (including prescription drugs)	1	
<b>SENIOR POPULATION HEALTH CONCERNS</b>		
Assisted living options	1	
Availability of home health		
Availability of resources to help elderly stay in their homes	5	7
Cost of long-term/nursing home care	1	

# Appendix F – 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 the above
  - Many have a strong faith life
  - People care about traditional family values
2. Considering the SERVICES AND RESOURCES in your community, the best things are: “Other” responses:
  - None of the above
3. Considering the QUALITY OF LIFE in your community, the best things are: “Other” responses:
  - It’s clean. Not a lot of litter and trash
4. Considering the ACTIVITIES in your community, the best things are: “Other” responses:
  - None of the above
  - Not enough activities for family, young kids, during winter

**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:
  - Need rec center for young people
  - So many run down empty places that should be removed to make our town more cleaned up
  - Lack of suitable healthcare
6. Considering the AVAILABILITY / DELIVERY OF HEALTH SERVICES in your community, concerns are: “Other” responses:
  - None
  - Dialysis unit is needed
  - Healthcare providers need to learn to listen
7. Considering the YOUTH POPULATION in your community, concerns are: “Other” responses:
  - Acknowledgement of nonathletes
9. Considering the ADULT POPULATION in your community, concerns are: “Other” responses:
  - Not enough activities outside of bar life
  - None
  - Safe environments to live in
10. Regarding impacts from oil development in your, concerns are: “Other” responses:
  - To many pets being left behind or just dropped off
  - No activity centers
  - Tax relief for boom in oil
11. What single issue do you feel is the biggest challenge facing your community?
  - Housing and daycare
  - Local people being discriminate and non-welcoming

- Availability of activities for adults and kids. For adults, it seems the only thing to do socially is to go to the bars. This leaves adults with little to no social life or spending numerous evenings in the bar to do something fun. Not a lot of places to eat or hang out. Kids are getting into alcohol, drugs, vaping, etc. With no real activities to keep them busy and out of trouble.
- Stopping drugs from coming in
- Quality teachers in our schools
- Lack of affordable childcare or lack of available childcare in general is a huge issue in our community
- More gym or rec center for younger people is needed
- Meth use
- Creative Conflicts and realignment
- Lack of quality employees, willing to work full time
- Cost of living including house prices.
- increase in crime with population expansion.
- Drugs
- High Housing costs
- Not enough AFFORDABLE childcare & Low wages with inflation of oil makes it hard to live
- Lack of affordable, healthy food in conjunction with very sedentary lifestyle.
- Cost of living
- Drug and Alcohol abuse
- Lack of affordable housing
- The drug abuse
- Locals treating newer people to community as “outsiders” - not treating them the same as everyone else.
- Affordable housing. Rent and home sale prices are obnoxious!
- Lack of leadership (adequate leadership) in our healthcare facility
- Kids activities.
- High costs, lack of workers, lack of good eating places
- Religious
- No grocery store where I live - food desert
- Inflation
- Lack of help....People not wanting to work, instead they live off the system. I am 74 and I work a full time job. The younger people would rather sleep and run around than work.
- No one wants to work anymore.
- Drug / alcohol abuse
- Day to day expense such as groceries.
- We desperately need a facility for the community to utilize for exercise, wellness, additional youth & adult league activities, etc. We have an outdoor pool we can use 2-3 months a year, a baseball complex that can only be used a few months of the year, two gyms that are booked solid most of the time, a tiny expensive fitness center that usually has some broken down machines, an indoor pool & even smaller fitness area, etc. We need a larger, all-inclusive fitness center when people can hold classes (yoga, zumba, pilates, etc.), they can run youth & adult sports leagues (volleyball, basketball, sports kinetics, etc.) & have 24-access to workout equipment.
- Not enough gym space for all the activities. Too many people not contributing to the community, but using resources. Stanley means nothing to them, except a paycheck.
- No restaurants. Many fast foods but need actual restaurants.
- Providing our youth with enough activities that aren't sports related. Stanley used to have dances & a place for kids to hang out. I love how the school teams up with the park board for sports. Even E sport. We are still dropping the ball with the kids who are not sport minded.
- Health care and affordable place for senior citizens

## Delivery of Healthcare

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

- None
- Not enough mental health counseling services

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

- At home degrees and certificates inherited RNs
- My own research
- Trusted on-line resources
- Research
- Myself my holistic education
- Prayer

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

- My own research

17. Are there any new community concerns in the area that is alarming to you? “If yes, please specify” responses:

- People cleaning up their yards
- Vagrants are getting off the train and terrorizing our citizens.
- The amount of unleashed dog services
- Lack of drs.
- Domestic violence and services unavailable to those experiencing this. There’s not much protection!
- law enforcement not doing their jobs
- Drug use & crime
- People are to nosey and they do not care about one another to be so nosey
- Drugs and Bullying-by adults and children
- Lead pipes

19. Mountrail County Medical Center currently has the following specialists coming to our facility: Orthopedics, Podiatry, Hearing, Audiology, OB/GYN. Are there other specialists you would like to see come to Stanley?

- None that come to mind currently
- Unsure
- “Dermatology”
- Dermatology or allergist
- Cardiology, arthritis specialist, GI drs
- Dermatologist
- Veins
- GI
- Surgery and endoscopy! I will work those depts so I can work local. Otherwise I travel out of town for work.
- I would welcome any specialists adding their services. I think that even with a limited schedule it is an amazing benefit to our community.
- Same day surgical suite.
- oncology
- Vision
- Dermatology, Cardiology, Endocrinology, ENT
- pediatrician
- Dermatology
- No
- Mental counseling elderly, adults, and especially children

- Ophthalmology, cardiology, pediatric.
- Same day surgical suite
- “Cardiology, rheumatology, ENT”
- Internal medicine cardiologists
- X-ray specialist
- Mental health
- mental health specialists
- Oncology, dialysis, CT and MRI
- MCHC is the best facility in our area for a small town. We get the best care there and we trust the people working there!
- Hearing orthopedics
- “Oncology Neurology”
- Neurologist Dermatologist
- allergy / pulmonology
- None that I can think of.
- Diabetic counseling
- Pain management specialist
- No

23. Have you supported Mountrail County Medical Center Foundation in any of the following ways? “Other” responses:

- I’m in the process of learning about one
- No
- Donations
- Does it matter:
- None yet

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

- decent health-care
- Mental health and addiction services
- Dietary guidelines
- Mental health services that are not just meds. Like a therapist is needed.
- Same day surgical suite and Colonoscopy
- Smoking Cessation classes - train own staff to do this. Allow the providers to write scripts for medical marijuana use.
- More counselors! We have a couple but one doesn’t take children under 10 and they are very difficult to get into.
- Fitness center
- Hospice
- Postpartum care, lactation counseling
- Humanity toward u welcome out of state or country home owners.
- Tiered cars for those who wish to live independently but will need more care as they age
- Cancer care...chemo.... radiation for those that can’t afford to drive even to Minot for treatment.
- allergy
- Pain management

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

- I would like the ambulance service and the hospital to get along. I would like to see a dermatologist added to the list of specialists.
- Thanks for your interest!

- Concerned about keeping local access. Currently adequate but do not want to lose any services
- Fixed appointments for certain scans.
- More counselors and domestic violence help, such as safe houses. Advocates for those experiencing DV available in Mountrail county, such as the Minot Domestic Violence Center is needed here!
- Walk-In clinic/ extended weekday or weekend hours
- Have a nice day!
- should always have same day appointments available for acute care. Need in-person mental health professionals.
- Continue to add services that will allow aging population to remain in the community. Medical transport options for non-emergency appointments. Better in-home support. More tiered care housing opportunities.
- Could use eye clinic closer than Minot or Watford City